

01872 266383 gateway@ageukcomwell.org.uk Your new hell and advice. C 7 days a wee Supporting people to Step into Wellness



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# Cornwall's Community Gateway

VCSE network for support and advice

#### Who is it for?

All adults

All conditions

Hub and spoke – locality shaped

Focus on people, their assets and their conversations Not an urgent service but a holistic one

# This is Gateway - a collaboration of people and place

Multi-agency, holistic and preventative focus through locality MDT and hub referrals Locality Volunteer engagement and leads support – welfare visits, short Locality Hospital 2 Home term support with practical tasks volunteer Connected to locality ITOCHs, Immediate 4-week coordinators Chaos Task Group, STEPS and discharge support Home First, Immediate 4-week or hospital support. Ongoing enablement, avoidance well-being, benefits advice & **Gateway** PHBs via Gateway Coordination Support Mental well-being **Planning** support plans. Mental **PHBs** PHBs. Longer term conversation via local well-being Wellbeing hubs. Specialist support with falls, coaches and activity, respiratory Step into Wellness prescribers Gateway Reflective and consistent practice development Connect projects and programmes lead Evidence human learning and

performance

## **Hub and locality**

Gateway

Coordinating referrals, requests and calls. 1st Conversation support planning.

Liaising, reviewing across systems, partners and communities.

Proactive case finding for unmet need.

Feedback, wellbeing measures and case studies.

Navigating across community hubs.

ITOCH/MDTs

Identifying local people at risk of vulnerability.

Connecting support around - advocating where needed.

Push/pull discharges - knowing the story of the person.

Acting as "bridge", across local and shared community; liaising with Gateway for specialist/bespoke support.

Community Hubs

Delivering activities, connection and engagement.

Identifying gaps, working with wider teams to identify new support activities.

Providing stories, evidence, performance and activity.

Forming part of a sustainable community response.

## Hospital to Home and Winter Plans

Hub and Community Hospital facing; 20 discharge/prevention packages pw.

H2H

Delivered through localities with Volunteer Cornwall; co-located in hubs working with statutory rehab/enablement.

Funded via ICB. Referrals via ITOCH's, Gateway, Strata; verbal and digital Humans: RCHT facing; 60 discharges pw. Referrals via ITOCH and Strata

**Partners** 

Chaos: Dom ED focus. Care/CQC partner; focus on mental health, respite.

Steps/Home First: statutory agencies. Focus on discharge and reablement.

Moving into Unmet

Needs

400 people waiting for social care assessment; focus on 1st conversation.

PHB call off for any support package; funding follows person

Testing model of first point of contact and social value

### Solution, asset and person focused

**Guided conversation** 

- What is the ideal outcome for the individual?
- Who else is involved?
- Can we add value what would help today?

Agree our involvement and timeline

- Listen for anything new
- Anticipation, mutuality, circle of support; shared outcomes
- Review

Who is best placed to support?

- Is Gateway the right place?
- Make the connection and create the link
- Share what we know advocate where required
- Review

### **Challenges**

Demand, complexity and fragmentation

2022 averaging **2,500** contacts; October 2023 **5,000 plus** 

Balancing Prevention with Urgent System Need

Managing expectations

#### Possible themes for discussion

Sustainability

Evidence and impact — what do you collect and how?

Funding – scope and length of contracts

Alliance contracts; what's the role of your VSF?