SHAPING OUR FUTURE

Cornwall and The Isles of Scilly Health and Social Care Partnership

Wave 2 co-production workshops

East Cornwall output report

To provide a report of the feedback received from the Wave 2 co-production workshop held on 20 September 2017 at Liskeard Public Rooms.

Contents

Executive summary

This was the fifth in a series of six coproduction workshops that were conducted across Cornwall during September. It was held at Liskeard Public Rooms. A further workshop was held on the Isles of Scilly as follow up to a similar exercise organised by the local authority in June.

All seven of the Wave 2 workshops aimed to build on Shaping Our Future's previous wave of coproduction meetings in July to continue the process of developing options for new place-based models of health and care for Cornwall and Isles of Scilly.

The workshops were attended by health and social care expert practitioners from all sectors (also referred to as local 'experts by delivery') that have direct experience of providing services and support to people. They were joined by people who have had experience of receiving services or those who work within groups or organisations that represent or work with patients and local communities (sometimes referred to as 'experts by experience').

Attendance

39 people took part in the second workshop. They represented 10 organisations filling 33 different roles across health and social care. This included people from three Third Sector organisations, the Shaping Our Future Citizen Advisory Panel (who are also members of local patient participation groups); Healthwatch; Parish and County councillors, and lay members of the work stream working groups. 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 give their thoughts, views and suggestions on a range of topics related to prevention, integrated and urgent and emergency care.

Shaping our future priorities

After the table discussions had concluded, each group was asked to prioritise what they had discussed into priority areas for review by the Shaping Our Future team (i.e. 'hot topics'). The table below summarises the 'hot topics' discussed by participants in East Cornwall.

Priority areas	Comments
Public and Staff communication	Needs to be clear and timely
Integrated Care -	- Housing - Integration social care

Priority areas	Comments
	- Partnership nursing / care homes and agencies ○ e.g., ear syringing, falls → prevent admission - teleassessment / therapy - Opportunities to eliminate duplication – health and social - Harnessing technology for therapy and assessment - Invest in community activities to combat isolation, facilitation of social activities in villages etc. - Quality/content of a single referral, not just process - Not so much high end diagnostics as getting basics right i.e. point of care testing/INR/bloods - Educate/prevention e.g. UTI in care agencies/care homes/community

Urgent Treatment Centre
-
	- Elements agreed. GP led.
	Strategically placed – what factors are considered?
	- Transport
	  ○ Patient services, wheelchair etc.
	  ○ Public
	- Cross-border Devon/Cornwall
	- Leases on buildings
	- Role still for MIUs – seasonal needs

Multi-purpose Community Hubs
-
	- Health promotion, education
	- Social interaction
	  ○ Transport options
	- Specialist access via technology
	Community Makers → signposting
	  – Volunteer Cornwall

Workforce	- Workforce development - Job satisfaction - Retention - GP options – salary and partner Understanding/learning/changes within Plymouth/North Devon - Workforce availability and skills
There are lots of local prevention approaches that are working well!	Communities have a wealth of resource for supporting healthy living and prevention. We need to recognise the value of this resource and support it to reach the population and

Priority areas	Comments
	flourish.
Directory of Services	While it is difficult to maintain a live directory of services, they are extremely important enablers for advertising and accessing the wealth of community resources available. There must be ways to ensure the information is available and maintained. The co-location options being considered offer a means for supporting this. These facilities could provide a focal point for accessing volunteers and community information.
Volunteers	While volunteers may not expect payment, they do deserve to be valued and supported. They provide a significant resource that can support health prevention. If the potential was harnessed in an effective way, it could have a terrific impact.
Things to support prevention and self-care	Make more of: • Natural environment, rurality and community spirit • Towns/parishes – village events, group, website • Health centres – health advice, links to leisure centres, on site pharmacy • Community transport • Shared management between a person and professional • Memory cafes • Integrated health centre in schools
What could we do differently?	• Support the physical health of people with physical disabilities/mental health problems • Intergenerational connections, schools, education • Affordable healthy housing • Flexibility on planning rules to improve health • Focus on areas of deprivation – smoking, food quality • Careers advice etc in schools • Really listen

East Cornwall workshop

Background

The Shaping Our Future programme held a series of co-production workshops with health and care staff, those working in the community and voluntary sector and experts by experience in September as Wave 2 of a programme of expert place-based coproduction. Reports for each of the first wave series of coproduction workshops are available at www.shapingourfuture.info

The coproduction programme is building on Shaping Our Future's previous phases of public engagement that took place over late 2016 and early 2017. They have been designed to provide opportunities for the insight and views of local staff, volunteers and residents to be fully considered in the development of models of care and transformation options for public consultation once this work is completed.

With this in mind, the workshops are not public events, but a series of working meetings specifically to discuss and test out ideas with local experts by delivery and experts by experience. Any final options will be subject to a full public consultation.

Details of the dates and locations of each workshop can be found in Appendix C. However, as coproduction programmes need to evolve to address gaps and work on participants' suggestions as work progresses, this schedule is subject to change.

The co-production workshops form an integral part of the Shaping Our Future programme's commitment to ensuring there is meaningful engagement by:

- Providing appropriate opportunities for local insight and views to be fully considered in the working up of models of care and possible options for public consultation.
- Being open and transparent as ideas progress so that communities and stakeholders can see progress, understand where and how their contributions have been considered and learn more about the challenges and benefits of any service redesign.

The feedback received from each workshop is reported separately so that any feedback and insight gained can be fully considered by all members of the Shaping Our Future partnership whilst taking into consideration the different health needs and challenges faced by different (place based) health and care communities.

Methodology

Dates and locations were set for all three phases of workshops in Cornwall in May 2017 and two were changed in response to suggestions and feedback during Wave 1 – details are available in Appendix C.

Please note that Wave 3 have been deferred from November until the New Year to pull together the evidence base to support our decisions, ensure we have fully reflected on the work already going on in localities and the suggestions people made during the July and September phases of co-production . Information in this report refers only to Wave 2.

Participants

Participants at all Wave 2 workshops were invited from a wide range of expert stakeholder groups including:

- Community nurses
- Community therapists
- Social workers
- Care home managers
- Mental health practitioners
- Learning disability support workers GPs
- Pharmacists
- Paramedics
- Local district nurses
- Community matrons
- Social workers
- Case coordinators
- Occupational therapists physiotherapists
- County and parish Councillors
- Volunteers
- Union Representatives
- Community mental practitioners
- Care home managers
- Health workers (who provide routine support to the frail elderly, people with dementia and people with chronic conditions affecting both physical and mental health.)

In addition, a range of voluntary, Third Sector, community network members, elected councillors, lay experts by experience and union representatives were invited.

39 people took part in the second workshop. They represented 10 organisations filling 33 different roles across health and social care. This included people from three Third Sector organisations, the Shaping Our Future Citizen Advisory Panel (who are also members of local patient participation groups); Healthwatch; parish and county councillors, and lay members of the work stream working groups.

A full list of the roles and affiliations of participants is provided in Appendix A.

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.

An agenda showing the workshop content and structure is available in Appendix B.

Each workshop followed the same format with templates created to facilitate table top discussions and ensure all feedback was gathered consistently.

A range of information was given to the workshop participants at each event:

a) Presentations on the headline themes of what Wave 1 participants had highlighted for priority across Cornwall as a whole; Cornwall's health needs and inequalities; the determinants of wellbeing; and a summary of what participants from the same community said in Wave 1 in relation to prevention. Emerging draft models of integrated and urgent and emergency care were also presented.
b) Information packs
c) Placed based outputs from the Wave 1 workshops

Presentations

To allow time for as much group discussion as possible, presentations were reduced to key/core information, with additional place-based information provided in hardcopies at each table. Presentation slides can be downloaded at www.shapingourfuture.info

Information packs

Information packs were available to facilitate table top discussions at the event and circulated a week before the first of the Wave 2 workshops in response to previous requests from Wave 1 participants to receive information more quickly.

Posters

The outputs from the Wave 1 workshop for East Cornwall were also presented on large posters around the room to share what we had heard and to prompt presenters to explain how this had shaped their thinking.

Equality monitoring data

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

Nineteen participants completed a workshop evaluation questionnaire to help us ensure engagement activities are meaningful, appropriate to the target audience and continuously improving (see Figure 1 below).

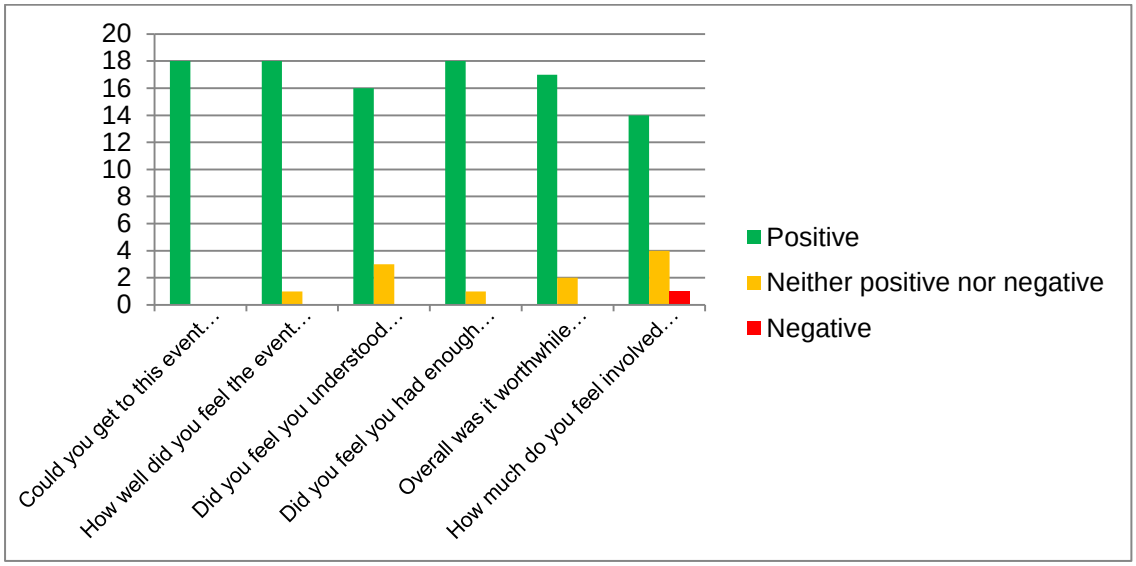

Fig. 1 Event evaluation from East Cornwall

Whilst the overwhelming majority of the feedback received was positive, the following areas for improvement have been noted:

- *It would be good to have water on tables*
- *We could discuss things for longer*
- *It would be good to have more care home managers here*
- *I'd like to see more members of the public there*
- *It's difficult to get staff availabilities - rural – travel*
- *There are no junior staff present as they would not be able to attend evening meetings. The problem is that they want bottom up, but it was really difficult to get that to happen. Slow progress.*

Nevertheless, all those that commented said the venue was good, and most thought the event was well organised and the information presented at the start was helpful.

Table top discussions

During the table top discussions participants were asked questions about prevention, and about the draft integrated and urgent care models that had been presented. In response to feedback received at earlier workshops the total number of questions each table was asked was reduced.

To allow as much discussion time as possible to be dedicated to each of the questions, the room was also randomly divided into two sets of tables so that one set of tables were asked the following questions related to prevention whilst the others were asked questions about Integrated and Urgent Care.

Discussion questions

Prevention

1. What Prevention approaches already work well in this locality?
   - What do you think helps them to work well?
   - Can you think of any initiatives that haven't worked well so we can avoid them?
2. How could practitioners work differently to promote wellbeing?
   - Whose responsibility is it?
3. What support and /or resources would you need to do this?

Integrated and urgent care

1. Has our slide on the integrated care team captured how you are seeing it develop locally?
2. Do we need to add to/change any element in the Urgent Treatment Centre description and are we considering the right factors that will determine 'strategically placed'?
3. What do you think of multi-purpose community hubs? Could it support your local plans? Have we missed any facilities that could be in them?
4. What else could we do to help people stay at home and avoid going into hospital?

At the end of the table discussions, each group fed back the 'hot topics' discussed at their table, summarising what they thought should be prioritised by the Shaping Our Future team.

A broad thematic analysis of what people said during discussions in East Cornwall is summarised below.

Feedback (you said)

Note: Information in quotes below is paraphrased from table top discussion notes and is not verbatim.

Prevention

What prevention approaches already work well

When asked what public health initiatives are working well in East Cornwall a number of interventions aimed at dementia, COPD, smoking cessation, weight loss and reducing social isolation were highlighted.

> *"Dementia Support Workers work closely with Memory Nurses and Social Care teams. They enable social interaction and person centred support planning.*

They provide an effective link into community resources and networks. They support the patient and family/carers. This proactive person (and family) support can help reduce health exacerbations and hospital admissions."

"Turning the Cogs is a charity that supports individuals with dementia that works really well."

"East Cornwall has a specialist respiratory team and multi-disciplinary team well supported by Derriford."

"Healthy Lifestyle Advisers work with self-referred individuals to support healthy living (smoking, physical activity, healthy weight). They also work with schools, supporting teachers to upskill them around sexual health, healthy lunch boxes etc."

"The Council is doing work around Three Conversations that is helping put people back in control to encourage their independence."

"They introduced GP rounds to Care Homes in Looe. Works very effectively. Need to be careful not to turn them into treatment centres (don't introduce tests, e.g., ECGs etc.), but they are very beneficial for patients, for GPs and also for staff at the home. They've been able to reduce the time taken at Residential Home rounds as GP gets to know patients more – less complex cases than Nursing Homes. They've also provided additional training for nurses at the Homes e.g., now trained to do ear syringing whereas beforehand patient would have to see GP."

"A defibrillator machine was recently bought for a local village. The training that was provided within the village bought people together and provided a common interest."

"There is a pharmacy service on site at the medical centre, which helps people who do not have access to their own transport and allows them to collect their prescription if visiting the GP."

"Any social events in rural locations so people can meet others will reduce isolation."

"Liskeard has: Real Junk Food Projects (x2); The Breather group – for people living with COPD; WRVS Library Service and befriending services; and a Memory Café."

"This new leg ulcer club, The Centipede Club, provides valuable social interaction, networking and access to information and services. This can help to alleviate isolation. They're able to treat social needs as well as physical needs, speeds up the healing process. However, transport can be an issue. Community nurses have been collecting patients to bring them to the Centre."

"Active Plus is commissioned to help people who are socially isolated, out of work (55+ age) etc. This project brings people together, work together to complete puzzles, working without sound, for example. It is supporting long term behaviour changes."

"Launceston medical centre offers a fabulous service to its patients. It has good links with Launceston Hospital and is a valued service. The medical centre offers different services within the centre that people can walk in and access, these services are all working towards prevention."

Participants identified a number of sources of information about what is available within the community and stressed the importance of ensuring this 'directory of services' is kept up to date and well publicised.

"Health Promotion also has an Information Line, but its usefulness is dependent on keeping the information up to date."

"Adult Social Care has an online Directory of Services that harvests information from the internet. The site is however not well publicised and can be difficult to navigate. The resource is valuable, but it could be improved."

"Looe Town Council provides a wealth of information for people on their website."

"There are new roles of Community Makers employed by Volunteer Cornwall who link into services and signpost to them. Who are they? Where are they? We didn't know about them at all. How do they link into Community Network Manager? Not clear…"

"Volunteer Cornwall have one Community Maker for each Area (East, Mid, West) and they are working with local groups. But they are not known about by the people providing the services – needs to be better publicised, to staff as well as to public."

"How do people know what is going on in their communities? How do we get messages out and help people find relevant groups/activities/services?"

"Check out the 'Enabling "Living' Community Service Directories."

"'Living Well' started mapping services, but this did not necessarily have information about community events and projects such as gardening clubs, isolation breaking clubs etc."

"What happened to Living Well (East Cornwall integrated care trial)?

Age UK were running and funding via a bequest but the funding ran out and no-one could take it on. Living Well ethos has however informed what we are doing now – to help improve community services and support people at home."

"There is a lot of uncertainty about prevention schemes that are available within communities – whether these are free of charge, have a cost or are run by volunteers."

"The community navigators' role and keeping a live community directory are key."

"People are key to maintaining community service networks/directories. They are active members of the community who are linked into a range of resources. Supporting these volunteers and key community members can enable health and social care services to harness this wealth of support services available."

"EPIC is a network of people who know what is going and on can help make connections between people and services. They provide an effective "live" people network."

Support for health and social care staff was also mentioned.

"Electronic support for health and social care, run by the University. Education through on-line resources. Using social media, apps, websites etc. Using communication channels for staff to make them aware of physical activities that are available to them."

How practitioners could work differently to promote wellbeing

People suggested that initiatives to promote wellbeing and to prevent existing problems from escalating need to be provided where people already regularly visit in the community, and target the young and those most at risk.

"Some people do not see themselves as a patient……..yet. Therefore, the proactive going out and meeting people in different settings needs to be taking advice to the people, different target groups, the male population etc. It is about getting to the "at risk" cohort of the population before they become patients."

"There is still a stigma around people living with Mental Health that puts people off talking about it that we could collectively work to address."

"There is also the primary prevention cohort of people, those who do not have current disorders or disease and who may just be overweight, smokers, inactive etc. It is important to make every contact count – i.e. if someone is seeing a doctor for a blood test, at the same time talk about cholesterol or other social needs. The question is how can this be done?"

"Physical activities tailored to disabled people – outdoor gym."

"Good careers advice in schools to encourage young people to live and work in the local community."

"High levels of deprivation – these people tend to eat a poor diet."
"Ask the voluntary sector to look at fresh ways to engage with the isolated and vulnerable. Age Concern held a Christmas party at a school, but the elderly were not allowed to interact with the children."

"We are all patients of a surgery, but how do we communicate to those who do not attend the surgery ever?"

"Do we know the top 5 solutions for the most benefit? For example, enabling older people to exercise more? Do we know who to target? We need to get out and talk to these people and provide them with the offer of help."

"Would it be possible to develop some initiatives to attract seldom heard groups to Practices for healthcare services, for example, street homelessness? In Plymouth, there is a possession storage facility for homeless people. Would it be possible to provide something like this in Cornwall? This could provide an opportunity for communicating with and supporting this hard to reach patient group (who often have complex health issues)."

"We need shock tactics for those whose health is at risk – free screenings, cholesterol testing, blood pressure bands, heart rate monitors, health campaigns – get the health professionals out and about showcasing to the population in supermarkets, in a mobile van, public libraries, post offices, banks, community centres etc."

"We need to engage people to get more active, but how?

"Earlier education for children. Targeted health and well-being education."

"Target men in particular where evidence has shown that they do not access health services. There are on-line chat facilities already available."

Health staff and large organisations were seen as role models for promoting healthy lifestyle choices.

"Target high employment, low salary industries. Start with the Council and NHS employees (best part of 15,000 employees). Promote a healthy workplace. There is a current programme being driven by the Council. Health professionals need to set good examples."

Largest organisations need to set good examples for food choices – i.e. chocolate/fast food in the main foyers of hospitals is not setting a good example.

Others suggested efforts should be made to change current regulations regarding the sale of unhealthy food and alcohol.

> *"Challenge to Government planning regulations to control/restrict fast food outlets and alcohol."*

The resources needed to promote wellbeing

When asked what additional resources participants thought were needed to promote wellbeing, several discussion comments centred on the key role that volunteers such as patient participation groups can fill.

> *"Volunteers are a tremendous resource and offer a range of skills and experience. They could be supported by practitioners to develop their skills and be more valued. Investing time to support volunteer networks could help expand the skills/capabilities and enable them to be used most effectively."*

> *"Patients working in partnership with professionals is good."*

> *PPG (Patient Participation Groups) could be utilised more. They know their communities.*

> *"Make a devolution case to secure funding to pump prime for prevention measures. Give funding to PPGs/communities to refocus non recurrent monies to improve the prevention deal. It can cover campaign costs, buy in expertise, publicity, equipment etc."*

Increasing access to existing provision and things such as exercise classes was also highlighted.

> *"Exercise classes – for example, aqua aerobics classes. Lack of opportunities and access and not always at concessionary rates. Approach organisations/businesses to ask for extended access and opportunities."*

Others cautioned that some people will never adopt a healthier lifestyle regardless of the approach taken to encourage this.

> *"Recognise that they also need to want to do something. This is secondary prevention."*

For example, transport issues and people's confidence and self-esteem were seen as potential barriers to people maintaining their wellbeing.

> *"People who have access to good transport links are not so isolated, especially when living in a rural location."*

"Local people rely on a community bus service to get to local shops, appointments, social activities."

"If using local transport from Liskeard/Alturnun, it can take 2 hours to get to Derriford hospital for an appointment."

"We live in a beautiful part of the country, but even those living near a beach, a park or woodland do not necessarily go out for walks as they may lack confidence or feel insecure walking on their own. Elderly people can have a confidence issue."

"Local coffee mornings are not always everybody's enjoyment. It depends if they click with other people there or maybe they're naturally shy."

Integrated and urgent care

Integrated care in the community

When asked to comment on the emerging draft models of integrated and urgent care participants were largely supportive of integration.

"People have more than one problem so there needs to be interlinking."

"Networks make it easier to pick up the phone. Conversations and relationships locally are required."

"Integration is challenging to plan and deliver, but we need to focus on that because it's a great idea."

"The plans for co-located community hubs mentioned in the presentations today offer an opportunity for an access point/"hub" for community/voluntary services."

Some people commented on the slides themselves.

"Social Work is not the same as Social Care. The slide said Social Work only, and it should say Social Care."

"The presentation did capture the challenges of developing integration, not sure it captured how to develop it."

Other suggestions pointed to perceived gaps in the integrated care model, such as housing, finance, care homes and telehealth.

"From the social care perspective there are broader challenges which link in via places like the One Stop Shop, e.g., financial, housing etc. – these need to be taken into account when looking at services working with the integration model. We need to make them more accessible – housing is a VERY key issue."

"Add in Care Homes (Residential and Nursing) – in partnership with other services. Care Homes should be able to provide some elements of what is in the model."

"Add Telehealth care."

"How do Care Homes get support?"

"There is a wide variety of Care Home types across Cornwall – some small family-run businesses, some run by large chains. How does the model relate to each of these?"

"Care homes could accept patients back, after fracture etc. for rehabilitation and physiotherapy if there was support and those teams and experts took the lead."

"Verification of death for care homes is scary stuff. The model could do something to make that better."

Participants also discussed a number of ways that current provision could be widened or improved such as expanding the range of services provided in General Practices, care homes, community centres and schools.

"Would it be possible to enable easier access to a range of services in General Practice, not just through your own registered practice. This flexible primary care provision would need to be supported by access/transfer of patient information between practices."

"I like the idea of "pop-up" services linked to local community centres – can be used for certain types of interventions in smaller villages."

"Combine GP Surgeries with Community Centres? Practical? Could be a good opportunity?" - "But given that reforms have mostly been about upscaling, it's unlikely that delivery of services in a small community centre would be considered practical /desirable/cost effective. Is it even worth discussing it?" "- It is worth discussing health promotion, local groups, whether small hubs can reduce social isolation issues; multiple services provided from larger hubs don't necessarily have to mean nothing is provided from smaller "pop-up" services in rural areas."

"Social prescribing – give more opportunities for voluntary sector to get involved via local hubs in community settings."

"Integrate Health Care, provide a service in schools."

"Do I really want a Mental Health Crisis Café in my GP surgery? No – it would be too many mental health patients impacting on our resource, we can't manage

that." - "But surely that's not how it would work – it would be alongside the GP surgery, not part of it – and the MH patient would go to the café not attend the surgery and take up GP surgery resource."

Workforce development

Training and empowering staff to blend and widen existing roles was also highlighted.

"Workforce development is essential – to ensure the workforce has the right skills to deliver the roles required and to ensure the jobs we need can be filled. Training takes time to set up and embed – whether new roles or upskilling existing – so need to review and sort it now or it won't be ready for new model of care."

"We need to empower Care Home staff to not have to go direct to GP but feel they can make some decisions themselves. Training, development and responsibility. Make them feel "professional" and not as though they are the lowest rung of the ladder. CFT were providing training for handling things like epilepsy – is this still happening?"

"SaLT teams tried to provide training in swallowing dysfunctions to Homes but staff didn't attend. Engagement is an issue anyway – Homes don't tend to respond very well to commissioners so getting them engaged in this could be tricky."

As in Wave 1, the importance of having information sharing agreements between different organisations and a single point of access to help people navigate their way through the integrated system was also stressed.

"Single contact point to reduce hand-offs and referrals is a good example. Would be much better."

"You need one person to take a referral and signpost."

"If there was a single point of access the members of the multidisciplinary team could refer. Referrals should be robust and be clear what is being referred for and to include what it is that they want to achieve. There could also be a conversation."

"Confidence in information sharing is an issue as already quoted on one of the posters provided at the Co-production session. Patients not having to provide their information multiple times, but it would require patient confidentiality."

"Having the right people and information on the referral is key."

Participants also urged the team to work more closely with Devon STP to consider people from East Cornwall who routinely access services over the border.

> *"The Derriford Ambulatory care unit was being reviewed. Cornwall had not been invited to those discussions."*
>
> *"Liskeard, Launceston, Looe and Saltash need to link with Derriford"*
>
> *"The model shouldn't be too Truro-centric as the bulk of work from the East goes to Derriford. It is disappointing to see no one from Devon is at the workshop.*
>
> *"Shaping our Future plan to have a meeting to discuss all workstreams and that would include Derriford."*
>
> *"Would the UTCs link to MAU? Is there a case for Liskeard to be a top size hub or was it too close to Derriford? How do Devon's plans affect Cornwall's?"*
>
> *"Stratton would have a relationship with Northern Devon so that needs to be considered." "Devon has said there would be no changes to the emergency offer at Northern Devon Hospital. So there is nothing planned that would impact on Stratton."*

People also stressed the importance of listening to the ideas of people who use services and those who have already completed similar work elsewhere.

> *"What can we do to learn from others who have done this or approached this? This is not just happening in Cornwall it is being proposed generally but may not be imminent."*
>
> *"People need to listen – for example at a meeting about Self Care at County Hall COPD 'gaps' were suggested with scanty evidence to support it. There was a lack of knowledge and there were delegates there who knew the facts. You need to talk to the people who know first."*
>
> *"Go into services and speak to people to capture ideas."*

As in Wave 1, people questioned whether there were enough resources to deliver the new models.

> *"If Cornwall is to be used as a "guinea pig" for merger of health and social care we need to be careful. Although this sounds good in principle and seems to make sense, this will only work if money isn't cut. This needs to be based on investment and to be certain that services will be better quality."*
>
> *"This is presented as a merger, but then we're told we have to find quarter of a billion in savings. That was not a good way to present it so now it is presented as 'if we keep doing what we have been doing, this is what it will cost. We don't*

have this money so we need to do things differently.' But do we have enough to do it differently?"

"We need to keep asking for more money, but we need to also demonstrate that we are making the most of what we have – working more efficiently and reducing duplication etc. as well."

Urgent and emergency (unplanned) care

During the introductory presentation the urgent care workstream described the emerging draft model using a shopping analogy involving 3 levels of service (shop) that offer different types of support based on the severity of people's symptoms. For example, people may want to be able to use (the 'Express') for quick support to manage less severe symptoms (as they do now for services provided by primary care teams, local pharmacy and some minor injury services). As people need to use these services more often they would need to be available for people residing within relatively small, strategically placed footprints.

As participants in Wave 1 said that they believe patients expect to travel further to access support for more serious non-life threatening symptoms than the Express service can provide, the 'urgent treatment centre' (UTC – 'the 'superstore') would provide everything currently provided by an Minor Injuries Unit (MIU) as well as providing other non-life threatening urgent care needs for communities that live within larger strategically placed geographical footprints. Similarly, Wave 1 participants said people are willing to travel even further for support that is more highly specialised when their symptoms are life threatening or very acute and this would be provided by the accident and emergency department of an acute hospital (i.e. 'Superstore Extra') to provide services for a much larger population than a UTC or Express service.

The aim is that by creating more opportunities for people to access support currently provided by GPs and A&E the new model will reduce the pressure on these services.

When asked what participants thought of the emerging draft model for urgent and emergency (unplanned/unscheduled) care some participants highlighted the benefits of the emerging model.

"The model increases what can be done and reduces hand-offs to Derriford for patients. Potentially saves extra journey if someone can't be treated at the UTC and they can find this out beforehand."

"The opportunities to co-locate sound great in principle, but how many and where is the contentious issue."

Others highlighted the potential impact on other services and stressed the need for a managed transition period.

"Services need to continue, nothing will happen overnight. There will be transition and impact on current services."

The express option

In terms of the express service, some discussions centred on aspects of the model that are already being provided and how practitioners could work differently.

"Are they doing this in some larger practices already? St Austell and Plymouth?"

"Liskeard had x-ray provision anyway and Derriford had a CT scanner. However, x-rays were not being reported quickly, specialist back up was required."

"Starting with Urgent Care there are little things going on already, but who has got a handle on everything?"

"Would pharmacy be involved? Support can come from them too. They can note / pick up drug interactions."

"Revisit the GP model – not all GPs want to be partners and often this is all that's available. Some are happy to be salaried."

The 'Superstore' (Urgent Treatment Centre/large community hub)

Participants could see a number of benefits to the urgent treatment centre model and suggested a number of services that they could provide.

"Minor Injury Units (MIUs) were more effective when they had doctors."

"A GP at Urgent Treatment Centre (UTC) could be in the background – available for consultation while they get on with other things."

"The UTC needs to include minor illnesses to be most effective."

"Should it be a mini-A&E? Not quite that extensive - no trauma provision needed."

Travel

In terms of where UTCs should be located people urged us to have regard for travel times, distances and parking, and position facilities based on population needs and levels of deprivation.

"The description of the UTC was quite good but strategic placement will be the challenge. For example, Liskeard and Stratton are 37 miles apart but travel time is 1 hour because of the route. In that case, many people would probably just call an ambulance."

"For Saltash residents the Cumberland centre has x-ray 7 days a week until 9.00 pm and is located in Devonport. However, the cost of the toll bridge is an issue for people on low incomes."

"In terms of strategically-placed – travel times and distances can't be used generically when compared to other areas. It takes longer to travel certain distances in Cornwall depending on type of road. Distances may look the same but time is not comparable. Summer is different to other times of year."

"Sphere of accessibility" is more important. We have little or no public transport and taxis are very expensive. Take into account layers of transport – what is available to whom, where."

"Patient transport criteria has got more restrictive – wheelchair users who don't need medical intervention are not entitled to patient transport, have no access to public transport so have to take expensive taxis as there are no alternatives."

"If Liskeard Hospital was to become an Urgent Treatment Centre teams might move. Would make sense for it to be a UTC, however there would not be enough car-parking."

"Which conditions and patients need what facility most? Bloods and point of care testing are probably more useful to have in a UTC than a CT scanner. The CT scanner in the West was used, so there should be one in the East, perhaps Bodmin or St Austell."

"It would be interesting to compare a UTC against the Robin Assessment Unit. It only had limited diagnostics and no transport links. It was understood to be very underused. It would be of interest to know how well that was used and view the latest data. It is unclear whether Plymouth GPs referred to that unit. It would have been good to have Kevin Baber present to discuss that issue. It was suggested that the unit was very expensive and it was being moved to the Derriford site to link with the acute GP service."

"Transport links remain an issue – smaller hubs of services could definitely increase social interaction and decrease isolation but transport links have to be in place for people to get to them and be able to use them."

"Bodmin and Liskeard are 15 miles apart, but cover areas above and below. The geography of North and East Cornwall is a challenge."

"People manage to get to shops, supermarket etc. with no transport but they can't come to the GP, who has to do a home visit." "Perhaps there are community buses laid on to get people to supermarkets for shopping, though?"

Hence, some participants suggested we work with patient transport services before deciding the location of UTCs.

> *"Are we asking SW Ambulance Services (SWASFT) for their views on location? – Yes and they are very keen on UTCs as it provides an alternative "disposal" route."*

> *"You need to take into account cross-border access too – cross border transport and use of facilities need to be mapped."*

Other considerations include the estates needed to provide unplanned services from and seasonal fluctuations in population size.

> *"Some of these things sound great but buildings have leases/are under contract. How do we manage this? Have to keep paying even if vacate, for the duration of the lease. Need to phase in what is pragmatic/possible - no big bang approaches – taking all this into account."*

> *"There is more to a hospital than the building, but buildings are important."*

> *"Are there grounds for having MIUs in certain places as well as UTCs – e.g., Newquay needs an MIU in the peak season to cope with tourists but does it need one outside this time? Is it feasible to run an MIU part-year? What do you do with the workforce when MIU isn't open? What about the patient who goes to the site in the winter because s/he doesn't realise it's not open? Even if we like the idea of a "pop-up MIU" on the beach, it may not be practical!"*

Capacity and workforce

Several tables also discussed the pressure on practitioners' capacity to be able to deliver the emerging draft models of care, which participants suggested would need more people to deliver than currently.

> *"I would like to see Consultants from Acute hospitals come to Community hospitals for some of their work. Is this feasible? Could save admission to hospital." "It's not practical – not enough consultants, not enough time, travel time is too high, and their capacity is stretched as it is."*

> *"There were workforce issues at the acute hospital as well."*

> *"There is an element of requiring more people. If Liskeard had a slightly larger District Nursing Team, with links to local groups, cafes, armchair exercises etc, that would be something that wouldn't take a whole tribe of staff."*

> *"Acute Care at Home Services are too stretched."*

> *"There is a lack of GPs, NHS Dentists and Bursaries to train new nurses."*

"With regard to patient flow, the problem is not just with the Emergency Department, but a lack of social care too."

"In East Cornwall there was no Geriatrician, due to Livewell South West workforce issues."

"Community Matrons can support care homes but would not necessarily support nursing homes although they could, but there aren't enough of them."

"Therapy services, rehabilitation teams, home first team and specialists were not fully joined up and had waiting lists because they couldn't meet demand."

"The Community Matron role in providing appropriate rehabilitation was only available to the most frail and complex patients. Meanwhile people under the critical threshold could be getting worse."

"Community beds were overused locally."

"Staff can't do any more."

This was thought to be further compounded by expected increases in population.

"Liskeard infrastructure was currently 2 GP surgeries for 23,000 patients (with Pensilva that was 27.000) for that cluster. Liskeard was due to have hundreds of new houses, with no new dental, GP or hospital services, no new residential homes and no investment in domiciliary care. No investment in schools and cutting back on health visitors. The community teams had not had significant investment and there were vacancies."

"There could be an increase of 3,000 or 4,000 in the population, with the number of Community Matrons staying the same."

Thinking digitally

As in Wave 1, some participants suggested increasing the use of digital technology to increase access and free up capacity by reducing travel time.

"Improved/increased use of technology – get smarter about services offered where and how. - But – does lead to the question of whether they could do any of their work remotely, via video calls etc?"

"SaLTs have been using tele-therapy e.g., Skype to speak to patients, this could work for care homes too in some instances - for connection to other services. BUT – broadband not universally available, not all Care Homes have it."

"Can some interventions/consultations be delivered remotely? Some genuinely have to be hands-on but some are just talking – this could be done via video calls."

"Can access to some specialist services be brought to the hubs through improved and increased use of technology? To do certain observations, tests etc?"

Others questioned whether existing staff have all of the skills they would need and suggested implementation plans would need to include resources and time to provide training.

"If MIUs were turned into UTCs, GPs and nurses would need upskilling."

"There needs to be a standard of competency that NHS staff are comfortable with when placing patients in nurse-led homes."

"Sicker patients are being put back in the community with visits from Community Matron or Acute Care at Home. Other carers have very little training and they need it."

"Training takes time – whether for new people coming in or upskilling existing workforce. Need to review it now otherwise too late to deliver the new model of care."

The recruitment and retention of existing staff was also seen as crucial.

"Recruitment problems could impact on the amount of services at the hospitals."

"Care sector recruitment is an issue, low calibre applicants, with the good staff tending to move around."

"How will it work with staffing smaller hubs? Is it really practical? Each one needs a back-up, administrative-type workforce – reception etc. – to make it a viable place to go for patients, especially if it's offering lots of services. That's a lot of people who need to be recruited."

"I have a fully recruited team, but the team has not been revamped, we just focus on trying to retain staff.

"Invest in the well-being and job satisfaction of the workforce: if we have a satisfied, happy workforce it will be easier to deliver the integration and other changes we need to happen and recruitment may not be such an issue."

"Recruitment –we know there are hot spots e.g., GPs, midwifery etc but we have also seen investment in roles such as generic support workers for Home First."

"The MIU staff at Launceston are awesome – they deal with whatever comes through the door from a sick febrile child to someone with chest pains, which were not Minor injuries. People think 'hospital' so go there (1hr from Derriford) and often people can't get to see the GP."

Participants also gave examples of where current urgent and emergency care services could be improved.

"Another problem was patients being discharged too soon then being readmitted."

"Can nurses do assessments which would prevent hospital admission?"

"Access to GPs from Care Homes remains inconsistent across the patch so at times they refer to A&E by default. It can get very messy where multiple GP surgeries deal with one home."

"As a patient, I was incorrectly triaged by OOH, sent to my GP and then on to Derriford for CT scan (6.30 pm to 2.00 am)."

East Cornwall's Headline Topics

After the table discussions had concluded, each group was asked to prioritise what they had discussed into priority areas for review by the Shaping Our Future team (i.e. 'hot topics'). The table below summarises the 'hot topics' discussed by participants in East Cornwall.

Priority areas	Comments
Public and Staff communication	Needs to be clear and timely
Integrated Care	- Housing - Integration social care - Partnership nursing / care homes and agencies ○ e.g. ear syringing, falls → prevent admission - teleassessment ./ therapy - Opportunities to eliminate duplication – health and social - Harnessing technology for therapy and assessment - Invest in community activities to combat isolation, facilitation of social activities in villages etc. - Quality/content of a single referral, not just process

Priority areas	Comments
	- Not so much high end diagnostics as getting basics right i.e. point of care testing/INR/bloods - Educate/prevention e.g. UTI in care agencies/care homes/community
Urgent Treatment Centre -	- Elements agreed. GP led. Strategically placed – what factors are considered? - Transport o Patient services, wheelchair etc. o Public - Cross-border Devon/Cornwall - Leases on buildings - Role still for MIUs – seasonal needs
Multi-purpose Community Hubs -	- Health promotion, education - Social interaction o Transport options - Specialist access via technology Community Makers → signposting – Volunteer Cornwall
Workforce	- Workforce development - Job satisfaction - Retention - GP options – salary and partner Understanding/learning/changes within Plymouth/North Devon - Workforce availability and skills
There are lots of local prevention approaches that are working well!	Communities have a wealth of resource for supporting healthy living and prevention. We need to recognise the value of this resource and support it to reach the population and flourish
Directory of Services	While it is difficult to maintain a live directory of services, they are extremely important enablers for advertising and accessing the wealth of community resources available. There must be ways to ensure the information is available and maintained. The co-location options being considered offer a means for supporting this. These facilities could provide a focal point for accessing volunteers and community information.
Volunteers	While volunteers may not expect payment, they do deserve to be valued and supported. They provide a significant resource that can

Priority areas	Comments
	support health prevention. If the potential was harnessed in an effective way, it could have a terrific impact.
Positives for prevention and self-care	• Natural environment rurality and community • Towns/parishes – village events, group, website • Health centres – health advice, links to leisure centres, on site pharmacy • Community transport • Shared management between a person and professional • Memory cafes • Integrated health centre in schools
What could we do differently?	• Support the physical health of people with physical disabilities/mental health problems • Intergenerational connections, schools, education • Affordable housing • Flexibility on planning rules to improve health • Focus on areas of deprivation – smoking, food quality • Careers advice etc in schools • Really listen

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 development of the improved models of care and transformation options that will subsequently be consulted on by the public.

Feedback is being considered by:

- The Shaping Our Future New Models of Care Group
- The Shaping Our Future Portfolio Board
- The Shaping Our Future Transformation Board
- The Shaping Our Future Clinical Practitioner Cabinet

Glossary

111	The NHS 111 Service is the NHS non-emergency number. When you call 111 you will speak to a highly trained telephone adviser, supported by healthcare professionals (nurses or paramedics) who will advise you what to do in response to any symptoms you are experiencing.
Accountable 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 mode, but 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.
A&E	Accident and Emergency
Bariatrics	Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity.
Better Care Fund	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 Connectedness	At an individual level, community connectedness

(also called social connectedness)	involves the quality and number of connections one has with other people in a social circle of family, friends, and acquaintances. Going beyond these individual-level concepts, it involves relationships with beyond one's social circles and even to other communities.
Community Connectors	Community Connectors are a network of volunteers are 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.
CIOS	Cornwall and Isles of Scilly
Cornwall's Health and Social Care Overview and Scrutiny Committee	This Committee is part of the structure of the council's democratic services department. It has responsibility for the 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
CQUIN	Commissioning for Quality and Innovation. These are schemes linked to NHS Trust payments; these schemes are focused on improving quality or innovation within NHS Trusts. Some of the schemes are set Nationally and the rest are set at a regional / local level.
Delayed Transfer of Care	A delayed transfer of care occurs when a person is well enough to be discharged from hospital, but is still occupying a bed.
Direct Payments	Direct payments are local Health and Social Care Trust payments for people who have been assessed as needing help from social services, and who would like to arrange and pay for their own care and support services instead of receiving them directly from the local Trust.
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.
DoS	Directory of Services
Early Intervention Service	The Early Intervention Service is provided by Adult Care, Health and Wellbeing, Peninsula Community Health and partners, and is an early intervention service that works with adults of all ages with a physical need. 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)
EPIC	Ehealth Productivity and Innovation is dedicated to improving the use of technology in both health and social care, aiming to improve the health and well-being of people in Cornwall and Isles of Scilly as well as the Cornish economy.
Fermentable Oligosaccharides, Disaccharides, Monosaccharides and Polyols (FODMAP)	FODMAPs are short chain carbohydrates that are poorly absorbed in the small intestine
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.
Information Governance	Information Governance refers to an organisation's rules that dictate what information can and cannot

	be shared between organisations and professionals within organisations.
In-patient beds	An in-patient bed is a hospital bed or hospital cot that is provided for hospitalised patients who need to stay in hospital overnight.
Institute of Healthcare Improvement (IHI)	A not-for-profit organisation based in Massachusetts, that focuses on motivating and building the will for change, partnering with patients and health care professionals to test new models of care, and ensuring the broadest adoption of best practices and effective innovations.
MIU	Minor Injuries Unit
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.
Motivational Interviewing	MI is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with non-directive counseling, it's more focused and goal-directed in which therapists attempt to influence clients to consider making changes.
MSK	Musculoskeletal
OOH	Out of hours services - Outside normal GP surgery hours you can still phone your GP practice, but you'll usually be directed to an out-of-hours service. The out-of-hours period is from 6.30pm to 8.00am on weekdays and all day at weekends and on bank holidays.
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 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	Patient Participation Groups (PPG) within General Practices have been in operation since 1972. At lMid 41 percent of General Practices in England and Wales have a PPG. 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).
Personal Independence Payment (PIP)	The scheme is replacing Disability Living Allowance, and is aimed at people who are aged between 16 – 64 who have a long term health condition or disability. For more information on PIP please visit https://www.gov.uk/pip.
Pokemon Go	Pokemon Go is a Free to Use App that encourages users to go hunting for Pokemon using their phones.
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.
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.
Single Point of Contact	A single point of contact (SPOC) is a person or a department serving as the coordinator or focal point of information concerning an person in need of health or social care.
Social Prescribing	Social Prescribing is about linking people up to activities in the community that they might benefit from. It's about connecting people to non-medical sources of support. There is increasing evidence to support the use of social interventions for people experiencing a range of common mental health problems.
Statutory Services	Health and social care services that must be provided by law such as NHS and social services.
Step Down	Step Down services refer to services that people are referred to when they no longer need acute care.
STEPS	STEPS stands for the short term enablement pathway service. These teams are there to ensure people are supported to remain or regain their independence after a period of illness.
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. Ours is called Shaping Our Future.
The 3 Conversations (3C) 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.
Unplanned Care	Unplanned care refers to urgent and emergency healthcare which is not a programmed (scheduled) activity. E.g. A&E, ambulance services, emergency social or mental health services, urgent care, out-of-hours, walk-in centres, minor injury units, telephone advice and triage, NHS Direct, etc.
UTC	Urgent Treatment Centre
WRVS	Women's Royal Voluntary Service

Appendix A: East Cornwall Wave 2 participants

Liskeard Public Rooms, 20 September 2017

	Total number		
People who attended (regardless of role):	39		
Organisations represented:	9	CFT RCHT NHS Kernow NHS England Cornwall, Town and Parish Councils GP Practices and Care homes • Old Bridge Surgery • Eventide Care Home Voluntary Sector • Alzheimer's Society • Volunteer Cornwall	9 reps 1 rep 5 reps 1 rep 13 reps 1 rep 1 rep 1 rep 1 rep
Lay people (include HW PPG and CAP members in this)	3	CAP member Experts by Experience Healthwatch Cornwall	1 rep 4 reps 1 rep
Professional roles represented		Acting Director of Public Health Admin Support Adult Social Services Alzheimer's Society CAP Member Care provider Chief Executive Community Maker Community Matron County Councillor County Council staff Director for Integrated Care Director of Strategy and Business Development Expert by experience General Practitioner Head of Service, Adult Care and Support Health Promotion Human Resources Launceston Community Hospital Doctor	1 rep 1 rep 1 rep 1 rep 1 rep 1 rep 2 reps 1 rep 1 rep 3 reps 1 rep 1 rep 1 rep 5 reps 1 rep 1 rep 1 rep 1 rep 1 rep

	Total number		
		Locality Director Locality Manager One Vision OT Team Lead Parish Clerk Parish Councillor Patient and Public Involvement Assistant Programme Manager Social Care Stroke Speech and Language Therapist Town Councillor Workforce Systems, Data and Planning Lead Workforce Transformation Facilitator	1 rep 1 rep 1 rep 1 rep 1 rep 1 rep 1 rep 1 rep 1 rep 1 rep 1 rep 1 rep 1 rep

Appendix B: Workshop agenda

Agenda for September Co-production Workshops

Time	Min	Activity
6:00		**Arrival and registration**
6:30	20	**Welcome, housekeeping and introduction**
6:50	10	**Presentation:** Prevention and self-care
7:00	20	**Presentation:** Urgent and integrated care

Group work

		Conversation 1	Conversation 2
7:20	60	Prevention and self-care	Urgent and integrated care

Feedback and close

8:20	30	Feedback
8:50	10	Next steps and close

Appendix C: Workshop dates

All meetings will take place between 6pm and 9pm.

Refreshments will be provided.

July
10 – Marazion Community Centre (West Cornwall (Includes Penzance, Hayle and St Ives)
11 – Heartlands Centre (West to Mid Cornwall (Includes Helston, Camborne and Redruth)
13 – Liskeard Public Rooms (East Cornwall (Includes Liskeard, Launceston and Saltash)
17 – Knowledge Spa (Mid Cornwall (Includes Truro and Falmouth)
19 – Bodmin Shire House Suite (North Cornwall (Includes Bodmin and Bude)
20 – St Austell Print Centre (Mid to East Cornwall (Includes St Austell and Newquay)

September
5 – Heartlands Centre (West to Mid Cornwall (Includes Helston, Camborne and Redruth)
6 – Penwith College, Zennor Building (West Cornwall (Includes Penzance, Hayle and St Ives)
7 – St Austell Print Centre (Mid Cornwall)
12 – Truro College (Mid Cornwall (Includes Truro and Falmouth)
20 – Liskeard Public Rooms (East Cornwall)
21 – Council Chambers (Isles of Scilly)
26 – Camelford Hall (North Cornwall)