Minutes

SHAPING OUR FUTURE
Cornwall and the Isles of Scilly Health and Social Care Partnership

Penwith integrated community services stakeholder event

30 April 2019
10am to 12noon
Marazion Community Hall

Present:

Mandy Angove (Community Mental Health team)	David Raymer (Chair, Bodriggy HC, PPG & Hayle Day Care)
Villy Colman (Family Hub co-ordinator)	Carolyn Rowe (Trustee Penwith Day Centre)
Marion Barron (Drug and alcohol team)	Martin Bogdaniec (Contract manager)
Melanie Faulkner (Occupational Therapy Team Lead, Cornwall Foundation Trust)	Andrew George (Former Lib Dem MP for St Ives)
Carol Steer (Cornwall Foundation Trust)	Stephen Day (Cornwall Foundation Trust)
Shirley Harris (Matron, RCHT)	Vaughan Tenby (Communications Manager, Disability Cornwall)
Deborah Stevens (Medical Director, Cornwall Hospice Care)	Harry Blakeley (Bodriggy Health Centre Patient Participation Group, and Hayle Town Council)
Ruby Bawden (Cornwall Council)	Helen Hawkins (Councillor, St Buryan)
Michael Miller (Member, Marazion Surgery PPG)	Dr Kerry Bailey (Cornwall Council / NHS Kernow)
Graham Carter (Penwith Dementia Friendly Communities)	Vanessa Luckwell (Cornwall Council)
Toni Carver (VC Edward Hain League of Friends)	Zara Mason (Cornwall Council)
Lynne Isaacs (Edward Hain League of Friends)	Andrew Mitchell (Councillor, St Ives West)
Joan Tanner (Chairman League of Friends, Edward Hain Hospital)	Sue Nicholas (Councillor, Marazion & Perranuthnoe)
Jennifer Paling (West Cornwall HealthWatch)	Colonel Richard Robinson MBE (Councillor, St Ives East)
Chris Goninan (Penwith 50+ Forum)	Linda Taylor (Councillor, Lelant and Carbis Bay)
Jan Portman (Cornwall Care Services)	Jackie Wardle (Cornwall Council)
Jeremy Preedy(CAP Member)	Sue Waring (Head of Service(West) ACS, Cornwall Council)
Chandelle Randall (Community Maker, Volunteer Cornwall)	Dan Rainbow, GP, Stennack Surgery

Please note that these minutes represent the views and observations of those attending the event and the specific detail and reference to any numbers and data may not be accurate at this point in time.

Minutes

NHS Kernow team	
Michelle Smith	Samantha Jacobs
Laura Patrick	John Garman
Kate Mitchell	Caroline Chick
Ben Mitchell	Rachel Murray
Neil Walden (Clinical Lead)	

We would like to apologise in advance for sharing incomplete notes from this meeting, but one of the note takers has had to take some unexpected time off work before she wrote up her notes. We will provide these as soon as she returns to work.

Introductions and why we're here today

Dr Neil Walden thanked people for attending this stakeholder event to support the Penwith integrated community services project. Dr Walden thanked everyone involved in all the work, and conversations to date held about Penwith services and Edward Hain Community Hospital. These include model of care workshops, Edward Hain League of Friends meetings and the ongoing work of the locality and Penwith Integrated Care Forum.

The group was invited to participate in the review of community services in Penwith, including those that were provided from Edward Hain community hospital. Similar sessions are also taking place in Saltash and Fowey, where community hospitals are also temporarily closed to inpatient services.

The purpose of today's session was to help identify a list of options for the possible future shape of community services in the locality, which will determine the future of Edward Hain Community Hospital.

People were asked to join three smaller groups and consider and discuss the following three questions:

1. What do we need to change to provide local care and support services that are fit for the future?
2. What are our key challenges in supporting communities and individuals to thrive?
3. What our community needs, and what's important to us?

By the end of the session, we hope to have:

- Enabled people to have decided if they would like to remain involved by becoming a member of either the options development group or the countywide criteria setting group.
- Begun having the conversations about community services in the Penwith area that will lead to the development of options for the future.

Minutes

SHAPING OUR FUTURE
Cornwall and the Isles of Scilly Health and Social Care Partnership

What do we need to change to provide local care and support services that are fit for the future?

Session one

Key points from the group discussion (please refer to appendix one for full list):

- The lack of community hospitals has a knock-on effect on care homes. Nursing care and dementia care in particular is a gap in the market. The domestic care market is full.
- Helston Hospital (as the nearest community hospital in the west) is too far away from St Just.
- Community beds are paid for by the state and are means tested. Who is going to fund all the care? We want more beds closer to home but how much money is available?
- Some people with mental health needs end up being cared for up-country which is not acceptable. The need for care staff is increasing all the time. We can't employ the staff requested by people in receipt of personal health budgets because there are not enough available. A recruitment drive is needed ASAP.

Session two

Key points from the group discussion (please refer to appendix one for full list):

- Easy and timely access to care packages, simplifying funding methods, better coordination across the system, short-term change to get to longer term goals, local sites for outpatient appointments; reablement and support and how do we make those viable?
- Training across care home agencies, prevention, increase rehab beds that GPs can admit to, respite provision for carers, centralising care, prevention, not one thing is going to solve the situation.
- There are constraints for Edward Hain posed by the fire risk but the beds could be used as convalescence beds for more mobile people.
- The definition of beds needed to be addressed to work out how they could be delivered locally. Previous discussions had included one 20-bed hospital placed somewhere that is accessible to everybody in the area.
- More and more pressure on Treliske, so whatever beds are provided at Edward Hain should be as flexible as possible.
- Funding needs to simplified and equitable. The Hayle day centre had £24,000 from assessed clients in 2017/18 compared to £6,000 in 2018/19. This highlights the viability of services within the community that are independent and not for profit, but provide a valuable service. These services struggle to continue when funding is cut. There is a perceived reliance on charities to support these community services. If these services don't exist people will need more support of the NHS or nursing homes, which would cost the public purse a lot more.

Minutes

SHAPING OUR FUTURE
Cornwall and the Isles of Scilly Health and Social Care Partnership

Session three

Key points from the group discussion (please refer to appendix one for full list):

- Local triaging and decision-making is needed. GP-owned step-up beds, frailty clinics and reviewing the current West Cornwall Hospital provision model, building workforce capacity and providing accessible and timely services which are locally owned was all identified as important. The defined model of care should then inform the re-purpose of buildings. It was felt that the default should be that the community provides most care, and people go to Treliske only where necessary for acute medical care.
- A model of care in Penwith is being developed where West Cornwall Hospital offers an assessment and diagnostic service.
- The Isles of Scilly model was discussed, and by making changes people were managed by the GPs and looked after by the multi-disciplinary teams. As a result, the average hospital stay had reduced from 21 to 25 days to, on average, four days.
- Workforce is an issue. If you wrap around one person, you have a nursing resource looking after one patient where as if you've got a facility with four or five short-term beds you can have a nursing team that looks after a number of people, carry out the diagnostics and then get them back out. The frailty bed model at West Cornwall Hospital should be reviewed.
- We need to look at the needs of the area and consider the required service provision, social prescribing, care at home and then the property solution as the end piece of the planning perspective. The accommodation has to be the last step and the focus should be on an integrated service provision.

What are our key challenges in supporting communities and individuals to thrive?

Session one

Key points from the group discussion (please refer to appendix one for full list):

- Rurality is a big challenge.
- We should make maximum use of West Cornwall Hospital as a sub-acute hospital.
- How many district nurses and community nurses are there? We can't support people in the community if we don't have qualified staff.
- We need to focus on prevention.
- There is a problem with recruitment as staff can't afford housing in a lot of areas and their partners can't find jobs here.
- There is a lack of awareness of what services are actually out there.
- We need more social prescribers as they provide a valuable service in making connections.
- We should consider sustainability and plan now for the future.
- We should frontload community services with clinical capacity.

- We could commission new roles to meet requirements, and focus on fully utilising what we have already.

We would like to apologise, but we do not have a complete set of notes from this discussion as one of the note takers has had to take some unexpected time off work before she wrote up her notes. We will provide these as soon as she returns to work.

What are our community needs and what is important to us?

Session one

Key points from the group discussion (please refer to appendix one for full list):

- Edward Hain has great importance historically and emotionally, but accessibility to service was the most important issue.
- Part of the problem when discussing Edward Hain was the NHS' inability to say what the beds could be used for. Edward Hain provided a good alcohol treatment service that is no longer available since the hospital closed. An individual was receiving acute hospital care at Treliske where previously they had been successfully treated at Edward Hain
- The winter reablement programme has been extended into the summer. The programme has received most referrals by relatives or other agencies. There are no mechanisms in place for the programme to take people who had been discharged from hospital. Some 30 referrals had been received for the programme in a relatively short time and 17 of these regularly attended the programme.
- The building has the backing of an organisation with money and that money is supporting the hospital presently and could also do so in the future. It was an iconic building with a local connection and held an emotional attachment for people in the town, which will guarantee an ongoing income that is over and above that which is funded publicly.
- Cornwall has an ageing population (two or three years ahead of the rest of the UK) and people are more likely to retire to the county for its quality of life. This will have an impact on any discussions regarding planning services for the future.
- A good aspiration for Penwith when discussing its need is that no patients should travel in a round trip more than 30 miles.

Session two

Key points from the group discussion (please refer to appendix one for full list):

- We need to have supportive relationships: everyone is doing more, with fewer services and money. We need to get smarter at the way we do things.
- We have an aging population – particularly prevalent in Penwith. We need to have services that meet the needs of older people, who may have mobility issues, no family nearby, and have multiple conditions.
- We need to make sure that there is more care closer to people's homes.

- People on the Isles of Scilly have managed to arrange their care needs really well. Everyone has come together, looked at what the issues are, what they need, and have arranged themselves really well. Perhaps we should look at how they have done it there and consider talking to them, see what we can learn and replicate in Penwith.
- We need a multi-agency multi-disciplinary single team, which people contact via a single number, to support people.
- There is a lot of regulation. We pay to have highly qualified people, and we should allow them permission to be trusted to do their jobs that they have been trained to do. We need to look at how we can unburden people from unnecessary regulation, whilst ensuring care remains safe.

Session three

Key points from the group discussion (please refer to appendix one for full list):

- Suggestions from the other groups include upskilling care staff and putting more mobile clinics in the community
- We need quality care closer to home.
- We should redefine what we mean by community. It feels like there are two separate communities: older people, and then younger ones whose community is almost entirely online.
- All schools have a Headstart group (targeted at the disadvantaged and those who don't tend to get involved in community activities). Schools want to become involved in designing services.
- There is a lack of home visiting by GPs and not enough available in the community.
- We need more multi-disciplinary hubs. The Merlin Centre acts as a very good hub for those in the area. We want to avoid people having to travel to multiple locations for treatment.
- There are gaps in training resources and people are not upskilled.
- People don't necessarily want to do things online. They want to have paper copies available and to be able to talk to people face to face.

Common themes

The overall message is the need for Penwith to have a range of community services, ideally providing a mixture of services both in one location and around the local area. For example, a multi-agency multi-disciplinary single team was referred to during several group discussions.

It was suggested that it could be possible to reinstate some services that were previously available at Edward Hain. It was felt there is a strong need for a community based resource with local triaging and decision making; GP-owned step-up beds; reablement programmes and frailty clinics. It was, however, thought that there would need to be additional local staff with appropriate skills to implement

these. It was recognised that most people want to be treated at home or close to home.

There remains an emotional and historical support from the town for Edward Hain hospital, and members of the group would like the site to be considered for provision of community based health and care support services.

Another key theme was to consider how we provide sufficient rehabilitation and reablement services in the community and consider how to make best use of available services such as the voluntary sector and care homes. Supporting discharge from Royal Cornwall Hospitals was also a key theme to ensure people are transferred home as soon as possible, ideally into community care rather that in a bed at Royal Cornwall Hospitals. It was felt that people living in Penwith should be supported in the community wherever possible and only attend Treliske as a last resort.

It is felt that any addition of services utilising the space provided Edward Hain will contribute to Penwith's sense of community, whilst reducing social isolation and reducing the stress of travelling out of Penwith to Royal Cornwall and West Cornwall hospitals for treatments. This particularly affects multiple groups such as the elderly, those with young children and people with mental health conditions.

What next?

NHS Kernow's project team has committed to providing notes from this meeting within seven working days. These will be shared with everyone who attended today's session to ensure transparency and accuracy of the conversations.

A dedicated Edward Hain Community Hospital page has been created on NHS Kernow's website, www.kernowccg.nhs.uk/get-involved/engagement/integrated-community-services-plans/edward-hain-community-hospital/ and this will include the materials that were provided for today's session, including presentation slides, case for change and video tour of the Hospital

People attending the workshop were also asked to confirm if they wanted to still be involved with the project and which group they wished to support: either developing a long list of options for future service provision in the Penwith area that will determine the future of Edward Hain Community Hospital, or help to develop a set of criteria against which the three long lists of options developed in Penwith, Fowey and Saltash will be measured.

NHS Kernow will write to people to confirm which group they will support.

A follow-up meeting is being arranged to progress this work, and we will keep people updated of this progress.

Completed evaluation forms from the event would be reviewed to ensure we respond to the group's requests for improvement and information.

Appendix one

SHAPING OUR FUTURE
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Appendix one: group session notes

What needs to change to provide local care and support services that are fit for the future?

Session one

Key points from discussion:

- There is a need for community beds.
- The lack of community hospitals has a knock-on effect on care homes.
- Nursing care and dementia care in particular is a gap in the market. The domestic care market is full.
- Helston Hospital has a very good reablement and rehab facility.
- Helston Hospital (as the nearest community hospital in the west) is too far away from St Just.
- Community beds are paid for by the state and are means tested. Who is going to fund all the care? We want more beds closer to home but how much money is available? Reply was given that there will be some additional funding available to GPs, but we need to consider what model of care we want, and how the system can best fund it, as opposed to what we can afford with the available money. The aim of this project is to come up with a list of possible options to then evaluate against criteria which will include affordability.
- Some people with mental health needs end up being cared for upcountry which is not acceptable. The need for care staff is increasing all the time. We can't employ the staff requested by people in receipt of personal health budgets because there are not enough available. A recruitment drive is needed ASAP.
- The council has now put in a real living wage and paid travel time for carers, after years of fighting for it. This has improved the situation and given agencies some assurance.
- Transport (both private and public) is an issue.
- We need more support for people with dementia and their carers.
- Young people don't have the same community spirit as the older ones, which means that people aren't being helped and supported in the same way as they used to be.

Session two

Key points from the discussion:

- We need to have easy and timely access to care packages, simplified funding methods, better coordination across the system; short-term change to get to longer-term goals; local sites for outpatient appointments; reablement and support. How do we make those viable?

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Appendix one

- We need training across care home agencies, prevention, increased rehab beds that GPs can admit to, respite provision for carers, centralising care and prevention. Not one thing is going to solve the situation.
- A request was made for clarifying the intention with Edward Hain. In response to this the process was explained and it was reiterated that there isn't a desired or predetermined outcome. The workshops are building on previous conversations regarding Edward Hain that have already taken place during many years and will allow the co- development of options that will determine the future of Edward Hain.
- Money is key when an organisation makes its budgets and puts together their funding proposals and at some stage a financial decision will have to be made about Edward Hain.
- An understanding is needed to be reached regarding the capacity and plan for community beds.
- There are constraints for Edward Hain posed by the fire risk but the beds could be used as convalescence beds for more mobile people.
- The definition of beds needed to be addressed in order to work out how that function could be delivered locally. Previous discussions had included one 20-bedded hospital placed somewhere that is accessible to everybody in the area.
- It was questioned whether Edward Hain was viable as a modern hospital and if it was sustainable to meet the needs of future generations. The question was asked if it would be fit for purpose in the next 10 to 15 years.
- The definition of 'beds' was discussed; was it rehabilitation, a convalescence bed or intensive interaction for people who have come out of acute hospital and what was the hospital going to provide that would benefit the community?
- There was recognition there are different types of beds including short stay, assessment to acute, sub-acute and hospice beds.
- The most prevalent diseases in Penwith as provided by public health figures are obesity, chronic kidney disease and diabetes.
- These are lifestyle illnesses and as such about public health and helping to prevent people from developing such diseases. This highlighted the importance of prevention and to look at this from the very start of the process.
- In a survey of GPs from Penwith about what beds they felt the community required one of the highest priorities were rehab and reablement. It was recognised that rehab and reablement could occur in a number of settings- your own home, in extra care housing, in care homes, in nursing homes and in community hospital.
- There was a wish to have community hospital types beds with reablement as well as having particular care homes and residential homes that have more specialist in-reach support and having rehab and reablement in the home.
- We need it all. People are leaving hospital when they are just good enough to come out of hospital, going back home with high level need and requiring manual handling equipment to manage at home. There isn't the capacity within the community rehab service to provide the level of input.

Appendix one

- On a ward with 12 beds, a nurse could see a lot more people in the day than if covering the locality. People are coming out of hospital, are more dependent and some opportunities are missed.
- The beds should include ones that GPs are able to admit to rather than sending people to Treliske, for people who require support to get 'back on their feet' but do not need acute care.
- Cornwall appeared to be shorter staffed of nurses that other areas including Devon.
- Someone in a rehab hospital bed would receive rehab every day but if they're in the community they might receive rehab once or twice a week for an hour from a support worker and it's not the same.
- Would like to see care homes and care agencies to have far more joined up training and working together in the future. Carers will then have the capacity to engage with that individual in their rehab.
- More and more pressure on Treliske and it seems that whatever beds are provided at Edward Hain should be as flexible as possible.
- Flexible but leaving out acute.
- People, everywhere, are sat waiting for packages of care. When Edward Hain and Poltair were open, the beds were being increasingly blocked by people who had high level care needs at home and just couldn't get a package.
- Commented on the bed reductions in (care) homes because care homes are closing that needed to be addressed as part of joining up the situation.
- Highlighted the model of care event a couple of weeks ago in Penwith. The event discussed the workforce as a whole across the whole of the care system so there may be flexible rotation to posts, or flexible recruitment.
- Acknowledged that a start had to be made which might help things in the short-term, but not necessarily in the long-term but would pave the way for the next effective stage.
- It would be good if more people are going to remain at home then there should be a centre that people can go to when they need higher level medical treatment, care and support.
- Barriers between organisations need to be broken down. Greater integration between the NHS and voluntary sector and better coordination (care packages should be ready to pull off the shelf as and when needed).
- The issue of financial wrangling over care packages as to whether it is health or social care needs to be resolved.
- Funding needs to simplified and equitable. Spoke about how at the Hayle day centre they had £24,000 from assessed clients in 2017/18 compared to £6,000 in 2018/19. This highlighted the viability of services within the community that are independent and not for profit making but provide a valuable service for the community and how these services struggle to continue when funding is cut. There is a reliance on charities to support these community services. If these services don't exist people will need more support of the NHS or nursing homes, which would cost the public purse a lot more.

- Raised the point regarding respite for carers and how this was going to be factored in to the work.

Session three

Key points from the discussion:

- Local triaging and decision-making is needed. GP-owned step-up beds, frailty clinics and reviewing the current West Cornwall Hospital provision model, building workforce capacity and providing accessible and timely services which are locally owned was all identified as important. The defined model of care should then inform the re-purpose of buildings. Rather than discussing specific need, whatever service is developed it needs to be accessible. The contributor drew on his experience in Helston where the only option for people who needed an upskill in their care was to send them to Treliske. The result was a long and convoluted pathway back out. There needs to be local ownership. GP owned and orchestrated beds should cover assessment, diagnostic, rehab and reablement.
- It was felt that the default should be that the community provides most care, and people go to Treliske only where necessary for acute medical care.
- There is a need to look at the services Treliske does provide such as end of life care and the ability to step up from the community rather than step down from the acute hospital.
- Triaging locally rather than sending to Treliske for triage. Local health professionals can make a judgement call as to whether local people stay locally rather than going in to Truro and then being told that they could be looked after at West Cornwall Hospital.
- A model of care in Penwith is being developed where West Cornwall Hospital offers an assessment and diagnostic service. The sensible option is to have this available in one place that is reasonably local to everyone.
- Being able to triage in the community is a step towards making decisions in the right place when working on the assumption that most people want to be treated at home or close to home.
- This offer would require more community matrons and district nurses required 24 hours a day rather than just daytime. Weekends are very difficult times for people who are elderly. Community matrons make decisions and wonder if community nurses could do the same.
- Discussed different levels of complexity that community matrons could manage that community nurses may not.
- Felt community nurses would be able to make those decisions if there were changes in the system. Staff shouldn't be labelled into a specific role or expectation.
- Discussed the different level of training and experience between community matrons, district nurses and community nurses.
- Importance had to be based on the community facility and the skills required to support it.
- Multi-disciplinary teams were important as part of the local decision making, triage assessment and coordination.

Appendix one

- The access to community triage and decision making has to be timely. The benefits of quick access into a community bed for people who are too poorly to stay at home and need some step-up care for a day or two where they have access to diagnostics are kept an eye on and then can return home with support. A barrier to providing this was that currently support can take a little while to access. Acknowledged the work with colleagues in adult social services to get the whole process in place and the difficulties faced to try to achieve this.
- Spoke about the Isles of Scilly model and how through changes whereby patients were managed by the GPs and looked after by the multi-disciplinary teams, the average hospital stay had reduced from 21 to 25 days to, on average, four days. It had been successful on the Isles of Scilly because the multi-disciplinary teams had access to resources.
- Asked that in terms of resources that would be required it would be diagnostic, short-term beds and the associated resources that run alongside the former resources.
- Not necessarily a bed somewhere, it could be in a home but the resource has to wrap around the patient in a timely way, and it has to be simple and effective.
- Workforce is an issue. If you wrap around one person, you have a nursing resource looking after one patient where as if you've got a facility with four or five short-terms beds you can have a nursing team that looks after a number of people, carry out the diagnostics and then get them back out.
- Emergency assessment looked after by the GPs rather than going into an acute hospital setting. The availability of the frailty clinic at West Cornwall Hospital and what that could offer to GPs. Confusion about if carers could refer to the service.
- Carers would like to do more but are not permitted by the rules that govern them around what they are authorised to deliver. Carers are paid less than the lowest care assistant on the NHS grade scale, the people who are providing care in the homes are underpaid which had an impact on delayed transfers of care. A need to have a basic rethink about how the care service is resourced.
- Carers cannot refer directly to the frailty clinic, but had been during the pilot service three to four years ago. Colleagues were using the urgent care centres.
- Different types of care accommodation such as extra care housing and its funding were discussed.
- We need to look at the needs of the area and consider as the required service provision, social prescribing, care at home and then the property solution as the end piece of the planning perspective. The accommodation has to be the last step and the focus should be on an integrated service provision.

Post-it notes

- Training. We need more people to do the work.
- Step down beds are needed here.
- Need greater coordination across the system.
- Focus on prevention and lifestyles.
- We can't go south, east, or west for health – end of the peninsula.
- People are travelling too far.

Appendix one

- Staff accommodation
- Services within the community.
- Rehab beds that GPs can admit to.
- Change how we deal with dementia.
- Travelling too far is an issue, Helston is too far.
- Who is going to be paying for the care needed? What money is available?
- Short term changes to help get to long term goal.
- Keeping people healthy reduces the need for services.
- Increase capacity for community rehab.
- Lack of community beds – knock on implications for care homes.
- Repurpose Edward Hain building.
- Simplify funding mechanisms.
- Local sites for attendance for outpatient / reablement day support.
- Transport and travel is a pressure on families.
- Joined up working – we don't want to be fighting over budgets.
- Centralising care in one place.
- A lot of people are waiting for care in the community.
- More support in the early stages to prevent a crisis.
- Training across care homes and agencies.
- Early and timely access to care packages.
- Changing expectations of older population. How will new technology help improve what people want in home?
- Capacity in nursing homes and residential care.
- More support in early stages to prevent a crisis.
- Accessible and timely services.
- Increase workforce capacity.
- Repurpose existing estate e.g. extra care housing, model of care feed into housing conversations.
- Local triage/decision-making and GP owned step up beds.
- Pressures on health staff. Value them; more staff needed; Cornwall Council is doing good work; pay them more; where to fund them?
- Rapid coordination response in communities.

What are our key challenges in supporting communities and individuals to thrive?

Session one

Key points from discussion:

- Rurality is a big challenge.
- We should make maximum use of West Cornwall Hospital as a sub-acute hospital.
- How many district nurses and community nurses are there? We can't support people in the community if we don't have qualified staff.

Appendix one

- We need to focus on prevention.
- The population of Cornwall is growing rapidly. There is a lack of aftercare for older people.
- There is a problem with recruitment as staff can't afford housing in a lot of areas and their partners can't find jobs here.
- There is a lack of awareness of what services are actually out there.
- We need more social prescribers as they provide a valuable service in making connections.
- Information in village newsletters, surgeries etc. would be helpful in keeping people informed.
- We should consider sustainability and plan now for the future.
- It is important to focus on what services are available locally and avoid escalating to Royal Cornwall Hospitals Trust, if possible. West Cornwall Hospital is an important asset.
- We should frontload community services with clinical capacity.
- We could commission new roles to meet requirements, and focus on fully utilising what we have already.

Session two

We apologise, but our colleague who took notes during this session had to take some unexpected time off work before she wrote up her notes. We will provide these as soon as she returns to work.

Session three

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Post-it notes

We apologise, but our colleague took the post-it notes with her to help write up her notes from the session. She has had to take some time off work before she wrote up her notes. We will provide these as soon as she returns to work.

What are our community needs and what is important to us?

Session one

Key points from discussion:

- Accessibility to services, thinking about a mixture of services both in one location and around the local area that people can reach, as well as care in people's own

homes, reinstating services that were previously available (detox at Edward Hain).

- The emotional and historical pull and support by the town for the hospital.
- We need to think about the existing services, no one should have to travel more than 30 miles in a round trip for services.
    - Connecting services (the NHS and voluntary together), reduce the disparity of things that are currently on offer and support each other in the various services available.
    - Asked for the area that the review was taking place to be defined and for the recognition that there will be slightly different view for the people who are responding with a view of Edward Hain to those of people looking at the wider view of Penwith.
    - Defined the geographical area of Penwith as the focus of the review. It was acknowledged that community network panels have a different footprint. The group if they would like it logged as something the project group should consider in the future?
    - Edward Hain has great importance historically and emotionally, but accessibility to services was the most important issue.
    - It was stated that the further away from home you receive you care the lengthier the hospital stay.
    - Friends' of Edward Hain were pleased with the winter reablement programme but wanted more information about the outcomes from the project.
    - Agreed it would be good for those outcomes to be available.
    - Important to know what the benefits of the programme have been to the community and if people who used it were local to the Penwith area?
    - Asked what the group thought of the current services available through the reablement programme and if there were any services they felt were missing.
    - This is hard to answer without knowing the benefits and if there was a correlation between the programme and people spending less time in hospital.
    - From an emotional point of view the hospital is open and that was appreciated by the people of the town.
    - For the past year a charity has funded a person qualified in reablement to provide support for people coming out of hospital to attend the Hayle day centre. During this time only two people who had been discharged from hospital had come to make use of the service in Hayle. Hospitals weren't making use of the service.
    - The reablement programme at Edward Hain is not being used by people who had been discharged from hospital, but by referrals from the community by GPs.
    - Part of the problem when discussing Edward Hain was the NHS' inability to say what the beds could be used for at the hospital. Edward Hain provided a good alcohol treatment service that is no longer available since the hospital closed. An individual was receiving acute hospital care at Treliske where previously they had been successfully treated at Edward Hain. He provided

personal experience regarding a relative who family members believe would not have died if the detox service at Edward Hain had remained opened.

- Information was provided that there was a detox facility in Hayle for inpatient care for people with more complicated drug and alcohol use. Community hospitals had been used for people who required a week-long stay rather than the six week detox programme.
- Edward Hain could still be used for detox and it showed a failure of the management to utilise the provision successfully.
- Asked which services were provided from Edward Hain when it was open and were they being provided elsewhere.
- Elder care and rehabilitation were previously provided at Edward Hain. Data showed these services are now offered further away.
- Mental health and also some heart clinics were offered at the hospital.
- The winter reablement programme has been extended into the summer. Details were provided about the types of referrals and that most were made by relatives or other agencies. There are no mechanisms in place for programme to take people who had been discharged from hospital. Some 30 referrals had been received for the programme in a relatively short time and 17 of these now regularly attended the programme.
- It was noted that more people were being nursed at home.
- Information provided about a programme in Exmouth where 70 to 80 volunteers (a mix of medical and non-medical) provide home-based visits and how this could be considered.
- It was felt that while that model was useful, group activities and wider engagement would be better delivered from some sort of centre. Acknowledged the difficulties of travelling for some people and drew on the experience of his mother when she was attending the Hayle day centre.
- Difficulty for carers to park when making home visits, which cuts short time with individuals. The chairman of Positive Parking informed the group a blue badge scheme equivalent for carers had been introduced to help alleviate the parking problems and is available countywide.
- Edward Hain has a fundraising organisation and that money has been invested into the hospital by the group.
- Frustration that money that had been used to build a day room and then the hospital had been closed a month later.
- The building has the backing of an organisation with money and that money is supporting the hospital presently and could also do so in the future. It was an iconic building with a local connection and held an emotional attachment for people in the town, which will guarantee an ongoing income that is over and above that which is funded publicly.
- Information was provided a scheme that took people out into the community and linked them with other activities and gave examples such as scrabble groups, college, coffee mornings. It allowed the person to make links with different networks. To succeed there needed to be joined-up working and an understanding of what is available and to who and where.

- Cornwall had a similar project called the Pioneer Project but it was only funded for two years and then stopped.
- Cornwall has an ageing population (two or three years ahead of the rest of the UK) and people are more likely to retire to the county for its quality of life. This will have an impact on any discussions regarding planning services for the future.
- A good aspiration for Penwith when discussing its need is that no one should travel in a round trip more than 30 miles to receive healthcare provision.

Session two

Key points from discussion:

- We have an aging population – particularly prevalent in Penwith. We need to have services that meet the needs of older people, who may have mobility issues, no family nearby, and have multiple conditions.
- We need to have supportive relationships: everyone is doing more, with fewer services and money. We need to get smarter at the way we do things.
- At a time when people's needs are increasing, it seems that services and support isn't keeping up to speed with requirements.
- We need to make sure that there is more care closer to people's homes.
- People on the Isles of Scilly have managed to arrange their care needs really well. Everyone has come together, looked at what the issues are, what they need, and have arranged themselves really well. Perhaps we should look at how they have done it there and consider talking to them, see what we can learn and replicate in Penwith.
- As a GP, I often have to make many calls to services to arrange someone's care. What we need is a single multi-disciplinary team or hub for people to work with. We need a multi-agency multi-disciplinary single team, which people contact via a single number, to support people.
- There is a lot of regulation. We pay to have highly qualified people, and we should allow them permission to be trusted to do their jobs that they have been trained to do. We need to look at how we can unburden people from unnecessary regulation, whilst ensuring care remains safe.

Session three

Key points from discussion:

- Suggestions from the other groups include upskilling care staff and putting more mobile clinics in the community.
- There has been a dramatic decrease in district nurses since one of the contributors worked at Edward Hain.
- We need quality care closer to home.
- We should redefine what we mean by community. It feels like there are two separate communities: older people, and then younger ones whose community is almost entirely online.
- People very much define themselves by the specific area in which they live.

Appendix one

- There are some ways of attracting workers to the area, e.g. in Telford employees were rented accommodation by the council which solved the issue of unaffordable housing.
- Have we invited young people to this meeting? How do we start engaging with them?
- All schools have a HeadStart group (targeted at the disadvantaged and those who don't tend to get involved in community activities). Schools want to become involved in designing services.
- My local shop is very much the hub of the community, maintaining awareness of people's wellbeing and keeping in touch with them.
- There is a lack of home visiting by GPs and not enough available in the community.
- We need more multi-disciplinary hubs. The Merlin Centre acts as a very good hub for those in the area. We want to avoid people having to travel to multiple locations for treatment.
- The podiatry clinic in Edward Hain is very good and is well used.
- The effect of tourism increases pressure on Cornwall and the summer season is becoming longer.
- There are gaps in training resources and people are not upskilled.
- Disability Cornwall has its own training programme, and also has online courses.
- How will artificial intelligence affect staffing going forward?
- Artificial intelligence may have some advantages, e.g. computerised imitation pets for people with dementia, which some companies in Cornwall are now trying to produce at affordable prices.
- Has the rate of urinary tract infections gone up since Telehealth was discontinued?
- According to stats Telehealth didn't actually make managing their conditions easier for people and they didn't seem to want it/use it.
- People don't necessarily want to do things online. They want to have paper copies available and to be able to talk to people face to face.

Post-it notes

- Winter project at Edward Hain. Not sure if it is actually supporting people who are recently discharged from hospital.
- Edward Hain reablement project. We need to understand and evaluate the people who are using the service.
- Detox facilities are no longer there. We need to reconsider getting these types of services back in the community.
- Need support for care at home – we need to help people to help themselves.
- Community nurses doing home visits to get people home.
- Volunteers go to people in their homes to support people.
- Important to define the area within scope.
- Blue badges for carers to help them park and not incur charges.

Appendix one

- Workforce: we need to coordinate needs.
- Look at the Isles of Scilly model and see how we can unburden regulation.
- Need at least what we have now.
- Stop being Truro-centric for training, and protect people's time.
- GP recruitment: need to do more to make it an attractive career.
- Need to do more to shift community services.
- Autonomy of the person – if they're happy to make a decision about their care, we should respect that.
- Get RCHT involved with discussions about community and primary care services.
- CCG insist not to agree to any spending with all partners.
- Housing issues. There is a dedicated planning officer for health who starts tomorrow. They will look at things like section 106, extra care housing etc.
- Bungalows for older people.
- Regulation scares people from doing what they need to do.
- Highly qualified nurses etc. should be doing what they're qualified for.
- Ambulance service staff to be able to do more to treat people at scene – not just take them to the emergency department.
- Technology should not replace face to face contact and care.
- AI (artificial intelligence) will impact on our workforce.
- Upskill staff and identify gaps in training for staff. Disability Cornwall has its own training courses.
- Upskill teams in the community to do more.
- More resources are needed, such as a drugs team.
- Multi agency, multi-disciplinary single team, with a single number to support people.
- Better pay and kudos for care staff.
- Mobile x-rays etc. to support people at home.
- More clinics at Edward Hain – e.g. podiatry.
- Include Headstart in these conversations to involve young people – add to the list.
- Shops etc. are good starting points to identify people in the community who may need help.
- A multi-disciplinary team hub for people.
- Need to know who people in the community are.
- Young people are carers and we need to do more to involve them in these discussions.
- Need to understand the impact of tourism and data on community services.
- What do we mean by community? More face to face conversations.
- Housing for health staff to attract and retain staff.
- Produce quality and safe care in people's homes. Come to each community – St Ives, not Penwith.
- Housing costs are expensive for people to stay in the community.
- Increase district nurses. Loss of connection with the family.

Appendix one

SHAPING OUR FUTURE
Cornwall and the Isles of Scilly Health and Social Care Partnership