

Impact Review Report

**Cornish Communities in Focus:
Evolving Voices in Mental Health**

May 2026

Impact Review

Cornish Communities in Focus: Evolving Voices in Mental Health

Executive Summary

What the engagement found

Healthwatch Cornwall's *Cornish Communities in Focus: Evolving Voices in Mental Health* issue report, published in February 2025 highlighted systemic pressures affecting access to mental health support across Cornwall. These included severe workforce shortages, extreme waiting times for neurodivergent assessment (up to 11 years for ADHD), high rejection rates for specialist referrals, fragmented pathways, over-reliance on CBT and medication, and persistent rural and coastal inequalities. Inequities in access and experience were particularly pronounced for neurodivergent people and those living in isolated communities.

What we did about it

Healthwatch Cornwall shared lived experience evidence and recommendations with system partners through formal reporting, strategic meetings and ongoing engagement with commissioners, providers and VCSE partners including the NHS Cornwall & Isles of Scilly Integrated Care Board (ICB), Cornwall Council, Cornwall Partnership NHS Foundation Trust (CFT), and VCSE partners. We sought assurance on how system plans, reforms, and investments responded to the issues raised.

What impact happened

The system has acknowledged the challenges highlighted and cited a range of actions planned or underway, particularly in crisis alternatives, trauma-informed practice, community-based provision, and neurodiversity support. However, evidence that these actions have yet resulted in consistent improvements in access, waiting times, or lived experience remains limited.

What is still outstanding

Workforce capacity, waiting times, clarity of pathways, and equitable access remain unresolved. Much of the reported response is planned rather than implemented, and outcome data demonstrating impact for people is largely absent.

Background and purpose

Why we reviewed the topic again

Poor mental health continues to be one of the most significant concerns raised by Cornish residents. The *Evolving Voices in Mental Health* report highlighted that pressures identified in earlier Healthwatch work persist and, in some areas, have worsened. This Impact Review examines whether system actions since publication have delivered measurable improvements.

Purpose of this Impact Review

To assess whether commitments and actions described by system partners have translated into improved access, experience, or outcomes for people seeking mental health support.

This review supports Healthwatch Cornwall's statutory duties to:

- represent patient and public voice
- identify inequalities in access and outcomes
- influence service improvement and integration

It aligns with strategic priorities relating to mental health, access, health inequalities, and integrated care.

Methodology

Evidence in the issue report drew on large-scale engagement with over 2,000 Cornish residents, alongside system-level data and partner insight.

Qualitative and quantitative evidence was thematically analysed. Themes were mapped against partner responses to assess whether actions taken aligned with recommendations and demonstrated impact.

Independence statement

Healthwatch Cornwall is an independent statutory body. All analysis and conclusions are our own.

Key themes and evidence

1. Workforce shortages

What we found: Only 19 Mental Health Practitioners (MHPs) in GP surgeries, well below the target of 46, leading to inconsistent early support.



“I was already feeling desperate, so having to wait several months was extremely hard”



What we recommended: Make best use of existing staff (e.g. group sessions), train reception/admin staff in signposting, and offer flexible working to aid retention.

Action taken:

- Acknowledge variation in MHP coverage, with some PCNs employing MHPs directly outside CFT figures.
- Workforce decisions depend on each PCN’s leadership and funding priorities.
- CFT reviewing communication and information access, including website updates and quarterly information sessions.
- Flexible working offered to CFT staff, unclear if standard across PCNs.

Evidence of impact

While workforce pressures and variation remain significant, the issue is now more clearly recognised within workforce and PCN planning discussions.

2. Excessive waiting times for neurodivergent assessments

What we found: Up to 11 years for ADHD and 6 years for autism assessments – among the longest in the UK.

What we recommended: Develop “while-you-wait” support (digital tools, peer groups, check-ins, pre-assessment workshops).

Action taken:

- Correction: waits are ~6 years for autism, ~11 years for ADHD.
- National problem; “Right to Choose” referrals possible but with GP prescribing complications.
- Exploring a transdiagnostic support tool (Cerina) and CBT-based app.

- Recovery College considering extra courses; Pentreath involved in course provision.
- Check-in calls trialled but not valued by service users.

Evidence of impact

Waiting times remain extreme. Interim support is being explored, but evidence of benefit or consistent uptake is lacking.

3. Barriers to specialist care

What we found: Many of 30,000 specialist referrals rejected due to eligibility criteria.

What we recommended: Use community venues for drop-ins, expand telephone and online support, and subsidise travel for appointments.

Action taken:

- Recovery College already delivers courses in community settings; 10 MH resource centres offer drop-ins.
- 60+ community “hubs” in operation, with new neurodiversity hubs planned for 2025/26.
- Digital platforms like Community Gateway in place; further promotion needed.

Evidence of impact

While community provision exists, people’s experiences indicate ongoing gaps for those not meeting specialist thresholds.

4. Rural and coastal inequalities and crisis care gaps

What we found: Isolation, transport barriers, and loss of some crisis services exacerbate access issues.

What we recommended: Train non-clinical staff in crisis de-escalation, expand helplines, and set up safe evening spaces.

Action taken:

- New and expanded crisis alternatives planned/underway:
- Nest reablement service (14→18 beds)
- Supportive stays, Oakleigh crisis bed, day service at St Erme (Autumn 2025)
- Mental health community bus (Autumn 2025)
- People in Mind programme delivering suicide prevention.
- Evening drop-ins to be included in day resource centre model.

Evidence of impact

The development and expansion of crisis alternatives demonstrate increased system focus on community-based mental health support, although measurable impact on access and crisis avoidance is not yet evidenced.

5. Expanding treatment options beyond CBT and medication

What we found: Over-reliance on CBT and medication, with limited trauma-informed or alternative approaches.

“One-size-fits-all CBT is entirely unsuited to me and other neurodivergent patients, but no effort was made to redirect me once this became clear.”

“I feel that doctors are way too quick to prescribe medication without putting anything else in place.”

What we recommended: Increase social prescribing, peer-led groups, and trauma-informed training.

Action taken:

- NICE-compliant Talking Therapies offer includes CBT, counselling, IPT, mindfulness, couples therapy.
- Trauma Informed Network Cornwall and “Compassionate Cornwall” framework in place.
- Neurodiversity training delivered to hundreds of staff in 2023; work ongoing but needs better publicity.
- New “Healing by Nature” project to expand green therapies.

Evidence of impact

Although additional approaches and trauma-informed models are now more visible within system delivery, people continue to report limited choice, awareness, and consistency of access.

6. Simplifying access to services

What we found: Complex referral pathways, variable processes, poor visibility of services.

“The processes and procedures that have to be negotiated trying to get help when not in a good headspace has been daunting and traumatic”

What we recommended: Standardise GP referral forms, create a central directory, and ensure written discharge plans.

Action taken:

- Single CFT referral form exists, but variation with Right to Choose providers.
- Past directories struggled with upkeep; digital app solutions under review (e.g. Joy app).
- Community Gateway helpline provides current information.
- All CFT discharges should include care plan; “Green card” protocol used for rapid re-access.

Evidence of impact:

Variation persists in practice, and people still report confusion about routes into support.

7. Making mental health care more inclusive

What we found: Phone-based access excludes some; gaps in school and workplace mental health provision.

What we recommended: Offer non-phone contact, strengthen school mental health teams, promote workplace champions.

Action taken:

- National mandate to expand Mental Health Support Teams (MHSTs) in schools to 100% coverage by 2029.
- Digital services Kooth (for CYP) and Qwell (for parents) available.
- Strong employment support offer across CIOS, including IPS and Work Well.

Evidence of impact:

Coverage is expanding, but current gaps remain for many residents.

8. Out-of-county placements

What we found: Lack of local specialist inpatient care leads to disruptive, costly out-of-county stays.



“I had to go out of county on two occasions, to Exeter and Bristol”.



What we recommended: Expand local crisis alternatives, use respite beds, improve discharge planning.

Action taken:

- National reduction target for inappropriate placements; CIOS target to halve cases in 2025/26.

- Crisis alternatives expanding (Nest, Oakleigh, St Erme, community bus).
- Dedicated CFT discharge worker and ICB oversight nurses in place.

Evidence of impact:

New crisis alternatives and improved discharge oversight are being put in place, but there is not yet clear evidence that these changes have reduced the number of people sent out of county or improved their experience.

9. Funding and service fragmentation

What we found: Concern over shift from NHS to VCSE delivery without consistent quality standards.

What we recommended: Strengthen integration and sustainability planning.

Action taken:

- Community MH transformation funding split (33% VCSE, 66% statutory).
- Work ongoing to create a VCSE quality framework for complex needs support.
- Integrated outreach and pathway models in development.

Evidence of impact:

The report has contributed to greater recognition of the need for clearer integration and quality assurance between statutory and VCSE mental health provision, although consistent impact for residents is not yet evidenced.

Impact assessment

What the system and partners agreed to do

- Expand crisis alternatives and community-based provision
- Improve neurodiversity support and trauma-informed practice
- Reduce reliance on out-of-county placements
- Strengthen VCSE integration

What they actually did

- Developed and planned multiple crisis alternatives
- Invested in training, green therapies, and digital tools
- Introduced additional discharge and oversight roles

Evidence of change

Most activity represents planned or early-stage implementation, with stronger evidence of strategic alignment and system acknowledgement than measurable improvement in lived experience outcomes.

Impact on people

People continue to experience long waits, fragmented care, and limited choice, with some positive localised examples.

Unmet commitments / gaps

- Waiting times and workforce capacity remain critical risks.
- Benefits of interim and alternative support are not consistently evidenced.

Outstanding issues and risks

The Healthwatch Cornwall report has prompted system-wide acknowledgement of the challenges and, in some areas, accelerated or informed planned work. There is clear alignment between our recommendations and ongoing initiatives, especially in crisis care, neurodiversity support, and trauma-informed practice.

However, there is still:

- Persistent workforce shortages and extreme waits.
- Rural inequity and transport barriers.
- Fragmentation between statutory and VCSE provision.
- Inconsistent awareness of available services.

Recommendations

1. Publish transparent outcome data on waiting times and service impact.
2. Strengthen and evaluate “while-you-wait” support for neurodivergent people.
3. Address workforce gaps and variation across PCNs.
4. Improve visibility and navigation of mental health pathways.

Conclusion

This Impact Review finds strong alignment between Healthwatch Cornwall's recommendations and the system's stated intentions. However, the impact on people's lived experience remains limited and uneven.

Healthwatch Cornwall will continue to monitor delivery, including continuing to highlight where system ambition has not yet translated into consistent improvement for residents.



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