SHAPING OUR FUTURE

Cornwall and the Isles of Scilly Health and Social Care Partnership

Shaping Our Future Wave 3 Co-production Workshops

Mid to East Cornwall – St Austell Print Works

To report on the information and feedback received at the Wave 3 co-production workshop held on 22 February 2018 at St Austell Print Company, St Austell.

Contents

Executive Summary

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

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

Attendance

In total, 42 people representing 13 organisations and filling 37 different roles attended the Wave 3 workshop for Mid to East Cornwall. This includes people from local third sector organisations, GP practices, Healthwatch Cornwall, the Shaping Our Future citizen advisory panel and local Patient Participation Groups. Elected councillors and representatives from across health and social care including dementia and social services were also in attendance. A full list of the roles and affiliations of participants is provided in Appendix A.

Feedback

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

Shaping Our Future priorities

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

Mid to East Cornwall Plenary Topics
Key themes identified by participants: **Seasonal Fluctuations** – Consider the increase of tourists in the summer and how best the workforce can be deployed to accommodate the fluctuations. The mixed model will look different in each locality and by season. Mobile unit could go to different areas – seasonal places such as festivals, summer schools and attractions such as the Eden Project. Consider technological requirements. Step down Newquay MIU in Winter. **Target support based on Linked Data** – We need more data around the activity and finances to enable informed decision making. The model of care should be based on population needs. Look at mid-age range of complexity with different focus i.e. mental health/drugs/alcohol and consider non-traditional groups e.g. gypsies/travellers so that UTCs become a countywide extension of the west based homeless MIU service. **Co-location** of services in the UTC building will promote cross-working practices that will increase efficiency and innovative thinking to improve patient care. **Communication -** Education for the public on what services are available to them, for instance the pharmacies in the community that are open 100 hours a week. Provide clear communication of what each element of the mixed provision offers. Acronyms mean little e.g. ICS creates suspicion in the public. People need to know what is going on. Inform the population of what we want to do and be consistent. **Place-based services -** Have realistic resources locally instead of people having to travel to the main hospital, especially for the older client group. Consider the wrap around services that would be needed as well as the UTC. Work with local practitioners to design the model. Each Minor Injury Unit needs a conversation to decide which ones could be enhanced. Review capabilities already in the community. What is appropriate? Examine population health needs and compare against current capacity and capability. **Consistency –** UTCs should be a one stop shop, offering a consistent service with consistent opening times. **Mental Health -** Improve direct access to mental health support in a crisis by including mental health in the UTC model. The model should include in-hours mental health teams, place of safety and Out Of Hours mental health provision. **Holistic services** - Shape services around “non-traditional” lifestyles such as the homeless and provision to support families caring for people with long term or complex needs. **Financial Viability –** The assessment and access criteria (for choosing UTC location) needs to be evidence based and linked to robust population data, then ask ‘can we afford it?’ The model needs to be financially viable so you also need to identify compromises (when good is good enough) rather than seek a gold standard that we don’t have the resources for. **Link to Care Homes and Home Care** – confidence to be at home with support. UTC nursing needs to link with nursing in care homes and MIU nursing. **Short Stay Assessment Beds -** More assessment beds is good, but could end up a dumping ground. Definition of the Frailty Assessment Bed needs to include clear eligibility criteria so you have the right number. Short stay assessment beds could be in care

homes, e.g. Lostwithiel has no Community Hospital so consider care homes when reviewing the sites. Set a maximum length of stay. Assessment beds could also be used for rehabilitation.

Expanded and blended MDTs - Include pharmacy, police and fire brigade in the model – Fire service now looking at slips, trips and falls. Resources are out there. Use staff flexibly in practices to do preventative work and pharmacists could do some of the minor illness work that some practice nurses can't do such as diagnose for minor illness/injury. The specification should include voluntary services support and things like wellbeing support to help families caring for frail elderly relatives could be delivered by police or fire service.

Self-care - Empower people to self-care via pharmacies and make every contact count.

Primary Care - Enhance services in primary care and involve them in care planning improvement, de-escalation and access to advice. Draft service spec. needs to be clear on roles and define skill set of GP on site as to requirement of UTC. Increase access to GPs and better access to dentistry to avoid need for urgent provision.

Resilience & Sustainability – Futureproofing the system by referring to local development plans for housing approvals and neighbourhood development plans to determine impact on population – Newquay + West Carglaze = 1000 new houses.

Diagnostics – We need local ultrasound with a dual trained radiographer and an out of hours' blood result facility. Need access to rapid blood tests and have IV access in the community. Include X-Ray for all open times. 8am to 8pm, 7 days a week in Falmouth and Newquay.

Digital Solutions – Provide consultations via video conferencing. Use self-help apps – take a picture, send it to receive a diagnosis by someone real who is going to help.

Transport & Travel – 30 minute travelling time to a UTC is the max. Consider transport challenges for those who don't meet criteria for hospital transport.

Workforce – Review capacity, skill mix, location. Cultural change is needed between staff – teams want this to happen. Common trust of assessments and shared care plans are needed. UTC staff should have a rotation through MIU and ED as part of induction.

Co-location and wrap around services - can easily provide the medical bit out of hours but not the 'care' because of reduced access out of hours. Look at Frome One Stop Model – Exemplar site in Somerset. Keep people in community by joining up all the bits of the system and have proper coordination and a gate keeper sending people who don't need treatment home. Model needs 24 hour district nursing, what others? What do we need in the community to stop people going to the UTC? Virtual working between different teams at present but soon to be in co-located. There is better patient care when sharing information on a daily basis. Consider MIUs with Capacity to treat in-hours routine primary care + staff for monitoring and co-locate them with UTC with point of care testing and skills for non-routine cases.

Clinical governance – Managing clinical risk across organisations needs to be considered. E.g. community hospitals, MIUs and others?

1. Background

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

The aim of Wave 3 was to

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

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

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

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

1.2.1 Methodology

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

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

1.2.2 Participants

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

In total, 42 people representing 13 organisations and filling 37 different roles attended the Wave 3 workshop for people working in or representing Mid to East Cornwall. This includes people from local third sector organisations, GP practices, Healthwatch Cornwall, the Shaping Our Future citizen advisory panel and local Patient Participation Groups. Elected councillors and representatives from across health and social care were also in attendance. A full list of the roles and affiliations of participants is provided in Appendix A.

1.2.3 Agenda and Workshop Content

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

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

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

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

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

1.2.4 Presentations

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

Copies of the slides presented are available to download here

1.2.5 Handouts

Hardcopy handouts provided more detailed information about the topics below.

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

Handouts are available to download here

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

1.2.6 Posters

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

1.2.7 Video

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

1.2.8 Equality Monitoring Data

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

1.2.9 Table top discussions

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

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

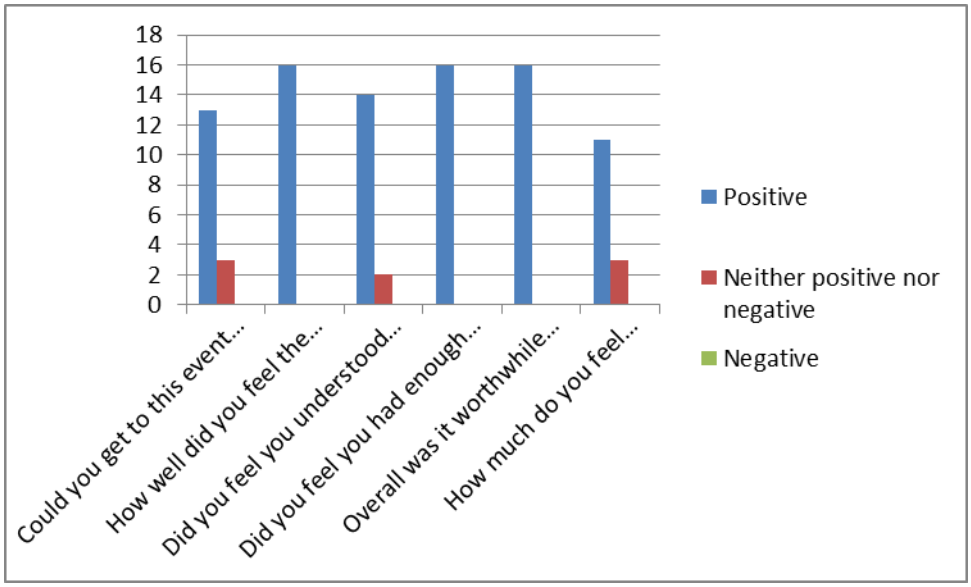
At the end of group discussions, a local clinician led a plenary session where each group fed back the main points discussed at their table. A broad thematic analysis of these discussions is summarised below.

2. Feedback (you said)

2.1 Feedback about the event

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

Table 1 Overview of Mid to East Cornwall Wave 3 Event Evaluation



Several people praised the organisation and facilitation of the event and said things like “It’s getting really exciting as I feel we’re moving forward” and “I can see what we said last time has shaped the evolving plans so it makes me feel like it’s worth being here again tonight.” Indeed, several people commented on how dynamic and enthusiastic the conversations were. However, this made it “too noisy at times” for some. Some people also found it “very hard to answer all six questions in an hour.”

A video of participants talking about the event and the coproduction programme can be viewed here.

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

2.2 Feedback related to the Linked Data Sets and Urgent Care

People suggested population need, deprivation and lifestyle related risk factors as this data should drive decisions regarding where to locate urgent treatment centres (UTCs) and other aspects of the model.

"We need to understand what the demand looks like for different times of day. There is lots to be unpicked and a great amount of duplication in the system. We will need to be brave based on the data."

"There will be winners and losers, but it shouldn't be who shouted the loudest during coproduction, but informed by looking at the data. Then a decision to take funding away from X and give it to Y based on that."

"Number of UTC sites need to be based on need and not on budget."

"St Austell is an area of high deprivation, similar to Camborne. Therefore if Camborne requires an UTC, shouldn't St Austell also require one?"

"We need to be honing in on a particular area looking at chaotic lifestyle and homeless cohorts."

"We have the largest concentration within china clay of travelling communities in this area."

"Services need to focus on areas of deprivation."

"There needs to be acknowledgement that the model may need to vary to take into account the differences in the areas. For example St Austell is a poor area in comparison to Truro."

"I feel we would benefit from an UTC specifically for the homeless."

"There is a fantastic service aimed at help for the homeless but, due to historic contracting, it's only for Truro down. There are none anywhere else. I suspect when you get the data that will show a massive need."

"We need a different response for different age ranges, homelessness support beyond the west and a reaction to increased population in the summer."

"In affluent areas you get walkers and those that are generally healthier, so not drunk and falling over. Focus resources where the need is greatest."

"GPs in areas with more deprivation have a higher demand for their services and have to manage as best as they can to see everyone on the same day. Planning the number and location of UTCs would need to account for this."

"If you are in an area where the population are getting sicker due to deprivation you're not getting more money in comparison to affluent areas where they can manage more effectively."

"You have different cohorts of patients including frail and complex. For example, Narrowcliffe surgery have more of an older demographic compared to Newquay Health Centre. The bulk of those patients are vulnerable adults with addiction or troubled families and children. They are three complex cohorts and they each need a different offer."

"We would really like to work with those homeless and traveller communities. We have people in those practices that will take longer than 10 minutes to see. I get a great sense of satisfaction come from dealing with the chaotic patient, but the system needs to build time in to do it properly."

"There are cohorts of patients we need to focus on when planning services: complex and frail, addiction and vulnerable, homeless and children."

"There are different reasons for presentation and they normally come in at 16:55 but staff find it difficult to say 'no'. When we talk about health profiles there are different services that need to be engaged. There is a rough sleeping hub, people who wouldn't phone 111."

"Age of population will determine what services you need in a community and where to put them."

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

"New housing sites should be taken into account when determining the location. These can restrict capacity even further."

"We need data to consider population growth including new housing developments."

"We need to look at population levels, exercise, lifestyle and forecast the adult population until 2023. There are four areas in Cornwall that are going to have large areas of housing development - Saltash, Treliske to Threemilestone, Newquay and West Carclaze with over 1000 houses in each."

"The Gannel development forecast was pretty accurate but with recent developments in Newquay we are growing at 500 – 1000. So we need to plan for that."

"We need to consider locally the planned numbers for short, medium and long term i.e. housing expansion can be forecast by looking at the local development plan. And then remembering that the demand is going to be extra on top of that also needs consideration."

"Unfortunately, the process of engaging health in the development in local development plans is sporadic, usually it's 'here's our draft and you have a week to comment' - it's not a joined up process. Perhaps we've not been as engaged in that case. I wouldn't say you'd have had real meaningful health involvement in the planning, which is partly our fault as well, but we need to join everything up."

"The planning department in the council have been very good - partners and health promotion and prevention are involved. There isn't a plan now that doesn't have their involvement and all partners are open to more involvement. We are

involved in the four sites being planned to ensure that the impact on health isn't hit and miss. It's about building an awareness into the system of work going on as well though."

2.3 Feedback about the Travel Time methodology

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

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

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

2.3.1 Access to Transport

After hearing a brief explanation about how the TRACC software works people's comments centred on existing transport related barriers to access as opposed to the methodology itself.

"Getting to hospital is already a challenge for older people who have to use taxis because non urgent patient transport is not available."

"The availability of ambulance transport to get the person home again also needs to be considered."

"Lack of transport meant a patient recently sat in a hospital chair for 12 hours until an ambulance could pick him up."

"Travel Time for people travelling to the UTCs needs to be considered in the context of the availability of transport."

"If MIUs were to go in areas like St Austell, Bodmin and Newquay it could make Treliske even busier."

"If any of the current capacity is lost in Helston there would be a huge gap because access to transport is particularly limited on the Lizard. So you need to also consider the transport infrastructure in different parts of the county when choosing locations for UTCs"

2.3.2 Seasonal Fluctuations

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

"The decision needs to take into account footfall and geographical location at different times of year."

"Demand for the service in a particular area changes so you need to look at the population in season and out of season."

"Seasonality needs to be considered in terms of the increasing demand and slowness of traffic in certain locations in the summer."

"It used to be that from May to June it was worse for Newquay as older population would arrive and they would have complex health needs."

"Use local knowledge to understand any issues which may impact on people accessing the UTC."

"Distance to travel to the UTC is one thing, the time it takes to get there is quite another depending on what time of day and year you make the journey."

"Need to include population data in these discussions and consider seasonality and the impact of big events/attractions. For example if the ski slope is built it would increase the amount of injuries in the area), traffic and demand."

"In winter you could close MIU in Newquay."

2.3.3 Reasons for current usage

Participants also suggested that travel and expected demand be considered in the context of why some people use the current system inappropriately.

"We would have to consider what it is that drives people's behaviour. There is evidence to suggest how people decide where to go is based on proximity but also levels of deprivation. For example, if you don't look after your own care proactively then you're more likely to use unplanned care whether you need it or not."

"Do you wait longer to go to Treliske if you cannot afford the parking? The big issue is some patients cannot afford to get home from hospital and can't afford to park if they need to go to hospital. Falmouth has a large student population with limited transport and money. Will UTCs address this or just add to the current problems?"

"People make decisions about where to go for care based on the experiences that they have when they access a service. Clinicians and the public can be unforgiving based on their first experience so default to highest level of care

even if the need is lower from then on. You do hear people say 'I came here last time so I've come here again'. And with ED, it's always open. So there would have to be a consistently better offer somewhere else that actually works before people will change."

Those who set a maximum travel time for travel to an urgent treatment suggested 30 minutes.

"30 minutes travel time is a reasonable amount of time to access a UTC."

2.4 Feedback about the Draft local Urgent Treatment Centre service specification

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

In the main people supported the development of a local urgent treatment centre model, but highlighted a number of gaps in the emerging model that was presented.

2.4.1 Mental Health & Social Care

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

"There should be quicker access to social care and mental health services, particularly access to Out Of Hours (OOH's) mental health services, which is poor. Child and Adolescent Mental Health Services (CAMHS) can also be difficult to access."

"We [GPs] can provide services out of hours, but the access to social care is what seems to be the problem."

"The UTC specification needs to include access to Social Care so it's not a 'this is a social care issue so not our problem'."

"Minor Injury Units often have people presenting with mental health problems. There needs to be more direct access to a mental health team who can respond to a crisis and, if necessary, referred to a place of safety. For example, a patient

that had recently been discharged from a mental health ward had a crisis so a relative brought the patient to the local Minor Injury Unit saying he could not get them back onto the ward and did not know where else to go. However, the Minor Injury Unit has to send people to the Royal Cornwall Hospital at Treliske to be assessed and the patient had to wait for a number of hours at the Minor Injury Unit until an ambulance could take them to Truro."

"Police have to sit with people in mental health crisis because an ambulance crew cannot get to them and also have to stay with them when they are taken to the acute hospital because of risks to staff."

"People ringing 111 for a mental health crisis go straight to the out of hours service but go into the same queue as everyone else for the out of hours service."

"I think we need a specific coproduction session on mental health urgent care with all the agencies that might get involved when there is an urgent mental health situation."

2.4.2 111 and Out of Hours Primary Care

The importance of having strong links between Urgent Treatment Centres (UTCs) and other parts of the system, such as care homes, home care services, 'out of hours' primary care and the 111 service were also highlighted.

"A care home has a protocol that whenever someone falls they should be examined by a doctor to make sure nothing is wrong. They are very worried about not spotting that something is wrong and there are frequent calls to the GP out of hours' service about people falling. So wherever you put them care homes will need access to a GP for advice."

"Nursing homes do also ring Minor Injury Units and nurses in Minor Injury Units provide advice. Being a trained Minor Injuries Unit nurse is a different competence to a nurse in a care home and current ad hoc advice from Minor Injury Unit nurses could be expanded as an advice line to support care homes."

"In Lostwithiel there is no hospital, but there are care homes so the flexibility of a mixed model would suit."

"Slips, trips and falls need to be covered by the spec. from a social care as well as a health perspective."

"Some GPs treat minor injuries already. This could be expanded with more funding."

"5pm time is the witching hour because a lot of teams go home so it's more difficult to get people out of hospital. There is no reason why we can't shape our services to avoid that."

"If services like Home First and the Short Term Enablement Pathway Service (STEPS) are full to capacity like they are currently, how would clinicians be able to move patients back into the community?"

"Therapy and social services would need to be available to make this urgent treatment service work."

"The Frome model is something that I would recommend people go and see. Everything on site in a purpose built place with inclusion of voluntary, GP, inpatient ward, mental health. Although they received a lot of funding for this model due to the population size around 30,000, it's classified as a super practice."

"There is a need for rapid social care response. If the person can manage at home, but might need a sitter to watch and take them to the loo they can be discharged more quickly."

"There is a need to instil a culture that says whatever your complaint/condition is, dial 111 and they will direct accordingly otherwise people will continue to go to the wrong place." - "And if 111 were robust then that would be great. It would work if the person answering were a highly qualified person willing to take the clinical risk."

"More than half of people calling 111 get through to talk to a clinician."

"We had a situation recently with a patient who went to her GP at 5pm and was advised to go to RCHT. We called 111 and got the sense that it wasn't somebody local." - "From experience, you are far less risk averse if speaking to someone that is local in the cluster. Families will use OOH (out of hours) GP services as they know they'll get a prescription as opposed to possibly not if they had seen their own GP. I would say that around half of people I see OOH could be deferred to their GP in hours, but we just deal with it because we're there. If working on a Sunday night you may see 3-4 overnight for example."

Hence, the need to align access hours was seen as crucial to the successful delivery of the urgent treatment model which might also reduce inappropriate use of the system.

"Services are not currently open late enough on the weekend to support the model."

"There are a number of GP Practices that currently provide MIU services. Perhaps more GP Practices would wish to provide an MIU service if given the opportunity. However GP Practices are usually open Monday to Friday and it is the evenings and weekends when the practices are not open that patients will go to A&E so access hours need to be aligned in the new model."

"Ensure adequate staffing to cover 24 hours opening everywhere it is needed or the new model won't be any better than what we have now."

"Out of hours it's even more difficult on a Saturday afternoon, I won't bother looking for care packages as it's so hard. UTCs will find the same thing unless you increase access to social care."

"Pharmacies open until 22:00 should be 24/7 instead so people who've been to a UTC can get any medications they've been prescribed."

"Minor Injury Units should be open 8am to 8pm, 7 days a week."

"A 24/7 district nursing service should also be part of the mixed model instead of finishing at 10:00 pm, particularly for the frail elderly cohort highlighted in the presentation."

"There is a need for accessible primary care in and out of hours. It can be easier for patients to call a paramedic than a GP at the moment."

"Minor illness should be treated 24/7 so perhaps UTCs could do this during the hours when GPs and MIUs close."

"We have Acute Care at Home which is a fantastic resource. 70% are GP managed and they keep people out of hospital. Acute Care at Home are usually staffed by nurses from an ED (emergency department) background and are absolutely passionate about delivering acute care in the person's home. Unfortunately the service falls down overnight."

"The GP out of hours (OOH) is accessible. People wouldn't necessarily come to a UTC but would receive primary care as the OOH GP could also be based there. So it would be seamless for the patient."

"To reduce costs the services could be simplified as volume of demand shrinks during the evening and night."

"You need a gatekeeper 24/7 to redirect non-urgent patients."

2.4.3 Prevention and Self-Care

Participants also wanted to see greater emphasis on prevention and access to dentists and district nurses and improved support for care homes included in the model.

"People who have severe dental pain out of hours or at the weekend, or who are not registered with an NHS dentist generally attend A&E or MIU to be able to access antibiotics or strong pain killers. If there were more NHS dentists for people to this may ease the need for people to attend emergency care. You also need an out of Hours booking system for urgent dental appointments."

"Better access to dentistry would definitely stop people attending UTCs and A&E."

"The drive is to be able to support folk as close to home as possible, whether it is a visiting service or a GP if in hours so why are we discussing what we need to put into an urgent treatment centre rather than discussing what we need to keep people out of them?."

"We need to help communities to stay well and signpost, about finding the right person and challenging areas to find the right people for them to engage with. It is important to have public health involvement with some local knowledge about planning issues to facilitate this so that new housing projects become healthy communities from the start."

"District nursing needs to move to a 24 hours service."

"My relative was taken down in the evening, was in from 3am by 3pm and the following afternoon was told "you can go home now". She was seen by HomeFirst by 5pm that night. If it had been available that quickly why did she need to even go in?"

"PEG (Feeding tubes) are an area of care that with the right care planning may not require a person to be sent to a UTC."

"If there was a dedicated team for the cohort of patients that are single parent families with dependents that can be supported at home you could avoid acute hospital admissions and some presentations to A&E."

"Care homes have their own issues. With access to advice and rescue medication the care homes may be able to continue caring for the resident at the home instead of having to send them to a UTC or the acute hospital."

"The prevention agenda should be linked into the local development plans when talking about place shaping services. For the Newquay community network panel, health is a priority and prevention in the community is key to that."

"Catheter care could also fall in the 24 hour district nursing service which would also bolster the Out Of Hours capacity. For example, rescue medication packs could be provided to patients with Chronic Obstructive Pulmonary Disease (COPD) to keep them from needing to go to an emergency department or treatment centre."

2.4.4 The role of pharmacy

As in previous waves, participants suggested pharmacists could be utilised more to reduce some of the pressures in the current system, particularly in relation to signposting, health promotion and treating minor illnesses.

"When attending MIU and a prescription is required, it takes the nurses away from the role of nursing. There is a requirement for a front facing pharmacy that can prescribe in the model."

"Public awareness of pharmacy services and their ability to provide urgent medicines needs to be addressed. We could also raise the awareness of what services people can access via the pharmacies. The number of extended hours' pharmacy along with increased Bank Holiday cover will be needed though."

"I get days regularly where 70% of work didn't need to be done by me [a GP]. For example, it could be pharmacy or nursing for minor ailments. Delegating would free up my time to deal with more complex patients. Some practices do not buy into that even if they can move simpler work to other roles. So there needs to be a cultural shift in thinking."

"There are other things to consider in the model such as an expanded role for community pharmacy; making people aware of healthy living pharmacy."

"Pharmacists and online support and guidance could be better used in the health system."

"Is Stennack minor injuries service which provides am enhanced service for St Ives a potential model that more GP practices could offer? Or could pharmacies provide the service? Or could the provision in Minor Injury Units be enhanced to cover it? Pharmacies in Wales routinely provide a service for very minor injuries such as sun burns."

"Need to educate people on going to a pharmacist for minor ailments."

"Could put advert on television about going to the pharmacy."

"Pharmacists can support long term conditions such as diabetes, hypertension etc., so they could be part of the model."

2.4.5 Short Stay Assessment Beds

When considering whether to support the inclusion of Short Stay Assessment Beds, people stressed the need to ensure there are adequate wrap around services linked to them and clear guidelines regarding eligibility and length of stay to support speedy referral and discharge.

"There would need to be eligibility criteria to determine which patients use short stay assessment beds. For example patients would need an open package of care to enable them to get back into the community. There would also need to be adequate medical staffing levels to ensure patient safety."

"Staff looking after the people in short stay beds will need access to housing and other types of advice, as issues by the relatives always get flagged on admission."

"Need to describe the fast track to get them home once assessed."

"If a patient was at a UTC, and they need to be transferred to an acute hospital would this de-escalate the urgency as they are already in medical care, which means the UTC then ends up with a blocked bed?"

"Voluntary services need to be involved to help them get home and support when they get home."

"Patients might have a number of issues for instance they might need their feet sorting out or they might need home environment sorted out. Patient is in a safe place if they are in an assessment bed so how do we ensure their care package is prioritised so they don't end up bed blocking?"

"The short stay assessment beds would get blocked very quickly if a time scale was not attached to how long the bed could be occupied by patients which had been admitted for assessment. This could allow clinicians to delay in making a decision about next steps for the patients care?"

"Are they a step down focussed resource?"

"What is the defined purpose for the beds?"

"You need to ensure the bed could be blocked to anyone who doesn't fit the criteria."

"Maximum length of stay needs to be defined."

"Whether the assessment bed should be available for the patient for 5-7 days or should it be shorter more like 2 days depends on the availability of social care because they won't have social care support in place within 2 days. In an ideal world the patient's admitted to these beds won't require social care, they should be medical patients where the GP needs to check if they respond to IV antibiotics, but a hospital stay for one thing can highlight other issues and needs when you are talking about frail elderly patients."

How will these patients be moved back into the community? There is the risk that patients will be bed blocked without adequate care packages and wrap around services in place."

"Administration of medicine at home is easy if that's all you need to discharge someone from an assessment bed, but the delivery of care through a package is more difficult to arrange quickly."

"There appears to be a myth that you can turn around frail elderly quickly. To get to the root cause clinicians' need time. Putting a patient in a bed for a few days is unlikely to work. Patients may need a period of rehab in hospital."

"If the number of MIUs decrease, there would be fewer beds for patients, so I can see there is a need for short stay assessment beds, but what about all the services you may need access to so they don't just get stuck there?"

2.4.6 Workforce & Capacity

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

"I'm frustrated at beds being empty when we could use 5 beds in St Austell as the assessment beds and home care could start taking them home for a half day as part of their rehab. I've escalated internally to a director who has agreed to use the beds, but workforce is a massive constraint to what can be achieved."

"Adequate staffing and skill mix is key to this."

"There are sometimes situations where it's safer to have people on a ward than being home alone, but you need the right skill mix of staff both in and out of the hospital."

"If you have assessment beds there would be a need to include Intravenous (IV) antibiotics and oxygen and the staff trained to administer them. It would be ideal for the cohort of patients that are just before needing 24/7 nursing, but might need "Acute Care at Home" input and would be well enough to be at home. We would need some data to look at to determine how many people could be managed at home if we had access to IV and oxygen."

"Are the observation beds going to be on the community wards? If yes, how will they be separated from in-patient beds? Additional nursing capacity will be needed to support this."

"Wards don't have as many beds due to regulations that specify minimum space required around each bed and the nursing staff required. Presumably this would also apply to these beds."

"A GP would be required to stay on site at the UTC rather than be contacted via telephone. There would be a requirement to clarify roles when working at the UTC. How would a GP based at the UTC be achievable; where would the GP practice gain cover?"

"Where will the GPs come from? The GP workforce is struggling in General Practice and CRCH (Camborne Redruth Community Hospital) are struggling to staff the GP rota. UTCs must link with the GP out of hours service so consider co-location. However there must be acknowledgement that OOHs GPs are also busy so there would need to be extra capacity and not a greater reliance on those GPs."

In addition to a review of current recruitment strategies, participants offered a number of suggestions for how capacity issues could be addressed such as blending roles by upskilling existing staff and delivering a greater range of support in care homes.

“The careers evening in Penrice didn’t include the NHS to start recruiting young people to work in the NHS.”

“UTCs could be led by a nurse practitioner.”

“I feel there is potential for short day assessments in care homes with the right support. Cornwall Care might be able to help. The GP could put people in there with the hospital at home team, but you would need additional staff.”

“With peer supervision and training a therapist can dip a urine sample and then feedback to GP if patient needs antibiotics.”

“Funding teams to undertake additional accredited training to undertake additional tasks like Occupational Therapist Assistants dipping urine will free up capacity.”

“There is a big push in the nursing community to reinvigorate care home nursing as a profession as it’s not currently an exciting option. Upskilling staff in this sector might help with recruitment and free up capacity.” - “It would be an opportunity to re-invigorate the care home workforce and enable them to be successful with broadened skillsets.”

“Change staffing to manage extra demand in the summer. The police run that model for change in seasonal demand.”

“Why does it need to be a GP who provides the UTC service? Band 6 nurses in MIUs see everything and a GP is available to support. Could MIU nurses work in GP practices during the winter when the MIU has low demand and go back to the MIU in the summer when demand in Newquay significantly increases?”

“There would be a need to consider x-ray in terms of demand and usage, but GPs could potentially accommodate it, yes. For winter, the MIU could focus on preventative work. The Newquay based group would require a slightly different skillset though. There is lots of nurse-led minor illness provision that would fit well with minor injury.”

“Some MIU nurses say they can do minor illness but are becoming deskilled due to occasional practice because they can deliver minor illness care at 7pm but not a 5pm.”

“The fire service support fallers and in some areas will support non-injurious fallers as back up when needed. You could expand this.”

“The fire service will run exercise classes, fire assessments in housing that is cluttered and could also offer flu jabs if trained.”

“Truro fire service is already doing risk assessments of patient homes to prevent slips, trips and falls.”

"Across Cornwall there are lots of good people and skills, but not necessarily in all or the right areas."

"Minor Injury Unit nurses would benefit in developing and maintaining skills if there could be a system of rotation with Emergency Department nurses."

"Nurses have to do educational modules and at the moment this places a demand on Minor Injury Unit nurses to provide training. Minor Injury Unit nurses would welcome ward nurses to work alongside to them instead develop competencies."

"The system needs to have a pool of people trained and ready to work in a Minor Injury Unit. The service would then be more robust."

"The skill mix in the Minor Injury Unit workforce does not change during the year whereas demand does. Consider needing to flex what is in the service and the skill mix as well as capacity at Minor Injury Units at different times of the year. For example, an emergency supply of drugs and contraception is more needed in Newquay in the summer."

"A suggestion was to provide an enhanced extra training period for GPs in OOHs, ED and MIU work. The group agreed this would be a good balance to their training, however the group acknowledged that training GPs will take time and the workforce gaps need filling now."

"If UTCs are collocated with GP practice there would be a different level of clinical risk and skill set required." - "Who would pay the indemnity fees for GPs' in UTCs? Currently clinicians pay a lot themselves for this."

"Nurse Practitioners could be upskilled to see minor illnesses, could then be supported by telemedics. Nurses at Newquay want to see more and have capacity during the winter."

2.4.7 Communication

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

"What is the difference between the service at Camborne Redruth Community Hospital (CRCH and a minor injuries unit (MIU)? Online CRCH is referred to as an MIU <u>and</u> a Primary Care Centre, but how do patients know the difference between an MIU and a Primary Care Centre? The wording is crucial because the public need to be able to understand what services an MIU offers in comparison to a Primary Care Centre and an UTC (urgent treatment centre). Who are each of these staffed by? How many of the public know that under 2s cannot be treated at an MIU? Can they go to a UTC instead?"

"It's not just about clear communication for the public, clarity for the ambulance service as to what is available to the person at the UTC before they are taken there by the ambulance service is crucial."

"Minor Injury Units can see people with minor illnesses 'out of hours' but not 'in hours' i.e. when GP surgeries are open. This confuses people. Adding additional elements to the current model won't help."

"When MIUs are closed due to staffing there is a loss in public confidence which leads to patients going to ED instead because they know it will always be open. We need to ensure the offer at UTCs is consistent and reliable if we are to avoid the same problem."

"Standardising facilities and opening times is key if you want people to access services as intended."

"Having a local specification is all when and good, but visitors think we have walk-in centres like other parts of the country. For example people in the summer attend Minor Injury Units with burns that need follow up dressings. They come to the Minor Injury Units for redressing sometimes daily. The Minor Injury Units have no provision for appointments and they will be low priority, so visitors sit for hours waiting for a redressing. Sometimes they were previously sent to Cardrew as an alternative. There needs to be a service in place for these specific groups of temporary residents."

"At the moment the public will go to a Minor Injury Unit in Bodmin because do not want to go to Truro but do not know that the unit does not have a doctor on site. It will be essential to have clear criteria and a clear guide of for people to know where to go. We need clearer communications with the public and with each other if this is to be a success."

"Educating people to choose the right place to access care is vital."

"There needs to be more communication with the public. The public are confused which is not helped by changing names i.e. ACS to ICS shows confusion. Acronyms need to be avoided; they can mean different things to different people. They will only confuse the public."

"Need to be clear about how MIUs, A&E, UCCs differ; what services will be available at each? Need to make the service offer clear to patients."

Consequently, people offered a range of suggestions about the best methods for informing and engaging with the public.

"Health promotion and information about self-care and information to help them navigate the new system could be provided within places like Asda."

"Senior school needs to cover where to go for minor illnesses and injuries as part of the curriculum so children can educate their parents."

“Any complex system is difficult to navigate. Keep the message simple and consistent.”

“Using a patient journey is a good way of understanding the pitfalls as well as describing what people can expect to receive in the new model.”

”Council website contains lots of information including health related information for example the list of pharmacies in a locality, but people might not necessarily think to access it on there. So you need to put key information where people are most likely to look.”

“We need an information hub including pharmacies, GPs, and social prescription information. So people just need to call one place for advice about where to go.”

2.4.8 Financial Considerations, Capacity & Operational Viability

The financial and operational viability of the model were also questioned particularly in terms of its ability to relieve pressures on the current system and the ongoing challenge to meet current and future demand. Hence, some wanted to challenge the criteria on which Cornwall’s funding is decided.

To ensure the potential loss of delivering a model that does not achieve expected improvements in outcomes and cost effectiveness is minimalised people supported the suggestion that the new model is tested in one area before being delivered more widely.

“I like the idea of piloting something in one site instead of implementing an approach across the county that does not work. However a pilot usually attracts staff who like change. When a pilot is expanded you risk moving staff from the original pilot site and the original pilot site negatively impacted as a result, or the next pilot site is staffed by staff that are resistant to change so you don’t see the same benefits.”

“I’m concerned that we don’t want to add primary care into the UTC specification. Is that because we don’t want to pay for it twice? That sounds counter to what we’ve been talking about doing. If it’s purely from a financial point of view it’s not for the good of the patient.”

“What assessment criteria are there for the financial number required? In the very initial engagement before coproduction it was presented as the Sustainability Transformation Plan to help Cornwall and Isles of Scilly to meet its savings target. So I need to understand the funding available for UTCs. We do recognise that if we don’t provide we will get into a downward spiral, but we need to be honest about what we really do need and don’t back away from closing what we don’t need. If the need doesn’t fit the funding so we include less in the delivery then it will be a false economy.”

"Politically, the conversation around funding required needs evolving and how it is shared across country doesn't recognise our needs in Cornwall. We mustn't short change ourselves by saying we can stop this and that without challenging the way that our funding is arrived at."

"We must look at what we need and then what we can afford. Not the other way around."

2.4.9 Digital Solutions & Shared Care Records

As previously, people also suggested various digital solutions could relieve pressure on staff by reducing some of the time practitioners currently spend monitoring patients. In addition, people saw the benefits of using online platforms as a way of sharing patient records between different teams and providing information to help people navigate the health and care system.

"The model should include better technology related to tests, something futuristic so we don't need to buy something new in a few years."

"Better use of telehealth and skype (video conferencing) is needed."

"Could you take a photo of a rash and send it to a GP for diagnosis via an online app.?"

"Self-care Apps could be used more."

"Other places in the country are offering online chat / web access to a clinician."

"Look at the NHS Quicker app."

"Cultural change is happening as people can see the benefit of working together for the team and for the patient. Really trusting each other's assessments is key. All teams should all be on the same Patient Administration System named Rio, so all the teams can view the same information, but some will only have read only rights."

2.4.10 Diagnostics & Triage

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

"*I'd need to know the cost of equipment CT Scanner, x ray machines etc. before I decide whether or not we can afford to include them in the model."*

"Extended hours for x-ray might reduce presentations to A&E."

“Point of care testing is a great idea if we are able to gain possible x-ray and bloods that could provide a diagnosis quickly whist a patient was using a short stay assessment bed.”

“More access to ultrasound locally is needed.”

“Regardless of where you put scanners and x-ray, c*linical triage needs to be local. We have had incidents recently where South London answer 111 and quite poorly people were sent to Bodmin when the level of service wouldn’t meet their need.”*

“You could consider looking at using a converted container that could be put into a car park in school to treat the patients – a mobile centre would include diagnostics. It could be deployed at festivals and if parked in school they can be locked in.”

“I like the idea of a bus that could offer mobile care.”

“There are issues with urgent bloods taken out of hours that require specialist interpretation of the tests so you need the relevant workforce in place to take the tests and people who can interpret the results available 24/7.”

“Computed tomography (CT) scanners are very expensive, Cornwall only needs one more.”

“It would make a huge difference if x-ray was available for all the time that Minor Injury Units are open.”

“Not sure of the impact of a CT scanner and whether it would pay for itself.”

“People know when they think they’ve broken their arm they need an x-ray. Do they know when they might need a CT scan to know to go to a UTC for it?”

2.4.11 Location of UTCs

Participants also made a number of suggestions in relation to where UTCs could be located and the assessment criteria that would need to be applied including the consideration of non-hospital settings, the cost of conversion to a UTC and the potential to co-locate with other services such as services for children, community pharmacies, fire and police services. Indeed co-location with allied services as well as selling existing stock to invest in urgent treatment centres were seen as primary ways to make the model more cost effective and affordable.

“Do not be limited by just looking at current sites.”

“When you’re planning some development, you need to think how the layout will help people to be healthy from an infrastructure sense but also what resources will be required from a health and social care perspective.”

"St Austell Community Hospital already has access to the OOH's GP MIU, community matron, and district nurses. They also have a Palliative care nurse and mental health drop in so would need less investment to become an urgent treatment centre."

"It's down to numbers and hours of the day. With current contracts of 8am-8pm you have 60 GP practices that people are used to visiting patients during those times. If you look at 8pm until 10pm numbers are smaller and demand is less, then less at 10pm until midnight. If someone wants to see a GP overnight then they must be very ill. I'm not saying we can only do certain things at certain times but the trick is about co-locating services to enable shutting down of services, but with availability of access when you need it."

"If we are going to keep people at home we need to expand capacity and coordination. If Acute Care at Home was co-located with Home First it could then become a rapid response resource."

"A plan has been drafted to move the district nursing team and occupational therapists in the same office space together. UTCs need to include that kind of co-located model."

"Some GPs are approved to deliver MIU enhanced so can be paid for treating minor injuries, but are they open to people not registered with them? Others don't get paid for treating minor injuries. It's very confusing."

"Lostwithiel can be paid to provide minor injury services for their own patients."

"Stennack MIU is due to Edward Hain closure. And in other GP practices, if a patient presents they won't be turned away. GP practices are more than capable to delivery due to skills from nursing staff. In the winter we would manage to deliver but in the summer, the demand would be too great. And that is the same challenge for the MIU."

"We [GPs] can provide services out of hours, but the access to social care is what seems to be the problem."

"With access to Social Care so it's not a 'this is a social care issue'."

"A dedicated line for Minor Injury Units to the Emergency Department is an essential part of the mixed provision. It enables nurses to get advice from a consultant. There is a silver line for geriatricians and another for paediatrics."

"With section 106 money for open space we have, for example, in Newquay applied for lots of open space projects for communities to take on and develop. Part of my role is to look into who owns land. New build UTC's could be part of that."

"If you think about geography Bude will need an MIU because of how far it is from everywhere else."

“The ambition is to support the local population, but we might not have the space or facilities in Newquay to accommodate the model.”

“Sell off land and buildings to reinvest the monies into appropriate builds.”

“It is easier to communicate to people what a new build is for than explain how an existing building’s use has been changed.”

“Keep abreast of new developments for example the Garden Village, St Austell and the possibility of being able to feed in to what a local community might like to see in the community that will build up around it e.g. do they want a UTC.”

“For this area if there is no UTC in St Austell patients are unlikely to drive away from Truro. Therefore this area would continue to go to A&E and you would be unlikely to see a change.”

3. Mid to East Cornwall Plenary Topics

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

Mid to East Cornwall Plenary Topics

Key themes identified by participants:

Seasonal Fluctuations – Consider the increase of tourists in the summer and how best the workforce can be deployed to accommodate the fluctuations. The mixed model will look different in each locality and by season. Mobile unit could go to different areas – seasonal places such as festivals, summer schools and attractions such as the Eden Project. Consider technological requirements. Step down Newquay MIU in Winter.

Target support based on Linked Data – We need more data around the activity and finances to enable informed decision making. The model of care should be based on population needs. Look at mid-age range of complexity with different focus i.e. mental health/drugs/alcohol and consider non-traditional groups e.g. gypsies/travellers so that UTCs become a countywide extension of the west based homeless MIU service.

Co-location of services in the UTC building will promote cross-working practices that will increase efficiency and innovative thinking to improve patient care.

Communication - Education for the public on what services are available to them, for instance the pharmacies in the community that are open 100 hours a week. Provide clear communication of what each element of the mixed provision offers. Acronyms mean little e.g. ICS creates suspicion in the public. People need to know what is going on. Inform the population of what we want to do and be consistent.

Place-based services - Have realistic resources locally instead of people having to travel to the main hospital, especially for the older client group. Consider the wrap around services that would be needed as well as the UTC. Work with local practitioners to design the model. Each Minor Injury Unit needs a conversation to decide which ones could be enhanced. Review capabilities already in the community. What is appropriate? Examine population health needs and compare against current capacity and capability.

Consistency – UTCs should be a one stop shop, offering a consistent service with consistent opening times.

Mental Health - Improve direct access to mental health support in a crisis by including mental health in the UTC model. The model should include in-hours mental health teams, place of safety and Out Of Hours mental health provision.

Holistic services - Shape services around “non-traditional” lifestyles such as the homeless and provision to support families caring for people with long term or complex needs.

Financial Viability – The assessment and access criteria (for choosing UTC location) needs to be evidence based and linked to robust population data, then ask ‘can we afford it?’ The model needs to be financially viable so you also need to identify compromises (when good is good enough) rather than seek a gold standard that we don’t have the resources for.

Link to Care Homes and Home Care – confidence to be at home with support. UTC nursing needs to link with nursing in care homes and MIU nursing.

Short Stay Assessment Beds - More assessment beds is good, but could end up a dumping ground. Definition of the Frailty Assessment Bed needs to include clear eligibility criteria so you have the right number. Short stay assessment beds could be in care homes, e.g. Lostwithiel has no Community Hospital so consider care homes when

reviewing the sites. Set a maximum length of stay. Assessment beds could also be used for rehabilitation.

Expanded and blended MDTs - Include pharmacy, police and fire brigade in the model – Fire service now looking at slips, trips and falls. Resources are out there. Use staff flexibly in practices to do preventative work and pharmacists could do some of the minor illness work that some practice nurses can't do such as diagnose for minor illness/injury. The specification should include voluntary services support and things like wellbeing support to help families caring for frail elderly relatives could be delivered by police or fire service.

Self-care - Empower people to self-care via pharmacies and make every contact count.

Primary Care - Enhance services in primary care and involve them in care planning improvement, de-escalation and access to advice. Draft service spec. needs to be clear on roles and define skill set of GP on site as to requirement of UTC. Increase access to GPs and better access to dentistry to avoid need for urgent provision.

Resilience & Sustainability – Futureproofing the system by referring to local development plans for housing approvals and neighbourhood development plans to determine impact on population – Newquay + West Carglaze = 1000 new houses.

Diagnostics – We need local ultrasound with a dual trained radiographer and an out of hours' blood result facility. Need access to rapid blood tests and have IV access in the community. Include X-Ray for all open times. 8am to 8pm, 7 days a week in Falmouth and Newquay.

Digital Solutions – Provide consultations via video conferencing. Use self-help apps – take a picture, send it to receive a diagnosis by someone real who is going to help.

Transport & Travel – 30 minute travelling time to a UTC is the max. Consider transport challenges for those who don't meet criteria for hospital transport.

Workforce – Review capacity, skill mix, location. Cultural change is needed between staff – teams want this to happen. Common trust of assessments and shared care plans are needed. UTC staff should have a rotation through MIU and ED as part of induction.

Co-location and wrap around services - can easily provide the medical bit out of hours but not the 'care' because of reduced access out of hours. Look at Frome One Stop Model – Exemplar site in Somerset. Keep people in community by joining up all the bits of the system and have proper coordination and a gate keeper sending people who don't need treatment home. Model needs 24 hour district nursing, what others? What do we need in the community to stop people going to the UTC? Virtual working between different teams at present but soon to be in co-located. There is better patient care when sharing information on a daily basis. Consider MIUs with Capacity to treat in-hours routine primary care + staff for monitoring and co-locate them with UTC with point of care testing and skills for non-routine cases.

Clinical governance – Managing clinical risk across organisations needs to be considered. E.g. community hospitals, MIUs and others?

4. Next Steps

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

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

Feedback is being considered by:

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

Glossary

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

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

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

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

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

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

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

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

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

APPENDIX A – Mid to East Cornwall Wave 3 participants

St Austell 22nd February 2018

	TOTAL NUMBER		
People who attended (regardless of role):	42		
Organisations represented:		CFT NHS Kernow Cornwall Council NHS England RCHT Beech Lawn Nursing Home Cornwall Local Pharmaceutical Committee St Austell Bay Parish Council GP Practices • Newquay Health Centre • St Austell Health Group	10 Reps 12 Reps 7 Reps 2 Reps 2 Reps 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep
Lay people (include HW PPG and CAP members in this)		Healthwatch Cornwall CAP member Newquay Health Centre PPG* Friends of Newquay Health Centre*	1 Rep 1 Rep 1 Rep 1 Rep
Professional roles represented		Workforce Transformation Facilitator Governing Body GP Director of Primary Care Consultant Chair Events Officer Cornwall Councillor Consultant in Public Health Community Link Officer Team Lead Intermediate Care Services Pharmaceutical Advisor District Nurse Locality Lead Head of Strategy and Development Prescribing Support Dietician Strategy Programme Manager Team Leader Minor Injury Unity Executive System lead for Urgent and Emergency Care Locality Director Minor Injury Practitioner Outreach and Engagement Officer Healthy Lifestyle Delivery Advisor Chief Nursing Officer	1 Rep 2 Reps 1 Rep 1 Rep 1 Rep 1 Rep 4 Reps 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 1 Rep 1 Rep

		Integrated Care Programme Manager Pharmacist Project Manager Project Assistant GP Modern Matron and Dementia Lead Admin Support Head of HR Interim Deputy Director, Adult Services Facilitator	1 Rep 1 Rep 1 Rep 1 Rep 2 Reps 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep

APPENDIX B - Wave 3 Agenda

Agenda for Wave 3 Co-production Workshops

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