Hospital and Home Services

April 1st 2023 to Mar 31st 2026

Who we are

Between April 2023 and March 2026, Hospital & Home helped people across Cornwall and the Isles of Scilly remain independent, recover safely at home and avoid unnecessary reliance on health and care services. Through a combination of discharge support, admission prevention, practical assistance and community-based interventions, the **service supported almost 3,000 hospital discharges, prevented more than 1,600 admissions and enabled over 4,000 people to reach a point where support was no longer required.** The impact extended beyond the individuals supported. Using conservative estimates Hospital & Home activity equates to **7,540 acute bed days released or avoided and over £10 million of indicative gross system value through reduced demand on hospital, health, social care and community services.**

Most importantly, behind every figure contained within this report is an individual who was able to remain independent, regain confidence and continue living safely within their own community.

Impact snapshot

2,946
number of discharges

4,594
discharge and prevention interventions

1,648
admission preventions

Cornwall & the Isles of Scilly age UK Let's change how we age

CHAOS GROUP

Volunteer Cornwall



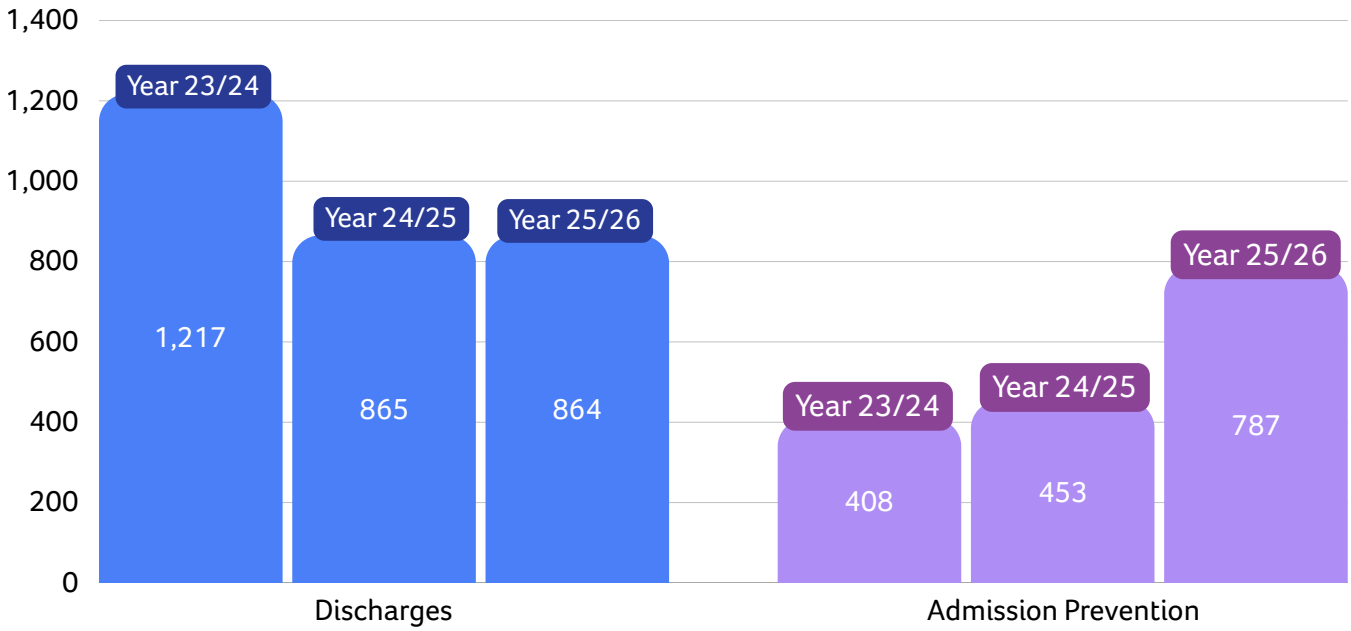
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Hospital & Home operates on the principle that timely support can significantly impact individuals facing health challenges. Hospital admissions can lead to loss of confidence and increased reliance on care services, while those ready for discharge often encounter barriers to safely returning home. This service bridges that gap by providing personalised, practical support to help individuals regain independence, improve health & wellbeing, and avoid unnecessary hospital admissions.

The report covers three years of activities from April 2023 to March 2026, highlighting the scale of assistance provided and its positive effects on individuals and healthcare systems. While financial metrics are included, the primary focus is on personal outcomes, emphasising the importance of maintaining independence and confidence in one's own home.

Supporting People Home and Preventing Admission



Whilst discharge activity remained consistently strong, the growth in admission prevention activity is notable. By FY2025/26, admission prevention activity had almost doubled compared with FY2023/24. This reflects an increasing contribution to helping people remain safely at home and supporting earlier intervention before concerns escalated into situations requiring hospital admission.

The figures demonstrate that Hospital & Home was not simply responding when people left hospital. Increasingly, the service was supporting people earlier, helping them remain well, connected and independent within their communities.

Sally's Story

Sally is from West Cornwall, and in her late nineties. She was referred to the H&H team following a challenging discharge from hospital. Following a fall that resulted in a broken leg, she endured pain and discomfort. Discharged at the earliest opportunity, sadly, the necessary provisions were not fully prepared for her return home.Recognising the escalating risks to Sally's health & wellbeing, the H&H team swiftly responded upon her referral, conducting an initial assessment to prioritise her needs. Their first steps focused on arranging transportation for upcoming appointments, ensuring Sally had access to warm, nourishing meals, and providing the necessary support at home.

Wiltshire Farm Foods jumped into action, which the client was delighted with, and provided an opportunity for easy preparation or for someone else to easily help without Sally feeling that she was a burden. The team also arranged to visit for four weeks, providing companionship and gently encouraging Sally to do her physio and recommended self-exercises. During these sessions, the team also found funding to support Sally with domestic support services—Active Living Service began helping out around the home and garden. Sally explained, ***"This is so helpful; I not only get the support I need, but I get to discuss my recovery and I can plan for my next appointments. I am feeling more confident and safe."***

The team also arranged for accessible transport, with Age UK Cornwall and Volunteer Cornwall taking the lead. This ensured that Sally could attend her appointments on time, which significantly reduced Sally's anxiety pre-admission, as previous transport arrangements had been a little unreliable.

During the four weeks of support, the team worked with Sally to rearrange some items in the house so it was easier for her to move around and carried items, some sentimental, upstairs for storage that Sally said got in her way. Thankfully, Sally also had a wonderful neighbour, who gradually got more involved with the support team and built up a connection with Sally. This meant that over the last ten days of support, as the team stepped back, Sally and her friend took over. Her neighbour has continued to support Sally with her shopping and maintenance—with Sally joining in the household tasks—it became clear that Sally would soon be doing this independently but was able to take a steady approach as her recovery progressed.

Sally made remarkable strides, her heart brimming with gratitude. Her neighbour, now a dear friend, also expressed thanks to the team for empowering them, as they no longer felt "scared" in providing support. Wiltshire Farm Foods continued their magical meal deliveries until Sally was ready to reclaim the kitchen once more. **Sally's inspiring journey underscores the significance of establishing the right foundations, demonstrating that practical measures can pave the way for greater choice and control, ultimately guiding a person toward regained independence.**



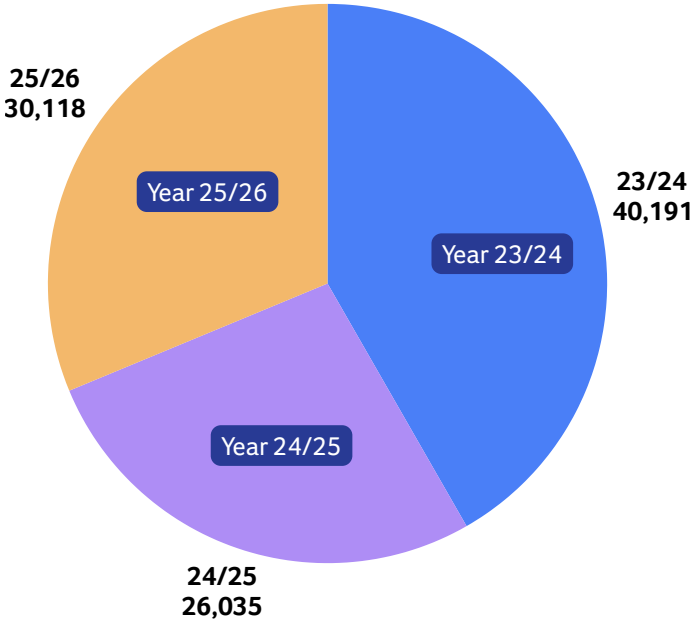
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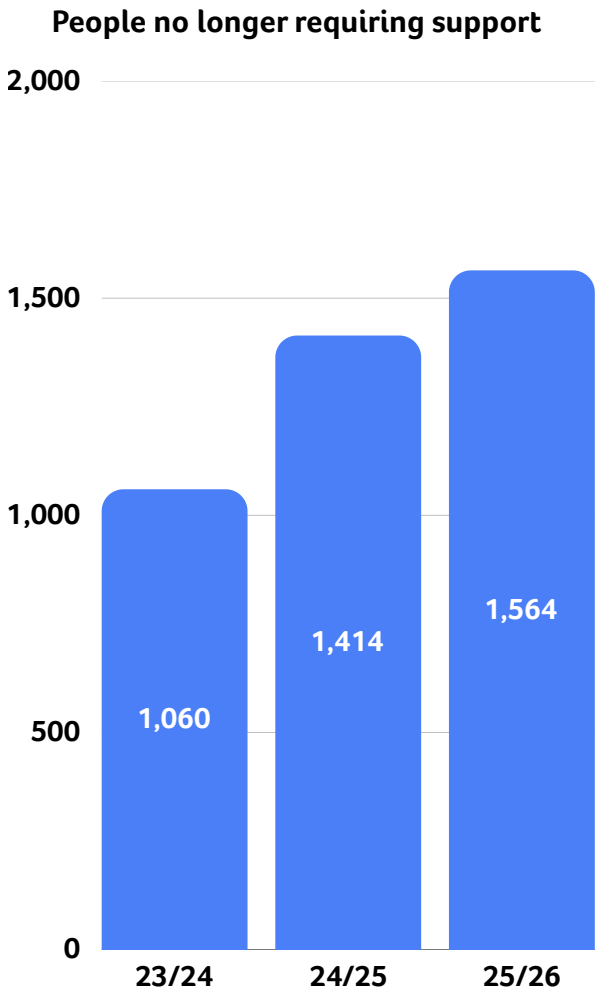
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Delivering Support in the Community

Alongside discharge and prevention activity, Hospital & Home delivered substantial levels of practical support within communities across Cornwall and the Isles of Scilly. This support helped people settle safely at home following discharge, access services, maintain daily routines, rebuild confidence and remain connected to their communities.

Between April 2023 and March 2026, the service provided more than 96,000 hours of support.





Supporting Independence

This is arguably the most significant outcome contained within the report and provides the clearest indication of the difference the service made to people's lives. Whilst hospital discharges and admission preventions demonstrate activity, the number of people who no longer required support demonstrates outcomes. It provides evidence that people were not simply receiving assistance at a point of crisis, but were being supported to regain confidence, rebuild routines and maintain their independence over time.

Behind these figures are thousands of individual stories of people regaining confidence, rebuilding routines, strengthening support networks and continuing to live independently within their communities. For many people, success was not simply returning home following discharge or avoiding hospital admission. It was reaching a point where formal support was no longer required.

I feel my confidence has improved since joining Hospital & Home Services - I was able to talk, share my feelings, and cry - there was always someone who listened to me. Pauline, Mid Cornwall

I had no idea how I was going to get home, your driver was fantastic and even helped me into the house; making sure I was okay. Darren, West Cornwall

I wish you could stay with us, since I returned from the Hospital, it's like having my on ray of sunshine every day. Maggie, Mid Cornwall

I spoke to someone on the Gateway about my needs following my fall. I instantly felt better - every concern was met with unwavering care. Soon after, they connected me with the Hospital and Home team, and oh, how my life transformed - thank you so much. David, North East Cornwall

The difference we made

Although the activity figures demonstrate scale, they do not fully capture the difference the service made to individuals. Throughout the life of the service, support was tailored to people's circumstances and often focused on rebuilding confidence, reducing isolation and reconnecting people with sources of support within their communities. **The feedback and stories we received consistently highlights the value of practical help delivered alongside compassion, reassurance and human connection. The numbers tell part of the story. People's experiences help bring them to life.**



The Community Hubs stand as a vital lifeline, offering essential support and services - infused with warmth and care - to countless patients in need. What a wonderful service and brilliant team.

Royal Cornwall Hospital feedback

I am feeling stronger thanks to regular meal deliveries - the little chats and check-in's are an added bonus.

delivery services and meals on wheels

Building Community Strength & Resilience

What a wonderful service this is! I am linked to The Chaos Group, Volunteer Cornwall, Age UK Cornwall, and I am now attending a local hub in Falmouth - who have put me in touch with a cancer support group, where I am able to get even more information and connect with people going through the same thing.

making connections throughout the community

Your support has built confidence, create connections, and helped Mum go out and experience new things - the difference is remarkable - thank you.

a loving Daughter

Making it real

The following case studies are based on real individuals supported by Hospital & Home. To protect privacy and maintain confidentiality, identifying details have been removed and some circumstances have been adjusted or combined. ***These short case studies remain representative of the situations encountered and outcomes achieved through the service.***

Case Study: Preventing Admission and Restoring Independence

A client was referred because of concerns around self-neglect and an increasing risk of hospital admission. The individual had become isolated, was struggling to manage their home environment and was finding it difficult to engage with available support. Through practical assistance, encouragement and regular contact, Hospital & Home helped the individual improve their living environment, reconnect with available support and regain confidence in their ability to manage day-to-day life. As support progressed, the individual became increasingly independent and was able to reconnect with their existing support network. What began as a referral because of concerns about deteriorating circumstances and potential hospital admission concluded with the individual in a much stronger position, requiring significantly less support and better connected to both community and personal support networks. ***This case demonstrates how relatively small interventions, delivered at the right time, can prevent escalation of need and support long-term independence.***

Case Study: Supporting a Safe Return Home

One individual was referred following discharge from hospital, having previously experienced difficulties at home that had resulted in readmission. The person was understandably concerned about managing independently and lacked confidence about coping once home. Hospital & Home provided practical support and reassurance, working alongside the individual to establish routines and build confidence. Over time, the individual became increasingly comfortable managing day-to-day activities and developed a clearer understanding of where help could be sought if needed in the future.
The outcome was not simply a successful discharge from hospital, but a sustainable return home supported by increased confidence and greater independence.

Case Study: Recovery Following Stroke

Following a stroke, one individual faced a combination of physical, financial and emotional challenges that affected both recovery and confidence. Hospital & Home provided practical support and assistance whilst focusing on enabling the individual to do as much as possible independently.
The emphasis was on supporting recovery rather than creating dependency. As recovery progressed, the individual reported feeling more positive, more confident and less concerned about burdening others.
The support provided helped focus attention on what could be achieved rather than what had been lost, enabling positive steps towards greater independence.



Support is great and being able to talk and cry when I needed to was really appreciated.

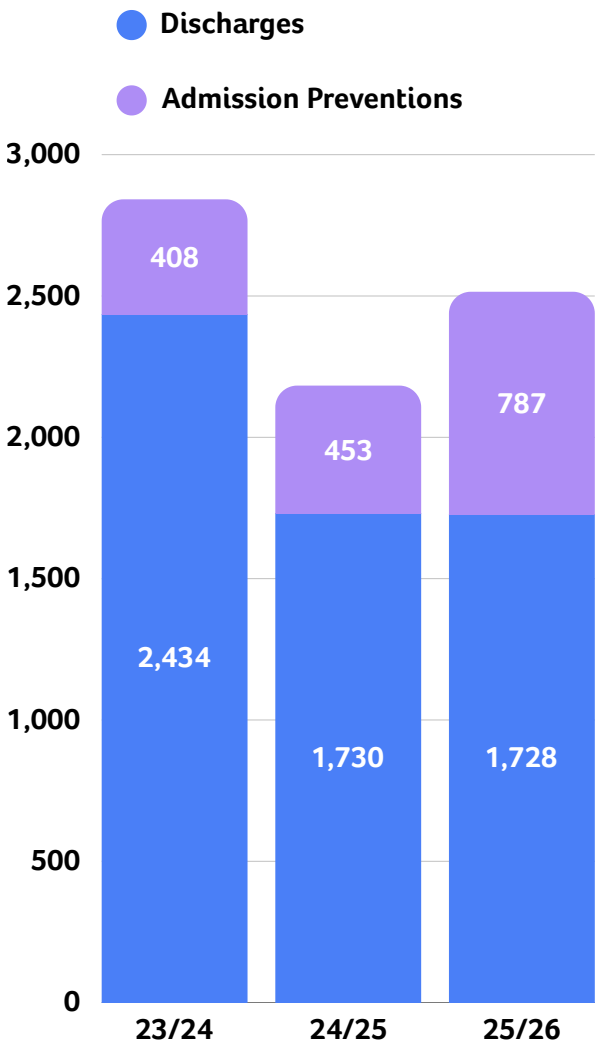
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Supporting hospital flow

In February 2025, Hospital & Home introduced the Community Gateway Transport service. Using volunteer drivers and their own vehicles, the service helped address a simple but important issue: people who were medically ready to leave hospital but unable to do so because transport was unavailable.

Whilst transport represented a relatively small proportion of overall activity, it addressed a practical barrier that can often delay discharge even when all clinical barriers have been resolved. By providing a flexible, volunteer-led solution, Community Gateway Transport helped people get home safely whilst supporting efficient use of hospital capacity. **Between February 2025 and March 2026, 296 people were transported home** - in many cases a welfare check and further support was provided to ensure the person was safe, comfortable, and had everything they needed.



Reducing Demand on Health and Care Services

Alongside the difference made to individuals, Hospital & Home also contributed to reducing demand across the wider health and care system. To understand this impact, deliberately conservative assumptions have been applied.

The analysis assumes:

- **Each admission prevention avoided one overnight hospital stay.**
- **Each supported discharge released two hospital bed days.**
- **Each person who no longer required support avoided only two weeks of health and care support, equivalent to:**

28 hours of social care support.
Four community health visits.

These assumptions were intentionally chosen to avoid overstating impact and are likely to understate the true contribution made by the service.

In total, 7,540 acute bed days released or avoided across the 3 year reporting period.

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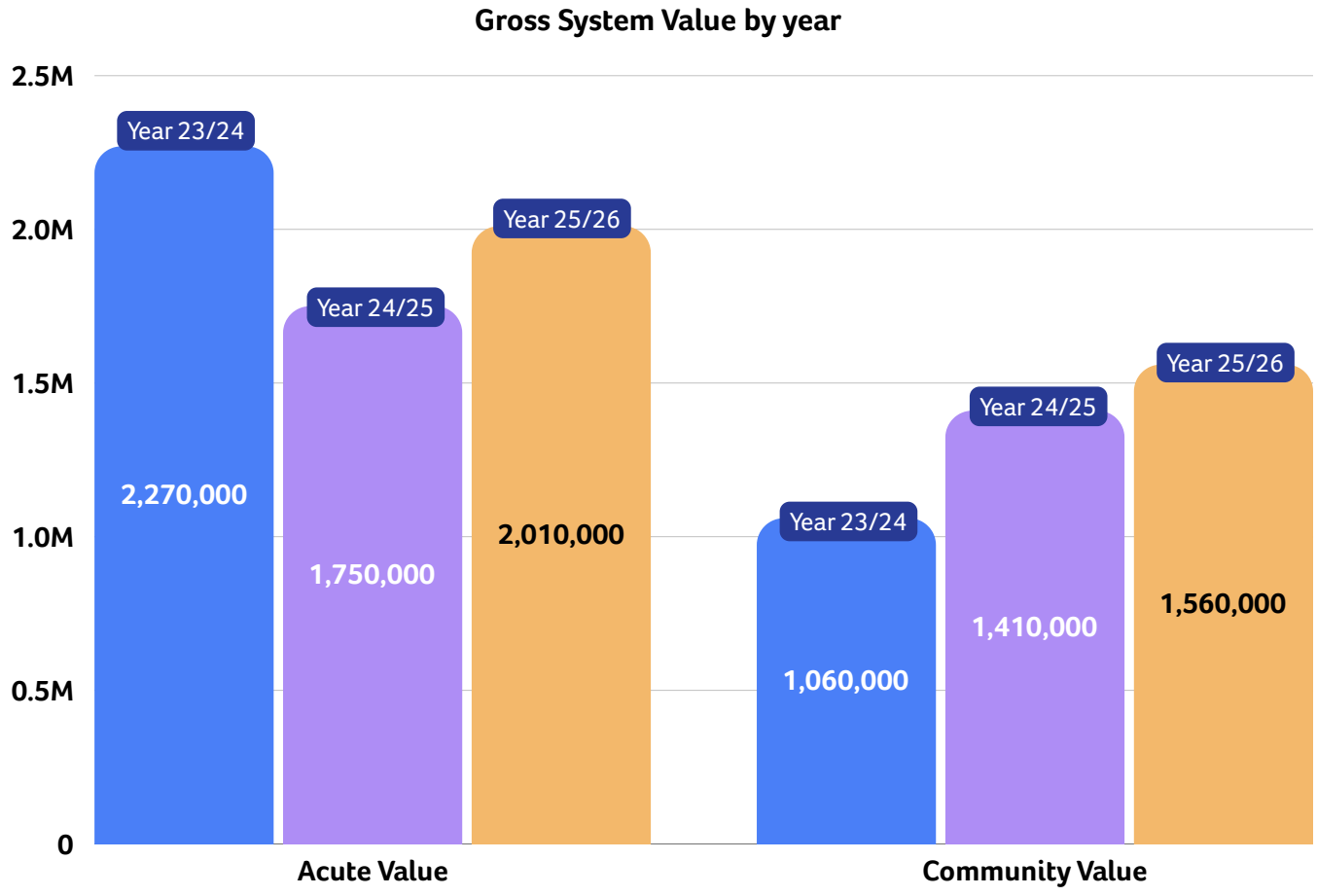
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A Valuable Service for our Systems

Using published NHS non-elective bed-day costs together with the conservative community support assumptions outlined above, Hospital & Home activity equates to the following indicative gross system value. ***The figures below combine the estimated acute hospital impact with the conservative community health and social care assumptions described within the methodology.***

These figures should be viewed as indicative gross system value and avoided demand rather than cashable savings. Importantly, the assumptions used are deliberately cautious. Many hospital stays extend beyond a single overnight stay, delayed discharges can occupy beds for significantly longer than two days and many people would be likely to require support for longer than the two-week period used in the community value calculations.

The purpose of the analysis is therefore not to maximise value estimates, but to provide a reasonable and transparent indication of the likely scale of contribution.



In summary, over a three-year reporting period, the estimated Acute Value amounts to £6.03 million, while the Community Value is £4.04 million. This results in a total Gross System Value of £10.07 million.

In Conclusion

Between April 2023 and March 2026, Hospital & Home supported almost **3,000 hospital discharges, prevented more than 1,600 admissions, enabled over 4,000 people to reach a point where support was no longer required and helped almost 300 people return home through Community Gateway Transport**.

The activity data demonstrates scale, but the stories behind the figures demonstrate something equally important: that relatively small, timely interventions can have a lasting impact on people's lives.

Taken together, these outcomes highlight the important role that community-based support can play, both in helping people live well and in supporting the wider health and care system.

Confidence was restored. Independence was maintained. People remained connected to their communities. Pressure on hospitals and community services was reduced.



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Understanding the methodology

The service's primary purpose was to improve outcomes for people rather than generate financial savings. However, understanding the wider contribution made by Hospital & Home can help illustrate the scale of its impact across health and care services. To provide a transparent and cautious estimate of this impact, a number of deliberately conservative assumptions have been applied. The methodology has been designed to avoid overstating the contribution made by the service and, where uncertainty exists, assumptions have been set at the lower end of what might reasonably be expected.

Bed-Day Cost Assumption

The estimated value of released or avoided bed days is based on published NHS non-elective bed-day costs. The most recent publicly available figures identified were provided by the Department of Health and Social Care in response to a parliamentary question in December 2025, drawing on NHS England's National Cost Collection data for 2024/25. These reported average costs of £791 per non-elective long-stay bed day and £806 per non-elective short-stay bed day. **A rounded figure of £800 per bed day has been used throughout the analysis.**

Community Health and Social Care Impact

Hospital & Home also recorded the number of people who reached a point where they no longer required support. To estimate the potential impact on community health and social care services, each of these individuals was assumed to avoid only:

- **Two weeks of support.**
- **Two hours of social care per day.**
- **Two community health visits per week.**

This equates to:

- 28 hours of social care.
- Four community health visits.

A rounded value of **£1,000 per person** was then applied.

The assumption is intentionally cautious and reflects only short-term avoided support. It does not attempt to quantify any longer-term impact arising from sustained independence, reduced reliance on services or future admissions avoided.

Why Conservative Assumptions were used

The purpose of the analysis is not to maximise financial estimates but to provide a credible indication of scale. It is recognised that:

- **Many emergency admissions exceed a single overnight stay.**
- **Delayed discharges can result in bed occupancy substantially longer than two days.**
- **Some individuals may avoid much longer periods of health and social care support than the two weeks assumed within this analysis.**

The figures presented within this report should therefore be regarded as indicative estimates of avoided demand and gross system value. They are not intended to represent cashable savings.

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Understanding the methodology

Acute Hospital Impact Assumptions

The financial model applies two assumptions:

Admission Prevention

Each admission prevention recorded by the service is assumed to have avoided a single overnight hospital stay. This assumption is deliberately cautious. Many emergency admissions, particularly amongst older people and those with multiple health conditions, result in stays significantly longer than one night. However, applying a single bed-day assumption ensures the estimate remains conservative.

Supported Hospital Discharge

Each hospital discharge supported by Hospital & Home is assumed to have released two acute hospital bed days. Again, this is considered a cautious assumption. Delayed discharges frequently occupy hospital beds for longer periods; however, a two-day assumption was selected to avoid overstating the impact.

Acute Hospital Impact

Applying these assumptions suggests that the service contributed to:

7,540 Acute Bed Days released or avoided

Equivalent to almost:

7 Acute Hospital Beds Continuously Available Across The Three-Year Period

This provides a useful illustration of the scale of contribution made through supporting discharge and preventing admission.