

CORNWALL AND ISLES OF SCILLY INTEGRATED CARE BOARD

TRANSFORMING HEALTHCARE (2022-2025)

“It's been a privilege to help lead this system. I'm proud of achieving a third ICB breakeven, £114m debt write-off, X-ray and falls cars, major capital developments and the set-up of same day emergency care and community assessment and treatment units, the investment in community-based delivery and inclusion of 12,000 citizens and all system partners in our planning. We've proven what a cohesive, efficient, and innovative health and care system can do.”



John Govett, Chair NHS Cornwall and Isles of Scilly ICB

“I am incredibly proud of the progress we have made as an integrated care system. The innovation that underpins our plans and the joint commitment for delivery being key strengths. This has been commented on regionally and nationally. Central to all of this has been our work with the voluntary sector in Cornwall - the jewel in our crown!

Our colleagues have worked with our people and NHS and local authority colleagues, avoiding admission and getting people home early. The pride with which this is done is palpable.

Our community health and wellbeing workers are working across Cornwall and the Isles of Scilly with our people, families and communities who have the most to gain from our services, providing care and support in neighbourhoods and homes. They have really turned 'caring where it matters' into action.

Finally we shouldn't forget the innovation of our people, the x-ray car (Chrissie Eade), the right care car, the single point of access (Kernow Health CIC), using our green space as a therapeutic intervention (Adrian Flynn), the Helston Gateway project where the local GP practice is working with local people to make a disused supermarket an exciting place for life and care, and the long awaited redevelopment of the integrated care facility on the Isles of Scilly bringing great new models of care to our most remote places. These form amazing examples of many talented people going the extra mile to make services better for our people.

So, as we look back, all our teams across our county should feel rightly proud. From the diversity of research and development at Royal Cornwall Hospitals NHS Trust, the place-based innovation from University Hospitals Plymouth NHS Trust to the Community Gateway and hubs across the county, together we have made a difference. We have a fantastic platform for further rapid change, giving our people what they have asked for... care where it matters.”



Kate Shields, Chief Executive, NHS Cornwall and Isles of Scilly Integrated Care Board

INTRODUCTION

Launched 1 July 2022, the new ICB was an important milestone enabling change to go further and faster.

It started with a common purpose shaped at our True North event:

- Place the individual at the centre of personalised care and ask: “what matters to you?”
- Locate innovative multi-skilled teams closer to homes.
- Drive out inefficiencies to invest in prevention.
- Improve population health and wellbeing and reduce inequity in healthcare.
- Build and retain a health and care workforce fit for the future, from our local communities.

Our aim was, and still is, to see connected, healthy, caring communities for one and all.

We have remained true to this common purpose even at the most challenging times, and the NHS 10 year plan published in July 2025, three years later, validates our approach and priorities, and demonstrates our foresight back in 2022.

The voices of over 12,000 people have shaped strategies, plans, and service redesign to achieve the changes we have made. We would like to say a big thank you to everyone who has taken part.



On 29 and 30 June 2022, 75 stakeholders and partners from across Cornwall and the Isles of Scilly came together to agree a common purpose and approach to transform care and support for the health and wellbeing of our population.

GETTING AHEAD OF THE NHS 10 YEAR PLAN: OUR JOURNEY TOWARDS NEIGHBOURHOOD CARE

In the recently published 10-year NHS Plan the Secretary of State for Health and Social Care showcased our neighbourhood work as 1 of 3 exemplars: *'We know we can build the neighbourhood health service, because teams in Cornwall, Camden and Northumbria are already showing us how to do it'.¹*



Our ambitious journey towards neighbourhood care has included all 3 of the shifts central to the 10-year NHS Plan, including novel community alternatives, capital investment in 21st century facilities, remodelling services, use of AI and establishing integrated neighbourhood teams.

To work with our geography, our system is subdivided into 3 integrated care areas. Each area has enhanced community facilities for diagnostics and for urgent care alongside integrated neighbourhood teams.

In 2022 an Integrated Care Area Committee was added to the ICB's formal governance arrangements and 3 directors were appointed to drive forward change, build relationships in their area with local communities, and strengthen local collaboration across general practice, Cornwall Partnership Foundation Trust, local authority services and the voluntary sector.

Recognising the critical role of General Practice, support was also provided to establish a GP Provider Collaborative, comprising the clinical directors of primary care networks and representatives of the Local Medical Council and Kernow Health CIC.

As the development of neighbourhood health, as set in the NHS 10-year plan, becomes ever more important, the ICB will be looking to set up a flexible and innovative governance model with our local providers to ensure progress on neighbourhood health continues.

“From a GP perspective, I’m especially proud of our support for the GP Provider Collaborative, which has been showcased nationally. We’ve ensured that GP voices are heard at ICB meetings, maintained high performing in and out of hours GP services, and secured key integrated neighbourhood teams funding.”



Dr Stewart Smith, Chair of the GP Collaborative Board and ICB Board member

¹ NHS 10-year plan page 142

SHIFTING TO PREVENTION AT THE VERY LOCAL LEVEL

Shifting and leveraging resources through collaboration with our local voluntary sector we have:

- A network of 51 community hubs provided by local voluntary and community organisations, which are an important informal link into communities for NHS teams and warm, safe spaces for people to connect to support.
- Pain cafes for people to share experience of coping with chronic pain and connect to support from social prescribers, health coaches and physiotherapists from primary care, developing their ability to self-manage the pain and rely less on medication.
- Fifty nine community health and wellbeing workers, living and working in half of our most disadvantaged communities², help people to access health services and encourage them to attend for vaccinations and health screening.

SHIFTING INVESTMENT TO PRIMARY AND COMMUNITY CARE

We have invested in 16 primary care hubs for extra capacity so that GPs can be at the heart of neighbourhood care with time for proactive care for people with complex long-term conditions. Based on their experience of multi-disciplinary care in primary care networks, GPs will lead the development of integrated neighbourhood teams. The whole of Cornwall and the Isles of Scilly will be covered by 16 neighbourhood teams within 3 years. We have the National Association of Primary Care working with us as a strategic partner.

By driving out inefficiencies through cost improvement programmes since 2022, we have now been able to allocate £6 million to the development of the first wave of integrated neighbourhood teams, maximising the value that can be created from available resources.

We have shifted investment into community diagnostics, including a novel approach to reaching people at home, and the development of 21st century facilities closer to people's homes:

- a. An x-ray car brings diagnostics directly to patients at home and, following our lead in Cornwall, x-ray cars are now being rolled out in a number of other areas of the UK.
- b. A partnership is also now in place with University Hospitals Plymouth NHS Trust and Devon ICB to implement an x-ray car for our East Cornwall population.
- c. Three community diagnostic centres in Bodmin, Penzance and Camborne/Redruth plus a new MRI at Bodmin, give people quicker access to important scans and tests closer to home and a shorter wait for diagnosis.

For planned care, moving outpatient care into neighbourhoods is being worked up as part of creating integrated neighbourhood teams.

Same day emergency care centres opened in Bodmin, Penzance and Redruth and integrated with the existing community assessment and treatment units have transformed urgent care from an acute to a community model.

Capital has been secured for a fourth in St Austell later in 2025. To ensure optimum efficiency in how these work alongside other urgent care provision, a single point of access has been implemented for professionals to direct people to the right service for them.

A new stroke ward at Camborne/Redruth community hospital has excellent rehabilitation facilities to improve outcomes for patients.

Increased use is being made of virtual wards with a target to reach the optimum 80% utilisation of our 212 'bed' capacity.

Care for people at end of life is being remodelled to include a 24/7 public and professional phone line, 24/7 end of life care rapid community response and care services, a hospital at home ward, and voluntary sector support service. This has been done with Macmillan as our strategic partner, offering us short term financial support to deliver progress at pace.

This is starting to align funding and resources strategically with the move to neighbourhood care.

Visiting people in their own home, in the first 14 months the x-ray car had an 87% non-conveyance rate, the average time on scene was 41 minutes, and 504 ambulance conveyances were avoided. 161 of the people the car attended were aged 91 or over and 13 of them 101 or over.



² As measured by the national indices of multiple deprivation

MAKING THE MOST OF DIGITAL OPPORTUNITIES

GP practices are implementing AI to understand who is most at risk of a hospital admission and needs extra support from neighbourhood teams. Collaborating with Devon and Somerset, we secured funding from the Health Technologies Adoption and Acceleration Fund for AI and our implementation is the first using a linked data set for the whole of primary care.

We are also one of the first integrated care boards to implement the local analytics hub on NHS England's new national platform.

WHAT OUR JOURNEY TO NEIGHBOURHOOD CARE MEANS FOR LOCAL PEOPLE

Our first priority has been to reform care for older people living with frailty and for people at end of life. This is being achieved.

For older people living with frailty and needing urgent care they can avoid hospital and the risk of becoming less able to live independently:

- They may stay at home with a rapid response to falls and x-ray at home or a response within 2 hours from community services.
- For more specialist assessment they can attend a community assessment and treatment unit (briefly overnight if necessary) and return home.
- A Same Day Emergency Care centre is also available in their integrated care area and they can return home the same day.

- 'Hospital at home' services offer acute care at home as an alternative to hospital or recover safely, under clinical supervision, at home, avoiding long stays in hospital. This saved 35,901 inpatient hospital days in 2024 and is continuing to expand.
- Older people will also increasingly leave hospital as soon as they are clinically fit to do so and their ability to live independently assessed once they are settled back at home.

At end of life more people will have the choice of remaining at home with the support of experienced teams in the community. In North Cornwall a new voluntary sector end of life coordinator post is enhancing support for patients and families, strengthening links between palliative care services and local resources.

35,901
INPATIENT HOSPITAL
DAYS SAVED
IN 2024

APPLYING THE SAME SHIFT FROM ACUTE TO COMMUNITY FOR MENTAL HEALTH

Our commitment to bring parity to mental health services includes the shift from acute care to community-based and innovative collaboration to improve outcomes.

A new community-based mental health reablement service will support people closer to home, prevent hospital readmission and enable earlier hospital discharge, helping reduce the number of people who have to go outside Cornwall for their mental health care. There are plans to add additional beds for people with neurodiversity.

The Dementia Together Advisor service (Memory Matters CIC, Disability Cornwall and the Alzheimer's Society working with Cornwall Partnership Foundation Trust) based in primary care networks, has supported over 1,000 additional people through a diagnosis of dementia to access help earlier to remain well in the community and to prevent carer breakdown through crisis.

The [People in Mind mental health suicide prevention and innovation collaborative](#) has a 5-year contract with the ICB. It is delivered by a partnership of community organisations offering targeted mental health support and aims to improve people's wellbeing, to increase their social connection, improve their financial security and to help to reduce suicide in Cornwall and Isles of Scilly.

For people experiencing a mental health crisis and making a 999 call there is now a dedicated mental health response vehicle for on-scene support.

521,156

calls answered by 111

84,889

supported through 111 online

438,076

mental health face to face appointments

270,966

treated or taken to hospital by
ambulance staff

40,273

virtual ward admissions

309,508

elective in patient spells

650,420

people treated at emergency departments, urgent treatment
centres or minor injury units

2,452,818

hospital outpatient appointments

8,563,717

face to face appointments at GP practices

CARING WHERE IT MATTERS

ACTIVITY SINCE JULY 2022



OUR JOURNEY AS AN ICB



NHS Cornwall and Isles of Scilly ICB launches (July 2022) with a True North Event



Local residents help shape the future of healthcare with the launch of Community conversations engagement (April 2023) – now totalling more than 12,000 people reached



"I was just one of your clients and you changed my life so much, I no longer want to kill myself and have some hope for the future. I don't think you know the effect you have had."

Resident, visited by health and wellbeing worker



Community hubs launch across Cornwall (autumn/winter 2022/3), providing advice, support and companionship



3 Community diagnostic centres are developed (December 2022-July 2025), offering tens of thousands of tests a year



15 new pain cafes (2022/3) across Cornwall help people cut their medication use

"It gave me my life back. I wasn't dopey, I was able to play with my granddaughter it made a completely different Christmas for me. I'd had 25 years of no Christmases"

Sean Jennings, pain cafe patient



16 Primary care hubs (winter 2023/4) offer on the day appointments for people needing urgent care



National visits to local services including Prime Minister Rishi Sunak (February 2024) and Professor Sir Stephen Powis



A new stroke ward opens winter 2023/4 at Camborne/Redruth community hospital



Three same day emergency care centres winter 2023/4) provide tests and treatment for older people living with frailty so they can return home



The Pharmacy First scheme (April 2024) offers treatment for several common conditions without a GP appointment

Mental health emergency response vehicle (October 2024) helps keep people experiencing crisis out of the emergency department



X-ray car (February 2024) helps keep older people living with frailty at home



Acute care at home expands significantly (2022-2025), saving thousands of acute hospital bed days a year



Cornwall and Isles of Scilly take gold for 'Excellence in Healthcare' at the NHS Parliamentary awards (October 2024)



St Austell elective care hub opens (January 2025) providing an extra 5000 planned surgical procedures a year



NHS Cornwall and Isles of Scilly ICB is the first to have all local GP practices registered as veteran friendly (November 2024)

"I was never so pleased as to see the X-ray car ladies. They made sure I was alright, asked whether I needed anything, if I wanted a drink. They got me comfortable, made sure I wasn't in too much pain. They were absolutely excellent"
Cath, X-ray patient

"I was happier at home, but you've also got the security of knowing there's someone at the end of the telephone that you can talk to if you're worried about anything. I would definitely go for a virtual ward every time, if given the choice"

Barbara, virtual ward patient



A mental health rehabilitation centre "The Nest" provides a homely atmosphere to help people recover

"I had pneumonia and bronchitis. Plus I had a breakdown. My mental health wasn't very good at the time, but gradually that has got better and better and a lot of that has got to do with here."

Brenda, Community hub attendee

Cornwall is chosen to pilot "Workwell" (May 2024) a new national work and health support scheme

A new mobile dental van launches (July 2025) to bring NHS check ups and treatment to vulnerable communities

£114m historic debt written off on the back of financial balance three years in a row

Integrated care teams bring health and care workers together to offer local personalised care (spring 2025)

A new facility combining health and residential care is built on the Isles of Scilly (May 2024), building work begins with a Royal visit



OPERATIONAL AND FINANCIAL RECOVERY

The impact of the pandemic meant we inherited long waiting lists and delays in care.

SHORTER WAITING TIMES FOR PEOPLE NEEDING PLANNED TREATMENT

A top priority was to stop people having to wait too long for treatment. We have reduced waiting times by investment in new facilities, increasing the proportion of day surgery, shifting to digital options for outpatient consultations, increasing advice from consultants to GPs before they refer, rethinking the design of outpatient clinics, and offering increased patient choice by organising alternative providers and supporting people to attend appointments and treatment. The number of people on waiting lists and waiting times have been coming down and the full benefits of our new facilities will be realised this year with the number of people receiving treatment within 18 weeks expected to continue to increase.

The new state-of-the-art elective surgical hub in St Austell has seen over 1,000 daycase patients since becoming operational and will deliver around 5,000 day surgery procedures a year.

Between 1 January and 31 March 2025 our planned care team, working with our providers, local GP practices and physiotherapists reduced the number of community patients waiting for musculoskeletal treatment over 18 weeks from 4,300 down to just 50. This work will feed into the guidance for other ICBs in the future.

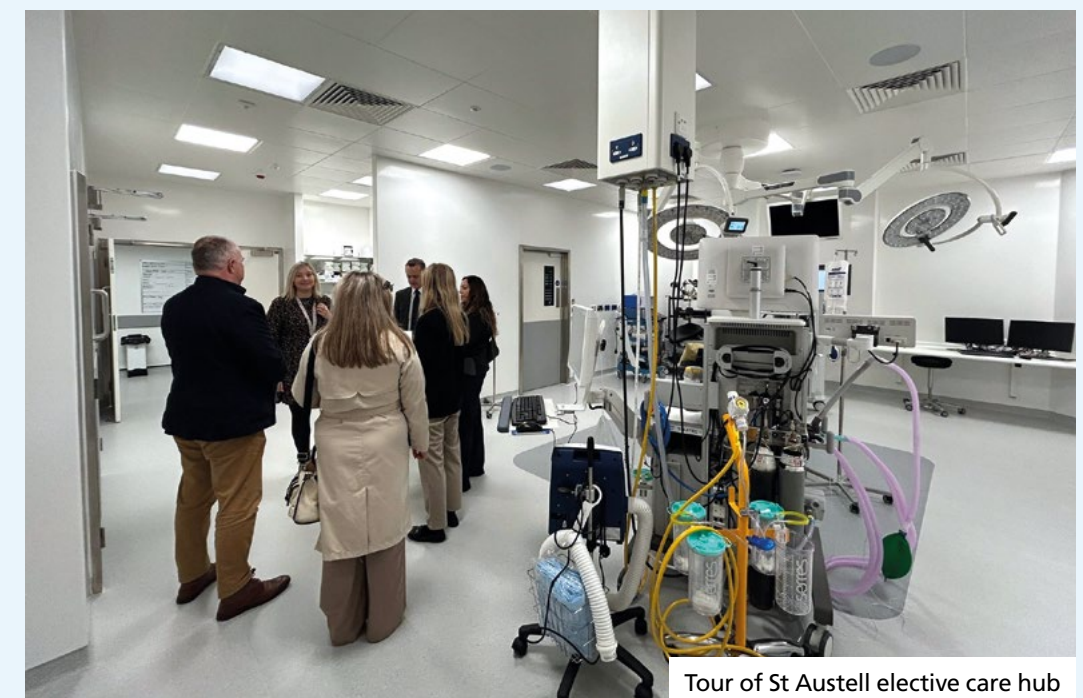
Multi-disciplinary 'super clinics' have been introduced to better support people waiting for orthopaedic surgery.

We have moved from being assessed nationally as a poor performer for planned care to being one of the top performing ICBs in the country.

	Jul-22	May/June 2025	Better/Worse
Total waiting list	61,976	52,850	Better
Total Over 52 Week Waiters	4067	665	Better
Referral to Treatment % within 18 weeks	61.2%	70.3%	Better
Total Over 78 Week Waiters	835	2	Better
Total > 6 week waiters for diagnostics	21,067	16,978	Better
% Patients waiting <6 weeks for diagnostics	61.80%	84.00%	Better
Cancer 62 days wait	74.8%	76.5%	Better
Cancer 28 Day wait	70.00%	80.00%	Better
Cancer 31 days wait	94.4%	96.1%	Better



Opening of St Austell elective care hub



Tour of St Austell elective care hub

OPERATIONAL RECOVERY
FOR URGENT CARE

With a clear objective to reduce delays and improve safety in urgent and emergency care, we have focused on ensuring only people needing acute emergency care are conveyed to emergency departments, that there is a smooth flow of patients through the hospital, and patients able to leave the hospital as soon as they are clinically ready for discharge.

Our intermediate care strategy and delivery plan developed by the ICB and Cornwall Council has led to increasing use of acute care at home in virtual wards and a reduction in the number of people in the acute and community hospitals with no clinical reason to still be there.

Average ambulance handover delays have reduced but remain an issue that we are addressing in our 2025/26 system operating plan. We are continuing to work with our NHS trusts and local authority and voluntary sector partners on improving discharge from the hospitals with a reform programme that started last year and will continue through to 2026/27. Overall the timeliness of our urgent and emergency care performance remains a concern, and we are working hard to do better for our local population.

	Jul-22	May/June 2025	Better/Worse
People in the acute and community hospitals with no clinical reason to still be there	249	162	Better
Average number of patients on a virtual ward	-	126	Better
People treated in emergency departments within 4 hours (All types including minor injury units)	77.6%	76.8%	Worse
People treated in emergency departments within 4 hours (Type 1)	44.3%	43.4%	Worse
% ED 4 Hour Wait > 12 hours	18.0%	16.1%	Better
Average ambulance handover delays (minutes)	201	88	Better
Cancer 31 days wait	94.4%	96.1%	Better

“I’m proud of the work we’ve done on our integrated care strategy, intermediate care strategy, and discharge to assess protocol. The development of standard operating procedures across services, and the Life Course groups—‘Start Well, Live Well, Age Well’—are really embedding and gaining traction across the system.”



Alison Bulman, Strategic Director for Care and Wellbeing, Cornwall Council



MENTAL HEALTH

Whilst there is more still to do, improvements in mental health services have included an increase in people achieving reliable recovery through talking therapies and double the proportion of people with severe mental illness receiving a full annual physical health check.

Our top priority is for fewer people to have to go outside Cornwall for treatment. The new community-based mental health reablement service will prevent readmission and enable earlier discharge from acute care so will improve availability of care locally.

In addition, working closely with local authority and voluntary and community sector partners, we have redesigned support for 132 individuals with complex psychosis who find it difficult to engage with services. Skilled staff from a dedicated team will join them in day to day activities and ensure support if they are starting to relapse to prevent further deterioration.

	Jul-22	May/June 2025	Better/Worse
Mental Health Out of Area Placements	6	23	Worse
Talking Therapies % that achieved reliable recovery	35.0%	46.6%	Better
% of people with severe mental illness receiving a full annual physical health check	25%	56%	Better
% of people with LD receiving a full annual physical health check	57%	60%	Better

IMPROVING HOW WE ENSURE QUALITY AND SAFETY OF CARE AND PREVENT SPREAD OF INFECTIONS

As demand and cost pressures increase, ensuring quality and safety of care is critical and we have strengthened our capability to do so, recruiting a new patient safety specialist and a new head of clinical quality. Quality assurance is embedded in the development of commissioning intentions and reform programmes with senior clinicians having oversight.

We have taken action where necessary to improve safety and quality, such as supporting almost 900 patients to have their orthopaedic surgery elsewhere to significantly reduce the number of people waiting more than 52 weeks for surgery.

Our System Quality Group comprising Healthwatch, the Care Quality Commission, Cornwall Council, our NHS trusts, NHS England and voluntary sector partners provides a forum for sharing intelligence and good practice and driving quality improvements.

We collaborate with Cornwall Council to jointly provide quality oversight and support to nursing homes.

The Infection and Prevention Control team have established and matured the system Infection and Prevention Control Alliance, successfully supported the management of over 365 outbreaks over the last three years, implemented a targeted support strategy for both adult social care and primary care settings, and launched projects based on learning from experience analysis to reduce community-onset infections.

FINANCIAL RECOVERY

By breaking even for 3 consecutive years, historic debt we inherited of £114 million has been written off by NHS England.

We have reduced the ICB's own costs by 30% last year and are now preparing to cluster with Devon to reduce our costs further.

We have done this whilst continuing to invest in new services, new technology and new equipment and space to care.



GETTING AHEAD OF THE NHS 10-YEAR PLAN: IMPROVING POPULATION HEALTH

Since establishment the ICB has maintained a consistent strategic direction. Our end goal, set out in our strategies and plans, has driven our approach throughout the last three years. It is:

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



START WELL

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



LIVE WELL

We all live well.



AGE WELL

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

We have connected, healthy, caring communities for one and all

People need different support at different stages of life in different circumstances. We can help people the most in collaboration with our local councils and voluntary sector partners.

To drive this forward we set up, in partnership with Cornwall Council, joint executive level steering groups for Start Well, Live Well, and Age Well, tasked with achieving joint priorities. The priorities focus on some of the most vulnerable groups in our population.

Giving babies, children and young people the best start to life is integral to reducing risks to both physical and mental health in later years.

We have improved maternity and neonatal care and a major capital investment is underway for a women and children's hospital.

We commissioned the Royal Cornwall Hospital Trust to run the 'Kernow Parenting Journey,' service user-led antenatal education. Together with implementation of personalised care and support plans, this is being reviewed nationally as best practice.

We have introduced initiatives for improving infant and parent relationships, taking good care of children's teeth, improved care for young people with food and diet related behaviours that negatively affect their health, and responding to growing concerns about children's mental health, we are one of the national leaders in providing access for children to psychological therapies.

For those who are neurodivergent, we have enabled the voluntary community and social enterprise sector to facilitate work with children and young people with lived experiences to design services including an advice and information hub for neurodiversity. We know we have more to do, particularly to reduce the waiting time for assessment. In the meantime we are supporting families whilst they wait.

For people of working age we are trying to help them continue to work despite long-term illnesses and ensure how we provide health services is not a barrier to work or makes it difficult for working people to access care. We are one of 15 areas nationally pioneering a new approach to work and health to help prevent people falling out of work and support them back into work, ensuring we have the workforce needed to drive growth in our economy.

We are 1 of 17 Integrated Care Boards across England to have secured funding to develop more efficient ways of getting people with musculoskeletal problems treated, off waiting lists and back onto the path of employment.

We are also redesigning care for people with long-term conditions and focused initially on diabetes, introducing 'super clinics' enabling people to attend one instead of multiple clinics, including at weekends making them more accessible to people at work and helping them to improve their management of the condition.

For older people to age well, our focus has been on enhancing community care for those living with frailty, as set out on page 04.

For people experiencing health inequalities

The challenge is to allocate proportionately more of our resources to those experiencing most inequity in access or outcomes. Our community health and wellbeing workers are based in the worst affected communities.

GP practices in areas of highest deprivation aim to ensure 80% of people with hypertension receive optimal treatment, reducing heart attacks, strokes, and death.

For people with learning disabilities we are the best in the Southwest region for the take up of annual health checks reflecting the strong partnership between Cornwall Partnership Foundation Trust's learning disabilities liaison team and screening teams and primary care.

Farmers who are at increased risk of asthma and musculoskeletal conditions, have higher rates of suicide, and are less likely to access healthcare in traditional settings. We commission Fairwinds Fishing and Farming to deliver targeted mental health support to fishing and farming communities.

A new health coaching service has been designed to empower people with long-term conditions to improve their wellbeing and self-management with a special project targeting farmers in Bude.

We are also working with partners to find innovative ways for fishermen to take up the offer of annual health checks as part of a programme sponsored by Health Innovation Southwest.

The Gypsy, Roma, and Traveller community experiences some of the worst inequalities and we are working with the Institute of Health Improvement CORE20PLUS5 Collaborative to ensure they have access to cancer screening.

The ICB is a member of the community safety partnership that is tackling the root causes of unhealthy relationships, domestic abuse and sexual violence and violence against women and girls. The Domestic Abuse Commissioner for England and Wales praised the partnership's strategy as 'ambitious' and recognised our local work to improve the health response to victims. We commission a general practice domestic abuse support service that directly links specialist domestic abuse services with general practices. We have seen the difference this has made, with a five-fold increase in the number of referrals.

A pilot initiative in Torpoint is seeking to upskill general practice with support for asylum seekers and refugees alongside Live Well Plymouth and community care.

More than 30 organisations are working together to tackle health inequalities through the Launceston health hub.

Inequalities in women's health

We are bringing integrated healthcare services to women across our area. They are designed to offer more advanced care than a GP practice may offer, but where a hospital referral may not be needed. They are also not limited to a single condition.

We recently hosted a conference dedicated to women's health and Dame Lesley Regan, Women's Health Ambassador for England, attended to share her reflections and to hear about the good work we are leading locally.

Our community provider has been running musculoskeletal community appointment days at the Royal Cornwall Showground in March, May and July designed to be a one stop shop of health check, Musculoskeletal (MSK) assessment, physio, plus a community village of multiple VCSE partners (healthy Cornwall, iCareiMove, social prescribers, talking therapies, health coaches, and many more). People coming for their slot, can have between 3 and 6 "touchpoints" reducing the need for multiple separate appointments and travel.



DOING THINGS DIFFERENTLY

Collaboration with the voluntary, community, and social enterprise sector is a major part of our journey towards neighbourhood care:

By investing £4 million in the development of the sector's infrastructure we are able to work with an alliance of organisations linked to the wider sector and linking health and care to voluntary sector delivery. This also incorporates investment in small grants to grassroots organisations, charities and community groups recognising the support and value for money they provide.

We have increased investment in VCSE delivery across multiple areas – mental health including dementia, hospital discharge, community hubs and community gateway, community health and wellbeing programme etc (in excess of £20m overall).

Community hubs and community health and wellbeing workers are hosted by our voluntary sector.

Introduction of community health and wellbeing workers, based on a programme originally developed in Brazil, demonstrates our ability to draw on global initiatives that we can learn from to support our local populations. Through individualised coaching conversations, the workers develop personalised care and support plans, which will include proactive care planning, with the addition of access to personal health budgets where appropriate. They are aligned to primary care networks and are valued contributors to multi-disciplinary teams, often transforming lives by linking to non-health related support. They are also a new addition in building a health and care workforce fit for the future from our local communities. The initiative was a finalist for a prestigious national health service journal (HSJ) award and won for the VCSE collaboration in the NHS parliamentary award.

The Hometogether Collaborative comprising Stay at home, disAbility Cornwall, Volunteer Cornwall and Age UK, in collaboration with Cornwall Council STEPS was recognised and awarded for outstanding contributions by the voluntary sector at the NHS Parliamentary Awards.

Together they are helping people to stay independent in their own homes by providing support that avoids hospital admission or enables earlier discharge. This includes:

the Community Gateway helpline; which took 48,000 calls and provided 7,000 personal support plans over 1 year

the network of more than 50 community hubs; which has supported roughly 1 in 4 people in Cornwall

The Home Together Reablement Collaborative; which supports 56 people a week to leave hospital

For the past three years the ICB funded a local charity, Volunteer Cornwall, to work alongside the Cornwall Greener Practice Network to support general practice to embed environmental sustainability combined with health creation. Change has been contagious with practices beginning to measure and reduce their carbon emissions, encourage people to spend more time in green spaces or by the sea, deliver energy efficiency projects, embracing walking and cycling as 'active travel,' creating new green spaces for health and wellbeing for staff, patients and the community, reducing waste, adopting sustainable procurement processes, and reducing single use plastics.

We were the first integrated care system where all local GP practices were registered as veteran friendly.

On St Mary's on the Isles of Scilly, groundbreaking work integrating community hospital and care home services on one site served by a single workforce is nearing completion, paving the way for how integration can work in remote communities. The facility provides 12 residential care home beds, NHS inpatient beds and a modern maternity suite.



WHAT HAS CHARACTERISED OUR WORK

The learning we can carry forward to the new clustering arrangements with Devon is that these characteristics are key success factors for transforming care.

- The convening power of the ICB to bring all players together in one space for a common purpose has had a major impact on accelerating change.
- Robust and influential engagement and vignettes of people's experience at our board meetings so we remain connected to the reason we exist.
- A consistent strategy and consistent commitment to delivering a common purpose.
- Reaching out into communities.
- Leveraging limited resources through collaboration.
- Positioning the voluntary and community and social enterprise sector as a key partner in neighbourhood care and investing in them early in the process.
- Balancing our budgets whilst investing in priorities for the future.
- Governance and executive oversight aligned to driving forward delivery of the strategy.
- A commitment to innovation.
- Strategy and plans are evidence-based.
- Bringing in strategic partners to ensure we are drawing on best practice and to challenge our thinking, approach and pace, as well as in some cases bringing in funding to get us started, e.g. as in the case of Macmillan.

- Working together with a common purpose focused on the needs of our population has led to the priorities for our population taking precedence over the traditional interests of organisations with us all rethinking our way of working and increasing collaboration.

We have laid the foundation for neighbourhood care and for closer working with local authority services.

We will continue to do things differently to improve the health and care of our population and we are taking this legacy of innovation into the new cluster with Devon.

STRIVING FOR IMPROVEMENT

We are also committed to continuing to work on those areas where we know we need to improve. These include:

- The timeliness and quality of urgent and emergency care
- Reducing the number of avoidable out of area placements for patients with mental health issues

We have established a Transformation Support Hub to provide us with the improvement capabilities and programme management approach we know is key to delivering improvements, and the discipline this is providing gives us a good foundation on which to build as we design our operating model for the future.



“It has felt an inclusive and diverse board that has managed difficult situations well and celebrated our successes, - it reflects true system working now producing population health based better outcomes for the people we serve within a balanced budget.”



Nick Kaye, ICB Board member

REFLECTIONS ON THE WORK OF THE ICB

Based on feedback from Board members and participants July 2025

Challenges Unwavering Neighbourhood
Prevention *Impact* GPs SERVICE DESIGN STEWARDSHIP ASSETS
Collaborative *Impact* Insight Case-Studies VISION Pioneering
Proud INNOVATIONS DIGITAL *strong* PRIORITISING
Trust VCSE Engaging Developments Community
People-centred Primary care STRATEGY INCLUSION
Investment Remarkable CHAMPIONING Achievements equity LIFESPAN

WHAT NEXT?

Priorities for the rest of the year to March 2026

The Government has set out a bold, ambitious, new course for the NHS.

The Government's 10-year plan for the NHS in England fundamentally reinvents the approach to healthcare so that we can guarantee the NHS will be there for all who need it for generations to come.

Through the 'three shifts' – from hospital to community, from analogue to digital, and from treatment to prevention – the NHS will personalise care, give more power to patients, and ensure that the best of the NHS is available to all.

You can learn more about the three channel shifts and how they will impact people's health and wellbeing in this [short film, Caring where it matters - that sets out our commitments for Cornwall and the Isles of Scilly](#).

Priorities for the rest of this year are:

- Improving care in the community for older people living with frailty.
- End of life care in the community offering the choice of a 'hospice at home' approach as an alternative to a hospital bed.
- Getting people home from hospital as soon as they are fit to leave.
- Improving care for people with serious mental health issues.
- Implementing integrated neighbourhood teams.

These changes will see ambulance delays reduce, and more people will receive timely emergency care in our hospitals.

Over the next few months, more of our workforce will be part of multi-skilled teams, caring for people in local community facilities,



Caring where it matters - scan QR code to watch

or people's own homes where it is easier to get an all-round understanding of what matters for each person and the help they need.

We will start to see more out-patient appointments and services that do not need the facilities of an acute hospital being provided more conveniently for people closer to home, reducing the footfall in our busy hospitals. There are a range of clinics, including pain clinics, rheumatology, dermatology, musculoskeletal, and paediatrics, that can be provided for most patients without the need for specialist hospital facilities.

Ultimately people will be receiving the right care in the right place, at the right time to achieve what matters to them and at a cost the NHS can sustain.

CARING WHERE IT MATTERS

Shifting health services closer to our people and communities.

We are doing this to improve access, reduce delays, improve performance and outcomes, whilst delivering financial stability.

Providing the right care in the right place, at the right time, and at the right cost.

CLUSTERING AND THEN MERGING WITH DEVON

The Government announced plans earlier this year to reduce the running costs of Integrated Care Boards, achieved initially by the clustering of integrated Care Boards, ahead of future mergers. As a result, it has been agreed nationally that Cornwall and the Isles of Scilly and Devon ICBs will cluster, under shared leadership.

Ahead of any formal merger, not expected ahead of April 2027, the ICBs for Cornwall and the Isles of Scilly and Devon will continue to exist as sovereign organisations, and whilst where possible the requirements and governance of each individual ICB will be fulfilled jointly through a committee-in-common, with shared leadership, financial allocations will continue to come to each of the sovereign ICBs to support the delivery of healthcare for the population of Cornwall and the Isles of Scilly.

The government has produced a national model blueprint for how ICBs will work in the future.

Our journey towards neighbourhood care has already started to transform healthcare in Cornwall and the Isles of Scilly, but there is more to do, now enabled by the framework set out by the Government. We are proud of the foundation we have laid for a health service that is truly fit for the future , and look forward to seeing this work flourish as we move into the new arrangements with Devon. This will of course also have a positive impact on our emergency services and waits for planned care as our acute hospitals will be able to focus on the services only they have the skills and expertise to deliver – a system working together at its very best for the patients we serve.





