Unlocking better care from hospital to home

Embedding the VCFSE sector in hospital discharge, prevention and neighbourhood health

Voluntary Sector North West

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Contents

This report is for health and care leaders, commissioners, VCFSE organisations and anyone interested in building a more preventative, person-centred system. It sets out not just why partnership matters, but how to make it work in practice — drawing on the growing body of evidence from across the North West and beyond.

Foreword

Every day, voluntary, community, faith and social enterprise (VCFSE) organisations play a vital, yet often under recognised role in supporting people to leave hospital safely, recover well at home and avoid unnecessary admissions from happening at all.

Often, the value of this support goes unnoticed - helping someone heat their home, settle back in after a hospital stay, access food or benefits, or simply feel less alone. But taken together, this work is making a significant difference to people's lives and to the pressures facing the NHS.

By building on the best of these VCFSE led services that support people to return home from hospital (known as 'step down' care) we have the opportunity to greatly improve health outcomes for patients, whilst at the same time make much needed savings for the NHS.

Our modelling in Cheshire and Merseyside shows that by connecting and scaling up high performing VCFSE led 'step down' service models, that health system has the potential to unlock an estimated £13.38 million in annual savings through an investment of £2.88 million per year[1].

These services naturally link to preventative 'step up' models of care that reduce demand on urgent and emergency care and stop people from needing to go to hospital in the first place.

Recent North West work illustrates just how powerful this approach can be. Lancashire & South Cumbria Alliance's VCFSE led winter programme[2] supported thousands of people in their communities - helping many avoid going to A&E altogether by getting the right help, at the right time, in the right place. It demonstrated that when trusted local organisations are part of the response, people are more likely to seek help earlier and stay well for longer.

Our report builds on all this learning. It shows how the same strengths that help people avoid hospital (through 'step up' care) can be connected to the support people receive when leaving hospital (through 'step down' care).

Together, these create a more joined up, preventative model of care - one that fits naturally with the ambitions of the NHS 10 Year Plan, and its push towards neighborhood health services, to better meet the shift from hospital to community – working more collaboratively with partners in the new architecture of the NHS, such as emerging integrated health organisations.

This is a pivotal moment - health systems now have the drivers in place to build meaningful, effective partnerships with the VCFSE sector, unlocking better outcomes for people, communities, and services alike.

It isn't about creating something new. It's about recognising the value of what already exists in our communities and working together to make it available to more people, more consistently.

Warren Escadale
Chief Executive
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[1]Based on learning and figures from Cheshire West's Home First and Warrington and Halton Healthy & Home programmes.
[2]UEC Programme Evaluation Report Framework, Lancashire and South Cumbria VCFSE Alliance & Spring North

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The opportunity: connecting support across home, hospital and community

Too often, people with the greatest health and care needs experience support that is fragmented, or arrives too late. Someone may receive help when leaving hospital, but not before.

Others may access community support, but without any connection to the health services that know them best. This lack of coordination leads to avoidable admissions, longer hospital stays and poorer outcomes — particularly for those living in our most deprived communities.

VCFSE organisations are already working in all three parts of the system:

- Step down care – supporting people to leave hospital safely and recover well at home
- Step up care – providing early help that prevents crisis and avoids hospital admission
- Neighbourhood health – delivering joined-up, local support before, during and after illness

The opportunity is clear: to connect and scale this support so people experience a smoother, more preventative journey of care — and the system benefits from reduced demand and better outcomes.

VCFSE organisations are uniquely placed to do this. Rooted in their communities, they understand the wider social factors that shape health — from housing and debt to loneliness and employment. They can respond quickly, flexibly and holistically in ways that clinical services alone often cannot.

Local VCFSE alliances, more often coordinated by councils for voluntary services (CVSs), provide the infrastructure to make this possible. They bring together a wide range of organisations, including those supporting people in the most disadvantaged communities, and create a single route into trusted, community-based support.

By partnering with these alliances, NHS and local authority systems can unlock:

- More effective and efficient care
- Reduced inequalities
- Better use of resources
- Improved experience and outcomes for people

This report sets out how to make that opportunity real - by embedding VCFSE support across step down, step up and neighbourhood health, and by investing in what already works.

Step down care: helping people leave hospital and recover at home

Leaving hospital can be a worrying and disorientating time. Many people need far more than medical care to recover well — they need practical help, reassurance and support to settle back into daily life.

This is where VCFSE organisations make a significant difference. They draw on a wide range of expertise to help people with issues from housing and debt to loneliness, mobility and access to food.

Central to high performing step down models are VCFSE hospital discharge link workers, embedded within hospital discharge teams.

Their role is simple but powerful: to understand what each person needs to return home safely, and to connect them to the right local support.

By providing flexible, practical and emotional support, they complement clinical care and help people regain independence more quickly.

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The case for investing in VCFSE led step down support

Modelling based on real data from a high performing VCFSE led step down service in one area of Cheshire and Merseyside (C&M) shows a compelling case for investment.

Analysis demonstrates that if this model were scaled up and rolled out across the rest of the C&M health system, an annual investment of £2.88 million can unlock £13.38 million in annual savings — a return of more than £4 for every £1 invested.

These savings come from:

- reduced hospital readmissions
- shorter lengths of stay
- fewer people discharged into bed-based care
- reduced pressure on urgent and emergency care
- improved flow across pathways

£13.38 million an annual investment of £2.88 million can unlock £13.38 million in annual savings — a return of more than £4 for every £1 invested.

The model is intentionally conservative. It focuses only on quantifiable system benefits and does not include wider social value, improved wellbeing, or long-term prevention - meaning the true impact is likely even greater.

What this could mean nationally

If similar models were adopted across England, the potential savings would be substantial. Even a cautious extrapolation - applying the Cheshire and Merseyside return on investment to a fraction of national discharge activity.

Figures based on Cheshire West's Home First and Warrington and Halton Healthy & Home programmes

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Warrington and Halton Healthy & Home programme

Case Study

Supporting long term recovery for someone with complex conditions

JE had been in and out of hospital for years due to Ehlers-Danlos syndrome and mental health challenges.

She often stayed for up to six weeks at a time and struggled to move on from NHS care, even when support was available at home. A VCFSE hospital discharge link worker worked with her to create a simple, personalised plan focused on improving mobility, reducing pain, managing anxiety and reconnecting with activities she enjoys, such as art.

Through this support, JE was linked to local organisations offering practical help at home, emotional support and techniques to manage anxiety and pain. Regular phone calls helped her feel more confident and in control. She also received a wheelchair assessment, making it easier and safer to move around her home and garden.

Why this matters

People with complex, long-term conditions often cycle repeatedly through hospital because their wider needs aren't addressed.

VCFSE hospital discharge link workers can break this cycle by providing personalised, whole-person support that clinical teams don't have the capacity to deliver.

What this achieved

- JE has stayed out of hospital for her ongoing conditions
- Improved mood, reduced pain medication and weight loss
- Increased confidence and independence
- Her physiotherapist reports she is "doing better than she has in years"
- Only one short hospital stay in the following year (for a Urinary Tract Infection)
- Minimum estimated system saving of £75k per year

What good looks like – a model for effective VCFSE step down care

Embedded VCFSE hospital discharge link workers within hospital discharge pathways

VCFSE hospital discharge link workers are integrated into multidisciplinary teams, receiving referrals from Transfer of Care Hubs, Rapid Response services, Urgent Community Response (UCR) teams, therapy teams and ward staff. They participate in ward rounds and discharge planning, ensuring people's wider needs are understood and addressed early.

A single point of access to coordinate support

A central coordination function ensures that referrals are simple, consistent and routed quickly to the right local organisations. This reduces delays, avoids duplication and gives clinical teams confidence that support will be picked up.

Strong local partnerships delivering support in each area

Local VCFSE organisations — including those working with people in the most disadvantaged communities — provide practical, emotional and social support tailored to local needs. This ensures help is culturally relevant, accessible and trusted.

Volunteer programmes to extend reach and capacity

Trained volunteers provide additional support such as befriending, wellbeing calls, shopping, light tasks and confidence-building. This enhances the service offer and helps people feel connected and supported during recovery.

Flexible funding to remove barriers quickly

Small, rapid-access funds allow VCFSE hospital discharge link workers to resolve immediate issues that could otherwise delay discharge or hinder recovery — for example, food, heating, transport, small home repairs or essential equipment.

Putting this into practice

We've developed a practical guide to creating high performing step down models. The service specification template and investment guide, provide a roadmap for collaborative, community centred care that can be delivered locally and coordinated at scale, helping health systems make the most of the untapped potential of VCFSE organisations.

Service specification template	
VCFSE embedded in discharge planning and delivery	Establish the provision of VCFSE hospital discharge link workers, integrated within the hospital's discharge team, providing a triage service to VCFSE connections and volunteer support.
	Establish a VCFSE Hospital Discharge Alliance to provide a wide range of services to support timely discharge, short-term practical and emotional support and specialist VCFSE services.
	Regular attendance of appropriate meetings e.g. NRTR, MDT, ward walks.
	Establish an agreed protocol with VCFSE Hospital Discharge Alliance to ensure that the process from assessment to discharge is effective to quickly mobilise the required services.
	Establish relationships within the trust. For example, falls, dementia, physio, Social Care, mental health and care homes.
Assisted discharge	Provide a range of practical support to facilitate rapid discharge, including transport home and access to mobility equipment.
	Support to safely transport frail older people and vulnerable patients from hospital, identifying initial support to help them settle back in at home before discharge.
	Utilise VCFSE organisations based within the hospital and enhance with input from wider VCFSE Alliance.
	Maintain databases of local transport providers which will include taxis, volunteer schemes and community transport.
	Coordinate a comprehensive home support package that includes key safe fitting, small repairs, maintenance, aids and adaptations to property (such as walk-in showers, grab rails, and banister rails), furniture moving, assessing and securing trip hazards, energy efficiency assessment, and hoarding support.
	Maintain databases of local contractors to provide home clearing and cleaning, handyman services, telecare support etc.
	Support patients on discharge with any immediate issues such as essential food shopping & prescription collection, heating and addressing food and fuel poverty issues.
	Manage a practical support fund, a flexible discretionary fund to resolve discharge barriers quickly.

Patients have access to the care and support they need to successfully transition from hospital to home	Provision of support with preparation for leaving hospital, enabling effective and quick mobilisation of a support package focusing on safety and positive experiences for patients.
	Provide access to assistive technology, and digital solutions to support rehabilitation and reablement
	Produce and disseminate VCFSE service information packs for patients and families to highlight service and community support available.
Support for patients to recover, build resilience and stay independent at home	Coordinate patient connections to VCFSE services via hospital discharge alliance and wider.
	Coordinate specialist support from VCFSE providers to include homelessness, substance abuse, and chronic condition.
	Provide support to help maximise income through benefits, grants and access to information regarding debt management where needed.
	Coordinate specialist support from VCFSE providers to support with housing, welfare, debt and benefits advice.
	Provide ongoing community-based support to support emotional wellbeing, such as befriending, linking into community volunteers and home settling services to maintain wellbeing in the community.
	Coordinate follow-up welfare calls
	Provide home visits as appropriate to evaluate the patient's living conditions, potential safety hazards and gain valuable insights into their overall wellbeing

Key components for success

- Whole system approach and buy-in
- Clear agreements and protocols from the onset
- Physical VCFSE presence in hospitals for real-time collaboration
- VCFSE engaged in multi-disciplinary teams with the hospital, enabling them to actively participate in discharge planning, case discussions, and decision-making processes
- Giving VCFSE access to NHS Care Records and data for informed decision-making
- Address short term funding, minimum of 2-year dedicated funding for all aspects of service delivery
- Access to data to provide effective outcomes measurement and prioritisation
- Appropriate annual cost of living increases

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Investment Guidance*

Based on delivery across a place with a population c.250,000, with minimum 125 patient discharges per month after initial 6-month set-up phase, with a unit cost per patient of £213.

Service	Description	Investment
VCFSE hospital discharge link worker	Direct staff cost ofVCFSE hospital discharge link worker @ NJC point 20 (£32,597 pa + on-costs = £39,229) x 2.5 FTE	£98,072.50
	Management and support cost (20%) – contribution to management supervision, governance, HR, finance, compliance	£19,614.50
	Staff travel expenses	£2,100
	IT and back office support (direct project costs)	£2,000
	Information packs	£1,500
Wider VCFSE investment	Up to 10 VCFSE orgs providing specialist support, £12,000 (each VCFSE organisation) x 10 per annum .	£120,000 per annum
Practical Fund	Discretionary fund for patient support	£25,000
Volunteer Programme	Direct staff cost of volunteer coordinator @ NJC point 12 (£28,598 pa + on-costs = £34,350) x 1 FTE. Approx 75 active volunteers will be supported	£34,350
	Office desk (based at VCFSE organisation setting)	£1,000
	Management and support cost (20%) – contribution to management supervision, governance, HR, finance, compliance.	£6,870
	Volunteer DBS checks £15 x 100	£1,500
	Staff travel expenses	£1,000
	IT and back office support (direct project costs)	£1,000
	Information packs	£1,500
	Volunteer expenses – including travel, food, activities & training	£4,000
	Overall total	**£319,507**

**Figures current April 2026*

Step up care: supporting people earlier to prevent crisis

Many of the same VCFSE organisations that support people leaving hospital are also helping them long before their situation reaches crisis. This preventative, community-based support — often described as 'step up' care — plays a crucial role in reducing avoidable admissions and easing pressure on urgent and emergency care.

Step up care focuses on identifying issues early, responding quickly and providing the kind of practical and emotional help that prevents deterioration. It is rooted in trusted relationships, local insight and the ability to act flexibly when someone's circumstances suddenly change.

This support can include:

- Helping someone who is struggling with heating, food or other essentials
- Supporting people who are isolated, anxious or at risk of deteriorating
- Working with frequent A&E attenders to find better, community-based solutions
- Providing rapid help when someone's situation changes unexpectedly
- Connecting people to local groups, activities and specialist support

Evidence from the evaluation of Lancashire and South Cumbria Alliance's urgent and emergency care (UEC) programme shows the impact of this approach. VCFSE led UEC support helped thousands of people in their communities, enabling many to choose alternatives to A&E by getting the right help, at the right time, in the right place. When trusted local organisations are part of the response, people seek help earlier, feel more confident managing their health and stay well for longer.

Step up care is not an add on - it is a core part of a preventative health and care system. It reduces demand on hospitals, improves people's experience of care and strengthens the resilience of communities. Crucially, it also creates a natural bridge to step down support, ensuring continuity before, during and after a hospital stay.

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Warrington and Halton Healthy & Home programme

Case Study

Preventing homelessness and improving mental wellbeing

John was referred to a VCFSE hospital discharge link worker due to loneliness and mental health challenges. During an initial ward conversation, he disclosed that his landlord planned to increase his rent, which would make his home unaffordable and leave him at risk of homelessness.

His VCFSE hospital discharge link worker liaised with the Mental Health Outreach Team, moving him up the waiting list for direct support. They connected him to a community arts and crafts project and used a direct referral pathway to Citizens Advice. With this help, John successfully negotiated a lower rent increase and accessed wider benefits advice — enabling him to remain safely in his home.

Why this matters

Housing insecurity is a major driver of poor mental health and repeat hospital use.

VCFSE hospital discharge link workers can intervene early, coordinating practical, emotional and specialist support that prevents crisis and stabilises people's lives.

What this achieved

- What this achieved
- Prevented homelessness
- Improved mental wellbeing and reduced isolation
- Faster access to mental health outreach support
- Sustained tenancy through successful rent negotiation
- Increased financial stability through benefits advice

Bringing it all together: joined up care from hospital to neighbourhoods

People's lives don't follow service boundaries — yet too often, the support they receive does. Someone may get help when leaving hospital, but not before. Others may access community support, but without any connection to the health teams who know them best. This fragmentation leads to avoidable admissions, longer stays, repeat crises and poorer outcomes.

The opportunity

By connecting VCFSE led step up and step down support through neighbourhood health, systems can create a smoother, more preventative journey of care — one that supports people before, during and after illness.

VCFSE organisations are already operating across all three areas. The opportunity now is to join these strengths together - working alongside NHS and local authority teams - so people experience coordinated, continuous support rooted in their community.

Neighbourhood health

The diagram on the following page illustrates how our model for VCFSE embedded step down care supports the core components of neighbourhood health.

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Neighbourhood health core component	How our VCFSE step down model contributes
POPULATION HEALTH MANAGEMENT Using data and technology to understand and meet the needs of the local population, allowing for more targeted and preventative interventions	• Uses shared data systems to provide preventative support and track outcomes • Coordinates specialist services addressing social determinants of health • Supports high intensity users and frequent A&E attendees to reduce admissions and readmissions
MODERN GENERAL PRACTICE Improving and streamlining access to general practice through online, phone, and in-person options to create a better patient experience	• Embeds VCFSE hospital discharge link workers to support continuity post-discharge • Connects patients to community services aligned with general practice • Facilitates digital rehabilitation and personalised care
STANDARDISING COMMUNITY HEALTH SERVICES Integrating community health services to ensure consistent, high-quality care that addresses both physical and mental health needs across different areas	• Establishes a VCFSE Hospital Discharge Alliance • Delivers consistent practical and emotional support • Provides specialist services for those with complex needs in Pathways 1-3
NEIGHBOURHOOD MULTIDISCIPLINARY TEAMS Establishing teams of various professionals to provide coordinated and proactive care for people with complex needs	• Embeds VCFSE in multi-disciplinary teams, no right to reside and ward rounds • Enables access to NHS care records • Builds cross sector relationships for integrated planning
INTEGRATED INTERMEDIATE CARE Providing a "home first" approach to care, where people can receive support and treatment in their own homes or community settings when possible	• Mobilises rapid discharge support for Pathways 0–3 • Offers transport, home adaptations and volunteer mobilisation • Manages a flexible fund to remove discharge barriers
URGENT NEIGHBOURHOOD SERVICES Offering urgent, community based services for people with escalating or acute health needs, providing an alternative to hospital care	• Central to ensuring the NHS meets its urgent and emergency care priorities • Supports admission avoidance and winter pressures • Coordinates specialist VCFSE input for acute social needs

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Warrington and Halton Healthy & Home programme

Case Study

Building confidence and mobility after surgery

Cath was recovering from surgery and using a stick to walk. A few weeks after discharge, she contacted her o VCFSE hospital discharge link worker, who connected her to a local “walk to wellness” project.

Her family quickly noticed she seemed more energetic, more confident outdoors and more physically capable. At a follow-up appointment, her Orthopaedic Surgeon immediately commented on how well she was walking as soon as she entered the room.

Why this matters

Recovery after surgery is shaped not only by clinical care but by confidence, mobility and social connection.

Community-based programmes can accelerate recovery and reduce the risk of deterioration.

What this achieved

- Improved mobility and walking confidence
- Increased energy and independence
- Positive clinical feedback from her surgeon
- Stronger engagement in community-based activity

Making it happen: what systems and VCFSE partners need to do next

The evidence is clear: VCFSE led step up and step down support improves outcomes, reduces demand and strengthens neighbourhood health. The building blocks already exist across every community. The challenge and opportunity is to connect them, invest in them and make them work at scale.

This requires action from both system leaders and the VCFSE sector.

For system leaders (NHS and local authorities)

Commit to the VCFSE sector as an equal partner in neighbourhood health

Recognise the sector's role in prevention, recovery and community-based care. Embed VCFSE partners in governance, planning and decision-making — not just service delivery.

Adopt the VCFSE step down framework as a standard approach

Use the model outlined in this report to shape consistent, high quality support across discharge pathways. Ensure VCFSE hospital discharge link workers are embedded within multidisciplinary teams.

Invest at scale — not just in pilots

The modelling shows that modest investment unlocks significant savings and better outcomes. Move beyond short-term funding to sustainable, multi-year investment that enables stability and growth.

Create a single, simple route into VCFSE support

Establish a coordinated access point so clinical teams can refer confidently and quickly. Reduce duplication and ensure people are connected to the right support at the right time.

Measure what matters

Shift the focus from activity to outcomes: independence, wellbeing, reduced demand, improved recovery and fewer avoidable admissions. Use shared metrics across neighbourhood teams and VCFSE partners.

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For VCFSE organisations and alliances

Strengthen collective voice and delivery through alliances

Work together to present a unified offer, share learning and coordinate support. Alliances help systems understand the breadth and depth of what the sector can provide.

Shape system design, not just services

Engage in strategic conversations about neighbourhood health, prevention and discharge pathways. Influence how models are developed, not only how they are delivered.

Be clear about your value and impact

Use evidence, case studies and data to demonstrate outcomes. Articulate how your support complements clinical care and addresses the wider determinants of health.

Scale what works — while keeping local strengths

Build on proven models but retain the flexibility and community insight that make VCFSE support effective. Maintain the diversity that enables the sector to reach people others cannot.

A shared ambition

If systems and VCFSE partners act together, we can create a model of care where:

- Fewer people reach crisis
- More people recover well at home
- Communities are stronger and more connected
- Health and care services are more sustainable

A stronger, more preventative health and care system is already within reach. By investing in the strengths of our communities and working in genuine partnership with the VCFSE sector, we can help more people stay well, recover well and live well at home. The opportunity is here — and the time to act is now.

Acknowledgments

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