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Placing the voluntary sector at the heart of Cornwall's channel shift ambitions

Cornwall and the Isles of Scilly Back to Health Programme

Foundation Research Report, Oct 2025

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What is the potential of the CGHN in supporting channel shift?

Helpforce recommendations

Executive Summary

Overview

This report brings together the findings of the Cornwall ICS Back to Health Programme's foundation research, delivered by Helpforce.

It explores how Cornwall's Community Gateway and Hubs Network (CGHN) deliver place-based, person-centred support, identifies barriers and enablers to its potential, and assesses its possible role in enabling a 'channel shift' from hospital to community.

The research involved participation from Cornwall's Community Hub and Community Gateway staff, as well as representatives from the Voluntary and Social Enterprise (VCSE) sector, Integrated Care Board (ICB), NHS, and council.

1 As it is now, how does the CGHN deliver place-based, person-centred support?

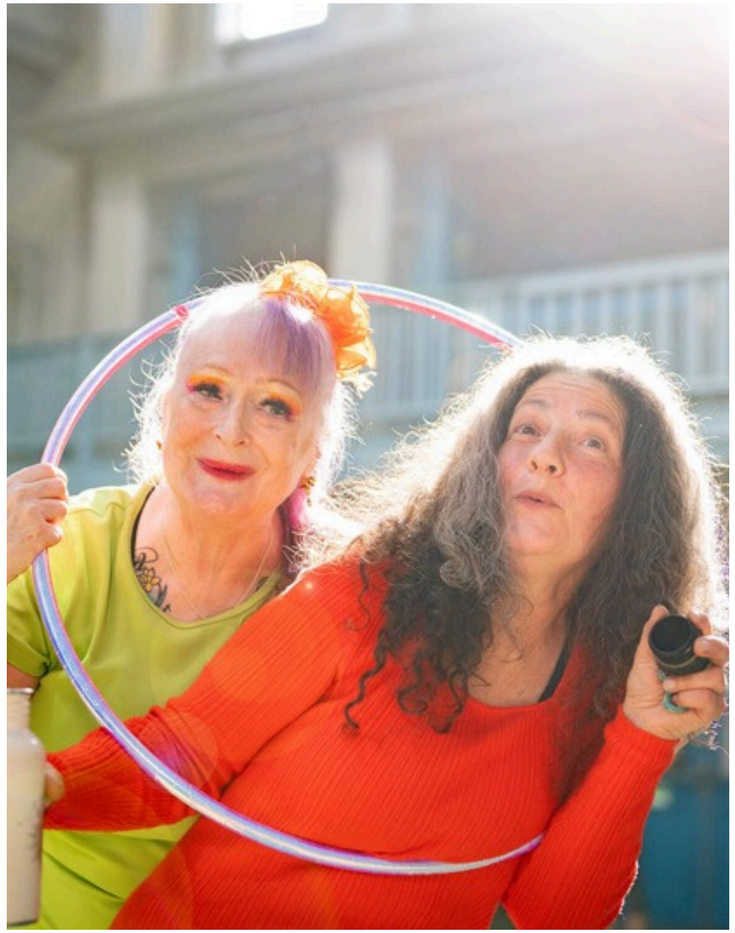
The CGHN delivers place-based, person-centred support through locally shaped services and flexible provision that is responsive to community priorities.

This support is grounded in 'what matters most to you' conversations and fosters a sense of empowering service users. The diverse, inclusive and holistic offer addresses social, emotional and practical needs and is available via a simple point of access - making support easily accessible for Cornwall's community members.

The network is underpinned by strong local connectedness, allowing for collaboration across other voluntary sector services and the wider healthcare system.

Overall, the CGHN is primed to effectively deliver community-driven, needs-led care that complements statutory health and social services.

Executive Summary (Cont'd)



2 What conditions need to be met / barriers need to be overcome to enable the CGHN to reach its potential?

The CGHN's potential is limited by systemic, cultural, and funding challenges. Sparse awareness and integration with NHS and statutory partners are seen as a key issue.

Specifically, NHS clinically focused culture, pre-existing perceptions of VCSE service provision limitations, and workforce pressures can be barriers to building integration.

From a practical perspective, limited space for service delivery, data sharing difficulties, inconsistent referral processes and challenges with evidencing CGHN impact were noted. Additionally, short-term, competitive funding was seen to compromise service delivery and sustainability, particularly for Community Hubs.

To achieve its full potential, the CGHN needs stronger integration with statutory services, shared trust, and increased recognition as an equal partner in health and wellbeing delivery.

The building of stronger partnerships, shared goals, and data sharing protocols across the system are recommended.

Further, taking steps towards a standardised data collection and evaluation approach will be key in both building recognition of CGHN impact and reducing an increasingly challenging administrative burden on the network.

However, paramount to success is the consideration of an alternative funding model that allows for long-term, flexible funding that can result in increased investment in CGHN services, staff and volunteers.

Executive Summary (Cont'd)

3 What is the potential of the CGHN in supporting channel shift?

The CGHN is well positioned to support Cornwall and the Isles of Scilly healthcare system ambition of 'channel shift' - moving care from hospitals and statutory services into the community. By providing accessible, preventative, and holistic community support, participants identified five main areas of opportunity for the CGHN:

'Front-door' support

The Community Gateway could serve as the first point of contact for health and social care, triaging needs and directing people to the most appropriate community or statutory support.

'Prevention and early intervention

Wellbeing, healthy living, and "waiting well" programmes could be further expanded or established through the CGHN to help people manage their health earlier, potentially reducing NHS and social care demand.

Live well

The CGHN already delivers several activities that support social connection, mental health, and lifestyle improvement, which could be further developed to help people maintain wellbeing and independence.

Age well

Increasing targeted support for older people (e.g., tackling isolation, mobility, and practical needs) which could potentially reduce the risk of deterioration and entry into formal care.

Discharge

The CGHN can help people transition home safely after hospital discharge, reducing risks that could lead to readmissions and ensuring integration into community support.

Key to achieving these ambitions will be consideration of the aforementioned barriers and enablers, alongside strong alignment with Integrated Neighbourhood Teams (INTs). To realise this, any services must be formally embedded within NHS and council strategies, with investment, shared accountability, and means to evidence impact.

Executive Summary (Cont'd)

4 Summary and recommendations

The CGHN represents a vital mechanism for delivering holistic, place-based, person-centred care in Cornwall.

It enjoys strong community trust and reach but requires systemic alignment, sustainable funding, and integrated evaluation to achieve full potential.

Strengthened collaboration between NHS, council, and VCSE sectors could transform the CGHN into a cornerstone of a sustainable, community-led health and care system.

Following completion of the foundation research, Helpforce will continue to work alongside Cornwall and Isles of Scilly partners for a further two years until October 2027. Based upon these research findings, Helpforce is proposing two possible options for the focus of this work:

1. **Develop a CGHN Evaluation Framework** to standardise data capture, reporting and evaluation across the network, using data to determine social and economic impact.

2. **Channel shift 'Test and Learn' pilots** Identify existing services that could be further embedded and developed or create new services, which are anticipated to result in channel shift.

Helpforce will work with partners to determine which of these options they will choose as the focus for the remainder of the programme.

The Back to Health Programme

The Helpforce Back to Health Programme

The Helpforce ICS Back to Health (B2H) programme involves Helpforce supporting six regional partners over three years.

The programme aims to deliver projects that prove how volunteers and the voluntary, community and social enterprise (VCSE) sector can be integrated into health and care pathways, and help tackle major system challenges, such as:

- Safely getting people out of hospital and back home quicker;
- Maximising use of community assets to support people post-discharge, and avoid unnecessary readmission;
- Improving access to local services.

The programme donor is the National Lottery Community Fund (NLCF) and involves working with five Integrated Care Boards (ICBs -Cornwall, Sussex, North West London, North East & North Cumbria, and Norfolk) and a provider collaborative (The Foundation Group, comprising of four NHS trusts in Warwickshire).

We want to prove that volunteers and the VCSE sector can be integrated into health and care pathways to help tackle major healthcare system challenges.

The Cornwall and Isles of Scilly Back to Health Programme

Helpforce started working with Cornwall over three years ago, undertaking an evaluation of the Community Hubs - a network of diverse voluntary sector organisations that act as a central point of support for communities.

The resulting evaluation report demonstrated the positive impact that the hubs make on local people's wellbeing and ability to manage their own health. The hubs provide vital place-based support that alleviates pressure on stretched health services, with 50% of hub users indicating they would have contacted a healthcare provider if the hub didn't exist.

The report underpinned a proposal for Cornwall Integrated Care Board (ICB) to fund the Community Hub network, allowing the network of hubs to grow and support even more people.

We've since discussed how Helpforce could build on this work. Cornwall ICB, in collaboration with its primary stakeholder partners - the three Integrated Care Areas, the two NHS Trusts, Volunteer Cornwall, and Cornwall Voluntary Sector Forum - joined the B2H programme in November 2024.

To define the scope and plan for Cornwall's subsequent three-year programme of work, Helpforce undertook a discovery phase over October and November 2024 working with the primary stakeholders to determine their key priorities.

Like many systems, Cornwall wishes to implement channel shift, moving more health and care support into the community. Recognising Cornwall's VCSE infrastructure will play a key role in this, our help was sought to understand how best to maximise their VCSE assets.

It was therefore agreed that the first year of the B2H programme would involve a foundation research year, working with participants across the Cornwall health and care sector to determine the extent to which the voluntary sector is already integrated within the system, but also how this could be maximised to its full potential in support of the ICB's channel shift ambitions.

Research Questions

Using its established Insight & Impact evaluation service, Helpforce undertook foundation research with an aim to obtain a deeper understanding of the CGHN, the support offered, and what the challenges are.

Through this research, we also hoped to identify potential opportunities where the CGHN could assist with the ICB's ambition of channel shift and inform future strategy, including highlighting any barriers that would need to be addressed to ensure the network is well-integrated and positioned to deliver against channel shift ambitions.

Our three research questions for the foundation research were as follows:

1 Person-centred support

As it is now, how does the CGHN deliver holistic, place-based, person-centred support?

To develop a greater understanding of the CGHN and how it delivers care that is place-based, holistic and personalised to the needs of the local community.

2 Conditions/ barriers

What conditions need to be met / barriers need to be overcome to enable the CGHN to reach its potential?

To identify what systemic and cultural barriers need to be overcome, and what conditions need to be met to enable better integration of the CGHN into the NHS.

3 Channel shift/potential

What is the potential of the CGHN in supporting channel shift?

To review how the CGHN can play a more prominent role in the system's channel shift strategy, identifying opportunities to prevent unnecessary use of the two NHS Trusts' services.

To note: there are reported to be ~2,500 registered VCSE organisations within Cornwall. It was, therefore, not viable to include the entirety of the sector in our scope. Focussing our research on the CGHN provided a clear focus for our work and allowed Helpforce to work alongside an aspect of the sector that has an established infrastructure but also a good understanding of other community assets that exist outside of the network.

Methodology

Secondary Research

This research employed a qualitative secondary research approach to systematically review existing resources including strategic and policy documentation relevant to CGHN.

The review focused on:

- Person-centred support.
- CGHN's potential role in supporting channel shift.
- The systemic and cultural barriers to its integration within the broader health and care system.

Screening and Review Process

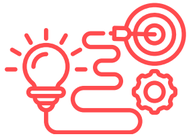
Resources underwent a comprehensive analysis to extract and document sections related to the research objectives.

- 67 documents were primarily identified through desktop research and direct input from Cornwall contacts.
- 44 documents were excluded following an initial screening, due to limited relevance.
- 28 additional documents were then sourced and analysed, to help provide further insight, evidence and examples of initiatives highlighted through interviews and focus groups.
- 51 documents in total were included in the final set of secondary research and analysis, of which 48 have been directly referenced within this report.

Criteria for inclusion

The criteria used to initially identify documents included:

- Published by Cornwall and Isles of Scilly Integrated Care System, NHS, council, and VCSE organisations or directly provided by programme partners.
- Clear relevance to channel shift strategies or conditions/barriers to integration of the CGHN into the NHS.



Analytical approach

This review used qualitative secondary research, through which documents were analysed to extract and systematically organise data relevant to the main research questions. Themes and subthemes were developed iteratively through categorisation and collaborative review, including:

Local Insights:

- Local scene setting (strategy/policy/performance/impact)
- Channel shift potential
- CGHN service provision
- Barriers / enablers

National Insights:

- National scene setting (strategy/policy)
- Channel shift potential
- Barriers / enablers
- Best practice examples

Methodology

Primary Research

The primary element of our research involved a combination of qualitative methods, including online interviews and focus groups.

Between February and August 2025, we spoke with

53

strategic and operational staff members across the Integrated Care Board, NHS Trusts, council, and Voluntary Sector.

Key considerations towards reporting, citing quotes and the approach taken towards data collection can be found in the appendices.

22 hub and gateway representatives, including...

- **12** Community Hub staff
- **5** Community Gateway Advisors or Outreach Workers
- **5** Community Makers

13 NHS trust representatives*, including...

- **9** Royal Cornwall Hospitals NHS Trust staff
- **4** Cornwall Partnership NHS Foundation Trust staff

7 Integrated Care Board representatives including Integrated Care Area Directors and Programme of Care Leads

6 council representatives including from Adult Social Care and Housing

5 voluntary sector representatives from Volunteer Cornwall, Age UK Cornwall and Cornwall Voluntary Sector Forum

*For staff members within the council and NHS Trusts who were unable to participate in focus groups or interviews, a survey alternative was offered. We did not receive any responses to the council survey, but we did receive one response to the NHS trusts survey, which was analysed alongside interview/focus group insights.

In 1951, a report by King Edward's Hospital Fund for London suggested:

> ***"Institutions… now protest they are having to undertake nursing duties because the hospital cannot take cases; whilst the hospitals protest equally strongly that they are having to care for patients who do not really need their services."*** [1]

The care of the aged sick: the story of an experiment in providing homes for aged patients within the National Health Service, 1951.

Health and Care Landscape: National

Context

The desire to move healthcare away from acute settings and into communities is not a new concept - for decades, the motion has been a prominent feature of NHS policy and priorities.

In more recent years, however, the drive to bring community services to the forefront of healthcare delivery has felt somewhat more pressing.

In Lord Darzi's 2024 review of the NHS, he discusses the promises made by successive governments to shift care away from hospitals whilst observing that hospital expenditure and staffing has only increased in recent years, as out-of-hospital services have declined.[2]

His report subsequently recommended that "the only sustainable solution to congestion in acute hospitals is to build up the capacity, capability, infrastructure and technology base of care that is delivered in the community".

At a time when the NHS continues to face significant change and challenge, the 2025/26 priorities and operational planning guidance reinforce the importance of 'channel shift'.[3] This guidance suggests that the shifting of care from hospital to community is key to making the NHS sustainable for future generations.

The implementation of Neighbourhood Health Services by Integrated Care Boards (ICBs) is paramount to these plans as they are intended to better connect and optimise healthcare, including by "providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care".[4]

The recent publication of the NHS 10-Year Health Plan further cements this agenda, with the movement of healthcare into the community being one of the three 'radical shifts' proposed.[5]

The changes laid out promise reduced fragmentation, improved access, and increased patient choice – by transitioning to a neighbourhood-based provision, the hope is that individuals' healthcare needs can be better supported within the community setting, leaving hospitals with the capacity to provide specialist care to those who most need it.

Responding to Lord Darzi's funding challenges, the plan reports that the pattern of health spending will evolve, with hospital expenditure falling and greater investment in community care to support the shift to Neighbourhood Health Services.

> ***"The only sustainable solution to congestion in acute hospitals is to build up the capacity, capability, infrastructure and technology base of care that is delivered in the community."***
>
> ***Lord Darzi*** [2]

Health and Care Landscape: National

Integration of the Voluntary Sector

For many years, the NHS has attempted to better integrate the voluntary, community and social enterprise (VCSE) sector within various healthcare strategies and legislation, including the Health and Social Care Act 2012.[6]

With the establishment of Integrated Care Systems (ICSs) came an opportunity for the VCSE to be brought into healthcare governance and decision-making. Further, it provided formal recognition of the specialist expertise the sector provides in supporting individuals with complex needs.[7]

Indeed, the plan suggests that voluntary sector partners will be key in driving innovation that supports healthier lives.

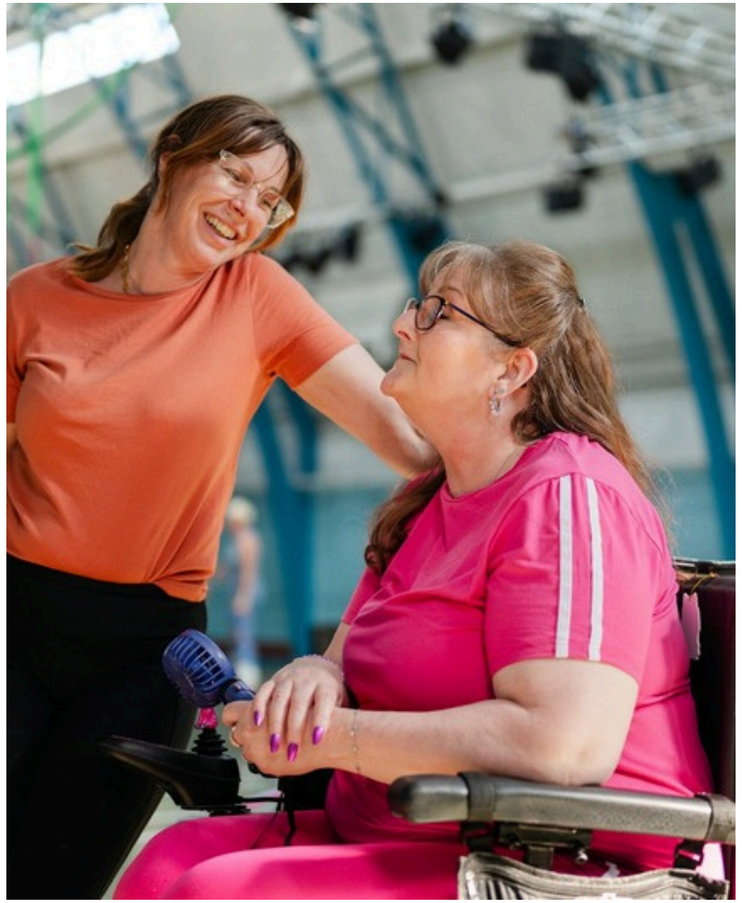
Plans for neighbourhood health services further recognise the role the VCSE sector can play in addressing individuals' wellbeing needs holistically.

The NHS 10-Year Health Plan discusses bringing the NHS, local authorities and voluntary sector services under one roof of Neighbourhood Health Centres (NHCs) -

> ***"NHCs will not only bring historically hospital-based services such as diagnostics, post-operative care and rehabilitation into the community, but they will also offer services like debt advice, employment support and smoking cessation or weight management services".*** [5]

Neighbourhood health services, therefore, further build upon the opportunity for the VCSE sector to be key strategic influencers and decision makers.

These organisations will need to be brought together with primary care, social care, community health, acute care, and wider system partners to collectively reach a shared vision for neighbourhood health that is person-centred, holistic and place-based.[4]



Health and Care Landscape: National

Channel Shift Opportunities

As part of Lord Darzi's review, Age UK submitted analysis illustrating that:

MORE THAN

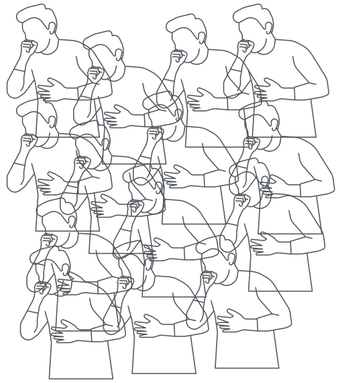
1 Million

admissions/readmissions to hospital were for conditions that should not usually require hospital treatment.[2]

On any given day,

OVER

2,000



aged over 65 years are admitted to hospital for a condition that could have been addressed by preventative community services.[2]

Statistics such as these clearly depict the value community services can bring, not only in addressing the needsof the individual but in reducing avoidable pressures on acute services.

So where are the opportunities to make channel-shift a reality?

Health and Care Landscape: National

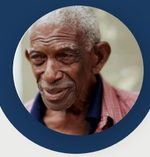
Channel Shift Opportunities (Cont'd)

Top 5 priorities

Complex health needs

Long-term health conditions

Social isolation



Aging populations

Homelessness

Health and Care Landscape: National

Channel Shift Opportunities (Cont'd)

Complex health needs

The neighbourhood health guidelines 2025/26 suggest the priority should be in supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations.

These individuals are estimated to account for approximately 7% of the population, but 46% of hospital costs.[4]

Whilst these individuals will likely always need an element of acute care, the NHS has recognised that the VCSE sector is well placed to support individuals with complex needs, having had a long history of finding creative ways to improve outcomes for those who experience the poorest health.[7]

Health and Care Landscape: National

Channel Shift Opportunities (Cont'd)

Long-term health conditions

Lord Darzi's report stated that "by the time people are aged 85 or above, 9 out of 10 will have at least one long-term condition". [2]

However, the report also notes other population groups who are now experiencing long term health conditions, particularly children and young people in relation to mental health needs.

Darzi suggests there is a key role for community services to play in supporting individuals with long-term health conditions, suggesting this would provide increased convenience for patients who may need frequent contact with the NHS.

However, there is also a role for the VCSE sector in supporting individuals to develop skills, knowledge and confidence in living with long-term health needs, providing health coaching or peer support. [8]

Health and Care Landscape: National

Channel Shift Opportunities (Cont'd)

Aging population

As part of the Lord Darzi investigation, Age UK submitted analysis of the GP patient survey which illustrated a significant decline in the number of older people who felt supported to manage their own health within the community.

Evidence showed that rates fell by around 10% between 2018 and 2023.[2]

VCSE organisations who specialise in supporting individuals aged over 65 years can provide vital support, building their confidence as well as better integrating them into wider community support.

Health and Care Landscape: National

Channel Shift Opportunities (Cont'd)

Social isolation

Previous estimates have illustrated that approximately one in five GP appointments are for non-medical reasons.[9]

This includes support for loneliness or to seek advice on housing and debt.

These challenges could be much better addressed by community and voluntary organisations who specialise in tackling the wider or social determinants of health, rather than taking up precious clinical resources.

Homelessness

People experiencing homelessness are reportedly four times more likely than the general population to attend A&E, and eight times as likely to require inpatient care.[2]

Various community and charitable organisations are well placed to support individuals who experience homelessness, supporting them to find suitable accommodation, which in turn may positively impact reliance upon secondary care.

Health and Care Landscape: National

Channel Shift Opportunities (Cont'd)

Research suggests that increased investment in community healthcare can indeed reduce reliance on hospitals, with the NHS Confederation reporting that systems that invested more in community care saw lower non-elective admission rates, ambulance conveyance rates, elective admissions and A&E attendances. [10]

It therefore appears prudent to not only focus efforts on shifting healthcare from hospital to the community, but also further understanding the role of the VCSE sector can play in keeping people living well closer to home.

Cornwall and the Isles of Scilly ICB has recognised this opportunity, placing channel shift at the heart of their ambitions for healthcare across Cornwall in the forthcoming years.

Health and Care Landscape: Local

Strategy

This section synthesises findings from a review of recent strategic documents from the Integrated Care System (ICS), Cornwall Partnership NHS Foundation Trust (CFT), Royal Cornwall Hospitals NHS Foundation Trust (RCHT), and Cornwall Council. These set out an ambition to create sustainable, person-centred services that respond to both current and future needs.

Integrated Care System Strategy

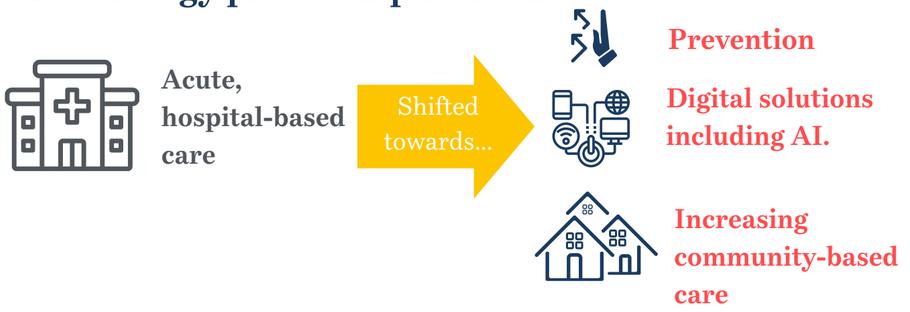
The Cornwall and Isles of Scilly Integrated Care System (ICS) recognises that improving health outcomes requires not only health and care services, but also coordinated activity across housing, education, and community sectors.

It defines health and wellbeing in broad terms, emphasising physical, mental and social aspects, while setting out a vision for people to live well across the life course.[11] The strategy also commits to tackling health inequalities and addressing local gaps in life expectancy across Cornwall and the Isles of Scilly.

A set of primary challenges are identified across the system.[12] In response, the ICS focusses on operational recovery, improving value and care transformation. These challenges are as follows...

- COVID-19: Despite improvements in 2023/24 performance standards, delays remain significant in both urgent and planned care pathways, contributing to long waiting times for patients. [12]
- Increasing health needs: Pressures are rising due to a growing and ageing population, preventable illnesses, widening health inequalities, and the effects of climate change - all contributing to greater demand for care.[12]
- Workforce shortages: The workforce strategy is anticipated to play a role in engaging communities as an extension of the workforce, helping local people to help themselves when it is appropriate. [11]
- Financial constraints: Cost improvement initiatives are presented not only as a response to budgetary pressures but also as a mechanism to enhance quality, equity, and value for money. The strategy places emphasis on the redesign of care in ways that reflect what matters to individuals, thereby increasing personal value and improving use of available resources. [12]

ICS strategy places emphasis on…



These shifts are seen as essential in tackling the three primary challenges - described not only as operational changes but as necessary cultural changes in respect of how the NHS acts and allocates resources.[13]

Furthermore, the strategy places communities at the centre of its ambitions, highlighting the importance of building strong, resilient and connected communities across the life course.

It sets out priorities for people to Start Well, Live Well and Age Well, with a focus on prevention, wellbeing, and enabling children, families and older adults to thrive.[11]

Health and Care Landscape: Local

Strategy (Cont'd)

Cornwall Partnership NHS Foundation Trust (CFT) Strategy

CFT is the principal provider of specialist community health, mental health and learning disability services across Cornwall and the Isles of Scilly.

The Trust strategy highlights a commitment to prevention, early intervention and care delivered as close to home as possible. This is considered essential to achieving service sustainability and requires transformation in both workforce development and resource allocation.[14]

Key strategic aims for the Trust are:

- Prioritising care at or near home, guided by what matters to individuals,
- Supporting alternatives to hospital admission (reducing reliance on hospital beds),
- Embedding learning and innovation.

In parallel, the CFT strategy defines its role as a community partner, with a commitment to strengthening joined up services and enabling resilient communities.

This includes:

- Investing in prevention,
- Adopting personalised models of care,
- Actively reducing inequalities.

The approach is underpinned by a reframing of care needs around personal priorities rather than clinical categories – elegantly described as

'What matters to people, not what is the matter with them'.

Challenges identified within the Trust's strategic plan include:

- Population ageing,
- Increasing inequality,
- Workforce shortages,
- Inadequate buildings,
- Persistent long waiting lists,
- Unmet demands.

These systematic pressures are acknowledged as barriers to the effective delivery of care and are presented as central considerations for ongoing transformation.

The Trust articulates a commitment to:[14]

- Reducing waiting lists,
- More effective responding,
- Better personalised care,
- A shift towards improving health and wellbeing in communities.

Health and Care Landscape: Local

Strategy (Cont'd)

Royal Cornwall Hospital NHS Trust Strategy

RCHT is the principal provider of acute hospital services for the population of Cornwall and the Isles of Scilly.

The Trust's strategy sets out a core aim of supporting 'connected, healthy, caring communities for one and all', with a focus on improving health outcomes across the region.[15]

It also outlines three strategic priorities:

- Delivering safe, high-quality care,
- Supporting and developing its workforce,
- Building a learning culture.

The strategy was developed with input from patients, staff and system partners, and sets out five levels of care delivery, including services provided at home and in local communities.

RCHT plans to increase the delivery of services outside of its hospital sites, using digital tools and partnerships to support access to care and reduce the need for people to travel.

This includes:[15]

- Supporting self-care,
- Offering personalised care plans,
- Enabling individuals to remain at home where appropriate.

Health and Care Landscape: Local

Strategy (Cont'd)

Cornwall Council Strategy

Cornwall Council's strategic approach to adult social care is centred on maximising independence and reducing reliance on traditional models of care by developing innovative, place-based community options.

The council positions people who draw on services as experts by experience and seek to ensure that their insights shape the design and delivery of support.[16]

This orientation of the strategic approach is also evident across both short-term and long-term commissioned services. Short-term support includes programmes focused on social inclusion, community-based mental health support, and services such as Empowering Independence and Lifeline.[16, 17]

These are designed to promote wellbeing, strengthen community integration, and prevent escalation.

In terms of longer-term support, the council commissions day services that offer structured activities in both building-based and community settings.

These services aim to:

- Sustain independence,
- Support ongoing participation in daily life,
- Reduce the risk of institutionalisation.

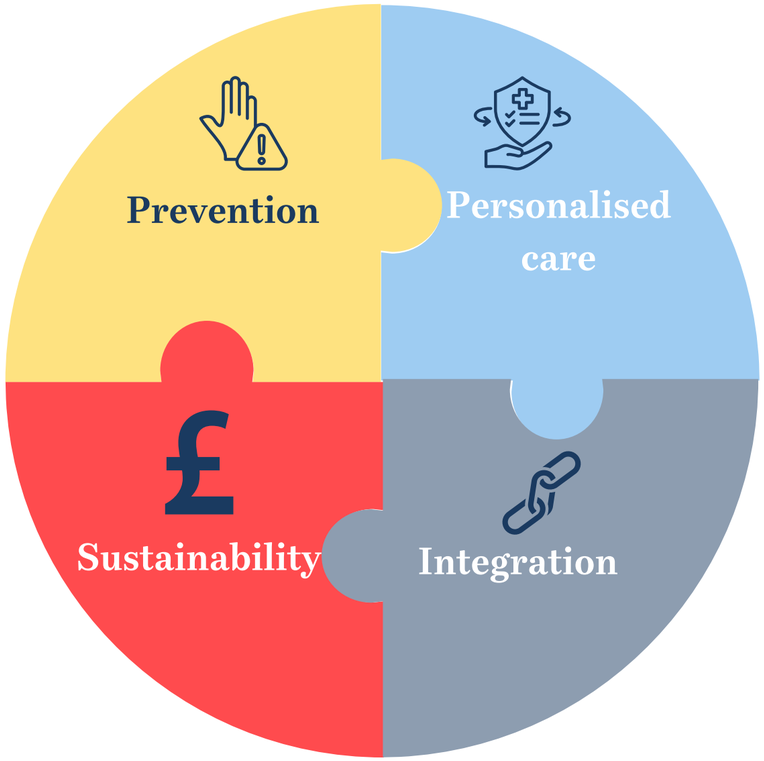
The council's strategy also highlights the alignment between local and national planning, such as the Cornwall and Isles of Scilly Health and Wellbeing Strategy.

The council's approach focuses on early intervention, personalised care and community-based support as mechanisms for delivering sustainable, inclusive services.[16, 17]

Health and Care Landscape: Local

Strategy (Cont'd)

Taken together, these strategic documents reflect a shared emphasis on…



Across the system and organisations in Cornwall and Isles of Scilly, there is a consistent direction of travel towards community-based models and a focus on what matters to individuals, rather than only on their clinical needs.

The strategies also acknowledge structural and demographic pressures facing the system – such as workforce shortages, inequalities and an ageing population – while indicating a collective direction towards long-term transformation and resilience.

Health and Care Landscape: Local

Voluntary, Community and Social Enterprise (VCSE) Sector

VCSE landscape

The Voluntary, Community and Social Enterprise (VCSE) sector plays a vital role in delivering services and facilities within the Cornwall and Isles of Scilly community to address local needs.

They are recognised as important strategic partners within the Integrated Care System (ICS), helping to deliver improvements in health, wellbeing, and the reduction of inequalities, often by working directly with communities.

Within Cornwall, these organisations offer essential support that complements and strengthens public sector services, from health management, to promoting well-being, improving living conditions, and tackling loneliness. VCSE organisations act both as service providers and as channels for community involvement and advocacy within local health and care systems.

As identified within the strategy review, there is recognition that traditional clinical focused models of support need to shift towards a more person-centred and inclusive model; a model that takes into account the context of people's lives and moves towards a 'what matters to you, not what is the matter with you' approach.[18]

The Cornwall ICB 5-year Joint Forward Plan recognises that the hospital is often not the best place for the elderly and for people with long-term health conditions.[12] VCSE partners can address non-clinical health issues with services offered within the local community, enabling people to manage their conditions and prevent these from deteriorating. [19]

To address social determinants of health - such as housing, diet, employment, and debt - the VCSE sector needs to be integrated as part of the wider health and care system more than ever before.[20]

VCSE Organisations – The Community Gateway and Hub Network (CGHN)

The VCSE sector across Cornwall and the Isles of Scilly is extensive and diverse, with approximately 4,500 organisations, and a notably high proportion of people who engage in volunteering.[21] Organisations like Volunteer Cornwall, Cornwall Voluntary Sector Forum (VSF), and Age UK Cornwall represent and support much of the sector.

Age UK Cornwall and Volunteer Cornwall, with partner support, have developed a network across the VCSE sector, with two of Cornwall's vital VCSE service providers at the centre of this: Cornwall Community Gateway and Cornwall Community Hubs.[18] The model aims to support two key system issues:

Providing immediate support to current system pressures.

Build longer-term capacity to address increasing demand for VCSE services.

Health and Care Landscape: Local

VCSE Sector (Cont'd)

The Community Gateway

The Community Gateway is hosted by Age UK Cornwall, having received a 5-year funding boost from the Integrated Care Board to fund services from April 2024 to 2029.[22]

The Gateway service is run by staff and operates daily from 8am to 8pm, 365 days a year. Assistance is available to anyone aged 18 and over living in Cornwall, as well as providing support to families who live outside Cornwall with a caring role to a family member living within Cornwall.[23]

As well as relationships built between NHS services and adult social care, the Gateway holds a two-way relationship with community hubs, with referrals both being received from and made to them.

Users of the Gateway are guided by a 'what matters most to you' conversation, followed by signposting to a wide range of professional and voluntary sector support and services that are tailored to their individual needs. [23]

These conversations aim to help the individual identify:

- What challenges they are facing towards their well-being.
- What provisions of support can be put in place.

Gateway Advisors support by listening, coaching, and co-producing personalised support plans to enable individuals to develop their wellbeing, independence, and resilience.

Community Gateway Outreach Workers also offer individuals face-to-face conversations and practical support as part of an agreed plan.

Health and Care Landscape: Local

VCSE sector (Cont'd)

The Community Gateway

Support is provided to individuals who are: [23]

Waiting for non-urgent medical treatment

Living with long-term conditions and/or disabilities

Physically frail

Economic challenges and/or housing instability

In recovery

Socially isolated

With care responsibilities

Between April 2024 - March 2025, the Gateway delivered [24]

54,814

contacts with or on behalf of Gateway users

5,274

personalised support plans

2,287

referrals via Health and adult social care electronic pathways

Health and Care Landscape: Local

VCSE Sector (Cont'd)

The Community Hubs

The Community Hub network, part-funded by Cornwall and the Isles of Scilly ICB and overseen by Volunteer Cornwall, now stands at over 50 hubs, covering much of the geography.

The network aims to support people to 'start well, live well, and age well in their communities.'[13] Hubs within the same localities work collaboratively to maximise the support they can offer to individuals living within communities.

The hubs offer safe spaces for people from the local community to come together, find help and advice, participate in local activities, and get help to return home from hospital.[13]

The hub model can represent various demographic groups and offer unique support personalised to the needs of the community, ensuring voices from all groups of people are heard.

Additionally, each hub has established their own links to other assets in the community including GPs, local charities, community groups, churches, and transport schemes.

Hubs can be based in a building or consist of virtual connected networks working together to increase community capacity and identify the best support available for people at a local level.[25]

Community hubs are, in the main, a network of existing charitable organisations – operated by paid staff, many with support from volunteers.

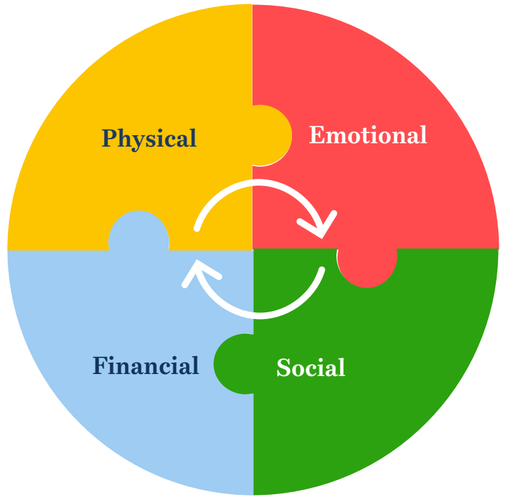
The consolidation of Community Hubs within a network has resulted in multiple benefits, including shared knowledge, peer support, and increased capacity to provide services.

Health and Care Landscape: Local

VCSE Sector (Cont'd)

The Community Hubs

Support is provided across four wellbeing pillars, examples include: [26]



- Pain and Cancer Cafes
- Frailty and Falls Prevention
- Stroke Support
- Chronic Obstructive Pulmonary Disease (COPD) /Respiratory
- Walking groups
- Practical support (cooking, cleaning, gardening)
- Meals on Wheels
- Hospital to Home support
- Debt and Money advice
- Housing support
- Energy advice
- Digital access and inclusion

Between April 2024 – March 2025: [27]

339,951

attendances were recorded

Of 4,800 people asked, 'If you weren't able to get to the hub today, which service would you have approached for support?"

24% would have accessed their GP

15% would have accessed mental health services

Health and Care Landscape: Local

VCSE Sector (Cont'd)

The Community Gateway and Hub Network (CGHN)

Support offered to the local community is strengthened when the Community Hubs and Gateway, along with other VCSE partners, work in tandem.

This model of support is often referred to as the Community Gateway Hub Network (CGHN).

Working in close collaboration with NHS Cornwall and the Isles of Scilly, the CGHN is a partnership between more than 50 voluntary and community sector organisations. The VCSE partnership organisations include:[26]

- Age UK Cornwall,
- Volunteer Cornwall,
- Pentreath,
- The CHAOS Group,
- Cornwall Rural Community Charity (CRCC),
- Cornwall Neighbourhoods for Change (CN4C), and
- Cornwall Voluntary Sector Forum (VSF).

VCSE partners work together to provide a simple point of access, crucially meaning that people from the local community only need to share their story once.

The Gateway facilitates the 'what matters most to you' conversation and, with support from the hubs and a network of VCSE professionals, guides individuals to the most appropriate services.

People are signposted to primary care, the wider NHS services, and adult social care where professional support is needed.

This model aims to support individuals from the local community to live healthier and independent for longer; move through and out of the system swiftly, enabling prompt discharge; aid rehabilitation and reablement within the community and their homes; and prevent unnecessary hospital admission or re-admission.

There is a recognition that the model aligns with the delivery of Cornwall ICS key health priorities:[18]

Place-based

Community hubs are developed from the local community needs and facilitated through community networks.

Personalised

Support is personalised to the needs of the community and the individual.

Tackles inequalities

Support is personalised to the needs of the community and the individual.

Prevention

Providing support to individuals with long-term conditions, mental health, and co-morbidity within the community.

Health and Care Landscape: Local - Example CGHN Pathway

Person

1

June* initially calls the Gateway for IT advice

2

After a brief conversation, June informs the Gateway Advisor that her husband, Alan, is in hospital after a severe COPD attack, and they need more support at home before he can be allowed to return.

3

Alan is referred onto the Hospital to Home team. June is supported to get her home ready, working with other VCSE partners in the area to install a new bed which is more accessible for Alan.

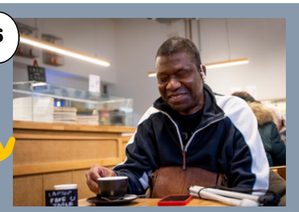
4

After having his transport arranged, Alan is discharged home as scheduled. Alan and June receive additional support getting medication and shopping being delivered, giving Alan the best chance of a full recovery.

5

Via his local Community Hub, Alan attends a COPD peer support group. They help him learn how to better self-manage his condition.

6



Alan is more confident leaving the house and has more social connections.And June is enrolled on adigital skills course to helpwith her original request.

Delivery

Referral

received from / for individuals aged 18+.

- Self-referral
- Community Hub or other charity
- GP (via social prescriber)
- Hospital
- Adult social care

Through a guided conversion based on "What matters most to you?", the Gateway Advisor better understands June's situation.

Community Gateway

They provide June with a Personal Plan bespoke to her and Alan's needs.

They make referrals/signpost on to a Hub and/or other VCSE partner for a local response. And to NHS/ ASC where needed.

Hub Network

Assessing their financial, physical, emotional and social needs, the local community hub provides various support to both June and Alan.

Infrastructure

Various additional supportive infrastructures that are essential in the successful delivery of the Gateway, hubs and their services, including…

- Funding from multiple partners, including the ICB.
- Advertising and promotion to ensure there is awareness of the services offered.
- Technology and data sharing to facilitate patient support and referrals/signposting.
- Buildings from which the community hub services can be delivered.

*This example is fictional, bringing together example pathways as found during our discussions with stakeholders. Names and images are used for illustrative purposes only.

Health and Care Landscape: Local

Community Needs

During the course of defining their service provision and strategies, Cornwall and Isles of Scilly ICS and Cornwall Council, undertook public engagement activities to understand what community members would like from health and care services.

Findings illustrated three key themes:

1

Accesibility

2

Provision

3

Workforce

Health and Care Landscape: Local Community Needs (Cont'd)

Accessibility

Community members were asked about accessibility to:

- Healthcare,
- Health information and technology,
- Community services.

They identified specific challenges towards:

- ***Accessing primary and secondary care,***
- ***The growing patient population,***
- ***Concerns over the cost of living.***

Accessibility barriers and concerns

- Appointment times and locations.
- Ambulance response times.
- Hospital waiting lists.
- Discharge support.
- Supportive health information, equipment and technology.
- Cost of living impact on access to community services, heating & food.

Primary care

Community members recognise the value of virtual GP consultations but continue to see a need for face-to-face appointments, which they feel should be easier to access.[11, 28]

A barrier towards getting to the GP included appointment timings, particularly when accommodating travel time. Services offered on evenings and weekends and within the local community would likely reduce this.[11, 28]

Consistency in methods of access irrespective of where you live and who you are was seen as important. However, methods should allow for flexibility to accommodate those who may be restricted due to having a disability or poor digital skills, for example.[11, 28]

Access to acute care services

Concerns related to different parts of the patient journey - from first contact (ambulance response), to hospital waits and discharge support.[11]

Being able to support the growing population and the high proportion of holiday makers were also highlighted as concerns felt to put accessible healthcare at risk.

Members also reported care across different life stages should be more balanced i.e., focusing on elderly care may in turn impact on care available for younger adults and/or children.

Timely access

Timely access to supportive information, equipment, and technology (including pre-emptive) are seen as key to maintaining independence when managing health and wellbeing.[16, 17]

This could include guidance related to activity, diet and staying well in the home.[11]

Health information should be tailored to the needs of patients and enable them to make informed decisions about their health.[28]

More generally, advice and support should be accessible to all regardless of health literacy and education level.

Access to leisure services and foodbanks

Access to leisure services and the availability of foodbanks are recognised as promoting quality of life, as are access to good quality housing and heating.

The latter are known to have an impact on mental health, prompting concerns with respect to cost-of-living challenges.[11]

Health and Care Landscape: Local Community Needs (Cont'd)

Provision

Community members see a lack of cohesion between different services as a challenge in the provision of health and social care services.

Key challenges

Long waits for mental health services, especially for young people, are recognised. [11]

Equity of service for physical and mental health and for those with additional support needs was also a consideration. [28]

Transport is a recognised barrier towards engagement with social opportunities. [11]

Valuable services currently in place

Being part of the community through peer and community groups and the provision of meaningful daytime activities were seen as a means to reduce social isolation and provide structure and a sense of purpose. [11, 16, 17]

There was recognition of the value of a local handyman service that provides individuals with practical assistance in their homes. [11]

Would like to see...

More effective IT to increase cohesion between different services. [11]

Healthcare professionals should really explore patients' health problems to identify root cause(s) and should offer holistic advice and personalised care throughout their journey from diagnosis onwards. [28]

Support and advice regarding how to be active in the community was identified as beneficial. [11]

Care should be tailored by listening to the needs of the patient and their families and offering treatment choices, [28] putting patients and their circle of support at the centre of care and support plans that feature goals and focus on patient strengths and abilities. [16, 17]

Health and Care Landscape: Local Community Needs (Cont'd)

Workforce: Health and social care services (paid and unpaid)

Community members were also asked about the workforce and findings concern both staff and unpaid carers.

Paid staff

Recruitment and retention of staff are a concern for care providers [16, 17] and the public.[11]

Barriers to this were identified as pay and the cost of housing.[11, 16, 17] There was acknowledgement of services being overstretched and consideration towards staff duties shifting to ease pressures, such as having administrative staff free up time for clinical workers.[11]

Unpaid carers

Better support was discussed in terms of providing respite but also ensuring carers are aware of what support is available to them.[11]

Part of a successful service is seen as involving trustworthy, kind and friendly staff who are valued and appreciated, have the capacity to support, and are compassionate.[16, 17, 28]

Health and Care Landscape: Local Community Needs (Cont'd)

How does the CGHN meet these needs?

Simple point of access

Hubs are a simple point of access, offering flexible and inclusive support available in the locality face-to-face or over the phone.

Practical support and advice

CGHN offers practical support and advice that serves to promote wellbeing, independence and better living conditions. Support is personalised and holistic, and a person is an active contributor, for example, to their care plans.

Meaningful activities

Hubs provide activities that facilitate opportunities for people to join meaningful activities affording a sense of purpose and a reduction in isolation.

Prompt support

CGHN supports people to move through the healthcare system promptly, supporting reablement in their communities and homes.

Timely access

The Information, Advice and Guidance (IAG) offer from the gateway supports timely access to tailored information that is accessible to all.

Health and Care Landscape: National and Local

Findings Summary

The consensus among national and local stakeholders is in favour of bringing care into the community, and that the VCSE sector play a key role in achieving this.

Across all stakeholders for whom we have reviewed strategic documents, there appears to be some parallels in priority areas of focus, including:

Personalise, place-based care

What matters to them, not what is the matter with them.

Alleviating system pressure

For example, ambulance call outs, waiting times, discharges.

Sustainability

Addressing financial workplace, and staffing challenges.

Integration and access

Seamless journey through healthcare - particularly for those who face inequalities.

Additionally, there appears to be some key elements of health and wellbeing where there is a consistent focus on:

Prevention and early intervention

Long-term/complex health conditions

Ageing population

Social isolation

Health and Care Landscape: National and Local

Findings Summary (Cont'd)

This review illustrates the appetite and opportunity for achieving channel shift, both locally and nationally, with the aim of supporting people to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care.

The move towards a neighbourhood-based provision provides much hope for individuals' healthcare needs to be better supported within the community setting, leaving hospitals with the capacity to provide specialist care to those who need it.

Further, it is clear to see that the VCSE most certainly has a role in achieving these ambitions, holding the key to delivery of holistic, person-centred care closer to home.

Our primary research further explores the way the CGHN currently delivers this, and what the potential opportunities are for the future.

The consensus among national and local stakeholders is in favour of

Bringing care into community

Research Question One

As it is now, how does the CGHN deliver place-based, person-centred support?

Research Question Summary

Connectedness between organisations

- The CGHN is rooted in knowledge of local needs and other support services available within the local community.
- The CGHN has an important role in developing and nurturing relationships between organisations and the wider system.

Locally shaped

- Community Hubs are shaped from the bottom up, reflecting the priorities and needs of the communities they support.
- Services shaped around the unique needs of Cornwall and its geography.

Personalised support that empowers the individual

- 'What matters most to you' conversation enables support to be shaped around service user needs and priorities.
- Empowering individuals to make their own choices through coaching and through shared decision making.

Diversity of the support offer

- CGHN offers a wide scope of support across their service user's life course.
- CGHN works across wellbeing, social connection, mental health, financial concerns, digital access, and more.

Looking at the person's whole needs

- Support provided is long-term and flexible, to meet people's changing needs over time.
- CGHN seeks to undertake conversations deliberately designed to look beyond the initial presenting need.

Simple point of access

- CGHN provides a simple point of access for support, reducing confusion in how to access services.
- Organisations work together to reduce risk of duplication of effort.

Inclusion and accessibility

- CGHN creates inclusive, welcoming spaces for individuals who may have previously faced exclusion or prejudice.
- Aims to provide an 'open door' policy, where individuals don't have an appointment and can access support face to face or on the phone, as opposed to digitally.

Introduction

To explore this research question, researchers asked a range of stakeholders – including operational Community Hub and Gateway staff, as well as representatives from the VCSE sector – to reflect on how the CGHN currently offers support that is truly place-based, holistic and personalised to the needs of the local community.

Participants were encouraged to think not only about whether this approach was happening in practice, but also to consider the ways in which the CGHN benefits service users, staff, volunteers, partners, and the wider healthcare system.

Where participants did not feel that the CGHN is taking this place-based, person-centred approach, researchers asked them to reflect on what areas were being delivered to a lesser extent, and why this might be the case.

Certain findings outlined in this section reflect differing perspectives with those presented under research questions two (enablers/barriers) and three (channel shift opportunities).

It is important to recognise insights shared in this section were contributed by those who are directly involved in or work closely to service delivery such as VCSE sector representatives and represent how those individuals believe the CGHN currently delivers a place-based, holistic, person-centred model.

Connectedness Between Organisations

Connection

The connection between the CGHN and the community was described by research participants as a key characteristic of how place-based, personalised support is delivered.

Local knowledge

Participants described the services delivered by the CGHN as rooted in their knowledge of the locality and the other services available to support community members.

This local awareness was seen as essential in making support accessible and relevant to the needs of the community.

Community bridge

Participants described Gateway Outreach Workers as a bridge between communities and the Community Hubs, ensuring that local needs are translated into support offers.

Similarly, Community Hubs were portrayed as places where relationships between organisations are developed and nurtured. They not only signpost but also pool resources with other organisations, reflecting a collective effort to provide joined up support.

> ***"The [Community] Gateway is aware of particular services that are operating within that locality, or a particular [Community] Hub that can support that individual. The first point of call will always be to connect them to that community."***
>
> *VCSE sector representative*

Connectedness Between Organisations (Cont'd)

Stitch together

A key element of the Community Gateway is its ability to connect with and "stitch together" a wide range of services and organisations to holistically support an individual's needs – from practical home support to social connection and groups.

This breadth was seen as setting the Community Gateway apart from other access points in the health and care system, which typically focus on one type of service.

Valuable wider connection

Several participants also noted the value of connections with wider systems, such as Integrated Neighbourhood Teams (INTs), in order to identify needs earlier and provide more holistic care.

This was seen as a way of complementing statutory services by drawing on local knowledge and non-clinical forms of support.

"Community Hubs need to be absolutely front and centre of an Integrated Neighbourhood Team… it's that early identification of individual need and then how that can be looked at alongside social care, secondary care and primary care colleagues."

VCSE sector representative

“The services that are connected [to the Community] Gateway are almost limitless… it’s not just about the individual service, it’s about the ability of [Community] Gateway to stitch together a range of services around that individual’s need.”

VCSE sector representative

Locally Shaped

Bottom up

Community Hubs were consistently described as being shaped from the bottom up, reflecting the priorities and needs of the communities they support.

Research participants reported that Community Hubs meet the needs of the locality by tailoring groups, activities and support offers in response to service users' needs.

Surveys and informal conversations were frequently used to shape provision - whether with regards to launching bereavement groups, adapting café menus, or offering activities suggested by parents and young people.

These reflect an approach where communities are valued as active participants in shaping support, rather than passive recipients.

Importantly, services were also discussed as being shaped around challenges specific to Cornwall.

For example, participants stressed the importance of Community Hubs in rural areas, where limited transport and fewer local services make accessibility a key issue.

In these contexts, Community Hubs acted as connectors, enabling people to find support close to home.

> ***"It comes from the community. It's about what the community would like to see in their community and it's about the participants taking a little bit of ownership for what they have got."***
>
> ***Community Hub representative***

Personalised support that empowers the individual

"All [Community] Gateway staff… are trained to start any conversation with 'what matters to you today'?

So, what is it that we could do that might add value to you, in this moment?

And that starts a very personal conversation, which is managed by the individual rather than managed through an assessment or checklist or a form."

VCSE sector representative

Personal approach

Participants reported that a personalised approach is at the heart of how the CGHN supports individuals.

Both the Community Gateway and Community Hubs use 'what matters most to you' conversations, which allow people to shape the support they receive around their own priorities and needs, rather than fitting into set criteria.

Active listening

Further, advisors are trained in responsive listening, able to pick up on what is said and unsaid, using these insights to develop tailored support plans.

This approach was widely viewed as a point of distinction from statutory services, which participants felt often focused narrowly on conditions or eligibility to receive support.

Safe space

A strong theme across participants was the emphasis on empowerment and guided support. Participants described the Community Gateway as creating an approachable and safe space where individuals could share openly, knowing they would be listened to with understanding rather than judgement.

This guided support extended into Community Hubs, where staff and volunteers positioned themselves as coaches and peers, rather than traditional support providers. They worked side-by-side with service users, encouraging resilience, goal setting and personal development.

"I would say we are coaches, we're not support workers… we're working side-by-side with someone and allowing them to build their resilience and look at their own goal setting to help them thrive and develop and meet their outcomes that matter to them."

Community Hub representative

Empowerment

Empowerment was also evident in shared decision making. Community Gateway advisors described involving people in decisions about next steps, ensuring that actions reflected their preferences and capacities.

Empowering individuals further linked to sustainability.

The CGHN's aim is not only to respond to immediate needs but to support individuals in building longer term independence and networks of support.

“The aim is always to help you to help yourself and to become independent and sustainable… create sustainable networks that support you longer term.”

VCSE sector representative

Diversity of the support offer

Diverse offers

Participants emphasised that an important aspect of the CGHN is the breadth and diversity of the support it can offer.

Unlike statutory services, which are typically designed to address one or two specific needs, the Network was described as offering a much wider scope of support.

This is reflected in the availability of support for people across different life stages.

> ***"What you get from the [Community] Hubs is that you get so much added value... it doesn't really matter what somebody walks in with - chances are they're going to find some support."***
>
> ***VCSE sector representative***

Flexibility

Importantly, diversity extended to the scope and flexibility of the support available. CGHN staff described working across wellbeing, social connection, mental health, financial concerns, digital access, and more.

Referrals into the CGHN were reported to vary widely, with requests ranging from hospital discharge and cost of living advice, to simply providing a contact number or signposting to local groups.

Flexibility was seen as essential in meeting the different and often complex needs of individuals.

Community Gateway advisors described the work as "never the same day twice", highlighting the adaptive and agile nature of their roles.

> ***"Referrals can be anything from hospital discharge, social activities, anything to do with wellbeing, finances, cost of living. All those general things that most people are struggling with at the moment."***
>
> ***Community Gateway representative***

Looking at the person's whole needs

Participants consistently described the CGHN as offering support that extends beyond single issues or conditions, instead focusing on the 'whole person'.

This approach was seen as a core strength of both the Community Gateway and Community Hubs, with conversations deliberately designed to uncover wider needs in people's lives.

The Community Gateway was described as undertaking "holistic triage" calls, in which multiple dimensions of people's situations were explored. Community Gateway advisors described these conversations as "looking at the whole picture", valuing the ability to identify both immediate and longer-term challenges.

Community Hubs were also described as settings where people were not defined by a single need, but aimed to be understood as a whole. Participants described open forums and flexible conversations that allowed Community Hubs to respond dynamically to needs.

Staff and volunteers described taking time to get to know individuals, recognising that presenting issues often revealed further, sometimes hidden, challenges. For example, a participant noted:

> ***"We work with people as people. We don't just go in and look at, say, a specific mental health or physical health issue and say, right, well, you need this kind of medication. We look at the bigger picture… they might come along because they think it sounds interesting… but actually then when we get to know them, we find out that they're having some issues at home with cleaning and they're falling behind with their bill payment. And we can then link them in to our community health wellbeing workers."***
>
> ***Community Hub representative***

> ***"We're looking at friends, family, relationships, mobility, finances, accessing support within the community, GP. We're trying to get that bigger picture so that we can really sort of have a good look at what's going on for people and what those barriers might be."***
>
> ***Community Gateway representative***

The commitment to holistic support was also described as long-term and flexible. Community Hub representatives explained that they may begin working with a child and continue to support them and their caregivers throughout key life stages. This continuity of support was framed as central to addressing the evolving needs of families and individuals.

“We’re not looking at a particular service that we’ve got or a particular need or diagnosis that the person has.

We’re looking at the whole of the person, and so we’re more likely to try and find solutions that fit that person’s lifestyle, their abilities, skills that they have and their experiences.”

VCSE sector representative

Simple point of access

One place

A consistent theme across participants was the value of the Community Gateway as a simple, straightforward point of access, with service users and professionals alike benefit from having "one number" or "one place" to contact, reducing confusion around how to access services.

"[For] the service users, it is a simple point of contact."

VCSE sector representative

Reducing duplication

Community Hubs were seen as working in tandem with the Community Gateway to ensure duplication of effort was avoided.

Representatives highlighted that conversations between providers in Community Hubs helped avoid multiple organisations unknowingly delivering the same service, while freeing up resources to reach more people.

"So whilst the [Community] Gateway is more of a centre point, the [Community] Hubs act as that place-based support. They work in tandem as much as they can… you start to reduce duplication. You're not getting three services providing the same support to a person… they just see it as one service."

VCSE sector representative

Clarity and simplicity

For service users, this translated into a sense of clarity and simplicity. Rather than navigating different doors, individuals could walk into a Community Hub and access a broad range of support in one familiar and safe space.

"The main benefit is that all services can be accessed from one [location]… rather than having to go to lots of different organisations, they can come to one place where they feel really safe and they can access all of those different kinds of support that they need."

Community Hub representative

Together, participants underscored how the CHGN can make support simple, accessible, and joined-up.

By reducing duplication of effort and offering a simple point of entry to receive support, it is seen to break down barriers that may prevent people from engaging with help when it is needed most.

Inclusion and Accessibility

A strong theme identified through participant feedback was that the CGHN creates inclusive, welcoming spaces for individuals.

For some, this meant a welcoming environment to talk openly without fear of being judged, while for others it was the simple reassurance of a friendly voice or a warm space.

Participants repeatedly described Community Hubs as places where "the door is always open", contrasting with the sense that many statutory services can feel difficult to access.

> ***"Often lots of doors feel closed, which is why people come to the [Community] Hubs because they know the door is open metaphorically and physically."***
>
> ***VCSE sector representative***

Indeed, participants highlighted how Community Hubs actively welcomed minority and marginalised groups, offering support when they may have faced prejudice in statutory services.

Communities of identity or shared interest (such as unpaid carers, people affected by cancer, or LGBTQIA+ groups) were also thought to shape how people connected to support offered by the CGHN.

This flexibility meant that the CGHN can respond both to local needs and broader forms of belonging, accommodating those who might feel excluded within their area. This was seen as key to building trust and making support accessible to those who might otherwise be excluded.

Ensuring support services are close to home was recognised as pivotal in helping individuals to stay rooted in their communities, while receiving the support they need.

Several individuals expressed how the CGHN works together to "get out into the community", both by visiting service users at home and by supporting individuals to participate more in their communities.

Inclusion and Accessibility (Cont'd)

Participants emphasised the importance of the face-to-face and telephone contact they have, particularly for those who might struggle to engage online or are digitally excluded. These approaches enabled deeper conversations that uncovered needs often hidden in yes/no questions.

> ***"I tend to do my first visit rather than having a form… I do mine as just a general conversation to start with. And that's how I find a lot more out about people than yes/no questions."***
>
> ***Community Gateway representative***

Inclusion was also addressed by small but meaningful acts – such as being available without an appointment, inviting informal conversations in cafes, or creating spaces where people could simply "be".

These examples were described as encouraging people to ask for help earlier, rather than waiting for a crisis. For some participants, the reassurance of knowing that "someone is there" appeared to be central to feeling included and supported.

Overall, these insights illustrate how the CGHN provides person-centred support that is approachable and inclusive. Through safe, welcoming spaces, personalised conversations, and reach to marginalised or digitally excluded groups, they enable people who might otherwise be overlooked to feel recognised, connected and supported.

> ***"I turned my phone on this morning and had a message… to say 'thank you so much, I don't feel by myself anymore'. It is scary for people when you're trying to support somebody you care about, but you don't know yourself which way to go. Just having somebody there for what they feel is sharing it with you, it's a lot of reassurance."***
>
> ***Community Gateway representative***

Research Question Two

What conditions need to be met / barriers need to be overcome to enable the CGHN to reach its potential?

Research question summary

Integration and Connectedness

Barriers

Awareness and knowledge

Awareness and knowledge of the CGHN, its service delivery, and the connections it has could be improved, particularly for those who work in acute NHS settings.

Lack of partnerships

A lack of partnerships between the CGHN and other voluntary and health and social care organisations was noted, with integrating with other providers often found to be challenging.

Lack of shared agendas and strategy

A lack of harmony between the CGHN place-based offer and other delivery or strategic programmes such as the ICB prevention programme, as well as the absence of a common language between sectors, challenge establishing shared agendas and strategies.

Difficulties with data sharing

Data sharing between providers is hampered by a lack of a central digital repository and a common interface between repositories, which compromises the ability to provide holistic patient care.

Referral concerns

Inappropriate referrals and poorly completed referral forms can cause frustration for service users and operational inefficiencies.

Enablers

Visibility

Advertising and marketing of community support could be improved to enhance visibility of CGHN services, supporting stakeholders to develop a comprehensive view of what's on offer whilst minimising overwhelm felt by providers.

Collaborative working

Building on existing collaborative working practices by offering more opportunities for services to co-locate or network was believed to enhance service user experience and outcomes.

Shared agenda / equal partners

Having a shared agenda and working towards the same set of aims was identified as important when working across multiple organisations.

Research question summary

Culture

Barriers

NHS prioritisation of essential clinical care over holistic

NHS prioritisation of essential clinical care can cause barriers in engagement with VCSE holistic models.

Staff perceptions of the VCSE sector

NHS staff perceptions related to limitations of the VCSE offer, concerns that VCSE involvement may negate the pressing need for additional NHS staff, and beliefs that the NHS is responsible for risk management. These perceptions tend to be linked to a resistance towards VCSE integration.

Patient culture

Current patient culture lends itself to a reliance on the NHS as a safe place for care and support, reducing possibilities for service users to take ownership of their own health and engage with VCSE services.

Enablers

Trust

Trust is an important enabler for collaboration and integration across health and social care services. Whilst the VCSE was felt to be well trusted by the local community, there was recognition that this needs to be built with NHS colleagues in particular.

Sharing best practice

Sharing best practice amongst health and social care providers can be an important enabler for inviting change across healthcare, which could help to build the aforementioned trust required to improve integration of CGHN services into service provision.

Research question summary

Service Provision

Barriers

Restricted space

Restricted space, particularly for Community Hubs, can limit the service provision offer to the community

Staff shortages, pressures and wellbeing

NHS and CGHN staff shortages, alongside recruitment and retention challenges, resulted in increased pressure on existing staff, difficulty meeting demand and limited time to deliver person-centred care.

These pressures can lead to a negative impact on staff wellbeing across the NHS and CGHN, leaving staff feeling limited in the support they can provide.

Gaps in provision

Inconsistency and gaps in the services available across different hubs and locations can hamper access to support. Furthermore, the geographically isolated and disperse nature of the Cornwall landscape, alongside a lack of transport options, creates additional barriers.

Enablers

Volunteers enhancing service delivery

Volunteers are a critical resource for community hubs in particular, enhancing service delivery.

Research question summary

Funding

Barriers

Grant administration

Grants are critical for many Community Hubs in ensuring their survival, however, applying for and managing these grants is extremely labour intensive

Limited funds

Limited funding compromises Community Hub service delivery, undermining the sustainability of provision.

Competitive tendering

Competitive tendering also compromises Community Hub service delivery, as well as impacting on the ability of providers to work cohesively, not competitively.

Enablers

Seeking funding from multiple sources

Despite the administrative burden, seeking funding from multiple sources was seen as an enabler to ensuring Community Hubs can deliver services.

Further, Community Hubs also generate income through room rentals, café sales, and admission charges, using the funds to support wider engagement in Hub activities and the provision of extra services.

Fundamentally, the funding model and environment needs to change.

There was a call for joint ICB and council commissioning and investment, as well as utilising a tiered investment model based on the diversity of support provision.

Research question summary

Evidence of Impact

Barriers

Challenges in establishing and reporting on impact

A lack of consistency in impact measures, difficulties in being able to attribute impact, and limitations of reporting on numbers as opposed to qualitative impacts all create difficulties in both being able to manage reporting requirements and demonstrate the value of CGHN services.

Enablers

Measuring impact

Aligning funder reporting requirements as well as the use of meaningful impact measures by the voluntary and health and social care sectors will support efficiencies and system integration.

Introduction

For this research question, operational Community Hub and Gateway staff, VCSE, and NHS representatives were specifically invited to reflect on any enablers and barriers that influence the CGHN's ability to reach its full potential.

The aim was to understand:

- What challenges exist,
- What is already working well, and
- What should be continued or built upon.

Equally, participants were asked to share any enabling factors that were supporting the CGHN to reach its potential.

Researchers also asked questions exploring:

- The extent to which participants felt the CGHN is integrated with statutory healthcare services,
- What conditions needed to be in place to enhance this integration, and
- How important participants felt this integration was overall.

These questions helped to understand both the challenges that exist and the opportunities for strengthening the CGHN's role in the health and care system.

Please note: enablers reflect current support for service delivery, as well as what could be introduced to support the CGHN in reaching its full potential.

Integration and Connectedness - Barriers

A. Awareness and Knowledge

"I think we're just so far removed from a patient's discharge, you can't really plan anything... I think the community hospitals are so much better at identifying what's available because they're local to the local services."

NHS representative

"There's also something about how they're advertised, like where are they, where do you how do you know where they are? So I live in [X] and I've been told there's [a Community Hub at] the Methodist church, but I've seen no signs around mentioning it... So unless you happen to know about them, how do you know about them?"

Council representative

Lack of awareness

A lack of awareness and knowledge towards the availability of the CGHN and VCSE more broadly was commonly reported by NHS representatives in acute care.

The CGHN's support offer and service delivery, and the relationships the CGHN has with the wider VCSE and statutory services were not well understood.
A number of factors were reported as the cause for this, including:

- NHS acute staff not always being involved in patient discharge,
- Staff changes,
- Being immersed in their own role to the extent that the broader picture is not fully considered, and
- The organic nature and variation in service provision by the CGHN.

A lack of engagement by the VCSE with acute hospitals was noted, limiting the exploration of what can be done to support patients in the community. This was felt to be particularly noticeable for psychological services.

Challenge with marketing

Some participants questioned how support available to a locality was marketed.

Several challenges on this topic were raised, including:

- Keeping information on the support offer up to date.
- Establishing and maintaining an awareness of all available support options, which is recognised as being vast.

Indeed, there was a sense of overwhelm given the enormity for a few participants.

Marketing that failed to include details of who services are aimed at (eligibility) and how services can be accessed were highlighted, as was the use of multiple terms to refer to the Community Gateway, which leads to confusion.

Several individuals felt there was a failure to convey a message of inclusive support, with adverts giving the impression that services are geared towards older adults.

Integration and Connectedness - Barriers

B. Lack of Partnership

Representatives from some Community Hubs highlighted a lack of connection with providers, including adult social care, GP practices and allied health professions.

In particular, participants discussed primary care, noting varying levels of appetite to integrate with the voluntary sector. They also shared a perception that this could be due to primary care not identifying strongly as part of the wider community and sometimes prioritising profit, given its structure as a collection of independent businesses.

Furthermore, the voluntary sector can be seen as a competitor by some in primary care, who see funding being lost when the voluntary sector take on duties ordinarily performed by primary care. One concern raised over the increased involvement of the voluntary sector in delivering primary care was the potential for complicating service provision, particularly with respect to patient communication.

Community Hubs reported attempting to integrate with others as sometimes being 'hard work'. Consequently, there is sometimes a focus on connecting with providers that are most receptive.

Overall, having poor or limited connections was identified as an obstacle towards providing support, with the recognition that more people could be supported if Community Hubs were better connected with other providers.

Indeed, one VCSE sector representative spoke of how better integration between voluntary organisations would be a 'game changer', exemplifying integrated neighbourhood working and providing a greater offer to the health and care system.

There was also recognition that the Community Gateway and its partners could use Community Hubs more to maximise the overall support offer.

A lack of a congenial working relationship between voluntary organisations was also noted by a council representative. This was observed when the representative attempted to follow up on impact data with a view to discussing how this could be improved. In response to this, the organisations they spoke to deflected responsibility, making it difficult to establish who they needed to engage with.

"Primary care doesn't sit in the same contracting model as the rest of the NHS. They are businesses, but they are a function that as the voluntary sector, and as communities, we need to and want to integrate better with...

There are different levels of desire to integrate with communities and with the voluntary sector... Some general practice and some primary care networks don't see themselves as an asset of their community. They are a business that sits in a community, and they run for profit."

VCSE sector representative

"There should be a much better link up with adult social care. So we all work to try to achieve that. There's no link with the [Community] Gateway at all. For me, the systems bit behind the [Community] Hubs [aren't] working in the way that [they] could."

Community Hub representative

Integration and Connectedness - Barriers

C. Lack of Shared Agendas and Strategy

The place-based and organic nature of the support offered by Community Hubs was highlighted when alignment with programmes and agendas were discussed.

It was reported that the continuation of retaining a unique service offer, whilst also feeding into strategic priorities such as the ICB prevention programme, will be a transition.

The role of Volunteer Cornwall in uniting the Community Hubs under key themes and aims, despite their diverse service offer, was acknowledged as an achievement.

However, the diverse offer of Community Hubs remains a challenge in communicating a universal message regarding available support.

A lack of a common language was highlighted between health and social care and the voluntary sector, with health and social care reportedly frequently using health codes to communicate, which is not accessible to all stakeholders.

The voluntary sector also spoke of needing to anticipate future strategic direction and priorities of statutory services to inform CGHN service delivery when strategies aren't shared in a timely manner.

In such cases, where there is misalignment, the voluntary sector has to respond in an agile manner.

"Shared language would be another thing. Because health and social care have their own language, GP's have their own language, and hospitals have their own language... and they all talk about codings... But actually, if somebody has got a respiratory condition, it doesn't matter whether they're in hospital, whether in a Community Hub, whether talking to the GP. Ultimately, it's a respiratory condition...

Why can't we use common language and just keep it text based, because again, I think that will start to break down the barriers. The voluntary community sector doesn't use any health codes at all. We are all text based; we tend to use language that the people we work with would use."

VCSE sector representative

Integration and Connectedness - Barriers

D. Difficulties with Data Sharing

"We need to be working smarter, not harder.

"So, looking at how we transform the use of our IT systems and also looking at how we interface with other organisations, looking at getting case management systems to talk to each other, and how we then get that to link in with statutory systems.

"How can we get them to interface, particularly with the roll out of neighbourhood health and the Integrated Neighbourhood Teams?"

VCSE sector representative

Not having a centralised digital repository and an interface between repositories held by statutory services and the voluntary sector was a common barrier towards data sharing among those who were interviewed.

Moreover, although having shared access to the Community Gateway customer relationship management system enables Community Gateway partners to access data, the system was described as cumbersome. Not having sufficient funding means alternatives can't be explored and a lack of sufficient capacity means there is no time to dedicate to investigating how the system could work better.

Being unable to share data was positioned as a challenge for holistic healthcare, with providers having access to limited patient history at the point of care.

This also prevents a full picture being established of what services a person has previously accessed across the voluntary and health and social care sectors.

Existing contracts requiring data sharing agreements and data protection impact assessments facilitate data sharing for some.

Requests for a database covering support available in the community was also mentioned. However, researchers also heard that the organic and dynamic nature of this support precludes the provision of this.

"One of the biggest issues for the work that we've been trying to do around transformation [includes] PCN, ICB, CFT, VCSE system interoperability, actually getting systems that talk to each other.

The VCSE has lots of different ways of recording its information and I don't think you are ever going to find... one solution for that. So actually, having a shared record... [as] a patient would be really challenging."

NHS representative

Integration and Connectedness - Barriers

E. Referral Concerns

Inappropriate referrals were discussed in the context of the Community Gateway receiving referrals that they are not able to support, and in some cases, the referring organisation being better placed to provide support.

Service pressures were thought to contribute to such cases, which lead to a backlog for the Community Gateway.

Completion of referral forms to the Community Gateway can sometimes be limited with only basic information being provided, which can be frustrating for service users who then need to share their information with multiple providers.

The process of referring cases was also discussed. Thought to reflect the action of the referrer submitting referrals to multiple organisations indiscriminately, there have been repeated instances of a provider following up with a service user, only to find that another provider has already intervened. Removing this duplication would afford greater capacity to offer support to others.

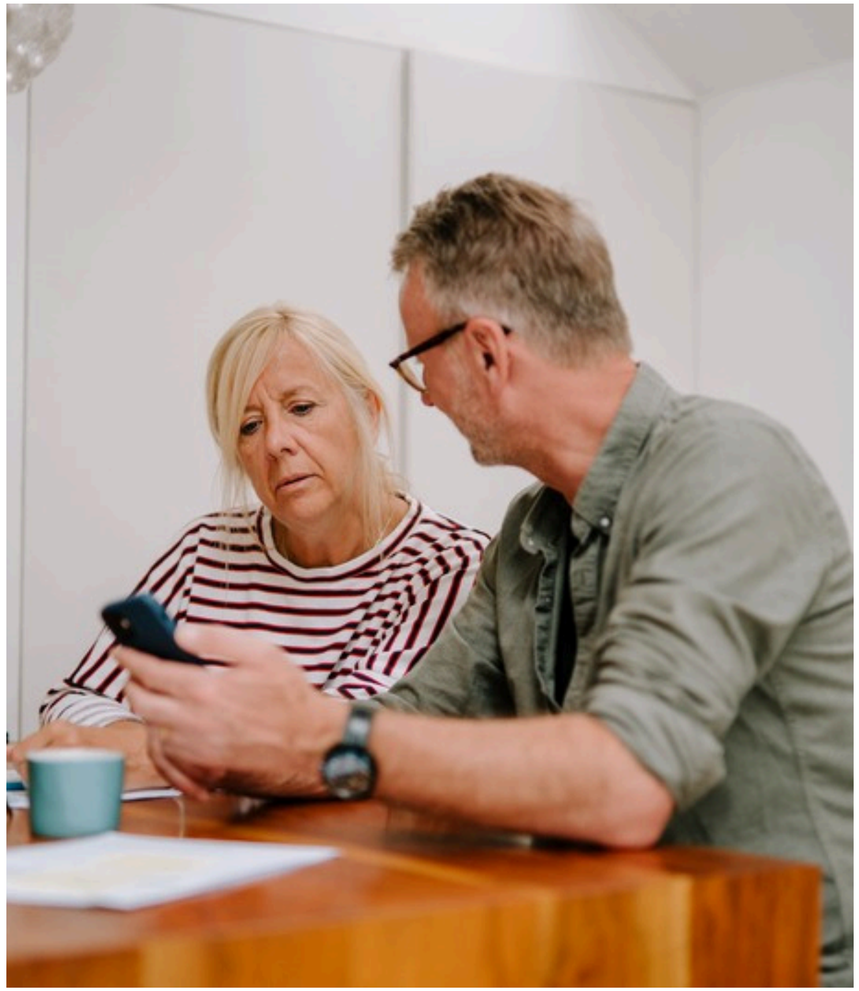
A lack of feedback after submission of a referral was emphasised by NHS representatives.

The absence of feedback leaves staff wondering whether a case has been followed up and impedes further referrals from being made due to a lack of confidence towards action being taken.

Participants highlighted that feedback should be provided following a referral that makes clear the appropriateness of the referral and details what support has been offered.

Integration and Connectedness - Enablers

A. Visibility



There were multiple suggestions as to how CGHN service delivery could have greater visibility.

These included:

- Acute hospitals holding 'in-reach' events where representatives of the voluntary sector visit clinical areas in hospitals to meet patients.
- Building links with staff and raise awareness of what support from the sector could look like.

Similarly, having NHS staff from Medical Directors to Healthcare Assistants visit voluntary sector organisations to observe how the work and impact they make has the capacity to "change mindsets". However, it was acknowledged that taking time away from work duties can be challenging due to pressures.

Marketing the support available from the CGHN was also discussed and it was suggested that this should be broad to capture different audiences - for example, leaflets in supermarkets or digital displays in GP practices. The provision of a database or a list to provide a record of service providers in the area and their contact details was a further suggestion.

> ***"Having some sort of method to get [clinicians] to be able to go out for the day and see [the] change [that] can happen in the community. That could change a lot of mindsets…***
>
> ***It needs to be from medical directors down to healthcare assistants - having that ability to look at… what can happen if we do things differently - that would be something that could change a lot of minds."***
>
> ***ICB representative***

Integration and Connectedness - Enablers

B. Collaborative Working

Service providers operating from Community Hubs are seen as complementing their service delivery.

This is recognised as a significant benefit to the overall support offer. In such instances, GPs, nurses, mental health and wellbeing teams treat Community Hubs as a base from which to support people in the community, enabling strong links between providers to be forged.

Cross referral such as Community Hubs escalating cases when more specialist support is required, is also recognised as an advantage of this style of working.

With respect to patient discharge, the voluntary service was acknowledged as contributing through participating in multi-agency support led by the NHS.

> ***"The wellbeing teams that are run outside in the shed by the local PCN are purely NHS funded... They'll quite often refer people into projects that we run purely with our own staff, as well as other organisations that hire the space at the centre, and that works reciprocally as well... we can refer people out to them who are really struggling with acute mental health."***
>
> ***Community Hub representative***

Volunteer Cornwall was praised for creating an ecosystem that supports service users to feel confident and safe, as well as connected to a community.

The contribution of Community Makers to facilitating connections was also highlighted due to their comprehensive knowledge of local providers and support, their expertise in signposting, supporting networking and mentoring, and advertising training opportunities.

> ***"I think the networking opportunities that we give the [Community] Hubs [for example]... mini road shows... [are] invaluable... One of my [bigger] [Community] Hubs... has given some mentoring to a smaller [Community] Hub, [sharing information on] things that they've found that have worked for them and helped them. So as well as having us on hand, there's also peer mentoring and training."***
>
> ***Community Hub representative***

Integration and Connectedness - Enablers

B. Collaborative Working (Cont'd)

With respect to INTs, Community Hubs are seen as being a key player given their place-based support offer.

Bringing the Community Hubs' knowledge of local needs and effective ways to promote health-related changes together with NHS population data on health outcomes and inequalities is seen as critical to improving neighbourhood health.

As for reducing demand on NHS services, involving the VCSE during an initial needs assessment of patients could mean appropriate support is offered within the community, thereby reducing demand on NHS services. Similarly, there was also a call to involve community services in the process of referring patients. This would afford the opportunity for the needs of the patient to be prioritised and for assistance to be offered in the community, as appropriate, to meet their holistic support needs.

> ***"At the moment, any assessment of that person's health requirements is only done by the NHS. So, they have a particular focus on how could the NHS help people. Sometimes they overprescribe NHS support…***
>
> ***They don't have that holistic picture… [If the Community] Gateway worked with them much earlier than we do at the moment, we could probably stop some of the interventions that the NHS deliver because they are perhaps not required."***
>
> ***VCSE sector representative***

"I think the danger of the Integrated Neighbourhood Team development is that we just have another group of practitioners in a room together, dreaming up solutions for our community when actually what we need to be doing - and I think that VCSE is really well placed to do this work... - is going out there in communities with our VCSE organisations who know their communities well, and having those conversations.

Because some of the [Community] Hubs will be able to tell you what their communities feel and want, and that needs to be pulled together with what NHS data is telling us about the local population in terms of... health outcomes [and the] inequalities faced."

VCSE sector representative

Integration and Connectedness - Enablers

C. Shared Agenda / Equal Partners

"I think it's really important when you work with more than one organisation that you feel like you're all [on] the same team - that you're not feeling like you're pulling against each other… to be on the same page with things."

Community Gateway representative

A shared sense of identity achieved through feeling like you're 'on the same page' and working towards the same set of aims was identified as important when collaborating with different partners and organisations.

Having similar approaches to the management of patient risk was also recognised as conducive to partnership working between the voluntary sector and primary care, this being evident during Living Well programme delivery.

Furthermore, framing support around the priorities of other services help partners to better understand the support offer of the voluntary sector. Council representatives also suggested Community Hubs could hold outreach and networking sessions with other providers to share current work and any associated outcomes and challenges.

The importance of a shared agenda was highlighted in discussions about the CGHN taking a greater role in reducing demand on statutory services, with research participants specifically requesting that clear expectations be established among all parties.

Consistent with this, council representatives felt that it would be helpful to focus on creating a mutual understanding across the sectors of what is to be achieved by greater involvement of the CGHN, allowing for shared ownership and partnership working.

"It's [a question of] how we bring everyone together with those different cultures.

It's always going to cause friction… but actually, it's all of us together creating that shared ownership or shared understanding of what it is we want to achieve … And it's understanding what people's remits are and what they can and can't do."

Council representative

Culture - Barriers

A. NHS Prioritisation of Essential Clinical Care Over Holistic

Deeply ingrained NHS practices and perceptions prioritise traditional models of healthcare.

Research participants highlighted that time and resources are generally directed towards a reactive, clinical and treatment-oriented approach to healthcare service delivery over more collaborative, preventative and person-centred models of care.

This leaves little time for recognition of the value of non-medical interventions that prioritise the holistic needs of patients and could reduce demand in the longer-term.

There was recognition from participants that this traditional medical-focused approach to healthcare leaves the NHS in a “firefighting” position.

In contrast, the CGHN tends to adopt a more person-centred approach, that is often sustained and has greater benefits in the long-term.

Some VCSE sector representatives felt that it can be problematic trying to support NHS colleagues to understand and embrace person-centred approaches.

> ***“Sometimes [within] hospitals, a very specialist surgeon will see the clinical problem. They'll see the diagnosis… they don't have the time for the human element.***
> ***And the human element is what [the] voluntary sector does best.”***
>
> ***ICB representative***

> ***“Where we can make the biggest difference is [increasing] the recognition of the value that non-medical or non-care-based interventions can make across all services… The knowledge of those existing services would [then] grow because you wouldn't have that closed thinking. I think [with] a lot of existing services… minds aren't open; the culture isn't open to alternative thinking.”***
>
> ***VCSE sector representative***

Culture - Barriers

B. Staff Perceptions of the VCSE Sector

Research participants reflected that NHS staff can be risk averse with regards to utilising services delivered outside of statutory healthcare, linked to perceived limitations to what the VCSE can offer, but also concerns that introducing more VCSE involvement may negate the pressing need for additional NHS staff.

Participants shared that they felt these issues with staff perceptions can tend to be linked to a resistance to getting people and practices to embrace change.

> ***"The biggest issue with anything like this is change and getting people to change... They've been in the same jobs for a very long time... and I sometimes think that can be a bit of a barrier... I think it's sometimes the attitude [of] 'we've tried that'...[but] they tried it 10 years ago – we can try it again."***
>
> ***Council representative***

Perceptions that there is a lack of trust amongst statutory healthcare services and the CGHN sector further reinforces this barrier, with VCSE sector representatives sharing that there is a paternalistic attitude in the NHS, with a tendency for NHS colleagues to want to do things themselves to the detriment of utilising CGHN services fully.

It was felt amongst participants that this was related to the NHS feeling responsible for risk management and wanting assurances from services that patients will receive the support they need following discharge.

> ***"I don't feel that we're linked in [sufficiently] with voluntary services - that we have any assurance that patients' needs would be met if they were to go home, and hence why we refer to services that we know will confirm and meet those needs before [individuals] go home."***
>
> ***NHS representative***

Culture - Barriers

C. Patient Culture

NHS representatives reflected that that the public need to take increased ownership for their own health, recognising that reliance on hospital-based care remains high.

Participants highlighted challenges with attitudes and behaviours amongst patients, where many perceive hospitals as the more secure option - which could explain why the public look to seek support from NHS services.

Conversely, Community Gateway representatives shared that older populations, in particular, may be reluctant to contact care providers, which tends to stem from perceptions of not wanting to be a burden to healthcare providers.

There was acceptance from NHS colleagues that integrating more VCSE support across the patient journey could encourage individuals to take control of their health and increase accountability, whilst reducing their reliance on health providers.

However, there was recognition amongst VCSE sector representatives that the CGHN can get caught up in a "rescuing" approach, which can cause service user dependence and drive demand to services.

Therefore, careful consideration of service utilisation versus self-management needs to be given to avoid overreliance on both CGHN and statutory support services, whilst also ensuring patients are receiving sufficient care.

> ***"I think [the voluntary sector] could help along any patient journey... if that's within a hospital setting, clinic setting or in the patient's home... If a patient turns up to a health setting and a health provider is there, then there's room for the voluntary sector to also be helping."***
>
> ***NHS representative***

Culture - Enablers

A. Trust

Research participants suggested that trust is an important enabler for collaboration across the sectors.

It was noted that for effective communication to work across sectors, there must be an element of trust and transparency, along with recognition that “this is your area of expertise”.

There is an observation that communities trust the VCSE sector, which could be attributable to the perception that the VCSE sector is closer to communities and has more of an in depth understanding of local needs - which supports relationship building, reputation and credibility.

This trust needs to be acknowledged and built upon across the healthcare sector, so it too can build relationships with the VCSE sector.

Furthermore, it was suggested that the system should support service users to have a choice with regards to how their needs are met and the service(s) they receive.

This was linked back to service users having some autonomy via ‘what matters to me’ conversations and ultimately having choice as to whether they go down a medical or a community model route.

B. Sharing Best Practice

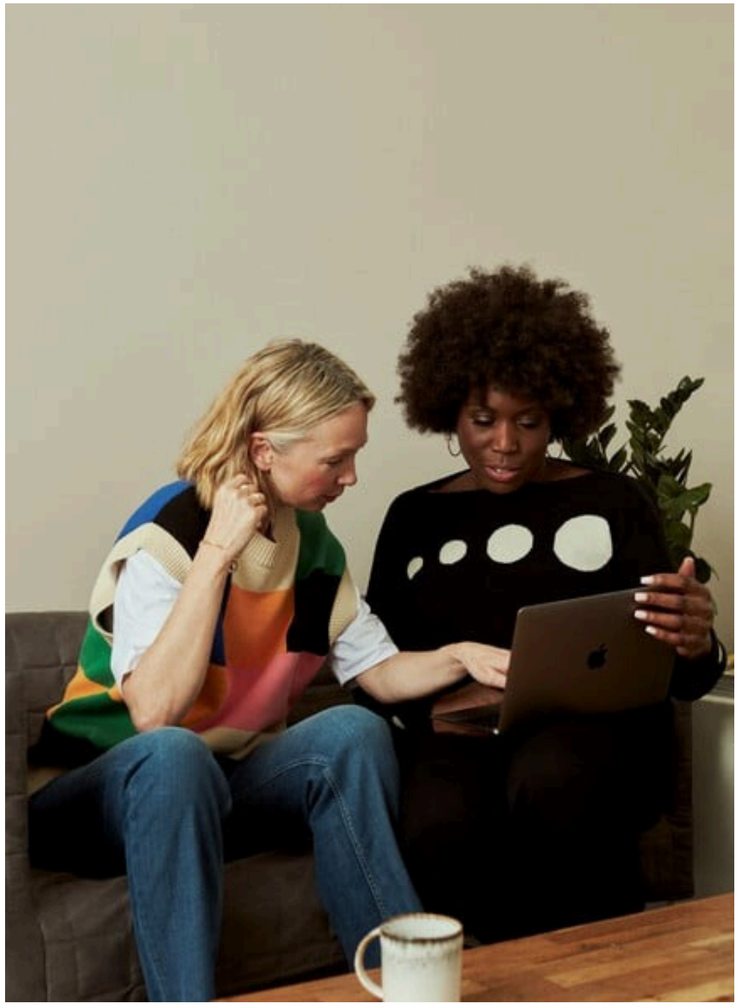
Sharing best practice was emphasised as an important enabler for inviting change across healthcare, which could help to build the aforementioned trust required to improve integration of CGHN services into statutory service provision.

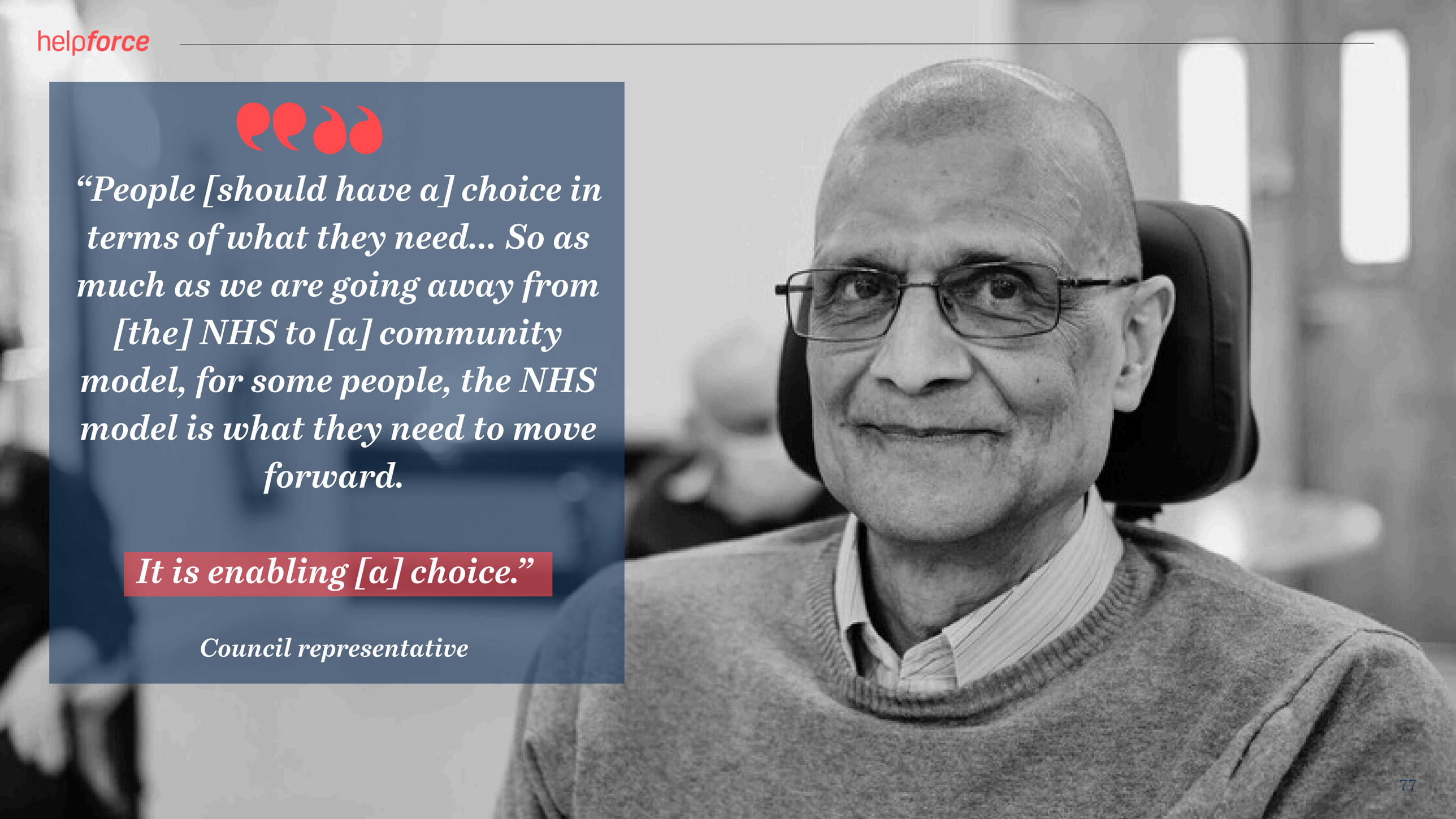
There was recognition that current practices do encourage a ‘lessons learnt’ approach to continuously improving and ascertaining what has worked well versus what has not worked from other models.

The Social Prescriber, Community Health and Wellbeing, and Learning Development roles that exist out in the community - “knocking on doors” - were recognised as pivotal to bringing services together and sharing information and experience across the sectors, which subsequently adds benefit to the CGHN.

It was also noted that more people are being seen with increasingly more complex cases, and it is important that models of best practice are shared to ensure that the staff or volunteers supporting patients have access to the right training and tools to foster confidence.

Furthermore, some ideas were shared around VCSE-led learning programmes delivered to NHS staff to encourage shared learning.





“People [should have a] choice in terms of what they need… So as much as we are going away from [the] NHS to [a] community model, for some people, the NHS model is what they need to move forward.

It is enabling [a] choice.”

Council representative

Service Provision - Barriers

A. Restricted Space

Restricted space was a prominent theme amongst Community Hub staff participants.

This was highlighted in the context of how having restricted physical space and smaller Community Hub size can limit community service provision.

It was recognised that if there was more space, there would be more physical resource and capacity to deliver healthcare services from the Community Hubs.

For example, some participants shared wanting more space to deliver services such as exercise groups, community acupuncture, and blood donations.

> ***"We would certainly like to have the space and the ability to be able to offer more community yoga groups or community acupuncture - those sorts of things where we can look at the bigger picture holistically or just provide more services."***
>
> ***Community Hub representative***

B. Staff Pressures and Wellbeing

Community Gateway representatives shared the difficulties in keeping up with increasing demand.

This can lead to frustration, with some staff describing a "soul destroying" feeling when they have not reached their target and people are waiting for support.

Community Hub staff representatives reported similar frustrations with trying to keep up with the demand for services, whilst providing the best quality of support for their service users.

With regards to NHS colleagues, they reflected that the values of the Trust do not always correspond with the demands required. Current pressures prevent staff from providing optimal care, which often conflicts with the values underlying why staff choose to work in the NHS.

It was also highlighted that these demands can lead to frustrations for patients, which can leave staff feeling disappointed and as though they have "not done enough".

As was reflected upon within the earlier 'awareness and knowledge' sub-theme, the pressures experienced by staff were felt to lead to an immersion in their own roles and responsibilities - therefore not having capacity to absorb further information or build relationships outside of their immediate responsibilities.

> ***"They have just got to get the jobs done and then move on to the next patient. And it does not look great. It does not feel great for patients.***
>
> ***"And often that is where the complaints will come in from... because [patients and their families] do not feel like we are giving the best care that we can. And it makes us really sad, because [we] do not come to work to give suboptimal care.***
>
> ***"But sometimes when we have so many patients that are really poorly and not enough staff - actually that's all we can do."***
>
> ***NHS representative***

Service Provision - Barriers

C. Staff Shortages

Staff shortages were raised as a challenge across both statutory healthcare services and the CGHN. While the demand for healthcare resource continues to rise to meet growing service pressures, staffing levels have not kept pace.

With NHS teams reflecting that they are stretched thin and unable to meet demand effectively, staff are often required to “wear many hats” and take on roles outside of their core responsibilities.

These additional pressures on professionals are felt to impact on patient experience and result in prioritisation of essential care as opposed to person-centred support, as was identified in the earlier ‘NHS prioritisation of essential clinical care over holistic’ sub-theme.

Further, community NHS representatives discussed their staff shortages can lead to acute admissions where referrals are not able to be picked up quickly enough.

Comments were also made around the delay between training NHS staff once recruited and then being able to fulfil role requirements and provide care for patients.

With recruitment and retention problems at the heart of staff shortages, both the NHS and CGHN representatives shared that they are facing high levels of staff turnover, with difficulties maintaining a stable workforce.

Inflexible hours

The shortfalls in the NHS were partly linked to funding but also to the lack of desirability of working in the NHS - notably the lack of appeal of long working hours.

Narrow recruitment models

Furthermore, current recruitment models in the NHS tend to focus narrowly on medical qualifications rather than recognising the value of broader skillsets, which can limit opportunities to diversify and strengthen the workforce.

This impacts the overall quality of health services.

Limited capacity vs growing demand

Additionally, capacity issues were frequently raised across CGHN participants. The Community Gateway is growing year on year and the need for increased resource was highlighted to cover this demand, whilst also ensuring the 72-hour response rate criteria is met.

Limited funding affecting retention

Furthermore, the current funding landscape was raised as a blocker for CGHN staff retention.

This was linked to the delay between staff waiting to be told that their contract has been extended and looking for a new job in the meantime to ensure their personal financial stability.

These funding challenges are further explored in the later ‘funding’ theme.

“The first challenge is not having enough resources to actually deliver the care.
There is only so many staff and they have a large area to cover. Once they are full, they are full - and so we are turning down referrals, which can lead to people getting admitted because we cannot provide the care in a hurry to prevent them going into hospital.”

NHS representative

“When we employ anybody, we then have to train them, and it can take up to nine months. So even if we do get that recruitment process moved along quite quickly, it actually doesn't fulfil our requirement [in terms of] providing treatment and care for patients at that moment.”

NHS representative

“Funding is always a huge one, which indirectly or directly leads to retention of staff. We've got a poor track record in Cornwall for notifying people when the contracts are going to end or be extended. People get nervous near the end of a contract and it's always the good people that go first and then after they've all left, you get told you've got a contract extension, but you've now got no staff left to deliver against it. So that's always a hurdle.”

VCSE sector representative

Service Provision - Barriers

D. Gaps in Provision

It is commonly recognised that service users often seek support outside of CGHN hours.

A desire for 24-hour services available to the local community was raised, based on the perception that people should "always have a place to go" in a time of need.

There was also acknowledgement that some geographical areas have more support services on offer than others, with the question raised – "it isn't about whether the Community Hubs can do more, but rather whether there are enough Community Hubs."

It was felt amongst participants that there was a service provision gap in the East of Cornwall, which can subsequently make it harder from a referral perspective when community services do not exist to signpost to.

> ***"People are not unwell or lonely 9am to 5pm, Monday to Friday. More 24-hour support [is needed or] even [a] crisis alternative. So even if I am feeling like I am in crisis at 2:00am in the morning - I might make a call to Samaritans. I might [attend] A&E - but wouldn't it be nice if I could just go somewhere and have a cup of tea with somebody?"***
>
> ***NHS representative***

Furthermore, transport issues were raised frequently across participants. These included lack of transport, unreliable transport, difficulties allocating resource for transport, and limited public transport options - therefore making it challenging for people to access Community Hubs or NHS support.

It was noted that much of this is related to the Cornwall landscape being geographically isolated and disperse, with many Community Hubs being located in rural locations.

Additionally, seasonal fluctuations, for example during the summer holiday months, can cause heavy road traffic, with demand impacting local people accessing healthcare services.

It was frequently acknowledged that these transport issues do cause restraints on what could be delivered via the CGHN and that if more resource was allocated towards transport, then it could enable a greater number of people to receive the support they need.

Service Provision - Enablers

A. Volunteers Enhancing Service Delivery

The importance of volunteers was highlighted as crucial to enhancing service delivery, with Community Hub staff representatives in particular highlighting that they would not be able to deliver the Community Hub services without their volunteers.

Further, CGHN representatives discussed the idea of creating career pathways across the VCSE sector. Suggestions such as a 'VCSE passport' would allow volunteers to move between organisations, gaining diverse experience and building their skillset.

It was believed that staff who want to progress onto different roles could also benefit from this type of training and exposure. For people using services, it was believed that this would translate into more skilled, confident, and consistent support across services, as staff and volunteers can bring learning from different contexts.

> *"We've got seven members of staff, but they're all part time. So that equates to three and a half full time equivalent.*
>
> *You can't run a Community Hub with just three people - we'd be nothing without our volunteers."*
>
> *Community Hub representative*

Funding - Barriers

A. Grant Administration

This sub-theme concerns key stages of the grant administration life cycle including application, monitoring and reporting.

For many Community Hubs, grants are seen as a lifeline that enable them to deliver against their objectives and priorities when supporting their communities.

Limited capacity and capability

Researchers heard from some Community Hub participants that they spend a lot of time writing grant applications and that grants feel like they are increasingly harder to obtain.

It was also recognised that not all Community Hubs have expertise in funding bid completion or capacity for completing applications, which can have an impact on success rate.

This is particularly problematic when Community Hubs are in competition with national charities who have staff with expertise dedicated to applying for funding bids.

Funding review meetings

Misalignment between the undertaking of and expectations towards funding review meetings was also reported. Consideration towards milestones met, current work plans, and strategy development are seen as being particularly helpful in this context.

Challenges with grant management

There were many accounts of Community Hubs benefiting from multiple grants simultaneously to support service provision, in addition to their core funding received from the ICB. Such instances create a lot of work for Community Hub teams to undertake with respect to grant management, monitoring, and evaluation.

Funder reporting requirements

Moreover, it was noted that there are differences in funding reporting requirements - some being more onerous than others. Responding to these differing requirements can take up a lot of time and compromise capacity for service delivery.

There was also an account of a Community Hub applying to the ICB for the minimum funding level to keep reporting requirements manageable with respect to the amount of time and effort needed to action these.

The Coronavirus Outbreak Management Fund made available to the voluntary sector during the pandemic was presented as being an exception, with light touch reporting requirements. Since then, it is felt that the funders have reverted to more labour-intensive reporting requirements.

> *"We probably have about between*
>
> ***30 and 35***
>
> *open grants at any one time... that's a hell of a job for the team to manage and monitoring and evaluation, so on and so forth."*
>
> *Community Hub representative*

Funding - Barriers

B. Limited Funds

Limiting funding availability creates a sense of precariousness for many.

Participants shared their perception of the funding landscape as being challenging for the voluntary sector currently and their sense that there is less funding available now than in previous years.

The growth of the Community Hub Network is seen by some as contributing to there being less funding available. Reassessing future expansion intentions and having a development plan that covers how all Community Hubs can be funded properly were proposed.

Limited funding availability

Fundamentally, the limited availability of funds is thought to restrict the potential of the CGHN by putting a strain on resources.

As was referenced in the earlier 'staff shortages' sub-theme, limited staff numbers for some Community Hubs restrict the extent to which personalised support can be delivered to those in the community, as well as the expansion of Community Hub opening hours.

Indeed, Community Hubs have been seen to scale back their support offer whilst they sit and wait for the next round of funding opportunities.

Furthermore, there may be a greater limit on the availability of funds in larger Community Hubs, where greater levels of footfall equate to less funding per service user.

Service interruption

Participants also shared limited funds can result in a pause in the delivery of a service or even a service being decommissioned.

This can be frustrating, particularly for providers when a service is known to have delivered impact and for service users who benefited from participation. This can also result in an erratic start-stop model of service delivery.

Funding distribution decisions

However, contrary to the idea of limited funds at funders disposal driving constraint, the issue may have more to do with funding distribution decisions. This suggests additional funds could be available if different decisions are taken.

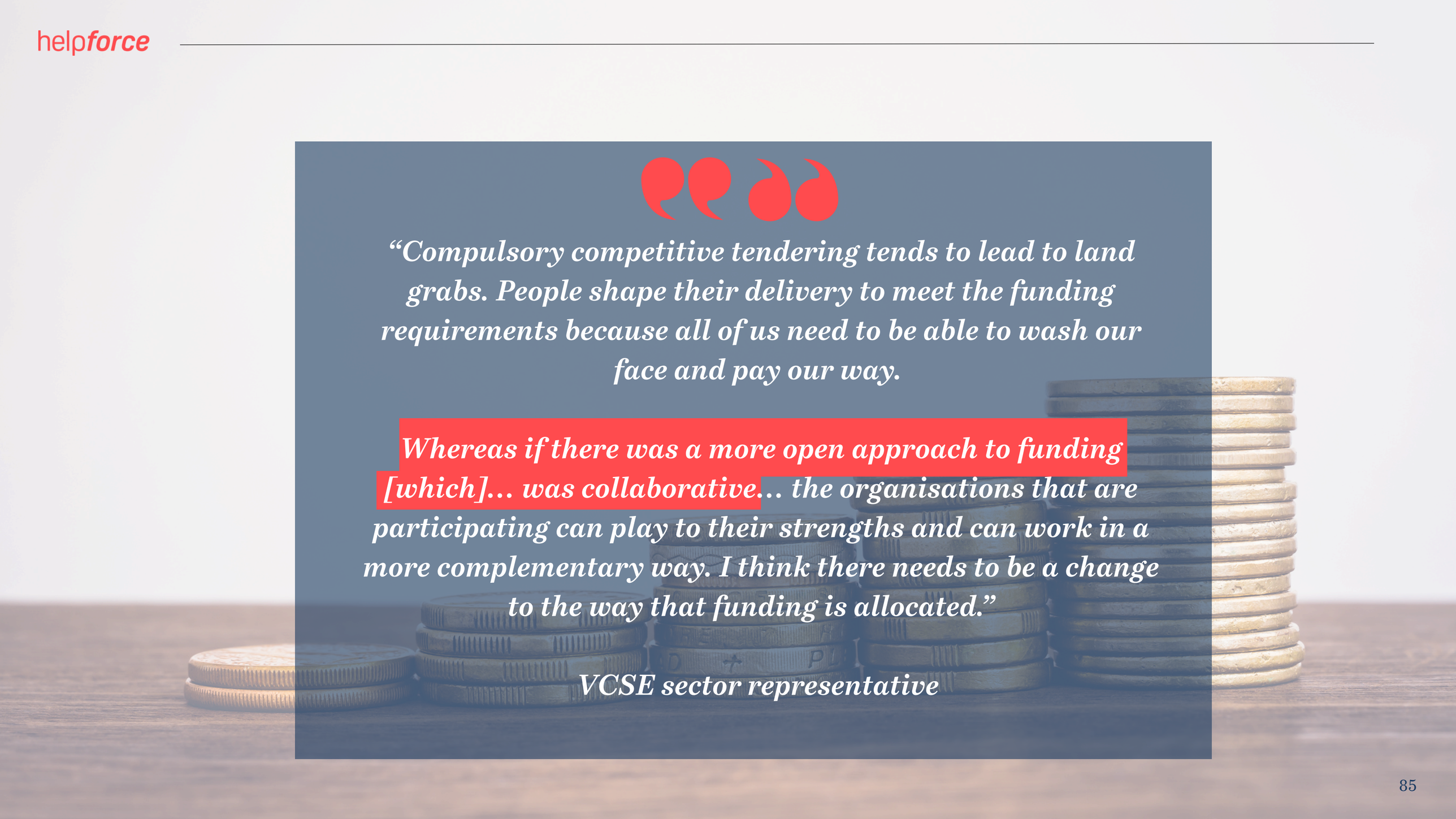
C. Competitive Tendering

The need for a cultural change away from competitive compulsory tendering was strongly conveyed.

This approach to funding in voluntary organisations can result in a narrow focus by prioritising how best to meet funding requirements and being fearful that working collaboratively may affect funding eligibility.

It also causes concern for those who refer into voluntary organisations, who feel effective signposting doesn't happen due to the competition that seemingly exists between voluntary sector organisations.

If tendering was more open and fostered collaboration, organisations could 'play to their strengths' and develop complementary offers that lead to a better spread of services.



"Compulsory competitive tendering tends to lead to land grabs. People shape their delivery to meet the funding requirements because all of us need to be able to wash our face and pay our way.

Whereas if there was a more open approach to funding [which]… was collaborative… the organisations that are participating can play to their strengths and can work in a more complementary way. I think there needs to be a change to the way that funding is allocated."

VCSE sector representative

Funding - Enablers

A. Seeking Funding From Multiple Sources

As discussed under the 'grant administration' sub-theme, grants are a vital means of support for Community Hubs, with service provision being reliant on these for many.

Funds received through grants also support Community Hubs to cover their core costs

Researchers heard from many Community Hub representatives that they are the recipients of multiple grants simultaneously, with some taking a strategic approach towards applying for grants in an effort to enhance the probability of being successful.

It was felt that the VCSE having a closer commissioning relationship with the council would be useful.

There was also discussion on the potential of the Community Gateway, which receives flat funding, to explore additional funding opportunities to meet resource demands.

> ***"We try spread it out as much as possible for us and we'll probably do better than in some other [Community] Hubs because there is less funding [being awarded to them] maybe."***
>
> ***Community Hub representative***

As well as funding from the ICB and grants, some Community Hubs also raise funds in-house through renting out some of their rooms/space to organisations, selling food and drink in Community Hub cafes and via charging for admission to activities offered.

There were accounts of these additional funds being used to provide extra services to service users as well as facilitating their engagement in paid activities, which they might otherwise be unable to afford.

> ***"The cafe income is what keeps us going and that covers the wages and the running costs of the building.***
> ***The [Community] Hub funding for us has been… a bonus, which we now have become reliant on to be able to offer those extra services – heating, free activities to encourage more people through the door, free cups of tea at cuppa companions, where you can come in and have an afternoon of entertainment, Golden Oldies.***
>
> ***But is it enough? No, we could always do more."***
>
> ***Community Hub representative***

Funding - Enablers

B. Funding Model and Environment

Central to this sub-theme is a call for the current funding model to be changed and based on what barriers and challenges were reported by participants, there are a number of suggestions as to how this should change.

Tiered investment

The amount of funding awarded to Community Hubs should follow a tiered investment model to reflect the diverse nature of support provision and the different skills and capacities available.

Furthermore, funding should be sensitive to the different financial and resource baselines of Community Hubs.

More timely

The commissioning process should be expedited so that service delivery is able to respond to the needs of the community in a timely manner instead of there being a significant delay between strategy development and delivery.

Significant delays result in service delivery that reflects outdated priorities and strategies. Where this isn't possible, contract holders should be able to adapt and update commissioned work plans to ensure provision is fit for purpose.

Bespoke support and collaboration

The funding model should accommodate and promote the bespoke nature of Community Hub support to a greater extent, affording continuity in support to address local priorities and needs.

Moreover, there needs to be a shift in focus away from treatment towards prevention. There should also be scope to fund joint working between Community Hubs, who would coordinate local support.

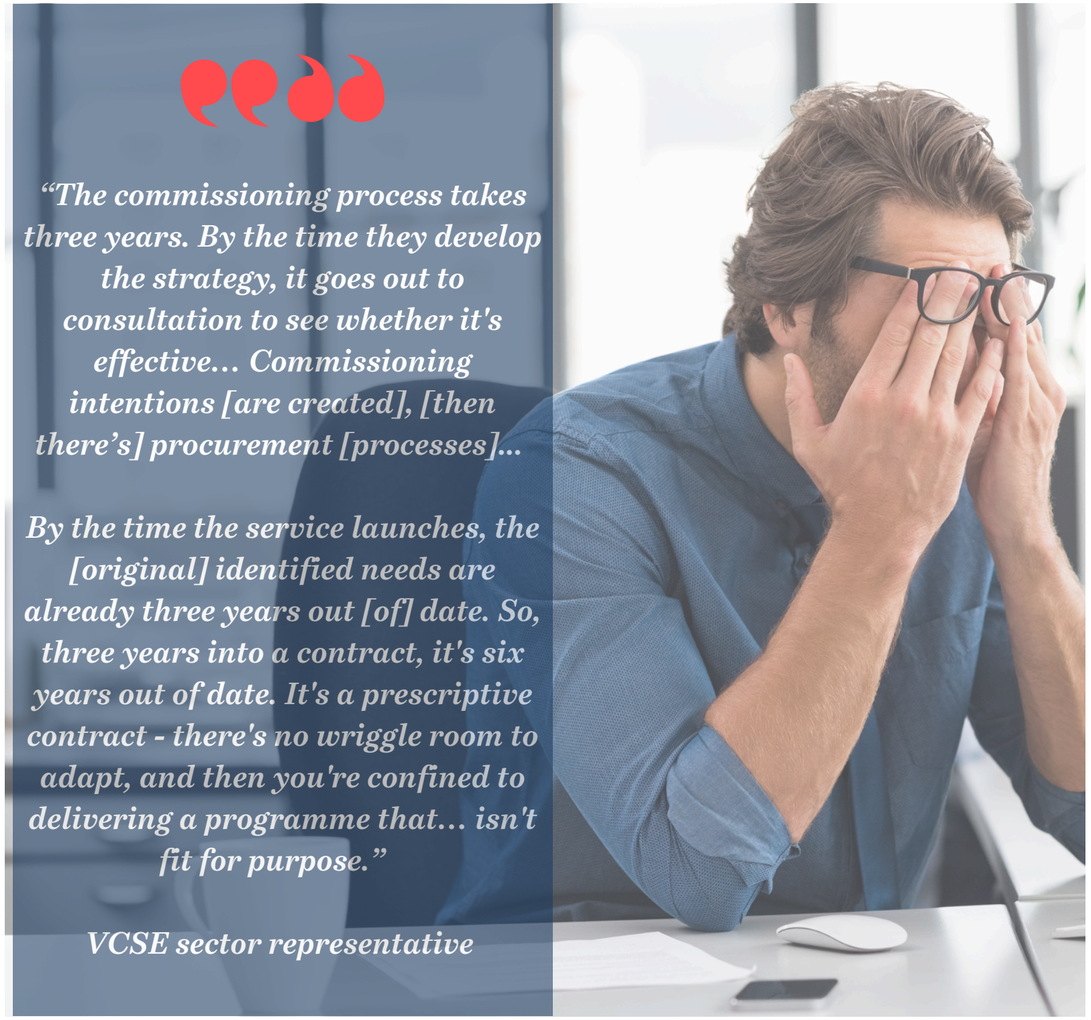
Longer contract to maximise impact

The duration of contracts with Community Hubs needs to be extended (i.e., up to 5 years) to afford enough time for relationships to be formed, provision to be planned and embedded, and impact and value to be properly evaluated.

Also, flexibility in service delivery should be allowed to ensure the support offer remains relevant to address the needs of the community. Having guaranteed funding over a longer period will offer staff stability, therefore likely reducing turnover.

Funding - Enablers

B. Funding model and environment (Cont'd)



"The commissioning process takes three years. By the time they develop the strategy, it goes out to consultation to see whether it's effective… Commissioning intentions [are created], [then there's] procurement [processes]…

By the time the service launches, the [original] identified needs are already three years out [of] date. So, three years into a contract, it's six years out of date. It's a prescriptive contract - there's no wriggle room to adapt, and then you're confined to delivering a programme that… isn't fit for purpose."

VCSE sector representative

A need for joint commissioning and investment between the ICB and council was raised, which is anticipated to lead to more efficient ways of working for stakeholders.

There was also emphasis on commissioners needing to create an infrastructure that empowers those who pay for their care needs (through benefits or personal funds) to buy what they need to remain independent.

Moreover, there was a proposal that much of the budget available to INTs should be focused on delivering greater health and social care in the community and related to this, funding priorities need to align with national agenda priorities e.g., health inequalities, and focus on prevention.

"So each Integrated Neighbourhood Team will have £1 million.

Primary care will almost certainly deem that to be money for [their provision], but that's not how it's intended and that's not how it's meant to work.

And a lot of it should be focusing on channel shift."

VCSE sector representative

Evidence of impact - Barriers

A. Challenges in Establishing and Reporting on Impact

Three main points were discussed under this barrier:

1. A lack of consistency in impact measures;
2. Challenges concerning the attribution of impact to service delivery, particularly when the support focuses on prevention;
3. The limited value of reporting footfall in Community Hubs when measuring impact.

Lack of consistency

Importantly, a few participants who were interviewed feel the lack of access to health and care data means the CGHN can't identify the extent to which the services they deliver result in a reduced demand on health and social care services - for example, by stopping a service user presenting to other healthcare and wellbeing services. Similarly, there was a call for consideration to be given towards whether the Community Gateway is currently collecting the right data to demonstrate the impact of its service delivery on the wider sector.

There was an appeal for commissioners to align impact measures to reduce time spent collating data across multiple distinct outcomes.

One participant noted they spend more time on the administration involved in evidencing impact than on service delivery.

More broadly, it's recognised that there is lack of consistency in outcome measures across the statutory services and the voluntary sector and this is seen as a barrier to connecting systems.

Impact attribution

It was highlighted that there is no way of knowing if a service user had not received support, whether they might have presented to another service.

Case studies documenting what support has meant to those who have benefited does address this challenge somewhat.

Furthermore, when multiple service providers are supporting a service user or a service user is in receipt of multiple interventions from a single provider, it's difficult to isolate the unique contribution of each.

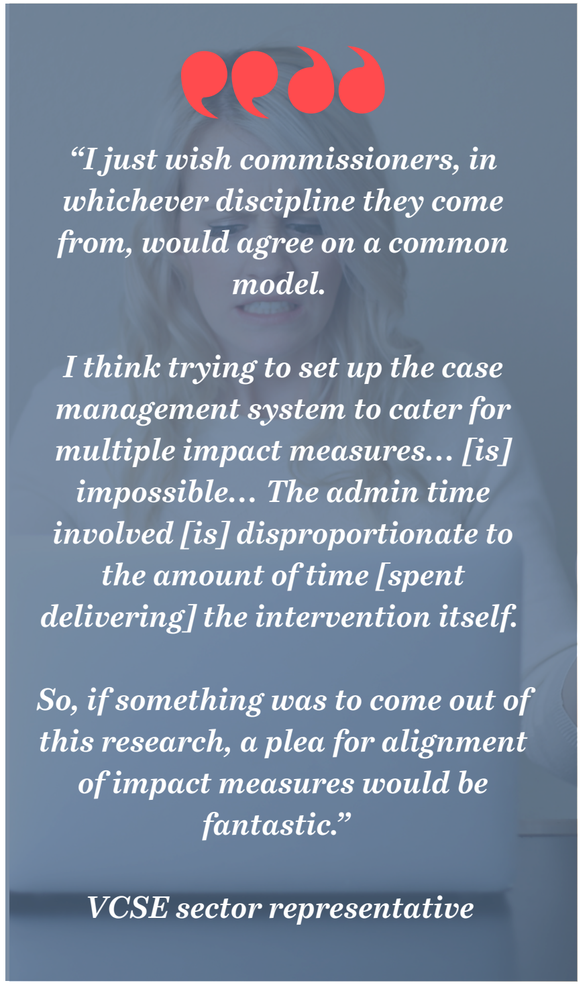
Related to this, it was acknowledged that the diversity of size and offer of Community Hubs means there are differences in the extent to which they contribute to reducing the demand for health and social care services.

Limited impact of activity reporting

The limited value of reporting Community Hub footfall data to commissioners was also highlighted. It was noted that this is not indicative of the benefit(s) of Community Hub service delivery on service users' health and wellbeing.

The notion that a person's health can be attributed a monetary value was also questioned. Moreover, statistics don't acknowledge how Community Hub staff and volunteers work with service users through especially challenging personal circumstances.

Some Community Hubs felt that having a focus on quantitative statistics such as footfall does not recognise the deeper, more meaningful impacts resulting from the support provided to service users.



"I just wish commissioners, in whichever discipline they come from, would agree on a common model.

I think trying to set up the case management system to cater for multiple impact measures… [is] impossible… The admin time involved [is] disproportionate to the amount of time [spent delivering] the intervention itself.

So, if something was to come out of this research, a plea for alignment of impact measures would be fantastic."

VCSE sector representative

“The feedback, it's all stats based really… What does that tell you? [It] tells you how many people come through the door in my [Community] Hub, but doesn't tell you what I've done with each individual…

It could have been one person that I did so much [with], it changed their life.”

Community Hub representative

“It's sometimes difficult to evidence from a prevention perspective.

How do you know if you hadn't have done that, someone would have gone there. But there are lots of case studies that have come through from the services in terms of what it has meant for that person.”

ICB representative

Evidence of impact - Enablers

A. Measuring Impact

Participants suggested a range of methods that could be utilised to evidence service delivery impact. These included methods currently in use that could be used more widely as well as new methods.

Using quantitative measures to identify ROI

Quantitative measures encompassed collecting data on GP appointments to identify any changes and return on investment (ROI).

ROI can be used to both forecast and detect how large any benefit is and how much it changes over time.

ROI is recognised as an important indicator to include in the next phase of Community Hubs impact monitoring.

More storytelling

The importance of qualitative data to highlight impact was also recognised such as service user stories, which audiences are known to connect with.

There was also a proposal to include testimonials more regularly to show impact.

Collecting data to demonstrate prevention

Collecting data on prevention as well as any reduction in the implementation of care packages and long-term care provision was also suggested.

Test and learns

A further recommendation was conducting test and learns based on frontline health and wellbeing staff delivering support in Community Hubs.

Showing social value

In respect of measures that are currently being developed, these include a direct cost savings calculator underpinned by government data, a stakeholder survey to capture impact of Community Gateway interventions on health and care professionals, and a social value engine to calculate social return on investment to support the measurement of CGHN impact.

A consideration towards the diverse portfolio of methods shared by participants concerns how this broad spectrum perpetuates a multifaceted approach to measuring impact.

This is therefore not consistent with the recommendation of aligning reporting requirements and impact measures covered in the previous sections.

Indeed, agreement on how to consistently measure impact in a way that is meaningful for all stakeholders is seen as a priority. Based on views collected during the research, it's likely alignment will result in better cohesion and capacity gains.

“I think it's [about being] consistent… about how we all accept data in a way that's meaningful for us all.

And actually, if we could get that agreed across the piece, that would be really helpful.”

Council representative

Research Question Three

What is the potential of the CGHN in supporting channel shift?

Research Question Summary

'Front door' Support

- By identifying and referring those who are at risk of hospital admission, there is an opportunity to position the Community Gateway as the ‘front door’ to health and care statutory services.
- The Community Gateway can then undertake the ‘what matters to you’ conversation and create a care plan for all the individual's needs. This may involve onward referrals to adult social care or NHS services but may also involve referrals to other community organisations such as the Community Hubs in their local areas.

Prevention and Early Intervention

- Participants reflected that health creation, prevention and early intervention would be key if Cornwall was to be successful in achieving channel shift.
- In addition to improving community members' quality of life, participants believed an increased focus on prevention by the Voluntary Sector would allow NHS services to focus on crisis intervention.

Service ideas

- Development of healthy eating programmes, to help individuals to adopt healthy eating practices
- Developing a centralised information, advice and guidance offer provided by the CGHN to include health and social care sector wide support.
- Supporting people to wait well for their treatment, increasing the opportunity for early intervention and reduce the risk of deterioration.
- Community health checks in which Community Hubs provide opportunities for health and care staff, supported by Community Hub staff, to undertake wellbeing checks.

Research Question Summary

Live Well

- Participants acknowledged the vital support already available across the CGHN that supports service users to live well, while identifying further opportunities to create new services. It was felt the CGHN could play a crucial role in tackling key issues that increase system pressures, such mental health and wellbeing, managing long-term health conditions, and housing.

Service ideas:

- Participants discussed various befriending, good neighbour and lived experience support programmes, which would aim to reduce social isolation and support individuals to integrate into the Community Hub network.
- Support schemes for individuals with long-term, complex health needs, focussing on community-based provision that both encourage engagement in community services and support individuals with activities of daily living.
- Housing information, advice and guidance services to support individuals to understand their options before they reach the point of facing homelessness.
- Respite support for carers through offering befriending or non-clinical tasks support for the individual in need of care might reduce the risk of those carers reaching crisis.
- Support to manage finances and ensuring access to appropriate benefits was noted by council representatives as a service that would help to stem demand for their services.
- Artificial Intelligence (AI) or Apps were proposed by some research participants to support people to navigate to and access services that could help them to live well given their needs.

Age Well

- Throughout primary research, there was a significant recognition of the ageing population in Cornwall. Participants believed that the CGHN could play a more active role in supporting individuals with frailty in their older years, working in collaboration with clinicians to establish new services or extend existing services that support individuals with social isolation, falls and end of life care.

Service ideas

- Frailty and falls prevention were often discussed by our participants as a key challenge for the NHS and social care as a result of the ageing population. Whilst there was acknowledgement that Community Hubs already do some work in this area, participants discussed a range of support options that could be coordinated, such as footwear checks, home checks, and falls prevention exercise programmes.
- End of life support was also discussed as another avenue of support that the CGHN could consider to reduce pressure on social care and NHS staff

Research Question Summary

Discharge

- NHS research participants discussed various challenges throughout the discharge process where the CGHN could support. Further, some participants reflected that on occasion, individuals could be put onto discharge pathway 1 (where they receive a package of care) as opposed to pathway 0 (where they return back to their usual place of residence without intervention) due to concerns that could be addressed by VCSE sector support and intervention.

Service ideas:

- Home checks prior to discharge, where an individual would go in to check the residence, ensure it was safe, warm and suitable for recovery.
- Discharge driver services were seen as a key area where support is needed and could be provided. Not only due to the current limited resources available to NHS staff, but also due to the rurality of Cornwall, resulting in patients often having to travel a long way to get home and the limited public transport links.
- Support in the community after discharge, both over the phone and via home visits, was requested to reassure staff that patients can recover well after discharge or whilst waiting for care packages and community support to come in. Further, there were requests that this support links recently discharged patients into local community organisations, such as the Community Hub network.

Patient Flow

- Whilst not directly related to the CGHN channel shift opportunities researchers were looking into as part of this programme, NHS participants discussed various issues within the hospital that are impacting upon both patient flow and the quality of care they are able to provide.
- Potential opportunities were highlighted that volunteers could look to support within the acute setting.

Introduction

Cornwall and the Isles of Scilly ICB intends to commission "shifts from care in the acute hospital to care in the community that will involve a range of organisations with a community focus: general practice, NHS community services, voluntary and community and social enterprise sectors, and local authorities." [13]

The hope is that these changes will result in improved timely access to healthcare services, a reduction in demand for acute care, and a more joined up healthcare provision for the community.

At the heart of this shift is the establishment of Integrated Neighbourhood Teams (INTs), comprising of NHS, council and voluntary sector representatives. Charged with providing proactive physical and mental health care and support, the ICB intends to facilitate further integration of these teams within the community.

As previously noted via the primary research feedback (within the 'collaborative working' sub-theme), the Voluntary Sector is recognised as a key part of the INTs in providing place-based care that builds healthy communities.[13]

A key element of Helpforce's research was, therefore, to understand what is possible for the VCSE, and more specifically the CGHN, in supporting the channel shift ambition. For this research question, researchers were specifically interested in responses from VCSE and NHS representatives, Programme of Care Leads, ICA Directors, and council representatives.

Participants were asked to reflect on their understanding of current challenges around service delivery and providing healthcare and support to people in the community, along with their views on how the CGHN could take a more prominent role in supporting these challenges. Participants were encouraged to consider whether the CGHN's existing services already reduce demand on statutory health services, to share any evidence of this where possible, and to highlight opportunities for developing new services that would reduce this demand. Participants were also asked to share their understanding of current links between statutory healthcare services in Cornwall and the CGHN, as well as any opportunities that exist for better integration.

Secondary and primary research findings were thematically analysed and segmented into five core areas: **'front-door' support, prevention and early intervention, live well, age well, and discharge.**

‘Front Door’ Support

What is the opportunity?

The Community Gateway is uniquely positioned, in that its services can offer assistance with a vast array of needs at any point in the patient journey.

However, at present, it is often being contacted at the point when someone has already reached crisis or post-receipt of support from NHS or social care services. Participants suggested that there is an opportunity to position the Community Gateway as the ‘front door’ to health and care statutory services.

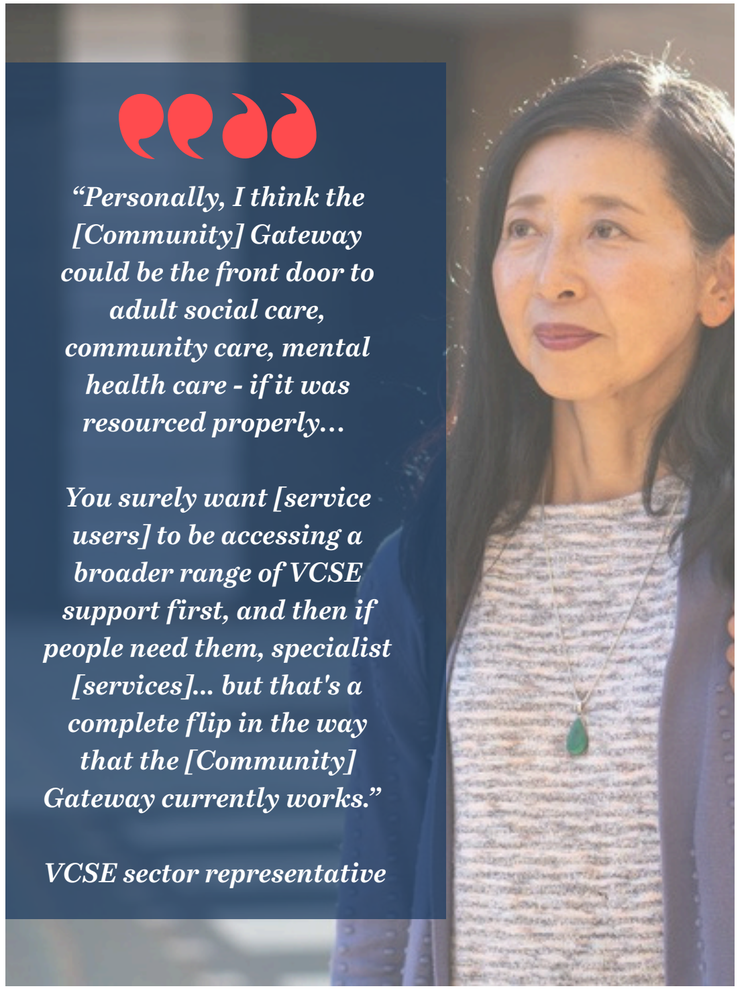
Where individuals are identified as at risk (for example, through risk stratification or BRAVE AI*), participants suggested that GPs, healthcare providers, or the council’s Access Team could make referrals into the Community Gateway.

The Community Gateway can then undertake the ‘what matters to you’ conversation and create a care plan for all of the individual's needs. This may involve onward referrals to adult social care or NHS services, as well as referrals to other community organisations such as the Community Hubs.

What are the perceived benefits?

- Participants discussed the alignment of this approach with not only channel shift, but also with the development of Neighbourhood Health Services. They identified that NHS and social care services are often overwhelmed and indeed costly – consequently, the Community Gateway can intervene as the first point of call, and manage demand by ensuring those who need statutory support can access it, while those who do not get directed to support through local community organisations.

- Additionally, the availability of the Community Gateway (operating until 8am to 8pm every day of the year) would also support continuity of access, beyond the usual opening hours of many other services.



*“BRAVE AI is a risk assessment tool that helps health professionals identify individuals who are at risk of going into hospital in the next year, but who may otherwise go under the radar.” – Health Innovation Network (2025). [29]

‘Front Door’ support (Cont’d)

Key considerations

- Partnerships: This shift would require significant relationship and knowledge building to ensure that processes for referrals to the voluntary sector are embedded and implemented.
- Existing services: There are existing services that providers would need to be considerate of, such as the council’s Carers Support. Therefore, the remit of Community Gateway’s front-door support would need to be established and agreed by all affected parties to ensure integration, collaboration and minimal overlap.
- Long-term needs: ‘Front door’ assessment conversations would need to be targeted towards making lasting, sustainable improvements to service users’ health and wellbeing, not just focussed on what is going to prevent them from entering statutory services in the immediate future.

Examples of where it has been/ is being done

Case Study Spotlight: Plymouth Community Assist (PCA)

Delivered by Improving Lives Plymouth, PCA acted as the ‘front door’ to adult social care “as both a community-based preventative service and also to support people pre/post assessment who are awaiting statutory services”. [30]

The PCA service aims to reduce demand for NHS and social care services by providing individuals on social care waiting lists with information, advice and guidance.

Support available ranges from management of long-term health conditions to social isolation, utility and food provision, and housing. PCA also facilitated referrals into wider voluntary sector services.

In 2024, the service was evaluated by Rose Regeneration, and it was found that for every £1 invested, Plymouth Community Assist delivered £5.31 of social value. [31]

Prevention and Early Intervention

What is the opportunity?

Secondary research indicated that increased prevention and early intervention was a key feature across NHS, ICB, council and VCSE strategies. [11, 14, 17, 18]

These strategies discussed the importance of focussing resources into preventative and wellbeing services to create a more sustainable healthcare system.

Additionally, concerns regarding long waiting lists and resulting challenges in gaining timely access to care were noted within various healthcare system strategic documents, and during an ICB consultation with patients. [12, 13, 32]

These findings were substantiated by primary research, where participants stated that health creation, prevention and early intervention would be key if Cornwall was to be successful in achieving channel shift.

Indeed, several individuals discussed challenges in their own services meeting demand and the knock-on effect this has in increasing the likelihood of someone being admitted to hospital.

VCSE sector representatives discussed that the Community Gateway was originally set up with the aim of being a preventative support offer and that various Community Hubs already offer support programmes aimed at better supporting individuals to manage their health and prevent illness.

However, there is the opportunity to further expand these and consider additional services, alongside bringing the CGHN in earlier to ensure individuals' needs are met at the point of prevention, as opposed to discharge following treatment.

Participants suggested GP practices and PCNs, who "know their patient base better than anybody else", could be mobilised to work alongside the CGHN to build preventative and early intervention services based on the needs of that locality.

What are the perceived benefits?

- In addition to improving community members' quality of life, it was believed that an increased focus on prevention by the CGHN would allow NHS services to focus on crisis intervention. Indeed, some participants hoped that this shift could possibly lead to a reduction in need for NHS intervention for that individual entirely.

> ***"Could the [Community] Gateway coordinate and have a conversation with somebody at the point of admission rather than at the point of discharge?***
> ***Because having a conversation with somebody at their hospital bed, earlier on in their journey, is probably more beneficial than getting the referral right at the end... I think we could look at reducing length of stay in hospital if we got in there earlier."***
>
> ***VCSE sector representative***

Key consideration

- Training: It was suggested that there may be additional training needs to aid advisors with providing preventative support and wider information, advice and guidance.

Prevention and Early Intervention (Cont'd)

Service ideas:

Healthy eating programmes

Development of the healthy eating programmes to help individuals to adopt healthy eating practices such as the WellFed programme. Hosted by Volunteer Cornwall and Cornwall Greener Practice, WellFed aims to encourage health creation alongside positive environmental changes.[33]

The programme brings together a network of health, food and voluntary sector representatives to connect "people with food that's good for their health, good for planetary health, and good for the community". One of the participating organisations is a member of the Community Hub Network, Newquay Orchard.

Supporting people to 'wait well'

Supporting people to 'wait well' for their treatment, increasing the opportunity for early intervention and reduce the risk of deterioration.

This could range from 'shape up for surgery' type interventions, in which an individual waiting for treatment could be supported to get in the best health possible before surgery (i.e., weight loss, smoking cessation) to providing support for individuals waiting for mental health support.

"'Waiting well' it is an interesting concept for people on a therapy waiting list because they'll be waiting weeks before a therapist can get to assess them.

While we wait for the therapist to go and see them, which could be 12 weeks away, how could we get them 'waiting well'? Just some straightforward exercises and activity that would help as opposed to waiting 12 weeks doing nothing."

NHS representative

Community health checks

Community health checks which would involve Community Hubs providing opportunities for health and care staff, supported by Community Hub staff, to undertake wellbeing checks and provide recommendations to ensure they live well.

"Could do it out of any of those Community Hubs and stop people having to come into the GP practice. To do that, you would need the skill stuff within it.

I don't mean anyone randomly going to take blood from people, but you could use it as a different base. I think health checks is definitely something I would look at. I think there's a whole range of things we could coordinate, co-locate some of our staff there."

ICB representative

Centralised IAG offer

Developing a more centralised information, advice and support (IAG) offer within the CGHN, covering health and social care sector wide support, rather than having multiple contracts delivered across different providers.

"By trying to put my prevention hat on, I can definitely see the potential in the [Community] Gateway model and the [Community] Hub model to develop and grow… to encompass the information, advice and guidance offer for the whole of social care under one roof."

Council representative

Prevention and Early Intervention (Cont'd)

Examples of where it has been/ is being done

Case Study Spotlight: Stronger Together programme

The Stronger Together programme has been designed in response to the frailty priority of the INTs within Cornwall and focusses on prevention and reducing the risk of deterioration.

The programme, delivered by the CGHN, is currently being piloted and provides individual guided conversations and goal setting with a supported self-management offer in groups and one-to-one.

"We've got the Stronger Together programme, which is looking at how we can make people more resilient and better able to look after themselves. It's risk mitigation - so trips and falls prevention, for example - educating people about how they can be safer in their homes and when they're out and about."

VCSE sector representative

Case Study Spotlight: Waiting well support by H4All, on behalf of Hillingdon Hospitals NHS Foundation Trust

This project saw partners working at a community level with patients in areas of high deprivation, supporting patients to 'wait well' as they were on the lists for treatment or diagnosis.[34]

H4All was identified as the voluntary sector partner for the project, responsible for recruiting and managing volunteers and delivering the service on a day-to-day basis.

Patients received a telephone call from a volunteer discussing how they had been managing while waiting for their appointment and any difficulties they may have had with accessing their appointment.

The volunteers then took any appropriate actions, such as:

- providing guidance about the appointment,
- reassuring patients,
- identifying opportunities for referral to community services.

Volunteers supported individuals to access their appointments by arranging transportation, an interpreter or asking the clinical lead to contact the patient.

As a result of the intervention, Helpforce evaluators noted a...

15% ↓

relative reduction in 'did not attend' appointment rates following the intervention

(n=10,792)

Live Well

What is the opportunity?

A key pillar of the Cornwall and Isles of Scilly Integrated Care System's (ICS) Integrated Care Strategy is supporting individuals to 'live well'.[11]

This strategy highlights the important role of voluntary sector support in keeping people well.

Indeed, research participants discussed the vital support already available across the CGHN in helping the healthcare sector to achieve this goal, as well as further opportunities to create new services.

These tended to focus around supporting individuals with long-term health conditions or complex needs, mental health concerns, and housing challenges.

Long-term health conditions and complex needs

"Cornwall has a higher rate of chronic disease and disability than average, which means that men in general spend over 16 years in poor health, and women nearly 18 years." [11]

Additionally, a higher-than-average proportion of Cornish adults live with a long-term health condition, with over 20% of the population reported to have their day-to-day lives limited due to a long-term health condition or disability.[21] The Voluntary Sector can and do play a key role in supporting these individuals, as explained by the Joint Forward Plan.

Research participants reported that individuals with long-term, complex health conditions, including neurodiverse individuals, are likely to have lots of different needs and will often first turn to the NHS or be provided with social care interventions.

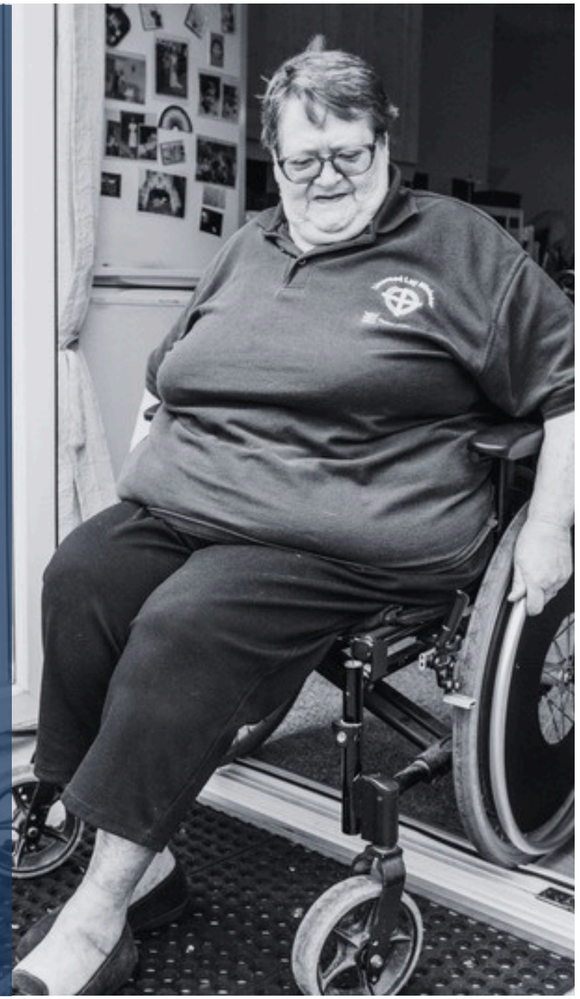
But in some instances, support could be provided to reduce isolation or support with non-clinical tasks in the home or community to support these individuals to live well and reduce reliance on these services.

"Some of our patients are sort of starting chemotherapy, and perhaps they don't have a big support network around them.

They're very used to doing their own shopping. They don't have transport, though, and we suddenly start giving them chemotherapy every week and suddenly they're feeling really tired and they're struggling to go and do their own shopping. Or perhaps they just need some very short-term help to finish a project...

You can offer befriending, some help with some light housework or shopping - that might be something that for some of our patients would be very helpful."

NHS representative



“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.”

Joint Forward Plan 2024 to 2029 from Cornwall and Isles of Scilly ICS [12]

Live Well (Cont'd)

Mental health and wellbeing

Within their 'Integrated Care Strategy', Cornwall ICS discloses that "mental health conditions are a common cause of ill health in the population, the prevalence is increasing, and people with severe mental illness have a higher risk of major diseases and lower life expectancy."[11]

Additionally, the document states that in 2024, 12.7% of patients within Cornwall are recorded on the depression register and that Cornwall has the third highest rate of suicide in the UK.

As a result, the ICS notes "significant and sustained increase in demand for NHS Talking Therapies" as well as high demand for inpatient mental health care.[35]

Indeed, mental health and wellbeing was a frequent topic of discussion across the research. NHS staff recognised the role the CGHN could play in supporting mental health, however, VCSE sector staff stated that more recognition of community support that prevents individuals needing to access NHS therapeutic services is needed.

> ***"What we keep saying to the NHS is 'let's stop people needing to go to your talking therapies'...***
>
> ***We can have activities in the [Community] Hub with trained volunteers who actually can have conversations at a level which might prevent them needing guided talking therapies...***
>
> ***What we need to do is, if there is going to be change in channel shift, is [to] get acknowledgement of the interventions that stop people from needing talking therapy."***
>
> ***VCSE sector representative***

Additionally, participants reflected that there is an opportunity to support individuals who are at risk of 'falling through the gap', where mental health concerns are not severe enough to warrant medical intervention but go beyond the current skills within and services provided by the CGHN.

> ***"[The] voluntary sector will say they'll support to 'this level', but you need to be 'this level' up here to access some of the medical interventions. So, what's happening to those people in that intervening gap and how big is that gap?... How do we make sure people have the right training to be comfortable and confident in that area? How do we fund those organisations so they've got the stability to have the staff that have that longevity... That's one example of how I think Community Hubs would be brilliant places."***
>
> ***Council representative***

Live Well (Cont'd)

Housing

Within their community consultation, the Cornwall Vital Signs report highlighted that 93% of their survey respondents agreed there is insufficient affordable housing.[21]

Further, the report reveals that whilst 22,000 households are on the social housing waiting list, only 11% of housing stock in Cornwall is social housing, compared to an average of 18% across England.

As a result of the pandemic, the cost-of-living crisis and a shift from long-term to short-term/holiday rentals, the report claims...

Cornwall has reached a crisis point with "unacceptable numbers of Cornish people on social housing lists, in temporary accommodation, living in vans and cars, having to move out of the area, or finding themselves homeless."

VCSE representatives reflected that they already see a demand for housing support within the CGHN.

Individuals present with issues around affordability and suitability of housing, evictions and private tenancies.

Further, whilst there was acknowledgement of the role the council play in supporting individuals once they face homelessness, council representatives discussed the need for simple and accessible information, advice and guidance around housing to increase prevention.

Live Well (Cont'd)

What are the perceived benefits?

- Supporting individuals to take control and self-manage their physical and/or mental health condition is hoped to reduce reliance on NHS and social care services.

- In relation to housing, putting preventative support in place to assist individuals before they reach the point of potential homelessness could reduce the risk of these wider determinants negatively impacting on their health.

Key considerations:

- Training needs: NHS and VCSE sector representatives highlighted that not all Community Hubs are equipped to manage complex needs, with smaller Community Hubs in particular lacking the resources and skills to deliver the kind of specialist services needed. In all of the above areas (mental health, housing, long-term complex health conditions), participants remarked that providing support would likely result in additional training needs for CGHN staff.

- Inclusive services and environments: A strong theme identified through this research, as discussed in the earlier 'inclusion and accessibility' theme, was that the CGHN creates inclusive, welcoming spaces for individuals. However, researchers heard from some participants that the Community Hubs were not always seen this way, particularly for people with severe and enduring mental health conditions who "don't feel that they can be themselves in these places because of their mental health and how they present". To overcome these challenges, participants discussed creating psychologically-informed environments and using trauma-informed approaches.

Live Well (Cont'd)

Service ideas:

Befriending

Participants discussed various befriending, good neighbour and lived experience support programmes, which would aim to reduce social isolation and support individuals to integrate into the Community Hub Network.

There was recognition of existing programmes across Cornwall (such as the GP buddy programme and Inclusion Matters – more detail on page 110) that could be built upon and better integrated to tackle loneliness for individuals living in Cornwall, particularly those with long-term health conditions or complex needs.

Support schemes for individuals with long-term, complex health needs

Support schemes for individuals with long-term, complex health needs, focusing on community-based provision that both encourages engagement in community services and supports individuals with activities of daily living. There was recognition for the provision across the CGHN in terms of health condition specific support groups/activities.

However, participants requested increased engagement of individuals in these groups, as well as additional services that encourage self-management of health conditions.

House support services

Housing information, advice and guidance services to support individuals to understand their options before they reach the point of facing homelessness.

The Community Gateway was seen as a key mechanism for this, referring into the Community Hubs or other local voluntary sector organisations as required.

Live Well (Cont'd)

Service ideas (Cont'd):

Respite support for carers

Respite support for carers was also mentioned as a possible channel shift opportunity by council representatives. These participants reflected that they "too often" see carers approaching them for support when they reach crisis point.

They considered if, by offering befriending or non-clinical tasks support for the individual in need of care, and as a result offering a regular break for carers, this might reduce the risk of those individuals' reaching crisis.

> ***"When they do come to us and say "I've had enough", we've got to put emergency respite in, and the care homes then are going [to be a] bit risky. So, it's a really hard offer to develop, but one that's definitely needed because... we will prevent so many carer breakdowns."***
>
> ***Council representative***

Support to manage finances

Support to manage finances and ensuring access to appropriate benefits was noted by council representatives as an intervention that would help to stem demand for their services.

Research participants discussed that the Community Gateway is already going some way to provide this support, but that it would like to increase the guidance given to individuals in managing their income to ensure they use the service effectively to help support their health and maintain their independence.

> ***"There's something about making sure people have got access to disability-related benefits and know how to use that money to get the best outcomes. So how do they use that money to get personal assistance, support, cleaning, shopping - all the things that they would need in order to be more independent…***
>
> ***But also stemming the flow of demand to adult social care, so how do we make sure there's an effective offer that actually enables people to not come to adult social care's front door anymore?"***
>
> ***Council representative***

Artificial Intelligence

Artificial Intelligence (AI) or Apps were proposed by some research participants to support people navigating and accessing services that could help them to live well based on their current needs.

> ***"Have they got an app that's got their background on there... they could just pull it up and go 'this is how I'm feeling' and then having some of those key activities around them that they could then access that might help them."***
>
> ***Council representative***

Live Well (Cont'd)

Examples of where it has been/ is being done

Case Study Spotlight: Inclusion Matters

Inclusion Matters, led by Cornwall Rural Community Charity, brings together multiple charitable and public sector organisations to promote social inclusion by building an individual's links with the community.

"The key objective of the partnership is to better understand and harmonise the support individuals and communities need by working together with local services and communities to develop a coordinated approach that can transform lives." [36]

Case Study Spotlight: Community Appointment Days

The provision of community appointment days was discussed by participants as taking positive steps towards shifting care for those with long-term health conditions into the community.

These days, led by Cornwall Partnership NHS Foundation Trust, involve the bringing together both clinical (i.e. physiotherapies, clinicians) and VCSE sector representatives into one venue, such as a Community Hub, so that residents can talk through their condition(s) with various teams who can help them to manage them.

Participants discussed the provision of community days for individuals with musculoskeletal and diabetic health concerns with great success.

"You get 120 people through the door as an opportunity to create awareness around what voluntary sector support there is for people living with their condition. So, in terms of information sharing and opening the door to people who otherwise wouldn't be aware, it's been really effective."

VCSE sector representative

Live Well (Cont'd)

Examples of where it has been/ is being done

Case Study Spotlight: Step into Wellness Programme

The 'Step into Wellness' programme provides mental wellbeing support to anyone over the age of 18.[38] Service users are guided through conversation-based sessions to explore how they can achieve their mental health goals.

Case Study Spotlight: People in Mind

The 'People in Mind' service, managed by Cornwall Voluntary Sector Forum, is a mental health and suicide prevention programme.[39]

Delivered by a partnership of community organisations, the project offers mental health support for individuals aged 16 and over, delivering "a trauma-informed and whole-family approach to improve the wellbeing of communities in Cornwall and the Isles of Scilly".

Case Study Spotlight: Recovery College Cornwall

Recovery College Cornwall provides individuals with mental ill health the opportunity to take control of their own journey through learning and developing their understanding of mental health.[37] Courses are open to anyone with mental health concerns and is led and delivered by people with lived experience.

> ***"I think the Recovery College is a particularly great scheme... This is around short courses for people to self-manage their mental health. I think that's a particularly innovative and great project."***
>
> ***VCSE sector representative***

Age Well

What is the opportunity?

In 2022, 24% of Cornwall's population was aged 65 and over, with this set to increase by 11% by 2025 and by 24% by 2030.[16]

Proportions of individuals aged 65+ with dementia were forecasted to grow by 31%, and those who require mobility support by 28%.

Further, by 2030, it is estimated that almost 30% of the 75+ population will be living alone.

Taken together, these increases are expected to impact on demand for NHS and social care services.

In their Maximising Independence strategy, Cornwall Council states "we will have more older people, but also more of them will require support, so we need to be creative and innovative now, to ensure we have the right support available for people to access."[16]

The ICS reflected that a significant proportion of individuals who experience frailty are attending emergency departments and that the NHS needs to explore how attendances and admissions could be avoided by providing care in the community.[12]

Throughout primary research, there was a significant recognition of the ageing population in Cornwall and that being supported in hospital isn't always the best option, with a heightened risk of infection and deterioration.

As a result, research participants felt that there was a key opportunity for older members of the Cornish population to be supported by the CGHN to support them to age well, minimising the need for hospital admission.

As a key priority for Cornwall's INTs, participants believed that the CGHN could play a more active role in supporting individuals with frailty in their older years, working in collaboration with clinicians to establish new services or extend existing services that support individuals with social isolation, falls, and end of life care.

"One of the things that we're looking [into] at the moment is a [Community] Gateway and Community Hub frailty pathway. Frailty is a big priority for Integrated Neighbourhood Teams."

VCSE sector representative

What are the perceived benefits?

- Supporting individuals to age well at home, in their own safe environment, reducing the risk of deterioration or infection whilst in hospital.
- Reducing falls risk and subsequent treatment required by NHS services, by building strength, coordination and mobility for frail residents.

Key consideration

- Existing services: There are various existing services available across Cornwall that aim to support individuals in the later years of their life, some of which already sit within the CGHN. Whilst participants called for additional services in this area, care would need to be taken to ensure these align with or complement existing support offers.

Age Well (cont'd)

Service ideas

Frailty and falls prevention

Frailty and falls prevention were often discussed by participants as a key challenge for the NHS and social care as a result of the ageing population.

Whilst there was acknowledgement that Community Hubs already do some work in this area, participants discussed a range of support options that could be coordinated, such as footwear checks, home checks, and falls prevention exercise programmes.

> ***"I think there's a lot around falls that could potentially be done. It's not my area of expertise, but I think that's something that could be explored, either around providing foot checks, footwear checks, home checks or something around falls and multifactorial falls risk assessments potentially."***
>
> ***NHS representative***

End of life support

End of life support was also discussed as another offer that the CGHN could consider to reduce pressure on social care and NHS staff.

A key element of aging well is dying well, and individuals and their loved ones having their needs met at the end of life stage.

There was recognition of the vital role of Butterfly Companion volunteers, who provide companionship to patients at the end of life whilst in hospital, but there were also calls for community-based end-of-life support.

> ***"Community Hubs could play a very big role in end-of-life in their local area... They could be training up volunteers to be end-of-life volunteers. They could be proactively having conversations with people who come through the door about end-of-life planning. They could facilitate death cafes, you know, talk about death and dying."***
>
> ***VCSE sector representative***

Age well (cont'd)

Examples where it has been/ is being done

Case Study Spotlight: GaitSmart

The GaitSmart programme, which is soon due to be launched, aims to increase falls management within the community.

The programme will be delivered in partnership between INTs, Cornwall Partnership NHS Foundation Trust, Cornwall Voluntary Sector Forum, and the CGHN. A clinician will undertake an initial gait assessment aided by technology. The assessment will result in a series of recommended exercises that the individual can undertake to help improve their mobility.

The CGHN will then support with ongoing monitoring. When discussing the GaitSmart programme, a VCSE representative explained "people are coming into a non-clinical setting, having their gait measured, both with somebody clinical and with somebody non-clinical from the VCSE sector. And then an entire series of recommendations will be made, which includes some clinical intervention, but also the intervention of a Community Hub."

Case Study Spotlight: York Community Frailty Hub

York Community Frailty Hub brings together the acute trust, the ambulance service, GPs, social care, community services, and voluntary sector into one hub in the hope of tackling frailty and preventing unnecessary hospital admissions.[42]

"The service is made up of 3 key parts: a frailty prevention team, a discharge support team, and a frailty crisis response team.

The crisis response team helps reduce avoidable hospital admissions through a dedicated advice and guidance line and rapid multidisciplinary community response."

"In 84% of cases,

the York Community Frailty Hub has helped paramedics avoid hospital transfers by providing advice after an ambulance is dispatched, enabling patients to be safely supported in the Community."[42]

Age Well (cont'd)

Examples where it has been/ is being done (Cont'd)

Case Study Spotlight: Falls prevention volunteers at Kingston Hospital NHS Foundation Trust

The falls prevention programme provided an eight-week intervention in which trained volunteers visited patients' homes to deliver a rehabilitating exercise programme.[40]

The aims of the service were to reduce deconditioning and the risk of falling post-discharge, increase social connectivity, and to improve quality of life for the elderly.

Whilst a small cohort of patients participated, Helpforce's evaluation of the service showed improvements in functional fitness measures and confidence in performing daily activities across patients.

Following the success of the Falls Prevention programme, Kingston extended the service to include other organisations in the area, incorporating GP practices and an additional care home setting.[41]

Patients were identified by their GP surgery or their care home team as being eligible for the service based on criteria that suggested they were at risk of deconditioning.

Again, improvements in functional fitness and confidence measures were witnessed.

Please note: this intervention involved volunteers, as opposed to the voluntary sector, however, service provision and learnings from this project could be applied in a VCSE setting.

Discharge

What is the opportunity?

Challenges with discharge from hospital were noted throughout several strategic NHS documents reviewed as part of secondary research, with a commitment to reduce delayed discharges,[11] improve discharge planning, and "working with the voluntary sector to manage the demand and to reduce length of stay in line with best practice."[35]

Through their community conversations, Cornwall and the Isles of Scilly ICB identified that residents wanted more communication and guidance whilst in hospital about how they prepare for going home. As such, they committed to providing more advice and information throughout individuals' acute stay so that they and their loved ones can best prepare for discharge.[12] Working alongside the voluntary sector was seen as key to optimising the discharge experience.

Indeed, NHS research participants discussed various challenges throughout the discharge process where the VCSE could support, such as delays due to transportation, ensuring patients can return home to a safe environment, and connecting individuals into community support post-discharge.

When discussing transportation at the point of discharge, one participant remarked that there are often inefficiencies due to limited resources:

> ***"They struggle with figuring out how the patients are going to get in safely and I think often we end up defaulting to more expensive options like [an] ambulance, when actually they don't need an ambulance... There is definitely some wastage and misalignment."***
>
> ***NHS representative***

Further, some participants reflected that on occasion, individuals could be put onto discharge pathway 1 (where they receive a package of care) as opposed to pathway 0 (where they return back to their usual place of residence without intervention) due to concerns that could be addressed by VCSE sector support and intervention.

> ***"I think people are clear about how to get to pathway 1. I think what they're not clear about is how to get to pathway 0 safely - to discharge people from hospital who don't need formal support, but just need someone going to make sure their fridge is not full of rotten food and they've got their heating on and their house isn't in disarray after they've been in hospital for three weeks.***
>
> ***What we need to create is that shift left... We need to stop those people from going down pathway 1, because it means we're wasting resources for people who end up in pathways 2 and 3 because there's not enough capacity on pathway 1 for them. So that shift left is really important in a new delivery model."***
>
> ***Council representative***

Additionally, NHS representatives discussed concerns from patients about going home, possibly due to a lack of support and risk of isolation once back in their residence:

> ***"I think if they're doing a few of the more normal things at home, that might lift their mood and encourage them, because some people delay their own discharge in a way, one because they're lonely and two because they're anxious about going home as well."***
>
> ***NHS representative***

All of these challenges were felt to be preventable if there was better VCSE integration into discharge conversations, resulting in pressures on NHS and social care services being reduced by allowing the CGHN a greater role in helping individuals to return to and recover at home safely.

Discharge (Cont'd)

What are the perceived benefits?

- Participants felt that if individuals were able to be supported to return home to a safe environment, this would reduce the risk of bouncing immediately back into acute care.
- Further, by providing ongoing support and community integration opportunities post-discharge, it was reported that patients would have the infrastructures in place to support their recovery, without continued reliance on NHS services.

Key considerations

- Existing services: There are various existing services available across Cornwall that can support with discharge, some of which are already commissioned by NHS services, such as Humans and the British Red Cross. However, participants discussed challenges related to the availability of these services due to demand, sometimes leading to delayed discharge. Further mapping of existing services and collaboration with these services to ensure complementary support would be advised.
- Integration into discharge pathways: Participants remarked that there may not be the confidence for hospital staff to discharge people "into the voluntary sector" due to a lack of awareness of and trust in the support available. To establish those connections, as well as ensure effective planning and delivery of support, better integration of the VCSE into discharge conversations is required.

Service ideas

Home checks

NHS participants reflected that they have a number of elderly patients who are discharged to a house that may have been empty for several weeks whilst they were admitted.

They therefore suggested that home checks prior to discharge, where an individual would go in to check the residence to ensure it was safe and warm, would be helpful to ensure it's a suitable location for their recovery.

Discharge driver

Discharge driver services were seen as a key area where support is needed and could be provided.

Not only due to the current limited resources available to NHS staff, but also due to the rurality of Cornwall, resulting in patients often having to travel a long way to get home with limited public transport links.

Support in the community after discharge

Support in the community after discharge - both over the phone and via home visits - was requested to reassure staff that patients can recover well after discharge or whilst waiting for care packages and community support to materialise.

Further, there were requests that this support links recently discharged patients into local community organisations, such as the Community Hub Network.

Discharge (Cont'd)

Examples where it has been / is being done

Case Study Spotlight: Volunteering for Health Community Health Volunteers

The Volunteering for Health programme, led by Volunteer Cornwall, aims to "maximise the benefits of volunteers as a vital resource in delivering health and social care."[43]

As part of the programme, partners have designed a new Community Health Volunteer role, in which volunteers will provide a bridge between hospital and the community, including making sure an individual's home is ready before they are discharged from hospital, and supporting them to attend community groups/activities once they are back home.

This role is due to be piloted in late 2025.

Case Study Spotlight: Healthy & Home Service

The Healthy & Home service in Warrington involved increasing integration of the VCSE in the discharge process.[44] Working alongside Warrington Hospital's discharge team, a support plan was developed with referrals made to relevant VCSE organisations.

In 2024, after a two-year pilot, it was reported that 81% of individuals accessing the service did not reappear in the hospital within a 12-month period.

Case Study Spotlight: Volunteer Drivers at North Tees & Hartlepool NHS Foundation Trust

An NHS-based volunteer drivers service, in which volunteers provide transportation for patients to get to and from outpatient appointments and to get home after an inpatient discharge.[45]

They also provide delivery and collection of medications and equipment to patients at home.

Helpforce's evaluation of this service found that, **as a result of this service, the Trust was able to provide transportation and deliveries for patients at around 60% of the cost of outsourcing the journeys to taxis.**

(n= 30,472 journeys)

Patient Flow

What is the opportunity?

Whilst not directly related to the CGHN channel shift opportunities researchers were looking into as part of this programme, NHS participants discussed various issues within hospital settings that impact upon both patient flow and the quality of care they are able to provide.

As reflected across the 'service provision' theme, concerns were voiced around increasing demands for acute care and high staff turnover. Potential opportunities where volunteers could look to support within the acute setting were highlighted.

Participants suggested that complaints regarding patient flow are on the rise, mainly due to staff shortages, meaning that tasks aren't always completed within a timely manner, or indeed, that things sometimes get missed.

What are the perceived benefits?

- If some of the non-clinical responsibilities that fall to staff are able to be supported by hospital-based volunteers, this may help to reduce these issues and staff pressures, as well as improve patient experience.

Key considerations:

Volunteer services team

Advertising for, recruiting, inducting, and managing volunteers for roles such as these would be dependent upon a volunteer services team who could undertake that support.

Volunteer reliability

Whilst volunteers were seen as being able to provide a valuable contribution, research participants discussed concerns that volunteers may lack reliability and accountability - making reliance on volunteers to support service delivery and care an operational challenge.

Any volunteering interventions implemented, therefore, should be considered as an additional benefit to service delivery, as opposed to an integral, core element.

Volunteer training and expertise

NHS staff voiced some concerns regarding volunteers not having certain skills or not being trained in a certain area, meaning they are / would be unable to perform various responsibilities in different settings.

Consideration should therefore be given to ensure appropriate and thorough training is provided to any volunteers.

Concerns regarding volunteers replacing paid staff

The scope to have volunteers more integrated into service provision was explored with NHS representatives involved in acute care.

Whilst staff were receptive, there were some concerns that volunteers could be seen as a substitute to hiring 'desperately needed' additional staff.

Caution should therefore be taken to ensure that any volunteer roles are carefully considered, implemented and embedded in a complementary way to support staff wellbeing and morale, while reducing pressure.

Patient Flow (Cont'd)

Service ideas

Activity and mobility volunteers

Volunteers that can support patients to remain active whilst in hospital.

"Volunteers that could come into the elderly care wards that are waiting for residential beds [and] keep them active."

NHS representative

Response volunteers

Volunteers who collect prescriptions and undertake non-clinical tasks (both within and outside of the hospital) so that staff don't need to leave the ward.

"I could do with another two healthcare assistants per ward to do that feeding for the patients, but they're not getting fed. So, I'm getting complaints that my patients aren't being fed... So I think if a volunteer was to come in and have to have a very specific job role, so 'you are literally going in to help with feeding'... to give the clinical staff back the time to do the clinical work that they need to do."

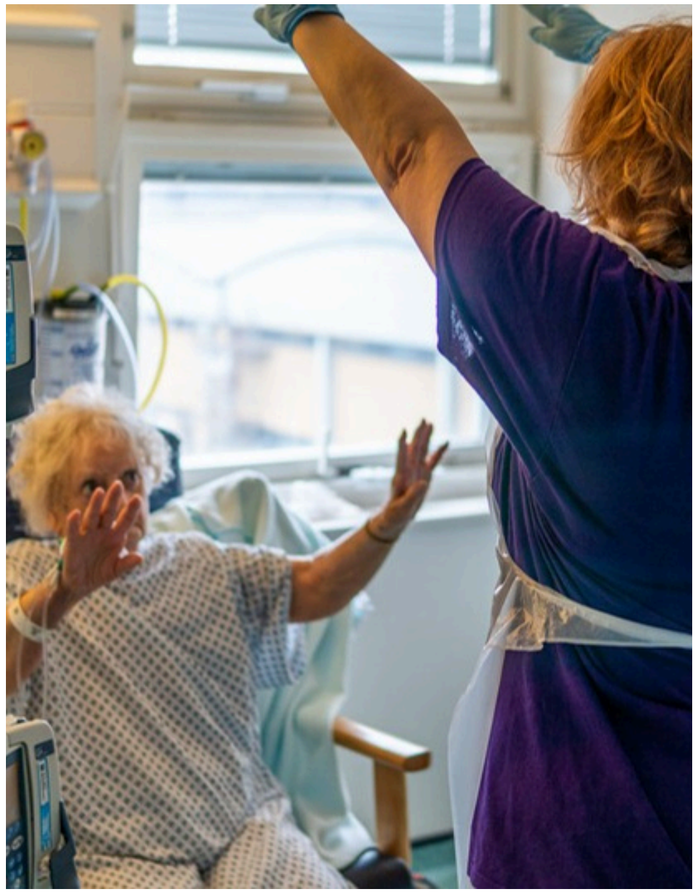
NHS representative

Mealtime support volunteers

To ensure patients have the help they need to eat their meals

"We did explore potential pharmacy pickups - a local volunteer that will go and pick up [medication for] somebody who simply has their monthly or weekly prescription. We can't even start antibiotics [as they] need to get that prescription [first]. They've got no family there, so we've got our clinicians going out and picking up that prescription. There could be an [opportunity] where volunteers could be contacted to go and collect that prescription and take it to that person."

NHS representative



Patient Flow (Cont'd)

Examples where it has been/ is being done

Case Study Spotlight: Activity and Mobility Volunteers at Sandwell and West Birmingham Hospitals NHS Trust

With guidance from ward staff and therapists, volunteers encourage some patients to get out bed, get dressed into their day clothes, walk, move, or exercise.[46]

Helpforce's historical evaluation of the role showed that there was increased patient activity, and a decrease in the number of requests made to the physical therapy team following implementation of the mobility volunteer role.

Case Study Spotlight: Mealtime Companion Volunteers at Northern Care Alliances

Dining Companions encourage and enable patients to eat and drink, therefore helping to reduce the risk of malnutrition and dehydration, whilst making mealtimes more sociable.[47]

They also promote an environment for independence by positioning trays and food/drink utensils so that patients can access them.

Helpforce's evaluation of the role in March 2022 illustrated that 25% more patients agreed they had enough support to eat their meals and 18% more patients agreed they had enough to drink when they received support from a mealtime volunteer.

(n=86)

Case Study Spotlight: Response Volunteers at University Hospitals Coventry and Warwickshire

Volunteers are trained to respond to tasks in real-time and have the fluidity to move around and adapt what they do in line with the daily requirements of the Trust.[48]

This includes tasks such as collecting and delivering To Take Out (TTO) medications and pathology samples and phlebotomy samples, supporting patient transfers and housekeeping tasks, among others.

A Helpforce final report illustrated that volunteers completed over 13,000 tasks between December 2022 and December 2024, resulting in almost 37,000 patient interactions.

Helpforce recommendations

The CGHN represents a vital mechanism for delivering holistic, place-based, person-centred care in Cornwall. It enjoys strong community trust and reach but requires systemic alignment, sustainable funding, and integrated evaluation to achieve full potential. Strengthened collaboration between NHS, council, and VCSE sectors could transform the CGHN into a cornerstone of a sustainable, community-led health and care system.

Following completion of the foundation research, the Cornwall and Isles of Scilly Back to Health Programme will run for a further two years until October 2027.

The research has provided multiple options that could be explored as a focus during years two and three.

However, Helpforce is proposing two possible options and will work with partners to determine which of these options they will choose as the focus for the remainder of the programme.

Recommendation 1

Development of a CGHN evaluation framework

Current challenge

As highlighted within the 'evidence of impact' theme, participants discussed difficulties in being able to attribute impact to service delivery, burdened by the inability to determine what would have occurred had a service user not accessed a service.

Further, various reporting requirements for different funders, as well as variations in services delivered across the CGHN has resulted in a lack of consistency in impact measures. These misaligned measures often create a heavy administrative burden on Community Hubs, in particular.

Moving forward

Going forward, there should be agreement across VCSE, health and care sectors on what is meaningful to measure to indicate channel shift whilst honouring the diversity in service delivery of the CGHN.

Helpforce's first recommendation, therefore, is to address this challenge through the Helpforce Back to Health Programme.

How this recommendation would unfold

During years two and three, further research and consultation would be undertaken across the CGHN to gather current reporting, evaluation and funder requirements, as well as exploring the possibilities of what data could be collected.

This information would then be brought together and aligned to allow for the development of a consistent reporting and evaluation framework.

Helpforce would assist with the implementation of this framework, data capture, and initial analysis. Throughout this, researchers would examine opportunities to implement data capture mechanisms that could be used to calculate Return on Investment (ROI) and/or Social Return on Investment (SROI) where feasible and useful.

To note, proceeding with this option does hold some risk. The feasibility of achieving a centralised evaluation framework is not yet clear and would be dependent upon a number of factors (such as funder and Community Hub cooperation). Current required data capture may also be too disparate to be standardised. Researchers would consider the feasibility as part of the initial research undertaken, and keep partners informed if the risk increases.

Recommendation 2

Channel Shift Test and Learn Pilots

Opportunity

The foundation research has highlighted a number of opportunities to shift care away from the NHS and towards the CGHN.

Participants discussed various work already undertaken, which is believed to be ***creating a channel shift, but also highlighted further interventions that could be established.***

Seizing the opportunity

Helpforce's second recommendation is to work alongside Cornwall partners to identify existing services that could be further embedded and developed or create new services which are anticipated to result in channel shift.

Depending upon the scale of delivery, this would likely involve two or three pilot programmes.

Key priorities:

These interventions could revolve around any of the areas identified within the foundation research and could be aligned with INT priorities. For example:

- Falls prevention programmes, providing preventative support to those at risk of falls or deconditioning due to frailty, such as the Stronger Together programme.
- Mental health and wellbeing support programmes, designed to support individuals either as they wait for NHS intervention, or as identified as at risk of needing timely intervention.
- Discharge interventions, helping individuals transition from hospital to home. For example, the Volunteering for Health Community Health Volunteer role.

Helpforce's support

1

Programme Management

Helpforce would provide programme management support to develop these interventions around the needs of the local community, social care and healthcare system, and implement and pilot them.

2

Evaluation support

Once piloted, Helpforce would then undertake an evaluation of each service to explore any potential impact on channel shift, but also on wider measures of health and wellbeing for local community members.

Wider system considerations

Whilst outside of the Helpforce programme scope, the foundation research has also highlighted a number of opportunities and challenges that require further consideration by the health and social care system in Cornwall and the Isles of Scilly.

1 Community Gateway as the front door to statutory services

Several research participants discussed the value of placing the Community Gateway as the 'front door' to accessing health and support services, as a key enabler in achieving channel shift.

However, this would be a fundamental change in how services are delivered, and how both providers and service users interact with services.

Further consideration should be given towards whether this is a desired service delivery model for Cornwall.

If agreed, the approach could be tested via a small-scale pilot and subsequently evaluated to ensure the approach is having the desired impact on ensuring appropriate use of healthcare and support services.

2 Volunteering interventions to assist with patient flow

NHS participants referenced several challenges that they currently experience in delivering care to patients. Further, secondary sources reviewed by researchers that reflected the voices of Cornwall's population often raised concerns about having timely access to healthcare.

Whilst outside the scope of the Cornwall and the Isles of Scilly Back to Health programme, Helpforce has implemented hundreds of volunteering interventions across the healthcare sector that have been proven to improve patient flow, reduce pressures on staff, and enhance patient experience.

Consideration should therefore be given to whether similar interventions could be adopted within Cornwall. However, any interventions implemented would need to be considerate of current NHS staff views and concerns around volunteers being a substitute to healthcare staff, being reliable, and being well trained to take on their responsibilities.

3 Visibility and understanding of the CGHN

One of the most commonly reported challenges across this foundation research concerned understanding what support the CGHN offers, how it can effectively support statutory services, and what happens following the referral of a patient into its services.

This lack of visibility was felt to be a key barrier in enabling integration into healthcare delivery and building trust between statutory and voluntary sector services.

Several recommendations were made by participants in how this could be improved, including clearer messaging around services offered, more advertising and marketing, and opportunities for healthcare professionals to visit the CGHN and shadow their work.

Building these relationships will be critical if embedding of the CGHN into health and social care services is ever to be established.

4 A new funding model

Limited, short-term funding was reported as a critical barrier for Community Hubs, in particular, to deliver sustainable services to the local community.

The current funding model adds several burdens to the Community Hubs, ranging from experiencing high staff turnover due to a lack of stability, having to decommission or pause delivery of some services, and an increased administrative burden from having to apply for and manage multiple funding applications.

Participants called for a refresh of the current funding model, reducing the need for competitive tendering and considering longer-term contracts that allow them to fully develop and embed services that would have a positive benefit for their service users.

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Appendices - Research Considerations

1

Researchers have taken additional steps to ensure anonymity of certain participants where smaller numbers were represented in the research.

For example, feedback received from Gateway Outreach Workers is reflected as Community Gateway Representatives, alongside other advisors that participated in the research. Likewise, Community Makers have been termed Community Hub representatives, and Programme of Care Leads/Deputy Programme of Care Leads and Integrated Care Area (ICA) Directors have been termed ICB representatives.

2

Where quotations are included in the research, these may have been slightly amended to allow for correction of grammatical errors or to ensure they translate from verbal to written text.

However, quotes remain directly representative of what research participants reported.

3

Where participants were not aware of the CGHN and the services delivered, they were asked questions more generally about the voluntary sector.

Therefore, throughout the course of this report, CGHN has only been used to reflect feedback provided specifically about the Community Gateway and/or Community Hubs.

4

In order to address the three research questions, tailored questions were developed for different stakeholder groups.

Whilst some questions were asked consistently across participants, others were adapted to reflect the specific knowledge, experience and perspectives of different audiences.

This approach enabled each research question to be explored from multiple viewpoints, while also recognising that different individuals were better placed to share insights on certain areas.

Although some questions were only directed to specific stakeholder groups, we also captured valuable comments from other participants relating to these questions. These comments have been included in the findings. The introduction sections describe how each research question was approached to gather insights.

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Appendices - Authors

Helpforce was founded in 2017 by philanthropist Sir Tom Hughes-Hallett. Partnering with hundreds of UK healthcare organisations, we unleash the power of volunteering and the voluntary sector to deliver measurable benefits for patients, staff, and volunteers themselves. Helpforce staff team has unrivalled expertise in designing, delivering, and evaluating high-impact healthcare programnmes.

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Helpforce is the only independent UK charity focused exclusively on establishing high impact volunteering services across the health system. Its team of experts:

- Co-create innovative volunteering solutions with health and care organisations.
- Enable organisations to maximise the potential of volunteering to improve outcomes for people and services.
- Connect the people leading volunteers to improve quality together.

Founded in 2017, the charity works with NHS trusts, hospices, local authorities, and voluntary and community organisations – directly and indirectly supporting hundreds of thousands of people.

Please note: All images used in this report are for illustrative purposes only.