Wave 2 co-production workshops

West Cornwall output report

To provide a report on the feedback received from the Wave 2 co-production workshop held on 12 September 2017 at Penwith College, Penzance.

Contents

Executive summary

This was the second of a series of six coproduction workshops that were conducted across Cornwall during September. It was held at Penwith College, Penzance. A further workshop was held on the Isles 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 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

43 people took part in the second workshop. They represented 16 organisations filling 33 different roles across health and social care. This included people from five Third Sector organisations, members of the Shaping Our Future Citizen Advisory Panel (who are also members of local patient participation groups); 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 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 & 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 West Cornwall.

Priority areas	Comments
Speed of response	Importance of speed of response across all services.
Urgent Treatment Centres (UTCs)	How will UTCs be staffed, GPs not doing trauma is a limitation.

Priority areas	Comments
Community Services	It's the community services that are needed, including transport and packages of care.
Existing services	Lots of services already exist in Penwith and patients already know where they are.
Geography	Wellness and creating healthy environments.
Education	Using the schools to educate younger people about the positives of activity and wider health.
Employee volunteering	Half day off work to enable staff to volunteer.
Communication	Media and publication so that the public are aware of the wider issues around health and inactivity.
Motivation	What motivates people?
Supermarket analogy	Not useful and potentially confusing.

West 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 patients who have had direct and recent experience of receiving care in September as Wave 2 of a programme of staff and local 'expert by experience' 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 clinical staff and patients 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 (practitioners across all parts of the health and social system and from all sectors) and experts by experience (people who live in the community who have recent experience of services or represent the people who live in the community in some way). 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 also 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 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
NHS Chief Executive
Citizens Advice Panel
Social workers
Care home managers
Mental health practitioners
Learning disability support workers GPs
Pharmacists
Paramedics
Local district nurses
Cornwall Hospice Care
Nurse managers
GPs
Health Promotion
Healthwatch Cornwall
One Vision
Director - Strategy and Development
Community matrons
Social workers
Case coordinators
Occupational therapists physiotherapists
Community mental practitioners
Care home managers
Locality Manager
PPE Manager
Portfolio Manager
Practice Educator, Adult Social Care
Cardiac Specialist Nurse
Workforce Transformation facilitator
Health workers (who provide routine support to the frail elderly, people with dementia and people with chronic conditions affecting both physical and

Pathology Service Manager mental health)
Director - Primary Care

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

In total 43 people representing 16 organisations and filling 33 different roles attended in West Cornwall. This includes people from five third sector organisations, two members of Healthwatch Cornwall and one member of the Shaping Our Future citizen advisory panel (who are also members of local Patient Participation Groups.

A full list of the roles and affiliations of people who attended 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 2 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 West 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.

Fourteen 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).

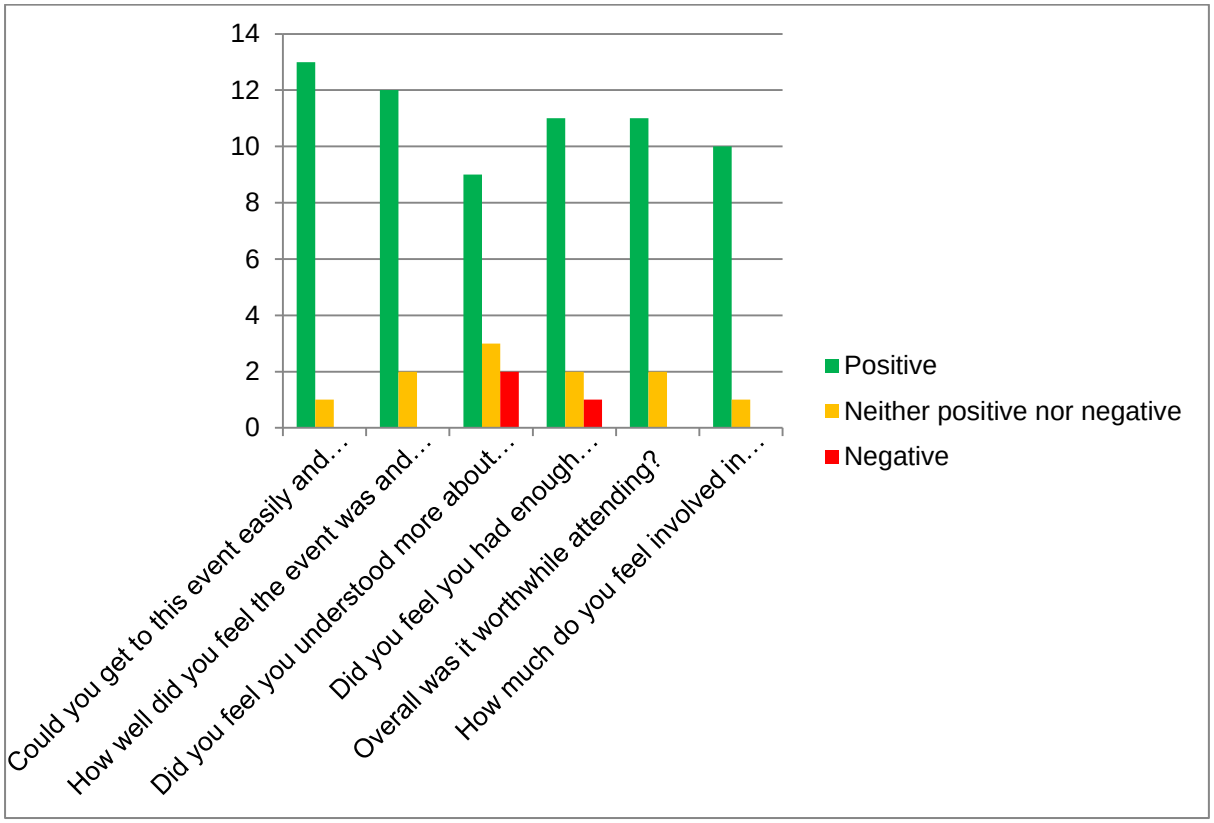


Fig.1 Event evaluation from West Cornwall

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

> *"I felt it was over organised. I would prefer to see all the tables addressing the same questions about, for example, priorities or specific issues instead of asking too many detailed questions. Leads to people feeling constrained to discuss*

issues they don't feel very strongly about, but prevents them from voicing those issues they believe in strongly - that reduces the commitment to the output."

"*I felt constrained by being required to address your agenda items rather than urgent priorities I would have liked to hear other people's ideas about.*"

"I hope this approach will be vindicated by maintaining transparency throughout, but it will be a challenge to the prevailing management culture of all the organisations involved."

"The whole agenda felt loaded towards exploring very acute clinical perspective that did not feel at all connected to representation of the needs of the local population."

"*I feel that the questions asked were very specific and driven by an acute sector agenda and did not take note of all the work/engagement/development that has been happening in Penwith for many years. Simplistic model of proposed hub service. Did not consider mental health, proportion/prevention children's services. Much of what is proposed - ECG!!! - available in every GP surgery."*

"I thought the 2nd half tasks were too complicated – fewer, bigger issues would have been a better target. ie. use a more robust, less managed process."

Table top discussions

During the table top discussions participants were asked questions about prevention, and the draft integrated and urgent care models that had been presented.

As the team had a considerable number of questions they wished to ask participants, the room was divided into two sets of tables so that one set of tables were asked questions related to prevention whilst the others were asked questions about Integrated and Urgent Care. Where time allowed, people at prevention tables were asked to answer questions 6, 7 and 8 of the Integrated and urgent care questions below.

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?

Participants sitting in the second half of the room were asked to answer as many of the following questions as they could within the available time.

Integrated and urgent care

1. What do you think of the emerging model?
2. What injuries or conditions could the express option be used for?
3. Who could use the 'Superstore' (Urgent Treatment Centre/Large Community Hub) to get help from a GP with access to x-ray, point of care testing, CT scanner?
4. Who else could use the 'Superstore' (Urgent Treatment Centre/ Large Community Hub if there was access to a specialist consultant either remotely for advice or on site?
5. What would you describe as the current purpose of inpatient care in community hospitals – do we offer good step up care and good rehabilitation?
6. Do we need a 'supermarket' level and if so what for?
7. What other additional services could be provided from a 'super hub' to avoid admission to either Treliske or Derriford?
8. Given that some people in our hospitals do not require on-going medical care what alternative services need to be in place for them to avoid going into hospital e.g. do we need short term 'observation' beds?

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 West 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 in this community?

When asked what public health initiatives are working well in West Cornwall a number of interventions aimed at mental health, exercise, diabetes prevention, yoga, and solution focused therapies based on the Three Conversations model were mentioned.

> *"Bloom (mental health project in schools) Liskeard breathers group, Lions Club glucose fingerprint testing, the singing for breathing pilot are all working well."*

"Walking buses (collecting children to walk to school)."

"Solution focused interventions like Three Conversations (for children and adults)."

"They have good programmes in Scotland getting children to run a mile a day."

"Staying active campaign via leisure centres for NHS / Council CFT staff."

"'Self-help' initiatives in the community like yoga etc."

"Let's involve Pirates rugby; gig rowers; surfers and clubs; pedometers; get active challenge (they could be prescribed by health); use of a smart phone."

"You can use resources in community for community resilience, use local neighbourhood plans."

"Day hospitals for physio / feet checks / meal / social interaction via transport or pick up etc."

"'Shared Lives' approach in Penwith move to support living in a home with foster/carers. Could also be scheme for students with adequate screening?"

"In Children's Learning Disabilities Services there was a call to look at alternate arrangements in the social work assessment model with a view to look at early intervention and prevention. The priority for Cornwall was to prevent escalation of cases into statutory social work as this proves costly, not helpful and usually a traumatic experience for the patient. Parent volunteers are involved in supporting change in partnership. There are solution focused interventions with a goal orientated process and interventions are time limited. Usually three issues are identified and steps will be put in place to monitor progress. There was a family used as part of the pilot; the daughter was transported to and from school. She had challenging behaviours (self-inflicted scratching) as a result of sensory triggers during the journey such as breaking/lights/noise. So the goals were set up around supporting the parents to manage anxieties. The behaviours were reduced to 1 and 2 behaviours for that journey. The parent feedback was that they had found the interventions to be really helpful. They were referred into the services and within 5 working days could be seen. The pilot commenced in October 2016 and has been extended and formalised. Three workers were employed initially and this has been increased to six and we are now looking for ten volunteers. There has been a measured reduction in the caseload number as well as the model proving to be more cost effective. The Audit Commission have recognised the model as good practice and innovation and are involved to support measuring outcomes."

"There are similarities with a Penwith pioneer (Living Well) during which Age UK would go out and have a guided conversation around what the patient and family

needs are. There was evidence that there was a reduction in reliance on social and health care. People would become more empowered, motivated and active. People managed their long term conditions better and there was real solid evidence to support it. Age UK would recruit volunteers and they would be co-located with District Nursing teams wherever they had space. Unfortunately AGE UK had no funding and the CCG didn't take it forward. Age UK now have a locality coordinator in post – they attend MDTs, take forward the principles of living well and help to set up things like leg clubs."

"Years ago commissioning of leg ulcer clinics were agreed, but it took some time to develop and refine the current leg club model - centipede club - moved from Poltair Hospital to GP surgery but now in community centres with volunteers are in attendance. The idea is that health workers can see far more patients and the voluntary sector input is there to support initiatives to target social isolation. There is clinical evidence to support that healing rates have improved in the 6 months since leg clubs have been in place. Things like leg club help patients become more self-caring and self-managing, are great at promoting independence and giving staff permission to work differently."

"The initiative 'Turning the Curve' is about learning from experience - Learning from experience to turn the curve and being empowered by the leaders to make changes."

What do you think helps them to work well?

People offered a number of reasons why these initiatives have been successful, such as the immediate benefits people feel to their general sense of wellbeing, improved self-esteem, reduction in social isolation, and obtaining rewards given (such as points) to positively reinforce healthy behaviours

"Day hospitals worked well. People got exercise, bathed, had a meal and there was social interaction with others."

"The solution focused and goal orientated approach seems to be the best philosophy - staff are empowered and are happy to drive this. The social aspect of the leg group has a prevention element in terms of reducing isolation as well."

"If people become active the benefit is immediate and works well for people."

"People feeling they can achieve."

"People committed to being engaged in social events or sports so they will attend the event."

"Scored points for scoring goals in match, but also scored points if they lost weight between matches."

"Have volunteers to encourage people to be motivated into exercise, this helps reduce isolation and low self-esteem."

"Have a Crisis Café - Community Centre / Barry's boxes and barrow."

Some people suggested that a cultural shift in the way professionals think and talk about 'prevention' was needed, with staff wanting to take a more holistic and positive approach instead.

"Don't use the phrase prevention as it implies you are looking at a problem when you are targeting people who don't have a problem yet to prevent them from having one later on – consider using more positive language like 'promoting good health'."

"For me, I do feel that our staff are looking less at the task in hand. We are encouraging them to move away from being task focused and to look at the whole family network. But with increasing caseloads, people tend to revert to their comfort zones."

"There is often a social situation as well and not just a medical problem. Address that and the problem might be prevented."

"It's about what the patient needs – 'we need to blur boundaries and just do it'."

"What tips someone into needing 24 hour care? People just need someone to be there – who they can call for help or sometimes just to speak to. Because of our mobile population and culture there are fewer people helping each other."

"My observation is that it is a very health focused approach within Shaping our Future. For social isolation prevention there is a need to engage people on a broader level. There is a need to have a wider focus."

"Healthy behaviour needs a cultural change model from treating illness to prevention, but treating illness is what we get paid for."

"There is a hierarchical approach and complex layers within organisations that create boundaries and prevent the kinds of relationships you need to have with people to be able to persuade them to make lifestyle changes."

"The barriers to this are bureaucracy. We need whole 'cultural change'."

"You need to address professional boundaries preventing us from making use of the services we have."

"We are talking about modifying people's behaviour, but do not try to modify my behaviour without understanding why I do it. For example, telling me to stop smoking or to drink less alcohol can be meaningless to me because it does not

address the issues that are leading me to smoke/drink, so understand those issues and do something about the cause."

People's ability to adopt advice regarding healthy eating and exercise was also said to depend on their socioeconomic status.

"The cost can prohibit some people from doing exercise, but need to look at how this can be done for free."

"People who are most unhealthy are often also the poorest so less able to afford more expensive healthy foods or gym membership."

"We need to try and have that honest conversation because the money does change. Within welfare and section 17 of the Children Act (1989) we have certain responsibilities but not in terms of healthcare."

The influence of people's self-esteem also needs to be considered.

"Using the gym or swimming at any age is beneficial, but people may feel intimidated by the way they look."

"How schools recording weight making a child obese if over a certain weight BMI can be counter-productive if you're a person who eats more when you feel bad about yourself."

How practitioners could work differently to promote wellbeing

When asked how practitioners could work differently to promote wellbeing, participants suggested that professionals should be better role models, encourage volunteering, ask questions that promote wellbeing and independence, and involve a wider range of professionals, such as pharmacists and leisure centres to actively promote wellbeing being and make referrals into services when they have concerns.

"Senior managers could be better as role models."

"Activity levels: the importance of staying active should start with the workforce."

"I'm an Occupational Therapist who often visits people at home. We don't ask people what they want to be able to do – something like be able to play with their grandkids - we just focus on the current issue. We need directed conversations that focus on being well. What do you need most now? How can we help you to help yourself?"

"It is time for more directed conversations."

"We need to do things like motivational interviewing (MI) and cascading it through the team, enabling people to get on board and getting them to think and support rather than doing the doing."

"MI is brilliant in terms of getting people to see when they're trapped. Read the trans-theoretical model around mental health addiction - Prochaska and Diclemente: https://www.prochange.com/transtheoretical-model-of-behavior-change"

"Recreate the village hall concept as a focus for health and call them health and wellbeing centres."

"Talking to colleagues after I met VCS at a Shaping Our Future meeting. Lots of similar thinking people are wanted. More team working – less duplication."

"Using local communities to encourage people to walk."

"Encourage people to have a days' volunteering."

"Setting up small groups to run activities that are competitive and increasing universal services putting them into the community rather than in the health service."

"Promote benefits of activity – achieving, being included, social element."

"Should we target wider population or focus in on a cohort of people? Focus on the wider population; all generations; engage whole community; engage ***with*** *the Community…how can we do this - health champion to engage at location – school premises?"*

"Promoting ALL skills and services not just those provided by statutory services."

"Holiday lets which are suitable for supported living are needed – register even if respite/day care so that people are supported to lead as full and normal lives as possible."

"Consider prevention approaches through pharmacies (early advice, dehydration as a factor in falls prevention)…promote healthy living pharmacies offering services like smoking cessation, alcohol reduction, as a signpost to other services."

"Pharmacy could deal with minor ailments / preventing access to services; preventing ill health / worsening health (e.g. UTI)." – ""People will not go to a pharmacy because they have to buy medicines – they see it as their right to have it for free."

"Can we get sports and leisure centres to refer patients to us and vice versa? Broad types of exercise e.g. tai chi and meditation help in falls prevention."

Encouraging young people to adopt health lifestyles early, be volunteers and support their parents to follow suit or pair them with older people to reduce isolation were also mentioned.

"How schools should promote physical activities is not just the statutory role of academic education."

"Need input on healthy lifestyles at early years of sure start and to manage minor illness."

"Education on self-care needs to start in schools. [some] y*oung mothers have no idea what to do, there has been no handing down of skills and parenting."*

"Go into schools to encourage children to ask the parents when they last went out for a walk."

"Education to schools; children as volunteers."

"Bring two generations together in a stimulating environment to promote activity."

People also suggested providing more support in people's homes to encourage them to exercise and maintain good health.

"Support at home to keep people active."

"Maintain good health rather than prevent ill health."

Other ideas included removing access to unhealthy food in hospitals and increasing support, such as benches for the elderly, within the community.

"Change food in hospitals – no choice but a healthy choice; stop unhealthy vending machines."

"Can [seem to be a] *complex situation when looking at prevention, but it should not be as it is small steps, looking at benches in the towns and villages so that if an elderly person goes for a walk they can rest when they need to."*

As in Wave 1, looking after practitioner wellbeing was also highlighted.

"How we look after staff and the way we work needs to improve."

"'Health' could provide a healthy work place group."

People also suggested free taster sessions to encourage people to get involved in healthy community activities, freeing staff to volunteer to support community groups, using existing premises and services in a wider range of ways where they are available, and supporting GPs to socially prescribe.

"What could help? – taster sessions at no cost; better deals at leisure centres; free options – walks on the beach; Penwith family walking league; building resilience and robustness."

"Be creative and look at how we could use organisations, council, health, private companies to allow staff to volunteer 2 days a year."

"How about if we gave up some of the long hours at work and went into the schools or work with "Rewards if working as a group activity."

"We need to make better use of what we have already got at Helston where there is already point of care blood testing and an out of hours service – variability of opening hours is an increasing problem."

"Think how to use existing small self-help groups to encourage people to be creative mentally and physically."

"Identify where existing opportunities are and can happen given the rurality of the area."

"*Education and awareness: what if the GP referred people to the gym – activity can be simple."*

"Persuading the whole population into just spending just 10 minutes a day doing exercise will have a major change… physical activity is one of the biggest determinants of health."

"Look at non med cause of good health – use community centres for cardiac rehab and mix with other activities."

Whose responsibility is it?

When asked who should be responsible for preventing ill health and maintaining independence, comments tended to place responsibility with the whole population.

"The public think it's their right to have the NHS provide for them – 'I've paid my taxes'. So they don't take responsibility for looking after their own health."

"Helping people to self-help is the way."

"*There could be a lot more self-care."*

"Promote self-managed healthy living rather than us doing things to people."

"Education – messages in schools that you personally can do something… living well can be sustainable…putting value on health and well-being…taking personal responsibility."

What are the resources needed to promote wellbeing?

When asked what additional resources might be needed to promote wellbeing some thought there were sufficient resources available, but people did not know how to access them or thought health and social care should support community groups to ensure their sustainability and use.

"How can we better support prevention services that already exist in the community to thrive?"

"We need sustainable resources and sustainable skills – this has to be long-term and we need to find ways to use existing skills and resources better."

"How do local groups become self-sustaining? We set up lots of pilots and then they close. We need to support them for the longer term to give them a proper chance of showing benefits."

"How can we better support prevention services to thrive?"

As suggested during Wave 1, people suggested that a directory of activities and support that is available in the community is needed to support their ability to confidently signpost people to community activities and groups.

"We need a live and managed directory of services that is kept up to date."

"There are lots of resources out there but I have to be honest – I don't know how to access them. Live information is really important – only today I tried to access a service, but the phone number I had was out of date."

"We need online information to direct people to VCS/SCPT; use town and parish councils as a resource."

Others suggested resources should be focused on people currently making the greatest use of health and social care, shared patient records across organisations and making greater use of technology.

"Need to align the 5/5/75 approach with the areas taking up the most clinical resources."

"Need core development as one tool/care record. Integrated in direct access patient records."

"Potential technology for, example, turning people in bed."

However, some saw resource allocation as a trade-off between prevention services and the acute sector, whereby investment in one would reduce the income of the other until prevention strategies started to succeed in reducing the number of people using hospital services, which could take several years.

"Money for prevention – there is more cost upfront but it's about spending funds better, so ultimately the number of people in the system is reduced. The trade-off is that non-acute care might drift until we find this balance."

"Prevention should be over the longer term – some benefits can take decades to show up."

Hence, participants urged the Shaping our Future programme to consider the length of time that different initiatives may take to show an effect.

"There needs to be a stronger focus on accountability for health outcomes, but over 5-10 years, not 6 months. Sustainable outcomes need consistent funding and time to work. The NHS' four year planning cycles don't help. We need to have much longer planning cycles to deliver outcomes."

"Need a long-term focus on outcomes."

"Accept a long term vision against population outcomes (£)."

"Initially focus on output not request data on outcomes, which haven't had time to appear."

Integrated and urgent and emergency (unplanned) care

When asked to comment on the emerging draft models of integrated and urgent care that had been presented participants were concerned that the models were too focused on health and questioned the feasibility of the emerging plans.

"You need to look at the service model first and see how the estate fits later. Look at what facilities go together naturally."

"Form has to follow function – this model looks at services, buildings, equipment – but we should be looking at outcomes, functions, people's experience and understanding their behaviour."

"Carers in the voluntary sector are part of this agenda and need more support to be sustainable – could have in HWB (e.g. dementia)."

"The linear model is 'health focused' as a starting point, whereas the functions and resource and support needs to loaded at the integrated team level."

"Hubs would be a good idea if it is possible to sort out the logistics. Social workers could be co-located in a hub. Could health visitors be in a hub? GPs rarely see health visitors in Practices, leave them messages but rarely get a response."

"How mobile can units, teams and centres be? Can't we have mobile hubs?"

"This could be in any building/room (but it needs parking!) and you could run temporary 'drop in' clinics (community matron) for crisis management not just appointment based."

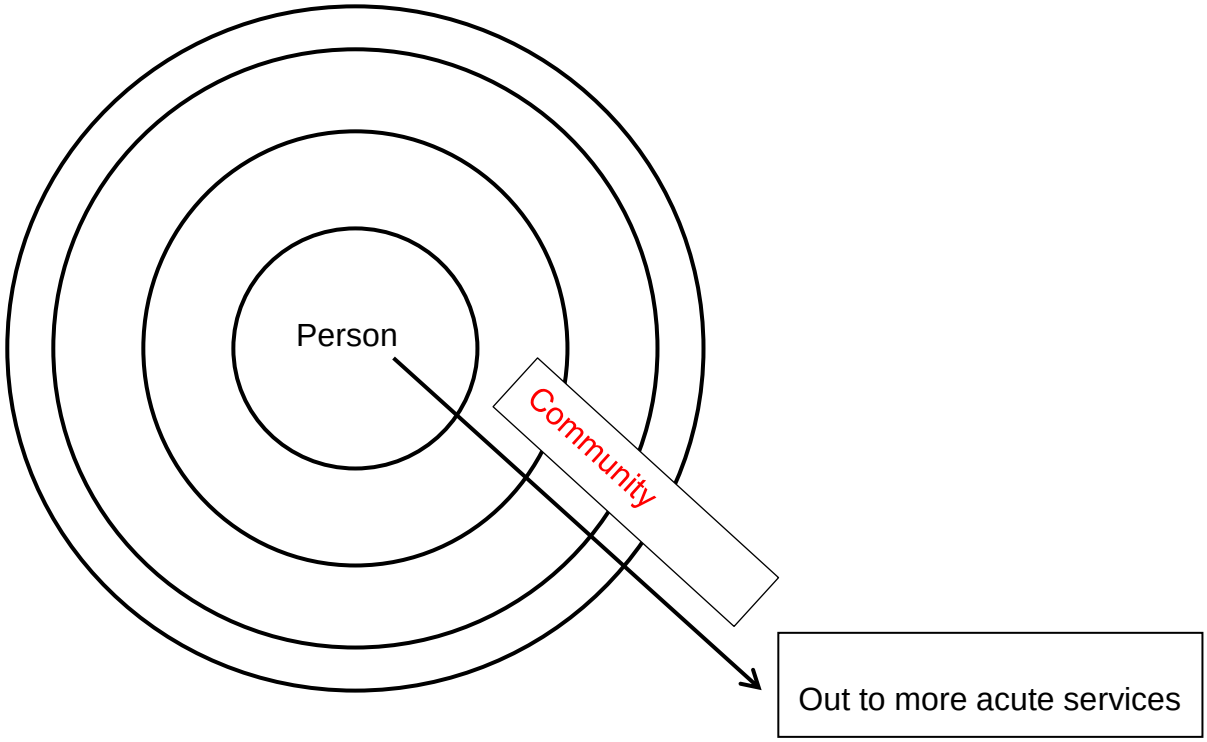
"Do mobile services need to be there every day?"
"Flexible space could be used for Specialist clinic, 1:1 consulting/clinic rooms, community room,group clinic, 1:1 psychological therapy space."
"What are the tools that the integrated team will need and how would we access them, from where? We don't have enough people."

"Look at what services can work flexible hours (nurses used to this – cardiac rehab) offer different time appointments e.g. by age/working rather than assume everything needs to be 24/7."

"We need more community services as a higher priority than superhubs - more nurses, befrienders, more hands on carers, upskill carers – let people who are capable do it rather than tell them they can't because it's not their job. Carers want to do more."

Some thought the "Integrated team circle (See Figure 2 below) "is considerate of both physical and mental health (including emotional and wellbeing) needs.", and will enable us to "have joined up conversations across Cornwall."

Figure 2: Draft Emerging Integrated Care Model



Others found the shopping analogy 'unhelpful and questioned, *"Where does empathy and patient-centred care figure in this?*

> *"The circular diagram showing the integrated team is good, but when translated into the retail model it is no longer an integrated model. It becomes a linear process. Any arrows on the retail model diagram should point left, to show the drive is away from acute and into local services. Also, the 'escalation' process in the retail model should refer to increases in services, not an escalation to the acute sector."*

> *"As a GP I do not recognise this model (retail).*

> *"The Tesco analogy is not helpful."*

A number of suggestions regarding the workforce and other resources that should and should not be included in the models where were also made.

> *"Outpatients: - include cardiac rehab, echo/consultants; diabetic – retinac/SP nurse etc/consultant, one stop shop; all tests done in once; respiratory; dieticians and weight management."*

> *"Use GP with special interest and link to consultants (e-health) so using expertise to specialise and reduce travel."*

"Things are changing rapidly in the community. We need to think of beds as anywhere (home, hospital and nursing home – what is needed to support that patient), but we have come to a point when we have run out of resources. We need more bodies and to work in a different way." "The best bed is my bed in my house is not always the answer."

"The hub should be the locality of services, with the spokes as the specialised services/diagnostics."

"A standalone MIU isn't viable to have x-rays in so these must be part of a larger unit with outpatient clinics (so with expensive equipment you need a clinic for it to be viable) …Some of the scans are planned i.e. CT. and MRI needed if there is traumatic injury. I'd probably go with MRI in ED rather than CT."

"Certain 'tests' can't be done in community, but you can fall between the net and you need admission. You could prevent that if you put diagnostics in the model."

"Taking bloods quicker enables a quick decision on whether to allow patients to stay at home."

"What if community hospitals were a step-up facility and community resource – maybe GP led – and not a dumping ground for the acute sector?"

"Potential closure of community hospitals means we need more 'hubs' e.g. Poltair."

"Cardrew would be a good place for a Hub, but too expensive!"

"The introduction of 'frailty units' can stop people being moved for the wrong reasons. We need Voluntary Sector solutions to transport."

"Why not bring a farmers market to hubs?"

"You could have a CT in 'every GP' [cluster?] if the CT was mobile e.g. 'Community hub Tuesday in Marazion'."

"Bring local services to the GP practice / Community Centre – Mental Health Seasonal drop in clinic at GP surgery; Day care treatment; Community short stay."

"There has been a gradual change from GPs doing everything to nurses to healthcare assistants, but there is a group of people who think the GP knows everything. We have nurses who can help very well with asthma, but the patient insists on seeing the GP. It's a generation thing and will get easier."

"District Nurses are not allowed to carry drugs so are not allowed to take medicines to patients. You could free up a lot of time if you changed that rule."

End of Life Care was also seen as an important part of any integrated care model and highlighted the positive aspects of current provision as well as areas for improvement.

> *"Some parts of End of Life provision works well. For example, doctors contact the hospice for advice. Nurses are doing so much end of life care they are getting quite skilled at it and if they're uncertain they ring the hospice. Hospice staff will come out if the situation is really complex. A bigger problem is getting medications to patients for end of life care – it needs a bit of forward thinking."*

> *"People don't want someone new treating them at end of life."*

> *"Whatever level of care people need at end of life we should be able to make it happen."*

However, participants suggested that optimal end of life care is not available for everyone.

> *"You cannot get packages of care to look after people at end of life, it is difficult to get night sitters and Marie Curie do not have enough capacity to support all requests in Penwith."*

> *"You cannot get people home from hospital who are dying because of a lack of transport – people should be able to die comfortably where they wish to – not have to accept that they cannot get home because of a lack of transport."*

Transport

Indeed, the need for good transport was repeatedly mentioned throughout discussions.

> *"This model is predicated on taking people to where the equipment is. What about people with transport issues?"*

> *"The most important factors are signposting, IT, transport, phlebotomy."*

> *"West Cornwall Hospital does not need any additional facilities. Transport is what would help, particularly late in the evening."*

> *"Transport is a major factor – isolation and distance from services is a major issue in this area."*

> *"Access to services – transport is a major issue."*

> *"It's all about location of facilities; using doorstep; lack of transport."*

"Provide cheap transport."

"Transport can be an issue as a person cannot get to an activity."

"How can communities become more active without transport?"

"We need local services due to transport difficulties. Local services need equipment; integration with other services and education."

How integrated does it feel now?

In terms of where integrated care across different parts of the health and social care system is already working well, people mentioned the advice lines for GPs that some departments in the acute hospital at Treliske provide; acute care at home and; signposting primary care patients to local pharmacies.

"Some specialties have advice lines for GPs and give feedback on the day or the next day – renal and cardiology are very good."

"Acute care at home has been getting better recently. Please maintain the improvement."

"People are receptive to change - they are now accepting telephone triage of doctor's appointments in surgeries. This is working really well in helping GPs manage their workload. People are also receptive to being signposted to seeing a pharmacist."

However, a number of concerns specifically around nursing homes, community hospitals and social care and ideas for how they could be improved were raised.

"The contracts in social care and health not well-managed and therefore nursing homes not given expectations."

"Care home beds are very scarce (with nursing). Also there is a lack of skill set, and there needs to be consistent care across all providers."

"Social care colleagues not aware of integration and council staff need more encouragement of therapists at the council… there has been in a change in client needs that we are not keeping up with."

"There is a lack of skills in residential homes to support complex patients."

"Some people need housing solutions before they can be discharged from hospital as many need adaptations, and if you can't adapt people's homes owners need to sell up or go to nursing home which takes time. There is no in between. Why can't we have shared ownership deals like LD clients have?"

"We have been feeding into needs and outcomes in terms of expectations for nursing homes but not really seen the results of this. Nursing homes are asking for this to ensure they are commissioned properly."

**There are very few nursing home beds and hospital beds are being blocked because of a lack of packages of care."*

"There is poor nursing/residential/EMI (Elderly Mentally Infirm) bed provision in Cornwall."

"There are only 2 care homes in Cornwall for young(er) people."

"We need to prevent admission to West Penwith by putting in early interview/social care, but delays due to lack of capacity is an issue."

"Need somewhere to put people temporarily in a safe environment e.g. three beds should be held for that in a care home."

"It's about managing the market. Also look at resource availability. We did a piece of work in trying to identify equipment in nursing homes and how to make best use of resources – it was seen as a quick win but surprisingly difficult to coordinate and I'm not sure if it was completed."

"We need skills development in care/nursing homes."

"Use video conferencing with patients at nursing homes or with their carer with a common sense, careful, steady approach."
"It is more difficult to get advice for mental health issues. Example given that patients call mental health services in the morning and get no response so call their GP instead in the afternoon."

"The response from social care is variable – referrals from GPs can be bounced around. GPs ask for a night sitter but the Early Intervention Service says they cannot ask for it, District Nurses have to ask for it. GP couldn't make a referral because the patient was not known to the District Nurses. Someone else other than the GP should be sorting this out and getting a night sitter for the patient."

"District Nurses provide an extended service from 5pm to 10pm and are very busy."

"District Nurses have a fantastic reputation in the community – they are so well respected."

"People should be able to access the STEPs services before needing hospital care, but they can't."

"The Early Intervention Service sometimes does not accept referrals because they are not in a certain box."

"When a nurse practitioner tries to refer to Adult Social Care they will not accept it because the referral has to come from a GP."

"If their problem doesn't fit into a nice letterbox people get passed around services."

Transition from paediatric to adult services was also highlighted as an area for improvement.

"In terms of short-breaks – there is a gap for ages 16 – 25. Young people are going into adult provision and it's not matching. You can't have someone who is 18 but cognitively 8 in an adult setting."

"A lot of the families can become quite upset when children transition to adult services as their cushion of support disappears."

"We find that at transition meetings parents are very often concerned by lack of support."

"You also can't supply certain products and equipment once a patient becomes a certain age. What they had previously they don't get as an adult because the funding streams change. Who would be the best person to discuss what to expect?"

Urgent and emergency (unplanned) care

During the introductory presentation the urgent care workstream described the emerging draft model for unplanned (unscheduled) using a shopping analogy involving 3 levels of service (shop) that offer a different range 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 they would expect them to be nearby within relatively small, strategically placed footprints.

As participants in Wave 1 said 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.

Some participants said the model was too focused on health and the acute sector and excluded mental health provision.

> *"The retail model is too 'either/or'. Look at the low onward referral rates of Stennack Surgery and Cape Cornwall Surgery. This is due to how we are structured and the services we provide. We are effectively working as a Minor Injury Unit."*

> *"This model is completely top-down and too health and acute focused."*

> *"Questions 2 to 8 inclusive assume support for the model, but as a table we do not support it."*

> *"The linear retail model does not work for mental health services."*

Moreover, some thought the draft model did not adequately reflect what had been said during Wave 1 and other work already happening in West Cornwall.

> *"The posters (around the walls) and the pan-Cornwall themes (on the slide deck) capture what people said in wave 1, but the retail model is not the solution to these issues."*

> *"I sense that the 'what if' question is heavily loaded towards an acute service outcome – doesn't feel reflective of the previous workshop or local efforts over a long time with a lot of people and lots of expertise.*

> *"This model (retail) is patronising and misses the points we made before."*

> *"This model is riding roughshod over a lot of work and trust building that has gone on in Penwith."*

> *"This process (the SOF events) feel like they are being reverse engineered to arrive at a 3-centre solution; west, mid and east; make the final form follow the function. This feels like we are starting with buildings and then finding services to fill them. An integrated service might have virtual limbs or elements."*

The express (unplanned care) service

When discussing the three elements of the draft model for Urgent and Emergency Care some participants thought that the Express part of the model had potential to reduce pressure on other parts of the system.

"Rather than a person going to dependant places – attend to GP, it could be in the 'community' e.g. GP 'express' option."

"Integrated care probably covers about 90% of total need, yet it's labelled 'Express' (in the retail model). The Express service should be the biggest part of the model to relieve pressure on GPs, with 'extra' being much smaller with a handful of specialised services/treatments/diagnostics."

"We need more self-care and primary care 'express' options (GP Practices and pharmacies) to free up resources."

Others questioned whether there are enough GPs to provide unplanned care when they are already stretched to provide the required number of planned appointments.

"Where do GPs fit into the retail model? They were referred to in the 'Express' element, but they have 90% of NHS contacts and people complain that they can't get to see us quickly enough already."

"Where will the GPs come from for GP-led superhubs?"

The hypothetical size of the planning populations that each part of the model would support to be viable in the presentation slides was also questioned.

"The Express has to work on a local level (30k population) or you lose local knowledge and community connectivity."

"60k populations are too big. This effectively means one superhub in Penwith. Populations of nearer 30k would be better."

"The hub should be a physical entity, based on populations of 30k. Services should be needs led. For example, West Penwith has an elderly population so will need services such as breathers clinics and memory café's, whereas Falmouth/Penryn has a young population that don't need those services."

In response to this and to address the confusion caused by presenting hypothetical planning population figures (which many assumed had been decided rather than posed to generate debate and discussion), this information was removed from the slides presented at subsequent workshops.

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

As with the Express part of the emerging draft model, participants questioned whether there are enough GPs to contribute to the provision of the Urgent Treatment Centres (UTCs – the 'superstore'). Moreover, the difficulties in recruiting GPs could undermine the model's sustainability and resilience.

"Where are the GPs coming from' to support the Urgent Treatment Centres? Not every Practice has the capacity to open 8:00 to 8:00 and cannot take on any additional work."

"Bear in mind, GP Practices are losing GPs and struggling to recruit."

"The model has to be future proof and take into account the changing demography – the supermarket does not have it because we can't get the staff."
"What we're developing must be future proof – look forward 15 years."

"You need to consider any long term changes to demand because of tourists and temporary residents."

Some suggested additional training might also need to be provided to ensure practitioners had the required range of skills.

"GPs are no longer used to handling trauma and have been de-skilled by increasing specialisation contracted to other parts of the system."

"Recruitment is key… and having the right skills."

"There are issues of skill set and workforce and training to deal with needs."

"The focus of this needs to be on functions and skills; not location."

"Make sure the people have the right skills in an Urgent Treatment Centre to meet the needs of the people going there. At the moment some people are being sent to Treliske who could have been treated at West Cornwall Hospital."

"An Urgent Care Centre works well with "bloods on site" and relies on GPs with appropriate skills. The majority of GPs would be uncomfortable if asked to deal with trauma (fractures etc.) Out of hours GPs do not do trauma either. GPs ok with urgent medical conditions and blood tests, but not things requiring x-ray. Some rural GPs will do sutures but many will not have done it for a long time."

"People expect GPs to deal with trauma as well as urgent medical conditions. A GP with a nursing team handling the trauma would work well. If networked with the Emergency Department the latter could also give them advice."

"There is a need for more training and we need to enable release time for the staff. We looked at other ways to work, like the leg club, part of the reasoning was to help free up time by seeing more people in one go - that is beneficial for patient and for staff."

"To provide this the staff would need more confidence and skills."

Workforce

In addition to training, staff also stressed the importance of good leadership, flexibility, time to implement changes and greater autonomy.

> *"There is a need for good leadership, people that will identify challenges and collect good quality performance data."*
>
> *"With complex adaptive systems you have to flexible. A locality based model means that you're more in control if the autonomy truly is given to the relevant leads."*
>
> *"We need time, space and permission to do things differently."*
>
> *"If staff are given the required time to implement changes this will improve staff morale and therefore quality of service."*
>
> *"My front line staff are changing rapidly and facilitating the movement, none are adverse to change. All can justify what they want in terms of resource. As their leader I am the conduit to feed up what is needed."*
>
> *"There is a need for devolved autonomy and devolved decision making. There is a gap in commissioning arrangements and provision and community beds. It doesn't matter how many community hubs there are, if you can't manage the flow then it won't help."*
>
> *"How do we stop the [hamster] wheel? How do we ensure that our staff are not out pounding the streets for hours and hours a day? We decided to change the way we practice. It has come from practitioners to generate the change."*
>
> *"Staff need to feel empowered and that they have 'permission' to carry out what they are qualified to do. In order to achieve this, we need to move away from being task focused to person focused, apply different methodologies based on learning from experience to help people 'turn the curve'. We need time and good leadership, autonomy and devolved decision making so we feel like we can develop care plans based on what a person needs not what an organisation is contracted to provide.*

In terms of what the model could include some suggested UTCs (the Superstore) could provide short in-patient as well as day case facilities, but stressed the importance of having clearly defined identities for each distinct part of the model if other local (planned) services were provided in the same building.

> *"Superstore: for those who need 'short stay' (overnight) also day treatments People on street don't know/care what urgent care/MIU means. They just want people to see them and manage the issue!"*

"If local services co-locate with a 'superstore' facility they must each remain a distinct identity."

Others questioned the efficacy of integration and co-location.

"A community hub and urgent care centre sitting together doesn't always fit. You're trying to keep people out of urgent care. They shouldn't routinely be bouncing back into urgent care because we should be preventing this."

Accessibility was also considered an important determinant of whether or not people would go to a UTC.

"Evidence shows that patient use of an Urgent Treatment Centre is based on how close people live to it; not because it is GP led."

"If you look at people using hospitals they do not necessarily live near them."

"There is urgent care in Penwith / West Cornwall which prevents admission to A&E, but you need a car to access it."

Superstore Plus (A&E)

Lack of capacity in different parts of the system was seen as a barrier to reducing pressures on A&E, with reducing patient flows into one part of the system seen as increasing pressure on another.

"You also need to prevent admission to West Penwith e.g. early interview/social care, but delays due to capacity is an issue."

"The real issue is that too many people end up in an acute hospital and how do we stop that?"

"We had a frail elderly patient needing both a catheter and bloods taken. West Cornwall Hospital could do the bloods, but the district nurses couldn't get across to do the catheter so he ended up at A&E. District nurses have a large caseload so it is often difficult to respond to an urgent request."

"District Nurses provide an extended service from 5pm to 10pm and are very busy so we need more of them."

"People in Helston know to go to the West Cornwall Hospital if they want to avoid Treliske. People from Penwith/West Cornwall don't like admission to Treliske."

People also suggested that the efficacy of the draft model to reduce pressure on the acute hospital would also depend on the time and day that someone's unplanned care needs became apparent.

"The time of day makes a difference because "everything else shuts down". People think they can manage and then late on a Friday realise that they cannot."

Communication

However, people also suggested any new model would need to clearly communicate the reasons for any changes in ways that would make them willing to access support in different ways, with each community/locality allocated its own budget.

"Educating patients to be receptive to change is key."

"You need one budget per locality."

"At what point do patients access an Urgent Treatment Centre, how do they decide when to go?"

"You need to think about the whole community because as well as a level of deprivation there is a lack of understanding in Kerrier and Penzance. For example, a mother and son recently presented at the hospital reception with a sharps bin after the father (the patient) passed away. They explained that they have taken the bin to the GP but they were turned away and advised to call the council. The council had been contacted and they had been sent forms from the council to complete, but they were unable to read and write. So they turned up at the community hospital. Sharps bins have to be traced and they should be disposed of in a certain way. This is partly due to cost of bins but also if there are problems with the bin itself they need to work out where it was manufactured. The nurse dealing with them took an hour to organise. The nurse recognised that they were not angry at her, but they were too embarrassed to say they could not read or write. System-wise these are the people that won't be able to access our services online. Public health demographics will come into play for this. North Kerrier have a high instance of people that can't read or write very well. North Kerrier have urgent care centre – people that are there want to access immediately. Any new integrated care model needs to give staff permission to apply some common sense so they're flexible to people's needs and abilities."

"Different advice given by GP and organisations – not easy for individual person to navigate. Women suffer quietly at home."

"How do we get the message out to keep people to keep them motivated - what is it that encourages people."

The following were considered to be central to effective communication:

- Perception
- Wide publicity
- Key messaging

- Electronic messaging
- Interoperable IT systems and access points for patients
- A wider public health message
- Wider media coverage
- Marketing good ideas and continue to try new ideas
- Public messaging, but building slowly so that people engage in what is been promoted

West Cornwall's headline topics

After the table discussions had concluded, each group was asked to prioritise what they had discussed into 'hot topics'. These are subjects, issues or concerns that each group considered to be priority areas for review by the Shaping Our Future team. The table below summarises the 'hot topics' discussed by participants in West Cornwall.

Priority areas	Comments
Speed of response	Importance of speed of response across all services
UTCs	How will UTCs be staffed, GPs not doing trauma is a limitation
Community Services	It's the community services that are needed, including transport and packages of care
Existing services	Lots of services already exist in Penwith and patients already know where they are
Geography	Wellness and using the environment we are in?
Education	Using the schools to educate younger people the positives of activity and wider health
Employee volunteering	Half day off work to enable staff to volunteer
Communication	Media and publication so that the public are aware of the wider issues around health and inactivity
Motivation	What motivates people?
Supermarket analogy	Not useful

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 (also called social connectedness)	At an individual level, community 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 counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence. Compared with non-directive counselling, 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: West Cornwall Wave 2 participants

Penwith College – 5th September 2017

	Total number		
People who attended (regardless of role):	43		
Organisations represented:		CFT RCHT Cornwall Council NHS Kernow GP Practices • Stennack Surgery • Alverton Practice • Rosemellyn Surgery • Marazion Surgery • Sunnyside Surgery Voluntary Sector • Age UK • West Cornwall Healthwatch • Memory Café • Cornwall Hospice Care Unknown	11 reps 5 reps 7 reps 6 reps 1 rep 1 rep 2 reps 1 rep 1 rep 1 rep 2 reps 1 rep 1 rep 1 rep
Lay people (include HW PPG and CAP members in this)	2	Healthwatch Cornwall NHS Kernow CAP	1 rep 1 rep
Professional roles represented		Chair Chief Executive Citizens Advice Panel member Community Matron Consultant in Public Health Cornwall Hospice Care staff member Delivery Team Director of Primary Care Director of Strategy and Business Development District Nurse District Nurse Manager General Practitioner Head of Prescribing and Medicines Optimisation Head of Strategy and Development	1 rep 1 rep 1 rep 2 reps 1 rep 1 rep 1 rep 1 rep 1 rep 1 rep 1 rep 3 reps 1 rep 1 rep 1 rep 1 rep

	Total number		
		Head of Workforce Transformation Health Promotion Healthwatch Cornwall Lay representative Locality Manager Occupational Therapist, Community Rehab team One Vision Pathology Service Manager Patient and Public Engagement Manager Portfolio Manager Practice Educator, Adult Social Care Practice Manager Public Health Social Care Lead Social Services Strategy Programme Manager Team Lead, Cardiac Specialist Nurse Team Leader, Community Nurse Workforce Transformation Facilitator	1 rep 2 reps 3 reps 1 rep 3 reps 1 rep 1 rep 1 rep 1 rep 3 reps 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 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 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)