Adult Social Care and Health Scrutiny Committee

Home First Spotlight Review

Report

9 March 2026

DRAFT

Councillors:

- **Councillor Jeanette Banks (Chair)**
- **Councillor Victor Floyd**
- **Councillor John Hodkinson**
- **Councillor Linda Mussell**
- **Councillor Damian O'Connor**
- **Councillor Bisi Osundeko**

Contents

2 Method of Investigation 1

2. Background 2

3. Findings 3

Introduction 3

4. Pathways 3

5. Home First Support Services Network 4

6. Reablement Services: Improving Outcomes Through Timely, Person-Centred Care 4

7. Home Improvement Team 5

8. The Wider Service Offer 6

9. Transfer of Care Hub 6

10. Confidence in Community Support 7

11. Therapy Provision and Pathway Integration 7

12. Transition from Hospital-Based Rehab to Home First 8

13. Sharing good Practice 8

14. Strengthening Community Therapy Equipment Provision 9

15. Looking Ahead: Staying Ahead of the Curve in a Changing System 10

16. Conclusions 10

Promotion 12

17. Recommendations 15

DRAFT

1 Introduction and Terms of Reference

1.1 The Adult Social Care and Health Scrutiny Committee agreed to establish a Home First Review as part of its work programme for 2025/26.This was based on evidenced provided within the Technology Enabled Care/Artificial Intelligence Update Report presented to the Adult Social Care and Health Scrutiny Committee in March 2025 and the subsequent site visit to the Brookfield Centre. The remit for the Task Group was to investigate the Council's Home First Model and to understand the progress made to implement the model, the challenges being experienced by some residents in accessing adult social care services, and to seek to identify areas where the Council could add value to its communities and residents through recommendations.

1.2 The Purpose of the Review was to explore:

- To what extent the Home First model was being utilised across local authorities and care systems.
- The measurable impact of Home First on independence, wellbeing, and service efficiency.
- Opportunities for improvement and innovation to ensure broader, more equitable access and more effective use of Social Care services.
- Utilisation of staffing resource in implementing Home First to enable better outcomes and reduce reliance on social care support in the long term.

1.3 This report presents the evidence and conclusions of the Adult Social Care and Health Scrutiny Committee's 'Home First' Spotlight Review, held on 17 October 2025.

1.4 Additionally, this report outlines the purpose, pathways, benefits, challenges, and strategic direction, as well as operational data, adaptations, partnerships, and recommendations for future development of the Home First model.

1.5 It concludes with a set of recommendations which link to and support the second of the six borough priorities "Promote good health, independence, and care across our communities

2 Method of Investigation

2.1 The Aims and objectives of the of the spotlight review were:

- To assess how Home First is currently being used in the Borough to enable people to stay in their own homes.
- Consider how resources could be re-allocated to facilitate full implementation of Home First.
- Consider how consistently Home First being deployed across different regions or demographics.
- Consider what the barriers are to the integration of services in a way that would enable people to remain in their own homes for longer.
- Consider whether there are any gaps in funding, awareness, training, or infrastructure.

DRAFT

- Understand the challenges in uptake and sustained use by individuals.
- Determine how Home First affects quality of life, independence, and patient care outcomes.
- To identify any barriers to access or implementation
- Understand what data exists on cost-effectiveness and service efficiency.
- Evaluate cost avoidance in terms of reducing reliance of Domiciliary Care and reducing admission to care home facilities.
- To explore opportunities for scaling up or improving the access to Home First support.

1.1 The following Councillors and officers attended the Spotlight Review meeting on 17 October 2025:
- Councillor Jeanette Banks (Chair)
- Councillor Victor Floyd
- Councillor John Hodkinson
- Councillor Linda Mussell
- Councillor Damian O'Conner
- Councillor Bisi Osundeko
- Lisa Birtles Assistant Director for Contact Care and Independent Living
- Dianne Charnley - Therapy Directorate Manager, Finance & Performance Lead – Therapy services. NHS
- Ottilie Jones Head of Independent living and Principle Occupational Therapist
- Karl Allender, Scrutiny Support Officer

2. Background

2.1 Officers informed the Task Group that the Council operated and adapted the Reablement Team to support people at home with independence and recovery. The adaptations introduced in response to the COVID-19 pandemic laid the foundations for the early development of the Home First model, positioning the Council ahead of the curve in rethinking discharge and recovery pathways. At a time when hospitals were under immense pressure and traditional care models were disrupted, the Council recognised the need for a more agile, community-based approach to post-acute care

2.2 It was suggested that despite the innovative groundwork, progress was initially hampered by the extraordinary circumstances of the pandemic. Staffing shortages, service reconfigurations, and the urgent demands of crisis response limited the pace of implementation. However, over the past two years the Council had invested significantly in strengthening the Home First model, demonstrating its continued commitment to developing robust community services that could support patients outside of hospital settings.

2.3 Officers believed that the progress made now presented a strategic opportunity to align Home First with broader system-wide priorities, including:
- The Council's Neighbourhood Plan,
- Addressing rising demand for services, and
- NHS 10-year plan.

DRAFT

3. Findings

Introduction

3.1 Defined by NHS England Home First was a collaborative model of care in which people who had been clinically optimised and did not require an acute hospital bed, but might still require care services, were provided with short-term, funded support to enable discharge to their own home (where appropriate) or another community setting.

3.2 The Council's Home First initiative aimed to reduce unnecessary hospital stays by enabling patients to continue their recovery and therapy at home once they were medically fit.

3.3 Home First was a person-centred approach that enabled people to return to their home environment, or remain in their home, where residents felt most safe and could live their lives as independently as possible. Home First was a model of practice that had proven successful in other areas of the Country and had also demonstrated significant savings in social care budgets. Additionally, the Council's Home First model had incorporated a 'trauma-informed proactive model' to support people in understanding the experiences they had faced that might have impacted their health and wellbeing.

3.4 Officers mentioned that staying in hospital longer than necessary could have had a negative impact on patient outcomes. Ensuring that patients were given the chance to continue their lives at home was considered vital for their long-term wellbeing. Furthermore, prolonged hospitalisation could have led to several negative outcomes such as physical deconditioning and loss of functional ability.

4. Pathways

4.1 Hospital discharge was the final stage in an individual's journey through hospital following the completion of their acute medical care, when patients left an acute setting and moved to an environment best suited to meet any ongoing health and care needs, they might have had. This ranged from:

- Pathway 0 – Remaining at home (or another temporary accommodation) with little or no additional care (simple discharge)
- Pathway 1 – Discharge to home, or other temporary accommodation with rehabilitation, reablement, and recovery.
- Pathway 2 – Short-term bed/hospice for rehabilitation, reablement, recovery, or end-of-life care.
- Pathway 3 – Discharge to a care home as a new admission, or to a hospice for a new admission for end-of-life care.

4.2 The Council's Home First model focused on patients in Pathway 1, those who no longer needed hospital care but did need formal support to return home. Patients' long-term needs were assessed at home rather than on a hospital ward. In such cases, it was noted that a full assessment on the ward was not required, with emphasis placed on what was needed for a safe discharge home. Following this, multidisciplinary teams collaborated to deliver an

DRAFT

effective wraparound service. Discharge planning, therefore, needed to be timely, coordinated, and patient centred.

The NHS Therapy Directorate Manager highlighted that prioritising patients' return home, where possible, had been the central focus, enabling better outcomes in terms of recovery and independence. It was mentioned that consideration of the NHS 10-year plan and its community-driven direction, along with the collective need to allocate resources for optimal service delivery and outcomes, was seen as a key element in the development of Home First. This was particularly associated with enhancing community-based therapy.

4.3 Since the inception of the Home First model, it had reduced deconditioning, for patients, shorter waits for assessment or care packages, and lower levels of care required following Home First support. This was largely attributed to the effectiveness of therapy-led interventions, multidisciplinary care, and reablement support. Officers highlighted that the landscape was always changing and that monitoring, coordination and collaboration was key to ensuring the continued progress in service delivery was enhanced to meet demand and best practice.

4.4 Furthermore, officers also highlighted that it had been important to consider demographics and outcomes to understand how Home First could be shaped and developed to ensure the offer met patients' needs. The Task Group was informed that this work had been progressed.

5. Home First Support Services Network

5.1 Although the principles of Home First had been in practice for many years, the approach was formally introduced in October 2024 with the establishment of dedicated team supervisors and additional support staff. Despite this progress, challenges remained particularly around recruitment and resource allocation which could slow implementation Officers mentioned that the long-term vision had been to create a more integrated and responsive system where hospital and community teams worked together seamlessly to support timely, safe discharge and recovery. It was noted that work had continued in this area and the services were now in a much better place.

6. Reablement Services: Improving Outcomes Through Timely, Person-Centred Care

6.1 Officers drew attention to the Reablement Team who played a central role in the Home First model. Operating from 7:30am to 10:00pm, the team included supervisors and intermediate care support workers who delivered therapy programmes based on hospital discharge plans. These programmes were coordinated with therapy and integrated care teams to ensure continuity and responsiveness.

6.2 The goal for the Reablement Service had been to help individuals return to their baseline level of independence, or as close to it as possible, without requiring long-term care. This was achieved through multidisciplinary input from therapy, nursing, and social care; a focus on self-care, recovery, and resilience; and close collaboration with intermediate care teams (e.g., NHS)

DRAFT

6.3 Officers explained that the Reablement Service was designed to maximise independence by removing environmental barriers and helping individuals regain practical skills after illness or injury. The reablement team was made up of social care professionals who delivered support in a person's own home. While most reablement took place at home, there were occasions when it extended into nursing homes or residential settings, depending on individual needs.

6.4 The approach was deeply collaborative, involving individuals, families, friends, and carers. Conversations were centred around the person, their goals, their priorities, and what mattered most to them. Timeliness was key:

> *"We aimed to respond to referrals the same day or the next day."*

6.5 To support this, officers noted that the Council had introduced an additional role that allowed the service to hold slots for people in hospital who were likely to be ready for discharge within 24 hours, ensuring that officers could act quickly and efficiently.

6.6 Maximising the workforce meant making the best use of therapy and intermediate care support. It was about deploying the right expertise at the right point in the recovery pathway whether at the beginning, middle, or end and ensuring collaboration across services, drawing on good practice and evolving the model to meet changing needs.

> Additionally, through the Technology Enabled Care Programme, the Service, via a Social Care Assessor, explored and administered the use of monitoring equipment, including GPS trackers. However, challenges remained, as these devices could be removed or disabled. Alongside this, the Council's Careline services team already provided a 24/7 response service, with staff working 12-hour shifts from 7am to 7pm. This was recognised as a highly effective and well-regarded service, which the team aimed to further develop and build upon.

7. Home Improvement Team

7.1 It was discussed that another key partner was the Home Improvement Agency, which supported minor adaptations such as grab rails and stair rails. They also conducted financial benefits assessments and worked under the Affordable Warmth programme. When occupational therapists (OTs) identified a resident's needs during their assessments, the agency provided technical officers to visit the home, prepare schemes, and manage the grant application process. This enables the installation of necessary facilities, with technical and occupational therapy sign-off upon completion.

7.2 A question was raised around the partnership with registered housing providers (e.g. Torus). It was discussed that the Home Improvement team worked in partnership with local authorities and social landlords. The Home Improvement Teams handled contractor accreditation and provided technical support for adaptation schemes. For example, when working with Torus, they split the cost of adaptations 50/50. In relation to privately owned properties, individuals were sometimes eligible for full grants up to £30,000 depending on their circumstances.

7.3 The Home Improvement team faced challenges regarding the interpretation of visits and the assumptions that hindered progress. After the information sessions, many people came forward, revealing that much of the confusion stemmed from how services were communicated, particularly for residents transitioning through care.

7.4 It was emphasised by officers that the change to single-handed care was about improving outcomes rather than reducing costs. It was suggested that patient-centred care flourished under this model. Officers highlighted that single-handed care worked well, and the benefits were clear. It was mentioned that some misunderstanding persisted. Previously, workers and care agencies were told that single-handed care wasn't safe or legal, but that wasn't correct. Care agencies often defaulted to two carers as a risk-averse strategy, but that didn't always reflect the best approach for the individual. It was noted that the promotion of services' outcomes and practices was essential to provide residents and service users with developing confidence in the Home First model and the new ways of working.

8. The Wider Service Offer

8.1 Following on, officers mentioned that there was also a misconception that these services were only for older people. There was no age restriction, and the team actively supported children with SEND who were transitioning into adult services. Around 30% of cases involved younger individuals, and a dedicated paediatric service handled everything from minor adaptations to full extensions. However, one of the biggest challenges in relation to supporting young people with SEND, was finding properties large enough to accommodate children's needs (e.g. wheelchair accessibility) especially when purpose-built housing was limited.

8.2 It was suggested by officers that the paediatric team did incredible work, particularly around sensory adaptations, an aspect of care that had evolved significantly. When the paediatric team first started, most cases involved physical disabilities, but overtime the focus became broader and more nuanced. The narrative needed to keep shifting as it wasn't just about someone who was "old" or "disabled." It was about getting people out of hospital and into environments where they could thrive, with the right support around them.

8.3 The Paediatric team was proud of the Service they had built, the expertise, the responsiveness, and the commitment to person-centred care. There was still work to do, but they were moving in the right direction.

9. Transfer of Care Hub

9.1 The Transfer of Care Hub based in Nightingale House at Whiston Hospital served as a key operational centre. The Integrated Discharge Team (IDT) conducted ward rounds and assessments as soon as an EDIS (Expected Discharge Information Sheet)) was issued to a patient. This triggered discharge planning and coordination with community services.

9.2 The COVID-19 pandemic had created a system-wide shift toward hospital-centric care. However, the Council worked to reverse this trend by refocusing on prevention and community support. The Home First model, alongside Urgent Community Response (UCR), was central to this effort.

DRAFT

9.3 By supporting individuals in their homes and communities before crisis points were reached, the Council, along with partners, continued its journey of progressing with a robust collaborative process of delivery for Pathway 1 patients to prevent avoidable hospital admissions, reduce demand on acute services, and promote independence and wellbeing.

10. Confidence in Community Support

10.1 Historically, officers highlighted that much of the Council's community support had been reactive. For example, services like Careline responded after a fall had occurred. While valuable, this approach often came too late. To truly support independence and reduce hospital admissions, the Council, via its technology-enabled care programme, shifted towards preventative care that identified risks before crises occurred. This enhanced:

- Proactive health monitoring: Using technology to track health conditions and intervene early.
- Wraparound care: Coordinated support that began at the right time, not just when a person was in crisis.
- Digital transformation: Leveraging smart sensors, remote monitoring, and predictive analytics to anticipate needs and tailor interventions.

10.2 As such, the Council accelerated its ambition to embed reliable technology at the start of the care journey, not just as a safety net. This further allowed Home First services to support people in their homes with confidence, reducing reliance on hospital services and improving outcomes.

10.3 It was noted that the wider Home First approach continued to develop positively and began to focus on promoting outcomes and successes, as well as expanding the provision of supporting services aligned to the model. In-turn, this helped reinforce the credibility of the model, encouraged uptake across neighbourhoods, and ensured that all partners were aligned in delivering integrated, person-centred care.

11. Therapy Provision and Pathway Integration

11.1 The focus on developing the Therapy Provision had been the integration of therapy services across the community. Previously, therapy provision included:

- Community Rehabilitation Centre (CRC): Offered structured therapy programmes.
- Occupational Therapy Services: Supported rapid recovery and independence.

11.2 However, it was mentioned that referrals were often fragmented, and transitions between services could be unclear. To improve this, it was considered imperative that the Service created a smooth, predictable pathway for individuals leaving hospital, ensured therapy services were coordinated and aligned with Home First principles, and Improved communication between hospital discharge teams, reablement, and therapy providers.

11.3 Additionally, the ambition had been for every person to understand their recovery journey from discharge to therapy to independence with minimal delays or confusion. As such, officers highlighted that one of the key aims of Home First was to increase the number of discharges

DRAFT

via Pathway 1 providing direct support at home rather than defaulting to Pathway 2 (intermediate care) or Pathway 3 (care home placement).

11.4 To achieve this, it was necessary to reduce unnecessary criteria that delayed discharge, including:

- Building confidence in community support services.
- Ensuring essential equipment and adaptations were in place quickly.
- Using reablement to reassess needs in the home environment.

11.5 In doing so, this approach not only reduced pressure on hospitals and care homes but also promoted independence. However, more work was needed around building public confidence and the promotion of support services and well as exploring opportunities for moving resources to community-based therapy.

12. Transition from Hospital-Based Rehab to Home First

12.1 In the past, patients remained in hospital for extended periods to undergo rehabilitation. Therapists played a key role in supporting daily activities such as washing, dressing, and kitchen practice to assess whether individuals were ready for discharge. However, this model changed significantly. It was noted that the extended rehabilitation period within hospital settings no longer existed. Assessments became quicker and less intensive, typically focusing on basic mobility and safety rather than comprehensive functional recovery.

12.2 Officers commented that assessing patients in their own home environment provided a more accurate and realistic understanding of their functional abilities and the challenges they faced. Moreover, therapy delivered at home was designed to help individuals regain independence, with a focus on essential tasks such as using stairs, washing, dressing, and moving around safely. A critical part of this process was ensuring that appropriate equipment such as profiling beds and mobility aids was installed and ready before the patient was discharged.

12.3 Furthermore, the care provided at home went beyond traditional domiciliary support. It was a proactive, enabling approach that helped individuals build independence rather than simply meeting basic needs.

13. Sharing good Practice

13.1 An example of good practice was provided in relation to NHS Greater Manchester Integrated Care Board where response teams were developed across localities, starting in South Manchester and expanding to North and eventually Trafford. Initially, Trafford had a service, but not the integrated model seen elsewhere. Over 12 to 18 months, an urgent care response service was introduced, alongside intermediate care, and the benefits were significant. The discharge process was streamlined, with patients seen quickly sometimes within hours by a team that included therapists and care staff working collaboratively.

13.2 It was highlighted that what made the Manchester model so effective was the co-location of services. Everyone was based in one building, which meant communication was seamless and team working was strong. Staff could go out together, assess patients immediately, and identify what equipment or support was needed right at the point of discharge. They also

DRAFT

worked closely with workers to ensure patients received the right therapy and care. The Discharge-to-Assess (Home First) Team operated as a seven-day service, flowing smoothly from hospital to home, with minimal delays.

13.3 It was noted that this approach created a much better patient experience. It reduced waiting lists and helped bridge the gap between hospital discharge and outpatient care. That gap from home to full recovery was often where patients felt most vulnerable. “Seeing how Manchester implemented this model showed how timely assessment and coordinated input could make a real difference”. Primarily, it was about making sure patients got the right support from the right people, at the right time and that was what kept them safe, stable, and on the path to recovery.

13.4 It was essential to show that patients could manage and cope at home that they were safe, supported, and able to thrive outside of hospital. The ability to step up or step down into the right service was critical, and ideally, this was managed in coordination with the hospital. Discharge to assess and intermediate care still required therapeutic input, but in some cases, it was simply about ensuring the right support was in place for a safe discharge. When the flow of services was well-managed and the right skills were available around the patient, outcomes were optimised.

13.5 Members questioned where the Council was in relation to the Manchester Model. In St Helens, the team acknowledged that they were not yet at that level. While the Community Occupational Therapy (OT) Team currently focused on equipment and adaptations, there remained a gap in the wider delivery of therapeutic services within the community. The Task Group asked how this gap could be addressed, and officers confirmed that it was on their radar, with solutions actively being explored. It was noted that, following many reorganisations over the years, there was now hope that resources could be transferred from acute care into community settings, enabling a stronger emphasis on therapy provision closer to home.

13.6 Officer mentioned that the Service had strong foundations to build something impactful, but to move forward, it was necessary to understand how other areas had successfully developed their Home First models. There was a lot of variation across regions, and learning from those differences helped shape the local approach. One advantage was that therapy services both in the hospital and in the community were employed by Mersey and West Lancashire Teaching Hospitals NHS Trust. Locally, there was a real opportunity for joint working.

14. Strengthening Community Therapy Equipment Provision

14.1 As the Home First provision moved forward, one of the most urgent next steps was to review the existing community therapy provision. Officers mentioned that resources needed to be in place to support therapists properly, especially as patients were being discharged from hospital much more quickly. The pace of discharge meant therapists were often focused on arranging equipment and facilitating safe exits, but they weren’t getting the time or space to deliver therapy. That was a loss not just for the professionals, but for the patients who missed out on meaningful rehabilitation.

DRAFT

14.2 Ultimately, this was about creating a system that supported recovery, not just discharge. Therapists needed time to do therapy. Patients needed access to the right equipment not just quickly, but appropriately.

14.3 It was considered a key focus that in developing the Home First Model, the Council should explore whether the MWL trust could review its existing therapy resources and consider whether some of that capacity could be reallocated into community settings. That was the key point shifting resources where they were most needed. This element is about recognising and maximising the potential for better outcomes through collaboration and shared investment.

15. Looking Ahead: Staying Ahead of the Curve in a Changing System

15.1 Officers mentioned that Adult Social care and Health were in a period of uncertainty and that nobody knew exactly how things would change, whether those shifts would come from national leadership, policy reform, or local innovation. There had been talk of a new 10-year plan for the NHS, with echoes of Tony Blair's original vision from 1996 which spoke of a "brave new world". While the language may have changed, it was suggested that the Government's underlying ambition remained: to reshape health and care around communities.[1]

15.2 Officers mentioned that if that was the direction being taken, then it was important to stay ahead of the game. There was a strong focus on digital transformation, moving health services closer to people, supported by technology. In some areas, the Reablement Team was already well-positioned. For example, the work done in community support.

15.3 It was reiterated that caution was necessary and that real progress meant looking forward, anticipating what was coming and shaping services to meet future needs. That included ensuring digital tools were interoperable, that community services were properly resourced, and that the team wasn't just reacting to change, but leading it. The Home First model had provided evidence that the Council had made giant steps toward positive change in supporting residents and the wider integrated care model.

16. Conclusions

16.1 Members agreed that work on Home First and the wider services working in collaboration had been commendable. Both officers and Task Group Members highlighted that change was not just coming, it must happen and that the Council, at a local level, was ahead of the game of a digital shift that would fundamentally transform how the Council delivered care. Additionally, efforts to move away from siloed working had given the Council a strong foundation.

16.2 As demographic pressures increased, particularly with an ageing population and growing complexity of needs, Home First offered a scalable model to manage demand more sustainably. By shifting care closer to home, the system could reduce reliance on acute beds and improve flow across services.

Resources

[1] Government takes action to deliver neighbourhood health services - GOV.UK

DRAFT

16.3 To support the sustainability and effectiveness of the Home First model, the Task Group recommends that the Council to explore opportunities to encourage a strategic shift of resources from acute hospital wards into community-based services. This reallocation would reduce pressure on hospitals, improve patient outcomes, and align with the ICB's 10-year vision for integrated, place-based care. With the potential for increasing demand in the coming years, ensuring that resources and services were well placed and operating effectively was paramount.

16.4 Home First will continue to be embedded within local neighbourhood health and care teams, supporting place-based delivery and ensuring services are tailored to community needs. This integration promotes continuity of care, local accountability, and stronger relationships between residents and service providers.

16.5 It was suggested that via the People's Board, the Council should support a strategic move towards decentralising therapy services, enabling greater provision within community settings. to improve reablement outcomes, reduce readmissions, and ensure timely support for individuals returning to baseline. And via the Care Board, advocate that the ICB engage with the Trust to explore opportunities for transitioning therapy services into the community, aligning with the Home First Report led by Local Government Association (LGA).[2]

Promotion and Data Sharing

16.6 Members suggested that, to ensure the Home First model continued to deliver effective, person-centred care, it was essential to strengthen performance monitoring across the wider service. This involved moving beyond traditional metrics such as readmission rates and adopting a more nuanced, data-informed approach that reflected the complexity of patient journeys and service delivery.

- Demonstrate timelines and outcomes:
  The service would establish clear reporting mechanisms to demonstrate timelines for discharge and post-discharge outcomes. Rather than focusing solely on readmission rates, performance indicators such as ASC018 (91-day reablement success) and ASC004 (long-term support needs following discharge) would be used to provide a more accurate picture of recovery and independence.
- Analyse conditions, demographics, and equipment need:
  A cross-organisational analysis should be undertaken to understand how patient conditions, demographic factors, and equipment provision influence recovery trajectories. This will help identify where gaps existed and where targeted interventions may be required.
- Utilise available data to identify trends:
  Even where datasets are incomplete, the service should use available information to highlight emerging trends, service pressures, and areas for improvement. This includes tracking the timescales for hospital discharge and assessing whether patients required ongoing care at the end of the programme. It was noted that the Council's business

[2] Home First: Discharge to Assess and homelessness | Local Government Association.

development officers were currently leading work in this area to ensure robust insights are developed.

- It was also recommended that case studies be developed to highlight success stories and lessons learned. These provided residents with greater confidence in the service and informed ongoing strategic development.

16.7 Enhanced performance monitoring will inform future commissioning decisions, workforce planning, and service design. By understanding what works and where delays or breakdowns occur the Council and its partners can better align resources to meet patient needs and reduce avoidable demand on acute services.

Promotion

16.8 Improvements in monitoring outcomes, and satisfaction from patients who can recover and thrive at home are important to promote the Services and enhance public perception and confidence. Work had already started in this area such as working on a video consultation project, and a team supervisor was engaging directly with patients and their families to ask about their experiences. Thus far, the Service hadn't received any negative feedback, which is encouraging. The engagement process had shown that when services are coordinated and person-centred, people feel supported and that's exactly the kind of momentum needed to build on.

16.9 Members suggested that there was a need to define what counts as a Home First intervention, especially when other services are involved. Without clear definitions, the Service risks underreporting success and missing opportunities to learn from what's working.

16.10 Officers noted that the Service had built a culture of lessons learned. Whether it's a medication error, a concern raised by a family member, or feedback from a service user, the Service document it, review it, and act on it. These lessons were shared with councillors and teams, and they helped shape improvements across the board. Complaints are relatively few, but each one is an opportunity to do better; to understand what is coming next and to make sure the Service is ready.

16.11 It was noted that the wider Home First approach was continuing to develop positively. However, public and user group confidence must be enhanced by widespread promotional activity, including promoting case studies highlighting successes and learning, and for transparent data sharing to build trust and drive adoption. It was discussed that to build trust and drive adoption, it was essential to:

- Raise awareness of Home First through targeted communications and community engagement,
- Share key performance data and impact metrics with stakeholders, partners, and user groups,
- Demonstrate how the model supports better outcomes, faster recovery, and reduced hospital dependency, and
- Involve service users in shaping and evaluating the programme to ensure it reflects lived experience

DRAFT

16.12 At its core, this work is about getting things right for patients and their families and doing it quickly. Officers highlighted that around 90% of what the service was trying to achieve depends on how fast the service can respond: how quickly therapy teams get involved, how swiftly equipment was delivered, and how well the network coordinate care packages. Officers noted that it is not just one thing, it is a whole system of moving parts. Members highlighted that progress had been commendable and embedded strong foundation.

16.13 One of the biggest challenges noted was identifying those who should have received care before they ever reached hospital. Often, people are not on the radar until it's too late. That is a gap that needs to close and to understand how many people are admitted who could have been supported earlier? And how do we make sure they're not missed again? This will help to track progress, identify gaps, and support evidence-based decision-making. It was considered imperative that the Home First model was embedded in the Neighbourhood plan to help share data and intelligence.

16.14 Based on the findings and Conclusions, the Task and Finish Group made the following recommendations:

(i) Explore opportunities for increased community-based therapy services.

- Present a proposal to the People's Board and relevant partner forums outlining specific opportunities to expand community-based therapy services and seek agreement on next steps.
- Initiate formal discussions with Merseyside & West Lancashire Teaching Hospitals NHS Trust (MWL) and the Cheshire & Merseyside Integrated Care Board to assess the feasibility of decentralising elements of therapy provision and to develop a joint plan for utilising community-based therapy capacity more effectively.
- Undertake a review of current therapy resources across acute and community settings to identify opportunities for more effective deployment and improved patient flow.
- Consider developing a workforce plan to ensure sufficient therapy staffing in community settings, aligned with projected demand and service-transformation objectives.
- Review the LGA report "Occupational therapists in councils: Unlocking capacity and driving change" and incorporate relevant recommendations into local workforce and service-development plans.[3]

(ii) Enhance Performance Monitoring

- Conduct wider regional analysis across organisations to understand patterns in conditions, demographics, and equipment needs, using available data to identify gaps and emerging trends even where datasets are incomplete.
- Support the development of the proposed monitoring dashboard and provide the committee with regular updates on progress, including timescales for hospital discharge and, at programme completion, information on whether patients require ongoing care.

---

[3] (Occupational therapists in councils: Unlocking capacity and driving change | Local Government Association)

DRAFT

- Improve the qualitative information used for monitoring performance against ASC-018 ("Percentage of older people discharged from hospital to their own home or to a residential or nursing care home or extra care housing bed for rehabilitation who are still at their place of residence 91 days after discharge").
- Strengthen the qualitative data supporting ASC-004 ("The outcome of Short-Term Services") to enhance understanding of service effectiveness and patient experience.

(iii) Embedding Home First in the One Neighbourhood Plan

Provide feedback on progress to the committee demonstrating:

- The promotion of collaboration between health and social care teams/services to improve outcomes.
- Strengthen local coordination between services to support more seamless patient pathways.
- Build trust between partners and promote the broader model of integrated working. Better Outcomes
- Showcase data demonstrating improved recovery rates and reduced hospital stays.
- Promote positive experiences and outcomes through appropriate media platforms to increase public and partner awareness.

DRAFT

17. Recommendations

17.1 The Task and Finish Group recommend that:

Rec No	Recommendation	Responsible Officer	Agreed Action and Date of Implementation
A	Explore opportunities for increased community-based therapy services.		
B	Enhance Performance Monitoring.		
C	Embedding Home First in the One Neighbourhood Plan		