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Wirral's Home First discharge and reablement model

June 2024

Wirral Home First Project Team:

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Home First principles and benefits

Home First is for people who no longer need hospital but do need formal support to go home. This is known as the Pathway 1 (P1) route. Their long-term needs are assessed at home, rather than in a ward.

Full assessments not needed on wards - emphasis on what's needed for a safe discharge home

Less deconditioning waiting for assessment and / or package of care

Lower levels of assessed care need when assessed at home, people tend to be more able in a familiar environment.

Lower levels of care needed following Home First support, due to effectiveness of the therapy-led and multi-disciplinary care.



“Everyone should have the opportunity to recover and rehabilitate at home (wherever possible) before their long-term health and care needs and options are assessed and agreed.”

Hospital Discharge and Community Support Guidance
(2022)

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Summary of positive impact and outcomes

From April 2023, as part of Wirral's Unscheduled Care Programme alongside other system projects, we have grown and improved the Home First service and model. Between April 2023 and January 2024*, we saw:

- 1) Wirral's No Criteria to Reside (NCTR) rates drop from among the highest to among the lowest in Cheshire & Merseyside, with Pathway 1 NCTR reduced by two-thirds (Dec22-Dec23)
- 2) Reduction in Pathway 1 NCTR-related bed/day pressures of ca. £7.5m equivalent (41 weeks, Apr23-Jan24)
- 3) Domiciliary care requests in circulation 25x lower (Nov22-Nov23)
- 4) Pathway 1 outcomes for long term independence now the best in Cheshire & Merseyside
- 5) Estimated displacement of ca. £2m domiciliary care expenditure (full year effect) and projected reduction in pressure on domiciliary care budget, due to fewer people needing ongoing care and reducing people's care needs for those that do,
- 6) Continuing excellent patient experience and feedback

*The majority of data in these slides comes from the 9-month evaluation that supported the extension of the model into 2024/25

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Wirral's Home First service

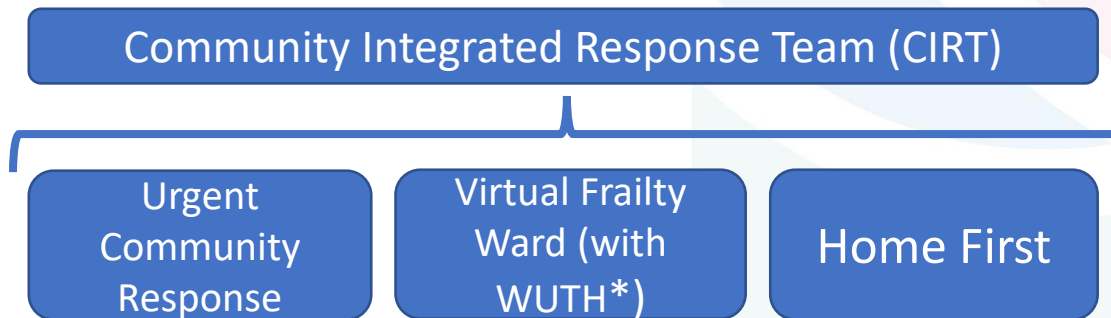
Coordinated through, and provided primarily by, the Home First team within CIRT in Wirral Community Health & Care NHS FT (WCHC)

Urgent Community Response and Virtual Frailty Ward are also provided by CIRT.

This gives rapid access to admissions avoidance and medical oversight.

The multidisciplinary, co-located Home First team targets 170 discharges/month. For 2024/25, the workforce model is:

- Health Care Assistants (HCAs) (50 WTE)
- Therapists (O/T and P/T) (12 WTE)
- Care Coordinators (6 WTE)
- Nurses (5 WTE)
- Adult Social Care staff (Assessment & Reablement Officers / Care Navigators / Social Workers – council employed) (ca. 12 WTE)
- Involve NW Community Connectors (in-reach)



*Wirral University Hospital NHS FT

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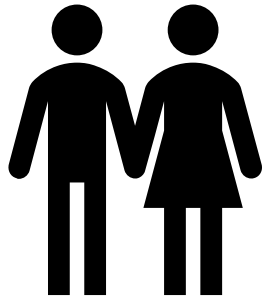
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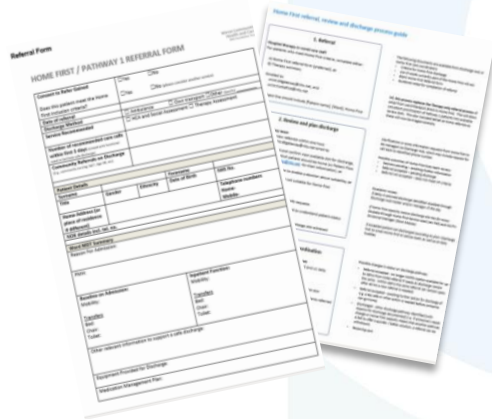


Home First pathways: multidisciplinary triage determines pathway

1. Pathway 1 patient identified on ward



2. Referral and MDT triage



3. Pathway identified; Discharge slot planned

- 1. Home First HCAs only (70%)
- 2. Home First hybrid, HCAs with dom' care (15%)
- 3. Home First with dom' care (15%)

4. Daily discharge coordination calls

5. Discharge home. 2-3 days from referral to first visit

All pathways have therapist or Assessment & Reablement Officer as lead professional

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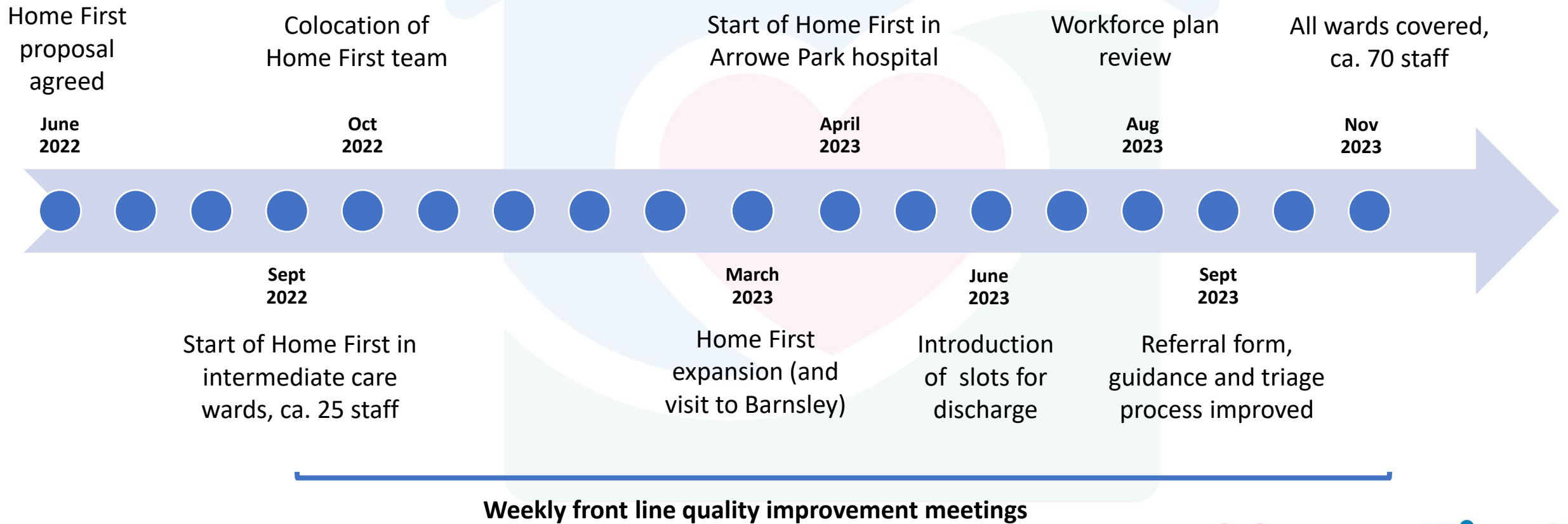


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Key project milestones



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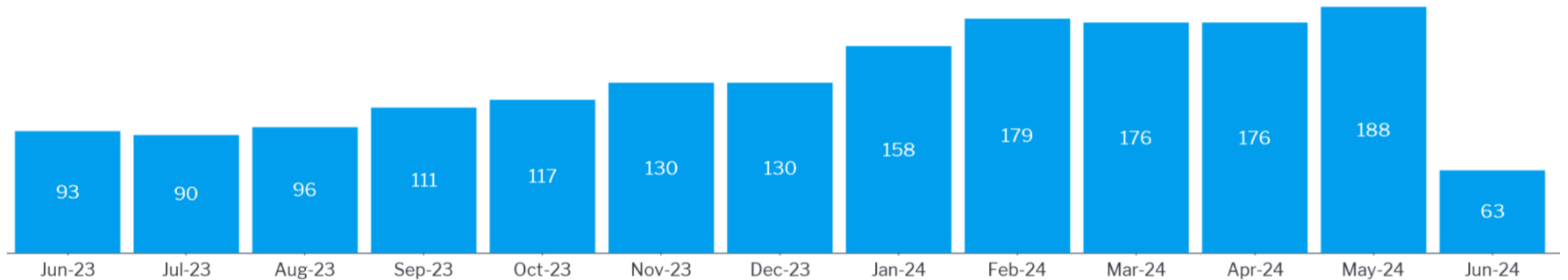
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Increasing numbers of discharges into service from WUTH and intermediate care wards

Discharges to Home First grew with capacity increases and key process changes during 2023/24, starting at 64 and 84 discharges respectively in April and May 2023, building to meet the long-term target of 170/month in February 2024.



Discharges 01/06/23 - 13/06/24 (monitored via WCHC dashboard using data from SystmOne)

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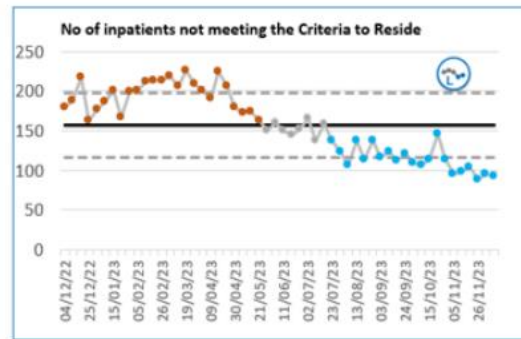
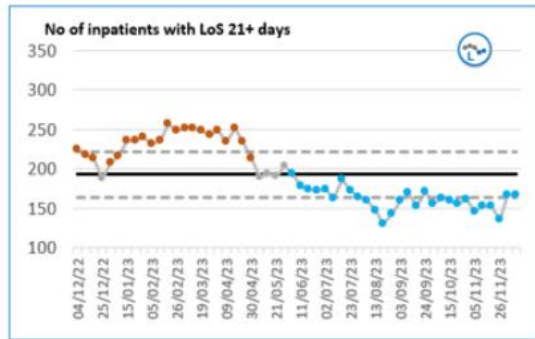
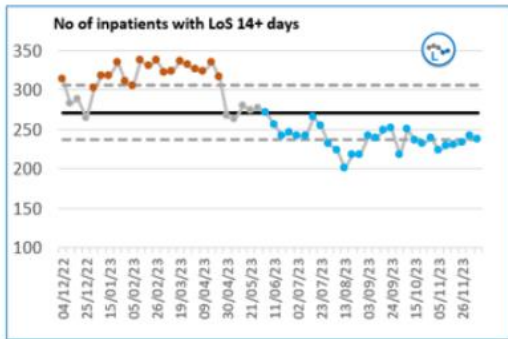
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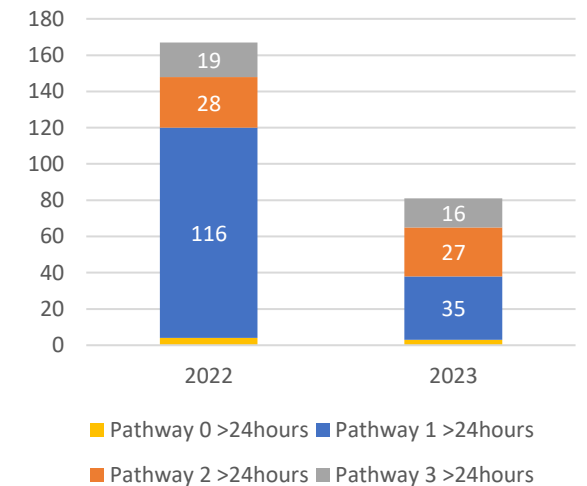


Reduced average length of stay in hospital

Hospital Urgent & Emergency Care (UEC) metrics show numbers of Wirral inpatients with Length of Stay of 14+ and 21+ days started to reduce significantly in April 2023, alongside a drop in the number of patients without criteria to reside (WUTH data).



Pathway Breakdown NCTR >24hours



Based on a snapshot comparison of December 2022 and December 2023 positions, this was driven by a reduction in the number of people with NCTR on Pathway 1 (WUTH data).

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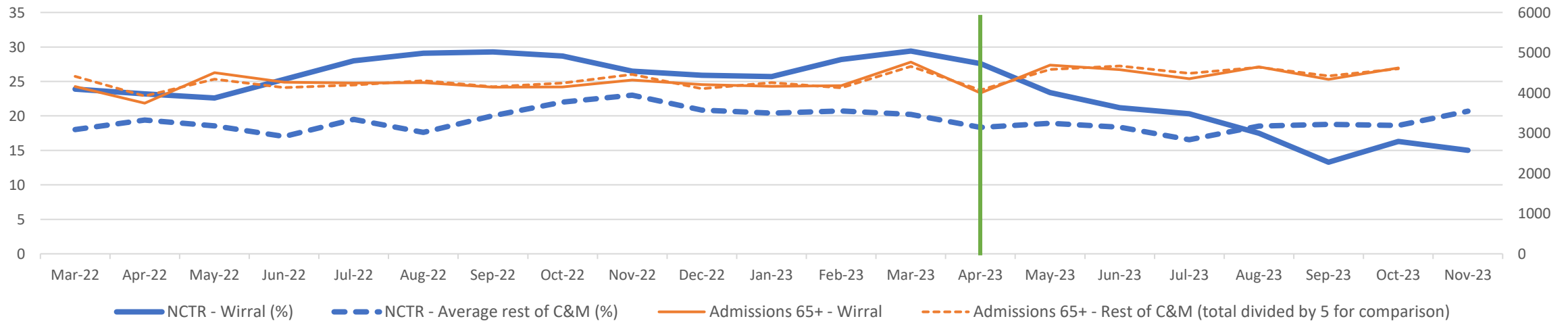


Wirral NCTR rates among the lowest in Cheshire & Merseyside

Implementation of Home First (green line) plus other system changes, coincides with significant reduction in NCTR as % of all beds relative to Cheshire & Merseyside (C&M) average. (C&M UEC Assurance data, Dec23).

Change is in P1 discharges (two thirds reduction).

% beds occupied by patients with NCTR against Admissions (65+) for Wirral and Rest of C&M, Mar22-Oct/Nov23



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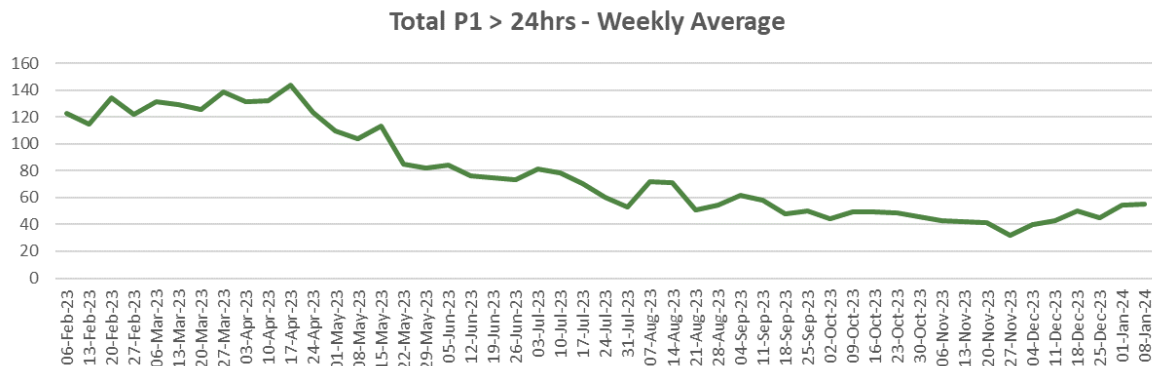
Reduction of P1 NCTR-related bed costs: ca. £7.5m / 41wks Apr23-Jan24

The average P1 (>24hr) NCTR bed days across the 8 weeks 6 Feb - 26 Mar23 was 892.

Between 3 April 23 and 8 Jan 24 (41 weeks), the aggregated difference between this and each weekly figure was -16,808.

At £450/bed-day this represents £7.5m care provision costs over 41 weeks.

Resources and care is now more focused on people with a medical need to be in hospital. Without Home First, additional pressures / costs would have been higher. Fewer escalation beds reduces staffing pressures related to these beds.



Weekly Average - 6th Feb 23 to 2nd Apr 23	127
Weekly Average - 3rd Apr 23 to 7th Jan 24	69
Variance	58
Weekly Cost of NEL (bed cost)	£3,151
Weekly Cost Variance	£183,407
41 weeks cost	£7,519,688

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Pathway 1 outcomes for independence the best in Cheshire & Merseyside.

Based on C&M-collected data, more of Wirral's Home First patients finish independent than elsewhere in Cheshire & Merseyside.

Graphic shows data from Intermediate Care dashboard. Services in bold are most comparable based on volume of discharges.

Data range w/c 9 July- 26 Nov 2023	# weeks of data reported	P0		P1		P3		Readmitted	
		Number	%	Number	%	Number	%	Number	%
CE Council Community Reablement	15	88	43	2	1	0	0	36	18
CoC rapid response	16	130	47	19	7	3	1	41	15
GNA bridging service Mid cheshire footprint	21	197	45	68	15	5	1	58	13
Halton BC reablement	12	51	44			1	1	23	20
Liverpool CC Home First	17	294	45	81	12		0	105	16
New Directions reablement (Sefton)	20	176	49	38	11	2	1	47	13
Routes Rapid Reablement (ECT footprint)	15	43	46	20	21	0	0	13	14
Wirral Home First	21	278	59	74	16	0	0	70	15

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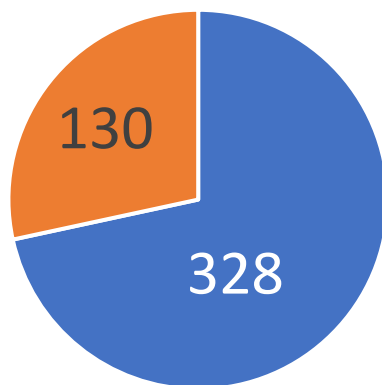
Reduced pressure on domiciliary care

Home First = 28% of total system capacity (Nov23), reducing previous pressure on domiciliary care to support discharges

Further reduction in pressure as fewer people needing care *and at lower levels* after Home First discharge (Apr-Nov23)

People not now having to wait for essential care

Packages circulating 250+ (Nov22) dropped to ca. 15 (Nov23)



All new Wirral care provision, Nov 23

- All new dom' care packages exc' Home First (72%)
- Home First care supported discharges (28%)

Hours/week per Package of Care (POC) from different sources	April-Nov23 average
Community	10.3
Hospital (POC)	18.0
Hospital (reablement)	12.2
Intermediate care beds	16.7
After Home First	7.4

POCs in circulation (daily averages)	
Nov22	Nov23
250+	ca. 15

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How would you describe your experience with Home First?

Patient

“I had been in a lot of pain from falls and broken ribs [reason for acute admission to hospital]. When the staff said I could go home with a team to support me [Home First Service] I was a bit worried that I still needed to be in hospital but excited to get home as well.

“The team visited me multiple times a day, some were carers, and some were physiotherapists and also somebody from social work.”

Patient’s wife

“His face would light up when they visited, and he was more confident after they had been.”

An infection meant that he deteriorated after discharge. An escalation to double-handed care calls was made in those first few days, for the safety of both patient and carers. The team liaised with the GP for pain management and antibiotics. He avoided readmission.

Both the patient and his wife expressed the gratitude they have for the Home First service, which meant he was able to stay at home with some additional care in place, **they never believed that he would be able to walk again.**



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Just some of the team who developed and deliver Wirral's Home First model...



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