In partnership:
Wirral Community Health and Care NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust
Wirral Council

Home First

Wirral Place Based Partnership Board

22 June 2023

Hospital may be where you get treated, but home is where you get well.

HomeFirst
Why not home, why not today?

Home First means assessing someone's long term care and therapy needs in their home environment

Hospital Discharge and Community Support Guidance (2022) - all NHS and social care services should adopt a Home First Approach

"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."

- ✓ **Faster discharge**
- ✓ **Less deconditioning**
- ✓ **Better understanding of need**
- ✓ **Fewer people needing ongoing services**

Therapy

Reablement

Personal care

Assessment

What's the difference from a patient perspective?

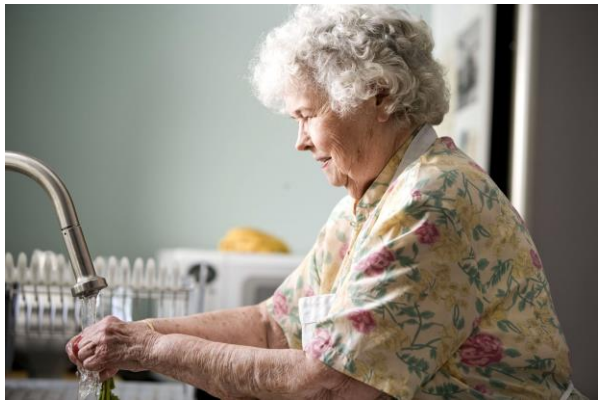
Wirral case studies show people on wards can be supported with Home First, reducing over-prescription of care

Plus, support and assessment at home means problems can be spotted and addressed earlier, avoiding readmissions.

Age 82. Three weeks in CICC following two delayed transfers. Supported at home whilst stairlift fitted (x1 call/day for 2 weeks)

Age 81. Discharged P0. Falls pendant activated next day as unable to move. Immobile in chair and needed support x2. CIRT arranged Home First with DN referral

Age 78. Five weeks in WUTH, listed for CICC, aim: unaided walking.
Assessed at home: able to move using furniture, care needs x1 visit/week.



Age 86. 17 days in Ward 26, APH. Previously independent but assessed needing x3 calls/day. Was due M1 awaiting POC. Assessed Home First. Able to live independently with aids. Likes to be independent. Supported by son. Managing well.

What's the difference from a team perspective?

Integrated team, part of Community Integrated Response Team (CIRT).

Enabling step up/down from 2 hr Urgent Community Response, quick access to Virtual Frailty Ward.

Single team structure enables

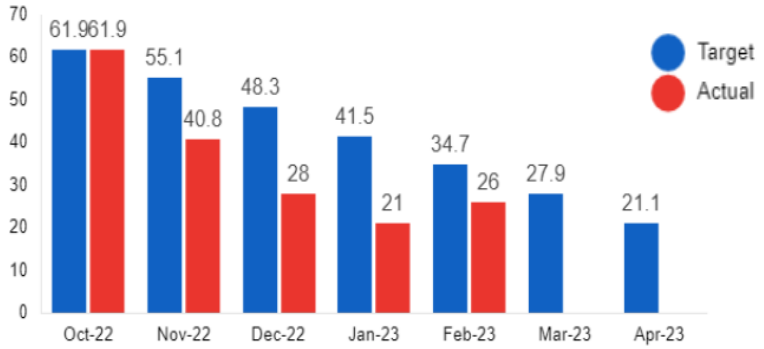
- ✓ *Flexibility*
- ✓ *Responsiveness*
- ✓ *Person-focused culture*

Model consistent with very best practice seen elsewhere.

- **Therapists**
- **Assessment & Reablement Officers**
- **Health Care Assistants**
- **Social workers**

Home First positive impact

- Significant reductions in LOS at CICC seen due to Home First
- Care Arranging Team attributing quicker pick up of packages to Home First easing pressure on domiciliary care
- Many examples where people were helped home sooner and become independent quicker: smaller and shorter care packages
- Great feedback from families

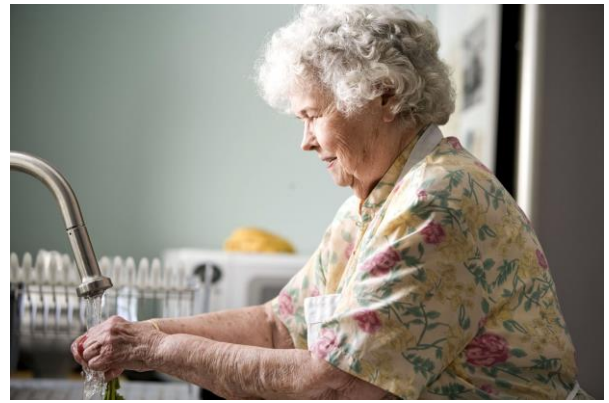


"My wife's improvement has been astonishing. I cannot praise the Service enough. …look forward to further visits and continual improvement. Thank you so much for offering the service."

Moving from 40 WTE pilot to full system 102 WTE Home First model

Plan for:

- 2040 Home First discharges / year one
- Up to 6 weeks therapy, reablement and support for all P1 discharges



Likely giving:

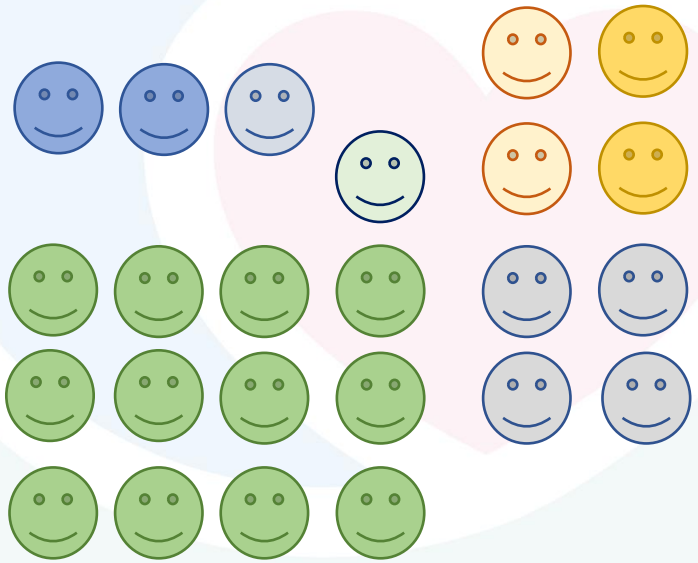
- 90% reduction in people on Pathway 1 No Criteria to Reside (NCTR) = 19k* bed/days saved per year
- Reduce related system costs:
  - Escalation beds
  - Short term step down beds
  - Block purchased D2A beds

*WUTH = average 140 P1 discharges / month in 2022. Cerner data, people with final pathway recorded as P1: 21k WUTH bed days for people on Pathway 1 with NCTR in 2022

Expanded Home First function: 102 WTE

Occupational therapists, Physiotherapists, Assistant Practitioners, Care coordinators

Health Care Assistants



Adult Social Care staff

VCFSE sector staff

Current

Full assessment on ward including determination of pathway based on available information

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For people determined as Pathway 1, prescription of:

1. Short Term Assessment & Reablement (care, reablement) for up to 6 weeks, or

2. Domiciliary Care package

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IDT arranges packages based on availability

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Discharge home with agreed support

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STAR package may become dom' care package if needed

Future

Simple assessment on ward – 'is someone medically fit for discharge and safe to go home with visiting services?'

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Same day handover to arrange same / next day visit from Home First team

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Therapy and/or care (with assessment if needed) for up to 6 weeks

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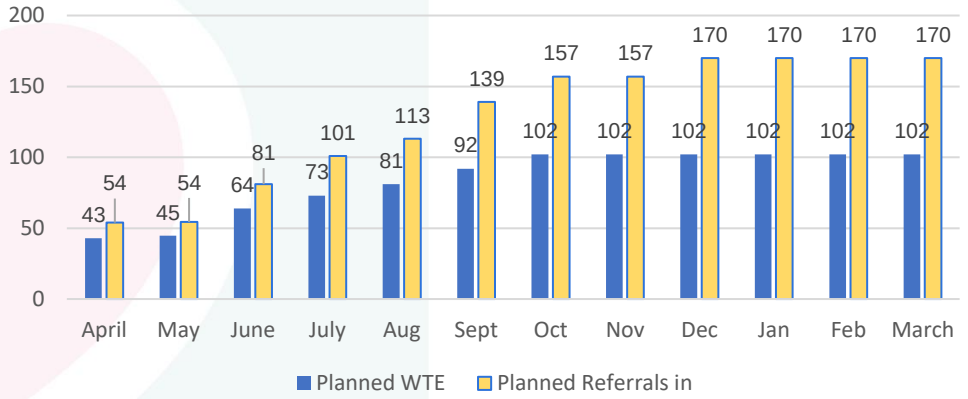
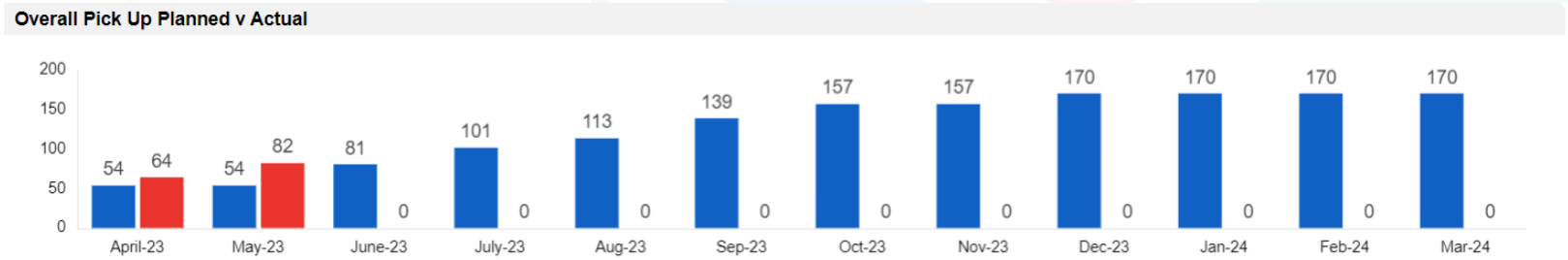
For those who need it, handover to domiciliary care

Tracking staffing capacity and activity levels – focus on hospital wards

- Working initially with 2nd floor wards at Arrowe Park Hospital, roll out plan for all P1 discharges
- Close working, wards and Home First team, refining model
- Already seeing significant effect, ahead of trajectory
- Most discharges same-day when someone is medically fit and ready to leave
- Ambitious recruitment plan on track for new staff needed by late summer

Planned Home First staffing and activity by month, 23/24





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Questions and comments?