SOCIAL POLICY RESEARCH FOR CORNWALL

A Q&A GUIDE TO CORNWALL'S INTEGRATED CARE SYSTEM

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Review of the draft Integrated Care Strategy for Cornwall & the Isles of Scilly

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IN A NUTSHELL

The draft Integrated Care Strategy for Cornwall & the Isles of Scilly:

- Is incomplete. It is described as a 'strategy' but offers no blueprints for action.
- Unjustifiably treats Penwith (Penzance and its peninsula hinterland) and the Camborne/Redruth conurbation as a single 'integrated care area' (ICA). The two localities will have to compete for scarce resources. NHS England's advice to consult local people about ICA boundaries has been ignored.
- Contains many statistics and general statements that apply to the whole of Cornwall, so are of no help in deciding where to target resources.
- Claims to be an attempt to create 'strong, resilient and connected communities' but turns out to be a flawed attempt at social engineering.
- Says Cornwall has the third highest suicide rate in England and poor healthy life expectancy for men and women, but offers nothing to tackle this situation.
- Dangles the tempting prospect of a better life for Cornwall's young people in front of them but offers no prospect of action to realize it.
- Fails to acknowledge that the combination of the Covid-19 pandemic, the housing shortage and the cost of living crisis is causing many Cornwall residents to be stressed, distressed and traumatized.
- Interprets 'engagement' as nothing more than listening to self-selected citizens and identifying 'general themes', rather than conducting proper surveys and providing opportunities for the public to challenge the process.
- Has evidently not drawn on the experience of the staff of Primary Care Networks who have considerable knowledge of local conditions.
- Says nothing about how health and social care services will be joined up to avoid the 'silo' working that is so damaging and costly to the NHS and local government, although that is a major reason for integrating care systems.
- Appears stuck in a 'top-down' way of thinking about strategy, when what is needed is a 'bottom-up' approach to health and social care today.

Introduction

The first draft of an Integrated Care Strategy for Cornwall and the Isles of Scilly (CIoS) was published at the end of February 2023.[1] It contains data and aspirations and targets for the whole of Cornwall. It was rubber-stamped on 24 February 2023 by the Integrated Care Partnership[2] in a meeting that lasted less than half an hour.

We are told that this is the first version of the CIoS Strategy, and that it 'sets out the key challenges to the health and wellbeing of our population both now and over the next decade, how we'll work better together as partners to address those challenges, and how we'll know if we've been successful. … We'll continue to update this strategy, to understand the most important issues facing our population and to reflect our progress.'

I appreciate all this, but already so much work has been done and published and ratified that those involved will inevitably be heavily committed to continuing along the same lines. Accordingly I judge it to be appropriate to assess the current draft as if it were the real thing. This review is offered as a contribution to the process of developing the Strategy, and I hope the authors will take it in that spirit and not as an attack on their efforts so far.

The questions

For the sake of readability, this review is presented in a Question and Answer format. The questions are as follows:

Q1: What is the plan of action that the draft Strategy implies?

Q2: To what localities within Cornwall does the draft Strategy apply? How were they chosen, and are they appropriate?

Q3: What targets does the draft Strategy set? How appropriate are they?

Q4: The draft Strategy makes many references to 'community'. What are we to make of them?

Q5: What does the draft Strategy tell us about health and disability of Cornwall residents in neighbourhoods with high levels of 'deprivation'?

Q6: I live in a neighbourhood where many people are poor and struggling, and many are in poor health. What would the draft Strategy mean for us?

Q7: How appropriate and competent was the 'engagement' undertaken in producing the draft Strategy?

Q8: Would an issue-based approach to forming a strategy be more fruitful?

Q9: Can there be a role in forming a health and care strategy for primary care workers and for the patient participation groups of individual surgeries?

Q10: What should 'joined-up working' mean as part of a strategy?

Q1: What is the plan of action that the draft Strategy implies?

A: The term 'Strategy' is defined in the Oxford Dictionary of English as 'A plan of action designed to achieve a long-term or overall aim'. In the 56-page draft Strategy the word 'action' occurs just four times. If we ask what it tells us about long-term aims, we find they are mainly expressed in terms of desired 'outcomes' (a word which occurs no fewer than 45 times in the document), while under the heading 'Turning our strategy into action' all we find is a diagram showing 'how this strategy … will inform our organisational plans'.

The draft Strategy outlines those 'key outcomes' by age group: 'Start well (approx 0-24 years): To give our young people the best start to life'; 'Live Well (approx 24-64 years): To support our adults to live well'; 'Age Well (approx 65+ years: We want our older adults to live well and independently in a place they choose to call home'.

Clearly these are all matters of judgement: there is no commitment here to expending resources or taking any specific action whatever. Indeed, there is nothing in this draft Strategy approaching a blueprint for action.

Q2: To what localities within Cornwall does the draft Strategy apply? How were they chosen, and are they appropriate?

A: For the purposes of NHS administration, Cornwall has been divided into three 'places': West Cornwall, Central Cornwall, and North & East Cornwall, each being designated an Integrated Care Area (ICA). We are not told who decided this or on what grounds, or why there has been no public consultation on it. In the case of West Cornwall, there are grounds to challenge it.

The West Cornwall ICA extends from Land's End to beyond Redruth, a distance of some 30 miles. In addition to the Isles of Scilly, it comprises two distinct sections: the area of the former Penwith district (centred on the town of Penzance and Newlyn, and with a hinterland of smaller settlements, notably St Ives, Hayle, Marazion and St Just) and that of the former Kerrier district (which includes the built-up area of the Redruth/Camborne conurbation).

Guidance from NHS England and the Local Government Association (LGA) says:[3]

> As far as possible, the footprint of place (sic) should be based on what is meaningful to local people, has a coherent identity and is where they live their lives – such as a town, city, borough or county. ... The LGA et al recommend[4] that 'Place-based systems should be established or amended following local discussion and considering the role of all the partners who contribute to health and care in a place, including housing, employment and training, and emergency services.'

There has been no public discussion in Penzance of how 'place' should be defined. But we can say with confidence that the area of the former Penwith council is well understood locally, while West Cornwall Hospital, which serves the local community, is situated in Penzance, and many other local services with a bearing on health and wellbeing are delivered in and from the town. The Penwith Primary Care Network (PCN) has a clear footprint in the area, with cooperation among GPs well established, while the Penwith Integrated Care Forum has been in existence for some time. Local bus services radiating from Penzance are well used, while the coastal nature of the Penwith peninsula creates a character that the urbanized former Kerrier area does not share.

In short, if a service for Penwith residents were based in Camborne or Redruth, that would require a significant amount of time-consuming and expensive travel on their part. Bundling all services for Penwith in an artificial 'West Cornwall' ICA disrupts a local, cooperative setup in Penwith that has taken years to establish. Moreover residents of Camborne/Redruth, which is known to have its own special difficulties in recruiting and retaining GPs, look not to Penzance but to Truro (only 9 miles from Redruth) if their healthcare needs cannot be met closer to home.

Furthermore, when in the future funds for new equipment or building become available, the obvious basis for sharing them out will be one-third for each of Cornwall's three ICAs. That will leave Penwith in direct competition with the Camborne/Redruth conurbation for the West ICA's resources. It is not hard to envisage a general preference to award any new facility to the more populous locality, imposing considerable travel and time costs on Penwith residents. We are already seeing exactly this with the overnight closure of the Urgent Treatment Centre at West Cornwall Hospital in Penzance: people in need of urgent

treatment are being directed to the Camborne-Redruth Community Hospital instead amid hints that the overnight service in Penzance will not be restored.

All this is simply not acceptable. Penwith is a distinct place with its own character and its own communities, and very different from the Camborne/Redruth conurbation. It meets every criterion to be treated as a self-contained 'place'. The new integrated care system must respect this.

Q3: What targets does the draft Strategy set? How appropriate are they?
A: Sections of the draft Strategy are devoted to 'Key outcomes for our people: How we'll know we've got there'. 'Key outcomes' are targets by another name. They include

- A reduction in the % of children living in poverty.
- A reduction in the % of babies born with a low birth weight.
- A closing of the 'Attainment Gap' between disadvantaged pupils and their peers at Key Stages 2 and 4.
- A 20% reduction in the suicide rate to level with, or better, the national average by 2027.
- A reduction in the gap in employment rate between people with long-term conditions or a learning disability and the general population.
- Reduce hospital admissions due to substance misuse.
- Reduce hospital admissions for mental health conditions for children and young people aged under 18.
- Continue to reduce hospital admissions due to self harm for children and young people aged 10-24.
- An increase in the uptake in NHS Health Checks for people aged 40-75 or with a Severe Mental Illness or Learning Disability.
- An improvement in delayed discharges from hospital.
- An increase the quality of life of people receiving social care.
- An improvement in the overall satisfaction of people who use services with their care and support.
- Narrowing the life expectancy gap between our most and least deprived groups of males and females: from 7.5 years in the case of males and 5.1 years in the case of females.

What we see here are Cornwall-wide aspirations. Targets that are not quantified – e.g. if simply labelled 'a reduction', 'an increase' or 'an improvement' – are merely aspirations. Once again it will not be possible to hold the Integrated Care System responsible if, for example, any improvement achieved is only marginal.

Q4: The draft Strategy makes many references to 'community'. What are we to make of them?

A: Yes. There are many such references. For example:

> We've previously identified a set of strategic principles ... that will enable us to make progress against the priority outcomes for action. These principles underpin all our work ... and will help us to achieve our aim of building strong, resilient and connected communities that underpin those specific life course outcomes we describe in this document.

It's time for some plain speaking. The draft Strategy as set out here is a classic example of attempted 'social engineering' by people who do not understand what it would entail and are not qualified to undertake it. Dating back beyond the new towns of the 1940s, like Stevenage and Harlow, also designed with the intention of creating 'communities', we find many examples of people in positions of power and with the most altruistic of motives trying – often at great expense – and failing to achieve that result.

The authors of the draft Strategy should read 'What Is Community? An Evidence-Based Definition for Participatory Public Health'.[5] That 2001 paper says:

> A common definition of community emerged as a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings.

In Penwith a community of precisely this nature emerged in recent years in the form of the Centipede Club, originally conceived as a leg ulcer clinic.[6] Patients are asked to attend an initial clinical assessment and weekly group meetings in a relaxed café-style setting in a community location. No appointments are required. Patients are treated whilst they sit together, with a separate room for those wishing to be seen privately. People continue to be seen even when their legs are healed. Tissue viability specialist nurses attend the group, updating the knowledge and skills of all the staff involved and the therapy services on offer.

The Centipede Club has a wider prevention remit too. Group members are offered an invite to a monthly healthy ageing clinic. Here, support is offered by a team led by a Frailty Nurse to empower them to understand and manage their long term conditions. Community matrons also run a weekly wellness café, providing for guided conversations and the informal sharing of health-related information for those who need further assistance to manage their conditions.

For members of the Centipede Club there have been improved outcomes in terms of ulcer healing, and patients have provided positive feedback about the relaxed and friendly nature of the group meetings, compared with more formal clinical encounters. Staff say they love working at the group and are more confident in applying compression bandaging.

What we see here is how a community has come into being and developed not through 'top-down' social engineering aimed at high-minded outcomes but by organic growth in the place where patients directly meet providers. There is a lesson here for people entrusted with drafting a strategy.

Q5: What does the draft Strategy tell us about health and disability of Cornwall residents in neighbourhoods with high levels of 'deprivation'?
A: Official figures show that Cornwall has significantly high levels of 'multiple deprivation' (an index covering not only health deprivation and disability but also income deprivation; employment; education, skills and training; crime; barriers to housing and services; and physical environment). Cornwall has 17 neighbourhoods that are among the 10% most deprived in England. Ten of them are among the 10% most deprived on the health deprivation and disability index. Thirteen of them are among the 10% most deprived in terms of income. Four of those in Cornwall are among the most deprived on both the health and income indices.

The draft Strategy does not name any of these neighbourhoods or their locations. We have to look elsewhere to discover that of the four most deprived in terms of health and income, three are in the Camborne/Redruth conurbation and one is in Penwith.[7] In those neighbourhoods people are significantly more likely to die prematurely (i.e. under 75) of cancer or cardiovascular disease, for example, and more likely to die from respiratory disease.

Cornwall also has neighbourhoods with very much less deprivation, where people on average live longer and suffer less ill-health. Some of them are among the 20-30% least deprived neighbourhoods in the whole of England. This tells us

something important when it come to forming a strategy: that statistics and generalizations about the whole of Cornwall are beside the point when it comes to deciding where to target resources to improve people's health and social care.

Q6: I live in a neighbourhood where many people are poor and struggling, and many are in poor health. What would the draft Strategy, if acted on, mean for me, my family and my neighbours?

A: The short answer to this question is: the draft Strategy does not tell us. We are told that of Cornwall's 109,000 or so children and young people under 18 years, around 30% live in poverty (after housing costs), but in some communities this rises to 40%. Fuel poverty, damp housing and poor diet are persistent problems, bearing hardest on the poorest.

In these neighbourhoods in particular, people will be struggling. More women than elsewhere will smoke in pregnancy, more than a third of children in year 6 will have poor diets and be overweight or obese. More older people will be living with ill health in the last years of their lives. Mental health conditions, a common cause of ill health,will be increasingly prevalent, and people with severe mental illness have higher risk of major diseases and lower life expectancy. Cornwall has the third highest rate of suicide in the UK. We don't have neighbourhood figures, but In Cornwall men in general spend over 16 years in poor health, and women nearly 18 years. The draft Strategy does not tell us how these figures would be improved or whether poorer neighbourhoods could or would be targeted.

Overall, about 41,600 young adults are aged 18-24 years. The draft Strategy says:

> Young people have told us they want to be able to live and work in Cornwall when they grow up, but to do this, they need better employment and career opportunities, more affordable housing options, better transport infrastructure, an accessible education system.

These aspirations are of course far beyond the scope of a health and social care strategy. The draft Strategy dangles the prospect of a better life in front of Cornwall's young people but offers no prospect of actions to realize it.

Q7: How appropriate and competent was the 'engagement' undertaken for the strategy?

A: The draft Strategy claims that a wide variety of engagement events have been carried out. Many of them took place before 2022. Others took place at various outdoor events, and involved promoting 'some key healthcare campaigns',

'[seeking] feedback from the public on their experience of accessing some of the most used NHS services', and '[asking] people for their thoughts about the wider NHS and care services':

> This engagement in particular highlighted challenges around access, particularly face to face. It also highlighted the incredible work that is undertaken by people working to improve health and care. … We've used what we have heard to shape our priorities, and we'll keep listening ....

The draft Strategy continues:

> We have started our first phase of engagement, which is a 'listening exercise' to test that what people have previously told us is still relevant and fill gaps in our knowledge. We also are using this time to find out who we should speak to, and how people would like to be involved.'

What has actually been learned from the public, and how has it been used?

> We used the Let's Talk Cornwall platform to ask how [people] feel, and to inform [them] about the Integrated Care Strategy. … We have reviewed the full feedback available in January 2023 and summarised general themes from the input that our people have provided ...

What is interesting is the language used in the Strategy document.

- 'Respondents highlighted …'
- 'Some people mentioned …'
- 'Some respondents spoke about … '
- 'There was a focus on …'
- 'The consistency of seeing the same [GP] was mentioned.'

As we see, 'engagement' has been interpreted as identifying 'general themes', such as could be encapsulated and written down on a Post-It Note. This is far removed from a survey that meets standards of good practice.[8] We do not know how representative the contributors were. It is clear from the content of the responses that some of them were from people who work for the NHS or local authority, but no distinction has been drawn between comments from them and those from the general public. It is also clear that the respondents were not participating in any systematic way in a policy-making process, such as by expressing preferences and making choices.

Listening to the voices of citizens is all very well, but genuine engagement must involve displaying the mechanisms of policy making, the constraints within which decision-makers feel they have to work, the commitments that they have already incurred, and the choices that remain to be made. In particular, decision-makers must be open to challenge. They must allow their assumptions, their reasoning and their way of working to be questioned. Otherwise 'engagement' will be regarded – with reason – as a confidence trick, as a farce.

Sadly, there is no sign that this has been taken on board by the authors of the draft Strategy or those who are employing them. For the purpose of forming a strategy, the engagement that was undertaken cannot be regarded as competent or appropriate.

Q8: Would an issue-based approach to forming a strategy be more fruitful?
A: An alternative or complementary approach to forming a strategy would be to ask residents to speak up about particular 'issues' that affect them. They could be asked to volunteer statements beginning 'something needs to be done about …'. Such an approach would provide starting points for discussion and could be used to reveal localities where there is a shortfall in provision, widespread support for action, and competition for resources.

An issue-based approach also provides connections to the political system, and can allow local people to take part actively if they wish to get involved in the process of reaching decisions.

An issue-based approach is conveniently already to hand in the form of the current national strategy for autistic children, young people and adults.[9] That strategy has a vision which is clearly expressed in terms of addressing and resolving issues: these provide both an imperative – 'Something must be done', 'How will we work towards this?' – and subjects for investigation, so we can all understand the complex processes through which those issues have come about. (In the autism strategy document the issues are presented as 'themes' but the 'how to' presentation makes clear that it is appropriate to describe them as issues: examples are '[how to improve] autistic children and young people's access to education', and '[how to tackle] health and care inequalities for autistic people'.)

Significant health and social care issues that confront Cornwall residents today and which should be addressed at local level as well as system-wide include:

- How to improve health and social care services in localities where there is marked under-provision, especially where the disparity is conspicuous, e.g. for young people in need of care for their mental health;
- How to reduce handover delays for ambulances outside the Emergency Department at Cornwall's main acute hospital at Treliske;
- How to minimize the incidence of hospital-acquired deconditioning (HAD) in patients who have completed treatment at Treliske;
- How to 'join up' health and social care services in local communities by 'collaborative working', as in multi-disciplinary teams, including working jointly for and with people suffering from multiple conditions;
- How to ensure that patients discharged from acute hospital are not sent against their will to community hospitals, nursing homes or residential care homes far from their home community;
- How to ensure that children and adults requiring mental health services can benefit from services that are readily accessible and of at least as good quality as those provided for physical health needs;[10]
- How to identify and respond to groups of people with conditions such as hearing loss, frailty and obesity that prevent them from participating fully in society.
- How to prevent South West Water from creating a health hazard by allowing sewage to flow on to Cornish beaches.

Q9: Can there be a role in creating a health and care strategy for primary care workers and for the patient participation groups of individual surgeries?
A: There are very few references in the draft Strategy to GPs and Primary Care Networks (PCNs) having made a contribution to it. This suggests that an opportunity has been missed. Since 1 July 2019 nearly all GP practices in England have come together in locality-based PCNs. Cornwall, with a population today of some 570,000, has 57 GP practices, grouped into 15 PCNs. Each PCN is headed by a clinical director, who may be a GP, general practice nurse, clinical pharmacist or other clinical professional working in general practice. PCNs today employ staff in a range of 'additional roles' besides GP, nurses and health care assistants: these staff include clinical pharmacists, social prescribing link workers, health and

wellbeing coaches, care co-ordinators, dieticians, first contact physiotherapists, community paramedics, mental health practitioners, and podiatrists.

With this wide range of 'additional' staff, PCNs are very well placed to monitor the overall health of their local community. And a paper by the King's Fund makes the point that clinical directors are well placed 'to provide a voice upwards to the wider integrated care system'.[11] It follows that the clinical directors of PCNs should be closely involved, if not given a central role, when an integrated care strategy is being formulated.

The role of PCN clinical directors should also include encouraging constituent practices to engage actively with their patient participation groups (PPGs), and facilitating the formation of a network-wide integrated care forum (such as already exists in Penwith), open to individual clinicians, people in additional roles, care providers, and residents with lived experience of the health and care system, to give them too a voice and a channel 'upwards' to the arena in which health and care strategy is being formulated. Such forums would enable systematic and ongoing engagement in processes of formulating strategy of members of the public with day-to-day lived experience of the health and care system.

Q10: What should 'joined-up working' mean as part of a strategy?

A: The idea of 'joined-up working' is fundamental to the notion of integrated care systems. It is straightforward to understand when we think of it as collaboration, a multi-disciplinary or cross-organizational team sharing information and discussing what is the best way of assisting a patient and coming to an agreement with them on the best course of action to take.[12]

Matters are more complicated when we consider a patient's journey (their 'trajectory') through the system, as when they are handed over from acute care to social care. The despatching clinician may feel that their responsibility does not extend beyond treating the patient's ailment and so does not include anticipating and facilitating their subsequent handover to social care (e.g. by maintaining their physical and social wellbeing). In such cases joined-up thinking has to take a sequential form, along the patient's journey.

There are already good examples of joined-up practice in Cornwall, in the Royal Cornwall Hospital at Treliske, where particular attention is devoted to older people living with frailty:

> A Same Day Emergency Care (SDEC) service operates from the Frailty unit, alongside an acute inpatient service for frail older people. [There is an] integrated medical, nursing and therapy team on the ward ... The SDEC service works to identify patients who need a comprehensive old age specialist assessment and treatment intervention. This intervention is hoped to avoid a hospital admission, returning patient back to the previous home environment quickly with any additional support and follow-up care they require.

If older people living with frailty are assessed with the ambulance service and frailty specialist nursing service as requiring a short inpatient stay, to receive investigations and treatment, they can be admitted to the inpatient side of the ward. Here alongside these interventions, a rapid discharge plan is coordinated to reduce any unnecessarily long stay in hospital. A stay in these beds is usually one or two days.[13]

The references to an 'integrated medical, nursing and therapy team', to assessment being carried out 'with the ambulance service and frailty specialist nursing service', and to 'a rapid discharge plan [being] coordinated' demonstrate that 'joined-up' working is alive and well within the hospital. The drawbacks of having clinicians and other staff working in their own 'silos' seem to have been fully appreciated. Strikingly, though, there is no mention of coordination with Cornwall Council's social services. And sadly, the term 'joined-up' gets only two passing mentions in the draft Strategy. It appears that its authors have yet to fully comprehend the principles of joined-up working and apply them across the whole range of health and social care.

Incidentally, the value of joining up elements of care was recognised more than a century ago. As the history of the Great Ormond Street Hospital for Children reminds us, the Hospital employed Almoners who

> saw themselves primarily as ... intermediaries between the Hospital and the patients' families. It was the Almoner who offered practical advice and guidance, and a sympathetic ear, to the parents of coeliac patients. It was the Almoner who conducted delicate conversations with long-term patients, affected by limited contact with their families, and it was the Almoner who found the money for respite care, and for the transport costs of cash-strapped relatives, so that they might visit as much as possible. As a group,

> the women took a practical approach to a role in which they were faced daily with the practical difficulties of having a sick child in the family.[14]

In the words of one Almoner, '[Our] work is not designed to make life softer but to help people cope with difficulties, changing in a constantly changing society.' That would make a good motto for the authors of an integrated care strategy.

Conclusion

I have no model to recommend for the perfect health and social care strategy. I rather suspect there can be no such thing. Any single strategy can only be a step on the way to the next one: we're in a process of continuous learning, forever puzzling out the best way forward.

I sympathize with the authors of the draft Strategy in their aspiration to see 'strong, resilient and connected communities' across Cornwall, but I very much doubt whether prescriptions by and for NHS bodies and Cornwall Council will lead to that result.

There are grounds for thinking that NHS England's 'top-down' approach of tasking a local statutory body to produce a 'strategy' is itself misguided. It follows on previous attempts such as the Vanguard 'New Care Models' programme, which was piloted in 2015-19 and cost about £389 million and covered around 5 million people. Aimed at integrating health and social care services, it slowed the rise in emergency admissions to hospital among care home residents over that period but it did not achieve its other aims.[15]

The authors of the Vanguard evaluation also concluded that there was a learning process taking place:

> Some Vanguard sites reduced the rate of increase in emergency admissions. Others did not. The reasons for that remain unclear and it is not known which integrated care models work best, why they work, and under what circumstances they work. A better understanding of how to integrate health and social care from the perspective of patients and service providers is needed. … This research also highlights that outcomes for integrated care and other initiatives should be assessed over the long-term.

But the NHS continues to be run on a top-down basis. We can see that already in the working of the CIoS Integrated Care Board. When the Chair and Chief Executive took office and wanted to run a brainstorming conference, they looked – presumably aided by a steer from NHS England's South-West Regional Office –

to international management consultants KPMG for advice, and chose to invite so-called ‘stakeholders’ and ‘thought leaders’ – not organizers of food banks, or members of the Centipede Club suffering from leg ulcers, or people living in neighbourhoods of multiple deprivation. And with the Chair on record as saying that in matters of health and social care ‘We are all customers now’,[16] we may well fear that to be an ordinary patient of the NHS in Cornwall today will mean being very much a second-class citizen.

I do hope that the authors of the draft Strategy share my misgivings at that prospect, and will explore ‘bottom-up’ approaches to designing the next health and social care strategy for Cornwall and the Isles of Scilly.