
Joint Forward Plan 2025 to 2029/30



Foreword	3
Executive summary	2
The challenges we are tackling	7
Operational recovery	10
Improve access to primary care services	10
Reduce delays in urgent and emergency care	11
Reduce delays in planned care	13
Speed of diagnosis and treatment of cancer	15
Access to mental health services	15
Improving value	19
Our new model of care	22
Clinical strategy delivery- applying our new model of care.....	30
Improving care for our most at risk populations.....	35
To start well: focusing on children and young people.....	44
To live well: focusing on the middle years of life	48
To age well: focusing on the later years of life	51
How we will know we are making a difference	54
How we will deliver these changes	56
Research and innovation	56
Developing our workforce	61
Taking advantage of digital opportunities	62
Tackling climate change as an enabler of living well.....	65
Collaborating.....	66
Finance	67
Further developing this Plan	69
Engagement.....	69
Appendix 1: The strategic and planning framework and where the Joint Forward Plan sits	72

Foreword

As we move forward, we are determined to ensure we listen, hear and provide the support you have told us you need.

This is the second refresh of our joint plan for health services.

You have shared your concerns over access to services and long waiting times.

Guided by you we will look every year to improve the care and support we provide. Over the last year, we have made progress in reshaping our services so that more care can be provided in our local communities and peoples' homes, enabling our acute hospitals to provide more timely care to those who most need their specialist care and support.

Over the next 5 years we will continue to ask you to help us reshape care and support to match changing needs. We have already heard from more than 11,000 local people.

We are undertaking our annual refresh of the Plan whilst also contributing to the national engagement on the future of the NHS and will further refresh this plan in the light of the 10 Year NHS Plan once published later this year.

This is the Joint Forward Plan of the Cornwall and Isles of Scilly Integrated Care Board, the Royal Cornwall Hospitals NHS Trust, and Cornwall Partnership Foundation NHS Trust.

It describes the challenges we must overcome and how we will continue to improve, and transform health services.

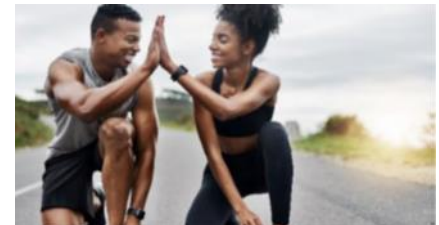
What matters

Cornwall and the Isles of Scilly are great places to be born, live and thrive, and to grow old.

Babies, children, and young people have the best start to life.



We all live well.



As we get older, we are able to live happy lives in a place we call home



Connected, healthy, caring communities for one and all.

Executive summary



Executive summary

We face 3 challenges:

- a) The changed needs of a super-ageing population with too much preventable illness and health inequalities.
- b) Difficulties in providing care because of a limited resources.
- c) We are still experiencing the consequences the pandemic had on health and services.

We have 3 areas of work to tackle the challenges

- Transforming care.
- Improving value.
- Operational improvement

The severity of the challenges means we have to make good progress quickly and concurrently on all three areas of work.

At the end of 2024/25 our performance standards have improved but too many people are still waiting too long for ambulances and/or for more than 4 hours in emergency departments and too many people are still waiting too long for planned care.

Our underlying expenditure exceeds our financial allocation and we end 2024/25 breaking even by making non-recurrent savings leaving us at risk of a financial deficit in 2025/26 and

future years. This must be addressed because we have a statutory duty to remain within a balanced budget.

This plan sets out what we will do in each area of work:

Transforming care

Implement a new model of care based on people, prevention, and place, with a different focus at different life stages.

Reshaping care around 3 major shifts in how we provide services, recognising the changed needs of our population and opportunities offered by new technological and digital developments:

- **From hospital to community:** community-based services and care at home when acute hospitals are not the best place for the majority of people, particularly those living with frailty or who are at the end of their lives
- **From illness to prevention:** proactive care preventing frailty or major conditions and preventing further deterioration.
- **From analogue to digital:** making optimum use of digital opportunities to improve care for people and improve efficiency and effectiveness of service provision, so that our clinicians can optimise the number of people they are able to treat and support.

We are also embedding integrated neighbourhood teams into our new operating model to underpin the shifts to

community and prevention, enabled by the digital opportunity.

Improving value

Deliver the highest quality health outcomes for patients at the lowest possible cost and living within our means. As well as improve social value through the way we commission and procure services to improve the economic, social and environmental wellbeing of Cornwall and the Isles of Scilly.

Operational Improvement

Improve access to primary care and mental health services, reduce delays in urgent and emergency care, and reduce waiting times and waiting lists in planned care and in neurodevelopmental assessments for our children.

Ensuring as we transform, improve value, and recover operationally, that throughout we:

- a) Improve care for our population groups most at risk of poor outcomes and tackling inequalities.
- b) Reduce healthcare related carbon emissions

Change will be accelerated by increased involvement in research and innovation and taking advantage of digital opportunities. The plan describes the links we are building with existing research and innovation networks across the Southwest and steps we are taking to develop digital opportunities and develop our workforce.

We began this journey in 2023 and this is a snapshot of achievements so far in 2024/25:

Focusing on people and personalised care

We have transformed urgent care for older people living with frailty. During 2024/25 we have:

- a) Introduced innovative rapid response vehicles (falls, x-ray, and right care cars) to prevent avoidable hospital admissions.
- b) Increased our community-based same day emergency care centres to three, in Bodmin, Penzance and Redruth, aligned to our existing community assessment and treatment units, so that we have community facilities which provide same day or short stay urgent care from which people can return home.

Improving care for children and young people

- Approval for our new Women and Children's Hospital on the Royal Cornwall Hospital site as part of the national new hospital programme

Prevention and personalised care that is place-based

- Over 50 community hubs continued to be provided in 2024/25 by voluntary and community sector partners collaborating to provide hot food, warm spaces, activities, support groups, and informal spaces for NHS colleagues to give advice on health and wellbeing.

- Increased provision and utilisation of primary care hubs so more people who are unwell are seen quicker and freeing time in GP practices for people with complex long-term conditions to see their own GP and healthcare professionals on a more regular basis.

Redesigning how we provide care for people with major conditions

- We have continued to develop the use of diabetes “super clinics” provided locally at GP practices bringing together 9 essential health checks.
- Increased utilisation of “virtual wards” offering people hospital care in the comfort of their own home.
- The Royal Cornwall Hospital introduced orthopaedic super clinics to better support patients waiting for orthopaedic surgery in a multi-disciplinary clinic.
- Encourage a programme of support and advice to help people to be as physically and mentally fit and well as possible ahead of surgery to support better recovery and outcomes

For people most at risk of inequalities

- We have continued to expand the work of our Community wellbeing workers recruited and living in the disadvantaged neighbourhoods they are supporting

Reducing waiting times and enhancing local facilities for planned care:

- Opening of the new state-of-the-art elective surgical hub in St Austell which has seen over 1,000 patients since becoming operational and will deliver around 5,000 day surgery procedures a year and for people in mid, north or east Cornwall potentially reducing travel.
- Up to 7,000 patients per month being seen through the Royal Cornwall Hospital Bodmin and West Cornwall community diagnostic centres
- Opening of a third community diagnostic centre for the Camborne/Redruth area

Reducing delays in urgent care

Royal Cornwall Hospital have:

- introduced a new process with SWAST to improve handovers between ambulances and the emergency department so no ambulance waits longer than 90 minutes
- made changes to their medical model to support the flow through our hospitals through ensuring senior clinical decision makers are available after into the evening

Cornwall Partnership Foundation Trust have:

- worked with Kernow Health Community Interest Company to deliver a single point of access for our urgent and emergency care system, directing patients to the most appropriate route of care and facilitating

greater access to primary and community-based alternatives to hospital admission.

- Collaborated with Southern Western Ambulance Service NHS Foundation Trust to launch a mental health response vehicle to provide discreet, on-scene support to people facing mental health crises, with only a 5% conveyance to emergency departments (previously approx. 65% from ambulance attendance).

Improving access to mental health services

2024/25 saw the launch of the 'NHS111 option 2' service, offering immediate support and advice for anyone facing mental health crisis.

This is being delivered as an enhancement to our mental health connect service and aims to provide rapid access to mental health professionals for people when they need it most.

Improving access to dentists

We have started to increase access for those needing urgent dental treatment and are working to stabilise the situation, including:

- A programme to assist dentists with recruitment.
- Working to establish a scheme to support foundation dentists within training practices.

- Creating a dental pilot at Lostwithiel on which we can now build to target NHS dental capacity for children and the most vulnerable adult patients

We are setting up cancer action support practices to provide dental treatment with patients with head and neck cancer.

We have 3 new contracts secured in 2025/26 including a site at West Carclaze and are continuing with our mid-year reviews with a view to rebasing contracts in order to free up activity to put forward for procurement.

The mobile dental van is operational and providing support for vulnerable groups to tackle oral health inequalities.

Research and innovation

Royal Cornwall Hospital has introduced a new mobile research unit to help people in remote communities access clinical trials

The challenges we are tackling



The challenges we are tackling¹

a) The consequences of the pandemic



Increased demand (physical and mental health) and long waiting lists increasing the risk of suboptimal outcomes.

b) Changing needs



A growing population: 83,000 more in 20 years



The baby boomer effect: 56% more people aged 75-84 and 87% more people aged 85+ (2019 to 2038)



An increase in health problems that can be prevented

More people have preventable illnesses and are having more years of ill health, often with multiple illnesses and combined mental and physical health problems.



Increasing health inequalities: 88,000 people at greater risk of long-term illnesses, part of the 20% most deprived communities in England.



Climate change: We are at risk from more extreme weather events and need to reduce our contribution to greenhouse gases.

c) Challenges in providing care and support



Workforce supply: workforce demographics and labour market supply across health and care.



Finite resources to meet growing demand: we need to bring our finances back into balance and make every £ stretch further



Our geography and settlement pattern affects where and how services can be provided

A peninsula and islands with 40% of people living in settlements of under 3,000 and only 5 larger towns with a population between 20,000 and 30,000.

We have to balance helping our children and young people, start well with support for a rapidly growing number of older people. A consequences of all these challenges in combination is that our traditional way of providing care based around the acute hospital is no longer able to meet the needs of our population, as seen in unacceptable delays in both urgent and planned care and ineffective use of our overall resources. For that reason we are changing our model of care.

¹ Sources: *A growing population and the baby boomer effect 2019-2038*, Cornwall and Isles of Scilly [JSNA/ONS population estimates](#); Preventable

illnesses, [Cornwall and Isles of Scilly Population Health Profile 2021-22](#); Equality and Health inequalities, NHS Right Care, December 2018.

How we will overcome these challenges

Operational improvement

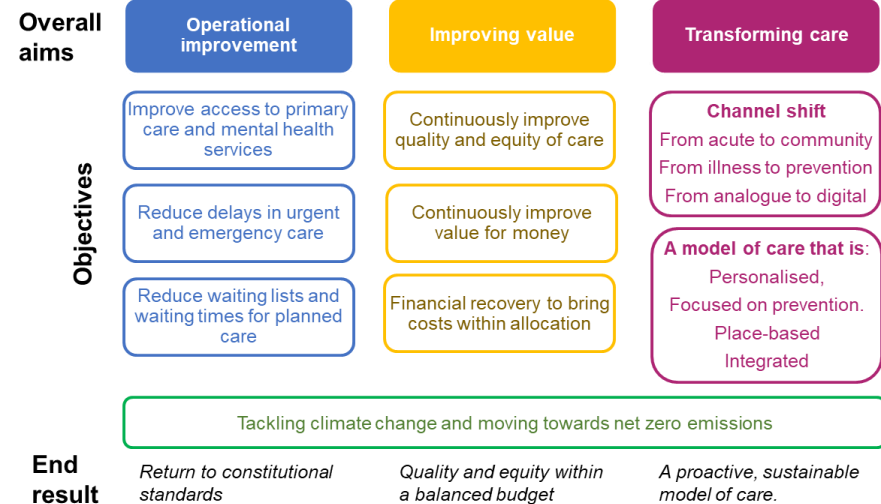
This focuses on:

- a) Improving access to GP and dental services.
- b) Improving access to mental health services
- c) Reducing delays in urgent care.
- d) Reducing waiting lists and times for planned care.

Improving value

To overcome difficulties in providing care requires:

- a) A focus initially on financial recovery with a significant cost improvement programme to bring existing costs within allocation.
- b) A programme of continuous improvement to ensure we get the most value from our finite resources. This will be a dedicated programme of change continuously looking for suggestions to improve value whilst transforming care as part of business as usual, utilising quality improvement and cost improvement methodology.



Transforming care

Responding to our population's changing needs:

- Care reshaped around people at different stages of life
- Integrated, focused on prevention and place based.
- Shifting where and how it is provided to meet local needs and take advantage of new technologies.
- Integrated Neighbourhood teams joining up care across organisations and bringing care closer to people's homes.

Operational improvement



Operational improvement

Local people have told us they are concerned about how long they have to wait for ambulances, for emergency treatment, for planned care, and for care and support following a stay in hospital. Many people told us they are having difficulty in accessing GP services, dental services, and mental health services.

Our primary care strategy now covers general practice, dentistry, optometry and pharmaceutical services.

This is what we have done in 2024/25 and what we plan to do further in 2025/26.

Improve access to primary care services

We have developed self-referral pathways for audiology for older people (including hearing aid provision), community equipment services, community optometrists and ophthalmologists.

The NHS Pharmacy First service has been operational from 1 April 2024 enabling the management of seven common infections by community pharmacies and 85.4% of pharmacies in Cornwall signed up to deliver the service. We have promoted this to help reduce demand in general practice related to lower-acuity conditions.

From 2026, all newly qualified pharmacists will be independent prescribers and Cornwall is part of the national pathfinder programme for this with 4 pathfinder sites exploring

how this may be utilised in our system whilst contributing to national learning.

Our GP practices have fully utilised their allocation from the Additional Roles Reimbursement Scheme since 2021/22, have continued to do so in 2024/25 and plan to do so again in 2025/26. The additional capacity this provides helps increase access to more appointments.

The proportion of work that is 'on the day' urgent demand had increased to such an extent that proactive care for people with long-term conditions or living with frailty had been affected, leaving them at greater risk of urgent hospital admissions.

During the winter of 2023 the Primary Care Collaborative Board tested implementing primary care hubs to provide additional capacity to see unwell people who do not need continuity of care, freeing up GP practices to spend more time with those who do need it and helping them to avoid unplanned hospital admissions.

Eleven hubs have operated in 2024/25 as part of our emerging new operating model and the plan is to increase from an average of 3,500 additional appointments each month to 4,500 from April 2025 and 6,000 per month from July 2025

We have also trialled the use of AI during 2024 to risk assess local GP populations to enable practices to take a proactive approach for those needing continuity of care and this will be rolled out to all practices to use in 2025/26.

There is future potential to integrate the hubs and minor injury units.

Reduce delays in urgent and emergency care

Delays being experienced are:

- Waiting for an ambulance when experiencing a life - threatening emergency.
- Waiting in ambulances to be transferred to emergency departments.
- Waiting in emergency departments to be treated
- Waiting in emergency departments to be admitted to hospital.
- Waiting in a hospital bed to be transferred to another organisation for ongoing care either at home or in a care home, including those at end of life.

As soon as there is a delay in someone leaving a hospital bed it means there are fewer beds available for people to be admitted from the emergency department and leaves people waiting there.

The emergency department then fills up and people have to wait in ambulances before being allocated a space in the department to be seen.

Ambulances having to wait with patients until they can go into emergency departments also then leads to delays in ambulances being able to respond to calls.

All of these waits mean that harm is more likely to occur to patients, and therefore we will also be improving quality by taking these steps

People have asked during our community conversations if we can find alternative ways to treat people at home rather than long waits in ambulances and emergency departments.

We need to manage the urgent and emergency care element of our healthcare system to ensure that emergency care is available 24/7 at the hospital without delay. Many people want to be able to access more locally available services before it leads to them needing urgent and emergency care.

This means differentiating between emergency care requiring acute hospital facilities and urgent care that is not life, limb, or sight threatening and does not require acute hospital facilities.

People needing urgent care can be treated at home or closer to home in facilities that are closer to where they live. There are three things we are focussing on to reduce delays:

- a) Ensure appropriate alternatives to going to emergency departments for people who need urgent care.
- b) Improve flow into, through and out of the emergency departments and hospital wards by having early senior assessments and plans in place.
- c) Increase support for people who need further care at home when they are ready to leave hospital, and ensure residential care is also available when needed, including for patients with dementia.

Provide alternatives to going to emergency departments:

Make full use of NHS 111 and our clinical assessment service. You have asked us to reduce the length of time between an initial call and call back. During 2024/25 we have improved how quickly you get to speak to someone, and we have included access via NHS 111 to 24-hour mental health crisis services.

We trialled innovative rapid response vehicles to people's homes during the winter of 2023, with national interest. These have been embedded in 2024/25 into our emerging new operating model to prevent unnecessary conveyance to hospital.

- a) We have developed a falls car service specially to respond in a timely way to non-injurious falls during peak times of the day
- b) An x-ray car providing a mobile x-ray service

We have increased the number of people receiving care at home from our multi-skilled teams providing an urgent community response within 2 hours.

During 2024/25 we have also introduced 3 same day emergency care centres in Bodmin, Redruth and Penzance alongside our existing community assessment and treatment units for older people living with frailty with the aim of enabling them to avoid hospital and return home. We have also improved how we coordinate care and direct people to the most appropriate service by introducing a single point of access for professionals to use to determine the most suitable available service for people to receive their care. We are

currently reviewing this service to ensure we have the operating model as optimal as possible to meet service demand and increase utilisation during 2025/26

For people deteriorating towards end of life, and wishing to remain at, or close to home, depending on the type of care needed, during 2024/25 we have developed a new model of care to avoid hospital admissions. Elements have been tested and we are planning for it to be operational in 2025/26 and fully utilised by 2026/27.

We have also increased the use of [virtual wards](#) so that more people can get the care and supervision they need at home and avoid going to hospital. In 2024/25 this has included a focus on increasing use of virtual wards for people living with frailty to prevent admissions. During 25/26 we will extend our use of virtual wards for cardiology, respiratory and palliative care services.

Improve flow through hospitals

In our community conversations people have asked if when they are admitted to hospital, people and their families can be offered guidance and have ongoing communication and support about how they can get ready to leave hospital.

Royal Cornwall Hospital have:

- launched a Home for Lunch campaign to encourage our communities to help discharge their loved ones before lunch

- In February 2025, held, a multidisciplinary workshop which brought together health and care professionals from across our system to really explore how we could improve flow this has led to our 'Clinical Vision for Flow', which will form the basis of our programme for 2025/26.
- Will also seek to expand our virtual ward offering, as part of our medical model work, convert our same day medical assessment unit to a medical same day emergency care open 7am - 10:30pm

Improve sharing of information across hospital departments to better coordinate patients' safe care with implementation in 2025/26 of the electronic patient record system.

Increase care and support for people ready to leave hospital

During 2024/25:

- a) Home care providers collaborated to provide additional support on discharge.
- b) We increased use of virtual wards for people who have been to hospital to complete their recovery at home, when it was clinically safe to do so.
- c) We helped more people to recover in the familiar surroundings of their own home instead of waiting in hospital for therapy by increasing access to physiotherapy and other support at home when people are ready to leave hospital.
- d) Actively promoted the range of discharge support and help available to patients and their families through an ongoing communications campaign.

- e) Our system coordination centre provided all year round real time insight into demand and capacity across the system to ensure we made the most effective use of existing capacity.
- f) We have increased the community offer to ensure more people are supported during and after dementia diagnosis.
- g) However, people continue to experience longer stays in hospital with the risk of deconditioning or developing hospital acquired infections and harm preventing or delaying their return home. We are establishing a programme that during 2025/26 will reform provision of care and support that enables people to be discharged from hospital as soon as they are clinically fit to leave so that their ongoing care needs can be assessed in their own homes.

Reduce delays in planned care

Royal Cornwall Hospital Trust have been recognised by NHS England as having a very efficient outpatient transformation programme and in 2024/25 are exceeding national targets for the percentage of patients receiving treatment within 18 weeks.

To catch up, for the next 3 years the volume of activity in planned care must be higher than before the pandemic to reduce waiting lists. More people also need to be seen more quickly for diagnostic tests.

Achievement of local and national interim targets and constitutional standards vary dependent upon the speciality.

We have specialities that are ahead on the achievement of interim targets, however, some specialities are capacity constrained, and we will focus on these.

There are 2 things we can do:

- a) Treat more people more quickly with existing resources for example, increase productivity by streamlining and standardising procedures or taking advantage of new technologies.
- b) Increase capacity, using additional funding provided by the Government, whilst also protecting surgical capacity.

Increase productivity

- a) Continued use of patient initiated follow ups
- b) In February 2024, our first orthopaedic super clinic saw over 85 patients who are currently on the waiting list. Providing a central place for those on the waiting list to receive an assessment, update on their care and where suitable, were listed for an operation with the option to also receive treatment sooner through an alternative provider. The second super clinic was provided in April 2024 and a further clinic in September 2024. There are 2 further clinics planned for March and May 2025 and this model will be expanded where clinically appropriate in 2025/26.

We continue to focus on reducing clinically unnecessary outpatient follow-up appointments to reduce avoidable travel

by patients and redirect resources to people waiting for their first or necessary follow-up appointment.

We have improved communications with patients utilising our local 'patient portal' and the NHS App to reduce non-attendance. There is also a plan to roll out Waiting Well initiative as part of the patient hub in 2025/26

Increase capacity

During 2024/25 we have established a new elective (planned care) surgical hub for day case surgery at St Austell Community Hospital with 2 day-case theatres. National guidance advises that elective surgical hubs should operate 6 days a week, 48 weeks of the year and our unit has been established with a plan that will build up to these levels. The unit is in St Austell on the community hospital site. It will have been operational for part of 2024/25 so the full benefit of the increased capacity of 5,000 procedures a year will be felt in 2025/26.

We have increased use of independent sector capacity to help reduce waiting lists and have offered people the opportunity to travel to other hospitals outside Cornwall to reduce waiting times. This offer has been taken up by 804 patients, with positive feedback.

We have also made it possible to do more tests to diagnose what is wrong by opening a third community diagnostic centre in Redruth.

Speed of diagnosis and treatment of cancer

We achieved the cancer faster diagnosis standard by March 2024 so that 75% of people who had been urgently referred by their GP for suspected cancer were diagnosed, or had cancer ruled out, within 28 days.

During 2024/25 we have:

Increased community capacity for routine diagnostics to create more capacity at the acute hospitals for more complex diagnostics.

Enabled a more rapid turnaround in histology with support from the peninsula pathology network.

Continued to expand and develop one stop services, for example, see and treat dermatology problems.

Ensured sufficient capacity to ensure rapid access to colonoscopy.

Tested very effectively the impact of paediatricians seeing patients in general practice, with a significant impact on waiting list demand.

Continued to prioritise cancer for surgical capacity.

Worked with Devon, as part of the Peninsula Cancer Alliance, to find solutions to workforce shortages and to share best practice.

As well as ensuring better outcome for people, this has reduced the number of people waiting over 62 days.

Access to mental health services

For children and young people

The impact of the pandemic on children and young people's mental health has exacerbated pressures on families. As a result there are significantly more young people needing help than before, but it is often not specialist mental health services that they need.

In 2024/25 we have:

Ensured any child or young person experiencing a crisis will be able to access support 24 hours a day.

Developed more easily accessible, safe and effective early intervention across schools, colleges and voluntary sector.

Made sure we have the right support for children and young people and their families, for children with eating difficulties they have displayed since the pandemic.

Children and young people who are queried to have a neurodevelopmental condition alongside their mental health need are offered neurodevelopmental assessments within children and adolescent mental health service as part of their care.

Supporting mental health in schools

In 2024/25 Cornwall Partnership Foundation Trust implemented the first phase of the children's mental health support team, working with education providers to help them consider their approach to children and young people's mental health. The focus will be on prevention and early intervention, and on supporting the transition to secondary schools from primary education.

For adults

Our plan is to provide easier access to mental health services:

- a) Enable earlier prevention advice and support for those with a lower level, or at the start of, mental ill health
- b) Ensure anyone feeling vulnerable or in crisis will be able to access support 24 hours a day.
- c) Improve waiting times for assessment and treatment of ADHD and autism.
- d) Increase access to dementia diagnosis, care and support.
- e) Ensure equitable access to integrated community mental health services.
- f) Increase the number of adults and older adults receiving a course of treatment via talking therapies for anxiety and depression.
- g) Achieve an increase in overall access to Transformed Community Mental Health services.

- h) Take action so that fewer people with mental health problems or learning disabilities and/or autism are sent outside Cornwall for inpatient care.
- i) Improve access to a place of safety for people detained under section 136 of the Mental Health Act.

In addition, Cornwall Council's Supported and Specialist Housing Strategy will improve access to housing where support and care is integrated with the housing provision for people with a learning disability or autism or serious mental illness, further supporting a proactive approach to improving health and wellbeing and avoiding crises.

In 2024/25 access to community mental health services for people with severe mental illness has improved. In September the target of 2+ contacts within a 12 month rolling period was 4,300 and the actual number was 5,705.

An innovative reablement bedded and community service was opened in November 2024 as part of our plan to shift care from acute to community and it is reducing the number of people out of Cornwall for care and will further reduce length of stay in acute facilities in 2025/26.

We increased numbers of people receiving annual health checks who have a serious mental illness, or a learning disability or autism and they will continue to be a focus in 2025/26 as part of our work to tackle health inequalities.

Health checks for people with learning disabilities to date are the highest in the Southwest region.

Increasing access to talking therapies remained an issue in 2024/25 and is part of plans for 2025/26.

Improving value



Improving value

Improving value in this plan includes:

- Redesigning care to achieve what matters to individuals, creating additional personal value for them.
- Resources distributed across population groups to create equity of access, experience and outcomes
- Achievement of best possible outcomes with the most efficient use of available resources.
- Cost improvements to bring expenditure into line with our funding allocation.
- Adding value for our population by building social capital and contributing to a sustainable local economy and environment.
- Working with system colleagues to develop a net zero plan to be implemented by 2040, with an ambition to reach an 80% reduction by 2036 to 2039.
- Work well service to pilot new ways of supporting people with health barriers to work and developing a regional work, health and skills strategy with new initiatives for employment and health in an integrated programme
- Up to end of December 2024, we invested £20million into the voluntary community and social enterprise (VCSE).
- As part of its major capital projects programme, the Royal Cornwall Hospital Trust is also supporting the

local economy and creating social value through its contracts such as work placements for local students.

We will increase the value our population receives from the care and support we provide by shaping it around people's experience at different stages of life and placing personalised care at the heart of our new model of care

In addition to transforming our model of care we will build continuous improvement in quality and cost with systematic use of improvement tools in day to day provision of care and support.

This will include improving:

- a) Equity of access, experience, and outcomes.
- b) Implementing the Mental Health Improvement Standard to achieve parity between mental and physical health.

We want everyone to have a good experience when using our services and get the best possible results.

We will work together to create a supportive environment for continuous learning and improvement where people feel empowered to suggest and make changes so that we keep on improving the quality of all services, make sure they are safe and make sure they help achieve what matters.

By practitioners, people experiencing services, families, carers, and communities coming together to look at how to improve services, those services will better meet local needs and be fit for the future.

We will look all the time at what we can do better.

We know that some people have difficulty getting to services and do not get as good results as others using the services.

We are working to understand better why this is and what could be done to help. To start with we are looking at:

- Who is struggling to get to outpatient appointments and why.
- Who on our waiting lists may be affected most by long waiting times.
- How we can make the most of the internet and mobile phones for you to contact us and for us to share information with you, whilst making sure everyone who needs a face to face appointment has one.

We also have to keep what we spend within the money we are given. Over recent years we have delivered our financial breakeven targets, but we have to reduce costs further to enable us to deliver financial sustainability on a recurring basis.

A thorough analysis of expenditure has identified a number of cost improvement initiatives, which commenced in 2023/24 and have continued in 2024/25. These will continue in 2025/26 and are being managed as a financial recovery programme.

The Financial Recovery Programme includes the following system workstreams:

- Workforce efficiencies, such as reducing agency costs.

- System flow for example reducing the costs of admissions to hospital that could be avoided and longer lengths of stay in hospital than clinically necessary.
- Medicines and consumables optimisation
- Estates
- Corporate services

Cost improvement and efficiency workstreams are led at Chief Finance Officer level through the System Recovery Oversight Group with additional dedicated programme leadership capacity to lead and drive this key delivery programme.

Whilst we continue to breakeven, we will still compare our services to those provided in other parts of the country to see if they have better results than ours or if our results are just as good but cost less in other similar areas. This will become a cycle of continuous value improvement.

Transforming care to respond to changing needs



Our new model of care

At the heart of our new model of care are:



This is helping people achieve what matters to them and looking at everything they need to have a good result from treatment.

Helping people avoid preventable illnesses.

Care close to home and building on strengths in local communities.

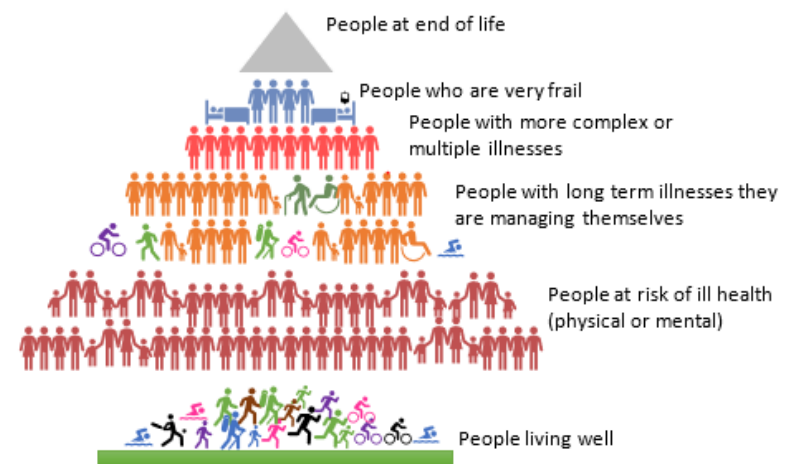
People at the centre

For people at different stages of life

The help people need is different at different stages of life. To get the most from our services we need to rethink how we support people at each stage



To match the current health profile of our population



When we look at the health of everyone living here:

- Some of us are living well, but many more are at risk of being ill either from risky behaviours (smoking, being overweight from an unhealthy diet and/or lack of physical activity, alcohol or substance abuse) or from wider determinants of health like poor housing.

- In the 2021 census 50,785 people recorded that they have conditions that limit their day to day activities a lot, 70,080 have conditions limiting day to day activities a little, and 42,538 have long term conditions but day to day activities are not limited.

To give each person the best care and support for them



Care and support will be personal, taking into account what matters to each person, their personal circumstances, and their skills, strengths and experience. This will include:

- Having equal regard to mental health, learning disability and autism as to physical health so that individuals are considered holistically across the life course and the wider determinants of mental and physical ill-health are considered together.
- Support for people to increase their understanding of what is affecting their health and wellbeing and how to manage health problems. Helping them to gain confidence in what they can do themselves.

- Encouraging everyone to get involved in decisions about their care and support so that it best fits what matters to them and their personal circumstances.
- 'What matters' conversations undertaken by voluntary sector colleagues, who will then work with each individual to develop a personalised care plan.
- Care with kindness given by people who are compassionate and understanding
- Communications (written and verbal) tailored to an individual's needs so that they are easy to understand, relevant, and timely.
- The use of personal health budgets
- Support for people to manage long-term illnesses.
- Social prescribing link workers and care coordinators.
- Voluntary and community sector colleagues helping to resolve non-medical issues.

Prevention

Wider determinants

We have been tasked as an Integrated Care System with improving outcomes from healthcare and improving the health and wellbeing of our population.

Treating ill-health in the way we have always done contributes to about 20% of people's health and wellbeing.

When we provide healthcare, how successful it will be is influenced by many other factors. Those factors also influence people's ability to live well.

Each person must be able to choose to live well, choice not limited by factors beyond their control. The means of living well must exist where people live, work, and spend leisure time. The task of our integrated care system is to help break down barriers and create opportunities to live well for people and communities.

We will work with partners to influence the behaviours and environments that will affect how well people recover following treatment or even cause them to be ill again.

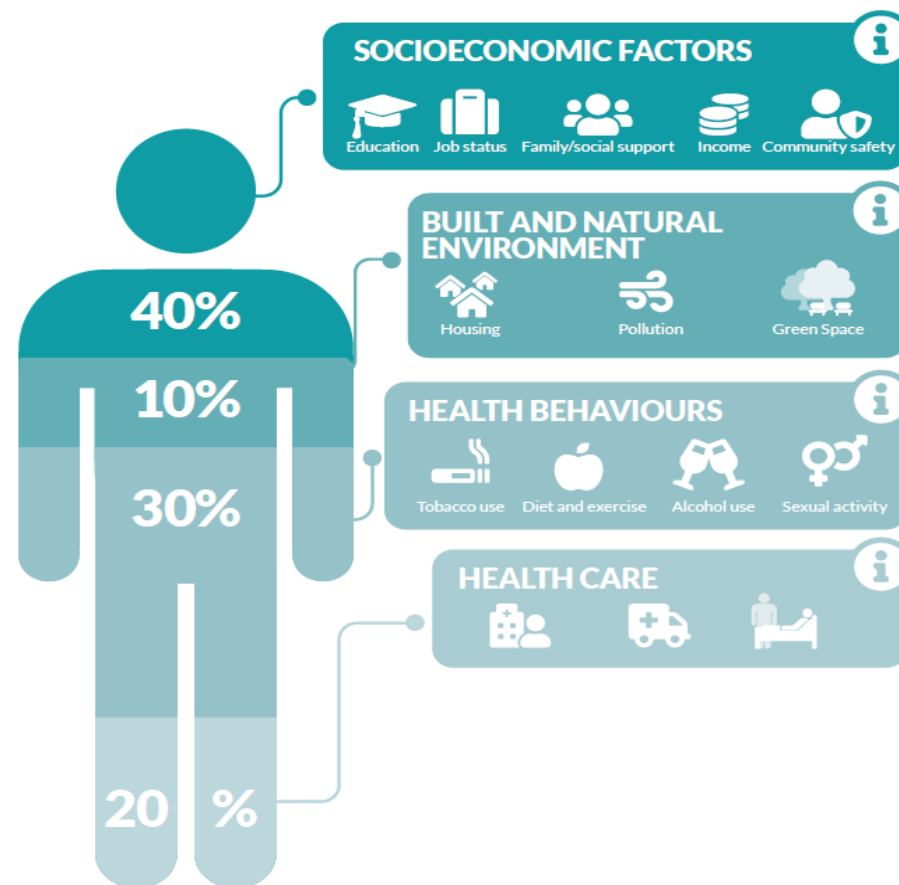
To prevent ill health, we need to promote the conditions for good health and wellbeing.

As part of this plan we will:

1. Increase our focus on prevention in all the physical and mental health services that we provide, embedding it in all aspects of care.
- Look for opportunities to understand and influence behaviours at every point of contact.
- Look at how we can contribute to a better built and natural environment in how we provide services and use our estate.
- As a major employer in our area, participate in the Work and Health Partnership to help people back into

work where there are health-related barriers to employment..

The many factors affecting health and wellbeing²:



² Source: [Cornwall and Isles of Scilly Joint Health and Wellbeing Strategy](#)

A shift from illness to prevention

In delivering our new model of care we will focus on three elements of prevention, embedding this in everything we do:

- a) Helping people stay physically and mentally well by being physically and socially active, breathing clean air, living in safe and warm homes, eating a healthy diet, having a reliable income.
- b) Reducing the impact of an illness by early detection and management of risks, for example, lowering blood pressure to prevent cardiovascular disease:
 - o Risk stratification initiative for high blood pressure in collaboration with public health, ICB and Health innovation network as well as a number of risk stratification approaches for diabetes with a dedicated tool in primary care .
 - o High blood pressure initiative based on a pilot run in 2023/24.
- c) Delaying and softening the impact of an ongoing illness and keep people independent for longer, for example, effective management of diabetes or physiotherapy and rehabilitation for older people if they fall.

To influence the future health and wellbeing of our population

If we can help babies, children and young people to have the best start in life, the next generation of adults will be healthier.

If we can support people aged between 25 and 64 now to live well, the next generation of older adults will be healthier.

If we can support people aged 65 and over now to stop long-term illnesses from deteriorating and prevent falls, they will be able to live well for longer in old age.

We need to reduce health inequalities across all age groups.

Place

Basing care and support on places and as close to home as possible.

Our services were originally designed around providing single episodes of treatment with most of our resources focused on caring for people in hospital. This approach is no longer fit for purpose because of the changing needs of our population requiring a focus on management of long-term illnesses.

To reduce health inequalities we also must take account of the local circumstances in which each person is living.

Our starting point is that care and support will be as close to home as possible, either at home or in local facilities. Our GP practices are based in our towns and villages and understand local opportunities and issues.



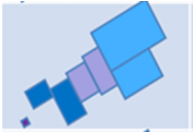

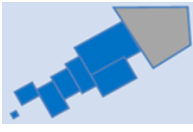
The advantage of being as local as possible, is the relationship that can be built with local people, local

organisations like schools and parish and town councils, and local communities.

Each of those communities has its own strengths and assets in people, community facilities, and open spaces that can contribute to improving people's health and wellbeing.

We have to work out what is practical because some services need specialist facilities or are dependent on seeing a certain number of people to be clinically or financially viable.

The following table gives examples of what is viable for different population sizes.

Population size	Examples of services that are viable with these sizes of populations
 <p>We have 55 GP practices with 3,000 to 30,000 people registered</p>	<p>A GP practice providing each individual with access to primary care.</p> <p>Understanding which individuals have (or are at risk) of long-term illnesses and which are most in need of continuity of care and support to manage those illnesses.</p>
 <p>15 primary care networks with 16,500 to 71,000 people in each network</p>	<p>Networks of GP practices working at greater scale with extended primary care teams including physiotherapists, clinical pharmacists, mental health wellbeing practitioners, and social prescribing link workers, and working with voluntary sector colleagues to tackle health inequalities.</p>
 <p>3 integrated care areas with 160,000 to 239,000 people in each area</p>	<p>The networks of GP practices are combined into larger integrated care areas. For this size population there are more specialised nursing services (such as cardiac nurses, psychiatric liaison nurse, dementia liaison nurse, respiratory nurse; strategically placed urgent treatment centres, community assessment and treatment units, and urgent community response teams.</p>
 <p>Our integrated care system covering the whole of Cornwall and the Isles of Scilly and 606,416 people</p>	<p>For this size of population NHS111, emergency care in life-threatening situations and major urgent care requiring specialist skills and equipment, planned care requiring operating theatres and acute treatment facilities either day care or inpatient care, mental health crisis alternatives and admission avoidance support and mental health inpatient facilities.</p>
 <p>Devon, Cornwall and the Isles of Scilly combined with a total population of 1.6 million people.</p>	<p>Specialist trauma and burns services, specialist mental health placements, highly specialised planned care, tier 4 child and adolescent mental health services.</p>

Transformation will be both local at place, working with local communities, and at scale, working across the peninsula with colleagues in Devon. We also have to take account of the impact of our geography and rural settlement pattern on how services can be provided.

The ambition over the next 3 years (2025/26 to 2027/28) is to develop 16 integrated neighbourhood teams which link into our primary care networks and are aligned to our 3 integrated care areas.

These teams are focused on providing the best care in a coordinated way to those with complex conditions, who are frail or end of life. These teams are multiagency and multidisciplinary including general practice, community services, social care, mental health and the voluntary sector.





We are starting year 1 in 2025/26, covering one-third of the population, and shaping a 3-year programme of change and investment.


From hospital to community

We are organising community care and support in three integrated care areas:



The plan is that each area will have:

-  Facilities for diagnostics, urgent care that is not life threatening, minor injuries, physiotherapy, and same day emergency care alongside community assessment and treatment units for older people living with frailty.
-  Multi-skilled integrated neighbourhood teams co-located in primary care networks and building a strong relationship with their local communities.
 - Accessible place-based mental health services that work closely with physical health services to provide care and support for the whole person.
-  A network of voluntary and community sector led activity and support, including local community hubs and peer groups talking about what matters and providing advice and support.
-  Community teams in maternity birthing clinics, family hubs, intervention in schools, and home based care for children and young people

-  Community pharmacies providing a minor ailments service and walk-in consultations.

Taking a place-based approach to understanding of need will guide decisions so that care and support is better matched to community resources and local demand.

Closer working between local health teams and communities to shape future care and support will help local people to be more actively involved in managing health and wellbeing.

In 2024/25, building on learning from current multi-disciplinary working in our integrated care areas and primary care networks, we have initiated a 3 year programme to develop integrated neighbourhood teams taking a further step forward to involve acute care clinicians, seeing patients much closer to their homes, and benefitting from advice about their care more quickly too.

For the Isles of Scilly, Cornwall Partnership Foundation Trust are working in partnership with the Council, primary care, Royal Cornwall Hospital Trust, South Western Ambulance Service NHS Foundation Trust and Voluntary and Community Social Enterprise Sector and mental health services to deliver the integrated model of care, future-proofing it for years to come, by the expansion of the existing hospital site on St Mary's that supports the needs of the island communities.

We are increasing our efforts to ensure this benefits our most vulnerable communities. In 2024/25 we have further embedded community health and well-being workers in some

of our most disadvantaged communities and intend to extend it to all of them in 2025/26.

This includes collaboration between primary care networks, public health, voluntary and community sector providers of a range of support, and the Department of Work and Pensions to mitigate the impacts of the pandemic and rising living costs on mental health with co-located services in each area.

It also includes an effective safeguarding response in each area.

Clinical strategy delivery- applying our new model of care

We are now applying all the above about people, prevention, and place to delivery of our clinical strategy

In 2024/25 to deliver our clinical strategy and make our future model of care a reality we have focused on people for whom hospital is often not the best option:

1. Keeping people living with frailty safe at home
2. Keeping people who have fallen at home if they do not need hospital care.
3. People at end of life having more choice for personalised care at home.

For people living with frailty

During 2024/25 we have changed how we provide care for people living with frailty in the community.

Actions taken in 2024/25 for people who are frail or have fallen are:

- a) Continuation of our falls car service which sees and treats over 80% of those visited at home without the need to go to hospital
- b) Personalised care and support plans to give people the best chance of remaining at home and achieving what matters to them.
- c) Right care car with a senior clinician deployed to people at risk of being conveyed to hospital to assess whether they need acute care or can remain at home with community support if needed.
- d) Increasing use of primary care hubs to provide extra capacity so that practices can provide more proactive care, reaching out to those people at risk of hospital admission to prevent it.
- e) An innovative iX-ray car providing a mobile x-ray facility to enable people to remain at home.

The impact of these in 2024/25 is being evaluated to ensure we can optimise benefits from them in 2025/26.

For people who are at end of life

We want to give each person the best support at end of life.



When we die it's as good as it could be – looked after by people who have the right skills, who involve us in decisions, give us the information we need about what to expect and what is there to support us.

We will develop personalised care at end of life for people of all ages cared for anywhere within our system who have:

- Advanced, progressive, incurable conditions.
- General frailty and co-existing conditions that mean they might die within the next year or so.
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition.
- Life-threatening acute conditions caused by sudden catastrophic events

This will include families supporting someone who is dying and families grieving the death of someone important to them.

It will also include voluntary sector colleagues exploring with people with lived experience the impact of death and dying on people with learning disabilities and/or autism.

Support will be flexible, holistic, seamless, and coordinated and include specialist services as needed.

People will feel confident to talk about dying as part of living – to be able to support each other to plan for what matters most.

During 2024/25 our Palliative and End of Life Care Strategic Alliance made up of local clinicians, Healthwatch, colleagues from social care and care homes, and other partners has assessed end of life care as it is provided at the moment against Healthwatch's '[My Life, My Death](#)' report and against the national [Ambitions of Palliative and End of Life Care](#), which is a national framework for local action.

The Alliance has worked together and with local people to co-design improvements and how the impact of improvements will be measured.

Potential improvements have been tested:

- a) An urgent emergency end of life care pilot in East Cornwall with a local hospice to provide care to people in their own home who are rapidly deteriorating and entering last stages of life.
- b) A Macmillan nurse working with voluntary sector partners to explore their support for people reaching the last 12 months of life
- c) Identifying people in their last 12 months of life on admission to hospital and Marie Curie nurses supporting their discharge.
- d) During 2024/25, a new model of care has been designed to enable more people to choose to spend their last days at home instead of in hospital. This will be implemented in 2025/26 and it is estimated it will take 18 months for the full benefits to be realised.

Redesigning our approach to major conditions

For major conditions, the focus of our clinical strategy is on people who have 1 or more of the following major conditions:

- Cardiovascular disease
- Diabetes
- Respiratory disease

Prevalence of major diseases is increasing, these are among those causing the greatest burden of disease for our population and our approach is focused on primary and secondary prevention with early diagnosis to make treatment quicker and easier, and prompt urgent care treating conditions in the community before they become a crisis.

Our focus on people and providing personalised care with support from partners in the councils and voluntary sector will help people improve management of their personal risk factors which often include wider determinants of health as well as health risks such as high blood pressure.

Enabling people to have more choice and control over their care and supporting them to manage long-term conditions and remain active and independent is at the heart of our approach.

We recognise that people may have more than one condition, including for example musculoskeletal disease and part of redesigning pathways for these diseases will be to look at where they need to be integrated with others to provide holistic care for people with multiple conditions. This will

³ As assessed nationally in the Indices of Multiple Deprivation

include access to mental health support for anxiety or depression.

In 2024/25 we targeted work within talking therapies to refer people going through a physical health pathway such as diabetes and MSK.

We know that people living in our most disadvantaged communities³ are at greatest risk of deaths from causes considered preventable. They are also at greatest risk of emergency admissions for coronary heart disease and chronic obstructive pulmonary disease⁴.

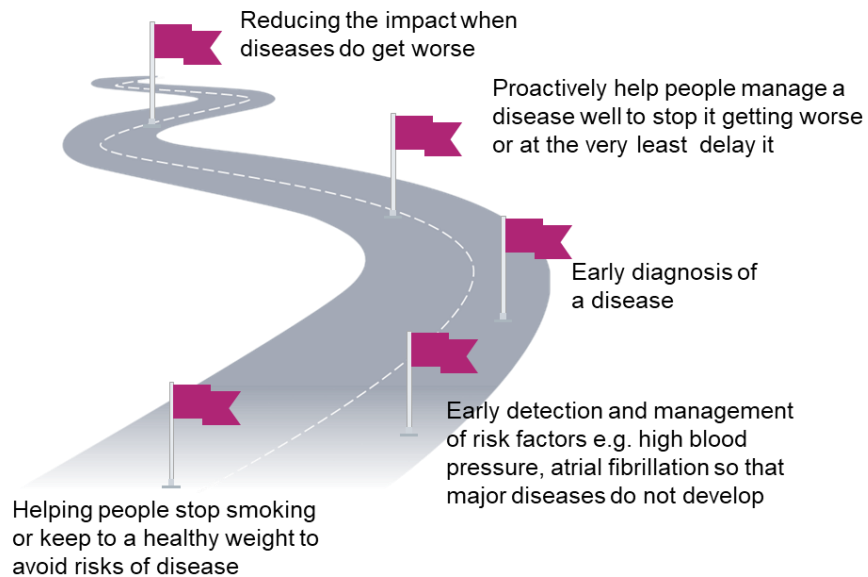
The practical redesign of care for people with diabetes, cardiovascular disease, or respiratory disease is being undertaken by clinical reference groups established in 2024/25.

This will include implementing the 3 shifts in delivery that support our new model of care:

1. From illness to prevention: embedding the three elements of prevention in the pathways.
2. From hospital to community: managing conditions at home utilising virtual wards and general practice creating capacity to focus on those with the most complex needs to avoid hospital admissions.
3. From analogue to digital: utilising AI to risk assess GP practice populations and extending digital opportunities to help people understand and manage the conditions.

⁴ Public Health England: Health inequalities slides: Cornwall (Jan 2020)

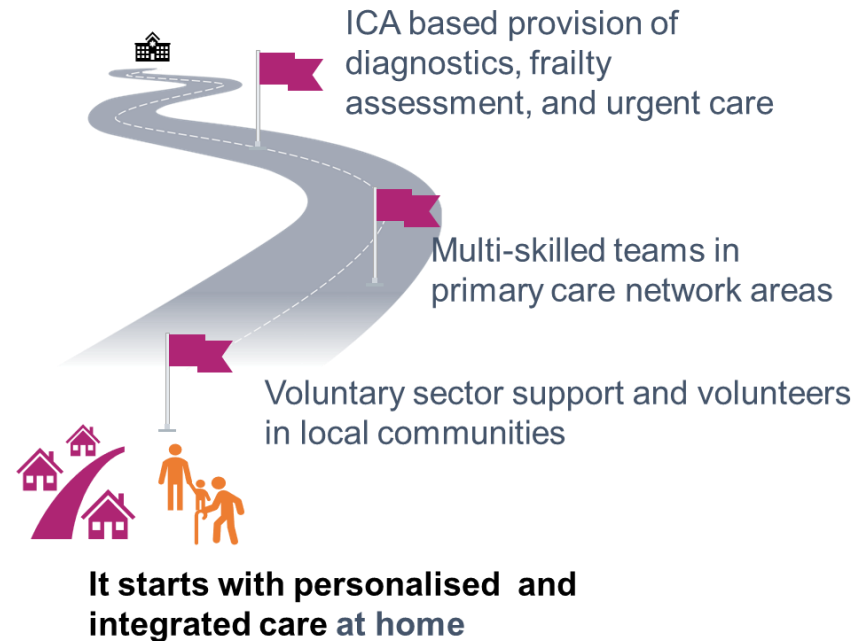
Focused on prevention



Tackling health inequalities is an important part of clinical strategy delivery for both population health and implementing a sustainable model of care.

We will include identifying and reducing inequity in access, experience, and outcomes as part of redesigning our approach to major conditions. Our experience is that, because this includes wider determinants of health, the role of place in delivery of care is crucial.

How we provide care and support is place-based



We rely on too many people being cared for in hospital when hospital is often not the best place for people with long-term conditions.

Voluntary sector partners can provide support to tackle non-medical things like financial problems, which could be preventing people with long-term conditions from being able to take proper care of themselves. They have started creating places in local communities where people can go for help and healthcare providers can also go to give advice on how to prevent long-term conditions getting worse.

Colleagues in our North and East ICA are working closely with community area partnerships and there are now dedicated working groups to support conversations and initiatives around health creation in the area.

In 2023/24 group clinics on a Saturday for people with diabetes proved popular and during 2024/25 the clinical reference group for diabetes has tested how these can be developed further working with Diabetes UK, public health and local voluntary sector colleagues to support a holistic approach for people with diabetes increasing the number of annual reviews as part of a one-stop shop at the weekend.

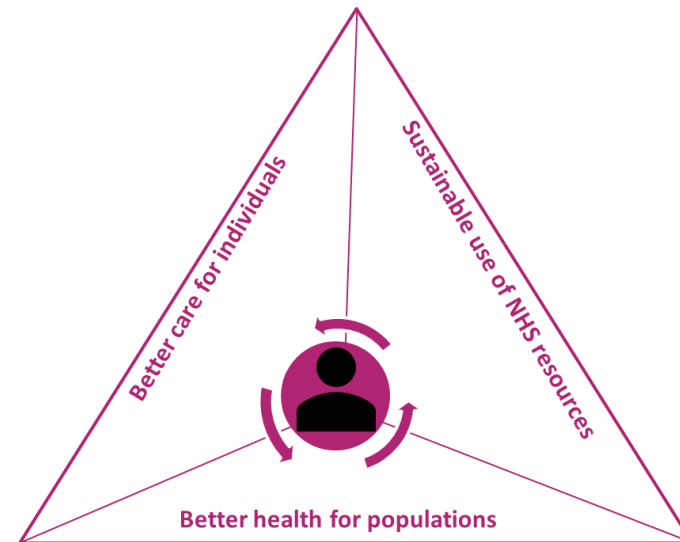
It is not easy for everyone with long-term conditions to travel across Cornwall to be diagnosed or assessed so we are making it possible to have diagnostics, overnight assessments, and urgent care that does not need acute hospital facilities, closer to home.

The role of our clinical reference groups for long-term conditions

The practical redesign of care for people with diabetes, cardiovascular disease, or respiratory disease is being undertaken by clinical reference groups.

They are bringing together people with long-term conditions, carers, clinicians, voluntary sector and council partners and independent sector providers with experience of working with people of all ages with long-term conditions to work out what can be done differently and how it can be done.

The clinical reference groups will redesign pathways to contribute to the triple aim of:



There will be a flexible approach whereby some groups may come together for a short period of time for a specific piece of pathway improvement and others to oversee a longer-term programme of pathway transformation.

There will also be times when a more holistic approach is needed to improve care for people across multiple pathways and the groups will collectively be a network of expertise that clinical leads can draw on.

Improving care for our most at risk populations

There are groups within our population at greatest risk of poor health (mental and physical)

They are:

- People experiencing health inequalities
- People experiencing abuse

People experiencing health inequalities

Health inequalities are systematic, unfair and avoidable differences in health across a population, and between different groups within society. They arise because of differences in the conditions in which we are born, grow, live, work, and age.

The Director of Public Health for Cornwall and the Isles of Scilly focused on this in her annual report in 2022/23: [A Life Less Equal](#). It highlights the inequalities that exist locally, for example if you travel just 7 miles between the villages of Shortlanesend and Perranporth, life expectancy for women drops by nine years. The difference in healthy life expectancy between our least and our most disadvantaged communities is 19 years.

People living in more deprived communities live shorter lives with more chronic illness at an earlier age than in more affluent areas in Cornwall.

The report provides an analysis of the factors influencing health inequalities in Cornwall and the Isles of Scilly.

Tackling inequalities in healthcare is one of the four key purposes of integrated care systems, which means taking action to ensure equity of access, experience, and outcomes.

Equity of access, experience, and outcomes is affected by both how we provide services and the socio-economic determinants of health inequalities. This means we need to both take action ourselves to change how we provide care to certain groups within our population and work with partners to mitigate the impact of wider determinants on people's use of, and benefit from, healthcare.

We can also contribute to tackling the socio-economic determinants of health inequalities as a major employer in our area.

Understanding who is at risk and their use of healthcare

We have adopted NHS England's [Core20PLUS5](#) approach. The Core20 are the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

The PLUS population are groups we are identifying locally as being at risk of health inequalities.

Around 71,900 people (12.5% of our population) live in communities recognised by the IMD as being among the 20% most deprived in England.

Looking across our Integrated Care Areas, numbers increase the further West we go:

	Number of people in IMD 20%
North & East ICA	18,242
Central ICA	22,999
West ICA	30,662

The West Integrated Care Area includes 3 of the most deprived areas in Cornwall and these feature within the top 15 across England. They are in the North Kerrier (East) and Penwith primary care network areas.

As part of our Joint Strategic Needs Assessment public health colleagues from Cornwall Council have provided a [population profile and inequalities overview](#) for each of our primary care network areas. We also know which Council wards are in the IMD worst 20%.

In addition, during 2024 we have developed a Population Health Management dashboard, which draws information from our linked dataset using pseudonymised data.

It enables us to segment our population into groups with similar levels of health needs, show each group's utilisation of services e.g. attendance at emergency departments; prevalence of long-term conditions by deprivation decile; which conditions and risk factors are more common among

our 20% most deprived communities compared to the remaining 80%. This information is available for the whole of Cornwall and the Isles of Scilly, by each of our three integrated care areas (West Cornwall, Central Cornwall, North and East Cornwall), and by primary care networks within integrated care areas.

We are working on how to incorporate outputs from the dashboard into our integrated performance report for Boards. The information will be included from April 2025 into all future integrated performance reports.

During 2024/25 our integrated care areas have embedded the role of community health and wellbeing workers in our most disadvantaged communities. By being part of the communities they are developing an in-depth understanding of what matters in each community and what is causing local inequalities. This complements the statistical analysis.

Our PLUS population include:

- a) People with learning disabilities and/or autism, who are more likely to experience trauma and for that to adversely affect their mental health, as well as having a lower rate of life expectancy.
- b) Adults with a severe and enduring mental health problem, who have a shorter life expectancy than the general population and are more likely to die from a range of chronic conditions that include cancer, cardiovascular, and respiratory diseases.⁵

⁵ NHS Kernow: Futures in Mind, Adult Mental Health Strategy (2020-2025), p.6

- c) Ethnic minorities of whom our largest are the Gypsy, Roma and Traveller communities.
- d) Farmers who are at increased risk of asthma and musculoskeletal conditions, have higher rates of suicide, and are less likely to access healthcare in traditional settings due to long working hours and travel times from remoter rural areas.
- e) Seafarers who are at increased risk of chronic musculoskeletal problems and work related health risks and also will similar difficulties in accessing healthcare.

We have included tackling healthcare inequality in each of our life course sections of this plan because we know that conditions that result in health loss vary over the life course:

- Children and young people aged under 20 are more likely to be living with conditions such as asthma, epilepsy, and experience alcohol problems.
- Mental health is the leading cause of health loss in those aged 15-49 followed by musculoskeletal disorders, and substance misuse.
- From age 30 disparities grow in rates of diabetes, COPD, and cardiovascular disease.
- In older age it is chronic pain, COPD, diabetes, cardiovascular disease, and dementia⁶.

⁶ Director of Public Health (Cornwall): A Life Less Equal (November 2023), p. 9

The following diagrams provide an overview of current action we are taking that follows the Core20PLUS 5 approach.

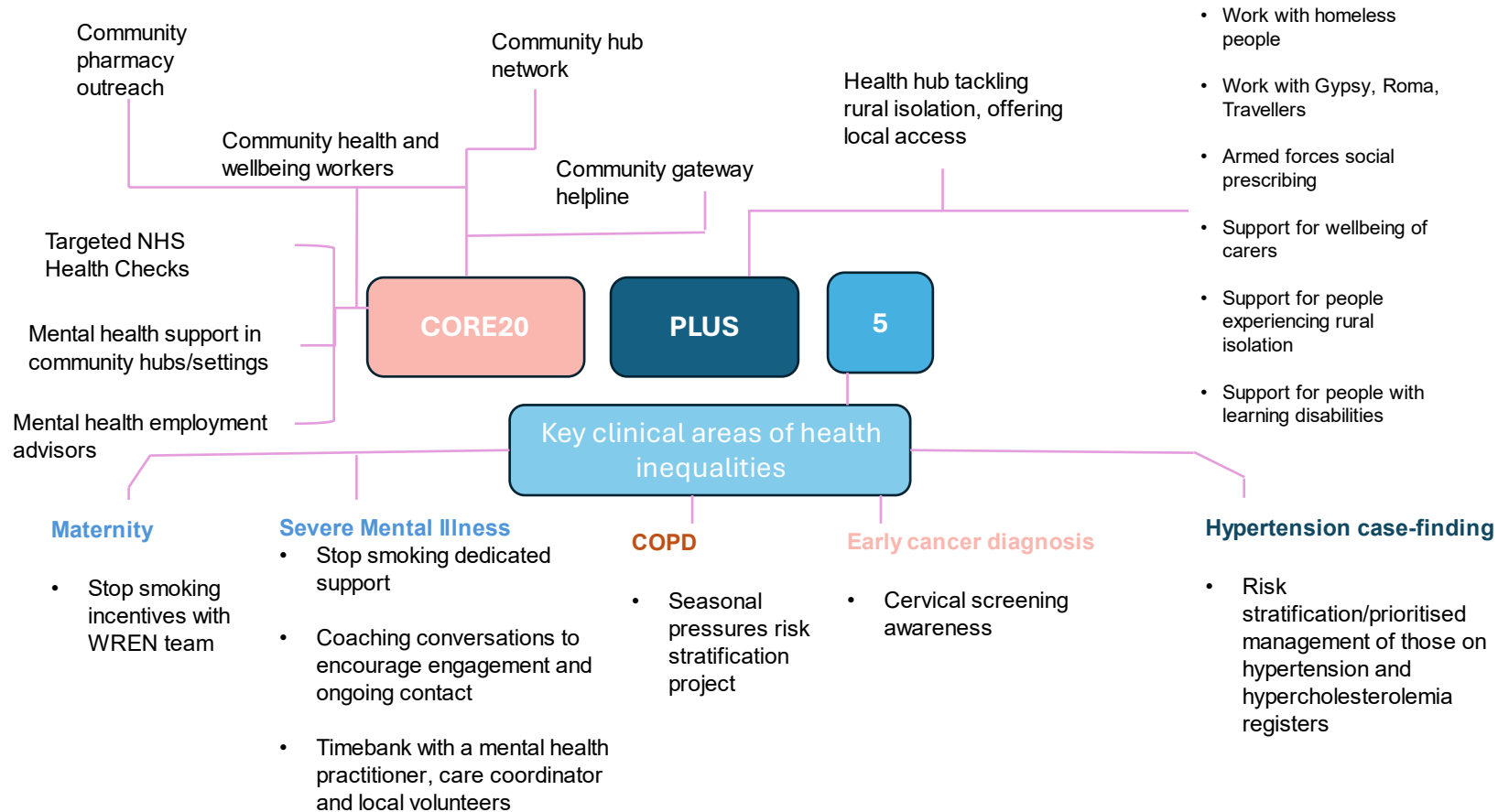
These initiatives are being delivered by:

1. A partnership between the ICB and Cornwall Council, whereby in 2022 the ICB invested in a 3-year programme led by public health colleagues.
2. Integrated Care Areas leading work on tackling health inequalities at place.
3. Primary care networks and integrated neighbourhood teams are testing and learning what works from their own local initiatives as part of implementing population health management.
4. Voluntary sector partners collaborating with all the above to reach those least engaged with public services.

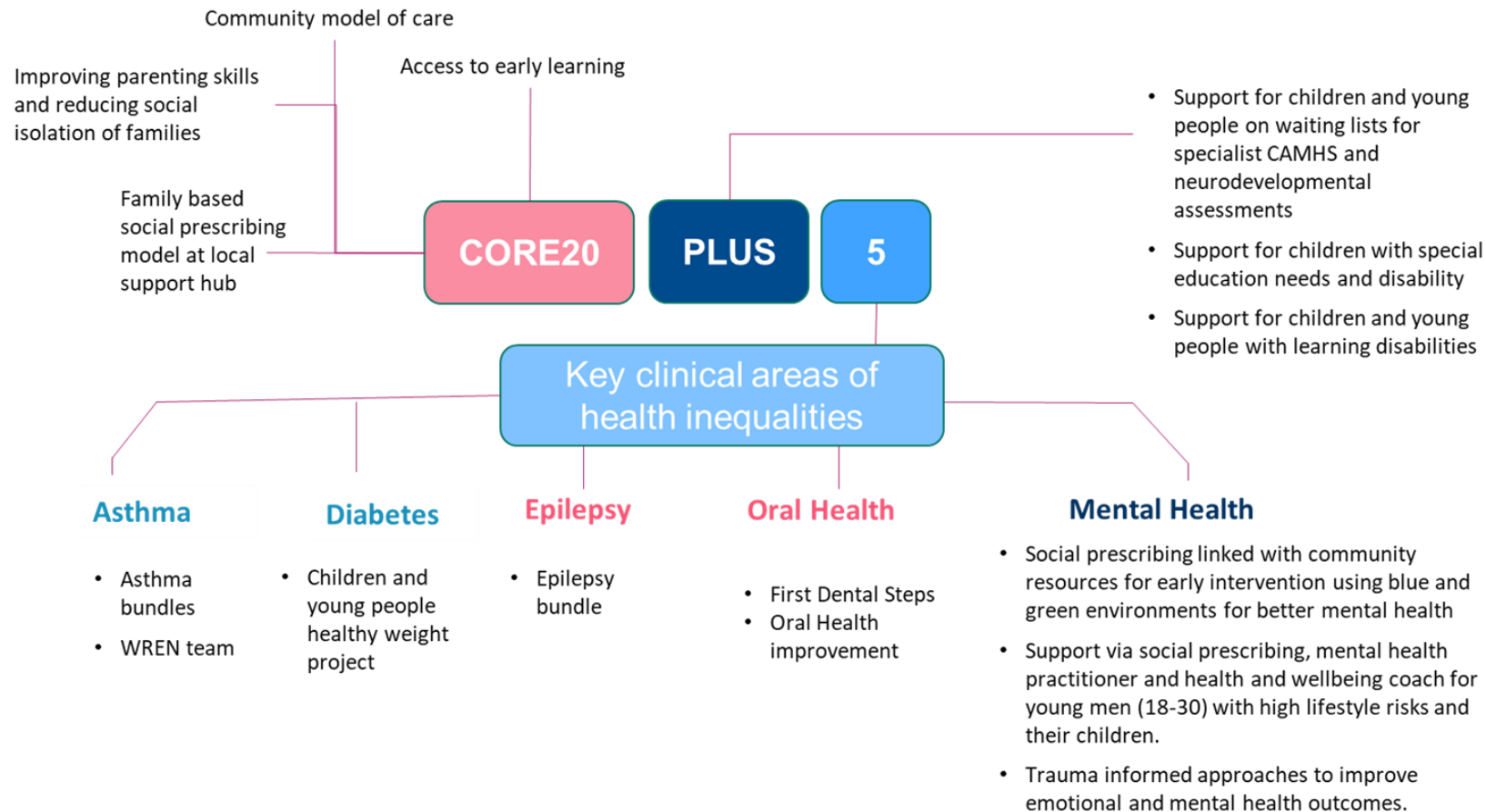
Capital investment for West of Cornwall integrated care area

Cornwall Partnership Foundation Trust have seen success with a capital project to improve the service delivered in the west of Cornwall, which is the new Rosewarne Stroke rehabilitation ward at Camborne-Redruth Hospital

Current initiatives linking to the Core20PLUS approach (for adults)



Current initiatives linking to the Core20PLUS5 approach (children and young people)



Our community health and wellbeing workers, started as a project in central Cornwall when our ICAs were asked to focus on health inequalities and determine the best use of the ICB's allocation of £1.7 million from NHS England to support Core20PLUS work. During 2024/25 they have been part of 39 out of 90 LSOAs across our area that have households among the top 10% most deprived in England.

The workers themselves live in these areas and talk to individuals in their communities about a range of health issues, encouraging people to seek the support they need from health services in a timely way, attending for vaccinations and health screening.

Through individualised coaching conversations, the workers develop personalised care and support plans, which will include proactive care planning, with the addition of access to personal health budgets where appropriate.

They are aligned to primary care networks and are valued contributors to network multi-disciplinary teams. They are hosted by our voluntary sector.

We participated in the Accelerator Programme run by NHS England and the Institute of Health Improvement in pursuit of scalable results. Our work with the Gypsy, Roma and Traveller communities was an accelerator site for the national Programme. This was an opportunity to share knowledge and develop a system approach to scaling up and embedding

successful innovation to reach one of our largest minority groups, who are at greatest risk of poor health outcomes.

Support for people experiencing abuse



We take an inclusive approach to protecting people from abuse, taking a trauma informed approach. Incorporating the voice of the person in all plans is a priority for us, including the voices that are difficult to capture. Our key aim is to ensure the rights of our population to live free from abuse, violence and neglect are upheld. This applies to everyone; babies, children, young people and adults.

We collaborate with partners to tackle abuse and help people affected by abuse and neglect primarily through the work of safeguarding boards and partnerships. These are:

- Cornwall and Isles of Scilly Safeguarding Adult Board
- Cornwall and Isles of Scilly Our Safeguarding Children Partnership
- Safer Cornwall, our community safety partnership
- Cornwall Corporate Parenting Board

Priorities identified by the boards and partnerships draw on feedback from people affected by abuse and learning identified in safeguarding statutory learning reviews.

These priorities guide our actions and are:

- Taking a whole family approach
- Being trauma informed
- Neglect and self-neglect
- Domestic abuse
- Sexual Violence
- Mental Capacity
- The voice of the person
- The rights of the child
- Exploitation
- Looked after children

We know and understand that children, young people and adults are best supported when teams work together around them and services are provided in their neighbourhood. We also know that people are protected and empowered when agencies share information and work together at place.

It is one of our priorities that we respond effectively to needs in neighbourhoods and that learning and improvements are led at place with input from people with lived experience.

Domestic abuse

Last year we stated our plans to enable people to access domestic abuse support services in their neighbourhood by provision of the general practice advocacy support service. Domestic abuse services are linked directly to GP practices.

As part of our joint forward plan to address the needs of victims of abuse, we have made a commitment to continue to fund the service. We have seen the difference that this ongoing commitment has made, with a 5-fold increase on the number of referrals made by general practice to domestic abuse services.

Between September 2024 and December 2024, general practice made 237 referrals to the domestic abuse support service. Of those 237 referrals, 125 people said they had never previously told a worker about the abuse. This is reflective of the [national picture](#) which is that victims and survivors were most likely to tell a health professional about their abuse, followed by the police. It also means that our plan to identify victims of domestic abuse earlier is effective and needs to continue.

In 2024/25 to 2025/26, we plan to build on the work done by the general practice domestic abuse advocacy service to improve the contribution of NHS services to the response once a person has been identified as at risk of domestic abuse. When a person is identified as being at high risk of domestic abuse, their circumstances are discussed at a multiagency risk assessment conference

(MARAC). We plan to develop the connections between general practice and MARAC to assist the multi-agency response to people experiencing domestic abuse

Sexual violence

We continue with our plans to improve support for people who have experienced sexual violence in collaboration with the Devon and Cornwall Pathfinder project to ensure there is effective, timely, sensitive, and appropriate support.

We recognise from national data, the importance of addressing the needs of staff affected by sexual violence and harassment in the workplace. The national NHS staff survey found that [9% of NHS staff experienced sexual harassment in the workplace](#) last year. To address this, we became a signatory to the NHS England sexual safety charter.

Serious violence

Last year, we said we planned to also ensure that we meet the new and emerging duties in relation the Serious Violence Duty.

As a specified authority, we have worked with our partners to publish a [joint strategic needs assessment](#) about serious violence, along with a strategic framework. This framework sets out [multi agency plans](#) to tackle serious violence across Cornwall and the Isles of Scilly. We plan to work with partners to deliver the work programmes within this framework

We will also expand the intelligence we collect to inform the strategic needs assessment for the serious violence duty. This

year we plan to work with partners with information provided through the NHS [emergency care anonymised data set](#) to provide helpful and effective data to our community safety partnership to tackle serious violence.

Mental Capacity Act 2005

The Mental Capacity Act 2005 provides a framework to protect the rights of those who may not be able to make decisions because of an impairment of the brain or mind. In response to learning from our [safeguarding adult reviews](#), ongoing delivery of a train the trainer approach to improve the application of the Mental Capacity Act.

Looked after children and care experienced people

Working with Cornwall Council and partners to treat care experience as a protected characteristic will create opportunities for those who are care experienced to start well, live well and age well. In particular, we are working with our partners to ensure that looked after children have timely access to initial and review health assessments and that these are of good quality.

New and emerging duties

Our plans continue to include a response to any new or emerging legislation or statutory guidance. In 2024/25 we [worked](#) with our partners to implement the changes to Working Together 2023, which is the statutory guidance for safeguarding children. We also will respond to the Victim and Prisoners Bill.

To start well: focusing on children and young people



A healthy start will give children the best start in life, equip them to reach their full potential.

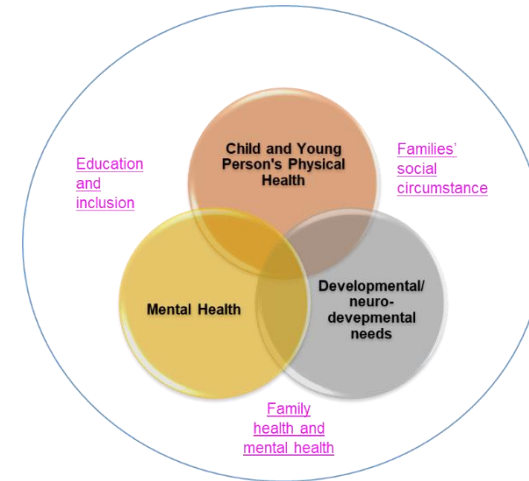
We will ensure children and young people receive the right care at the right time to:

- Optimise their health and prevent ill health being a barrier to life chances.
- Enable them to manage their health well for the rest of their lives.

Integrated healthcare closer to home

It is important to understand a child's needs as early as possible and consider the whole of their needs,

For successful outcomes for children and young people, all care and support requires an understanding of the interdependencies between physical, child developmental, and mental health needs.



We are developing care and support that will be focused on early intervention at every stage of care and integrated care for those with complex needs.

We will act as one health system to develop integrated service models and provider collaborative approaches for services dedicated to children, young people, and parents in our Integrated Care Areas, to meet the physical, developmental and mental health needs of our children aligning with wider support for their educational and social needs.

To achieve this, we will develop a more integrated approach across primary, community, and specialist care in the community. We will improve outcomes for children by

developing our local model of care for child health hubs in the community ([as outlined in the Fuller report](#)).

We made a start in 2023/24 in bringing care closer to home by expanding children's community nursing to a 6 day week helping families with children with complex care needs access care for which they may previously have had to attend hospital.

Young children and their mothers from conception to birth and during their first 1001 days

Our Integrated Care Strategy has highlighted the need to focus on all young children and their mothers from conception to birth and during their first 1001 days.

In line with the 3-year delivery plan for maternity and neonatal service we will continue to drive improvements in core aims of:

- Listening to and working with women and families, with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

In order to achieve this we will:

- Develop workforce training opportunities and ensure we have the right skill mix across perinatal services

- Increase personalised support in perinatal care through adopting self-assessment and improvement approaches across all services in the perinatal journey.
- Develop approaches that identify and targeted women vulnerable to poor outcomes with increased opportunities for women to inform how services work with them and developing offers of support, in line with our equity and equality plan
- Working with partners in the Start for Life Programme integrating our approaches to improving parent infant relationships, including our whole system perinatal, maternal, infant feeding, and infant mental health offer and our work to ensure good standards of parent support (Kernow parenting journey).

Children and young people struggling with their mental or emotional health and wellbeing

Our Integrated Care Strategy has highlighted the need to increase support for mental and emotional health. We must respond to increasing requests for help and to ensure it is considered effectively alongside physical and developmental needs.

Our plan is to:

- Increase collaboration between mental health support teams in schools and other education-based services and target those most at risk of poor outcomes.
- Continue to improve our mental health access to psychological therapies, long term therapy and

integrated 24/7 crisis support within our needs led approach.

- Improve work with adult services to develop a greater focus on family mental health and the impact of parental anxiety and poor mental health on children and young people.
- Continue to develop work across adult and children's services to ensure a more targeted approach to the mental health of vulnerable young people, including care experienced young people, up to the age of 25 years.

Children and young people with ill health or long-term conditions

All parents, carers, and families will have access to information to help them understand and manage common childhood illnesses and we will continue to develop online information and services.

We will:

- Focus more on reducing preventable long-term conditions and long term ill health.
- Integrate pathways across GPs, community services and hospital trusts for young people with asthma, epilepsy, diabetes, and long term conditions, to get the right care to prevent crises and reduce impact on functioning and outcomes

- Work with partners to review and improve how we support children and young people whose health is at risk because they are obese, and to understand the links with adversity and health inequality.

Children with additional and complex needs

Our Integrated Care strategy has identified 2 further groups of children and young people to focus on:

- Children with complex medical and social needs
- Young people with learning disabilities and/or autism approaching adulthood

Ensuring we identify children with developmental disorders, disabilities and complex medical needs early is critical to enabling the right understanding of how to manage need, make the right reasonable adjustments in education settings and increase children and young people and families' confidence in managing need.

We recognise there are lengthy waiting times for assessment and treatment locally, and that these can have a significant impact on a child's development, and consequently their ability to thrive in a range of settings. This will be an area of improvement focus as part of service planning.

There will be a good understanding of the interdependencies of physical, child developmental, and mental health needs reflected in our future model of care.

Our plan is to:

- a) Train those working with children, in schools and the wider workforce, in using a developmental profiling tool with parents.
- b) Build on our online resources from neurodiversity and mental health across the system to ensure improved access to information, advice, and self-help for children, families and education settings.
- c) Check we have enough people allocated to providing services and support for these children, including for therapy and speech and language support.
- d) Join up care and support around those who have more than one condition or need integrated care for education, health and care services.
- e) Embed better approaches through our increased investment to care and support for children who will have a short life, including enabling choice of where to die.
- f) Improve training in how to care for children with healthcare needs for colleagues in schools, public health nursing, primary care, and voluntary sector.

Children living in poverty and adversity

Among people at greater risk of ill-health are families in our most disadvantaged communities and children living in poverty. We will target health inequalities in childhood to improve individual outcomes. For children living in poverty we will:

- Ensure they are not disadvantaged in being able to access healthcare, in how they experience care and the outcomes from it.
- Work with partners to develop improved approaches to mitigate the impacts of poverty on the children's health.
- Work with partners to help lift them out of poverty and protect them from adverse childhood experiences.

We know that we have children and young people experiencing poorer-than-average health access, experience, and/or outcomes. They are:

- At risk because they live in our most disadvantaged communities with lower life expectancy.
- In, and on the edge of care, unaccompanied asylum seekers, care leavers, in the criminal justice system.
- Those with neurodiversity experiencing poor outcomes.

Our initial focus will be on:

- a) Delivering the Maternity Equity Strategy which looks at how we better engage and support parents to be who are most at risk of poor pregnancy outcomes
- b) Tackling issues of poor housing, smoking and access to medication which can worsen the severity of asthma
- c) Promoting tooth brushing in primary schools
- d) Better supporting family trauma and adversity that impact on children's anxiety

- e) Promoting a good understanding of the adaptations needed to provide the right environments for children with neurodiversity to thrive.
- f) Tackling the barriers and causes that impact access to services and ensure we don't exclude people who are less able to use digital services.

As we move forward, we will review more of our pathways of care to better understand how health inequalities for these children impact long term conditions pathways.

We will follow the [CORE20PLUS5](#) approach to drive targeted action for healthcare inequalities improvement focusing on the following key clinical areas of health inequalities for children and young people:

- Address over reliance on reliever medications and decrease the number of asthma attacks
- Increase access to real-time continuous glucose monitors and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds with type 1 diabetes.
- Increase the proportion of younger adults (18 to 39 age group) with type 2 diabetes receiving annual health checks
- Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.

- Address the backlog for tooth extractions in hospital for under 10s.
- Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation.

The transition to adulthood and the next stage of life

We will review both our children's and adult's services against the NICE guidance and best practice recommendations to ensure we are providing the most effective care and support for young people at this time of change. We will work with our integrated care partners to ensure multi agency transition pathways include health.

Who is involved?

We are drawing on the expertise and experience of:

- The Maternity Voices Partnership and Kernow Parenting Journey
- Young People Cornwall
- Healthwatch
- The Parent Carer Council

To live well: focusing on the middle years of life

Healthy bodies and minds during the middle years of life.

Starting well has set the right course, and to live well we will help people stay on course. This is not only through helping people live healthier lives, but also by supporting physical, mental, emotional, social, and economic wellbeing.

People are getting long-term illnesses when it could have been avoided, having to live with ill-health, and sometimes dying early.

We are developing how we can prevent ill-health and mitigate serious physical and mental illness.

For those people who already have long-term illnesses it is also about preventing them from getting worse and helping them to live well despite the illness.

We will:

- Support smokers to give up smoking.
- Do more checking to see if anyone has high blood pressure because that can lead to a stroke or major heart problems.
- Check if anyone has an uneven heartbeat because that can mean they are more likely to have a stroke.
- Help people who are overweight to lose weight so they are less likely to get major illnesses like diabetes, cancer and heart disease.

- Help people with diabetes keep it under control.
- Help more people with learning disabilities and people with severe and enduring mental illness to have annual health checks.
- Improve physical health monitoring for adults living with eating disorders.
- Find out how we can improve how we help people with long-term illnesses manage the illness.
- Work with others to help people get back into work, who have been out of work due to a disability or for reasons related to physical or mental health.
- We are piloting new ways of supporting people with health barriers to work.
- Providing dedicated coaching as part of personalised support for people struggling to stay in work, or who have recently left their job due to their health
- Developing a regional work, health and skills strategy to bring together existing and new initiatives for employment and health into an integrated programme.
- Make sure more people can easily get help if they are often worried or very unhappy.

We have worked with colleagues in the voluntary and community sector, Cornwall Council (Public Health), and people with lived experience, to develop a Mental Health and Suicide Prevention collaborative to support people before they reach crisis in areas such as finances and debt, social

isolation, long-term illnesses, and difficulties in accessing employment.

We are also working with voluntary and community sector colleagues as part of providing care for mental health to build resilience, increase recovery, reduce waiting times, and support admission avoidance. Continuing in 2024/25 and into 2025/26 are: a crisis café alternative and garden rooms, admission alternatives, use of personal health budgets, recovery college, sanctuary house; talking therapies; hearing families/advocacy, citizen checkers.

We are also working with Cornwall Council to jointly develop an awareness raising campaign about problem gambling and its impact on mental health and wellbeing.

We are also looking at how we can tackle climate change in a way that helps people to live well, for example:

- Reducing how far people have to travel and encouraging walking and cycling.
- Getting more supplies locally and more locally grown healthy foods reduces transport of goods and helps local jobs.
- Helping people improve how they manage their medicines reduces risks to them and reduces waste.

To age well: focusing on the later years of life

This is about everyone living well in later life, actively part of local communities.

Ageing well with long-term illnesses

People can have a long-term condition and/or become frail at any age, but both are more common in older age groups.

We are developing integrated care and support in the community, which will be personalised, prevent health problems getting worse, and be close to home.

Hospital is not the best place for older people and it is our intention that people will be supported by services in the community. Being admitted to hospital will be for surgery that requires a stay in hospital or for use of specialist facilities.

For people whose health problems do not affect their day to day activities, or only limit them a little, we will minimise the risk that they could experience a deterioration of their condition.

Understanding the whole person



People successfully managing their conditions themselves

We will:

- Provide information and advice on how to manage long term health problems well and prevent deterioration.
- Work with partners to prevent falls.
- Support management of risk factors that could cause further complications, such as high blood pressure
- Provide flu and COVID vaccinations, also pneumococcal, shingles and respiratory syncytial virus (RSV) vaccines
- Support those feeling socially isolated to reconnect with their communities.

People needing additional support

We will provide additional support for people who have long-term health problems that limit their day to day activities a lot.

Within this group, most will need care coordinated to help them cope with multiple problems. There will be others with more complex conditions needing care managed for them, and there will be others approaching end of life.

The older people get, the more likely they are to have more than one long-term illness and may live with increasing frailty. People affected by poor physical health can also become anxious and sometimes depressed.

There is also a greater risk of dementia among older people and, because of the increasing numbers of older people in our population, there is an increasing need for support for people with dementia.

We will make sure we understand what matters to each person, for example, to be able to walk their dog on the beach, and what is needed to help them achieve it.

We will plan their care and support with them and the people caring for them and ensure they have the information they need to be able to plan ahead for deteriorating health.

We will join up services so that people get seamless support for both mental and physical health needs. It will also include support from voluntary and community sector colleagues to tackle non-medical issues that are affecting recovery, helping cause health problems, or causing health inequalities.

New technologies make this much more possible now. They can help people to live at home. They also mean nurses can check how people are doing 24 hours a day at home and get an early warning if their illness is about to get worse.

Care and support in the future for people to age well will be made up of:

- Information and advice on maintaining good health and wellbeing in later life, including through our prevention communications campaign.
- Falls prevention.
- Reducing the risk that people who have had one fracture due to fragile bones, have further fractures.
- A free check-up for cardiovascular problems for people aged 40-74, who have not previously been diagnosed with any to find potential problems before they do real damage. It will include advice on how to reduce risks of getting heart disease, diabetes, kidney disease, stroke, and dementia.
- Information and advice on managing specific long-term health problems.
- Continue to provide the 'community gateway' helpline and community hubs provided by local voluntary sector organisations for people to have conversations about what matters to them. This enables planning the care and support they need.
- Local multi-skilled, multi-sector teams working with primary care networks and with skills matched to the needs of people with long-term conditions in local communities.

- A rapid community response team in each integrated care area for when people do have a crisis to provide urgent care to help them avoid going to hospital, or if a hospital visit is essential, to support them on leaving and help them recover at home.
- For people who are frail when even a minor illness may be causing them problems, there will be a local unit for them to go for a doctor who cares for the elderly to check what further support is needed, where they can stay for up to 78 hours to be treated, and then return home.
- Enhanced urgent care in the community for people living with frailty, including providing 3 same day emergency care centres and a rapid response falls car in 2024/25.
- Virtual wards (also called 'hospital at home') which allow people to get the care they need at home safely and conveniently, rather than being in hospital. This can include both remote monitoring and face-to-face care from local multi-skilled teams.
- Therapy at home instead of asking people to wait in hospital.
- Access to psychological therapy.
- Safeguarding services.
- More people working locally to support people with dementia and those people caring for them.
- Additional specialist clinical support to care homes that are looking after people with dementia.
- More training for NHS staff in looking out for dementia and supporting people with dementia.
- More joined up support for people with dementia and their families from initial diagnosis through living with the condition.
- Consistent promotion of support available for carers and people with dementia.
- Continue to support and promote memory cafes where people with dementia and their carers can go in local communities.
- Extra care housing.
- Disabled facilities grants.

How we will know we are making a difference

Challenge 1 was recovery from the pandemic and its impact.

We will know we are making a difference when we see a consistent improvement in waiting times and ambulances are no longer waiting outside of emergency departments.

Challenge 2 was responding to changing needs.

By 2028 we will have transformed the care and support we provide.

More children and young people are able to get support when they need it in ways that work for them.

People feel enabled and motivated to actively manage their lifestyles and reduce risks to health.

- More people are protected by screening and immunisation programmes and benefiting from early detection.

Points of delivery of healthcare are local and convenient.

- Everyone knows where and how to access support
- People only have to tell their story once.
- Multi-skilled, co-located teams have trusted relationships with local communities.

We will have created sufficient capacity in integrated care in the community to meet the needs of our expanding older population:

- a) Older people are more able to be helped effectively without using emergency services.
- b) People with long-term conditions or who are frail are supported locally within integrated care areas by a proactive approach to care and support.
- c) More people are supported with their mental health needs to remain in or engage with work, education or employment opportunities.

People experience better outcomes from care and reach their personal recovery goals with fewer returning for further care.

Health inequalities will have started to reduce.

People feel confident to talk about dying as part of living. They are able to say what matters at the end of their life – to know when they might be dying and to be involved in making decisions that are right for them and those important to them.

Challenge 3 was difficulties in providing care and support.

By 2028 we will have made progress in working collaboratively as a system to develop our local workforce

The focus of where we deploy our resources will have shifted to prevention, early intervention, and proactive care and

support in the community enabling us to stretch finite funds to support more people. Digital developments will have also enabled us to make greater use of limited resources and reduced travel for people using and providing services.

How we will deliver these changes

The needs of our population and the health challenges that we face make it an imperative to act now with the development of Integrated Care Systems, which are underpinned by their duties to improve the conditions for research and innovation (R&I).

The Levelling Up agenda presents an opening to build a real understanding and recognition of the particular problems facing our peninsula. There is collective energy to leverage place-based investments for testing and adopting solutions that work and that can have real impact for our rural and coastal communities

The pandemic showed us that health systems can innovate at pace when there is a clear focus and aligned support to make change happen. It also showed the vital contribution that research activity in the health sector can make to society – research funded and conducted in the UK saved lives across the UK and beyond.

Research and innovation

Research

ICBs have a statutory duty to facilitate and promote the use of innovation and research to prevent ill health and reduce health inequalities.

Research is a key part of both improving value and will underpin transforming our model of care. [Maximising the](#)

[value of research in transforming health and care](#) is vital, and the impact significant; additionally, staff satisfaction, recruitment and retention is higher among staff who are involved in research. The national institute for health and care research is there to support the integrated care systems and [their position statement](#) outlines the benefits to patient outcomes, staff, organisations and the system of being research active.

There is an opportunity now to work with partners to develop Cornwall and the Isles of Scilly as a leading area of multidisciplinary research and development, and work at scale where beneficial with partners across the southwest peninsula.

Leadership capacity

To enable this, the Integrated Care Board has created a new role shared with Health Innovation Southwest (formerly known as the Southwest Academic Health Science Network) to work with partners on developing and delivering upon the ICB statutory duty to promote research and innovation for the benefit of our integrated care system and the people who live here.

Supporting delivery of both the southwest peninsular research and innovation strategy, and partners' strategic aims and plans, this new role will seek to align research and innovation opportunities with our integrated care strategy and advance research in support of our integrated care system's core purpose and local priorities.

The peninsula research and innovation partnership

In late 2022, 8 health, research and innovation organisations from across the Southwest peninsula began to work together having identified the potential of a collective research and innovation strategy for health and care; the goal being to address the unique challenges of the rural and coastal context by combining the collective capability of the Peninsula's leaders and major players in research and innovation. In doing so, increasing impact that is greater than the sum of its parts. In consultation with stakeholders, the partners collectively chose to focus on a small number of major population health, care and system challenges. This culminated in the creation of the peninsula research and innovation partnership (PRIP) and a shared strategy.

In July 2023 the ICB approved the PRIP strategy and established a PRIP board and PRIP delivery group to oversee implementation of the strategy.

The PRIP strategy set out shared strategic priorities across the 3 areas of the peninsula:

- to enhance the productivity of the health and care system
- strengthen how we attract and retain our workforce
- increase inward investment into the region.

Together these aim to support:

- improved population health
- the prevention of ill health

- the reduction of health inequalities.

5 areas of focus, or missions, were agreed as:

- Multiple long term conditions and frailty
- Mental health
- Urgent care
- Cancer
- Maternity and neonatal care

With our partners across Somerset and Devon we share the rural and coastal nature of the peninsula, and will look to spread research, innovation and learning into other rural and coastal regions in the UK and globally.

Building upon local strengths and assets, together partners with the ICB will:

- identify and address local research priorities and needs, and work collaboratively to address national research priorities
- improve the quality of health and care and outcomes for all through the evidence generated by research
- increase the quality, quantity and breadth of research undertaken locally
- extend and expand research in settings such as primary care, community care, mental health services, public health and social care
- drive the use of research evidence for quality improvement and evidence-based practice

- influence the national research agenda to better meet local priorities and needs
- improve co-ordination and standardisation within and between localities for the set up and delivery of research
- harness the patient and economic benefits of commercial contract research
- co-ordinate and develop the research workforce across all settings.

The research strategy and the new role will facilitate a joint approach to research with partners across the health and care sector, building on existing assets.

Existing assets that already exist locally:

- The University of Exeter Medical School at the Knowledge Spa on the Royal Cornwall Hospital site, which includes the European Centre for Environment and Human Health
- The [NIHR southwest clinical research network](#), based out of Exeter University but with a local presence.
- The Health and Wellbeing Innovation Centre, next to the Royal Cornwall Hospital campus and managed by the University of Plymouth on behalf of Cornwall Council.
- Falmouth university which specialises in the creative industries and has joint agreements with the Royal Cornwall Hospitals Trust to the development of innovations which improve health and care for

example: Olly the Octopus children's IV pole created using the recycled gowns and face masks from our sterimelt machine by a student at Falmouth

- Exeter University's Environment and Sustainability Institute on the Penryn campus shared with Falmouth University.
- Internationally recognised research expertise in learning disability through [CIDER](#) – the Cornwall Intellectual Disability Equitable Research capability

Next steps:

- Developing a 'One Research' approach across our integrated care system, built around the PRIP and a new shared approach to research strategy and delivery enablement.
- Continuing to build strong relationships with our local universities, neighbouring ICBs, Health Innovation Southwest, NHS England, and the clinical research network.
- Delivery of ongoing engagement for further involvement of staff, people using services, and local communities to get involved in research activity, specifically addressing known inequities in research involvement and outcomes for rural and coastal communities.
- Identifying and supporting bid opportunities locally and regionally, collaborating where beneficial and aligning where necessary.
- Working with partners to create a shared roadmap to deliver against both statutory duties and address the

local gaps in infrastructure and align to local priorities. This shared roadmap will become the detail workplan for the 24/25 and subsequent operating plans.

Innovation

Having the capability and capacity to advance innovation, facilitate local adoption of solutions proven successful elsewhere, encourage our own innovators, and participate in innovation across the Southwest is an essential part of our plan to improve value and transform our model of care. Key elements of this are:

- Having an established approach that is easily understood and applied;
- Involving people experiencing our services either as users themselves or carers or family members.
- Networking or partnering with a range of organisations across the public, academic, voluntary and independent sectors.
- Supporting the development of our staff to be innovators and create a culture of innovative practice and continuous improvement.

Our next steps will be to consolidate and build on what members of our Integrated Care System are already doing.

The Royal Cornwall Hospital NHS Trust already has a well-established innovation programme and approach to innovation and quality improvement. This enables any of its employees to propose changes to processes or design new

products that the Trust can adopt for use in its services. The Trust also partner with Falmouth University to support students to develop innovations that could improve health and care outcomes.

Adopting successful innovations from elsewhere

In 2019 the Royal Cornwall Hospitals Trust was recognised by NHS England and the Care Quality Commission as a national exemplar site for innovation adoption. A number of nationally evaluated innovations have been adopted, for example Heart Flow, which reduces the need for invasive angiography

Our 2 trusts and primary care networks are participating together in a Health Foundation funded Adopting Innovation Programme. It aims to support healthcare providers to create conditions which will enable faster and more effective uptake of innovations.

This will be informed through evaluation and learning from adopted innovations such as the Community Health and Wellbeing Worker model implemented within our central integrated care area. It will encompass feedback from experienced innovation adopters highlighting strengths, areas for improvement and future opportunities for system wide innovation adoption and spread.

Working with partners across the wider Southwest Peninsula, enabled through the PRIP, will further support collaborative working on innovations, to make the region attractive to industry to invest in and grown innovative ways of working

and innovative products, drugs, medical technology and care pathways.

Encouraging our own innovators

The Royal Cornwall Hospitals NHS Trust holds successful Innovation Breakfast Clubs, open events to bring colleagues from across the Trust together to share ideas. It has a training programme to create innovation scouts to identify innovation at an early stage and produce advice and guidance to the innovators.

The Trust is planning to become an accredited regional training centre for innovation leaders and scouts and will be developing an innovation leaders course with Falmouth University in 2023/24.

Examples of local innovators being supported are:

- Two products to reduce medicines errors

The Trust has a pipeline of medical innovation ideas and will continue to support local innovators to develop their products.

Developing key relationships to support local innovation

We have a number of groups within our local population who can be at a disadvantage from current methods of service delivery. We are working with partners to find innovative ways to improve outcomes for two of those groups:

- For more fishermen to be able to take up the offer of annual health checks as part of the health inequalities

programme sponsored by Health Innovation Southwest.

- For the Gypsy, Roma, and Traveller community to access cancer screening as part of the Institute of Health Improvement CORE20PLUS5 Collaborative.

The Trust has recently challenged design students at Falmouth University to design clinical products using the sterimelt plastic produced in-house by the Trust from recycled face masks and theatre drapes.

The Trust's Innovation Leaders have also established relationships with:

- A vibrant community of small to medium enterprises with which the Trust has successfully connected for the development of staff innovations.
- Bodmin College Design and Technology department which has supported a number of projects and prototype development.

Taking part in innovation across the peninsula

There is an established Innovation Network across acute trusts and universities in the Southwest supported by Health Innovation Southwest.

As part of the desire to grow the Innovation and Research function in the integrated care system we are actively pursuing a dedicated space for research and innovation within a locally owned innovation space.

This will enable our dedicated Innovation and Research leads and champions to come together in a 'think space' to develop, design, adapt and adopt innovation spread.

We will utilise the clinical librarians to look at best practice internationally, national, regionally and locally to support the adopt and adapt best practice ethos.

Developing our workforce

Our health and care system is working with significant workforce challenges arising from supply and retention of staff, industrial unrest, post-pandemic demand and the current cost of living crisis.

We face demographic challenge of an aging workforce and have challenges in recruiting in some clinical roles or specialties that leads to demand for agency staff, reduced workforce resilience and consequential impacts to workforce engagement. Operational demands reduce staff capacity for learning, innovation and the development of new ways of working.

Our workforce efficiencies programme and development of new clinical models of care aim to enable us to provide care in a more patient centred and cost effective way. This means that the impact of vacancies is less but we are able to continue to deliver care well.

To support the delivery of this joint forward plan, we will develop a system-level workforce strategy that responds to

this context and builds on good practice happening across our health and care organisations.

Initially the workforce strategy will focus on immediate priorities arising from service and financial recovery, the requirements of system oversight framework and operational plan relating to workforce productivity and agency usage.

For future years, the workforce strategy will:

- strengthen system-level values and culture through leadership and development of equality, diversity and inclusion.
- grow system level workforce planning capability to develop strategic plans that ensure workforce capacity and skills are better aligned to population health need.
- build workforce change capability to redesign work, roles, and ways of working to support place placed, personalised and preventative care models of care.
- increase supply, diversity and inclusion by developing more entry level routes into health/care roles from Core20PLUS5, further increase the number of apprenticeships, enabling preregistration study within Cornwall and international recruitment across health and care.
- increase retention through improved staff experience, development and access to clearer career paths, increased opportunities to work across our health and care system and increased flexible working.

- develop new workforce capabilities around personalised care, anticipatory and preventive care, population health management, system design and change, digital literacy and skills.

We know that our future workforce will consider how working fits into their life and will expect to use digital solutions more frequently - we need to be responsive to this generational change and adapt our services and work patterns accordingly.

As major local employers we can help grow a skilled local workforce, contributing to the local economy and providing a pathway into skilled employment for people for whom lack of employment may be contributing to health inequalities.

Through our Work and Health Strategy developed jointly with Cornwall Council, we will increase employment opportunities for working age people who are looking to work, or want to remain in work, whilst living with long term health conditions or disabilities. Our plan is to:

- Create a good place to work for everyone.
- Ensure the right support is in place for the individual to prepare for work.
- Provide early intervention and the right support for people to stay in work.
- Increase how we collaborate across organisations to help people get into and stay in work.

Taking advantage of digital opportunities

Our digital strategy for the Cornwall and Isles of Scilly Integrated Care System (CIOS ICS) sets out how digital, data and technology will enable the 3 programmes of work to support improvement, improve value and transform care

It has been developed in line with national NHS guidance and alongside existing digital strategies from the Royal Cornwall Hospitals NHS Trust (RCHT), Cornwall Partnership NHS Foundation Trust (CFT) and Cornwall Council and included consultation with representatives from different organisations from across the ICS.

Our strategy significantly raises our digital ambition to provide the digital capabilities we need for a digitised health and care system.

- Our workforce, visitors and the people of Cornwall and the Isles of Scilly will be able to access the digital services and information they need, any time and at any place, to effectively manage and improve their health and wellbeing.
- Enabling integration of care as part of our channel shift from acute to community-based care

Shifting towards more digitally enhanced services

Recovering from the pandemic

During the pandemic, the pace of digital transformation accelerated and solutions such as N365 (NHS Office 365), Virtual Consultation, Single Electronic Referral System and

hybrid working were delivered in a few weeks. On-going developments include the Devon and Cornwall Care Record (DCCR) and Patient Portal which is one of the first to integrate with the NHS App

Improve Value

Across the Integrated Care System a large portfolio of several hundred projects is delivering continuous improvement of quality, equity of care and value for money. The projects cover every aspect of services from behind-the-scenes digital infrastructure modernisation to new frontline patient services such as Silvercloud.

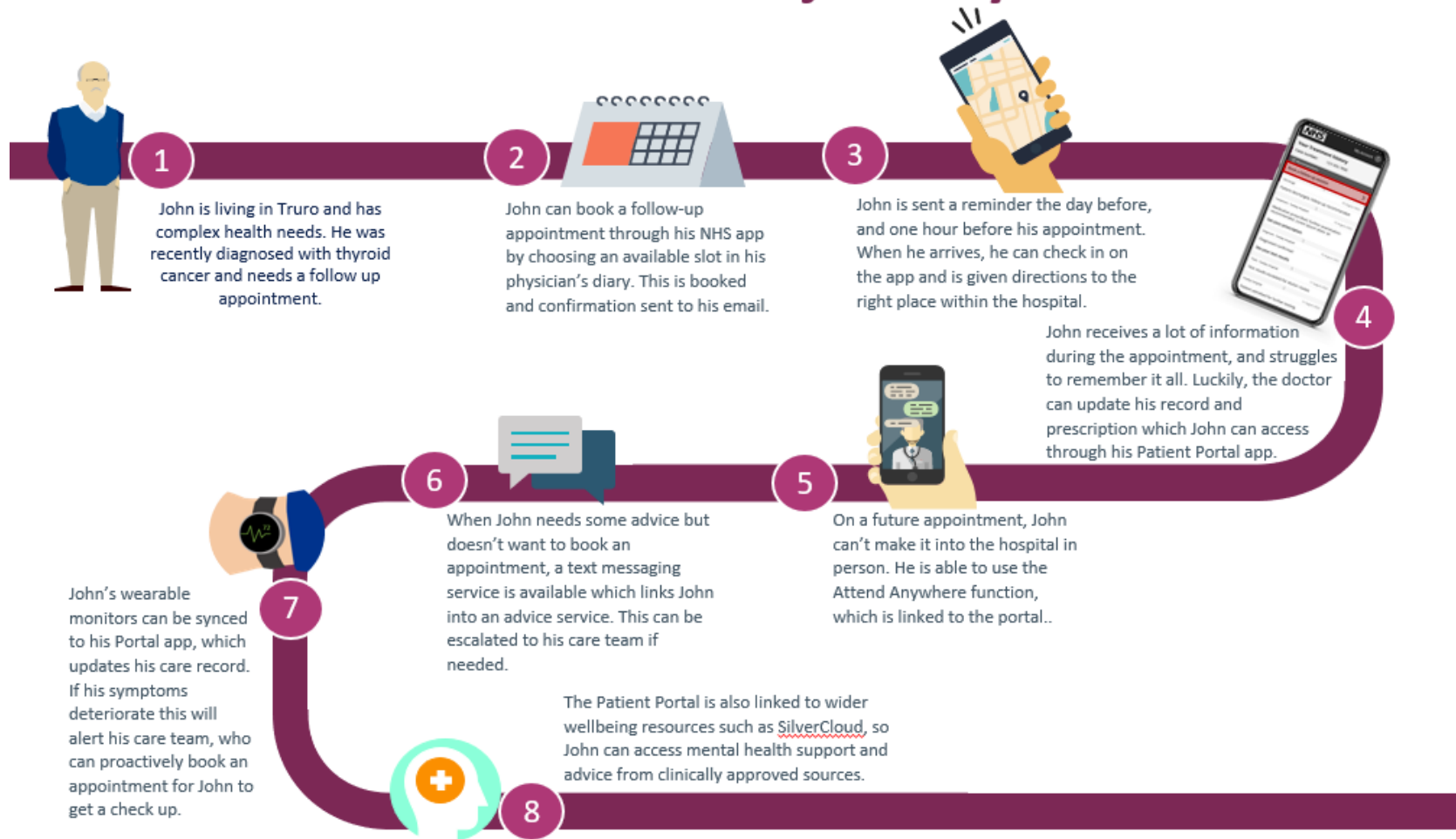
Transform

The transformation programme to reshape our model of care is underpinned by major digital transformation programmes.

- a) Royal Cornwall Hospital Trust plans to introduce e-Care our electronic patient record in 2025/
- b) Digitising Social Care (DiSC), integrating with third sector partners and modernising our data platforms will also provide new insights into health for clinicians and the citizens of Cornwall alike.
- c) The Devon and Cornwall Care Record to support integration of care has been established and on-boarding further NHS organisations. The next step is developing a shared Devon and Cornwall shared treatment escalation plan.

Digitally enabled care pathways give you control

How it could look – John's journey



Tackling climate change as an enabler of living well

We have a Net Zero climate resilience plan and have a climate resilience team.

Climate change is a threat to health. Tackling it does not just mitigate the effect, it can also act as an enabler of living well and help to create resilient communities.

The threats to health we need to mitigate are storms and high winds, flooding, heatwaves, and drought which can lead to heat-related deaths, food and water shortages and problems with air quality.

The opportunities we will explore further for action to reduce our carbon footprint as an enabler of living well are:

- Reducing travel distances and increasing 'active travel' such as walking and cycling.
- Reducing transport of goods by developing and procuring from a local market could help increase opportunities for employment and at higher wages
- Reducing 'food miles' by increasing healthy foods grown and distributed locally.
- Reducing waste by improving medicines management could also reduce risks from polypharmacy

Since 2022/23 our primary care networks, through a programme hosted by a voluntary sector partner, have been developing a greener practice network; switching asthma inhalers and using an asthma toolkit, using the [Green Impact](#)

[for Healthcare toolkit](#); and upskilling on health benefits of active travel.

We have a climate collaboration group which includes all key partners (providers, voluntary services, local authority and regional colleagues). This group is focusing on the refresh of the green plan in line with the national guidance released in February 2025.

Areas of focus:

1. Workforce and leadership: to engage with all staff to support the green plan delivery.
2. Clinical transformation: moving to out-of-hospital and digitally-enabled care where clinically appropriate, improving prevention of ill health and reducing health inequalities.
3. Digital transformation: will prioritise sustainability in our procurement of digital services.
4. Medicines: Work with all care to support high-quality, lower-carbon care in line with clinical guidelines
5. We will work with the local authority to align partnerships with local authorities and local transport authorities to maximise funding and infrastructure opportunities on behalf of the ICS member organisations
6. Estates and facilities: There are significant opportunities across the NHS estate to reduce emissions and lower costs, while improving energy resilience and patient care, including use of LED lighting, insulation and double-glazed windows
7. Food and nutrition: To consider opportunities to make menus healthier and lower carbon by supporting the

provision of seasonal menus high in fruit and vegetables and low in heavily processed foods.

Collaborating

Across the NHS

The boards of the Cornwall Partnership NHS Foundation Trust and the Royal Cornwall Hospitals NHS Trust have formally approved setting up the '*Cornwall hospitals and community health group provider collaborative*' to work in partnership to improve health and wellbeing, deliver joined-up services closer to home, and reduce inequalities.

The 2 boards have identified 4 initial workstreams:

- a) Clinical transformation – ensuring that practitioners drive improvements, initially focusing on services that can have the biggest impact on experience and outcomes such as stroke, Cornwall @ home, psychological support for people with long term conditions, and urgent and emergency care.
- b) Aligned workforce – to ensure efficient and effective operating models and systems, reduce agency staffing, and harmonise terms and conditions of employment to build a system approach to recruitment and retention.
- c) Shared support services – initially looking to optimise contracting/procurement, project management, and business intelligence functions.
- d) Digital transformation – to ensure that digital and technology are key enablers to achieve the overall aims

and make delivering and receiving services as efficient and effective as possible.

Collaborating across the peninsula

Hospitals in Plymouth and North Devon provide urgent and planned care for our residents in North and East Cornwall and University Hospitals Plymouth provides highly specialised care for all our residents that is not available locally.

We also collaborate with Devon for the provision of secure and specialist mental health care.

We are part of the Peninsula Cancer Alliance to improve cancer care.

The Royal Cornwall Hospitals NHS Trust is part of the Peninsula Acute Providers Collaborative, which bring Cornwall and Devon acute Trusts together to improve clinical pathways across the peninsula.

Collaborating with the councils

In 2024/25 the Integrated Care Board and Cornwall Council established 3 life course steering groups to oversee shared outcomes and report to the Integrated Care Partnership.

Their roles are being developed in relation to the start well, live well, and age well elements of this plan.

Collaborating with the voluntary and community sector

The voluntary, community and social enterprise sector are key partners in delivering care and support and tackling health inequalities.

Between April 2025 and the end of December 2024, we invested £20million into the voluntary community and social enterprise (VCSE). This included for example:

- *People in Mind* is personalised support from voluntary and community sectors organisations collaborating to reduce suicide, improve wellbeing, increase social connections, and increase financial security starting with a conversation based on ‘what matters to you?’
- Voluntary sector led local community hubs and community gateway provide access for people to advice and support.
- Helping people develop personal care plans.
- Supporting high intensity users of urgent care find the non-medical solutions they need.

Drawing on a range of expertise

There is expert clinical and professional involvement at all levels of decision making in formal governance and in local projects and system-wide programmes.

The Chair of the Voluntary Sector Forum sits on the ICP, ICB, System Executive Group, and the ICA Committee and can facilitate involvement of a range of experts from across the Voluntary Sector.

We also draw on expertise from the Health Innovation Southwest and from local universities.

Governance

Delivery of priorities for recovery is being driven forward and monitored by existing programme boards for planned care, flow (urgent care), intermediate care, dementia, and mental health and learning disabilities. The programme boards comprise representatives from the Integrated Care Board, Royal Cornwall Hospitals NHS Trust, and Cornwall Partnership Foundation NHS Trust, voluntary sector, and local authority.

How we monitor delivery of the full Plan from 2024 onwards will be determined during the next stage of its development.

We are exploring how to establish joint committees comprising representatives of the ICB and Trusts for future oversight of the whole Plan.

Finance

The purpose of this Plan is to establish a model of care that is better for our population and is financially sustainable. We need to ensure that our expenditure does not exceed the money allocated to us by NHS England.

It has the following advantages:

- It is a 5 year plan

- Its population health management approach will more effectively match resource allocation to population health need and avoid wastage
- It covers all elements of healthcare and can spot and remove duplication
- It provides an overall picture of service change programmes alongside value creation workstreams.
- Interdependencies and opportunities for synergy can be identified and managed.
- The impact of changes can be collectively assessed on activity, workforce, and finance over a 5 year period.

This Joint Forward Plan aligns with our 3-year system medium term financial plan and our system capital plan.

Our medium term financial plan for our system has assessed and set out the efficiency requirements each year from 2023/24 to 2027/28 in order to achieve a financially balanced operating plan for the year.

Achieving this requires our Joint Forward Plan to include both continuous value improvement and transformation of our model of care.

Our financial plans will be subject to significant performance management, tracking, reporting and assurance across all our organisations and through to the Integrated Care Board.

Further developing this Plan

We are keen to inform, involve and engage local people in the way we shape, improve and deliver local health and care services.

This plan is updated annually and see feedback and ideas to shape future versions throughout our annual engagement programme.

As part of our citizen engagement strategy we are currently implementing new ways for people to be involved, you can [subscribe](#) to receive engagement updates or visit our '[Get involved](#)' section on our website to see how you can get involved.

The next version will focus in on more detail of the high impact changes to be delivered with SMART objectives, milestones and trajectories

The next iteration will steer the development of the system operating plan for 2025/26.

Engagement

To ensure we shape our plans effectively, we deliver an annual inclusive engagement process which includes face to face and online methods to suit the audience, with a particular focus on reaching people who may experience health inequalities, to get their feedback and ideas.

Our annual '[Community Conversation](#)' engagement programme in partnership with system partners reached over 10,000 people to inform our 10 year integrated care strategy and 5 year forward plan. This feedback helped to shape the 6 system change programmes in the 2024-2025 operating plan with a focus on providing more care in local communities and intervening earlier to prevent ill health:

1. 24/7 Integrated urgent care including enhanced community provision
2. Primary Care Hubs
3. Discharge to assess (reducing length of stay in hospital)
4. Transforming our approach to major conditions including diabetes, cardiovascular and respiratory
5. Mental health: increasing access to services and maximising the value of investment to improve equity with physical health
6. Providing 24/7 end of life care in local communities

The engagement fundings from the community conversations are published on the [ICB website](#) alongside a summary of both the engagement carried out and the findings and analysis of Core20plus5 audiences reached.

During 2024, and in response the public feedback, we delivered a series of wellbeing festivals and events which 'wrapped' around our conversation engagement programme to gather feedback and provide 'pop up' access to health checks and wellbeing advice for local people.



These events, part of our Healthier Together prevention campaign, were delivered in partnership with local community hubs, town councils, health and wellbeing services. Held across Cornwall, in locations driven by population health needs, there were 8 summer wellbeing festival events, which attracted over 2,000 people to give feedback, access local wellbeing advice and over 300 people received health checks including blood pressure, cholesterol, oral cancer and the

NHS health checks. Watch the [film about the summer of wellbeing](#).



Over the winter, 12 winter wellbeing and NHS 10 year plan events took place across Cornwall and Isles of Scilly to further gather local feedback and ideas to feed into the local and national NHS 10 year plan engagement. [Local NHS 10 year plan engagement](#) was targeted to reach our Core20+5 audience, including people who are deaf, living in rural and fishing communities.

Bespoke engagement over the year also included targeted place based engagement to understand views on health services in Fowey and the future of the community hospital, and the set up of expert reference groups with people of lived experience for diabetes and for palliative and end of life care support, to shape new pathways for future services. The personal experiences from local people and staff are also collected from our engagement and 5 filmed stories are shared at every ICB meeting, which forms part of our ['your story shapes our future' initiative](#) to collate and document in a lived experience online library, which is also shared with staff and partners across the system.

What we asked people about

Questions were themed around:

- Recent experience of your GP surgery and health care services (from pharmacy, 111, dentist, MIU, mental health, ED, calling 999 to community), measuring happiness with service, what was good, what could be better)
- Overview of ICS strategy priorities for start well, live well and age well – asking people if we should do anything else and if they want to, what their experiences are.
- What would make CIOS a healthier place to be born, live and grow old – asking for ideas and feedback on what our people are doing to keep healthy and what is stopping them?
- Preferred ways for finding out information about health and care services and asking people if they would like to get involved in the future
- Demographic details – from postcode, age, gender, to if people are a carer or have a disability

What people told us they would like to experience from their health and care services in the future

- Consistency in the way access and services are provided across Cornwall and Isles of Scilly
- Services to be more easily accessible for people (including being locally available, on

evenings/weekends, in person where needed and quickly when its urgent)

- Not just online booking available for GP/health appointments (and helping those who need support to book and access appointments in ways that best meet their needs)
- Equal care for physical and mental health offered to everyone
- A fairer service which makes sure those who need extra help are supported to receive health and care services
- Care with kindness – staff to be more compassionate, understanding and to listen to the needs of people and their families
- Personalised care based on what people need with choices for people to consider
- Professionals to dig deeper into their problems to find out the root cause and offer holistic advice on diagnosis and ongoing throughout their treatment
- Communications they understand – both verbally and written which are relevant to improve a person's health or health condition
- To feel empowered to look after their health and well being, know choices and be communicated with about what is help is available to them – tailored to their need/medical condition

Appendix 1: The strategic and planning framework and where the Joint Forward Plan sits

'[Gyllyn Warbarth, Together We Can: The Cornwall Plan](#)', sets out a vision for Cornwall in 2050 and the [Joint Health and Wellbeing Strategy for Cornwall and the Isles of Scilly](#), which follows on from the Cornwall Plan sets the direction to improve the health and wellbeing of our population over 10 years to 2030.

The Cornwall Plan was created after Cornwall's biggest ever listening exercise, *The Cornwall We Want*. The Cornwall people want is a great place to be born, grow up, get on and grow old.

The Joint Health and Wellbeing Strategy has 4 outcomes to aim for to achieve the Cornwall Plan:



Healthy Start: children are given the best start in life enabling them to equally reach their full potential.



Healthy Bodies: people feel enabled and motivated to actively manage their lifestyles and reduce risks to health.



Healthy Minds: Our mental health and wellbeing are valued and considered equally as important as physical health.



Healthy, safe communities: together we all create healthy and sustainable places and communities to live, learn, work, and age.

The principles set out in the Health and Wellbeing Strategy are also guiding this plan:

1. Collective responsibility and understanding of the benefits of actively managing our health and wellbeing.
2. Investing in prevention over the longer term to promote a more sustainable system.
3. Communities and systems working together to drive a healthier culture.
4. Promoting inclusion, recognising diversity and reducing inequalities.
5. Ensure we all safeguard the most vulnerable to enable them to live healthy, safe lives.

Statement from the Cornwall and Isles of Scilly Health and Wellbeing Board

The Joint Health and Wellbeing Board considered the NHS Joint forward plan and were supportive of the outline approach and found it in line with the ambitions and delivery of the Joint Health and Wellbeing Strategy.

The Integrated Care Strategy complements the Health and Wellbeing strategy by looking at different life stages and identifying groups within our population who most need care and support joined up around them:

- Everyone needs a healthy start, but for some children and young people and their families, starting well involves managing complex medical and social needs, mental health issues, or special educational needs and disabilities.

- For healthy bodies and minds, everyone needs to start well and then live well during the middle years of life. For some people this is more difficult and they need our support to avoid preventable diseases or a deterioration in their mental health.
- For some people maintaining healthy bodies and minds in the later years of life is more difficult and we need to join up support to help people with long-term conditions or who are frail to live independently at home for as long as possible.
- For those people reaching the end of their lives we need to ensure they are supported to make decisions about preferences for care, and that these are known and respected.

This Joint forward Plan sets out NHS commitments to deliver the Health and Wellbeing Strategy and the Integrated Care Strategy. This is in partnership with Cornwall Council and the Council's commitments are covered in its Business Plan.

By developing and implementing this plan we help the Integrated Care System achieve its core purpose. The plan will:

- Improve population health and healthcare.
- Help reduce inequity in access, experience and outcomes of healthcare.
- Enhance productivity and value for money in healthcare.

- Help the NHS support broader social and economic development.

This plan will also deliver universal NHS commitments as described in [NHS priorities and operational planning guidance](#) and in [the NHS Long Term Plan](#) and its [implementation framework](#)

We are taking the opportunity to consolidate existing plans into this one single plan. It will also be our delivery plan for the [Integrated Care Strategy](#).

There is also a legal requirement that the Plan describes how the [Integrated Care Board](#) is fulfilling its [legal duties](#).

Our Plan sits within this strategic and legal framework.

Our strategic and planning framework

