NHS
Kernow
Clinical Commissioning Group

Cornwall and Isles of Scilly integrated community services and community hospital reviews and engagement.

Penwith model of care position statement

November, 2020

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1.0 Executive Summary

This report provides the strategic context for the 3 community hospital review and engagement projects. It focusses on outlining Penwith Primary Care Network's (PCN) model of care which remains in development. Penwith PCN's model of care aims to understand and improve the way that current resources both in hospitals and in the community are used with a focus on the following objectives:

a) Increasing capacity of home-based and community reablement,
b) Increasing community end of life care provision,
c) Ongoing development of integrated and multi-skilled primary, community and voluntary sector teams,
d) Developing West Cornwall Hospital as a centre of excellence for healthcare for West Cornwall residents,
e) Implementing the 'Embrace Care Programme' with focus on the 'community intervention offer'.

Whilst this report focusses on the Penwith model of care and the Edward Hain community hospital review and engagement project, some background information is also provided for the other 2 hospital reviews. This provides strategic context and rationale for the concurrent but separate approaches in each area to deliver a local response to the NHS Plan and a need to deliver modern integrated healthcare.

The process to co- develop, appraise and evaluate options with the community has concluded for Edward Hain community hospital, but remains ongoing for the other 2 sites. Public engagement on the outcome of the evaluation of Edward Hain community hospital is due to finish 4 November.

The outputs from the public engagement will be presented to Health and Adult Social Care Overview and Scrutiny Committee (HASCOSC) 25 November. This information and the feedback from HASCOSC will then be presented to NHS Kernow Governing Body at its December meeting to inform their decision in respect of the Edward Hain community hospital and related health service provision in St.Ives and Penwith. Due to the depth of engagement and community collaboration conducted to date and the fact that the model of care has been in development for over 4 years since the temporary inpatient bed closures, no further engagement is planned prior to the Governing Body making its decision. Work to co-develop, appraise and evaluate the options with the communities in the other 2 hospital locations continues.

2.0 Background

The 3 community hospitals (Edward Hain community hospital, St Ives; St Barnabas community hospital, Saltash and Fowey community hospital, Fowey) have been part of community service reviews as the hospitals have been temporarily closed to inpatient beds for up to 4 years. The 3 sites have been prioritised for reviews over other sites due to requests from the local communities to make a decision on the future of the hospitals. These projects sit within the countywide transformation programme that is developing a new model of place based care. Further information

on the background and context for each of the 3 projects can be found in appendix 1. The location of the hospitals and travel considerations can be found in appendix 2.

3.0 The countywide strategic context

Cornwall and Isles of Scilly (CIOS) Health and Care Partnership[1] is founded on collaboration and integration. Representing the health and care system, partners are committed to the vison to ensure people stay well and healthy for long as possible, that people support themselves and each other to remain well in their community and that we can create services that we're proud of that reduce cost overall. Further information on our countywide strategy (including estates) and case for change can be found in appendix 3.

Within this overarching vision, NHS Kernow (alongside health and care system partners and people who live and work in our communities) have been looking at how local assets (community activities, staff, volunteers, buildings and services) can be best used to create an integrated, community-based health and care system. By 'integrated' we mean how individuals, teams, services and organisations can work better together in a more joined up way to ensure people receive the right care and support at the right time, in the right place by the right person. If we can achieve that then people will experience the best outcomes for their needs. This is the context for the review of the 3 hospitals and the consideration of their role to play in the delivery of place based integrated community services.

4.0 Integrated Care Areas (ICAs) and place-based model of care

The 3 projects aim to develop our strategy for integrated community services. They are doing this by reviewing the local population needs and the community services that respond to those needs and considering the role the community hospitals have to play in healthcare provision. This will determine what local place based model of care is required with reference to the emerging strategy for the rest of Cornwall and the Isles of Scilly (CIOS). Further information on the countywide strategic direction is in appendix 3.

CIOS health and care partnership system has organised place based care in 3 Integrated Care Areas (ICAs): West (location of Edward Hain hospital), Central (location of Fowey hospital) and North and East Cornwall (location of St Barnabas hospital). The ICAs contain groupings of Primary Care Networks (PCNs). Maps with the location of all hospitals are in appendix 2.

The principle of place based care recognises that people live in communities and expect services to work together in those places to support them to achieve their health and care outcomes. ICAs are a geographical footprint to aid the logical grouping of services, partners and people working at a size and scale that enable targeted population health management and bespoke solutions to improve people's outcomes and meet different geographical needs.

[1] https://cioshealthandcare.nhs.uk/

The 3 ICAs are our infrastructure for providing place-based care which is why the 3 community hospital projects have been tailored to specifically consider the needs of individual communities. Care will be designed, planned and delivered around 'place' by integrated teams in local communities best able to respond proactively and cohesively to local needs, i.e. place based care. Accessible good quality, resilient primary care services will be at the centre.

Within each ICA, senior managers from key partner organisations form leadership groups to work collectively and collaboratively to strategically plan, design and deliver integrated services that deliver agreed local priorities and system objectives with the purpose of meeting population health needs and improving health outcomes. This promotes a distributed leadership model to deliver integrated primary and community care closer to home. People, systems and processes are aligned to the 3 ICAs. Penwith PCN (and Edward Hain community hospital) sits within the West ICA. Further information on the services in the West ICA is found in appendix 2.

Fundamental to this approach is the integration of locally managed community based health and care teams, aligned across adults and children, and better able to coordinate care and support, in partnership with our vibrant voluntary sector.

The co-development of each of the 3 community hospital stakeholder group's working ideas and options for the future of the hospital have all had the place base approach at their heart-driven by the views of the local stakeholders.

There is already a step change in our approach to improving health and wellbeing, including a fundamental shift from services that are predominantly reactive to a proactive and cohesive health and care system that has improving health and tackling inequalities at its core. We are working with individuals, families and communities to start well, live well and age well.

This will result in a sustainable, thriving health and care system meeting the needs of our local communities today and tomorrow.

4.1 How we are organising staff differently to support this new approach

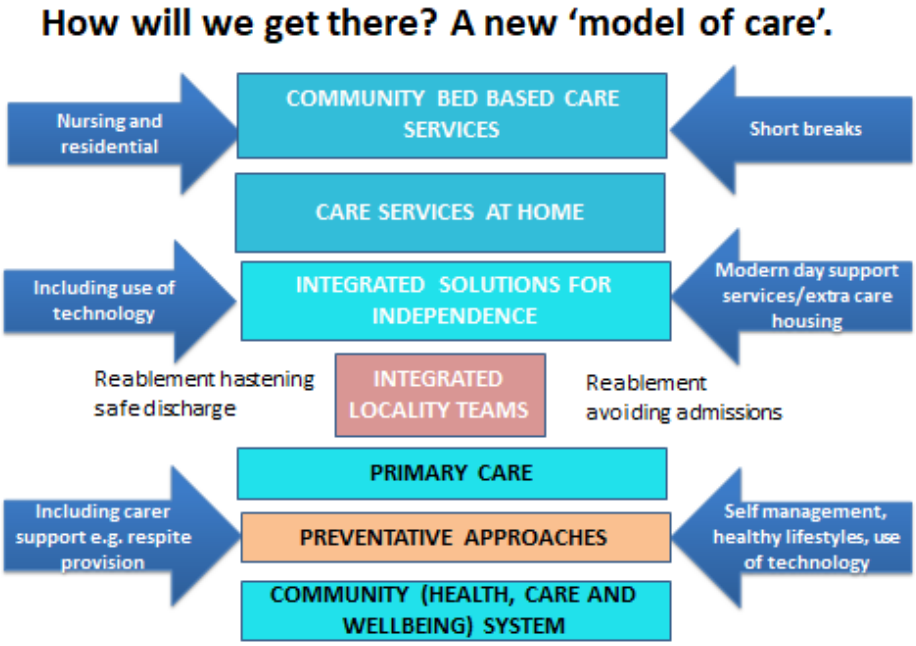
Our Long Term Plan outlines key aims that include:

- Re-balancing the system to have a much greater focus on helping people stay as healthy and independent as possible for as long as possible in their community. This will reduce the impact of ill health for individuals and the consequent demand for (and cost of) more interventional services.
- Care designed, planned and delivered by integrated teams in local communities best able to respond proactively and cohesively to local needs, i.e. place-based care.
- Care personalised for individuals, getting to the heart of what motivates a person to get better or live well with long term health issues, and tackling head on what matters most to individuals to support them to be happy, healthy and independent.

- Making a demonstrable impact on health inequalities, recognising that if we do not support those who are not able to make best use of services, we will widen inequalities.
- Equipping our collective workforce to support a new care model: ensuring every contact is a health promoting opportunity, encouraging and supporting self-care, prevention and independence and delivering holistic care personalised to what matters to individuals.

The model of care will therefore have community health and wellbeing at its foundation, with a focus on primary care and community prevention approaches, supporting people through integrated teams in their own home and communities to develop and maintain their independence with the options of bedded care as led by clinical need. This model is represented in figure 1 below.

Figure 1: Diagrammatic representation of the model of care



4.2 Penwith Primary Care Network: leading the model of care

Penwith Primary Care Network (PCN) is comprised of 8 GP practices and has 2 co-Clinical Directors. As outlined above, the development of PCNs sits within an overall strategy for building the resilience of GP Practices, developing the role of primary care and addressing the foundation of the care model by implementing the community health management approach. PCNs are an essential component of our Integrated Care System, and under the new Network Contract, general practice are taking the leading role in every network working collaboratively with partner agencies, the voluntary sector and local communities. GP practices and their registered populations are the building blocks for a new model of service delivery where practitioners and communities collaborate and optimise community assets.

The Edward Hain community hospital review and concurrent development of the Penwith place based model of care is a prime example of this approach.

By the end of 2023/24 we aim that:

- PCNs will support seamless care across primary care and community services;
- PCNs will lead population health management in their area, increasing action on prevention and reducing health inequalities for their population;
- Networking will have helped to stabilise general practice and enable a closer working relationship with secondary care clinicians offering opportunities to integrate some elements of secondary care into place-based care and support.

This will have been underpinned by development of a flexible, multi-skilled workforce, digital transformation and development of a fit for purpose estate.

The ambition of the Penwith community and PCN is that care will be delivered in a person's own home unless it is clinically or operationally essential for it to be delivered in a specific care environment. Through the review of Edward Hain community hospital and model of care development workshops, Penwith community stakeholder group identified key design principles for the development of any local model of care:

- Treat people close to, or at home.
- Provision of care and support within the local community should be the default option.
- Focus on prevention and healthy lifestyles and use a family as well as an individual approach.
- Enable local flexibility, control and capacity in community-based services, sharing resources across organisations so more people can be cared for in the community.
- Local services should be based on local need.
- Build sustainability across all services - including the voluntary and independent sector.
- Make the most of what we have - connect people and services.

The priority focus areas for developing the model of care in Penwith are to understand and improve the way that current resources both in hospitals and in the community are used with a focus on:

- Increasing capacity of home-based and community reablement.
- Increase in community end of life care provision.
- Ongoing development of integrated and multi-skilled primary. community and voluntary sector teams.
- Developing West Cornwall Hospital as a centre of excellence for healthcare for West Cornwall residents.
- Implementing the Embrace Care Programme.

The ambition is to ensure that there are sufficient alternatives to bed-based care so that people receive care and support in their own home unless it is clinically

necessary for it to be delivered in a specific care environment. Information on the use of hospital beds is found in appendix 4. Information on the services that have been put in place to provide alternatives to bed based care since the bed closures at Edward Hain community hospital is found in appendix 5.

4.3 Penwith Primary Care Network: community intervention offer

A large part of the development of Penwith model of care is the continued shaping and development of the Penwith 'community intervention offer'. This is underway in Penwith, further developed through the service changes required to respond to Covid -19 to create a single integrated community team. This Penwith integrated community team spans multiple disciplines and is currently being tested alongside the Covid inspired infrastructure of the community coordination centres (CCCs) and bed bureaus as described in appendix 5. These functions are currently being tested on a small scale alongside existing services and Penwith CCC will remain in place until at least March 2021 to allow sufficient operational testing. Figure 2 below outlines this ambition where the Embrace programme that initially undertook an important diagnostic of CIOS bed demand (appendix 4) has now implemented transformational work streams to continue to develop the place based model of care. The key Embrace work streams for the development of community model of care is the temporary bedded care and community intervention offer.

Figure 2. An integrated approach to care in the community

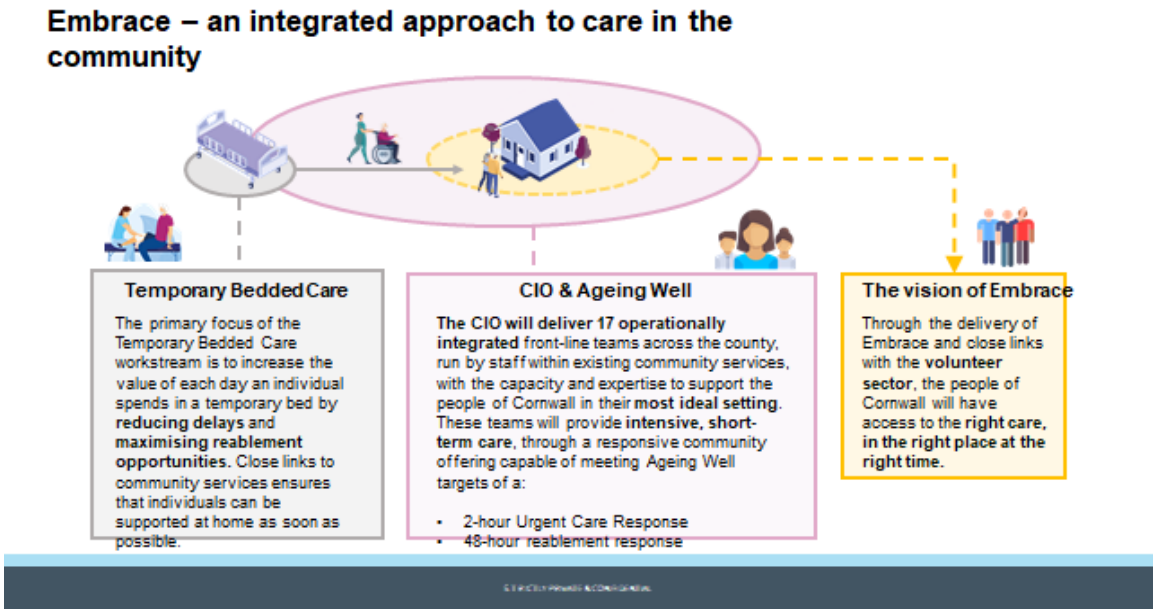
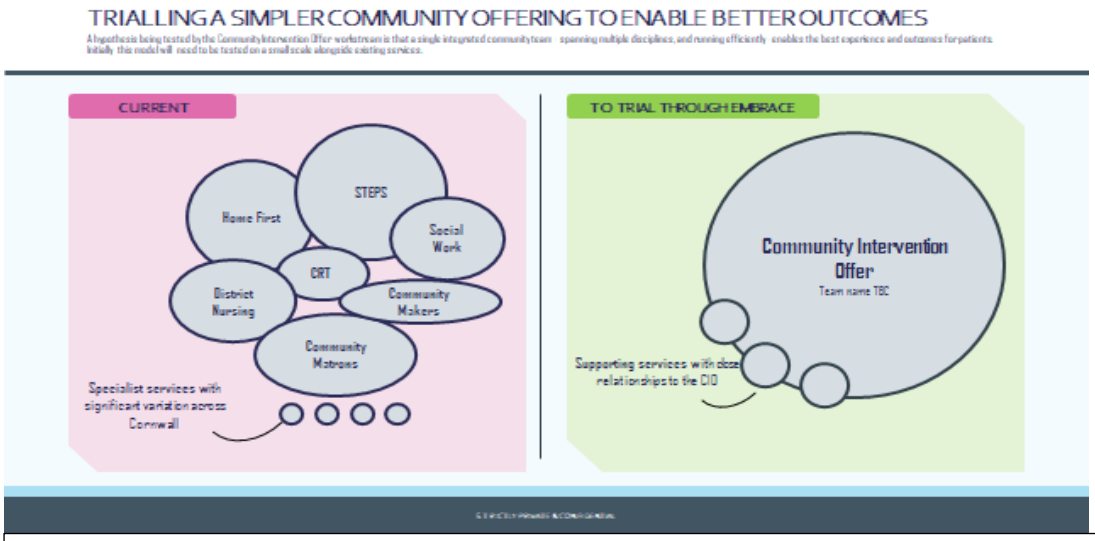


Figure 3 below shows a infographic of how the current service functions on the left are being integrated to create a single access point (via community coordination centres) and a single electronic referral to access a single 'community intervention offer' where the allocation of the right resource to the person at the right time occurs through the single access route. Further information is provided in appendix 5.

Figure 3. Penwith community intervention offer



Key to above service names:

CRT=community rehabilitation teams.
Home First= short-term community reablement team comprised of nurses, occupational therapists, physiotherapists and generic support workers. Service aims to enable discharge and admission avoidance. Health-led.
STEPS=Short Term Enablement and Planning Services. Short-term community reablement team comprised of occupational therapists and generic support workers. Service aims to enable discharge and admission avoidance. Social care-led.
Community makers: Staff working in the communities of Cornwall to encourage voluntary action. Each Community Maker is there to know and understand the network of voluntary and community groups in their area and how they can support community needs. They also help facilitate local solutions to problems and issues through people power – galvanising communities to take action and connecting them to appropriate support. They are supporting the transformation of health and care services by harnessing local resources so that everyone can help play a role in maintaining or improving the health and well-being of individuals, families and communities.

Within the development of the model of care for each ICA, the community hospital function is a key consideration. As part of the engagement and options evaluation process Edward Hain community hospital has been considered in its ability to respond to the provision of health care provision.

5.0 The role of community hospitals in the context of local models of integrated community care

Integrated community care will be shaped locally according to the needs of the local population (ideally shaped around populations of 30-50,000 people). Its development will play a significant part in how our community assets (including estates) are utilised in the future. Further information on the hospital locations and facilities can be found in appendix 2.

Our current community hospitals fulfil a range of pathways and functions that include some or all of the following:

- **Step-up** – admission avoidance, stepping into a community frailty receiving facility.
- **Step-out** – rapid transfer from Older People's Assessment and Liaison (OPAL) Service and/or Community Assessment and Treatment Unit (CATU) facility to community frailty receiving facility.
- **Step-down** – planned transfer to reablement / rehabilitation facility.

Currently, our understanding of step up provision (being admitted to/attending a community hospital directly from the community rather than being 'stepped down' from an acute hospital) is that such a unit would have at minimum, access to diagnostics, point of care testing, ultra sound and X-ray provision. In addition a step up unit would ideally provide some or all of the below:

- 24 hour medical care (with the potential to be provided by new senior practitioner roles such as Associate Practitioners).
- CT scanning.
- Seven day admissions, assessment and discharge management.
- Co-located primary care out of hours services.
- Access to multi-disciplinary frailty assessment team (which could include community in reach provision).

For those sites where they do not have sufficient diagnostic facilities there could be opportunity for step up provision if the diagnostic work up were to occur elsewhere or was not deemed to be needed by the community team.

It is expected that community hospital functions and capability will include some or all of the below:

- Inpatient beds that are capable of providing an alternative to acute hospital admission or early return from the acute hospital where someone's medical condition allows.
- Provision of skilled staff in an environment that is Health Technical Memoranda (HTM) and Health Buildings Notes (HBN) compliant (safe and suitable).
- A minor injury / treatment assessment area that is capable of providing assessment / care and treatment as an alternative to going to the emergency department if appropriate.
- Clinical engagement space that is multi-functional and can be used by a broad range of health and care services.
- Office and meeting accommodation for co-located community teams.
- A minimum of 16 inpatient beds as recommended by the Clinical Senate[2].
- A high standard of inpatient, medical, nursing and therapeutic treatment and care which cannot reasonably be provided to individuals in their own homes and for whom admission to an acute hospital is not indicated.

[2] https://www.swsenate.nhs.uk/wp-content/uploads/2019/10/2019-19-09-Senate-Recommendations-Community-Hospitals-FINAL.pdf

- A planned outcome of maximising independence based on a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- Multi-disciplinary working within co-ordinated assessment processes and shared protocols.
- Palliative care, if chosen as the persons preferred place of death
- A range of outpatient services, including those managed by acute providers, which will be accessible to people of all ages.
- A range of ambulatory care services including diagnostics and rehabilitation.

5.1 Edward Hain community hospital capability

Prior to the service review and engagement process, Edward Hain community hospital was not being maximally utilised (3 clinic rooms providing up to 13 clinic sessions a month) and had long term temporary closure of 12 beds since 2016. The site is not fire safety compliant for bed evacuation, requires significant investment, and is not identified as a priority site for strategic investment nor is a designated site for an urgent treatment centre (UTC).

Edward Hain community hospital did not achieve the necessary status in terms of key configuration of UTC facilities such as:

- Physical and environmental accessibility-ease of access for a large proportion of the population. Travel information in appendix 2 provides more information.
- 24/7 or daily medical cover.
- Allied health professionals (such as physiotherapists, occupational therapy, speech and language therapy) on site.
- x ray, ECG, point of care testing or ultrasound.
- Strategically placed unit with a long term economic viability.
- Standardised capability of enhanced MIU (Minor Injuries Unit) / urgent care provision aligned to standardised diagnostic capability.
- 7 days a week multi-disciplinary admissions management service.

The process to evaluate the option to re-instate the 12 inpatient beds at Edward Hain has confirmed that the site is not viable to provide the community hospital function as outlined above. Appendix 2 includes some context for the consideration of any travel impact for Penwith residents. Edward Hain community hospital is 10 miles away from a sub-acute hospital in Penzance with inpatient, outpatient, 24/7 urgent treatment centre and community assessment and treatment unit.

6.0 Edward Hain community hospital and the service provision

The context for this project was to determine what role Edward Hain community hospital could play in the emerging Penwith model of care based on local population need and taking in to consideration all the service changes that have taken place since the closure of 12 beds in 2016. Further information on the service changes can be found in appendix 5. Further information on the process undertaken to develop

and appraise potential options with the community stakeholder group can be found in appendix 6.

Key activity information for Edward Hain community hospital is outlined in the following sections with an appraisal of alternative service provision for the bedded care since bed closure in 2016. The inpatient activity is based on the demand and use from 12 months before the bed closures and adjusted against the current average length of stay to provide the current projected capacity for inpatient beds were the site to be open. The community clinic activity is based on current levels of activity.

6.1 Prior to bed closure: 12 reablement inpatient beds (with reablement, end of life care and 1 drug and alcohol detoxification bed)

This bed based provision excludes provision for:

1. People with dementia and/or significant cognitive difficulties and bariatric care needs due to environmental constraints.
2. People requiring specialist neurological, stroke and amputation pathways as these pathways are provided elsewhere (within 30 minutes car drive from Edward Hain community hospital).

The ward model of care was nurse led with in-reach therapy provision from community teams and GP support from the local GP surgery in St Ives.

The 12 beds provided capacity for 220 people per annum (including 29 people for drug and/ or alcohol detoxification treatment). Based on previous levels of activity, the percentage of attendance for residents of Penwith would be 64% (140 people), 19% (42) of these would be registered to the local surgery in St Ives and the rest would be for residents outside of Penwith. Due to the lack of medical staffing and diagnostic facilities at Edward Hain community hospital (no x-ray, point of care testing, CT scan or ultra-sound), step up care was limited to provision of end of life care.

6.2. Current delivery: podiatry and community mental health clinics

Since the bed closures in 2016 community clinics have continued to operate in Edward Hain community hospital. Podiatry clinics run 2 days a week and mental health clinics run 1 morning a month. The summary information for attendee numbers is provided below:

- **Mental Health clinic activity (**15 month period from April 2019 to June 2020)**:**
    - 28 individuals have attended Edward Hain mental health clinics (1 receiving early intervention in psychosis treatment, 22 receiving

support from community mental health teams and 3 receiving psychotherapy).
    - The majority of attendees over the last 15 months (26 people and 93%) have been registered with the local Stennack Surgery in St Ives.

- **Podiatry clinic activity (**15 month period from April 2019 to June 2020)**:**
    - 390 individuals have accessed Edward Hain podiatry clinics.
    - The majority of attendees over the last 15 months (285 and 73%) have been registered with Stennack Surgery, St Ives. The next highest group of attendees are from the neighbouring town, Hayle (57 and 15%).

The community stakeholder group did not wish to evaluate the option to hold community clinics as a standalone option in the community hospital. This was because it was recognised that the occupation of 1 to 2 clinic rooms for up to 2 days a week and maintaining the hospital infrastructure costs for the long term to enable this was not viable.

The purpose of the following sections is to set out what the alternative provision to bed based reablement, end of life care and hospital based drug and alcohol detoxification is for the population of Penwith should the decision be made to maintain permanent closure of the 12 beds at Edward Hain community hospital. It will also provide information on the proposed re-location of Edward Hain community hospital existing podiatry and mental health clinics should the decision be made that the hospital is not viable for ongoing healthcare provision.

7.0 Alternative model of care provision

7.1. Prior to bed closures: 12 reablement inpatient beds (with reablement, end of life care and 1 drug and alcohol detoxification bed)

The service review found evidence that the system has an over reliance on bed based care and that there is an inefficient and ineffective use of existing bedded hospital care. On the basis of this evidence (more detail can be found in appendix 4), the 12 inpatient beds that were closed in 2016 are not intended to be re-located elsewhere. The function of the 12 reablement beds (including provision of some end of life care) and 1 bed for drug and alcohol detoxification are provided by alternative and/or enhanced community services. Figure 4 below provides the summary information for this and appendix 5 provides more detail on the alternative and enhanced services.

All of the service changes outlined in appendix 5 form part of the development of an emerging model of care for Penwith with the strategic intention to keep people at home or close to home for as long as possible. This is also in line with what the community stakeholder group identified as being important principles when considering services. These changes all work towards reducing the demand for

hospital beds and supporting an appropriate length of hospital stay when a hospital admission is required for people.

Figure 4. Summary of alternative model of provision

Service function
• 12 inpatient reablement beds supporting up to 220 people a year and offering the choice for end of life care
Alternative model of provision (more detail in appendix 5)
• Increasing capacity of home-based and community reablement. • Increase in community end of life care provision-community 'hub' and additional 2 hospice beds (10 miles from Edward Hain community hospital). • Ongoing development of integrated and multi-skilled primary, community and voluntary sector teams to increase ability to support people in their communities. • Developing West Cornwall Hospital as a centre of excellence for healthcare for West Cornwall residents (10 miles from Edward Hain community hospital). This includes the provision of bed based rehabilitation and reablement and 24/7 Community Assessment and Treatment Units. • Implementing the Embrace Care Programme and the development of the 'community intervention offer' to increase ability to support people in their communities and provides alternatives to bedded care. • Plans agreed by Council Cabinet for new purpose built extra care housing (70 flats), 4 miles from Edward Hain community hospital.
Service function
• Provision of 1 of the 12 beds for drug and alcohol detoxification. This bed was accessible to the whole county-not just for Penwith or West Integrated Care Area residents.
Alternative model of provision
• The single bed for drug and alcohol detoxification for the West ICA is provided at Helston Community Hospital (15 miles from Edward Hain community hospital). • This bed continues to be accessible to the whole county-not just for Penwith or West ICA residents.

7.2 Alternative provision: potential re-location of Edward Hain community clinics

In order that NHS Kernow can make a formal decision on the future of Edward Hain community hospital, work has been undertaken to identify potential alternative locations for the existing Edward Hain community clinics, should a subsequent decision be made by the Governing Body that the hospital is to close.

Currently Edward Hain community hospital is open 2 days a week for podiatry and 1 morning a month for mental health clinics.

Working with the current clinic staff and the Edward Hain community hospital multi-agency project group the following work was undertaken to help inform the location for potential clinic relocation. We are currently seeking views on this through a wider public engagement process and have written to all clinic attendees.

Potential sites were identified looking at a 20-mile radius to Edward Hain community hospital. 11 sites were reviewed taking into consideration the below elements:

a. Quality (safety and appropriate environment).
b. Access (equity of provision and access and distance required to travel).
c. Deliverability (time to transfer and implement services, 'readiness of site' to accept the services).
d. Finance (affordability).

There was a clear preferred option for a potential relocation of the existing community clinics should the decision be made to close the hospital. This preferred site was the local surgery in St Ives, Stennack, 0.5 miles from Edward Hain community hospital. The proposal would be that the existing clinics move in their current form to the GP surgery which is more centrally location in town with adequate parking and level access. This improves the environment and access currently experienced by individuals attending Edward Hain community hospital (currently at the top of a steep hill, limited parking, not Equality Act compliant and limited clinic room space). 93% of the current podiatry clinic attendees (26 people) and 73% of the mental health clinics attendees (285 people) are registered with this GP surgery.

8.0 Future Penwith model of care developments

Work still continues within Penwith and across the West Integrated Care Area to further develop the local model of care (this includes considering all bedded care provision in hospitals, care homes, extra care housing, hospices and people's own homes). This development of Penwith (and West Cornwall) integrated community services and enabling estates strategy will continue under the leadership of Penwith PCN and Cornwall and Isles of Scilly Estates Strategy Group, reporting to and including community stakeholders via the well-established Penwith Integrated Care Forum. This includes individuals from the Penwith and Edward Hain community hospital stakeholder group.

Appendix 1

The background and strategic context for the 3 community hospital review and engagement projects

The 3 separate integrated services and community hospital review and engagement projects were established in January 2019. At the NHSE stage one assurance review meeting at that time it was agreed that each project would be implemented independently, following the same process, but with recognition that the pace may be different according to the local context. Each project has its own separate governance and multi-agency project group, but has the same project lead to ensure consistency of approach and that learning is shared across all sites as the work progresses. Each project has a working 'community stakeholder group' who meet face to face through workshops and a larger 'virtual stakeholder group' who are kept informed of the progress and process. Further information on all projects can be found here. Further information on the adherence to the NHSE Five Tests is found in appendix 7.

The 3 separate, but concurrently run projects aim to identify and evaluate options to determine the future of each hospital based on local population need, set within the overall context of the system plan and the changing community place based model of care. This has been achieved in each area through robust local engagement and the ongoing development of the model of care.

The process that was agreed with each of the 3 community stakeholder groups was to explore local population need, review local service delivery and develop a potential long list of options for the hospitals based on that need. The long listed options would then be appraised with the community stakeholder group to provide a short list for full evaluation. The entire process to develop, appraise and evaluate the options was all developed with, and agreed by, the community stakeholder groups. It was accepted that whilst the process would be the same across the 3 sites, the pace and options would vary according to the local context.

For background information, the stage that each of the 3 projects is at is provided below:

1. **Edward Hain community hospital, Penwith** - long listed options developed and appraised (7 out of 8 were discounted), short listed option identified and formally evaluated. This process has concluded and determined that the short listed option (to re-instate the 12 inpatient beds and continue with existing community clinics in a fire safety compliant and refurbished building) is not viable. A 4 week wider public engagement (including current clinic attendees) is now underway. A summary of this work can be found in our public engagement report here.
2. **St Barnabas community hospital, Saltash** - long listed options developed and appraised. This process is still ongoing, with a focus on developing a short listed option for a 'health and wellbeing hub'. This is the community's current preferred option. There are currently 4 Saltash community 'hubs' and the group is considering what needs to be provided in addition to these and

what role St. Barnabas community hospital could play in future provision. Further work is required to clearly define this before any appraisal or evaluation can occur. Further information can be found here.

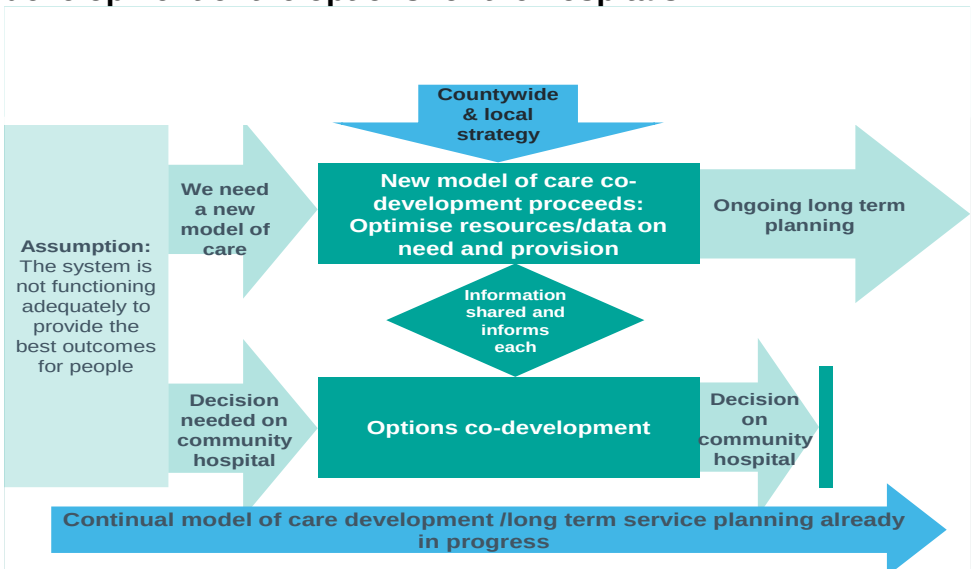
3. **Fowey community hospital** - long list of options are not yet developed. We are still working with the community exploring local need and population data. The community stakeholder group broadly accept that the site is not suitable for inpatient provision and has stated they would like a nursing home in Fowey. The option of a Fowey care home has been explored with community representatives through reviewing data, local strategy and undertaking site visits to assess site feasibility. This work is ongoing. Information is found here.

The ongoing work to develop the emerging model of care for each of the above areas continues alongside the process to specifically determine the role that the hospital sites could play in enabling the service delivery. As the model of care is iterative and ongoing, it was agreed with the community stakeholder groups that:

a) The 2 work streams (developing the model of care and developing options for the hospital sites) would occur separately, but had inter-dependencies and each would inform the other.
b) Due to the time frame of bed closure at each hospital site (up to 4 years) it was felt there was sufficient information already available to determine the options for the hospital sites and to determine their potential role within the model of care despite the recognition that the model of care remains in progress through a 'test and learn' approach (accelerated by the demands of Covid-19).

Figure 1 below shows how we described the 2 processes to develop the model of care and hospital options to the community stakeholder groups.

Figure 1: The concurrent process of model of care development and development of the options for the hospitals



Summary of context and services at each hospital:

St Barnabas community hospital, Saltash

Before temporary bed closure in February 2017 (due to fire safety and staffing concerns), St Barnabas community hospital provided 9 inpatient beds and a minor injury unit (MIU) (with no x-ray) which was dependent on staffing from the inpatient wards. The beds and MIU have remained closed since then, but several community clinics continue to operate on a daily basis. MIU provision is currently provided from 2 GP surgeries in the town. Since Covid-19 face to face clinics have reduced and have been supplemented by remote delivery options such as telephone and video consultations. Currently, the only clinics that are running from the hospital are podiatry and orthotics. No other clinics are running due to the constraints of the building layout and needing to keep a Covid safe environment as there are adult and paediatric clinics on site and waiting areas cannot mix. District nurses, health visitors and acute care at home teams are still working from the site.

Fowey community hospital, Fowey

Before temporary bed closure in August 2016 (due to infection control and safe staffing concerns), Fowey community hospital provided 6 beds and a minor injury unit (MIU) (with no x-ray) which was dependent on staffing from the inpatient wards. The beds and MIU have remained closed since then and no other clinical or non-clinical activity happens at the hospital. MIU provision is currently provided from the GP surgery in the town.

Edward Hain community hospital, St Ives

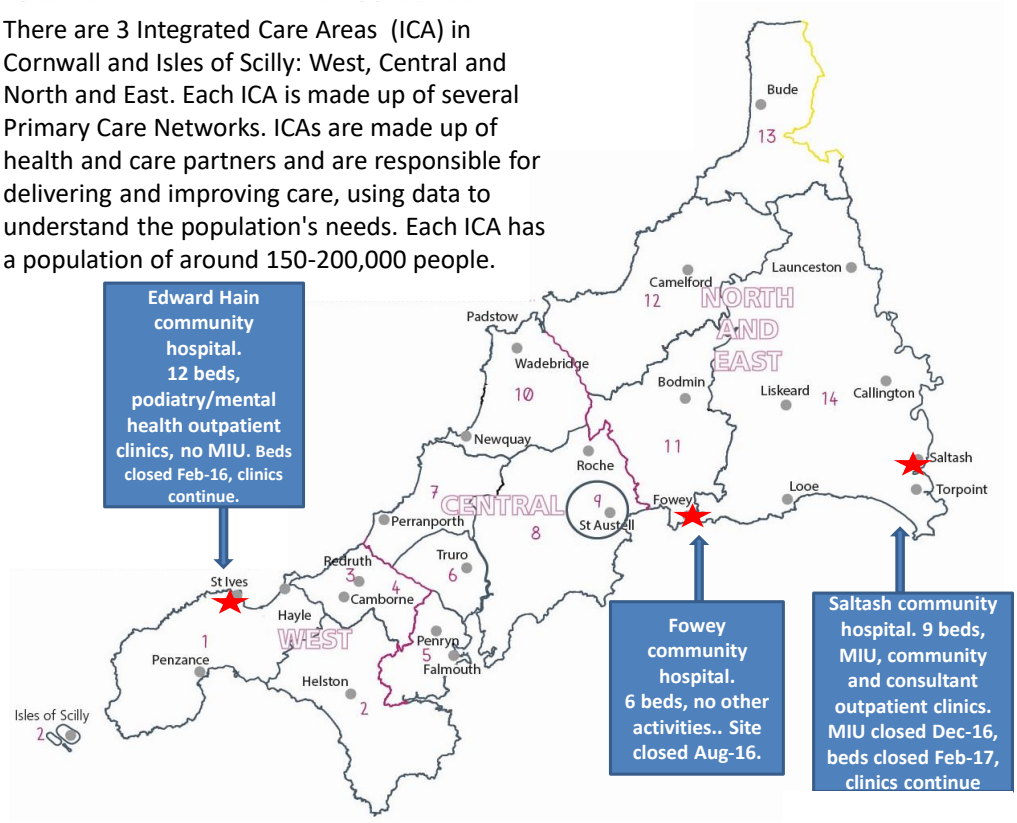
Before temporary bed closure in February 2016 (due to fire safety concerns), Edward Hain community hospital provided 12 inpatient beds (historically supporting up to 220 people a year, and an average of 42 from St Ives) and podiatry and community mental health clinics (supporting up to 366 people a year pre Covid-19). The beds would provide reablement (helping people to regain their independence after all illness or injury) and end of life care with 1 bed also being available for drug and alcohol detoxification treatment (supporting up to 29 people a year). The beds have remained closed since then. The podiatry and mental health clinics continue to operate 2 days a week.

Appendix 2

Place based commissioning, location of the hospitals and travel considerations

The 3 community hospitals are located in separate integrated care areas (ICA) as figure 1 below shows. The community stakeholders have defined what 'catchment area' they would like to consider in terms of population need and developing options for the hospital sites based on this need. For Edward Hain community hospital, St Ives it is Penwith (population 65,170), for St Barnabas community hospital it is Saltash (population 23,600) and for Fowey community hospital it is a specified Primary Care Network footprint around Fowey (population 19,500).

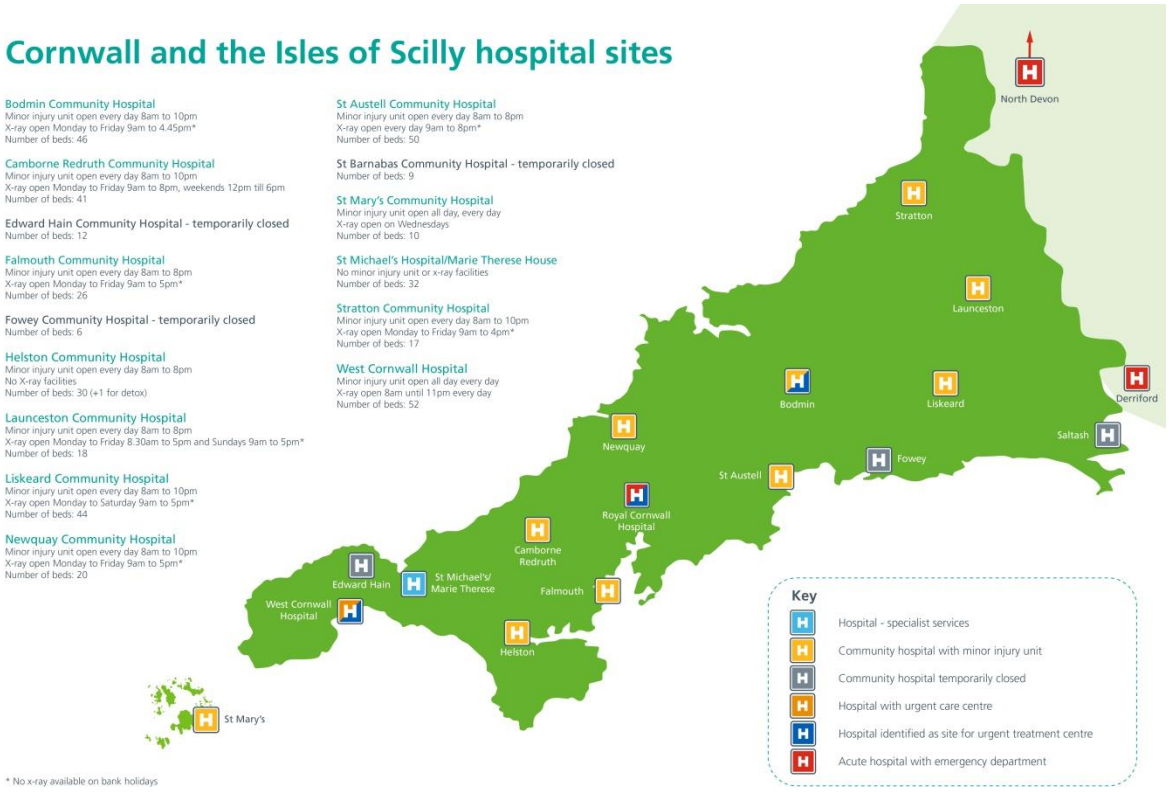
Figure 1. Map showing 3 integrated care areas and location of the 3 hospitals



The community hospitals in these reviews are 3 of the total of 14 community hospitals across CIOS.

Figure 2 below shows the location of the 3 community hospitals in relation to other hospitals. The coloured key indicates those hospitals that are designated urgent treatment centres, have integrated minor injury units or an emergency department.

Figure 2. Hospital sites and their function within the system



The closest hospital facilities to each of the 3 hospitals in question are outlined below:

1. Edward Hain community hospital is 10 miles away from a sub-acute hospital in Penzance with inpatient, outpatient, 24/7 urgent treatment centre and community assessment and treatment unit.
2. Fowey community hospital is 8 miles away from the nearest community hospital in St Austell (inpatient, outpatient, Minor Injury Unit) and 12 miles away from Bodmin community hospital, a site identified for an urgent treatment centre.
3. St Barnabas community hospital is 6 miles away from an acute hospital with an urgent treatment centre in Plymouth and the nearest community hospital is 14 miles away in Liskeard.

Figure 3 below shows a high-level summary of the service provision across West ICA.

Figure 3. High level service summary for West Integrated Care Area

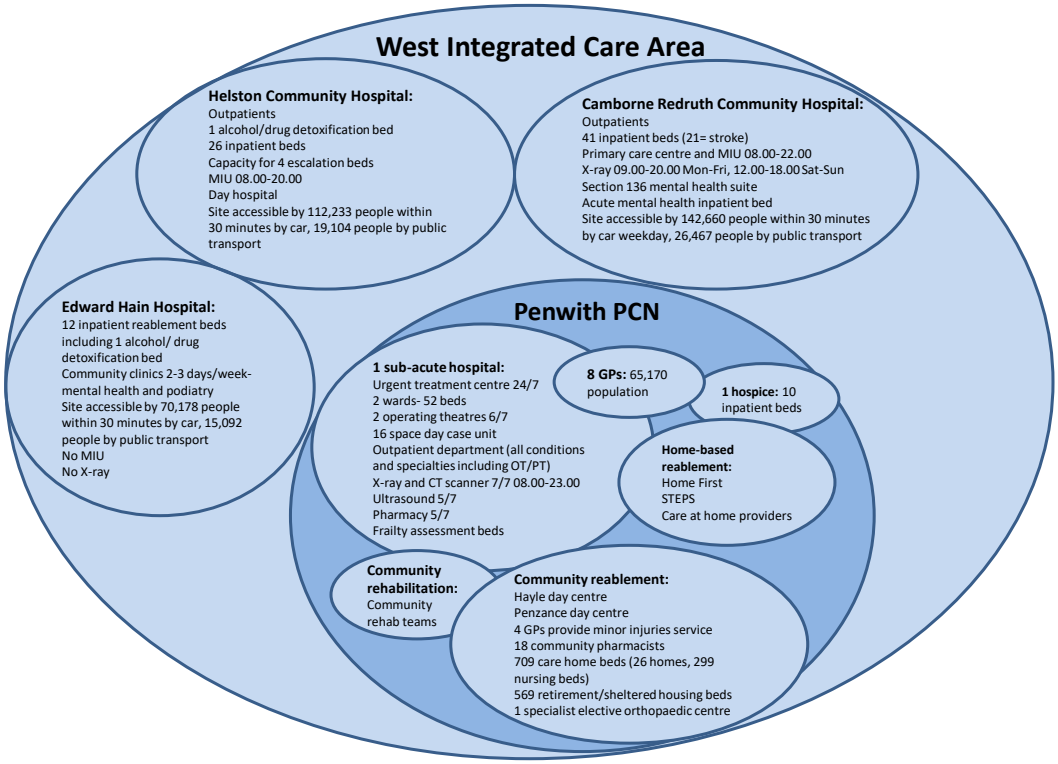


Table 1 below shows Edward Hain community hospital's relative accessibility for all people living in Cornwall compared to other nearby hospital sites. It shows the number of people who can access each site in the west within 30 minutes in a car or using public transport (one in four households in Penwith has no car) during the weekday and at weekends. Edward Hain community hospital is the least accessible site in terms of numbers of people who can attend within 30 minutes. These figures do not take seasonal variation into account. Edward Hain community hospital is in St Ives which has a year-round significant tourist influx which causes seasonal challenges with access in and out of the town and considerable additional travel times.

Table 1: Numbers of people across Cornwall that can attend hospital sites in the West ICA within 30 minutes by car and public transport at the weekends and weekdays

	Public transport		Car travel	
Site	<= 30 mins		<= 30 mins	
	weekdays	Weekends	weekdays	weekends
Camborne Redruth Hospital	26,467	22,559	142,660	141,283
Helston Hospital	19,104	13,961	112,233	113,427
West Cornwall Hospital	16,729	13,391	73,179	76,361
Edward Hain Hospital	15,092	13,960	70,178	73,144

Source – South West Academic Health Science Network.

Consideration of the impact of travel on Penwith residents

As part of our engagement work and developing equality and quality impact assessments we understand that travelling for healthcare is a consistent concern for local residents. The following sections provide information to answer specific questions on the potential impact on travel for Penwith residents should Edward Hain community hospital beds not re-open. This information looks at data from July 2019 through to July 2020.

Question1:

During the past year, how many people whose home is in a Penwith postcode area have been discharged from the Royal Cornwall Hospital at Treliske to a bed in community hospitals and how does this compare with the numbers in the last 12 months of Edward Hain community hospitals being open?

Response:

The number in the table below shows how many Penwith residents have been discharged from Royal Cornwall Hospital Treliske to a community hospital. By way of a comparison it shows this information for the last 12 months of Edward Hain community hospital being open and in the most recent 12 months.

Hospital site location for Penwith residents who were discharged from Royal Cornwall Hospital	Number of Penwith residents who were admitted to these hospital sites in the last 12 months of the Edward Hain community hospital beds being open	Number of Penwith residents who were admitted to these hospital sites in the most recent 12 months (1 July 2019 to 1 July 2020)
Null-no location entered	8	*
Edward Hain hospital	44	0
West Cornwall hospital	23	46
**St Michael's hospital	7	<5*
Helston hospital	22	9
Newquay hospital	*<5	20
**Camborne Redruth hospital	65	94
Falmouth hospital	*<5	17
**Longreach house (Camborne Redruth)	13	<5*
Stratton hospital	*<5	<5*
St Austell hospital	*<5	12
**Bodmin hospital	*<5	11
Launceston hospital	*<5	*<5
Liskeard hospital	*<5	15
Totals	195	232

Denotes where the number is lower than 5 to protect and potential person identifiable information. The total in the table reflect these numbers.
****Denotes where there is specialist beds for neurology, psychiatry, amputation and stroke which could necessitate transfer there based on clinical need regardless of an individual's home address. Please note that we do not have the level of detail to know at this stage whether these admissions were to the specialist beds or to the generalist rehabilitation/reablement community hospital beds.***

The table above shows that:

- In the last 12 months 232 residents from Penwith have been discharged from Royal Cornwall Hospital Treliske (RCHT) to a community hospital site or West Cornwall Hospital.
- For contrast, the data for the last 12 months of Edward Hain community hospital beds being open shows that 195 people from Penwith were discharged.
- In the last 12 months of Edward Hain Community Hospital being open. Penwith residents were discharged from RCHT to the following hospitals: West Cornwall, St Michael's, Helston, Edward Hain, Newquay, Camborne Redruth, Falmouth, Longreach (acute psychiatric ward at Camborne Redruth Hospital), Stratton.
- In the most recent 12 months people from Penwith have continued to be discharged to the above hospitals, but also to Bodmin, St Austell, Launceston and Liskeard hospitals.

What the data doesn't tell us is the number of people in each time period who were discharged to the setting that best matched their clinical need and therefore likely to provide an outcome best suited to those needs.

In summary therefore, the data describes the community hospital destination for local people in these two time periods, and clearly a small, but important, group of people were transferred to more distant hospital sites. Conclusions cannot however be drawn on the overall impacts arising as this data does not provide information on whether the distance travelled was required due to clinical need. It is also not possible to determine if the distances travelled were required due to clinical need-for example to attend a specialist bed or due to the impact of Covid and the need to keep some sites Covid free.

Question 2:

During the past year, what has been the extra distance that relatives, friends and neighbours have had to travel to visit an inpatient in an alternative hospital, compared with travelling to Edward Hain community hospital when it was open?

Response:

The data in the table below does not provide the exact distance that relatives, friends and neighbours have had to travel to visit someone in a hospital outside of Penwith. We do not have access to this information.
However, we have used the post code 'sector' (the first 3 digits of a post code which represents the lowest level of data we can go down to, to protect patient identifiable information) and the post code of the hospital site and used a web link to find the quickest route.

The table below gives the numbers and mean distance travelled in miles of Penwith residents comparing the last 12 months of Edward Hain community hospital beds being open with the most recent 12 months.

Hospital site location for Penwith residents who were discharged from Royal Cornwall Hospital	Number of Penwith residents who were admitted to these hospital sites in the last 12 months of the Edward Hain community hospital beds being open	Mean miles travelled from home to stated hospital*	Number of Penwith residents who were admitted to these hospital sites in the most recent 12 months	Mean miles travelled from home to stated hospital
Null-no location entered	8	Unknown	**<5	Unknown
Edward Hain hospital	44	5.06	0	N/A
West Cornwall hospital	23	4.03	46	3.34
***St Michael's hospital	7	6.12	**<5	8.70
Helston hospital	22	11.64	9	10.63
Newquay hospital	**<5	28.58	20	33.86
***Camborne Redruth hospital	65	16.24	94	15.16
Falmouth hospital	**<5	22.68	17	24.27
***Longreach house (Camborne Redruth)	13	14.58	**<5	N/A
Stratton hospital	**<5	75.56	**<5	72.08
St Austell hospital	**<5	N/A	12	40.29
***Bodmin hospital	**<5	N/A	11	46.77
Launceston hospital	**<5	N/A	**<5	56.86
Liskeard hospital	**<5	N/A	15	63.17

Depending where the individual lives across Penwith, and the time of day, month of year, this distance and time could be more or less than the numbers stated.
****Denotes where the number is lower than 5 to protect and potential person identifiable information. The total in the table reflect these numbers.***
*****Denotes where there is specialist beds for neurology psychiatry, amputation and stroke which could necessitate transfer there based on clinical need regardless of an individual's home address. Please note that we do not have the level of detail to know at this stage whether these admissions were to the specialist beds or to the generalist rehabilitation/reablement community hospital beds.***

The data above is presented below in summary format comparing Penwith resident's travel with the rest of Cornwall as a comparator.

How far did people in Penwith travel for inpatient care when Edward Hain community hospital was open compared with the rest of Cornwall?

Average miles that Penwith residents travelled to access inpatient care (based on discharges from Royal Cornwall Hospital only and the postal code of each attendee)	Average miles that the rest of Cornwall residents travelled to access inpatient care (based on discharges from Royal Cornwall Hospital only and the postal code of each attendee)
10.96 miles	10.28 miles

Additional distance travelled by Penwith residents = 0.68miles.

How far do people in Penwith travel now (in the most recent year) for inpatient care due to Edward Hain community hospital beds being closed compared with the rest of Cornwall?

Average miles that Penwith residents travelled to access inpatient care (based on discharges from Royal Cornwall Hospital only and the postal code of each attendee)	Average miles that the rest of Cornwall residents travelled to access inpatient care (based on discharges from Royal Cornwall Hospital only and the postal code of each attendee)
22.25 miles	16.89 miles

Additional distance travelled by Penwith residents = 5.36 miles.

In conclusion, this data shows that in the recent 12 months compared with the 12 months when the Edward Hain community hospital beds were open, Penwith residents were admitted to community and West Cornwall hospitals on average 5.36miles further away than residents outside Penwith who were discharged from RCHT. If people's relatives, friends and neighbours all live within the same post code sector as the person who was admitted then they would have had an average increase of 5.36 miles to travel also.
What this data doesn't tell us is the impact of Covid on bed use and travel time to access services.

Appendix 3

Countywide strategy and case for change

Our local Long Term Plan is founded on the national Long Term[3] Plan principles, committing to boosting out of hospital services including expanded community health teams to provide fast support to people in their own homes with the greatest need as an alternative to hospitalisation. There is an emphasis on expanding and strengthening primary and out-of-hospital care and improving the scale and consistency of integrated primary and community care. Our Long Term Plan is the Cornwall Health and Care Partnership's response as an integrated care system which provides the framework for these 3 projects to operate within.

It is fundamental to the sustainability of our care system that the Health and Wellbeing Strategy vision is achieved:

'Everyone in Cornwall and the Isles of Scilly can enjoy good wellbeing and can grow, live, work and age equally well'.

The Strategy has 4 overarching objectives:

1. Healthy communities;
2. Healthy start;
3. Healthy bodies;
4. Healthy minds.

Our aim for health and care provision

We need sustainable local health and care provision to ensure we safeguard the model of the NHS and support Penwith population (within the wider context of Cornwall and the Isles of Scilly) to live well and to be able to access timely and appropriate support as and when it is required. In the light of the current challenges around population growth, quality and regulatory requirements, workforce recruitment and retention and limited real investment in health and care provision we need to maximise all available resources to place more emphasis on prevention to achieve improved outcomes for individuals and reduce demand on services. Engagement with people who live and work in Penwith has corroborated this view locally.

Part of this is recognition that we need to improve our out of hospital care, whilst ensuring we have sufficient bed based care within communities (which includes support provided to people in their own homes, hospices, accommodation with care models such as extra care , sheltered housing, residential and nursing homes) to provide adequate care for people's needs.

[3] The NHS Long Term Plan, Department of Health, 2019

Our vision for health and care provision

1. We will work together to ensure the people of Cornwall and the Isles of Scilly stay as healthy as possible for as long as possible.
2. We will support people to help themselves and each other so they stay independent and well in their community.
3. We will provide services that everyone can be proud of and reduce the cost overall.

Our strategic objectives are to:

1. Improve health and wellbeing.
2. Improve people's experience of care.
3. Reduce the cost of care per capita as a consequence of people using services less frequently and needing less expensive help.
4. Improve people's experience at work.

Our local Estates Strategy

Our local estates strategy states the need for community estate optimisation and requires strategically placed and flexibly designed infrastructure to create the right environment to support integrated care fit for the 21st century. In view of this some of our collective health and care public estate may need to be transformed or reconfigured to provide a cost efficient estate with better outcomes for patient care and to enable our ambitions for sustainable health and care provision to be realised.

The emergent models of care will have varying degrees of impact on the NHS estate, and given the emphasis on expanding and strengthening primary and out-of-hospital care, it will not be possible for the NHS to achieve its vision without changes in the estate. Most fundamentally, integrating care and improving the scale and consistency of primary care requires a transformation in out-of-hospital care and the estate used to deliver that care. Part of the engagement work with the Penwith community was to consider whether Edward Hain community hospital could play a different role in the development of local integrated care. Eight long listed options were considered which included the delivery of inpatient beds, staff admin base, day reablement services, family and children's services and hub and site expansion.

We have been clear with our local communities that the it is the model of care based on need driving the utilisation of buildings and not vice versa. As these new models are developed, and the options for future use of the hospital sites are developed, the evaluation considered value for money, affordability and sustainability as well as clinical effectiveness.

Alignment with System Work Programmes

A high quality, modern, accessible and welcoming estate is critical to our ability to provide modern health and care provision to our local population. Our current estate portfolio presents us with a number of challenges. Like many health and care

systems our estate is a patchwork of historic and bespoke buildings built in a range of different eras across multiple sites and rural communities.

Our estate needs to support longer-term resilience within our integrated community care programme, especially primary care and community provision due to the demographic change and growth as a result of significant housing development plans affecting all integrated care areas and most major towns in our rural county.

The aims of the estate programme include maximising effective utilisation (clinical and non-clinical) of our current NHS estate (and where possible the public sector portfolio) and identifying opportunities to deliver capital receipts through disposals and reduced annual revenue costs across the system. Disposals will only occur if the site is deemed surplus to requirements based on the model of care developed through local population need. This will support and be shaped by the emerging estates requirements of the new care model and system changes identified via the local transformational initiatives and ensure the estate portfolio is fit for the delivery of modern health and care services that meets the expectations of people.

The key principles of the local estates strategy which are important to this review are below:

- Supporting the delivery of care in or close to people's homes, with less emphasis on institutionalised, buildings based care;
- Strategically placed and flexibly designed infrastructure to support place-based, integrated care;
- Enabling the transformation of the local estate into a multi-purpose and flexible mix of provision which meets the changing needs of local people;
- Providing longer-term resilience and facilitating our programme of health and care integration both in Cornwall and on the Isles of Scilly;
- Addressing historic backlog in estates maintenance, as well as a disproportionately and growing, ageing population which will require infrastructure to provide services;
- Addressing a system-wide view of the estate requirements in terms of use and refurbishment of estates to meet present and future need, through the very real requirement for capital investment;
- Identifying the most urgent investment to mitigate and remove maintenance requirements around key sites which we know will underpin our ongoing transformation of health and care;
- Creating capacity for greater focus on rehabilitation and reablement services;
- Establishing multi-disciplinary led urgent treatment centres within the critical 'spine' of community hospitals;
- Providing flexible space in local communities that supports more services and diagnostics being provided closer to home, and allows for the optimal co-location of health, care and wellbeing services, multi-disciplinary teams and shared enabling services;
- Contributing to the financial recovery plan, including site optimisation and land disposals to support national strategy.

Edward Hain community hospital is not currently identified as a priority site for investment. This is due to its size, facilities on site, state of repair and its geographical location.

Case for change and the need to transform models of care

In order to respond to a growing and aging population with associated increase in complexity of health and care needs we need to target preventable disease and tackle health inequalities. Through this we can reduce variation, improve decision-making and improve productivity but we still need a new model of care that requires less cost per head of population.

Hospitals may not necessarily be the right environment for older people-especially if they have no medical or nursing requirement to be there. This is for a range of reasons that include the below:

- For older people in particular, longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs as they can quickly lose their mobility and the ability to do everyday tasks such as bathing and dressing once they're admitted to hospital[4].
- There is 43% increased mortality after ten days being in hospital if people are admitted via a crowded ED[5]. This is important as most people who are admitted to acute and community hospitals generally come via emergency departments.
- For every 10 days of bed rest in a person over the age of 75, there is 10% loss of aerobic capacity and 14% loss of muscle strength – the equivalent of ageing ten years in ten days[6].
- There's a risk of getting a hospital-acquired infection, which can cause serious complications or even death. If someone is already receiving regular care at home, sending someone into hospital can interrupt the relationship with their carer. This bond can be hard to re-establish[7].
- Older people are also at significantly increased risk of developing a state of acute confusion called delirium if they are admitted to hospital. It can have serious effects, such as accelerating or triggering dementia, and often leads to people spending a longer time in hospital and eventually ending up in residential care[8].

[4] Discharging older patients from hospital, National Audit Office, Department of Health, 2016.
[5] Overcrowding in emergency departments and adverse outcomes, The British Medical Journal, British Medical Journal, 2011.
[6]The Journals of Gerontology (2008). Functional Impact of 10 Days of Bed Rest in Healthy Older Adults. Kortebein et al
[7] Nuffield Department of Population Health: Hospital or 'hospital at home' – what's best for older people? 2019 [https://www.ndph.ox.ac.uk/longer-reads/hospital-or-2018hospital-at-home2019-2013-what2019s-best-for-older-people]
[8] Nuffield Department of Population Health: Hospital or 'hospital at home' – what's best for older people? 2019 [https://www.ndph.ox.ac.uk/longer-reads/hospital-or-2018hospital-at-home2019-2013-what2019s-best-for-older-people]

- People living in Cornwall and the Isles of Scilly do not want their hospital stay prolonged unnecessarily and find delayed transfers of care distressing[9].

Whilst it is recognised that bed-based hospital care is not necessarily the most appropriate solution for our older population an enhanced responsive community model is required that substitutes this with self-care/management and strong and responsive community-based care to deliver better outcomes for local people.

Four challenges that are driving the growth in demand

1. More people

The rate of births is at a level last seen in the 1980s and with younger people coming into Cornwall as well. With more people moving here than leaving, we are expecting in total 62,400 more people of all ages over the next twenty years.

Penwith community has a total population of 65,170 and in terms of population growth, in the fifteen years from 2015 there will be a population increase of 3,792 with 18% of that increase from Hayle (the neighbouring town to St Ives where Edward Hain community hospital is).

2. The baby boomer effect

Penwith has a growing elderly population, with the greatest increase in proportion of the over 75 and 90 year olds in Hayle and St Just areas.

There are 7,770 pensionable households (27.8% of the population and higher than the England average of 20.7%. The Penwith population of 65 years and over accounts for 27.5% which is higher than both the national and Cornwall average (24.34%). An increasingly ageing population means people live longer with greater incidence and complexities of co-morbidities and people will have a greater risk of developing frailty.

Given that Penwith will have higher rates of elderly people who are frail we therefore need to ensure the service model does not over rely on bed based care which may cause a greater likelihood of hospital admission and then delayed transfers of care even when it is not the ideal outcome for that individual (Embrace Care Diagnostics, 2019, and appendix 4).

3. Preventable illnesses are increasing and more people are living for longer in ill-health

Medical advances mean people live longer, but often with illnesses like cancer, heart problems, dementia and diabetes, and years of healthy life lost are increasing.

[9] Delayed Transfers of Care: What it's like for patients and families. A snapshot of people's experiences of delayed transfers of care from hospitals in Cornwall, during July 2019. Healthwatch Cornwall

Local disease prevalence for Penwith that is of particular importance for preventable illnesses includes the below:

- 30% of people die from cardio vascular disease– a similar percentage die of heart disease than the rest of the UK but more die of strokes.
- Circulatory system disease is the main cause of death in Hayle and St Ives. This and the bullet point above indicate the population need for cardiovascular disease (CVD) prevention programmes to reduce the impact of death and disability from CVD.
- More people suffer from, and have operations for, knee, hip and back pain.
- A higher percentage of people live in residential and nursing homes.
- 1 in 4 people have 'Life Limiting Illness' -higher than England (1 in 6.)
- There is a high number of local people with dementia (643 people across Penwith, with 252 just from St Ives and Hayle), and an estimated 94 people who are undiagnosed.
- 12.43% of Penwith residents are classified as obese. 18.25% of those registered at Cape Cornwall Surgery, St Just are obese and 13.72% registered to Bodriggy Surgery, Hayle. All Penwith surgeries are over 10% obesity rates. Obesity is often linked to diabetes type 2 rates.

People with frailty (the incidence of which increases with age-approximately 50% of people aged 85 and over will encounter frailty) will have specific needs and national best practice states that people living with mild, moderate or severe frailty could often have their needs met best in settings outside of acute hospital care. In view of the high proportion of elderly and frail in Penwith there is therefore likely to be an increased demand for enhanced community-based reablement and home care.

4. Health inequalities

There are some specific elements for Penwith residents that are linked to health inequalities that we need to consider which are included below:

- 40% of the over 65 year olds in Penwith also live alone. Living alone is a risk factor for social isolation and loneliness and can increase the risk of death by 30%. There is therefore a need to consider how we support people in their own home to stay connected with their communities and provide community based opportunities for social activity to reduce or eradicate loneliness and any adverse impact it may have on a person's wellbeing.
- St Ives is the least deprived part of Penwith, and yet other areas (including neighbouring Hayle) have multiple deprived communities (lack of education, poor health, high crime levels, high unemployment) and therefore consideration should be paid to the inverse care law. This is when the provision of services are closer the more affluent parts of Penwith rather than closer to the more multiple deprived areas could represent an historical inverse care law provision of health services. This means the need for services does not necessarily reflect the current utilisation and therefore

availability of good medical care tends to vary inversely with the need for the population served.

- There are 1,555 (44%) people on mental health related benefits which is significantly higher than the England average (27%). There is evidence that people with mental health have a greater burden of physical health inequalities[10].

There are 4 key challenges in Penwith that affect our ability to respond to increased demand with traditional models of care. These 4 challenges are outlined below:

1. Delivering a workforce for the 21st Century

As our model of care embraces new technology and teams operate across the system, we shall be upskilling our workforce. Like other places, Penwith has difficulty recruiting in health and care for the following reasons:

- There are less people of working age compared to the national average in some areas of Penwith due to the lower than average number of permanent family households (12 fold the national average of second home use and 14.5% of homes are empty), higher than average age group (27.4% are over 65years- the England average is 18.0%).
- Competition with the tourist industry (high demand particularly in St Ives where Edward Hain community hospital is).
- Travel to get to and from work can be time consuming and costly due to the rurality and seasonal influx of visitors.
- Higher numbers of local Penwith staff are reaching retirement age which has a negative impact on the potential recruitment supply as shown by the table below.

Numbers of local Penwith staff reaching retirement age[11]

Staff group	Head number	Percentage aged 55
Practice nurses	40	33 % (13 people)
GPs	56	15 % (8 people)
Community nurses	40	28 % (11 people)

- Cornwall Partnership NHS Foundation Trust's Human Resources department state that the vacancy gap (the difference between funded staff and staff actually in post) for community hospital based registered staff is around 10% (November, 2019).
- Across general practice according to Kernow Health Community Interest Company (November, 2019) our biggest workforce issues are:-
    1. 75% of our general practice workforce is part time
    2. 25% of GPs are eligible to retire in the next 5 years

[10] Health Profile for England 2018. Public Health England.
11 Data Sources: General Practice - NHS Digital GP Workforce data (as at Sept 18); Community Nursing – CFT, ESR Data (as at Oct 18); All GP practices in Penwith.

3. 35% of practice nurses are eligible to retire now
4. It is difficult to recruit and retain GPs to Cornwall because of the relative geographical isolation.

- GP recruitment in the west of Cornwall is more problematic than in other areas of the county. In November 2019 there were GP vacancies in four Penwith GP practices and two practice nurse vacancies. (Source Kernow House CIC, November, 2019).

2. Finite resources to respond to growing demand

The budgets available to the NHS and local councils are finite and as demand continues to grow we will need to prioritise how we use available resources and make every pound stretch further. On closure of Edward Hain community hospital's 12 inpatient beds in February 2016 the staff were redeployed to community rehabilitation teams and inpatient wards in larger neighbouring hospitals to provide resilience and sustainable community provision.

3. Our geography and settlement patterns

24,119 of Penwith residents (39%) are classified as being 'rural residents'. (England average is 10.5%) and this has implications for isolation, community networks, access to community facilities etc.

4. Matching care and support to changing need

The way we provide traditional care and support is under pressure from growing demand and was not designed to respond to the complexity of today's health and care needs. This leads to difficulties in achieving optimum care, for example, the length of time people wait for both urgent and planned care or to be discharged from hospital. We have evidence from a system endorsed review of clinical utilisation of beds and services that people are not being cared for in a setting that achieves their ideal outcomes (Embrace Diagnostics, 2019). This evidence is a key driver for the system to implement a model of care that achieves greater outcomes for people.

We will not be able to continue to address these challenges without significant changes in what care is delivered, how it is delivered, and where it is delivered.

All these elements have been raised by our community stakeholders as well who outlined planning and design principles for service changes to help address local gaps and needs.

Appendix 4

Evidence for use of hospital beds

The Embrace Care Diagnostic findings[12] (2019) identified how local bed based care is delivered, what decisions are being made about people's care and support and if those decisions lead to the ideal outcome for individuals based on their needs. The findings demonstrated that there are high numbers of people in acute *and* community hospitals that do not need to be there (i.e. no medical and/or nursing need) and that people are staying longer than necessary due to a range of reasons, such as lack of capacity in community services or nursing homes, or reduced efficiency of discharge planning decisions. These findings indicate a reliance on bed based settings of care, which means the system is using beds in a way that doesn't always meet people's needs, or support the achievement of their ideal outcomes. The Embrace Care Diagnostic key findings, derived after 131 practitioners reviewed the 'next steps' for people in 943 acute and community beds, from 265 individual cases, were that:

1) 41% of admissions for people over 65 years reviewed were documented as a less than ideal outcome for that individual.

2) 43% of the cases reviewed were not felt to be ideal, whether that was an admission, a discharge decision or community provision.

3) Only 56% of people were in residential or nursing placements, where that was the ideal outcome for them.

4) When we discharge from the acute hospital into another short term setting (care home or community hospital), that is only the ideal outcome for half of the people.

5) 22% of our acute beds and 67% of our community beds are occupied by people who would be better suited elsewhere.

6) In all of the acute hospital settings involved in the Embrace diagnostics (Royal Cornwall Hospital Treliske, West Cornwall Hospital and University Plymouth-previously known as Derriford), 4.7% of individuals were in an acute bed which was not the ideal outcome for them and they were awaiting a bed in a community hospital.

Following the completion of the Embrace Care Diagnostic, the ultimate conclusion was that that the CIOS Health and Care System only achieves ideal outcomes for older people on 57% of cases.

[12] https://doclibrary-shapingourfuture.cornwall.nhs.uk/DocumentsLibrary/CIOSHealthAndCare/TransformationBoardMeetings/Minutes/1920/201908/Item6app4EmbraceCareDiagnosticSummaryBooklet.pdf

Appendix 5

Service changes and enhancements: alternative service provision

In the four years since the temporary closure of Edward Hain community hospital beds the range of community based services available in the area has continued to develop, providing more alternatives to community hospital admissions. Some of these changes include:

- **Increasing capacity of home based and community reablement to support more people at home and in the community to reach their maximum level of independence and wellbeing.**

This is a priority to ensure people receive timely and appropriate support to maintain their independence so people can avoid unnecessary hospital attendances and admissions and be supported at home. This will also free up hospital beds for those that need them. Reablement is an important service offered to people for a time limited period to specifically work on personalised goals to improve independence and wellbeing-especially after a period of illness or change in health status. Specific areas of recent work since the temporary closure of inpatient beds at Edward Hain community hospital include:

- Increased provision of eight Generic Support Workers (GSW) in the Home First teams across the west integrated care area, which provides more reablement in people's homes. This has created 515 additional reablement appointments per month for Penwith residents with 55 of them provided for people registered to Stennack Surgery in St Ives.
- Cornwall Council's Kemeneth project (2018-2019) re-designed systems and pathways in the reablement service called Short Term Enablement and Planning Service (STEPS) to improve efficiencies (seeing more people) and effectiveness (gaining more positive results for people more quickly). In the first year of service re-design (October 2018 - September 2019) a total of 365 people who were discharged from West Cornwall, Helston and Camborne and Redruth community hospitals were seen for reablement at home by STEPs; this is an increase of 79 more people compared with the year before the re-design. This is in addition to the existing enhanced reablement service through CFT's Home First service with the additional GSWs. More reablement is therefore happening outside of hospital in people's homes.

- **Increase in community end of life care provision**

- The beds at Edward Hain additionally provided an option for end of life care. Since the temporary closure of the beds there has been the provision of an additional two beds for end of life and specialist palliative care inpatient provision in neighbouring Hayle at St Julia's Hospice. The inpatient beds here have increased from 8 to 10.
- As well as additional inpatient hospice beds there is also a new end of life Neighbourhood Hub in neighbouring Hayle to help people to manage their symptoms, to increase their independence and support the avoidance of

hospital stays. The hubs provide palliative reablement to maximise people's wellbeing through occupational therapy, physiotherapy and complementary therapy for people undergoing palliative care, while complementary therapy is also available for their carers, free of charge.

- More people are choosing-and are being supported-to die in their usual place of residence rather than in hospitals. An end of life audit in November, 2019 by Stennack GP Surgery, St Ives (looking at 8months of expected deaths) identified that across the previous 12 months that 94% of expected deaths occurred in people's own homes or nursing and residential care homes.

- **Ongoing development of integrated primary, community and voluntary sector teams to ensure improved coordinated and multi-disciplinary team ownership of the management of people in the community.**

This work aims to improve multi-agency and multi-skilled team working to maintain people's independence and wellbeing in the community. Work has been underway for some time and specific focus areas include:

- Changes to the national GP contracts mean that Primary Care Networks (PCNs); which are clusters of GP practices working together to share resources for a specified area; have had financial investment for PCNs to develop their workforce capacity. An example of this is Social Prescribing Link Workers aligned with every GP practice. This role is part of the expansion to the primary care workforce and the link workers work with people to access local sources of support giving people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. This has the aim to respond to population health needs and keep people well in their communities.
- The national GP contract changes also include additional service specifications aimed to support people in their communities and to spot any changes or alterations in health that undetected may result in hospital attendances/admissions. The key additional services include:
    - Provision of extended surgery hours access across the PCN (additional clinical appointments).
    - Medication reviews which include those who may be most vulnerable such as the frail and elderly and those in care homes.
    - Deliver 'enhanced health in care homes' alongside other health and care practitioners to support care home staff to keep their residents safe and well.
- Development of innovative new ways of working with a new community geriatrician consultant role working closely with primary care to increase the ability to keep people in their local communities at home supported by multi-agency, multi-skilled teams. This means people can be seen in their communities in a timely manner to spot and stop symptoms that otherwise could lead to attendances at, and admissions to hospital. For example, the new role means that instead of waiting a minimum of 10 weeks to see a geriatrician in the acute hospital, or deteriorating so they are admitted, people are being seen in primary care and their communities within a matter of days (or hours in some urgent cases). This work also brings more care under one

consultant allowing a more comprehensive and holistic approach so an individual does not need to attend two-three different clinics. This new way of working maintains care in the community and ensures community resources rather than bed resources are used effectively.

- **Development of West Cornwall Hospital: A centre of excellence for healthcare in the west of the county. This includes working with local primary and community teams to be able to access local beds directly to avoid admission to Royal Cornwall Hospital Treliske.**

- West Cornwall Hospital (WCH) is the closest hospital to Edward Hain community hospital at 9 miles and approximately 25 minutes' drive away. It has always provided a wide range of services, offering a much higher level of modern diagnostic facilities and staffing expertise than community hospitals including Edward Hain.
- Since the closure of Edward Hain community hospital in 2016, the services provided at WCH have changed to reflect the local population needs. WCH's strategic direction is to continue to provide the current services and in addition to develop the site to create a 'Centre of Excellence for Healthcare for the West of Cornwall'.
- The priority for WCH is to provide care closer to home and in order to achieve this WCH will prioritise those individuals who live in the west of the county, who are inpatients at Royal Cornwall Hospital, Treliske (RCH), but who cannot be discharged home and/or who need further assessment and intervention to enable discharge and prevent future admissions. These individuals will be 'pulled' from RCH so they can be seen and treated closer to their home. WCH will also continue to provide acute admissions through the Urgent Treatment Centre and local GPs as currently.
- If people are transferred to WCH from RCH more quickly, the WCH team will be able to provide medical intervention earlier so people can be discharged sooner to ensure their independence is not negatively impacted by an extended stay in hospital such as hospital acquired infections[13], losing independence[14] or muscle wastage[15].
- WCH has the facilities and staff to provide rehabilitation and reablement as part of its 'core offer' to inpatients. It has on site Occupational Therapy and Physiotherapy staff with in-reach input from Dietetics and Speech and Language Therapy as required. The team work across 5 days at the moment, with an ambition to move to 7 day working.
- This focus on increasing independence more quickly will help to reduce an individual's overall length of stay in hospital and will mean people will be less dependent upon additional support services on discharge resulting in reduced onward care needs. This should, in turn, reduce the need for onward transfers to a community hospital, such as Edward Hain, for rehabilitation.

[13] Nuffield Department of Population Health: Hospital or 'hospital at home' – what's best for older people? 2019 [https://www.ndph.ox.ac.uk/longer-reads/hospital-or-2018hospital-at-home2019-2013-what2019s-best-for-older-people]
[14] Discharging older patients from hospital, National Audit Office, Department of Health, 2016
[15] The Journals of Gerontology (2008). Functional Impact of 10 Days of Bed Rest in Healthy Older Adults. Kortebein et al

The vision for WCH is for anyone in the West of Cornwall, requiring bed-based reablement, who is unable to remain in their own home, to be seen and treated in WCH. This is primarily possible because of WCH's level of staffing, expertise and the co-location of additional diagnostics facilities. As a result, WCH can respond to greater acuity of need. This is because WCH have enhanced bed based provision compared with Edward Hain community hospital such as:

- More comprehensive senior on site medical cover
- Larger and more modern wards
- Greater ease of accessibility for ambulances
- Provision of a centre of excellence for frailty
- Daily, ward based occupational and physiotherapy
- Access to speech and language therapy, dementia liaison service, social care support, on site memory café
- Access daily to eldercare consultant and multi-agency assessment and discharge management team
- On site diagnostics such as x-ray, point of care testing, ultrasound.

- **Implementing the Embrace Care Programme to improve the way we care for and support older people in Cornwall and the Isles of Scilly. We want to do this by getting colleagues from all areas of health and care services to work more closely together.**

The Embrace Care Diagnostic findings (2019) identified how bed based care is delivered, what decisions are being made about people's care and support and if those decisions lead to the ideal outcome for individuals based on their needs. The findings demonstrated that there are high numbers of people in acute and community hospitals that do not need to be there (i.e. no medical and/or nursing need) and that people are staying longer than desirable due to a range of reasons, such as insufficient capacity in community services or nursing homes, or reduced efficiency of discharge planning decisions.

The Embrace Care Diagnostic key findings, derived after 131 practitioners reviewed the 'next steps' for people in 943 acute and community beds, from 265 individual cases, found that:

- When we discharge from the acute hospital into another short term setting (care home or community hospital) that is only the ideal outcome for half of the people.
- 67% of community beds are occupied by people who do not need to be there.

Therefore, when considering the current and historical use of hospital beds, Embrace Diagnostic has demonstrated that this does not provide an optimal level of care for all individuals. It also provides evidence that we have an over reliance of bed based care and due to this our current/historic bed use should not be a predictor of future need for bedded care. Part of the work delivered under the Embrace Care Programme includes improving the capacity of care homes and care at home. This is because they are important support mechanisms to a) keep people well in the community and b) provide support to people requiring timely discharge from a

hospital bed. These two aspects help to achieve our ambition to support people to stay longer in their usual place of residence and to reduce the unnecessary time required in hospital so we reduce the time people are exposed to risk of hospital acquire infection. Insufficient capacity in care homes and care at home sector is consistently in the top 3 reasons for delayed discharges so it is important to improve this. Recent work has included:

- **Care homes**-The Council and NHS Kernow have reinstated the Joint Strategic Commissioning of Care Homes Project Group, which was suspended at the beginning of the COVID period. The project group includes three sub groups that are responsible for a) redesigning the commercial approach, b) market development and c) implementation. An immediate priority for the team is to further develop the operating model that will secure additional bedded care capacity for Discharge to Assess. The Discharge to Assess Model is a key element of the nationally recommended high impact changes to support the safe and timely discharge of individuals from a hospital setting. The Discharge to Assess model is where people in a hospital bed do not require to stay there, but may still require care services and so are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting such as care home.
- **Home Care**- During wave 1 COVID the demand for homecare and other community services increased and with the ongoing social distancing requirements in acute and community hospitals this demand trajectory has continued. The Council and NHS Kernow continue to work together to build additional capacity in the home care market. Key actions are:
    - Provider led reviews to proactively reduce any unnecessary allocated care hours. This process has already released 1,000 hours of capacity to support the system for new packages of care.
    - Daily meetings take place with locality commissioners and operational staff in the Community Co-ordination Centres (more information provided below) to increase the number of deployed hours, make efficient placements of care packages, support providers to work together to cover shifts and focus on prioritisation of care requirements. This will help to expand the workforce and increase utilisation of staff hours to meet high priority unmet demand.
- **Extra care housing**-a priority site has been identified at Lelant, 4 miles from Edward Hain community hospital to provide a minimum of 70 units. This will provide alternative, purpose built and quality accommodation with care for older people. The environment is specifically designed to promote independence, provide integral technology to support people and have on site 24/7 care and support teams.

In addition, more recent service changes due to Covid-19 have demonstrated the increased use and acceptance of digital technology and remote consultations which will undoubtedly change the way in which care can be delivered across our rural areas. The new ways to deliver care have increased the capacity and capability of community based care closer to, or at home for local residents. These include:

- **Remote access to care** - all GP practices in Cornwall and Isles of Scilly initiated online, video and telephone systems to determine people's need and

requirements for face-to-face contact to provide care remotely where safe and appropriate to do so.

- **CATUs – Community Assessment and Treatment Units** – set up in West Cornwall Hospital (WCH) and Camborne/Redruth Community Hospital (CRCH) – whose purpose is to rapidly diagnose, assess and treat people to help keep them safe at home rather than needing an acute hospital bed. The CATU at WCH is open 7 days a week, 24 hours and the CATU at CRCH is open 7 days a week, 8.00am to 8pm.
- **Community Co-ordination Centres (CCC)** – integrated health and social care place-based teams linked to primary care-8am to 8pm, 7 days a week. The CCCs include colleagues from different functions, organisations and skillsets located together in the same building to provide the best care for residents. This allows all care and support requirements to come to one place where the multi-disciplinary team decide the best care response which improved communication and coordination of care needs and has led to a reduction in bed based care, with more people being cared for in their own homes.

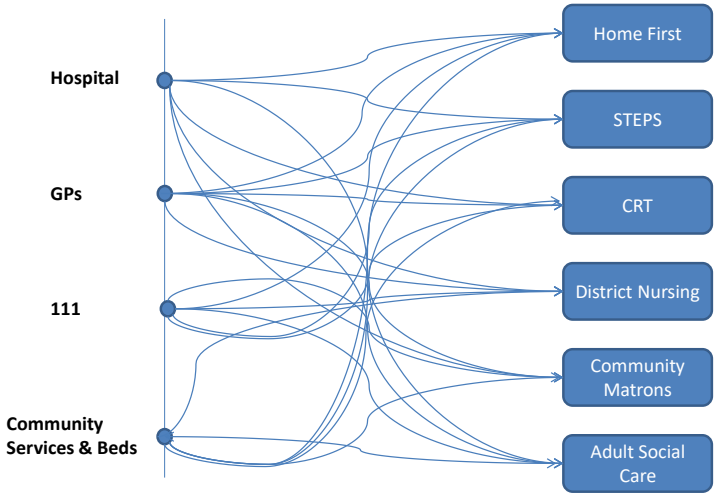
  The CCCs are seen as a first step to a more integrated, local point of access based model of care in the community. The CCCs are key to simplifying referral procedures and their main function is to:
  - Have a single route of referral for all community resource requests
  - Have one clear picture of demand and capacity for all community services
  - Make difficult, but well informed decisions around where to prioritise our community services

  Within the West ICA there are 3 local triage centres, one of these being Penwith. The Penwith local triage team is made up of an adult social care, health and therapy ‘prioritiser’ to maintain close contact with frontline workers, understand the full range of community capacity and prioritise the demand into all community services (district nurses, community matrons, adult social care, community rehabilitation teams, and community reablement teams (Home First and Short Term Enablement and Planning Services).

  The integrated function of the CCCs can best be seen below:

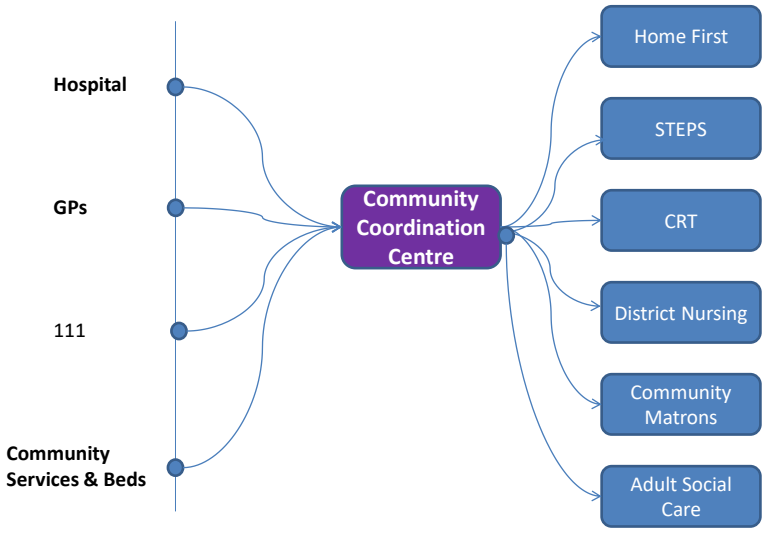
To simplify a complex web of referral pathways …

Before



To simplify a complex web of referral pathways …

After



Key to above service names:

Home First= short-term community reablement team comprised of nurses, occupational therapists, physiotherapists and generic support workers. Service aims to enable discharge and admission avoidance. Health-led.
STEPS=Short Term Enablement and Planning Services. Short-term community reablement team comprised of occupational therapists and generic support workers. Service aims to enable discharge and admission avoidance. Social care-led.
CRT=community rehabilitation teams.

- **Community bed bureau-**multi-agency staff who have an overview of all community beds in the system (residential, nursing care, extra care housing, community hospital) to match the person's needs to the right type of care.
- **Support to care homes and provision of Discharge to Assess beds –** primary care, community teams and acute staff coming together to support care homes through COVID-19 outbreaks. More people receiving interim placements in care homes to increase their independence before going home.
- A **single electronic referral** process was developed for all referrals to go via the CCC. Practices were quick to take on this new way of working to change the way that we plan community care and support so responses and delivery of care became more 'joined up'.
- **Geriatrician support** – allocated to every Primary Care Network to ensure prompt community access to specialist eldercare support to enable primary care and community teams to care for the frail and elderly in their own home and community locations.

Appendix 6

Edward Hain community hospital-the process undertaken to co-develop, appraise and evaluate options with the community stakeholder group

Further information about the extensive engagement process can be found in our engagement report here. Through this process we have co-developed and agreed with our local representative community stakeholder group:

1. Local case for change including population needs and plans for development of local services to respond to these needs,
2. Local design principles of approach for any service change,
3. Single countywide evaluation process and criteria,
4. Stakeholder 'roles' and membership such as being involved in developing the options, developing the evaluation criteria or evaluating the options,
5. Local long list of options for the future of the community hospitals, leading to
6. An appraisal of the long listed options to agree and define short listed options,
7. Local short list of options for the future role of the community hospitals,
8. Evaluation of short listed options.

The extensive engagement and robust evaluation of the Edward Hain community hospital option to re-open 12 inpatient rehabilitation beds (with one alcohol detoxification bed and end of life care provision) determined that this was non-viable. The reason for this following an assessment by 13 evaluators against 21 different evaluation criteria was that:

1. The option is not viable or deliverable as the minimum scores for safety, financial affordability and financial sustainability were not met.
2. The option also does not meet adequate levels of quality, access, workforce, deliverability, environment, finance and wider system/community impact criteria.
3. All scores for each of the 21 evaluation criteria are low (either '0=no evidence' or '1=limited evidence'). The option scored a total of 13 out of 84.

There are no other viable options for Edward Hain community hospital-the community stakeholder group involved in the options development and appraisal across the last 18 months considered all long listed options and identified nothing further to consider. At this point the community stakeholder group understood the constraints and limitations of the site; particularly that it did not provide capacity for the minimum bed number of 16 as recommended by the NHS South West Clinical Senate[16] in order to provide safe, reliable and efficient staffing. The community stakeholder group requested that the option was still formally evaluated against agreed criteria in order to definitively confirm or deny its viability for healthcare provision.

A period of wider public engagement has now commenced in order to gain feedback on what impact this may have for communities, ahead of this being presented at HASCOSC in November and NHS Kernow's Governing Body in December where a decision is expected on the future of the hospital.

[16] https://www.swsenate.nhs.uk/wp-content/uploads/2019/10/2019-19-09-Senate-Recommendations-Community-Hospitals-FINAL.pdf

Appendix 7

Planning, assuring and delivering service change for patients: The five tests of service change: a summary of key activities to date

One - Strong public and patient engagement

Key activities include:

- Active communication with 687 stakeholders who receive all meeting minutes and presentations – 133 of those are 'in the room' stakeholders who receive meeting invitations to attend events.
- Building on three Shaping our Future engagement workshops in West Cornwall, July 2017-February 2018 - 126 attendees.
- Building on four West Cornwall workshops across October 2018 - March 2019 to develop the local model of care - 120 attendees.
- One workshop with 19 community representatives to develop a local case for change for this project.
- Four workshops (April 2019 - August 2020) specific to this project with an average attendance of 25 attendees to co-develop the process, options and evaluation process.
- Healthwatch Cornwall –were involved in co-developing our evaluation criteria and process and provide links to our dedicated website pages for the projects. The organisation receives regular updates on progress and supports the project in the promotion of all engagement with their volunteers.
- West Cornwall HealthWatch - representatives attend local community groups and workshops to help feed in wider views and opinions. We also had a member of West Cornwall HealthWatch on the options evaluation panel to ensure there was local community representation at each level of the process.
- League of Friends of Edward Hain Memorial Hospital-members of the League of Friends were regular attendees and participants of all meetings and workshops.
- Edward Hain family-all meeting notes and presentations have been shared with the family as part of our wider virtual stakeholder group.
- Using our network and partnerships to share information, messages and encourage feedback as well as ensure a wider reach to the community.
- Clear and accessible documents – all meeting minutes, related documents and presentations are shared and published on our website. The community stakeholder group have opportunities to comment on the accuracies of all workshop minutes.
- NHS Kernow website – dedicated page for the Penwith area work, which is regularly updated with details on project progress, all meeting minutes and presentations. These include video tours of the hospital and interviews with stakeholders and clinicians. At the time of writing there have been 717 unique 'hits' on the Penwith and Edward Hain community hospital page (if one person views multiple times it will only show as one). There have also been 105 views of the videos which include interviews with local

practitioners and 265 views of the hospital tour. There have been 53 views of the You Tube announcement of the option evaluation outcome presented by the project clinical lead, Dr Neil Walden. The web page is: https://www.kernowccg.nhs.uk/get-involved/engagement/integrated-community-services-plans/

- Cornwall and Isles of Scilly Citizen Advisory Panel (CAP) – CAP provides an independent view and critical friendship on matters relating to health and care. This group approved our proposed evaluation process, scoring and criteria and were assured of the level of engagement undertaken. We have continued to keep this group up to date on progress and seek their feedback throughout.
- Patient Participation Groups (PPGs) - made up of people who are registered with the community's practices and have an interest in the services provided by GP and local services. We have attended local group meetings to inform people of the work and to listen to views and opinions. Members of PPGs attend the workshops.
- Social media - using Facebook and Twitter, we promoted the different ways people were able to get involved and have their say on our plans and work. When we promoted our public drop in events we had a total of 1,704 views on Facebook and 1,680 views on Twitter for the posts.
- Web platform- Healthwatch Cornwall has developed a new Digital Community Platform, Ask Cornwall, connecting people in conversation for our health and wellbeing in Cornwall and the Isles of Scilly. There are dedicated discussion topics for Edward Hain community hospital and Penwith integrated community services. This platform allows an interactive and ongoing discussion around various topics and all stakeholders were encouraged to sign up and use the site to post their views and ideas.
- Surveys – we initially surveyed GPs at the outset of the project in order to understand the views of local primary care teams in addition to the GP representation provided at workshop and clinical meetings. We will continue to use surveys to better understand the needs of local people and those who use our health and care services to inform the development and delivery of services that meet the needs of local people.
- Existing meetings, events and public drop-in sessions – we have attended local community networks, panels and groups such as town and parish councils and public forums etc. By attending existing groups' meetings and events we have explained the project, answered people's questions, and ensured they understand how they can get involved, have their say and influence the work. We also held three planned public drop in sessions in a variety of locations across Penwith: St Ives, Penzance and St Just. These were held in the evening (6.30pm-8.30pm) as all workshops to date were held during the day and we wanted to target those individuals who had not yet attended a workshop to contribute their ideas. We also ensured when there were generic health public drop in sessions and health stands such as in the local supermarket that there was an opportunity for people to leave their views on comments cards.
- Media – we work closely with the media to keep them informed of our work, and respond to enquiries in a timely way. This also includes online community groups and independent online news outlets and community

publications such as parish council newsletters and town council web pages. We have worked with local press and radio to promote specific events such as public drop ins and workshops.

- The method of engagement has been based on open and continuous collaboration with the community stakeholder representative group agreeing together how to progress the below key components:
  - Identifying appropriate stakeholders
  - Contribution to the development of the case for change
  - Co-development of local design principles and priorities for service improvement
  - Self and other nomination to various stakeholder 'roles':
    - 'in the room' stakeholders - attend planned workshops,
    - 'virtual' stakeholders - receive all meeting notes and presentations,
    - 'options development' - to be involved in planned workshops to develop and appraise options,
    - 'co-development of evaluation' - to be involved in developing evaluation process and criteria,
    - 'evaluators' - to participate in the full evaluation of options.
  - Co-development of process to develop options and evaluation of these,
  - Co-development of evaluation criteria,
  - Co-development of evaluator membership,
  - Co-development of long listed options and appraisal of these,
  - Co-development and agreement on the shortlisted options based on the appraisal above,
  - Evaluation of shortlisted options,
  - Review of evaluation outcome and process,

Two - Consistency with current and prospective need for patient choice

The evaluation process included main criteria of access and one of the sub criteria which the evaluators needed to score (0-4) was based on patient choice. Quality and equality impact assessments of the option to a) reinstate the inpatient beds and continue community services at the hospital and b) not to reinstate the inpatient beds and continue community services at the hospital included consideration of patient choice.

Through the evaluation process, the evaluators specifically considered the aspect of choice in the context of the annual numbers likely to be supported through inpatient provision (220 with 42 people coming from St Ives-based on historical data), the person's clinical need and the level of care provided at Edward Hain community hospital. Key considerations discussed by evaluators are below:

- Due to the structure, size and lay out of the hospital, people who had specific bariatric requirements (due to being obese and requiring larger sized furniture and equipment) and those who had cognitive impairment such as dementia and/or who are frail (corridors narrow and sloping so causing a falls risk and rooms not having a 'line of sight' to a nurse's station causing safety issues due to limited observation/supervision) the hospital would not necessarily be an appropriate choice for placement.

- Specialist pathways for stroke and traumatic brain injury were provided elsewhere (Camborne Redruth community hospital and Marie Therese House, St Michael's Hospital respectively) so people with these new diagnoses would not attend Edward Hain community hospital.
- If a person required a higher level of inpatient provision (medical cover each day, access to 'diagnostics' such as X-ray and ultrasound, access to daily multi-disciplinary teams for rehabilitation) then they may have a better clinical outcome attending West Cornwall Hospital even if their choice was to attend Edward Hain community hospital.

The evaluators considered the above in the context of the event of Edward Hain community hospital beds being open and defined it as a 'false choice' if clinically the best place of care was an alternative location.

Three - A clear clinical evidence base

Clinical leadership and involvement of frontline practitioners in transforming care and support is a guiding principle of all our work and a key part of shaping services to meet local needs. This project has been led clinically from the start. Whilst working together with the community stakeholder group we have had strong local clinical leadership and involvement at each and every level. This has instilled trust and commitment from local stakeholders knowing that locally the process is being understood and defined by local population need. Local clinicians and care professionals are united in working towards local out of hospital models of care, where services are provided in peoples' homes and local community settings wherever safe and sustainable to do so.

Various methods of clinical leadership and involvement influencing this work includes the below:

- Over the summer of 2019 we held a number of workshops for clinical leaders across the system to engage on the Health and Wellbeing Strategy for Cornwall and the Isles of Scilly, as well as delivery of the NHS Long Term Plan. This has brought together the knowledge and experience of clinical leaders as part of our planning process for effective collective decision-making, setting priorities as a system and in localities and redesigning care and support as a system and in localities as appropriate.
- The project has built on three Shaping Our Future workshops, four Model of Care workshops and four project specific workshops all attended by local clinicians. The project has a local clinical lead who is part of the project group and local staff attend the workshops. The multi-agency project group overseeing the governance of the project also has a local GP, Public Health consultant and local hospital matron as part of their membership to ensure the model is clinically led.
- The work has also been informed by the Embrace Diagnostics[17], historical and current service activity data, public health profiles and The South West

[17] https://doclibrary-shapingourfuture.cornwall.nhs.uk/DocumentsLibrary/CIOSHealthAndCare/TransformationBoardMeetings/Minutes/1920/201908/Item6app4EmbraceCareDiagnosticSummaryBooklet.pdf

Clinical Senate recommendations for community hospitals[18]. Review meetings have been held with the Clinical Senate to inform them of the emerging model of care.

- Clinical membership (GPs, Occupational Therapist) of stakeholder group co-developing the draft evaluation criteria, process and scoring,
- Clinical membership on evaluation panel (nursing and GP).Local GP survey to understand perceived needs, service function and to contribute their views if they could not attend meetings
- Strong and varied local clinical attendance at stakeholder workshops to co-develop service principles and development and appraisal of long listed options,
- 2 GPs in the project group - one being the clinical lead for the project and the other being the lead GP for Stennack surgery who provided medical input to Edward Hain community hospital inpatient beds,
- GP Chair for all community stakeholder workshops,
- GP and Public Health consultant on project group membership and involved in the co-development of shortlisted option,

Four - Support for proposals from clinical commissioners

Specific actions to gain support and involvement from clinical commissioners includes:

- Invitation to local GP practices to be involved in local workshops to develop options and evaluation criteria,
- Presentations and papers to Clinical Leadership group (a group with representation from every GP practice) ensure sign up and endorsement of evaluation process and evaluation criteria,
- GP membership in system's Community Services, Planning, Design and Delivery Group which has been subsequently renamed as the Collaborative Communities Board (the system group who endorse the project group's recommendations),
- Project updates provided at GP Locality/Primary Care Network and integration meetings to allow feedback,
- Governing Body GPs received weekly updates on progress (along with other key stakeholders) to allow feedback.

Five - Bed test

During the time since the Edward Hain community hospital bed closures in 2016 and since the start of this focussed engagement project, there have been ongoing and significant changes in the delivery of local services (as described in appendix 5) and population need. These changes have formed part of this engagement and service review process to ensure that the process of developing new models of care and examining their impact informs the process to determine the future role of the hospital.

[18] https://www.swsenate.nhs.uk/wp-content/uploads/2019/10/2019-19-09-Senate-Recommendations-Community-Hospitals-FINAL.pdf