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

Home First evaluation and 24/25 model

Draft v0.4

24 January 2024

Wirral Home First Project Team:

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Summary

From April 2023, as a central pillar of the Unscheduled Care Programme, we have continued to grow the Home First service whilst defining and continuously improving Home First pathways from WUTH. Since then, we see:

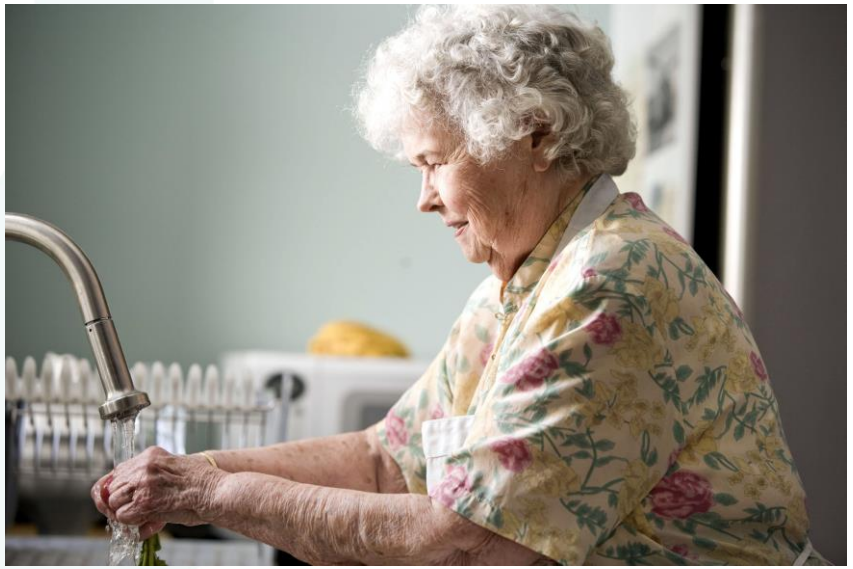
1) Wirral NCTR rates now among the **lowest in Cheshire & Merseyside** and **Pathway 1 NCTR reduced by two-thirds** compared to the start of 2023
2) Reduction in P1 NCTR-related bed/day pressures of ca. **£7.5m** (41 weeks, Apr23-Jan24)
3) Domiciliary care requests in circulation **25x lower** than one year ago
4) Displacement of ca. **£2m** dom' care expenditure (full year effect)
5) **Pathway 1 outcomes the best in Cheshire & Merseyside** (75% of people finishing independent)
6) Projected reduction in pressure on dom' care budget, by reducing people's care needs, of **£3.5+ m pa**
7) Continuing excellent patient experience and feedback

Report sections:

1. Principles and key milestones to date
2. Impact and comparison with other Places
3. Pathways development, demand & workforce modelling
4. Effect on system costs and 2024/25 model

1. Home First principles, key milestones and activity to date

- Principles and benefits
- Key milestones to date
- Wirral's Home First model
- Home First activity since April 2023
- Home First and other improvement work



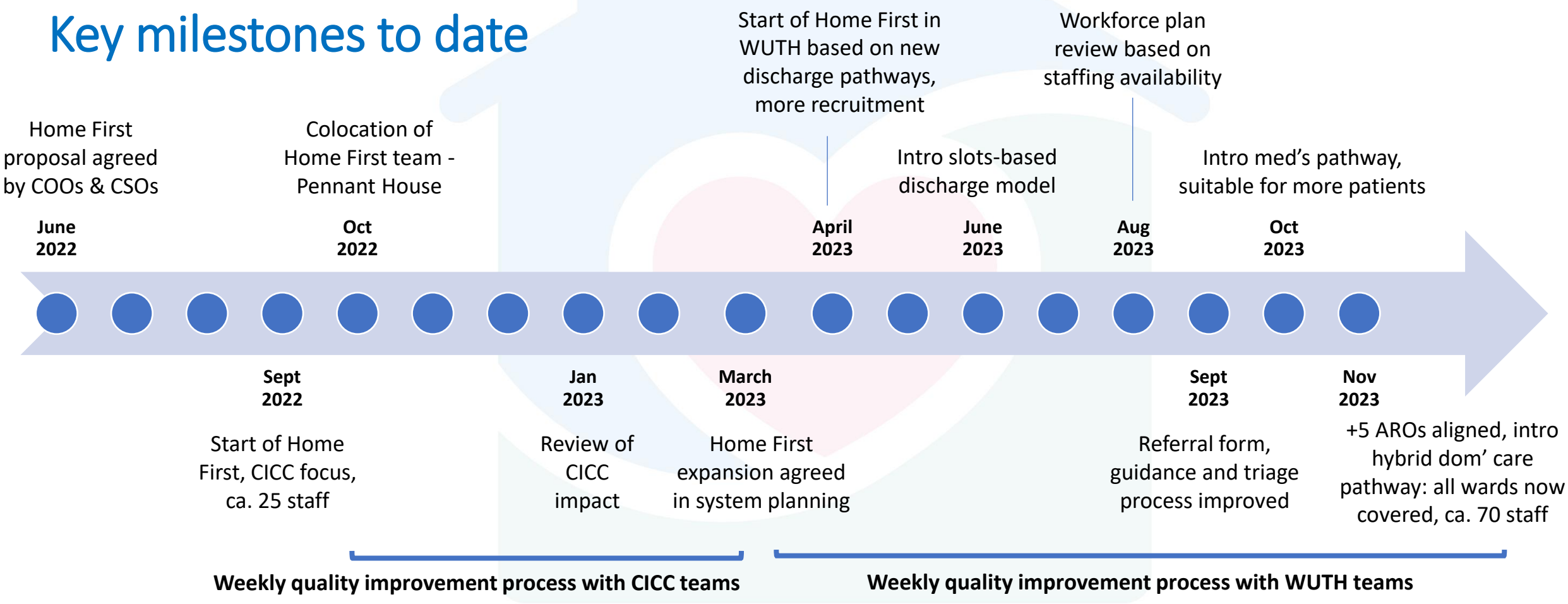
Principles and benefits

Home First is for people who no longer need to be in hospital but need formal support to go home (Pathway 1 route). Their long-term needs are assessed at home, rather than in a hospital or intermediate care ward.

Benefits include:

1. **Full assessments not needed on wards** - emphasis is on establishing what someone needs for a safe discharge home once they no longer meet criteria to reside.
2. **People in wards not waiting for home care support to be arranged** following assessment on a ward.
3. **Lower levels of assessed care need when assessed at home**, as people tend to be more confident and able to cope once back in a familiar environment.
4. **Lower levels of assessed care need following Home First support**, due to effectiveness of the therapy-led and multi-disciplinary care from Home First team.

Key milestones to date



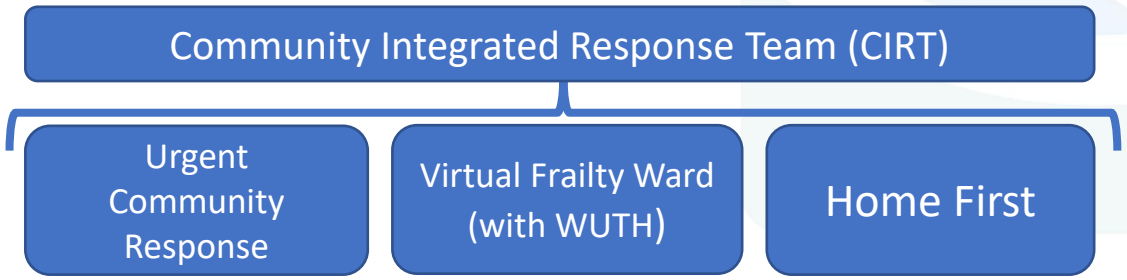
Wirral's Home First model

…is coordinated through, and provided primarily by, the Home First team working as part of CIRT.

Urgent Community Response and Virtual Frailty Ward are also in CIRT. This gives instant access to admissions avoidance and medical oversight.

The extended team adds flexibility.

Based on his experience, Prof. John Bolton described this as a model of best practice.

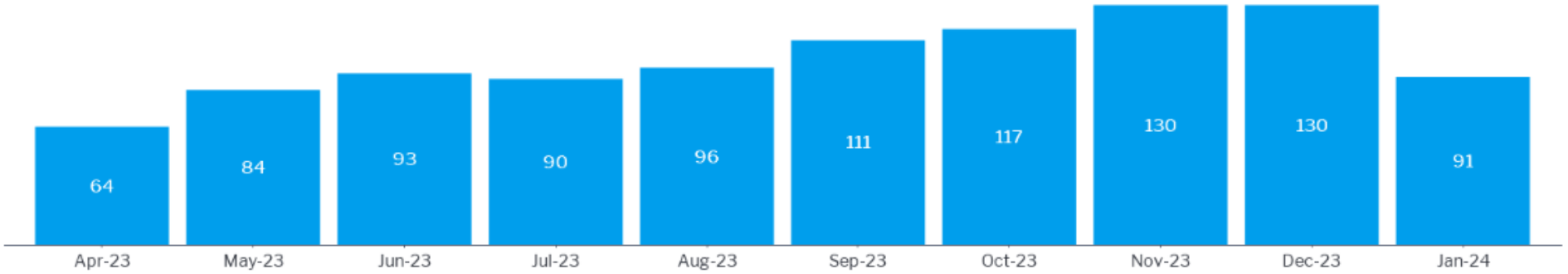


The multidisciplinary Home First approach involves:

- Therapists (O/T and P/T)
- Health Care Assistants / Clinical Support Workers
- Care Coordinators
- Nurses (from wider CIRT)
- Assessment & Reablement Officers /Care Navigators / Social workers (WBC-employed)
- Domiciliary carers

Home First activity since April 2023

Discharges to HF increased with capacity and key process changes. (WUTH represents 90+% of activity from Oct23.)



Therapy + care discharges into Home First at 17 Jan 2024

In addition to the therapy + care discharges, reported towards monthly discharge targets, CIRT therapists have also supported an average of 64 people per month on 'therapy only' Home First discharge pathways.

In November 2023:	Since April 2023
130 discharges with Home First therapy + care **4435 visits in month** (by Home First service staff) *plus* ca. 70 therapy-only discharges = additional activity	**1006 total Home First service discharges** (at 17 Jan 2024)

Home First and other improvement work

Within and beyond the Unscheduled Care Programme, Wirral's improvements include:

1. Best 2 hour response rate across C&M in Urgent Community Response (admissions avoidance)
2. Introduction, with WUTH, of Virtual Frailty Ward
3. New processes in hospital discharge hub
4. Ongoing hospital flow programme
5. WBC's care market sufficiency programme, increasing domiciliary care capacity.
6. WBC's implementation of '3 Conversations' model, reducing demand on care market capacity

Adding to this picture, Home First is now:

- Offering **ten hospital discharge slots / weekday**
- Supporting **hospital discharges in an average of 2 days** once a discharge slot is confirmed
- Providing **HCA capacity for discharges (130 discharges & 3924 visits in Nov23),** directly releasing dom' care capacity
- With the **best independence outcomes** in Cheshire & Merseyside, **reducing demand on the care market** after a Home First discharge

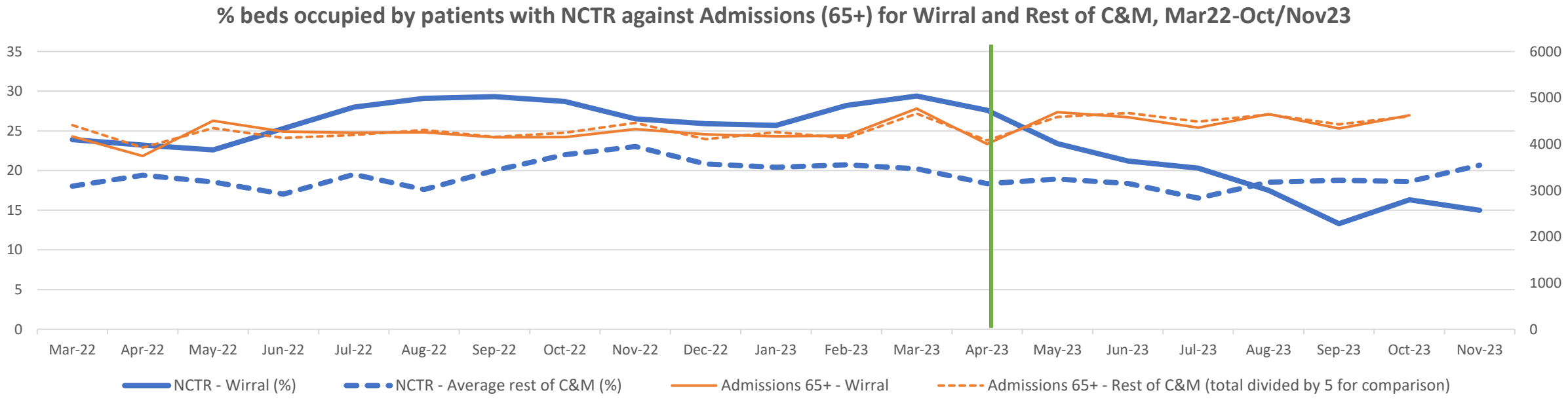
There are many positive impacts corelating with introducing Home First hospital pathways from April 2023…

2. Impact and comparison with other Places

- Overall NCTR rate
- Bed occupancy rate
- Pathway 1 NCTR rate
- Domiciliary care packages in circulation
- Outcomes post-Home First

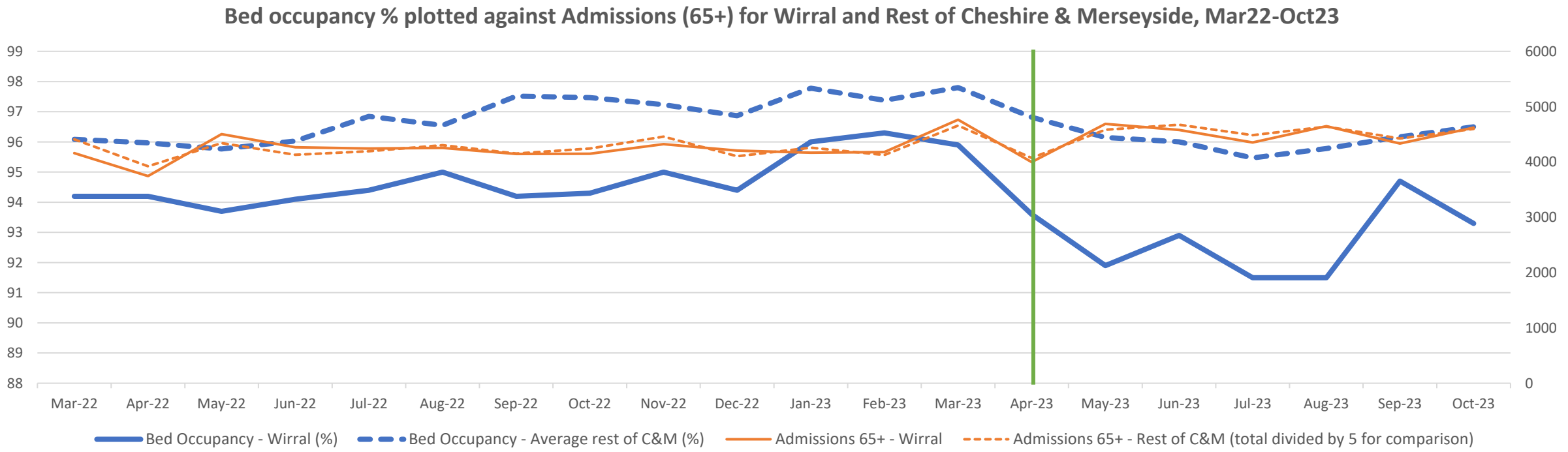
Wirral's overall NCTR rate is now lower than the C&M average

Implementation of Home First (green line) coincides with significant reduction in NCTR (as % of all beds) relative to hospitals in the rest of C&M, even with Wirral admissions slightly higher than 2022. Comparison of admissions data between Wirral and rest of C&M for people aged 65+ shows little variation. (C&M UEC Assurance data, Dec23.)



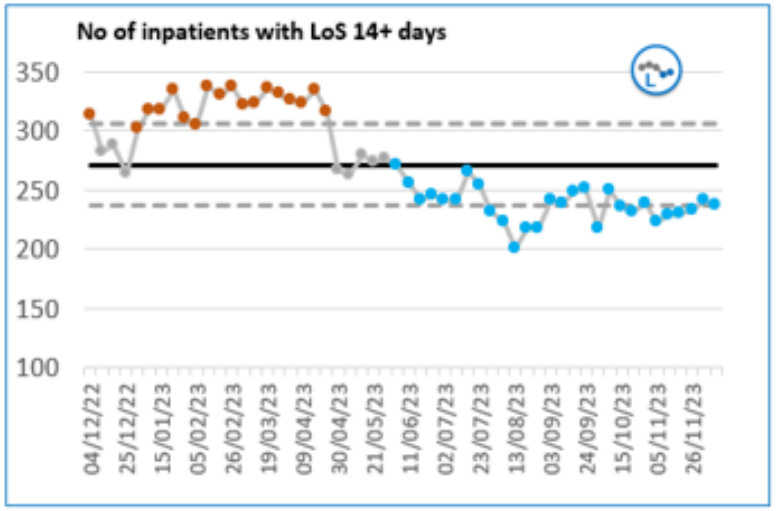
Wirral's Bed Occupancy rate has improved relative to C&M average

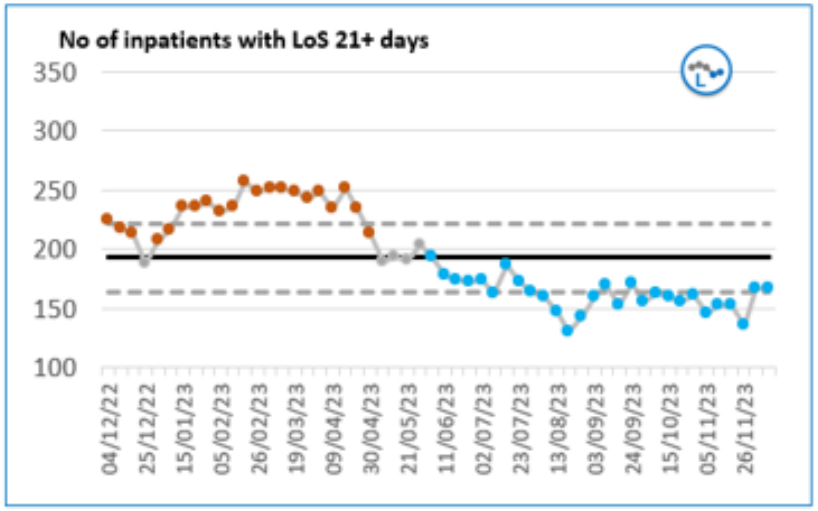
Implementation of Home First (green line) coincides with increased gap in bed occupancy (all patients) relative to hospitals in the rest of C&M. Admissions data for people aged 65+ shows little variation. (C&M UEC Assurance data, Dec23.)

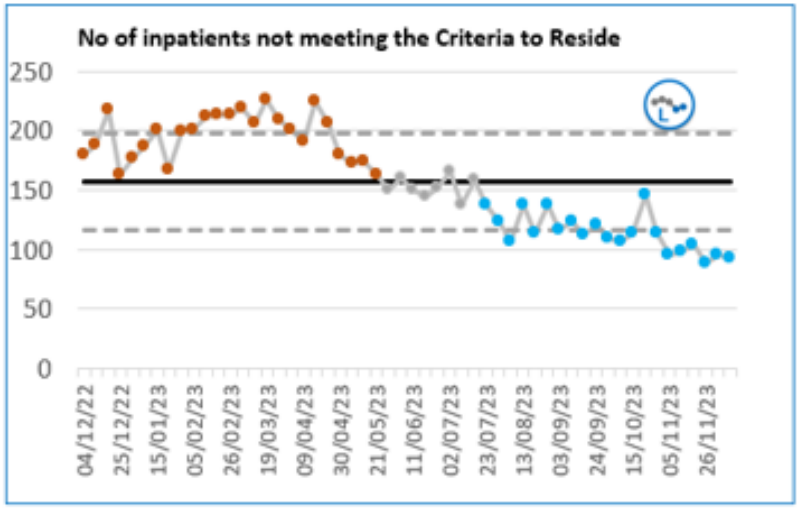


Wirral's 14+ and 21+ LOS has reduced, alongside NCTR (figs to 10/12/23)

Hospital UEC metrics show numbers of Wirral inpatients with LOS of 14 and 21+ days reduced in April 2023, alongside a drop in the patients without criteria to reside (WUTH data).

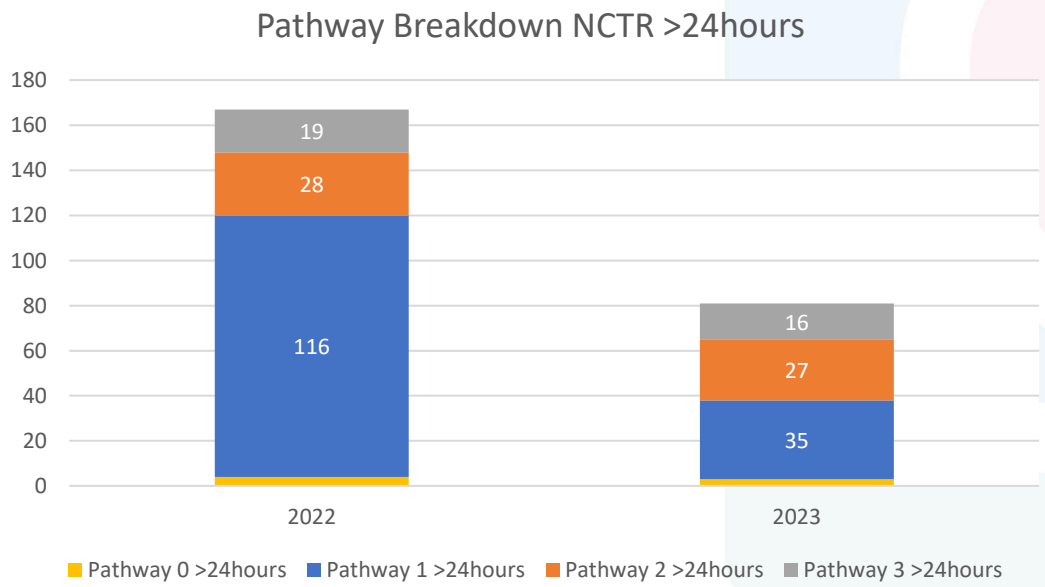


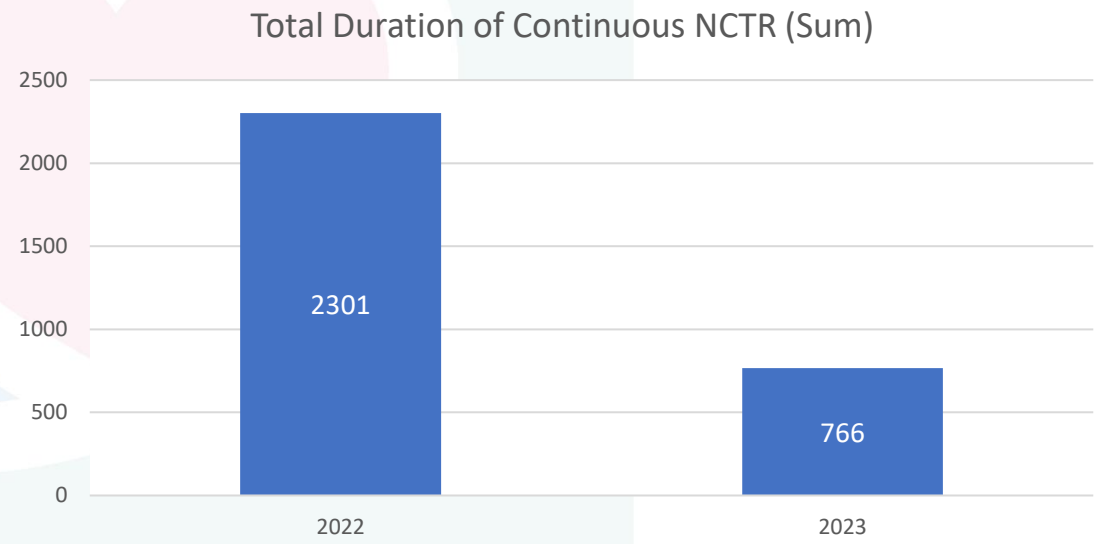




Greatest NCTR impact (comparing Dec22-Dec23) has been in Pathway 1

Of the complex discharge pathways (P1-3), the most significant change in NCTR in the last 12 months has been seen in Pathway 1, i.e. people going home with support/ Home First. This impact reduced total duration of NCTR bed/days by two thirds (WUTH data).





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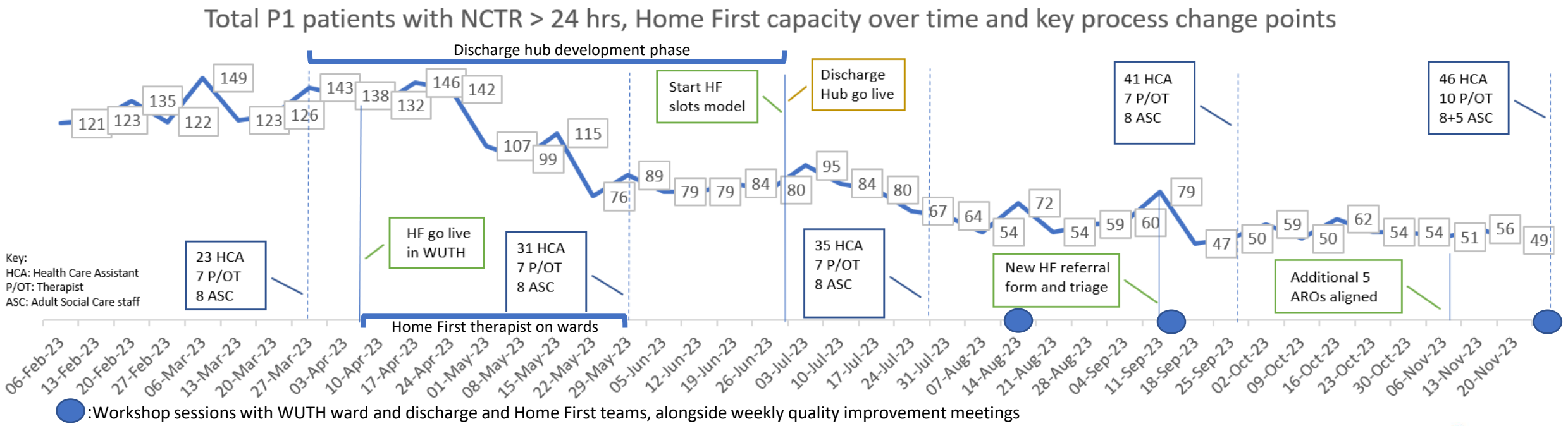
Wirral's Pathway 1 NCTR numbers reduced by two thirds pre-Home First levels

Alongside other changes (discharge hub, flow improvement projects), Home First pathways and additional discharge capacity (3,924 HCA visits in Nov23) has had a very significant impact on P1 NCTR.



:Workshop sessions with WUTH ward and discharge and Home First teams, alongside weekly quality improvement meetings

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

HomeFirst
Why not home, why not today?

Wirral's domiciliary care circulation lists are much lower than late 2022

A significant impact of Home First has been reduced numbers of people waiting for packages of care (POCs).

These have come down drastically in the last 12 months due to a combination of Home First, care market capacity increases and demand reduction (3Cs). This means people are waiting less time for necessary care to be arranged. (Info from WBC.)

POCSs in circulation (daily averages)	
November 2022	November 2023
250+	ca. 15

In **November 2023**, the **130 Therapy + Care Home First discharges** were **28**% of all new packages across domiciliary care and Home First combined, or **40% of the number of all new domiciliary care packages**.

Wirral has the best outcomes for long term independence

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

Based on Home First data, 75% of Home First patients finish independent. Prof. John Bolton suggests 66% represents good performance, so Wirral performs very well nationally.

Data range w/c 9 July- 26 Nov 2023		P0		P1		P3		Readmitted	
	# weeks of data reported	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 serivce 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*

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**."

Both patient and his wife expressed the gratitude they have for the Home First service as they never believed that he would be able to walk again - he was unable to walk without assistance on discharge.

Patient reported that all the staff have been friendly and patient, encouraging him to be more independent and try his best. **Patient said he wouldn't be as good as he is now without their help**.

NB, infection meant that patient deteriorated on discharge with escalation to double handed care calls was made in those first few days, for safety of patient and carers. Liaised with GP for pain management and antibiotics for UTI. Patient was able to stay at home.

When Home First patients do need ongoing care, levels are lower

Fewer Home First patients are likely to need ongoing care than in other areas / comparable pathways.

And, when they do, the level of care required is also lower. (WBC data.)

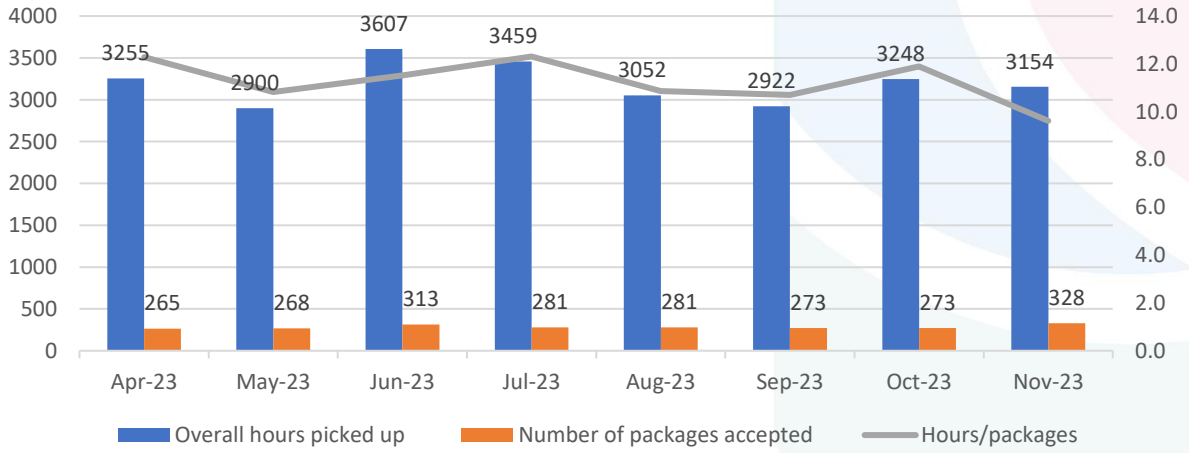
This is likely due to A) more accurate picture of need from assessment at home following, B) highly effective intermediate care model from an integrated team resulting in lower levels of need.

Hours/week per POC	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	**Average**
Community	10.8	11.8	10.2	9.9	10.8	10.4	9.7	8.4	**10.3**
Hospital (POC)	16	18	19	21	17	16	19	19	**18.0**
Hospital (reablement)	9.7	12.0	11.7	11.1	12.5	12.1	11.8	16.9	**12.2**
Intermediate care beds	16.8	20.2	14.9	14.8	17.1	17.3	16.2	16.4	**16.7**
Home First	6.6	7.7	7.3	6.0	7.5	8.3	7.6	8.0	**7.4**

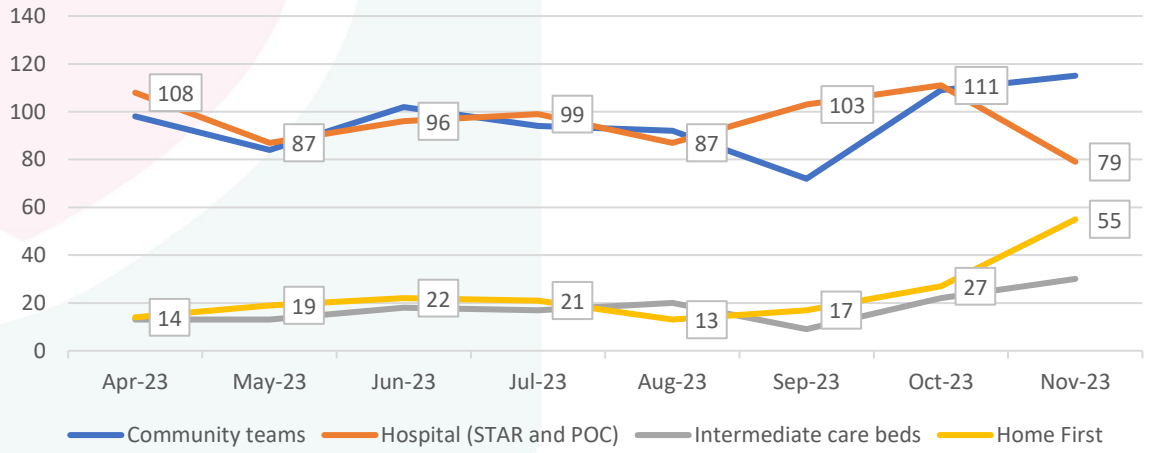
Fewer POCs needed direct from hospital, overall numbers similar

No. of POCs picked up from hospital has reduced since ARO alignment to Home First in Nov23, though overall new POCs Wirral-wide have stayed consistent. With far fewer POC requests in circulation, this suggests previously unmet demand for POCs is now being met. (WBC data.)

Overall number of new dom care hours and packages, and average hours per POC (inc change of provider)

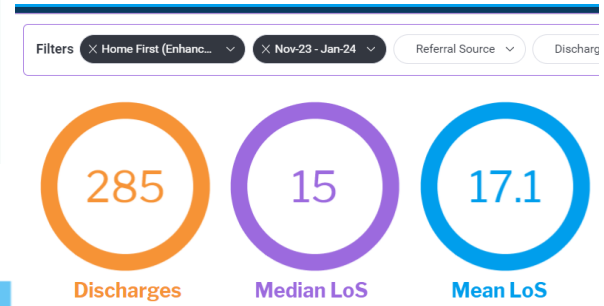


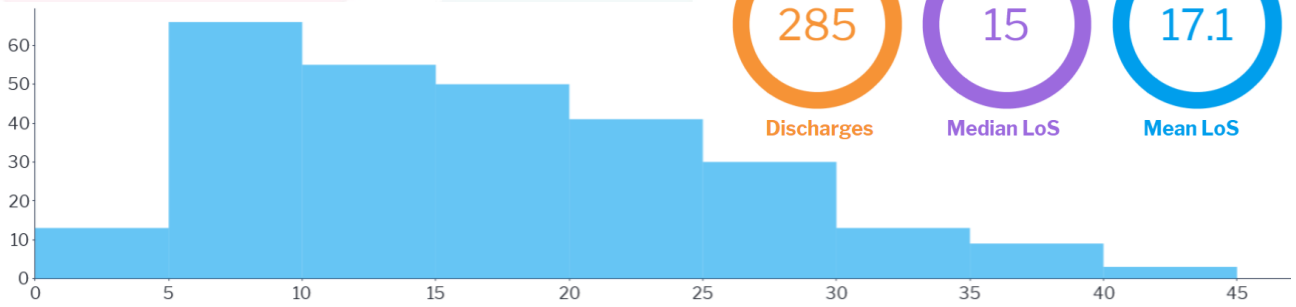
Number of packages by source, hospital and Home First numbers shown



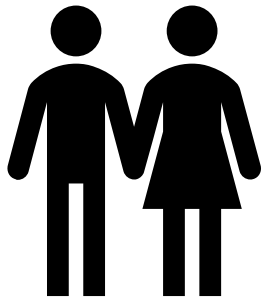
3. Home First pathways, workforce, demand variation & development

- Home First pathways
- Planned and current workforce
- Average demand and variation
- Time between referral and first visit
- Pathway development focus





Home First pathways: MDT triage determines pathway



- Therapy only → 1. Therapy only / no personal care needed
- Therapy + care →
  - 2. Home First HCAs (**ca. 70%** people expected to finish Home First independent)
  - 3. Hybrid Home First HCA + dom' care (**ca. 10%** people with previous dom' care and expected temporary increased needs)
  - 4. STAR dom' care (**ca. 20%** people with long term dom' care expected, low likelihood of reduction)

Pathways 3 & 4 introduced Dec23.

All pathways involve HF therapists as lead professional or available to support AROs

Home First: planned and current workforce

Staff roles	Band	Plan for end 23/24 @Mar 23	Revised for end 23/24 @Aug 23	Actual (Jan 24)
Health Care Assistants / Clinical Support Workers	B3 B2	60	40 12	40 7
Therapists* Therapy Assistants	B6 B4	9 6	5 5	5 5
Therapy Lead Service Lead	B7 B8a	1 1	1 1	1 1
Care Coordinators	B5	5	5	5
Nurse Associates	B4	0	2	1
Social care staff	WBC staff	20	18	13

*March23 plan for 7 therapy staff aligned from hospital (per Barnsley approach).

August 23 revision corrected assumption that therapists could be released from wards.

Led to skill mix and reduction in planned B2/3 roles, increased B4 therapy roles, more nursing input due to clinical need.

VCFSE sub-contracts not included as planned due to combination of contracting and commissioning issues – still scope to include, requires review. Aim to further involve existing VCFSE services.

24/25 plan based on demand and capacity modelling and evidence of staffing needs from operating service (slides 32 & 33)

Home First demand: averages and variation

Total recorded by discharge team 13 weeks, w/c 11 Sept-11 Dec 23		**Average per week**	**Variation**
Total P1 discharges	536	41 (180/month)	35-49
Suitable Home First	**416**	**32** (142/month)	**26-42**
Not for Home First			
Fast track	57	4.5	0-8
Likely complex POC (10% of P1 discharges)	52	4	3-5*
Other	11	1	0-2

*Estimated

- Variation in P1 discharges means relatively reduced care capacity when referrals and/or care needs are significantly above average, unless excess capacity is maintained.
- People being withdrawn or delayed from planned discharge slots reduces capacity, average **25%** of Home First discharges (range 9%-53%)

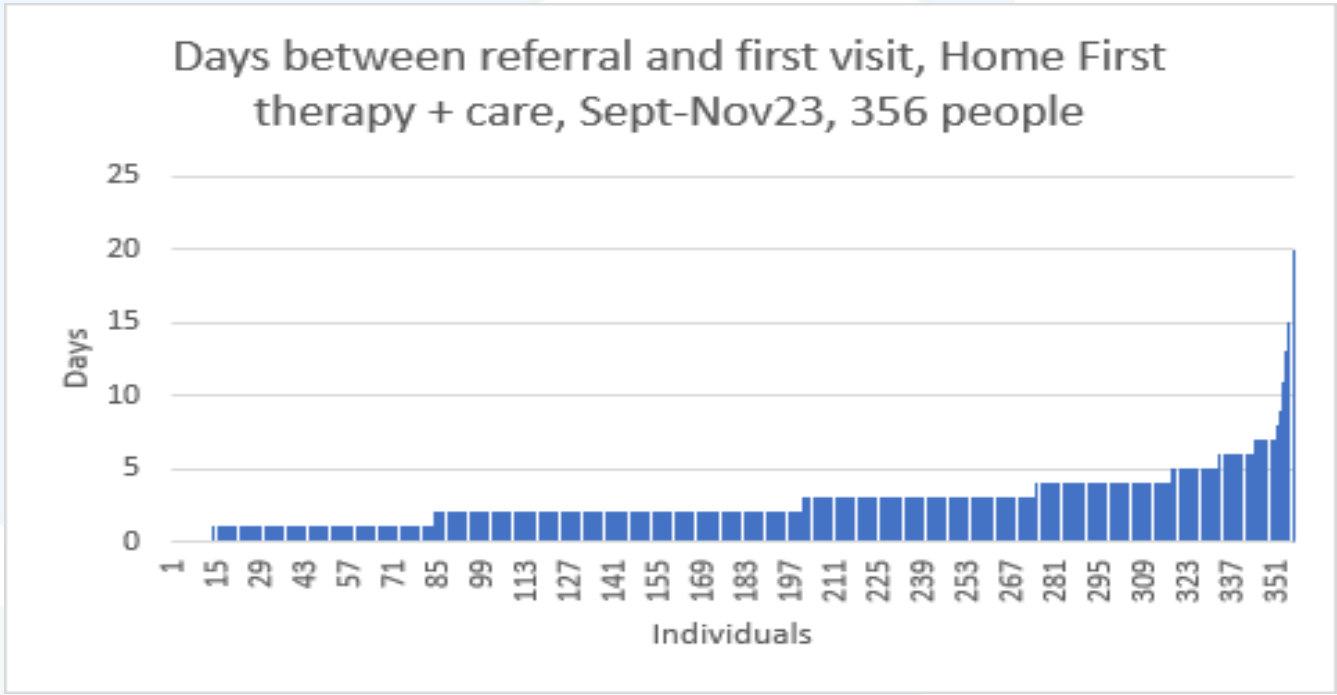
Time between referral and first visit for therapy + care

Time from referral to first visit

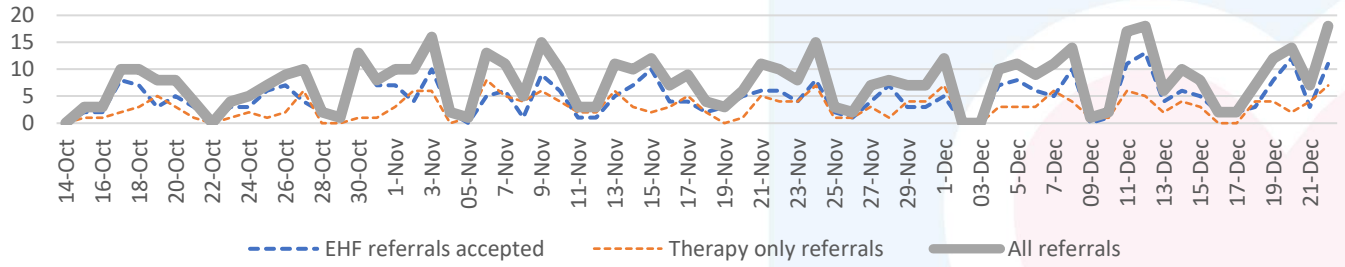
- Median and mode, 2 days
- Average, 2.7 days

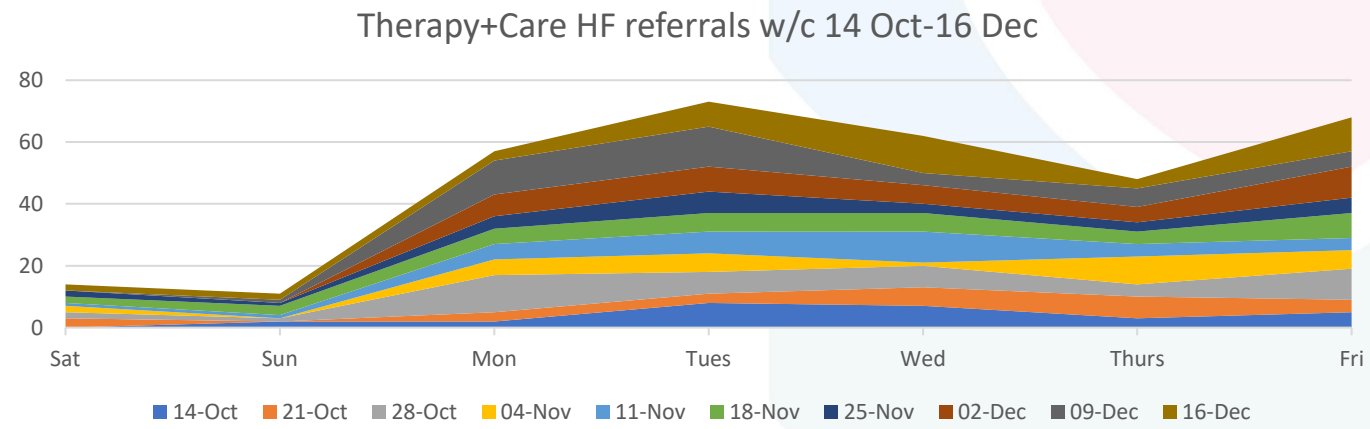
Of all 356 people, Sept-Nov23

- 77% of people, 3 days or less
- 89% of people, 4 days or less
- 3.7% of people, 7+ days



Variation in referrals by day and week, Oct-Dec 2023





More referrals earlier in the week will reduce time between referral and discharge.

Referral day	Median time to first visit	Mean time to first visit
Mon	2	2.3
Tues	2	2.3
Wed	2	2.7
Thurs	3	3.2
Fri	3	3.4
Sat	2	2.5
Sun	2.5	2.2

Current and future Home First pathway development focus

Current focus, to increase effectiveness of discharge pathways and avoid wasted capacity, development work between Home First, discharge and wider hospital teams will focus on:

1. Addressing variation in referral and discharge numbers, during and between weeks
2. Maximising speed of decision-making and discharge planning
3. Maximising fill of available discharge slots, reducing numbers of people withdrawn or delayed on day of discharge
4. Achieving discharges earlier in the day, to enable people to be settled at home sooner and smooth peaks and troughs
5. Ongoing implementation of hybrid working with care arranging team and dom' care, so people who are very likely to need dom' care after Home First have this arranged to support discharge

Future focus, to enable 'left shift' from P3>P2 and P2>P1:

1. Working with CICC team to actively support more CICC discharges (as in pilot phase)
2. Supporting decision-making about who is safe to be supported at home, to enable P2>P1 shift
3. Introduction of existing VCFSE services and pathways (e.g. Community Connectors) into Home First model

4. Effect on system costs and 2024/25 model

- Reduction of bed pressure costs related to P1 NCTR
- Replacement of most dom' care costs related to discharges
- Reduction of ongoing dom' care requirements
- Workforce and financial model, 2024/25

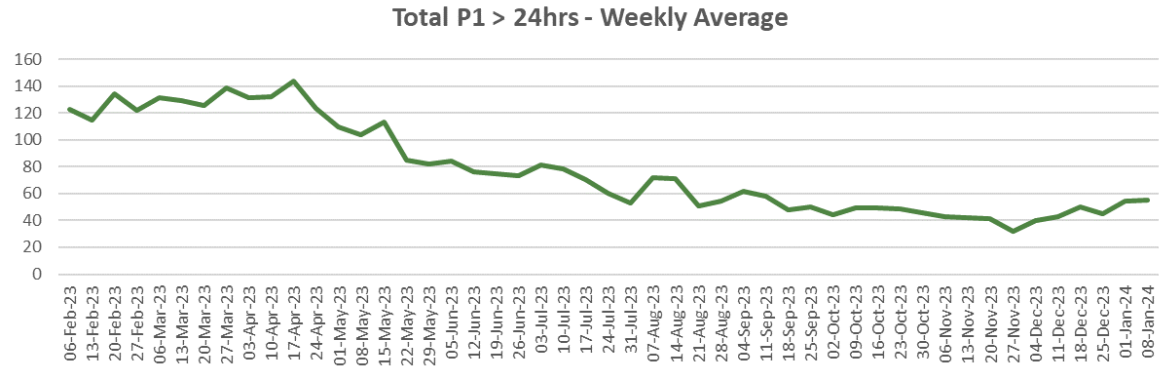
Reduction of P1 NCTR-related bed costs: ca. £7.5m / 41wks Apr23-Jan24

Based on average weekday P1 (>24hr) NCTR figures (x7 to give a weekly total as not reported at weekends), 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 (£9.5m full year).

Whilst this doesn't reflect actual savings, it suggests that resources and care is now more able to be focused on people with a medical need to be in hospital and represents cost-avoidance, i.e. without Home First, additional pressures and costs would have been higher. Fewer escalation beds also reduces staffing pressures related to managing 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**

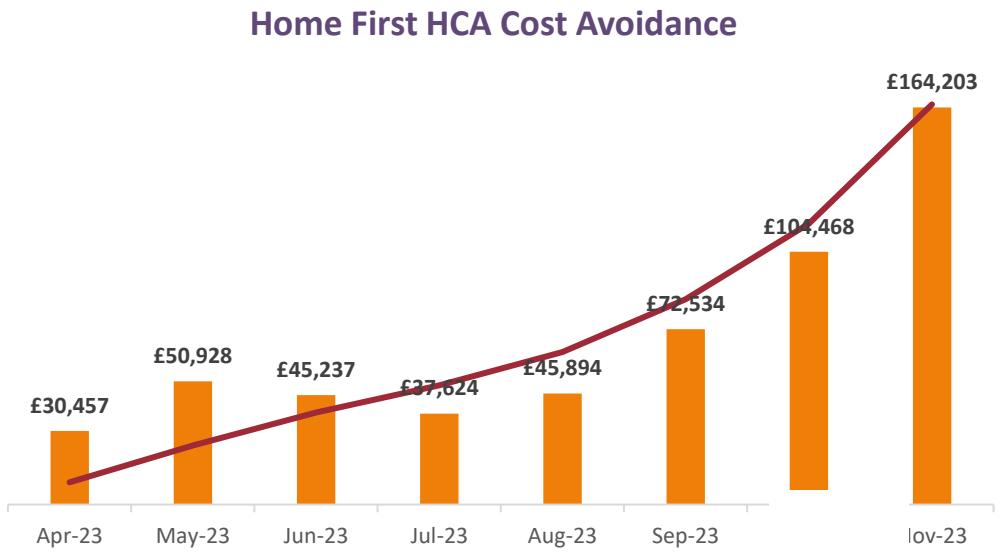
Replacement of most dom' care costs related to discharges: ca £2m/pa

As Home First capacity has grown, it has replaced personal care provided by domiciliary care agencies as part of STAR discharge pathways. The number of visits for 130 Home First discharges in Nov 2023 was 3,924. This represents £164k cost avoidance at this level of activity, if these visits had been provided by domiciliary care.

Over a year this represents £1.97m cost avoidance.

Month	Home First HCA Visits	STAR Hrly Rate	Cost Avoidance
Apr-23	1447	£21.72	£30,457
May-23	2015	£21.72	£50,928
Jun-23	2127	£21.72	£45,237
Jul-23	1971	£21.72	£37,624
Aug-23	2679	£21.72	£45,894
Sep-23	2712	£21.72	£72,534
Oct-23	3171	£21.72	£104,468
Nov-23	3924	£21.72	£164,203

NB. Cost avoidance calculated based on all calls <30 mins being charged for a full 30 min call



Reduction of ongoing dom' care requirements: £3.6 – £8.4 m / pa

Fewer patients needing ongoing dom' care after Home First discharge, and those that do needing lower levels of care, pressure on dom' care capacity and costs of provision should be reduced.

Indications suggest Wirral's Home First discharge model has a **cost pressure reduction effect of £1.8 - 4.2m pa per 1000 people**, **i.e. £3.6 – 8.4m at 170 discharges/month,** based on lowering requirements for ongoing dom' care (depending on 12 or 18 hours used as ongoing care requirement after hospital discharge).

Cost pressure reduction effect is notional and based on assumptions, shown at Appendix 1. Actual dom' care activity has not obviously reduced in 23/24 (slide 20), suggesting unmet demand now being met and/or demographic change adding pressure.

In addition, expanded capacity and reduction in demand has enabled block-booked beds at Park House to be closed, already saving against their (non-recurrently funded) cost.

Capacity planning based on expected activity, 24/25

Home First demand and capacity modelling is based on the following:

- Weekly hospital P1 discharge numbers during Sept-Nov 2023 range of 127 (min) to 165 (max) Home First suitable discharges/month
- Planning capacity for 90% of the maximum means ca. 150 discharges/month.
- +20 capacity for CICC discharges will improve flow from CICC, improving WUTH flow and improving outcomes.
- **150+20= 170 discharges** (consistent with original March23 model)
- Of these discharges, 20% are likely to have long term care needs and should have dom' care involved early, for continuity and to make effective use of resources, though we expect some bridging may be required

Therefore, full Home First HCA capacity is needed for ca. 80% of discharges needing care (plus bridging capacity), and therapy capacity is needed for 170.

NB, Expectation of additional (previously P2) patients coming to P1, to enable more P3 patients to P2. System modelling not concluded. **Each additional 20 discharges = 5 HCAs and 1 therapist capacity.**

Home First: revised workforce requirements for 24/25

Role	Band	Revised (for 24/25)
Health Care Assistants	B3	50
Therapists Therapy Assistants	B6 B4	6 6
Therapy Lead Service Lead	B7 B8a	1 1
Care Coordinators	B5	6
Nurse Associates	B4	2
Nurses	B6	2
Nurse Lead	B7	1
Assessment & Reablement Officers / Care Navigators	WBC staff	

Modelling based on estimated 170 P1 Home First discharges month from WUTH and CICC*.

- HCAs all B3 due to meds admin requirements

  Full HCA support planned for 80% of total patients / month and at 85% max demand seen day to day in Q3 23/24. Expectation of ca. 20% of P1 Home First discharges supported by dom' care but with bridging available = 153/month HCA-supported discharges modelled.
- Therapist numbers planned for 170 Therapy + care discharges
- Care coordination capacity increased.
- Nurses added to skill mix to support clinical oversight of HCAs, meds administration and clinical needs, e.g. skin integrity.

*therapy-only discharge numbers are additional to this as a separate pathway also delivered within CIRT by Urgent Community Response. Funding and specification for those discharges are not in scope of this model.

Home First financial model, 2024/25: 170 P1 discharges/month

		Cost
Staffing 7 days Care provision 8am-10pm	Health Care Assistants B3 (50 WTE)	£1.8m
	Care Coordinators (6 WTE) Service Lead (1 WTE)	£395k
	Therapists B6 (6 WTE) Asst therapists B4 (6 WTE) Therapy lead B7 (1 WTE)	£667k
	Nurses B6 (2 WTE) Nurse Associates B4 (2 WTE) Nursing Lead B7 (1 WTE)	£281k
Non-Pay (direct) @ 5%		£157k
Overhead @ 15%		£495k
TOTAL pa		£3.8m

Staffing costs reflect even staffing 7 days per week. To maximise impact, this would require equivalent focus on 7-day referrals and discharges.

Expectation of increase in P1 activity due to P2>P1 shift (and P3>P2 shift) though system modelling not concluded.

Estimate for each +20 P1 patients = requirement for ca. additional 5 HCAs, 1 therapist = ca. £280k pa.

NB £3.8m pa is comparable to the projected 23/24 cost in March 2023 proposal. The March 2023 proposal included £400k for VCFSE, excluded from this financial model.

Home First, 2023: key messages

Since April 2023, as a core project within Wirral's Unscheduled Care programme, the Home First project has been delivered by a multi-organisational team from WCHC, WUTH and WBC, with a clear focus on continuous improvement, staff engagement and what is best for patients.

Outcomes:

- Reduced hospital Pathway 1 NCTR
  (NCTR two-thirds lower, Dec22-Dec23; 1600+ fewer P1 NCTR bed-days, Apr23-Jan24)
- Reduced pressure on domiciliary care provision (providing 28% of total system capacity at Nov23; fewer people needing lower levels of care after Home First discharge, Apr-Nov 23 figures)
- People not now having to wait for essential care (packages circulating 250+ Nov 22, ca. 15 Nov 23)
- Best outcomes for people now able to continue living independently post-discharge (75%, best in Cheshire & Merseyside)

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

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








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

HomeFirst
Why not home, why not today?

Appendix 1: reduction of ongoing dom' care requirements

Fewer patients needing ongoing dom' care after Home First discharge, and those that do needing lower levels of care, pressure on dom' care capacity and costs of provision should be reduced.

Indications suggest Wirral's Home First discharge model has a **cost pressure reduction effect of £1.8 - 4.2m pa per 1000 people**, **i.e. £3.6 – £8.4m at 170 discharges/month,** based on lowering requirements for ongoing dom' care (range depends on 12 or 18 hours used as ongoing care requirement after hospital discharge – see slide 19).

Cost pressure reduction effect is notional and based on assumptions, as below. Actual dom' care activity has not obviously reduced in 23/24 (slide 20), suggesting unmet demand now being met and/or demographic change adding pressure.

It is based on the following

- In 2022, half of hospital discharges on Pathway 1 were via direct POC, and half STAR
- 23/24 figures for average ongoing care needs are: i) from hospital, 18hours, and ii) after STAR discharge, 12 hours, and iii) after Home First discharge, 7 hours (as per slide 18)
- The cost of delivering Home First for 1000 people was approx £2m in 23/24
- An assumption that 50% of people would have had ongoing care needs after STAR discharge (a reduced figure compared to the 54% average for ongoing care needs for all STAR outcomes in 20/21 and 21/22, which include step up outcomes. The Q1 23/24 figure was higher, 63%.)

Assuming:

- 20% of people on Pathway 1 continue to have dom care provision straight from hospital, so higher ongoing care needs
- 30% of costs can be recovered for dom care provision
- Ongoing care needs / costs after P1 discharge are for one year