Healthcare Improvement Scotland

Older people/acute adult hospital at home services

Report of the national programme 2024/25

July 2025

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Summary

This report summarises the impact of the national older people/acute adult hospital at home programme for the period April 2024-March 2025, delivered by Healthcare Improvement Scotland. The focus of the programme in 2024/25 was to develop the maturity of services to a point of resilient, sustainable delivery. The programme prioritised sustaining the capacity built up in previous years, as opposed to rapid growth.

Key information

Definition of older people / acute adult hospital at home

Older people/acute adult hospital at home is a service that provides acute hospital-level care by healthcare professionals, in a home context, for a condition that would otherwise require acute hospital inpatient care.

Impact of hospital at home

- The median number of patients managed per month in 2024/25 was over 1600, an increase from 1400 patients per month in 2023/24. This indicates that services are sustaining the capacity built in previous years.
- In 2024/25, hospital at home prevented 15,470 people spending time in hospital, reducing pressure on unscheduled care and delayed discharges.
- An estimated 672 additional hospital beds and 477 care home admissions would have been required over the year if hospital at home services did not exist.
- An estimated £16.7 million in healthcare costs were avoided in 2024/25 because hospital at home admissions cost less than traditional hospital admission.
- An estimated £39.4 million in healthcare costs were avoided due to reduced healthcare usage in the 6 months following a hospital at home discharge.

2024/25 workstreams

- **Developing sustainable services:** In 2024/25, Healthcare Improvement Scotland aimed to guide services to build resilience and maintain the capacity they had built in previous years, as opposed to increasing their capacity at a rapid rate.
- **Demonstrating impact through national data collection:** Healthcare Improvement Scotland committed to helping services collect meaningful data in 2024/25 to inform evaluation, with a view to presenting a business case to the relevant NHS boards/HSCPs.
- **Improving efficiency through technology:** As services were increasing in maturity, the national hospital at home team sought options for improving efficiency, such as point of care testing. Work was conducted to understand how this technology could add value to services and improve the experiences of patients across Scotland.

- **Understanding impact on vulnerable groups:** Healthcare Improvement Scotland aimed to better understand how hospital at home can support vulnerable groups such as those living in care homes and those living with dementia. A scoping evidence review and a series of semi-structured interviews were conducted with hospital at home staff over the period 2024/25.

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Background: Older people/acute adult hospital at home

Older people/acute adult hospital at home is a service that provides acute hospital-level care by healthcare professionals, in a home context, for a condition that would otherwise require acute hospital inpatient care.

The term hospital at home can also be used to describe a broader remit of services, which include Outpatient Parenteral Antibiotic Therapy (OPAT), respiratory, and heart failure. Some older people/acute adult hospital at home services include OPAT, respiratory, and heart failure within their remit.

This report focuses on older people/acute adult hospital at home which we will refer to as hospital at home.

Guiding principles

In 2020, Healthcare Improvement Scotland (HIS) published the Hospital at Home: Guiding principles for service development. The document details the key components of Scottish hospital at home services which are listed below:

- A hospital specialist acts as senior decision maker and responsible medical officer (RMO), sometimes with the help of other grades of medical staff.
- The severity of the condition managed (such as sepsis or pulmonary embolism) differentiates hospital at home from other community service provision.
- It covers short, time-limited, acute episodes of care and is not intended to prevent access to specialist acute care. Patients are treated as though admitted to hospital but managed within their own home.
- It provides urgent access to hospital-level diagnostics, such as endoscopy, radiology, or cardiology where necessary.
- It provides a different level of interventions, such as access to intravenous (IV) fluids and oxygen.
- Care is delivered by multidisciplinary teams of healthcare professionals, complying with current acute standards of care.
- It complements other community-based health and care initiatives which support patients to remain in their own homes.

Although all hospital at home services across Scotland have these key components, there is variation in how services are designed and delivered. Variation exists because hospital at home services are designed to interface with existing services and accommodate local context and population needs.

Evidence of safety and impact 2020 – present

Our previous annual report referred to the literature search conducted during the development of the guiding principles. Since the guiding principles were published in 2020, new literature has emerged to evidence the safety and impact of hospital at home. Notably, two Cochrane reviews relating to hospital at home were published in 2024, by Edgar et. al and Wallis et. al.

Edgar et. al assessed the effectiveness and cost-effectiveness of admission avoidance hospital at home services in comparison to hospital inpatient care[1]. Admission avoidance hospital at home refers to the element of the service which keeps patients out of hospital where appropriate. Another type is early discharge hospital at home, which supports patients to return home quicker following surgery or treatment. Most hospital at home services in Scotland are a combination of both models.

Wallis et. al[2] explored the factors affecting the implementation of hospital at home, including 52 qualitative studies, published between 1995 and November 2022, in their review. The studies included admission avoidance hospital at home, early discharge hospital at home and combined models. The review reported findings based on the perspectives of multiple stakeholders including policy makers, healthcare managers, staff, patients and their caregivers. The key findings of both reviews are included in the below summary.

Hospital at home does not adversely affect the health outcomes of patients when compared to traditional inpatient care.
Edgar et. al found that hospital at home was unlikely to affect the mortality rate of patients at 6 months post-treatment or to affect the likelihood of re-admission within 3 to 12 months. They also found that admission avoidance hospital at home probably reduces the likelihood of patients living in residential care at 6-month follow up. Both findings were reported with moderate certainty in the evidence.

Hospital at home may be a cost-effective alternative to inpatient care.
Edgar et. al found that hospital at home probably reduces health service and societal costs when relating to the care of some patients. They reported that the magnitude of savings was variable, and studies varied greatly in their methods of cost analysis. Wallis et. al found that staff and patients were doubtful the benefits of hospital at home would be sustained, unless it was expanded. The benefits included financial savings, reduced stays, reduced waiting times, reduced demands on acute hospital services, and increased capacity for hospitals to treat the “sicker” patients. This finding was reported with high confidence in the evidence. Wallis et. al did not report on the cost-effectiveness of hospital at home.

Patients report higher levels of satisfaction with hospital at home than inpatient care, but concerns still exist.

Edgar et. al found that patients allocated to hospital at home in randomised clinical trials, generally reported higher levels of satisfaction than those allocated to traditional inpatient care. This was consistent across patients with a range of different conditions. However, this finding was based on low certainty evidence due to differing response rates between hospital inpatients and those treated at home. Wallis et. al also found that patients considered hospital at home as a suitable alternative to inpatient care, appreciated staff attitudes and competency, and recognised the reduced risk of hospital acquired infections (HAIs). Patients felt that hospital at home facilitated optimal recovery, and staff motivated them to get better. Some patients preferred to be admitted to hospital due to concerns around the lack of 24hr supervision in hospital at home. Wallis et. al reported these findings with high confidence in the evidence.

Caregiver views of hospital at home are underrepresented and more research is needed.

Edgar et. al found that caregivers were more satisfied with the person they cared for being treated by hospital at home, than via traditional inpatient care. However, only two studies reporting on this factor were reviewed, and both reported differing response rates between the hospital at home and inpatient care cohorts. The review concluded that the benefits of hospital at home for patients must be weighed against the potential burden for caregivers. Wallis et. al looked more in-depth at caregiver impacts and reported that caregivers considered hospital at home as an appropriate alternative to hospital. However, there were some negative impacts identified. Caregivers reported anxiety and stress due to feeling underqualified to care for an acutely unwell person, and some felt that they were not adequately involved in decision-making. Other impacts included disruption to routines which affected work, energy and sleep, as well as straining the patient/caregiver relationship due to providing a higher level of care. Despite challenges, the review found that caregivers appreciate the support provided by hospital at home and appreciate the reduced hospital visits and lower risk of HAIs. The findings relating to caregiver impact in this review were reported with high confidence in the evidence.

A more recent systematic review, including evidence up to January 2024, found that carers were well informed by hospital at home staff about the patient's treatment which enabled shared decision making.[3] They also found a benefit to hospital at home in identifying carers who were frail themselves. However, the review did agree with the others that carers require more training and support to care for acutely unwell people.

The reviews agreed that a future research priority is understanding the impact that hospital at home can have on caregivers, and how negative impacts can be mitigated by providing support and focusing on shared decision making.

Programme objectives 2024/25

In 2023/24, the focus of the national hospital at home programme was growth and expansion; with services treating significantly more patients and preventing more hospital admissions than in previous years. For 2024/25, focus shifted to sustaining the capacity that had been built to date, by developing the maturity of services.

The programme objectives for 2024/25 were to:

- Ensure that hospital at home services reach a level of resilience in their service delivery, and obtain sufficient data, to demonstrate their impact to NHS boards/health and social care partnerships (HSCPs).
- Improve the efficiency of hospital at home services by using technology such as point of care testing (POCT).
- Improve understanding of how vulnerable patient groups access hospital at home services.

Resilience

Healthcare Improvement Scotland has been working with NHS boards and HSCPs to develop hospital at home services since early 2020. During this time, some services have matured and developed to a point of resilient service delivery. The programme of work for 2024/25 was geared towards helping other services to obtain this level of resilience based on previous learning and to sustain the growth of previous years.

Demonstrating Impact

Hospital at home services in Scotland continuously evaluate the impact of their work. Healthcare Improvement Scotland worked with services to collect meaningful data to inform evaluation, and support discussions with boards/HSCPs about ongoing funding.

To demonstrate impact consistently across services, a national data collection process was required, including the collation of data on patients managed, overnight bed days and length of stay in hospital at home. Healthcare Improvement Scotland sought to develop a data collection system aligned with other virtual capacity services and to publish regular national summary data.

Efficiency

Using technology in hospital at home delivery has the potential to improve the efficiency of services and enable quicker decision-making about patient care. Healthcare Improvement Scotland worked with services to assess the impact of POCT and to develop an evidence summary of the technology which could benefit services.

Vulnerable groups

In 2024/25, Healthcare Improvement Scotland sought to better understand how hospital at home delivers care to vulnerable groups; particularly people living with dementia and those in care homes. Healthcare Improvement Scotland aimed to undertake work which would describe the current state of hospital at home in relation to these two groups, to identify areas of good practice and opportunities for improvement.

Our year in review

Developing resilient and sustainable services

Support to services

Healthcare Improvement Scotland works with NHS boards and HSCPs to design, implement and improve hospital at home services. This includes:

- Providing in-depth support to model patient pathways from referral to discharge.
- Sharing advice on measuring and evaluating the implementation and impact of services.
- Providing quality improvement (QI) support to help plan, deliver and evaluate tests of change to patient pathways. For example, implementing point of care testing.
- Managing relationships with boards/HSCPs/Scottish Government and other national organisation leaders, to address the infrastructure improvement required to expand hospital at home at a national level.

Healthcare Improvement Scotland has additionally developed a learning system for those working in hospital at home services across Scotland. The learning system provides professionals with networking opportunities and the chance to share knowledge, create connections, ask questions, and gather insights. The aim is for the learning system to contribute to the development and maturity of services.

Healthcare Improvement Scotland manages a range of learning system activities which support sharing knowledge and turning knowledge into action, including:

- Quarterly networking sessions
- National hospital at home events (face to face and virtual)
- Online hospital at home community forum
- Reports and outputs of relevance to current landscape of hospital at home

Service development

In previous years, the hospital at home programme has aimed to grow and expand services, building month by month upon the number of patients managed. In 2024/25 the focus was on increasing the resilience of services to maintain the capacity they have built over the years, ensuring that the number of patients being managed stayed relatively consistent with the number managed in the final quarter of 2023/24.

Figure 1: Patients managed per month by hospital at home services 2023-2025

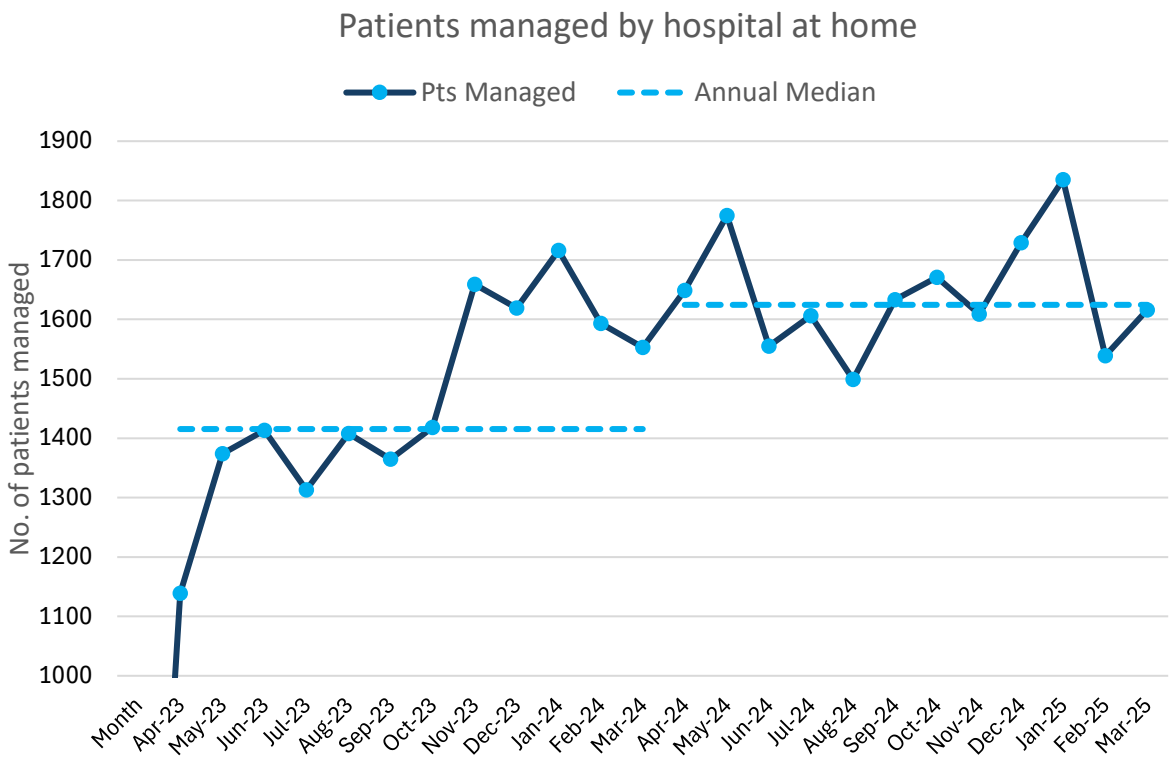


Figure 1 shows that there were steep increases in the number of patients managed at two intervals in 2023/24. This was likely due to services focusing on increasing their capacity, as well as new services being established. The median for 2023/24 was just over 1400 patients per month. In 2024/25 the peaks and troughs were not as dramatic, and the median rose to over 1600 per month, indicating that services were sustaining the capacity built in previous years.

In both years, a decrease in the number of patients managed can be seen in February, with only a slight increase in March 2025. This is likely due to uncertainty around the recurrence of funding in the next financial year, and staffing instability as fixed term contracts neared completion. Staff are usually redeployed up to six weeks prior to their contract end date to avoid redundancy, therefore services have reduced capacity from February – April.

Demand for hospital at home

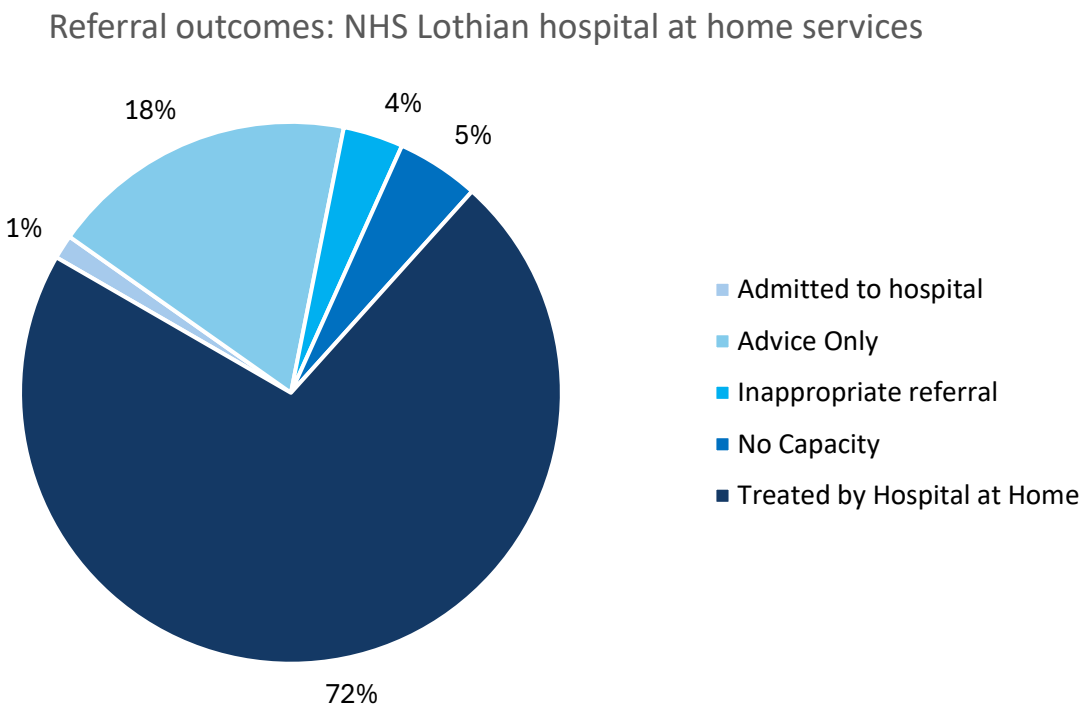
Healthcare Improvement Scotland collects hospital at home admissions data from services to understand impact, but also samples data on referrals that are rejected. The reason for gathering this data is to understand the current demand for hospital at home services and

how well this is being met. The four services in NHS Lothian (East Lothian, Edinburgh City, Midlothian and West Lothian) consistently reported the outcomes of referrals to their services across 2024/25. Outcomes were defined by five broad categories:

1. **Treated by hospital at home:** New patients admitted to NHS Lothian hospital at home services.
2. **Admitted to hospital:** In some cases, a patient needs to be admitted to hospital. This could be for a variety of reasons, including lack of appropriate support at home or safety of their home environment.
3. **Advice only:** The hospital at home service provided advice on the patient's management but the patient did not require admission to the service. Providing advice to other services reduces the likelihood of a patient unnecessarily attending hospital and is a benefit which is not currently measured or reported at national level.
4. **Inappropriate referral:** The patient was referred to the service but did not meet the criteria for hospital at home as their condition was not acute.
5. **No capacity:** The patient could not be admitted to hospital at home due to lack of staff capacity within the service. This is a useful indicator of potential unmet need that a service could deliver if resourced appropriately.

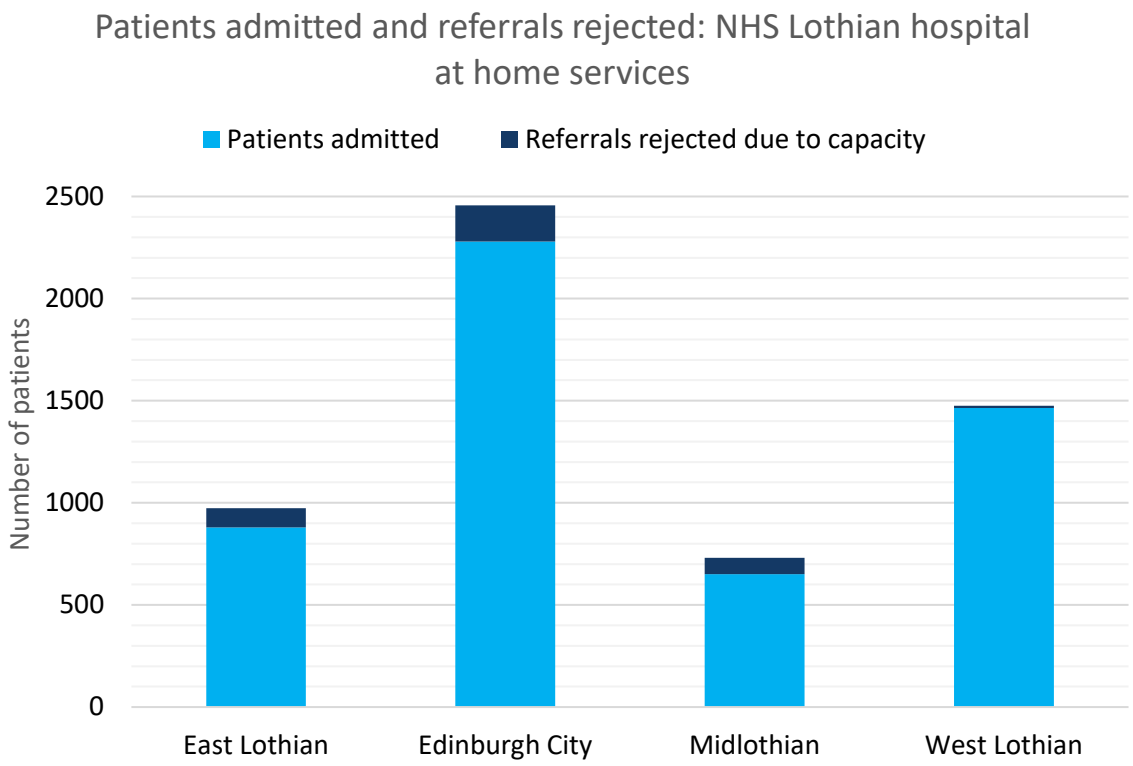
Using NHS Lothian services as a case study, the percentage of the total referrals concluding in each referral outcome is shown below in Figure 2.

Figure 2: Outcomes of referrals made to NHS Lothian hospital at home services 2024/25



Healthcare Improvement Scotland has also calculated a conservative figure of unmet demand, from the number of rejected referrals reported due to capacity issues. Rejected referrals due to other reasons were not considered unmet demand, as the patients were not suitable for treatment by hospital at home. In Figure 3 below, each bar represents the total known demand for hospital at home in the NHS Lothian localities, as the sum of patients admitted the service over the year plus the referrals rejected due to capacity issues.

Figure 3: Demand for hospital at home services in NHS Lothian 2024/25



The chart shows that all NHS Lothian hospital at home services met more than 89% of their demand in 2024/25. West Lothian met almost all their demand at 99%. It is important to note, however, that there may be additional demand for hospital at home, which is not captured above. Additional demand could exist, but not be known to services, where referrals have not been made by primary care or other services, although the patient is suitable for hospital at home.

Demonstrating impact through national data collection

In addition to the rejected referrals information, Healthcare Improvement Scotland gathers other data from services. This includes the number of patients in the service at the start of each day, the number of new patients admitted, the number of patients discharged, and the number of occupied beds per day. The national team analyses the data to calculate several indicators of impact, including the number of acute “beds” hospital at home provides which are equivalent to acute hospital inpatient beds.

Healthcare Improvement Scotland has balanced the need to capture and report national data with ensuring the process is as efficient as possible, to reduce the burden on hospital at home

services. In 2024/25, it remained a manual process whereby services submitted data to Healthcare Improvement Scotland monthly. In the future, data collection is planned to be adopted by Public Health Scotland, with a view to making the process automated, linking with patient records which are routinely completed by staff.

Improving efficiency with technology

Point of care testing allows certain diagnostic tests to be performed at the site of the patient without sample analysis in a hospital laboratory. This allows results to be received rapidly on site and, in hospital at home settings, means that routine tests could be performed in the patient's home. Point of care testing could potentially enable healthcare professionals to provide diagnosis, monitoring and treatment without the need for the patient to visit hospital.

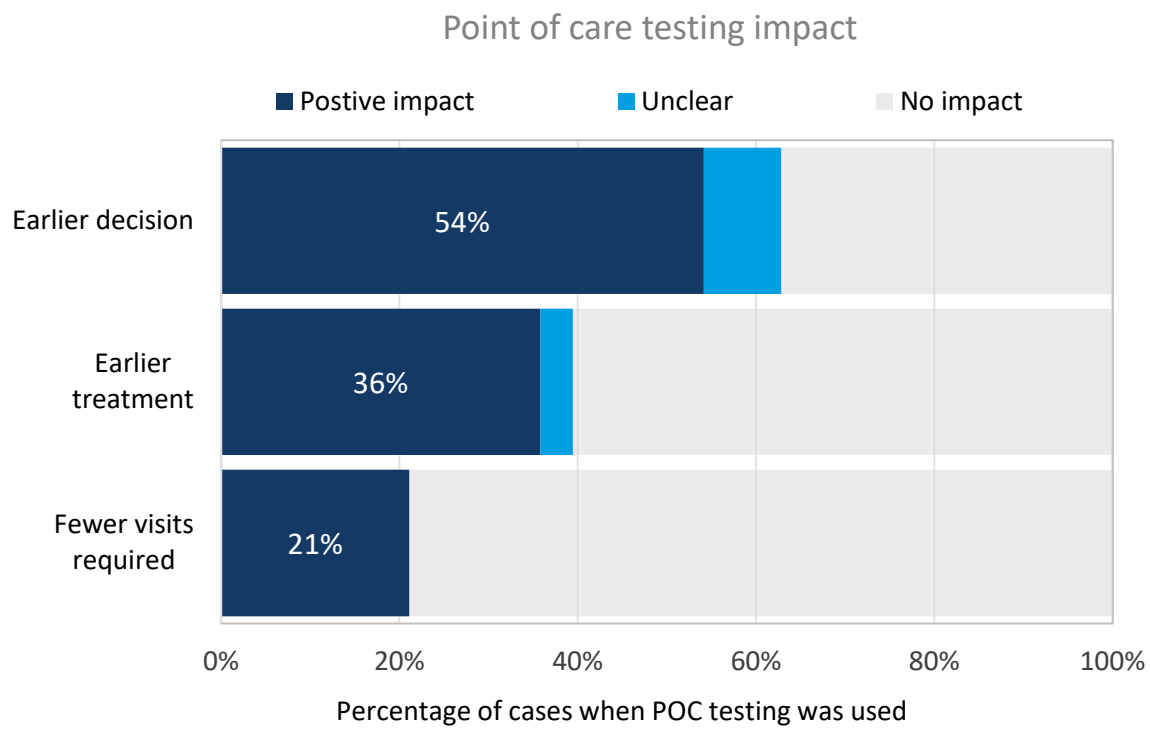
POCT has been trialed independently by hospital at home services in the past, however 2024/25 saw the first concerted look by the national hospital at home programme at the options available to teams, and the benefits of introducing POCT at service and national scale. Work was conducted to understand how POCT could add value to services and improve the experiences of patients across Scotland.

NHS Lanarkshire conducted a 12-month test of change in which they implemented the use of two POCT devices.

Key results from the NHS Lanarkshire trial include:

- In 54% of cases point of care testing enabled a quicker decision to be made about a patient's care.
- In 36% of cases the patient started treatment earlier than if a decision would have relied on a traditional laboratory route for blood results.
- 21% of cases resulted in fewer visits to the patient's home (as a result of knowing blood results during the first visit). This had a positive impact on capacity.

Figure 4: Impact of point of care testing on efficiency of hospital at home care



The above describes the impact on the timeliness of decision making and treatment as well as the number of visits required, as a percentage of the times POCT was used across whole days in the hospital at home service. This effect was seen to be amplified in a snapshot of data from between 3pm and 9pm each day. This could be because hospital laboratories are closed (or at reduced capacity) outwith normal working hours therefore results may not be available until the next day. POCT has the benefit of providing rapid results at the point of care.

Table 1.0 below shows the impact of POCT at various time periods throughout the working day. Note that there is a greater impact after 3pm, with an increase in earlier decision making, earlier treatment and fewer repeat visits to the patient.

Table 1: Impact of POCT at various time periods across the working day

Time of Day	% of POC Tests Resulting in Earlier Decision	% of POC Tests Resulting in Earlier Treatment	% of POCT Tests resulting in fewer repeat visits
06:00 – 08:59	33%	17%	17%
09:00 – 11:59	43%	22%	12%
12:00 – 14:59	49%	35%	18%
15:00 – 17:59	**69%**	**47%**	**31%**
18:00 – 20:59	**63%**	**50%**	**25%**

Following NHS Lanarkshire's testing pilot, Healthcare Improvement Scotland produced a short case study and POCT guide. This guide has been shared with hospital at home professionals via the learning system. The guide will be actively updated as new knowledge and practice emerges.

Understanding impact on vulnerable groups

Healthcare Improvement Scotland conducted a scoping evidence review and a series of semi-structured interviews over the period 2024/25 to better understand the impact of hospital at home on those living with dementia and those living in care homes.

The evidence surrounding these topics was scarce, however many sources talked about the negatives of hospitalisation for both groups. Hospitalisation can result in poorer outcomes for these patients, including hospital acquired infections and increased chance of mortality.[4] Hospitalisation is particularly stressful for people living with dementia and their families/carers. In the evidence review, one source was identified, which compared an acute outreach service providing care in nursing homes to hospitalisation. This study found that hospitalisation risked the patient losing their daily functional capacities and that providing care in the nursing home could help prevent delirium.[5]

Semi-structured interviews were conducted with hospital at home staff. Staff were asked about treating patients in care or nursing homes as well as treating patients with dementia. Most staff had experience with both groups and there was significant crossover between the groups as many patients living with dementia also live in residential care facilities. The key findings were as follows:

Dementia

- Hospital at home services are well suited to treat patients with dementia. Completing cognitive assessments with every new referral is an important part of the patient pathway that all services should undertake.
- Whilst most hospital at home staff are well informed about the factors to consider for patients with dementia, there is scope for national programmes to support hospital at home services with training and education.
- Hospital at home evaluates positively for patients and family members, however the impact on carers is an important factor for delivering acute care at home. Carer fatigue can occur, and work may be needed to coordinate support at local and national level as more people receive acute care at home.
- Data on patients with dementia receiving hospital at home treatment is limited and there is no national dataset which can be interrogated to understand the impact on this patient group.

Care homes

- People living in care homes are likely to benefit from hospital at home care given the multi-morbidities and frailty of that demographic. In general, care homes demonstrate

a willingness to work with hospital at home services, however frequent and consistent communication is needed to ensure the roles and responsibilities of care home staff and hospital at home services are clear.

- Escalation during a patient treatment episode is crucial to ensure that people are not transferred to hospital unless it is necessary. Hospital at home services have experience using communication tools, such as the Situation, Background, Assessment, Recommendation (SBAR) tool, to bring clarity to the patient pathway but there is opportunity to develop this further at local and national level.
- While much of the communication is handled at local level, there is an opportunity to address the issue of risk appetite and care planning at a national level by working with national organisations such as the care inspectorate.
- Future care planning is a crucial aspect of ensuring a patient's wishes are followed during a crisis. While recognising that hospital at home plays a limited role in the development of future care plans (given the short length of stay), there may be benefit in supporting services to share examples of what works.
- Data relating to hospital at home patients who are resident in a care home is available at a local level for some hospital at home services. However, there is no national data set that brings this intelligence together.

Following this learning, Healthcare Improvement Scotland has engaged with stakeholders with expertise in dementia and frailty to identify opportunities to address the issues raised and incorporate this action into the 2025 to 2027 work plan. The knowledge gathered is also being shared with hospital at home professionals nationally via the learning system.

Patient experience

All hospital at home services capture patient feedback and use it to understand the impact of their service and inform improvement. Services use Care Opinion (www.careopinion.org.uk) as well as locally developed feedback forms and processes.

Quotes from patients and relatives

- *"It is a fantastic service, rather than a long journey for my elderly dad out in the cold and probably a very long wait in A&E. I cannot praise them both enough and the whole concept of hospital at home." Relative of patient supported by Midlothian hospital at home team (via CareOpinion.org.uk)*

- *"I believe this service should continue to help older people especially as they know their own surroundings and more comfortable at home." Relative of patient supported by Forth Valley hospital at home team (via CareOpinion.org.uk)*

- A patient of Argyll & Bute's hospital at home service also wrote a poem to express their gratitude for the team:

"Each nurse is blessed with different skills

All illnesses they cover

They're kind and gentle, on the ball

No patient left to suffer."

Aberdeen City patient experience survey

Aberdeen City hospital at home service is running an anonymous patient experience survey. Some of the results to date include:

- **90%** of people who answered the question "How would you rate your experience of hospital at home?" rated the service as "Excellent" or "Very Good".
- **94%** of respondents said they would recommend hospital at home to their friends or family.

Borders patient experience survey

The Borders hospital at home team have developed a patient feedback form which can be completed by patients, their relatives or carers. From 30th January 2025 up to 31st March 2025, they had 35 responses. Of the respondents, **86% rated the care they received from hospital at home as 5 out of 5.**

Social pressures & economic impact

Relieving hospital pressures

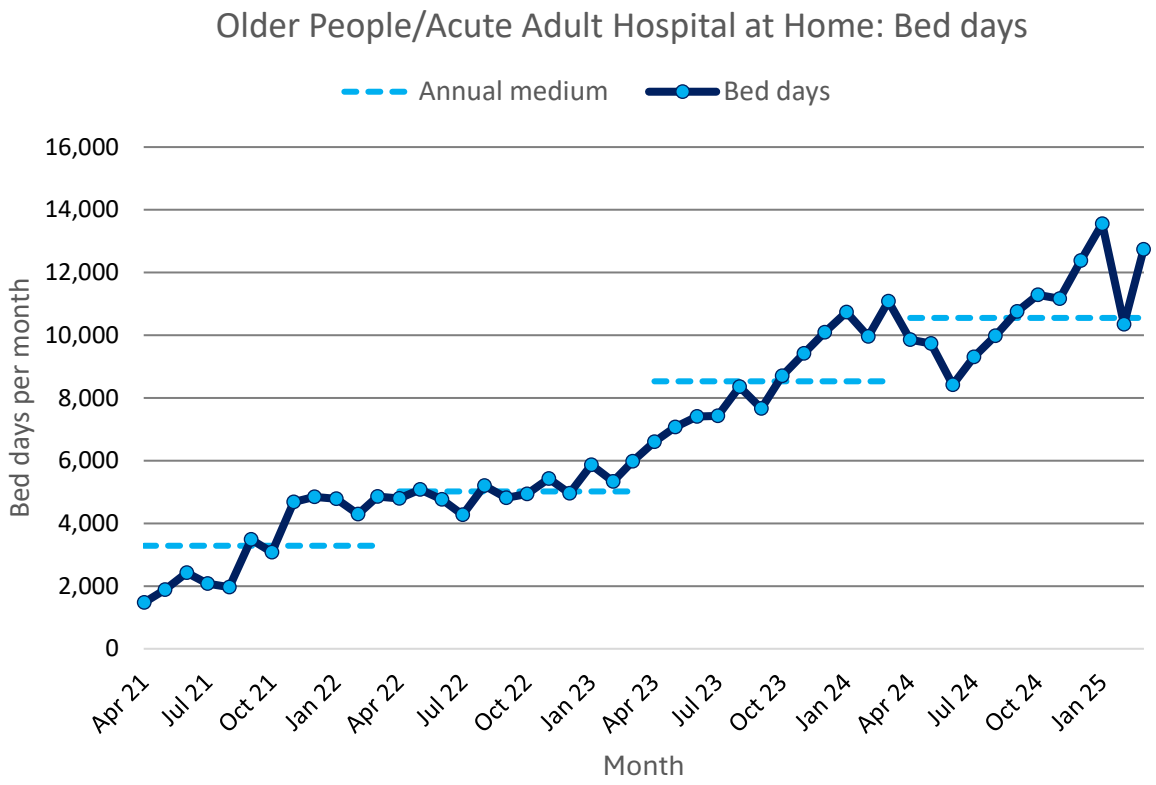
Increasing hospital at home capacity directly impacts on reducing hospital pressures. Over 15,470 people avoided time in hospital due to hospital at home in 2024/25.

Older people/acute adult hospital at home services provide an admission alternative which:

- Prevents delayed discharges for its patients as they are already at home. Evidence shows that delayed discharges home from hospital are associated with increased risk of mortality, hospital acquired infections, mental ill health and reduced mobility for patients.[6]

- Reduces demand on ambulance services, accident & emergency (A&E) departments, and wards. As per Figure 5 below, this included **saving over 129,000 overnight bed days in 2024/25** that would have added additional pressures to hospitals.

Figure 5: Monthly bed days delivered by hospital at home services 2021-2025



The above chart shows that the median bed days delivered by hospital at home per month has risen year on year since the launch of the service. **From 2023/24 to 2024/25 the median bed days rose by 24%.**

Due to a shorter on average length of stay in hospital at home, **actual bed days saved is estimated to be in the region of 220,000.** It is estimated that an additional 672 staffed hospital beds operating at 90% occupation would be required to manage the same number of patients if hospital at home services did not exist. An estimated 477 care home admissions have also been avoided by providing hospital at home care.

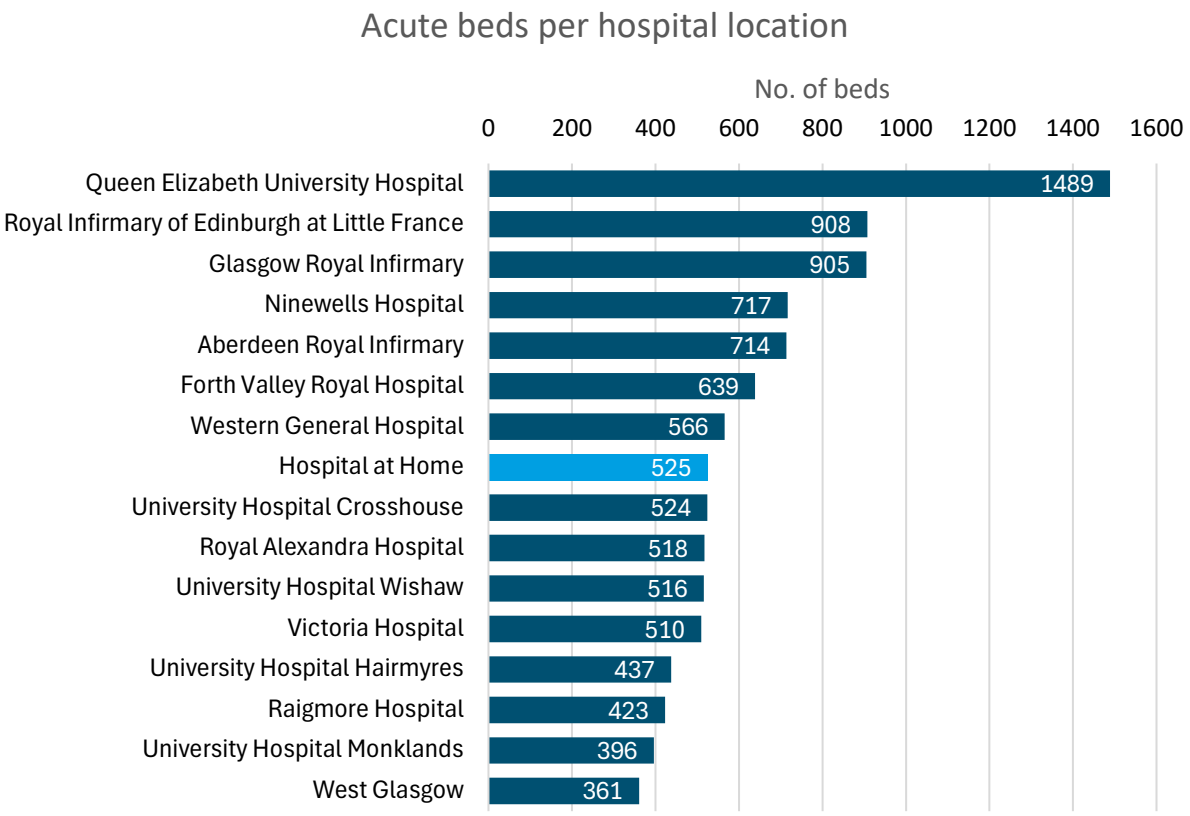
Equivalent beds

Figure 6 below shows the number of hospital at home beds in Scotland compared with the average number of acute beds in the 15 largest Scottish hospitals[7] for the period October-December 2024.

Hospital at home:

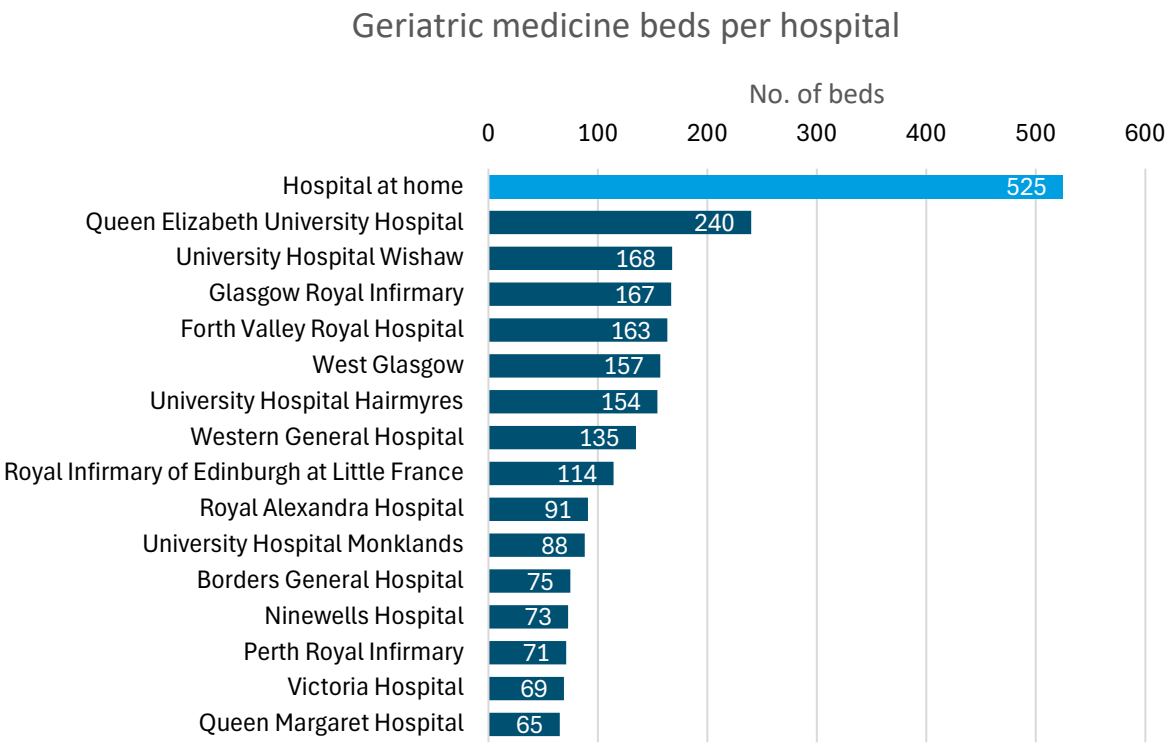
- Has the 7th largest acute bed capacity, providing 525 beds.
- Makes up 4% of all acute hospital beds in Scotland.

Figure 6: Acute beds in Scottish hospitals Oct-Dec 2024



Some acute hospitals have beds specifically assigned to geriatric medicine. In 2024/25, the 525 beds provided by hospital at home were for older people and acute adult services only.

Figure 7: Geriatric beds in Scottish hospitals Oct-Dec 2024

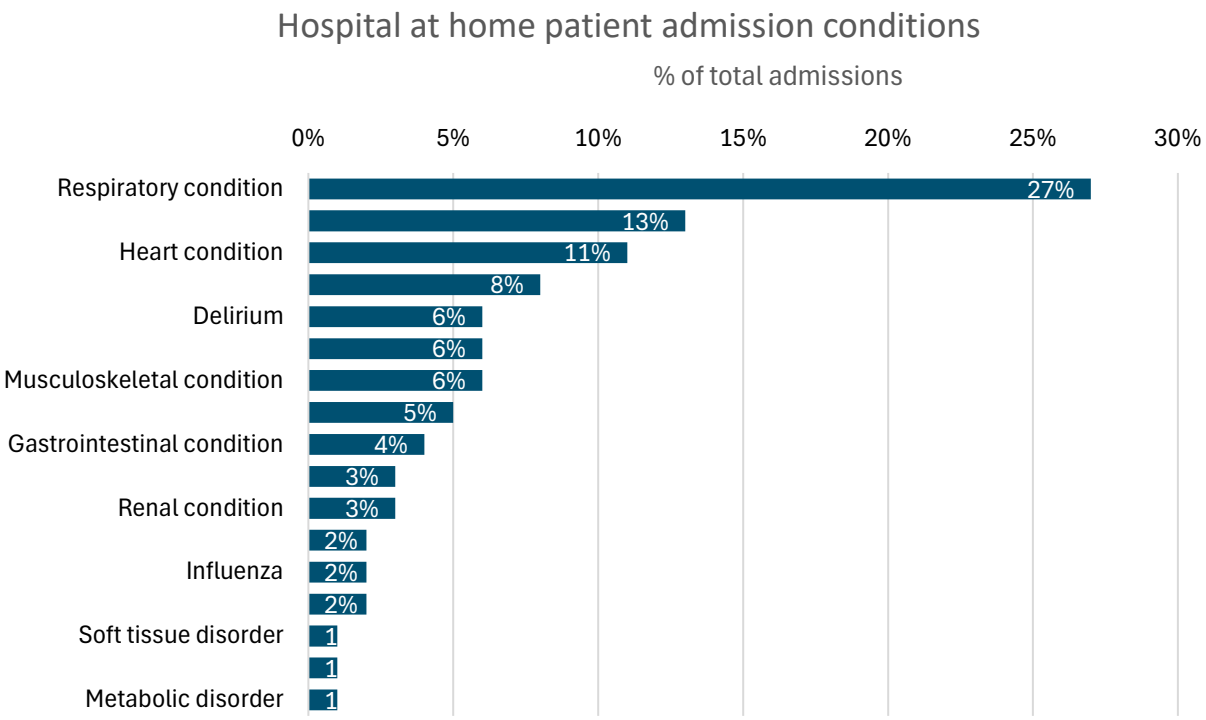


The chart shows that, compared with the 15 hospitals with highest geriatric bed capacity in Scotland[5], hospital at home provides the most geriatric beds.

Conditions

Older people/acute adult hospital at home services treat patients with acute conditions which would ordinarily require admission to hospital. The chart below contains details on the most common reasons people are admitted to hospital at home.

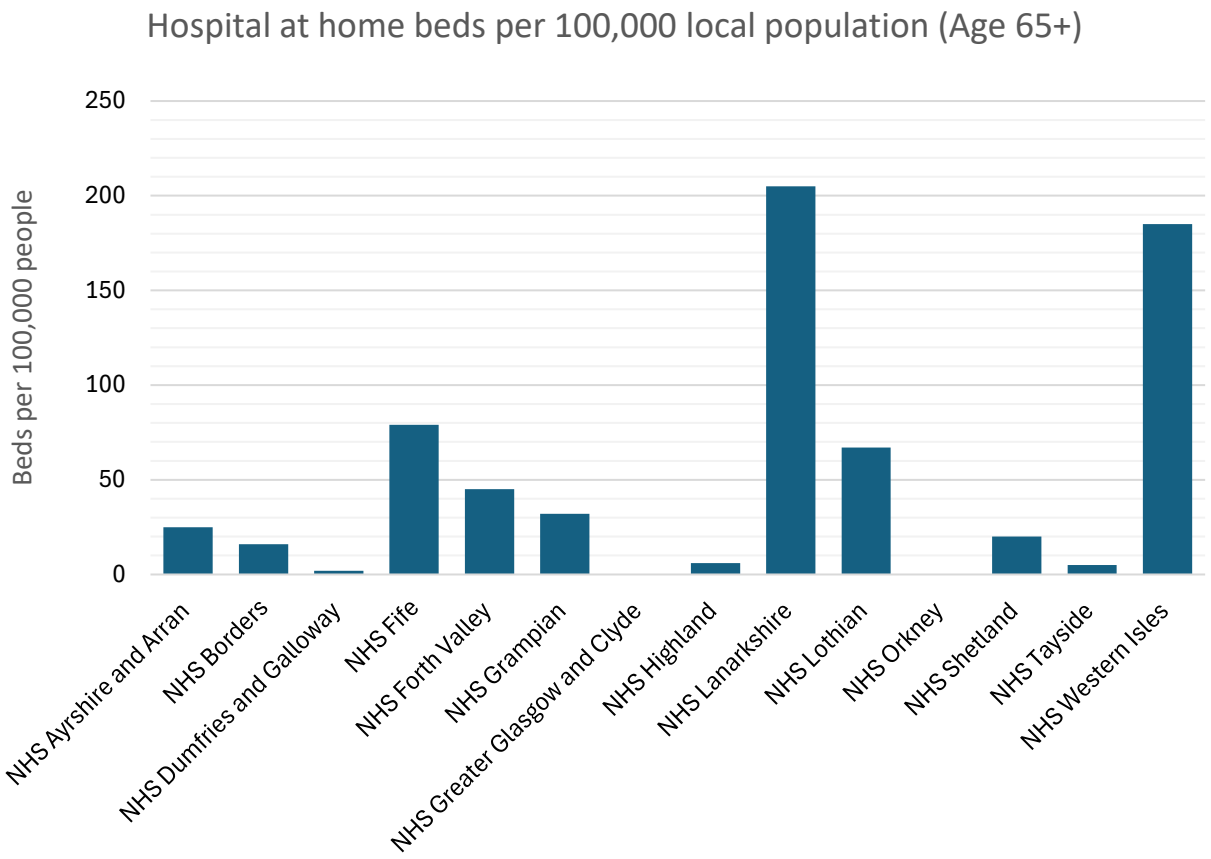
Figure 8: Common conditions for hospital at home admissions 2024/25



Local coverage

Breaking down the above bed numbers into health boards, hospital at home has varying coverage depending on the local area. Figure 8 below shows the coverage of hospital at home in the 14 Scottish health boards, measured by the number of hospital at home beds per 100,000 of the population aged 65 plus.[8]

Figure 9: Number of hospital at home beds in Scottish health boards per 100,000 local population



NHS Lanarkshire has the longest standing hospital at home service and the largest number of beds per 100,000 people aged 65 plus. NHS Western Isles has similar coverage, in a much smaller population. It is important for hospital at home to reach remote and rural areas such as the Western Isles. Other rural areas, including NHS Dumfries & Galloway and NHS Shetland, have launched hospital at home services more recently and are working towards greater coverage per population. More about these services can be seen later in this report.

Cost savings

A randomised control trial across nine hospital at home services demonstrated hospital at home costs to be up to 53% less than a traditional hospital admission.[9] Healthcare Improvement Scotland has calculated theoretical savings for the system as a result of hospital at home.

- Approximately **£16.7 million was saved in 2024/25**, based on 53% reduction in cost for hospital at home admissions compared with nationally reported costs for geriatric inpatient admissions.[10]
- Approximately **£39.4 million was saved in 2024/25** based on estimated reductions in health and social care usage for six months after patients are discharged.

Service information

New services

Three hospital at home services have been established since December 2023, in the localities of Dumfries & Galloway, Renfrewshire and Shetland. This has expanded hospital at home services to people living in some of the most remote and rural areas in Scotland. New services cover a limited geographical area within their NHS board/HSCP until they become more established and have the infrastructure required to expand.

Dumfries & Galloway

- NHS Dumfries and Galloway started delivering a hospital at home service in May 2024, based around the locality of the Dumfries & Galloway Royal Infirmary.
- The service started with a small team of one nurse practitioner and administrative support, before increasing to three nurse practitioners and a GP with specialty interest in January 2025.
- The service is delivered seven days a week and has expanded to cover a 30-minute driving radius of the hospital.
- In its short time, the service has engaged with primary care to generate referrals. At the last check, more than one third of the patients in the service were admission alternative referrals from GP practices.

Renfrewshire

- In 2024/25, Renfrewshire HSCP/Clyde Sector received Scottish Government funding to develop a hospital at home service. The funding was used to develop a hospital at home pathway and draft standard operating procedures.
- In January 2025, the pathway was tested with two patient referrals from Royal Alexandra Hospital.
- The team have developed Steering and Operational groups to help progress with the service development. They have successfully recruited staff to deliver the service for 12 months.
- Pathways are currently in development, and it is hoped an evolving service will commence early June 2025. As this hospital at home service is still in development, their data will be included in future reports.

Shetland

- NHS Shetland started a hospital at home service in December 2023, in the Lerwick locality. The service started with minimal staff and a focus on referrals from hospital to test the pathway.
- The service has developed processes to enable:
    - Accessible notes for both primary and secondary care
    - Prescribing pathways
    - Referral processes
    - Establishment of a virtual ward on Trakcare
    - Development of standard operating procedures
    - Data collection for evaluation, with the aim of designing a hospital at home service that would be sustainable in Shetland
- After securing additional funding in June 2024 the pilot was expanded from two up to four beds.
- After adding pharmacy and physiotherapy time, the service expanded to accept referrals from primary care services and admission avoidance from the emergency department, alongside early supported discharge.
- The service used the HEPMA system for prescribing, allowing pharmacy oversight and a new process for generating timely discharge letters.
- The expansion allowed testing of patient pathways including heart Failure, respiratory and OPAT, along with IV Monofer and IV Zoledronic acid administration.

Service maturity self-assessment

Experience of working with boards/HSCPs to design new, and develop existing, services, has resulted in a set of criteria that explains the maturity of a service.

Services were asked to complete a self-assessment against the nine criteria below. Services were asked to report their status as either progressing, achieved or established.

Progressing (P): Working towards meeting criteria

Achieved (A): Met criteria during period April 2024-April 2025

Established (E): Met criteria prior to April 2024

The results of the self-assessment can be seen in the table below. Some services provided further comments to contextualise their choices.

1. **Equitable access to hospital at home service for all patients within the NHS board / HSCP area**

   To meet this criterion, services offer equitable access to hospital at home for all patients regardless of where they live within the board/HSCP area.

Aberdeen City	Argyll & Bute	Ayrshire & Arran	Borders	Caithness	Dundee	Dumfries & Galloway	Fife	Forth Valley	Lanarkshire	Lothian	Western Isles	Renfrewshire	Shetland
P	P	P	P	P	E	P	A	E	E	E	P	P	P

   - Ayrshire & Arran confirmed that there is ongoing work to extend their service to the third HSCP within the board, North Ayrshire.
   - Caithness and Argyll & Bute services are within NHS Highland. The Argyll & Bute service currently covers Oban, Lorn & Isles which is a large geographical area.
   - Renfrewshire is part of NHS Greater Glasgow and Clyde NHS board however the service is currently only open to patients registered with a Renfrewshire GP.
   - Dundee's service is open to all patients with frailty syndrome registered with a Dundee GP and the team are exploring broadening of the age range accepted.
   - Aberdeen City are progressing to equitable access within the HSCP but not currently the wider board.
   - Lanarkshire advised that only a small area of Camglen is still to be achieved.

2. **Developed referral pathways from both community and acute services**

The service provides an alternative to hospital admission for referrals from the community (e.g. primary care, Scottish Ambulance Service (SAS) and other community services) as well as offering supported discharge from the acute hospital.

Aberdeen City	Argyll & Bute	Ayrshire & Arran	Borders	Caithness	Dundee	Dumfries & Galloway	Fife	Forth Valley	Lanarkshire	Lothian	Western Isles	Renfrewshire	Shetland
E	A	A	P	P	E	P	A	E	E	E	E	P	P

- Renfrewshire currently only accept acute referrals.

3. **Fully functioning multidisciplinary team (MDT)**

To meet this criterion, the service will be comprised of a range of roles that enable the service to provide holistic care and facilitate shared decision-making. The makeup of the service will vary from one board/HSCP to another. In some areas, roles such as pharmacy and allied health professionals (AHPs) may not be part of the core team, but input can be accessed immediately when required. In such cases, this criterion is met. Staff will also work to competencies.

Aberdeen City	Argyll & Bute	Ayrshire & Arran	Borders	Caithness	Dundee	Dumfries & Galloway	Fife	Forth Valley	Lanarkshire	Lothian	Western Isles	Renfrewshire	Shetland
E	A	P	A	P	E	P	A	E	E	E	E	P	P

- Ayrshire & Arran currently work cohesively with an Integrated Care Team but feel they would benefit from hospital at home specific MDT members.
- Dundee have an established MDT but are continuing to improve links with AHPs.

4. **Training and development of staff**

The service has a framework for teaching, training and professional development for all staff members.

Aberdeen City	Argyll & Bute	Ayrshire & Arran	Borders	Caithness	Dundee	Dumfries & Galloway	Fife	Forth Valley	Lanarkshire	Lothian	Western Isles	Renfrewshire	Shetland
P	A	E	A	P	A	P	A	P	E	P	A	P	P

- Ayrshire & Arran have a tailored framework for training and development, dependent on experience level.
- Caithness are still developing their training and development framework.
- Forth Valley have an established framework for advanced nurse practitioners (ANPs) and are in the process of developing similar resources for the rest of the workforce.
- Within Lothian, the service which has progressed most in this area is Edinburgh City.

5. **Recurring investment from NHS board/HSCP/SG**

This criterion relates to the funding source and economic sustainability of the hospital at home service. To meet this criterion the posts that makeup the hospital at home service will be permanent dedicated roles for hospital at home.

Aberdeen City	Argyll & Bute	Ayrshire & Arran	Borders	Caithness	Dundee	Dumfries & Galloway	Fife	Forth Valley	Lanarkshire	Lothian	Western Isles	Renfrewshire	Shetland
E	P	P	P	P	P	P	A	E	E	E	P	P	P

- Aberdeen City have recurring funding from their HSCP at present however the service has been under review. Funding from NHS Grampian is also minimal and liable to reduction. Funding from Scottish Government is recurring.
- Ayrshire & Arran are currently supplementing insufficient recurring funding with non-recurring funding. Non-recurring funding for some posts has lead to recruitment and retention difficulties.
- Argyll & Bute plan to progress towards meeting this criteria in 2025/26.

- Borders noted that the barrier to meeting this criteria in their service is a lack of funding. They are awaiting the outcome of their funding bid for 2025/26 to progress.
- Caithness and Dumfries & Galloway do not currently have recurring investment in place.
- Dundee have established core funding and are progressing towards additional funding for expansion.
- Lothian have established permanent roles in some services but not all.
- Staff in Renfrewshire are currently employed on a secondment basis.
- Lanarkshire advised that some areas have non-recurring funding.

6. **Established model of secondary care specialist/RMO oversight**

To meet this criterion, the hospital at home service will have a dedicated secondary care specialist that acts as responsible medical officer (RMO) for the service. The patients that are treated by the service may have different RMOs for their individual care, but the oversight of the service is consistent.

Aberdeen City	Argyll & Bute	Ayrshire & Arran	Borders	Caithness	Dundee	Dumfries & Galloway	Fife	Forth Valley	Lanarkshire	Lothian	Western Isles	Renfrewshire	Shetland
P	A	E	A	P	E	A	A	E	E	P	P	P	A

- Lothian's specialist oversight is not dedicated.

7. **Defined clinical governance structure**

To meet this criterion the service will undertake regular activity and performance reviews, mortality & morbidity reviews and have a mechanism for review of significant adverse events.

Aberdeen City	Argyll & Bute	Ayrshire & Arran	Borders	Caithness	Dundee	Dumfries & Galloway	Fife	Forth Valley	Lanarkshire	Lothian	Western Isles	Renfrewshire	Shetland
P	A	E	A	P	E	P	A	P	E	E	E	P	A

- Argyll & Bute hospital at home representatives attend hospital and HSCP clinical governance meetings regularly and plan to attend mortality & morbidity reviews regularly.

- In Forth Valley, service activity and Safeguarding Adult Reviews (SARs) are reviewed. Mortality & morbidity reviews are being established.
- Renfrewshire are in the very early stages of establishing their clinical governance structure.

8. **Capacity and capability for data collection and quality improvement within the team**

To meet this criterion the service will have dedicated time for staff to focus on improvements to service delivery. The service will also be supported by colleagues that can facilitate quality improvement work and data collection.

Aberdeen City	Argyll & Bute	Ayrshire & Arran	Borders	Caithness	Dundee	Dumfries & Galloway	Fife	Forth Valley	Lanarkshire	Lothian	Western Isles	Renfrewshire	Shetland
P	A	P	A	P	A	P	A	P	E	E	E	P	P

- Ayrshire & Arran are constantly evolving in this area and data collection is a local challenge.
- Support for this aspect in Forth Valley is reliant on funding.
- Renfrewshire are in the early stages of establishing capacity and capability in this aspect.
- Despite being established, Lanarkshire are struggling with dedicated data analyst.

9. **Consistent access to speciality input where required**

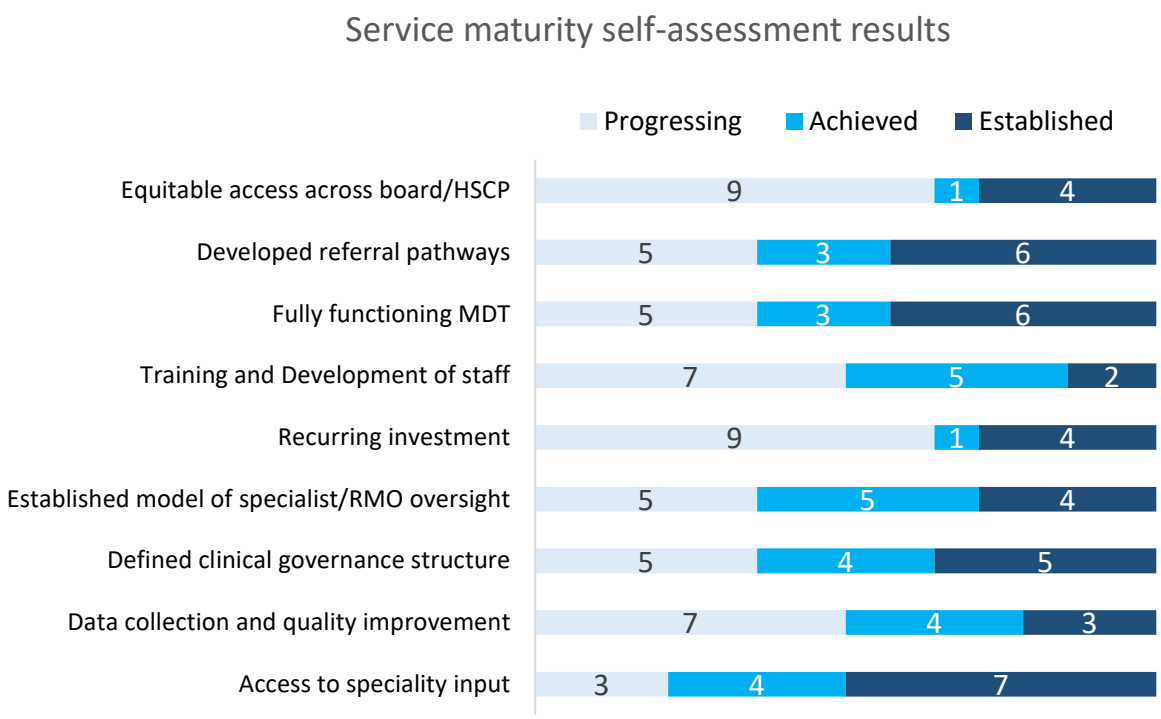
To meet this criterion, services should be able to access real time input from other specialties regarding patient diagnosis and treatment. For example, for a patient with heart failure, the service can seek advice from a cardiologist or heart failure specialist to inform the patient's treatment plan, without the patient having to be transferred to another ward.

Aberdeen City	Argyll & Bute	Ayrshire & Arran	Borders	Caithness	Dundee	Dumfries & Galloway	Fife	Forth Valley	Lanarkshire	Lothian	Western Isles	Renfrewshire	Shetland
E	A	E	A	E	E	P	A	P	E	E	E	P	A

- Argyll & Bute are a rural service therefore do not have speciality services on site.
- Aberdeen City's service is able to access specialist input on specific patients but work is ongoing to strengthen relationships for some pathways.

The aggregated results of the assessment are shown below in Figure 10.

Figure 10: Service maturity self-assessment aggregated results



The chart above shows that the areas which require most work are services expanding to provide equitable access across their board/HSCP area and securing recurring investment. The area in which most services have achieved or established maturity is having access to speciality input where required.

Next steps

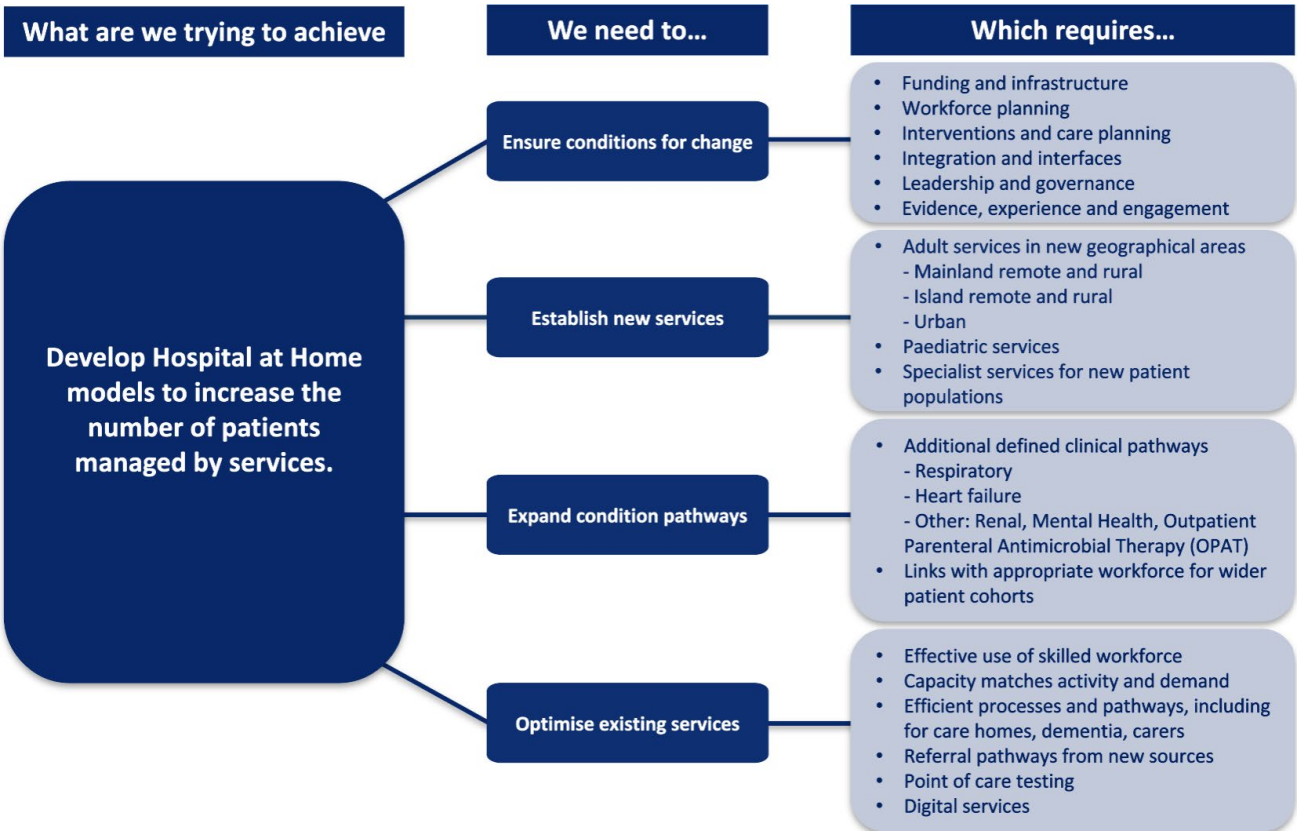
For 2025/26 and beyond, Healthcare Improvement Scotland will offer support to all hospital at home pathways with a primary focus on older adult, respiratory, heart failure and paediatric services. The level of support provided will be based on the needs of each individual service, following consultation between Healthcare Improvement Scotland and the hospital at home teams. Some of the support activities offered will include access to a national learning system for hospital at home professionals, direct implementation support from improvement specialists, knowledge & information advice, and evaluation support. Healthcare Improvement Scotland will also update and develop the guiding principles for service development to broaden its remit to the management of new patient pathways.

The programme will commence in August 2025, with four key objectives:

1. Share evidence and best practice
2. Increase the pace of implementation through tailored improvement support

3. Enable measurement of progress and evaluate impact
4. Facilitate learning and connections both locally and nationally

This work aligns with and complements Scottish Government's aim of reaching 2,000 beds by December 2026. The programme driver diagram below identifies the primary and secondary drivers for the development of hospital at home services in 2025/26. Ensuring conditions for change are present for all services will underpin their efforts to achieve one or more of the other primary drivers: Establish new services; Expand condition pathways; and Optimise existing pathways.



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Appendix 1: Breakdown of services by area

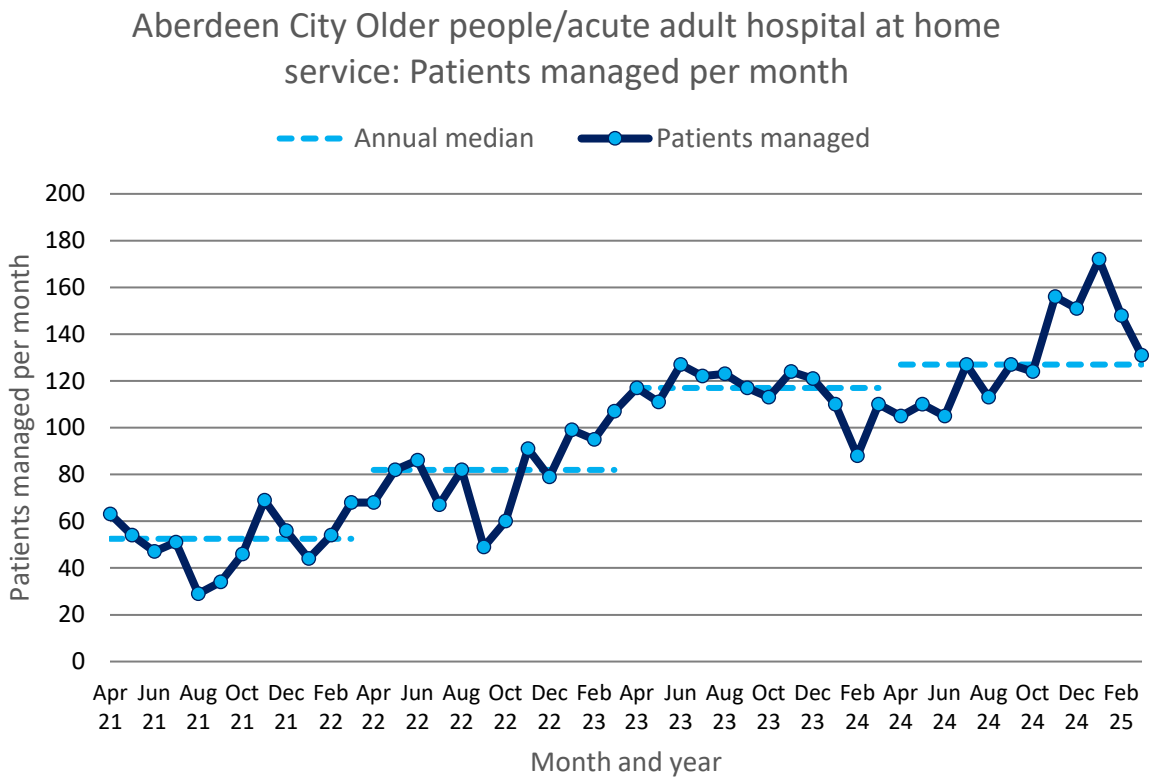
Profile for each service focused on maturity.

Aberdeen City

Aberdeen City HSCP's hospital at home service was set up in June 2018. Frailty is the core focus of the service alongside further pathways developed with respiratory, acute medicine and OPAT.

It operates 7 days per week. The service is available to support all patients across Aberdeen City HSCP. The chart below shows the patients managed per month by the Aberdeen City HSCP's hospital at home service since April 2021.

Figure A1: Patients managed per month by Aberdeen City hospital at home



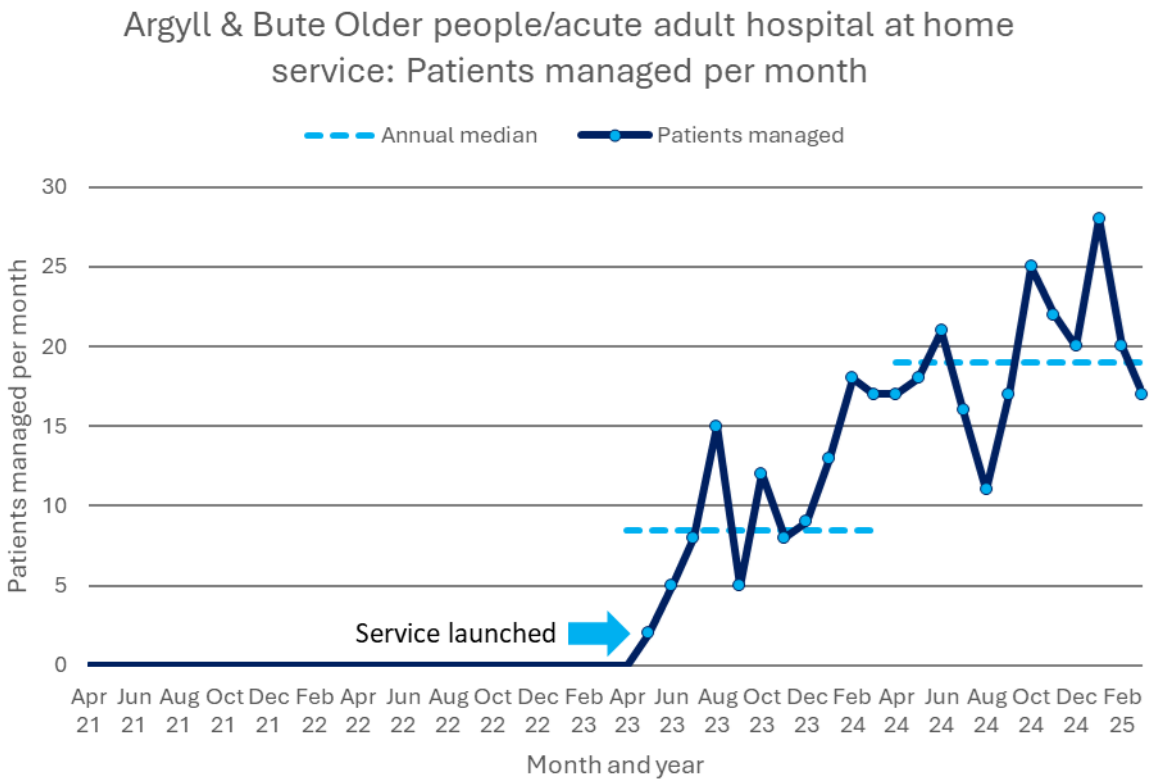
In 2024/25 the team focused on improving and standardising their processes to improve the efficiency of their service.

They have gained additional GP input into the team which has enabled them to conduct more engagement with primary care and increase direct referrals into their service.

Argyll and Bute

Argyll and Bute HSCP started delivering a hospital at home service in May 2023. The service covers the population of four GP practices over 250 square miles. The chart below shows the number of patients managed per month by the Argyll & Bute hospital at home service since its launch.

Figure A2: Patients managed per month by Argyll & Bute hospital at home



The service in Argyll and Bute encompasses treatment for a variety of conditions including frailty, cardiac, respiratory and OPAT.

Referral pathways started from inpatient supported discharge hospital but have extended to admission avoidance pathways via A&E. Admission avoidance referrals from A&E now account for over half of patient admissions.

Argyll and Bute developed an operational group with a hospital at home consultant, pharmacist and nurses meeting with GP practices, HSCP lead nurse for care homes, GP cluster leads and SAS to increase our admission avoidance pathways and target care home admissions.

The result has been an increase in direct GP/SAS referrals of care home patients to hospital at home and a reduction in care home admissions to hospital.

Funding during 2024/25 was used to increase staffing to support the delivery of services across seven days a week enabling admissions later in the week. This increased activity helped to improve bed occupancy rates, reduce admission, and length of stay.

Ayrshire & Arran

Ayrshire & Arran hospital at home service started in January 2022 and covers the areas of South and East Ayrshire. The chart below shows the number of patients managed by the service per month.

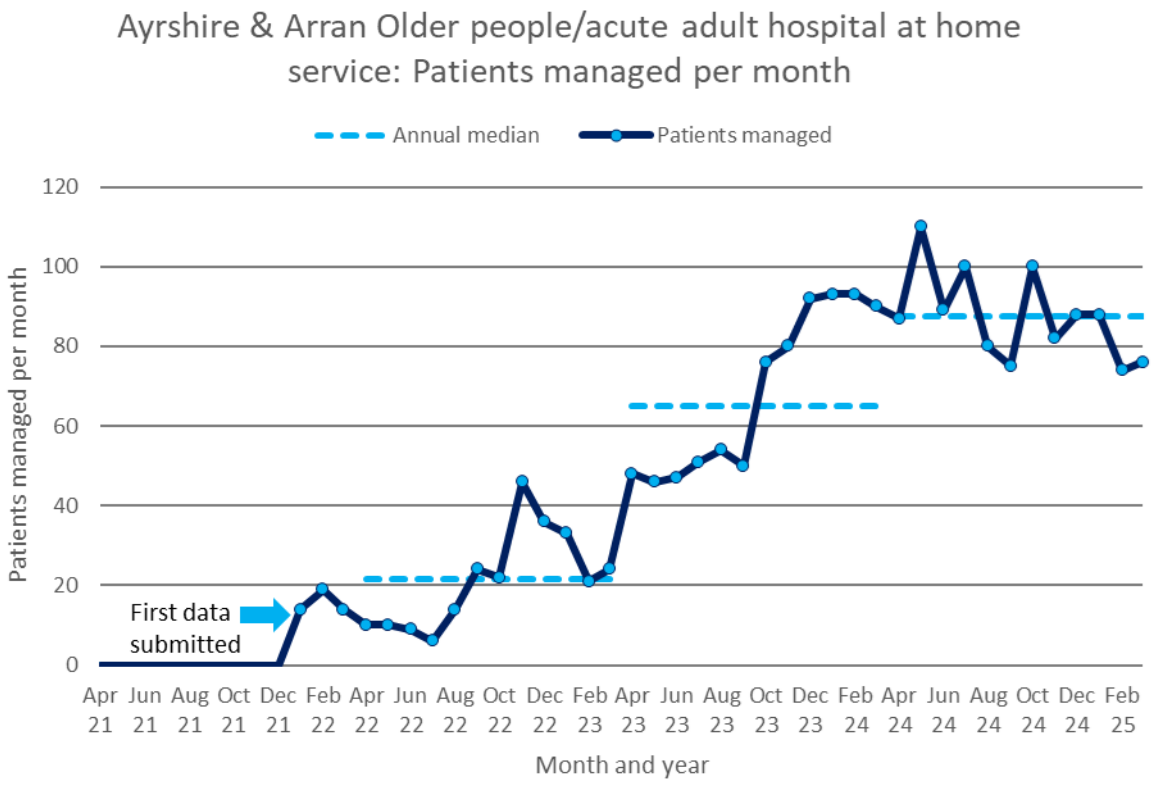
The service has experienced significant growth compared to the previous year, with a commitment to expanding patient pathways. This includes work with SAS to enable referrals up to seven days a week, direct referrals from care homes, and work with primary care MDTs.

Ayrshire & Arran hospital at home service has explored digital and technology options to support service delivery in rural communities. This includes an attempt to embed an electronic comprehensive geriatric assessment document that could be transferable between agencies, primary and secondary care.

Training and education has expanded, with Patient Group Directions for staff to decide and administer IV fluids.

The service has worked with the combined assessment unit and A&E front door at University Crosshouse hospital to identify patients eligible for hospital at home and has increased GP input to enable the service to increase its capacity.

Figure A3: Patients managed per month by Ayrshire & Arran hospital at home



Borders

Borders hospital at home services began submitting data in April 2023. The chart below shows the number of patients managed per month by the Borders hospital at home service since its launch.

The service operates 8am-6pm, 7 days a week. The service is open to adults aged 18 years and over, with the majority of admissions for those aged 50 and over.

NHS Borders hospital at home service has been a significant part of the model's expansion into rural NHS boards, having started taking referrals for patients close to the Borders General Hospital base (Eildon locality). The service has since expanded to also include Cheviot locality.

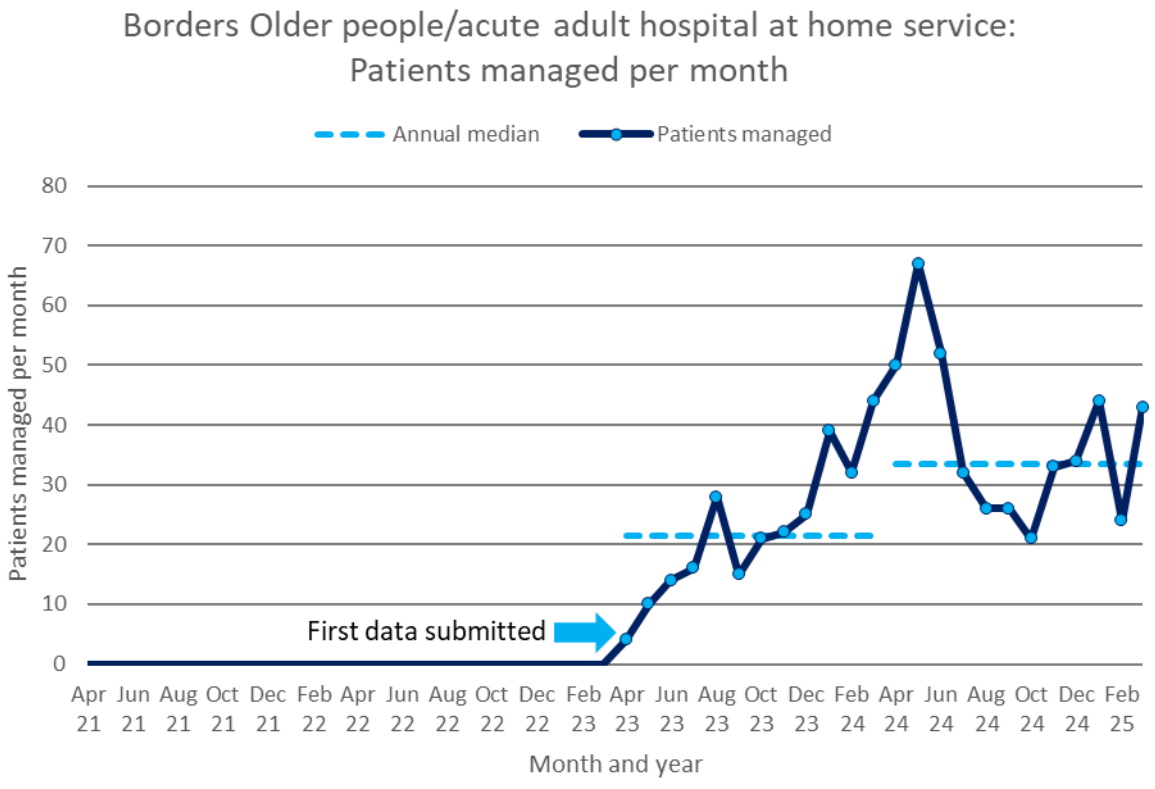
The service has experienced several developments during the previous 12 months, such as close working with respiratory to expand clinical pathways. Nurse practitioners have increased the capacity and skillset of the MDT and are undertaking masters-level ANP modules at Edinburgh Napier University. An increase of GP session time has further developed capacity.

Referral and discharge processes have improved with a weekday coordinator presence in Borders Medical Assessment Unit (MAU) ward.

The efficiency of the service has further developed with the adoption of single-checking IVs.

Borders intends to develop a hub and spoke model for hospital at home to enable greater geographical coverage.

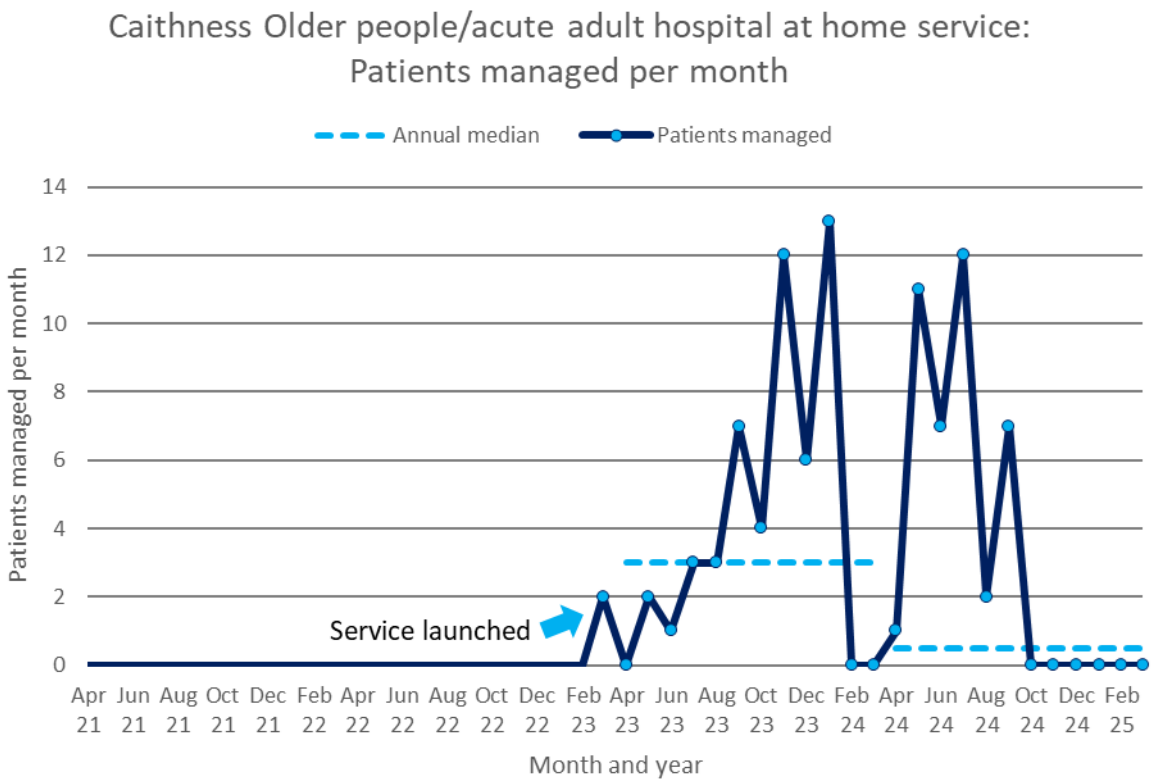
Figure A4: Patients managed per month by Borders hospital at home



Caithness

NHS Highland started delivering a hospital at home service in March 2023 in the Caithness area. The chart below shows the number of patients managed per month by the Caithness hospital at home service.

Figure A5: Patients managed per month by Caithness hospital at home



The service has collaborated with the rural support team when capacity has allowed and has explored branching out to parts of Sutherland locality. Staffing such a remote service has proved difficult and has resulted in limited patient numbers.

NHS Highland has focused on the training needs of staff that would enable a sustainable hospital at home model to be delivered throughout Highland.

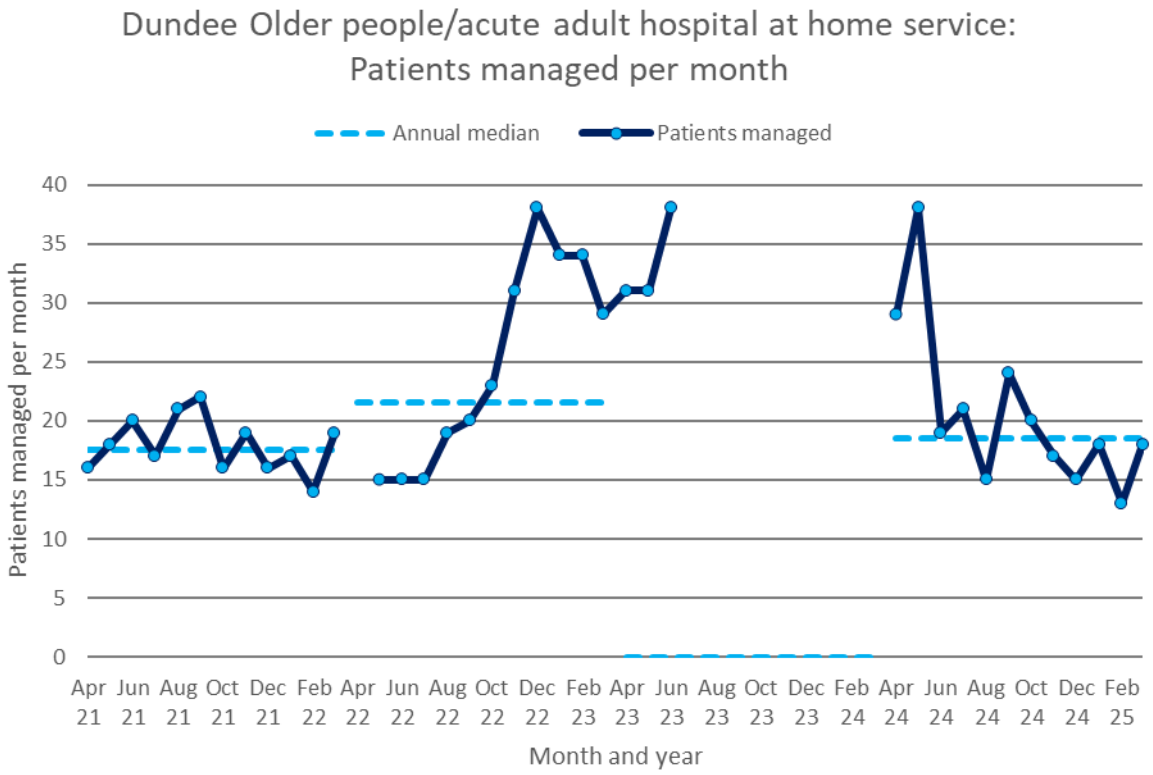
NHS Highland continues to explore options for a hospital at home service based in Inverness.

Dundee

Dundee City's hospital at home service is delivered alongside a broader enhanced community care model.

The chart below shows the number of patients managed per month by Dundee's hospital at home service. Note that the HSCP reported the model did not align with the national definition for hospital at home, and therefore data was not submitted between June 2023 and April 2024. In the spring of 2024, the HSCP rejoined the national programme and started submitting data for hospital at home patients. Additionally, no data was submitted for April 2022.

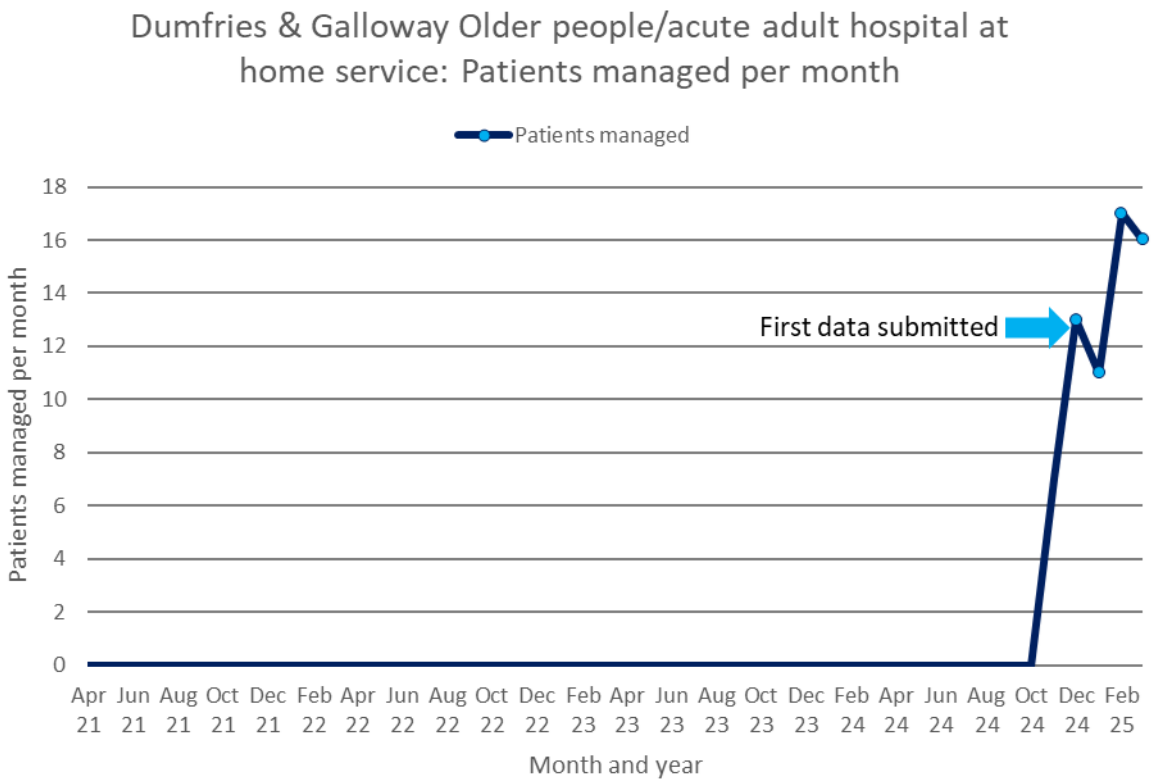
Figure A6: Patients managed per month by Dundee hospital at home



Dumfries & Galloway

NHS Dumfries & Galloway started delivering a hospital at home service in May 2024, based around the locality of the Royal Infirmary. The chart below shows the number of patients managed by the service since they started submitting data in December 2024.

Figure A7: Patients managed per month by Dumfries & Galloway hospital at home



The service started with a small team of one nurse practitioner and administrative support before increasing to three nurse practitioners and a GP with specialty interest in January 2025.

The service is delivered seven days a week and has expanded to cover a 30-minute driving radius of the hospital.

In its short time the service has engaged with primary care to generate referrals that have resulted in more than a third of patients being admission alternative referrals from GP practices.

Fife

NHS Fife started their service in April 2012. There are three hospital at home hubs which provide cover for the whole of Fife:

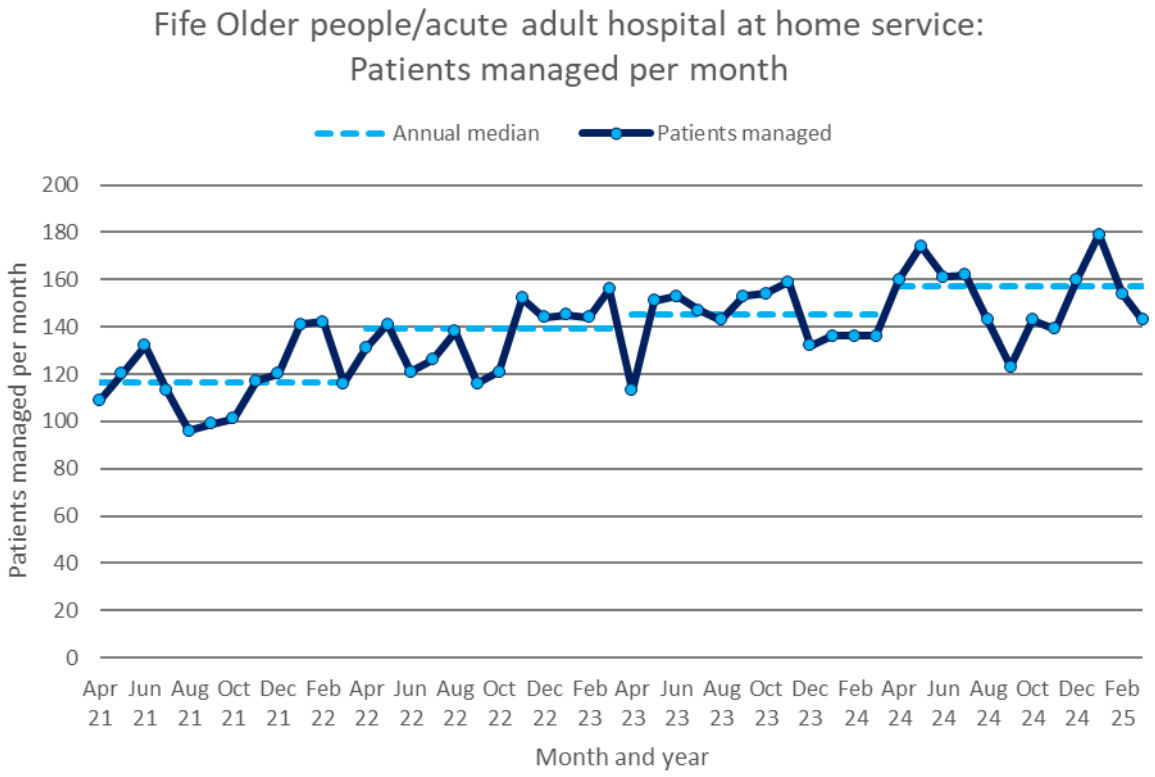
- Queen Margaret Hospital, Dunfermline - covers Dunfermline/West Fife.
- Whyteman's Brae Hospital, Kirkcaldy - covers Kirkcaldy/Leven.
- Adamson Hospital, Cupar - covers Glenrothes/East Fife.

Multi-factorial full service review has been completed and the service is actioning option appraisals. They have streamlined and developed new pathways to improve patient flow and increase hospital at home capacity, such as:

- A&E to hospital at home
    - Hospital at home now supply the IV antibiotics
- Management of IV antibiotics longer than 7 days
- Collaborative working with community nurses for patients with diagnosis of Osteomyelitis
- Increased access hours for patients being discharged back to care homes
- POCT
    - Finalising standard operating procedures and aiming to commence validation testing in August/September 2025

The chart below shows the patients managed per month by Fife's hospital at home service since April 2021.

Figure A8: Patients managed per month by Fife hospital at home



NHS Fife is a well-established service. In 2024/25, focus has been on increasing efficiency, consistency and capacity across the three sites. Having a lead ANP working alongside the operational manager has enabled this work to progress with a key area being point of care testing.

All three hubs have implemented 7-day working for ANPs. This has enabled the team to access clinical advice and support between 8am and 10pm which has improved efficiency and confidence in managing complex patients. It has also supported ANP development and involved around all four pillars of practice.

They service now has two dedicated in-reach practitioners working with the acute frailty team to support identified patients to step down to hospital at home. This has resulted in an increase in stepdown patients and improved processes.

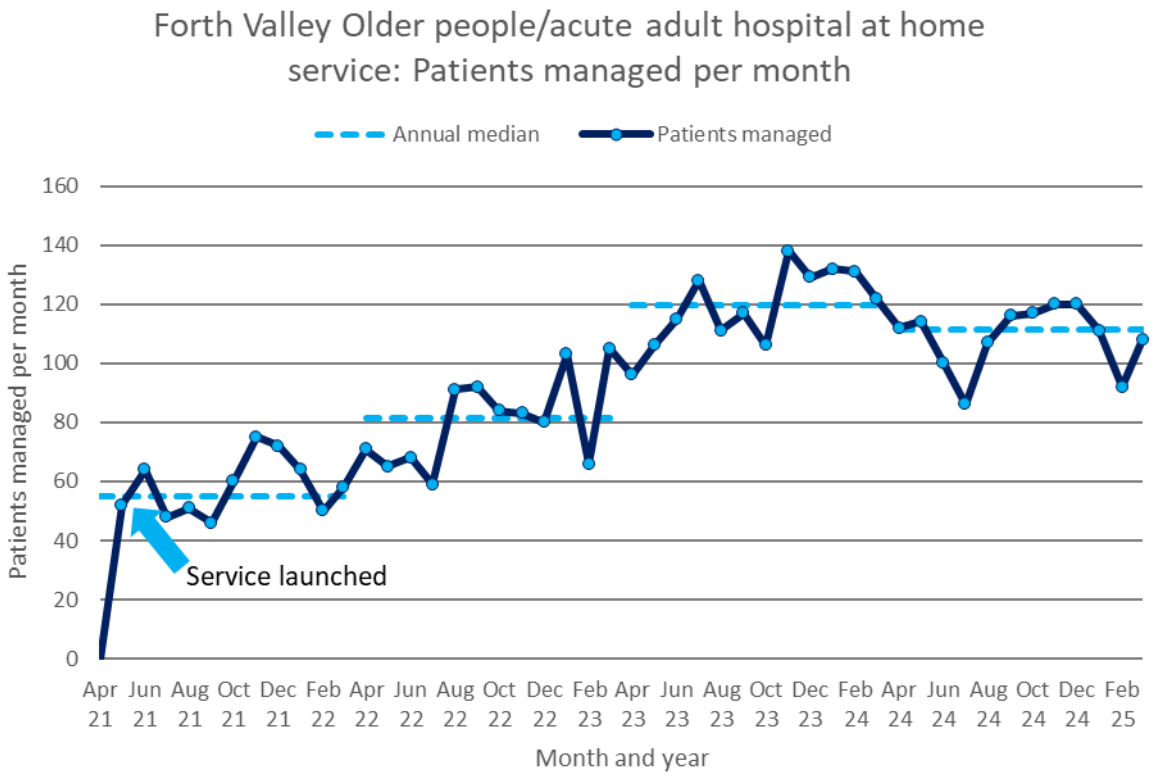
Forth Valley

The Forth Valley hospital at home service was established in May 2021.

The service operates 24 hours a day, 7 days a week. It is available to support all patients across Forth Valley.

The chart below shows the patients managed per month by the Forth Valley hospital at home service since its launch.

Figure A9: Patients managed per month by Forth Valley hospital at home



In 2024/25, Forth Valley started trialing the use of point of care testing to improve the efficiency of clinical decision-making and ensure that patients receive the interventions they need as quickly as possible.

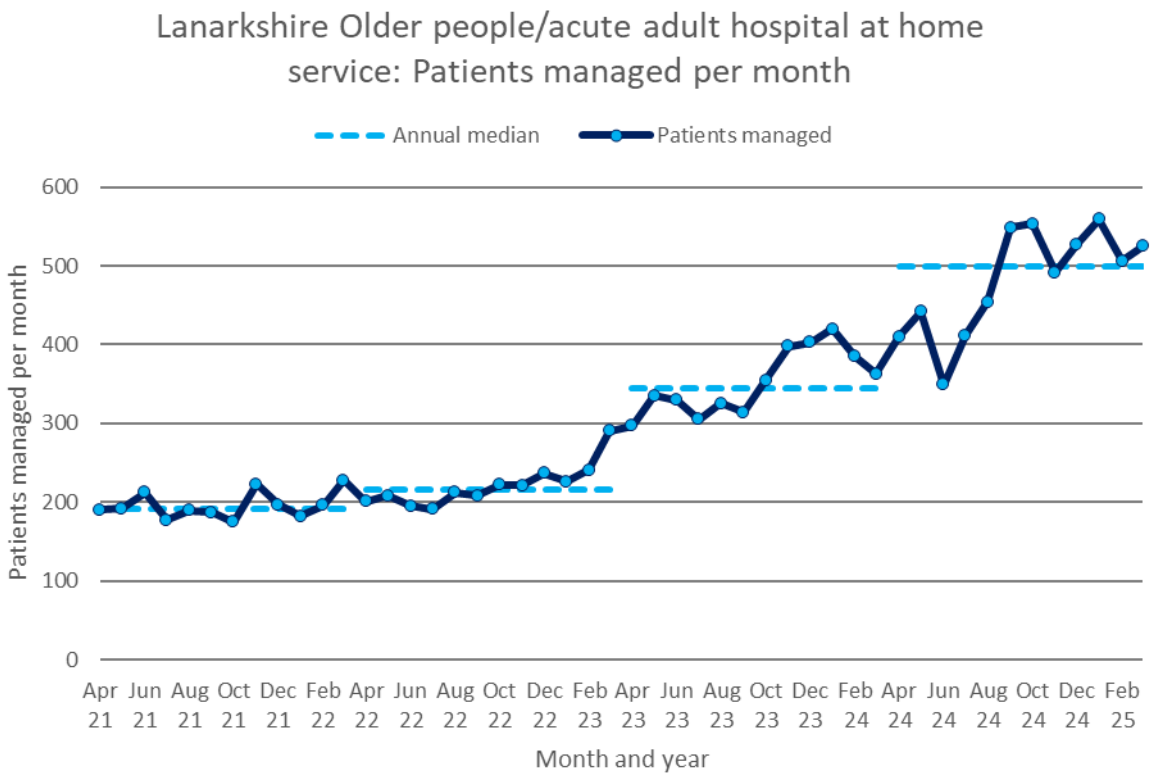
This year they have expanded their service to include specialist clinical input from respiratory and heart failure. This has enabled them to treat patients with more complex and a wider range of healthcare needs and reduce the length of stay for these patients.

They are also continuing to trial a community link worker within the team to support patients post discharge to help prevent readmission and improve staff utilisation.

Lanarkshire

NHS Lanarkshire's hospital at home service started in 2011 and is the longest running in Scotland. The chart below shows the number of patients managed per month by Lanarkshire's hospital at home service since April 2021.

Figure A10: Patients managed per month by Lanarkshire hospital at home



The service covers the area of North Lanarkshire in its entirety and has recently expanded in South Lanarkshire to include the Clydesdale. This has resulted in an increase in patient numbers which was presented to World Hospital at Home Congress in March 2025. They have been able to maintain high numbers, despite this expansion does not have recurring funding.

NHS Lanarkshire has continued to explore a number of developments to their service while increasing patient numbers.

Lanarkshire tested the use of two POCT devices in their service to assess the impact technology could have on the speed of clinical decision-making and timely treatment of patients. 220 patients received POCT over a 12-month period with results indicating an improvement to clinical decision-making and time to commencing treatment for patients.

The service has used Teams consultations to improve team-working, a pilot of evening working to increase capacity, and have worked with SAS to reduce conveying to hospital.

Lothian

NHS Lothian has four separate hospital at home services across the four HSCPs as follows:

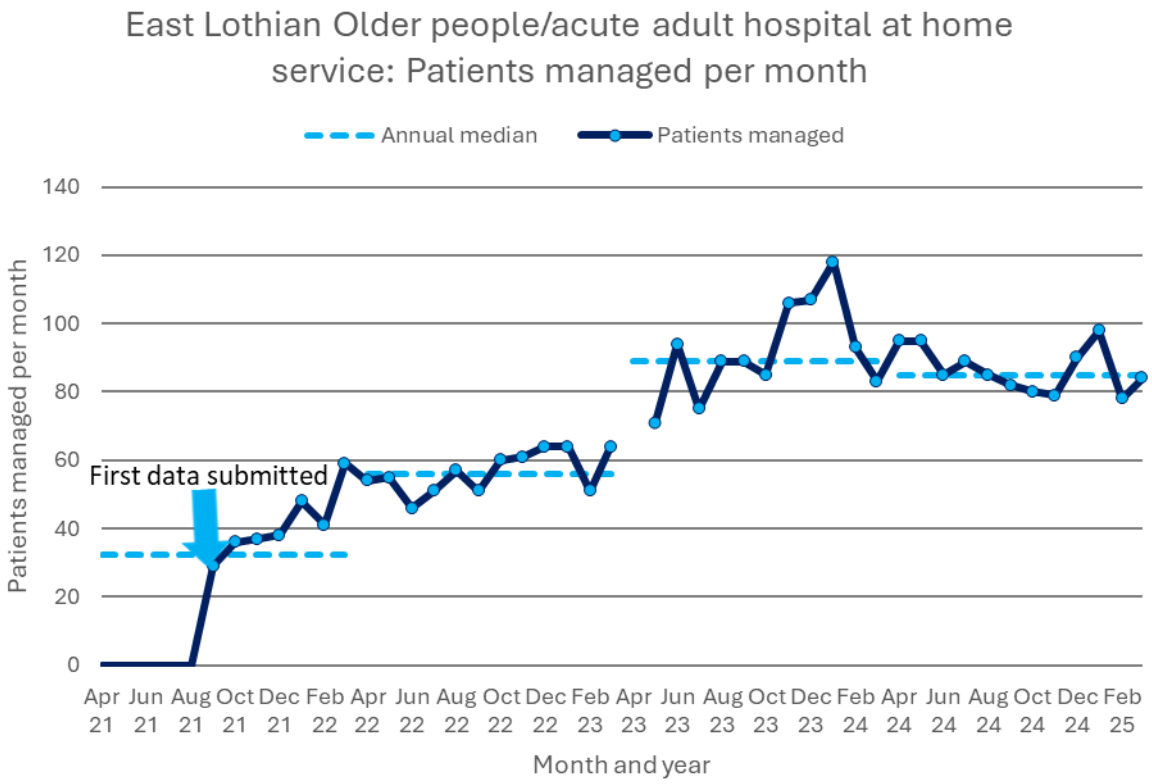
- East Lothian
- Edinburgh City
- Midlothian
- West Lothian

These four services provide full hospital at home coverage to the population of NHS Lothian.

Despite these services operating independently, there is a central governance structure within NHS Lothian providing oversight and ensuring consistency across all four services.

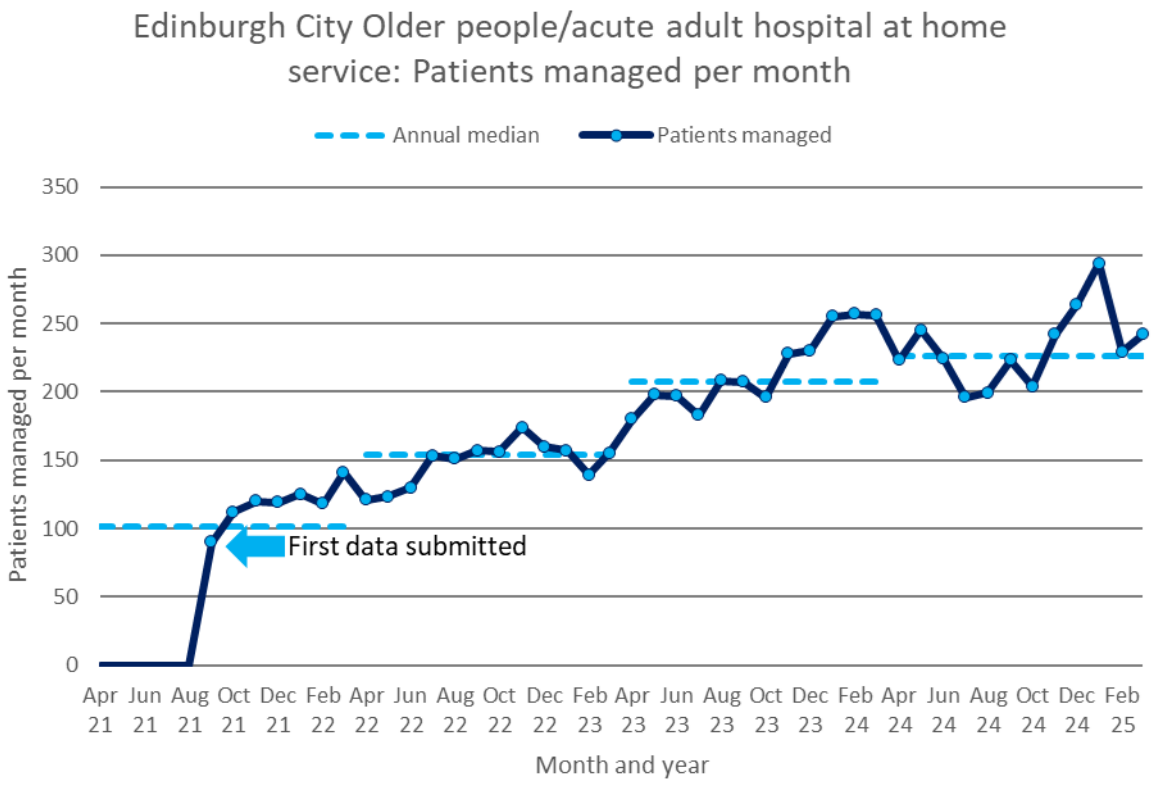
The chart below shows the patients managed per month by the East Lothian hospital at home service since August 2021. Please note the gap in the graph for April 2023 is due to missing data.

Figure A11: Patients managed per month by East Lothian hospital at home



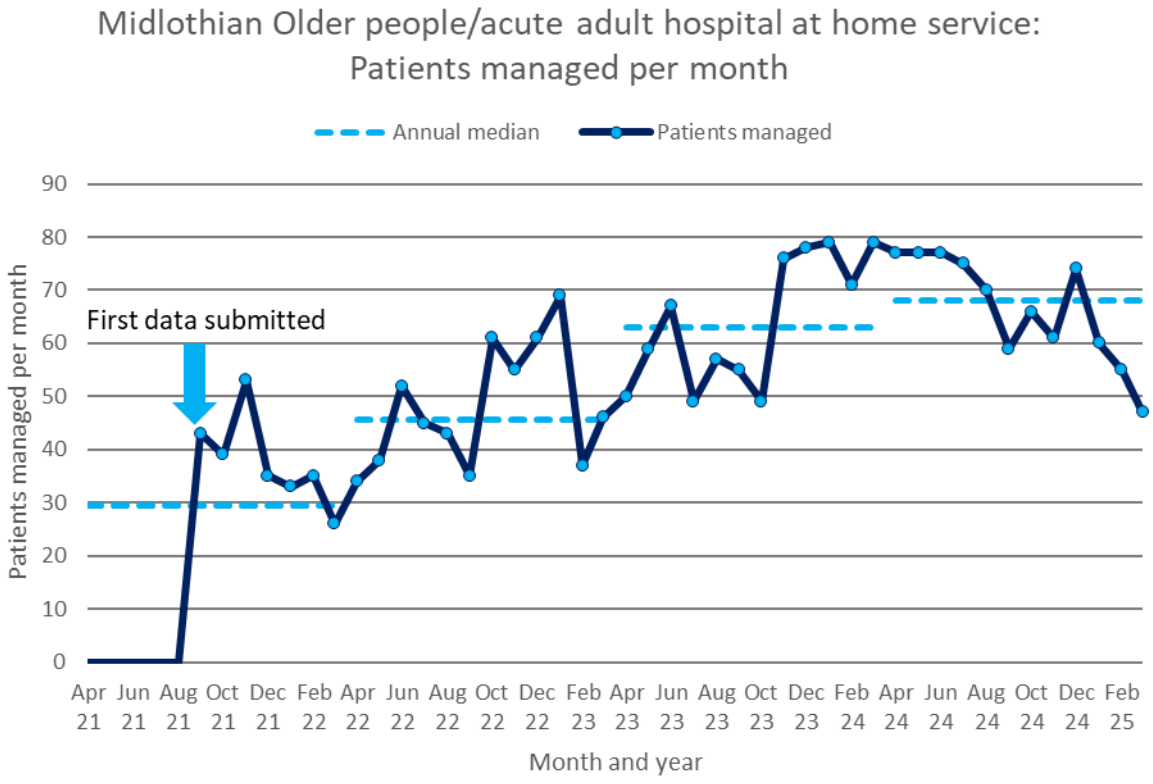
The chart below shows the patients managed per month by the Edinburgh City hospital at home service since September 2021.

Figure A12: Patients managed per month by Edinburgh City hospital at home



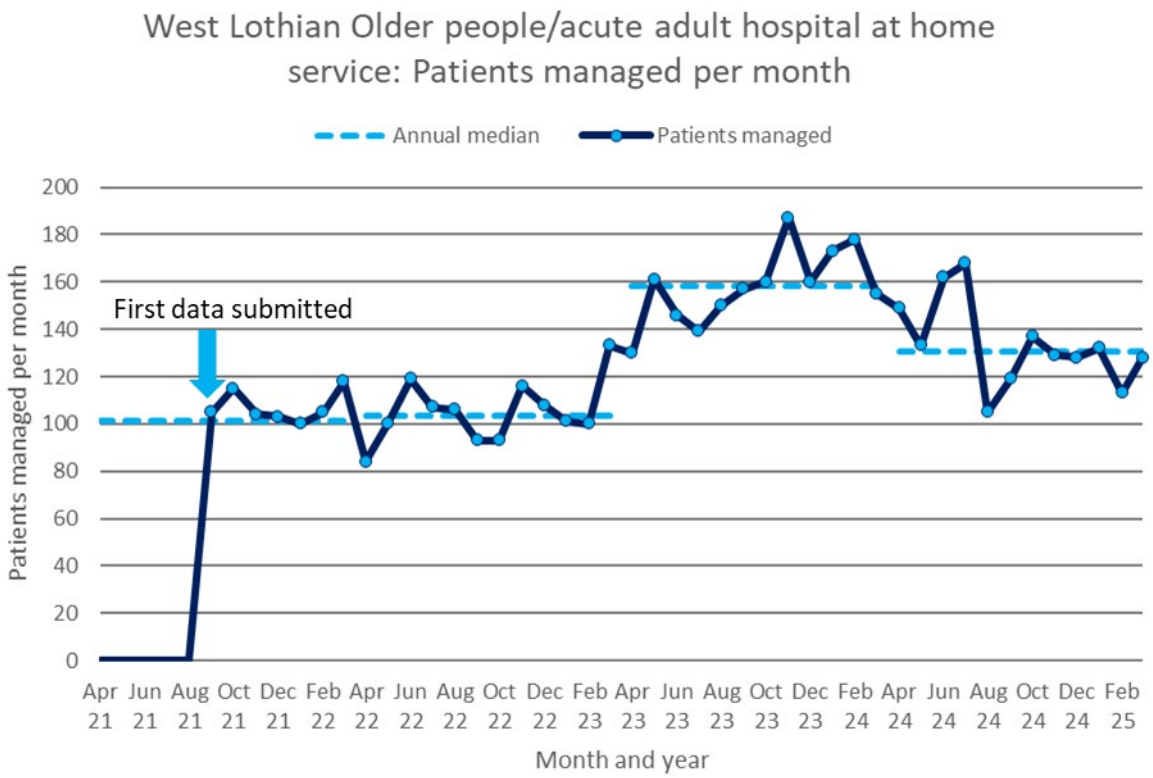
The chart below shows the patients managed per month by the Midlothian hospital at home service since September 2021.

Figure A13: Patients managed per month by Midlothian hospital at home



The chart below shows the patients managed per month by the West Lothian hospital at home service since September 2021.

Figure A14: Patients managed per month by West Lothian hospital at home



In 2024/25, Lothian have focused on improving efficiency and standardisation across the four services. They mapped and reviewed the processes from referral to discharge across the different services to identify and spread good practice. This included standardising the discharge template and patient feedback and adopting daily ward rounds in three out of four services.

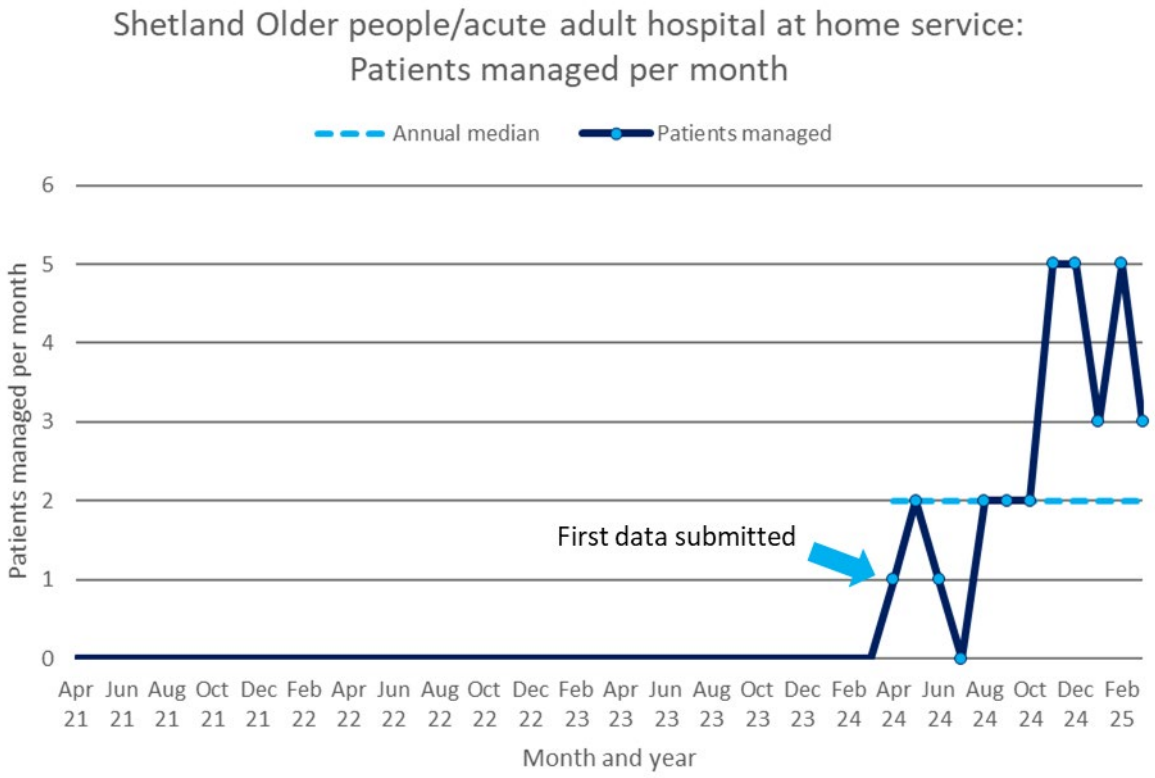
Lothian have started trialling the use of POCT to improve efficiency of clinical decision-making and ensure that patients receive the interventions they need as quickly as possible.

They will also be the first hospital at home service in Scotland to test point of care ultrasound. This year they have made significant progress with developing the information governance and training required and will start using the machines in 2025/26.

Shetland

NHS Shetland started a hospital at home service in December 2023 in the Lerwick locality. The service started with minimal staff and a focus on referrals from hospital to test its pathway. The chart below shows the patients managed per month by the Shetland hospital at home service since they started submitting data in April 2024.

Figure A15: Patients managed per month by Shetland hospital at home



The service has developed processes to enable accessible notes for both Primary and Secondary care, prescribing pathways, referral processes, establishment of a virtual ward on TrakCare, development of standard operating procedures and data collection for the evaluation with the aim of finding a suitable hospital at home service that would be sustainable in Shetland.

Between December 2023 and June 2024, the small-scale pilot demonstrated that delivering hospital at home services in Shetland was feasible and welcomed by patients, and the foundations were established to look to expand this further. After securing additional funding in June 2024 the pilot was expanded from two to four beds

After adding pharmacy and physiotherapy time the service expanded to accept referrals from Primary care services and admission avoidance from the Emergency Department alongside early supported discharge.

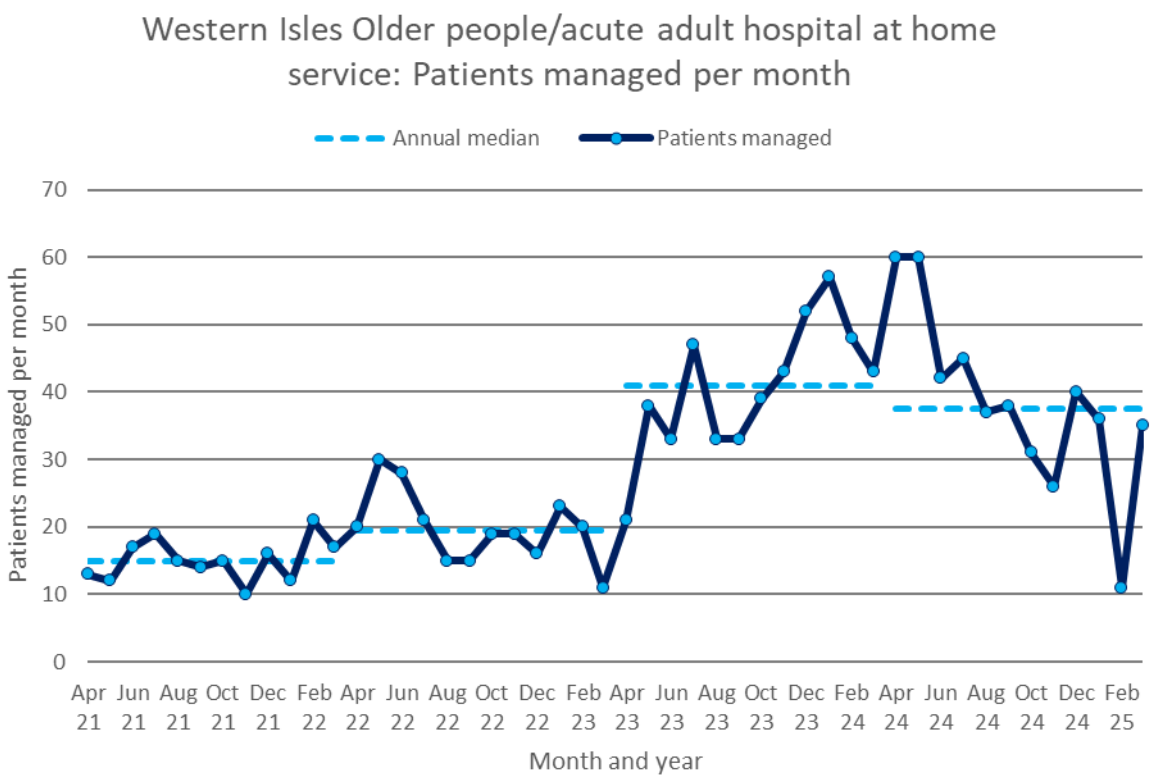
The service has used the HEPMA system for prescribing, allowing pharmacy oversight and new process for generating timely discharge letters. The expansion allowed testing of patient pathways including heart failure, respiratory and OPAT along with IV Monofer and IV Zoledronic acid administration.

Western Isles

NHS Western Isles launched their hospital at home service in May 2020. They have had success in developing a service in a remote and rural NHS board.

The chart below shows the patients managed per month by the Western Isles hospital at home service since April 2021.

Figure A16: Patients managed per month by Western Isles hospital at home



Western Isles hospital at home previously provided a service covering Lewis and Harris. In 2024/25 they successfully developed a service in Uist. This enables an additional 20% of their population to access a 7-day hospital at home service. There are significant benefits for patients in Uist because of its remote location. Without hospital at home some patients would have to travel long distances to the hospital.

Through continued front door redesign work they are now in the process of stabilising the senior clinical decision maker role within the hospital at home team. This work so far has resulted in closer working with other front door services and increased direct referrals for hospital at home.

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