1 JANUARY 2025-
31 DECEMBER 2025

Community Home First

2025 REPORT

NHS England

Prepared by:
Mark Reading
Chief Executive
Cheshire Community Action

SUMMARY

There has been a 50% increase in demand across both Mid-Cheshire Hospital and Countess Of Chester Hospital (which includes Ellesmere Port Hospital) sites, with a total of **2081** people supported over the twelve-month period compared to **1384** supported in the previous year.

Over the 12-month period, referrals continued to be predominantly community-led, with self and family referrals forming the largest source. The majority of support provided required mixed or multi-element responses, highlighting the complexity of presenting needs and the importance of flexible, preventative interventions.

The team at **COCH** continue to provide high levels of face-to-face support, including **home visits** and **direct coordination** with families, and recorded the highest volume of **complex, multi-agency actions** – with over 60% of interventions involving blended or narrative casework.

MCH delivered a proportionally higher number of formal referrals to **partner** agencies, such as **Snow Angels, Carers Trust, Healthbox** and **Age UK**, indicating strong links with voluntary sector services and proactive coordination. Around one in three MCH interventions resulted in onward signposting, supported by concise and efficient handover processes.

Themes of support remain broadly aligned with earlier reporting periods. **Emotional and social support, access to daily living assistance,** and **home safety interventions** continued to feature prominently in referral reasons. The team also managed complex cases involving **home environment risks,** including hoarding and safeguarding, with evidence of escalation to appropriate pathways when needed.

Narrative notes reveal the continued importance of **relationship-based working,** with team members regularly liaising with **families**, gathering consent, sourcing practical support (e.g. clothing, key safes, cleaning), and in some cases delivering **urgent in- person help** such as heaters, food, or medication-related follow-ups.

Regarding **social value,** the Community Home First programme, led by **Cheshire Community Action**, continues to demonstrate an exceptionally **strong return on investment,** creating over **£9.39** of social value for every **£1** invested, and achieving both **health system efficiencies and improved individual wellbeing at significant scale.**

INTRODUCTION

This report contains data for 2025 with comparative figures from 2024. We have captured key data in relation to demographics, referral pathways, common issues, actions taken, and ongoing challenges across both MCH and COCH (includes EPH) sites.

COCH & MCH MONTHLY REFERRALS

2024

Jan	61
Feb	61
Mar	62
Apr	123
May	122
Jun	119
Jul	114
Aug	120
Sep	120
Oct	157
Nov	165
Dec	160

2025

Jan	201
Feb	169
Mar	154
Apr	181
May	196
Jun	197
Jul	233
Aug	114
Sep	163
Oct	180
Nov	159
Dec	134

HIGHLIGHTS

A total of **2081** individuals were referred into the service and received support in 2025 compared to **1384** in 2024.

Referral sources continue to be dominated by **Therapists, Discharge Facilitators,** and **Self/Family** referrals.

Direct referrals to partners rose by over 25% across the board when compared to 2024 figures with direct referrals to Snow Angels and Healthbox showing the biggest increases.

COCH maintained strong levels of **in-person** and **holistic case management,** with over **60%** of interventions involving mixed or narrative casework.

Common areas of support included **daily living assistance, emotional and social support, home safety modifications, and health-related interventions.**

Case management activity highlighted the importance of **practical interventions,** including **securing homes, providing urgent equipment,** and **supporting families with signposting** and **advice.**

ONWARD REFERRALS

Snow Angels: lower level support at home; took on **485** new referrals and provided support to **949** people over the period with **555** home visits. A big increase from 2024 where the figures were 326, 536 and 310 respectively.

Age UK: more intense support for older patients; took **148** new referrals in the period January to August 2025 and provided support to **170** people over the period with **124** home visits.

Carers Trust: supporting carers; took **138** new referrals and provided support to **182** people with **9** home visits.

Healthbox: in the home strength and balancing sessions; took on **141** new referrals and provided support to **239** people with **596** home visits.

DEMOGRAPHICS & OTHER DATA SETS

Gender/Age Breakdown

Female: 47%
Male: 53%
Average Age: 78 years

Referral Sources (%)

Self/Family: Significant proportion across both sites.
Therapists: 12%
Discharge Facilitators: 10%
IDT: 6%
Adult Social Care and Ward Staff: smaller proportions.

Action Taken (%)

Mixed/Other Support: 65%
Referral to Partner Organisations: 25%
Advice / Communication with Families: 16%
Home Visits and Practical Support: 3%
Safeguarding Actions: small number, appropriately escalated

TOP FOUR REASONS FOR CONNECTOR REFERRAL

01 Daily Living Assistance (Approx. 35%):
Support with shopping, cleaning, and basic daily tasks to promote safe and sustainable home life post-discharge.

02 Emotional and Social Support (Approx. 28%):
Addressing loneliness, anxiety, and rebuilding community connections.

03 Home Safety and Modifications (Approx. 25%):
Support fitting keysafes, pendant alarms, furniture adjustments, and home mobility aids.

04 Health and Medical Aid (Approx. 12%):
Support managing medication, nutrition, hydration, and safe discharge planning.

SOCIAL VALUE

The Community Home First (CHF) programme generated an estimated Total Social Value of **£3,718,507** during 2025.

After applying a standard HM Treasury discount rate of 3.5%, the Total Present Value (PV) of the programme's outcomes was calculated at **£3,592,292**

Taking into account direct programme costs of **£382,650**, this results in a Net Present Value (NPV) of **£3,209,642**.

The Social Return on Investment (SROI) for CHF over this period is estimated at **£9.39** for every **£1** invested, or a Net Social Return of **£8.39** for every **£1** once programme costs are deducted.

KEY OUTCOMES

Supported Discharge: **6000+** overnight stays avoided improved physical health outcomes valued at **£3,027,230**.

Home Visits: **1,528** patients visited, reduced social isolation valued at **£108,258**

Integrated Support at Home: **949** patients received ongoing support, additional social value generated: **£67,236**

Additional Outcomes: Tackling loneliness generated an additional social value of: **£473,656**

Deadweight was assumed at **35%**, with no leakage, displacement, or other external attribution applied.

CONTRIBUTION TO SUSTAINABLE DEVELOPMENT GOALS

“I am looking forward to going home and I deeply appreciate the free support you’ve provided for me.”

COCH Patient, February 2025

The outcomes delivered by Community Home First primarily contribute towards the **United Nations Sustainable Development Goal 3: Good Health and Well-Being**, through improved discharge outcomes, reduced hospital dependency, and enhanced wellbeing at home.

STAKEHOLDER IMPACT

Patients: receiving improved health, wellbeing, and support to live independently.

Partners: benefiting from reduced hospital bed days, faster discharges, and alleviated demand on services.

“The programme helped me to get out more and I really felt I benefited from the additional support and company.”

Healthbox Program User

ISSUES, GAPS & CHALLENGES

Data Completeness:
Continued challenges with data recording in some areas and access issues, which we are attempting to address.

Financial Barriers:
Patients on the west side still face costs for services like pendant alarms, potentially limiting safe discharge options.

Engagement Reluctance:
Some individuals remain reluctant to accept support after discharge, despite agreeing in hospital. Ongoing relationship-based work is crucial.

Home Environment Challenges:
Significant cases involving hoarding, environmental risks, and safeguarding concerns have been managed with support from council partners.

Staffing and Turnover:
Staff turnover within hospital teams continues to impact continuity and awareness of CHF services.

OTHER NEWS

Onward Referral Partner Changes- 2025 saw us part ways with Age UK and bring onboard Neston Community Youth Centre to help cover support in the Neston

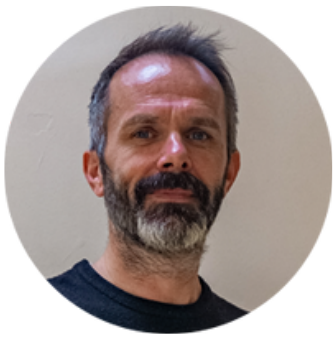
Healthbox started trialling strength and balancing classes on site at COCH in May 2025.

CONCLUSION

This period reflects a steady demand with continued complexity across many referrals, with teams at both MCH and COCH adapting through strong partnership working, relationship-based case management, and proactive community integration.

For the COCH team, the importance of flexible, person-centred approaches remains central to effective outcomes for patients leaving hospital care.

The service creates over **£9.39** of social value for every **£1** invested.



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