Service name	**Hospital at Home**
Service specification number	QVV/313

Population and/or geography to be served

The service is for those registered with a GP practice in Dorset. As of January 2025, 832,808 people are registered with a GP in Dorset - Patients Registered at a GP Practice - NHS Digital

Service aims and desired outcomes

1. Service aim

1.1. **Preventing Admissions and Attendances**: Hospital at Home services reduce hospital admissions and readmissions, impacting emergency department presentations by providing timely, consultant-led multidisciplinary care.

1.2. **Reduced Hospital Length of Stay**: Step-down Hospital at Home models decrease the length of stay for specific conditions like chronic obstructive pulmonary disease and heart failure.

1.3. **Cost-Effectiveness and Productivity**: Hospital at Homes offer significant cost savings and productivity gains, with technology-enabled care and remote monitoring enhancing efficiency.

1.4. **Improved Patient Experience and Choice**: Patients report positive experiences, increased choice, and personalised care, with opportunities for family engagement.

1.5. **Improved Patient Outcomes and Protection from Avoidable Harm**: Outcomes in Hospital at Homes are comparable to or better than inpatient care, reducing risks like deconditioning, loss of independence, and hospital-acquired infections.

2. Desired outcomes

Principle	Outcomes
Improving population health and healthcare	Hospital at Home allows patients to receive acute care, monitoring, and treatment at home, which can significantly improve health outcomes. By avoiding hospital stays, patients are less exposed to hospital-acquired infections and can recover in a more comfortable environment. This approach supports better management of chronic conditions and reduces the strain on hospital resources.
Tackling unequal outcomes and access	Hospital at Home helps tackle health inequalities by providing care to patients in their own homes, regardless of their location or socioeconomic status. The use of technology in hospital at homes also helps bridge gaps in healthcare access.

Enhancing productivity and value for money	By reducing hospital admissions and enabling earlier discharge, Hospital at Home enhances productivity and provides better value for money, freeing up hospital beds and reducing overall care costs.
Helping the NHS to support broader social and economic development	Working together to integrate health and social care services can support patients to remain within their communities, which can have positive social and economic impacts. By focusing on preventive care and early intervention, Hospital at Home can help reduce the incidence of chronic conditions and hospital readmissions. This proactive approach leads to better long-term health outcomes and reduces healthcare costs.

Service description and location(s) from which it will be delivered

3. Service Description

3.1. Hospital at Home is an acute clinical service that delivers hospital-level staff, equipment, technologies, medication and skills to selected patients in their usual place of residence, including care homes. It serves as a direct substitute for acute inpatient hospital care for patients with conditions that would otherwise require admission.

3.2. A Hospital at Home is defined by the following core service components:

- Effective governance and clinical leadership
- Operating hours (8am–8pm, 7 days a week, at a minimum)
- Clear admission criteria and assessment processes
- Personalised care and support planning and shared decision-making
- Daily board rounds
- Hospital-level diagnostics
- Hospital-level interventions/treatment
- Technology-enabled care, including remote monitoring
- Pharmacy, medicine reconciliation and optimisation
- Clear discharge processes, including monitoring of length of stay

3.3. Hospital at Home is **not** a mechanism intended for:

- Routine GP-led medical and urgent care
- Proactive deterioration prevention
- Safety-netting, for example when patients are medically optimised for hospital discharge/do not require acute care but their symptoms may change
- Intermediate care and reablement
- Bridging care for patients awaiting a care package
- Standalone:
  - Remote monitoring or virtual care
  - Outpatient parenteral antimicrobial therapy (OPAT)
  - Home-based end-of-life (EoL) care
  - Home intravenous or infusion therapy.

3.4. Service Description:

3.5. Providers must work towards delivering the core service components for Hospital at Home as defined in the NHS England Virtual Wards [sic] Operational Framework.

Providers will use the NHS England "Self-assessment Tool for Virtual Wards/Hospital at Home Services" to evaluate their service delivery, with the Key Lines of Enquiry (KLoE) detailed in Appendix 1.

3.6. Providers will allow patients to safely and conveniently receive acute care at their usual place of residence. The service operates through two core functions:

- Step-up care: Direct admission of acutely unwell patients from their usual place of residence, typically from sources such as Single Point of Access (SPoA), Same Day Emergency Care (SDEC), or Emergency Department (ED). Additionally, patients can be referred from primary care, community care, and emergency ambulance services.
- Step-down care: Facilitated early discharge from inpatient wards for patients requiring ongoing medical treatment, oversight, and diagnostics

3.7. Providers should ensure alignment of both step-up and step-down functions and consider opportunities for collaboration and economies of scale when delivering the core components. This may require joint working between acute and community providers, increasing flexibility to match capacity and capability to fluctuations in patient needs and demand.

3.8. Providers shall collaborate at a local level to maintain Hospital at Home capacity, particularly focusing on direct admission from the community ('step-up' care). This includes appropriate referrals from ED and SDEC following initial assessment. Providers are expected to be actively engaged in enhancing social care integration within Hospital at Home through partnership working.

3.9. Providers shall collaborate with primary care, community care, emergency services, and social care partners to create integrated care pathways. This collaboration aims to enhance coordination, reduce fragmentation of services, and improve overall patient outcomes.

3.10. Providers shall develop and implement comprehensive end-to-end pathways that support patients along the entire continuum of care. These pathways should ensure seamless transitions between different levels of care, from acute hospital settings to community-based services and home care.

3.11. Services shall accommodate varying levels of acuity, from patients requiring daily virtual/telephone monitoring to those needing multiple daily Multidisciplinary Team (MDT) home visits. Patient acuity must be sufficiently high to warrant consultant physician, consultant practitioner, or GP oversight, distinguishing it from other community services.

3.12. The expected length of stay shall not exceed 14 days, though duration will be determined by individual patient needs.

3.13. The Provider shall ensure Hospital at Home services are distinct from other community healthcare services. While staff may work across multiple services, standalone services as detailed in 3.3 do not constitute Hospital at Home care, though they may form part of the MDT care delivery.

3.14. Providers shall collaborate at a System level to develop and implement appropriate acuity measurement tool/s. This collaborative approach aims to ensure effective patient

selection and system flow, and to evidence a flexible approach to service capacity. The tool/s should include clinical criteria to reside and may be based on clinical interventions, professional input requirements, and condition-specific factors.

4. Recording and Reporting

4.1. Robust and consistent data is essential to assess progress in scaling services and to build evidence about their effectiveness. Data should be gathered on clinical effectiveness, patient safety, patient and carer experience, staff experience, and resource use for Hospital at Home.

4.2. Provider data will feed directly to the System Hospital at Home dashboard to allow:

- Understanding service capacity and utilisation
- Optimising resource allocation
- Tracking health inequalities
- Monitoring patient flow effectively
- Coordinating care across different pathways

5. Location/s from which it will be delivered.

5.1. Services shall operate from locations that ensure high standards of patient safety are maintained. These locations must be equipped to deliver high-quality care and support effective service delivery.

5.2. Locations should maximise accessibility for patients, ensuring that services are available to all segments of the population, including those in rural or underserved areas.

5.3. The nature of HaH services is such that aspects of care will be delivered virtually, such as by telephone monitoring.

Appendix One – Hospital at Home Core Service Components

NHS England published the following Key Lines of Enquiry in October 2024 aligned to the August 2024 operational framework for hospital at home services.

Key Lines of Enquiry (KLoE)	
1	**Effective governance and clinical leadership, with consultant physician/consultant practitioner/GP oversight**
1.1	A named consultant physician/consultant practitioner/GP for the HaH, which could be a doctor (including a medical consultant or a GP with an Extended Role), nurse or allied health professional (AHP) with consultant-level practice and knowledge and capabilities in the relevant specialty or care model, holds accountability for all patients admitted to the HaH.
1.2	Where a patient is admitted from an inpatient ward, the accountability should be transferred before the patient leaves hospital unless the accountable clinician is the same individual in both care settings.
1.3	Patients should be monitored to support early recognition of deterioration and appropriate escalation processes should be in place to maintain patient safety. Training on escalation processes should be provided to carers and staff as necessary.
1.4	HaHs should have processes in place to monitor clinical safety and incident reporting. This should capture learning on clinical safety, including digital clinical safety across service partners, with a route into system clinical governance. There should be regular monitoring of patient morbidity and mortality for the HaH, which should include reviews of clinical incidents and complaints.
2	**Operating hours (8am–8pm, 7 days a week at a minimum) and out-of-hours provision**
2.1	HaHs should ensure staffing for a minimum of 12 hours a day (8am-8pm), 7 days a week.
2.2	Operating procedures should be in place to ensure support is available out of hours to manage deterioration and maintain patient safety 24 hours a day, with access to specialty advice and guidance as required.
2.3	HaHs should ensure that it is clear to patients and carers what support out of hours services are able to provide.
2.4	HaHs should continually review out-of-hours contracts to support any additional service demand that might emerge. This is particularly important when proactively identifying step-up demand that could be diverted from inpatient care.
3	**Clear admission criteria and assessment processes**
3.1	For all admissions to a HaH, a senior clinical decision-maker, under the oversight of a consultant physician/consultant practitioner/GP, should promptly assess patients to decide whether they should be admitted to a HaH. This may be in consultation with other specialty clinicians.
3.2	Assessment may include comprehensive geriatric assessment where indicated, calculation of NEWS2 score, Clinical Frailty Score (CFS) screening and 4AT rapid test for delirium in adults. These assessments may help risk stratify the appropriateness of HaH care but should not be used on their own to exclude a person from admission to a HaH. PEWS could be used to support admission decisions for CYP.
3.3	For patients transferring to a HaH from an inpatient ward, hospital staff should proactively identify suitable patients, including during their twice daily ward rounds at a minimum. The decision to admit a patient to a HaH will be made in conjunction with the senior clinical decision-maker in the HaH.
3.4	Admission criteria should reflect the acuity of HaH patients.
3.5	They should work with care transfer hubs to support discharge to HaH care, in line with the Hospital discharge and community support guidance.

3.6	An assessment of a patient's holistic needs should be undertaken – or have been undertaken by/jointly with a care transfer hub for patients transferring from an inpatient ward – to ensure that HaH care is adapted to the individual patient's circumstances and their wider needs.
3.7	Assessment should help recognise when an individual might be in their final days or weeks of life, and occur in line with the Gold Standard Framework.
3.8	An assessment of the needs of a patient's carer should also be undertaken to ensure they are properly supported, for example by reference to the carers' checklist.
3.9	There should be policies in place to ensure equity of access in the admission and assessment processes and reduce health inequalities.
4	**Personalised care and support planning and shared decision-making**
4.1	Services should provide patients (and/or their carers) with adequate information to ensure informed consent for treatment on a HaH and make any reasonable adjustments required. If an individual lacks capacity to make informed consent, then their representative or a best interests assessor should be involved to advocate on behalf of the individual's interests and needs.
4.2	There must be a documented shared decision-making process with patients and/or carers consenting to admission with full awareness of the benefits and risks. This includes delivery of care in their home environment and carers' circumstances.
4.3	Personalised interventions, including co-produced care and support plans, should be agreed. Advance care planning conversations should occur to ensure what matters to patients is documented in a place that all staff can access and these advance care plans are respected in the event of patient deterioration. Care should otherwise reflect of any previously agreed advance care plan.
5	**Daily board rounds involving a senior clinical decision-maker, medical input and the wider MDT**
5.1	Board rounds should be overseen by a senior clinical decision-maker, occur daily, include medical input and be supported by a dedicated MDT encompassing a variety of disciplines as would be the case in a hospital (that is, consultant physicians/GPs, physicians, registered nurses, AHPs, advanced clinical practitioners, pharmacists). The MDT should include other relevant professionals when required, including social care teams, mental health and voluntary sector organisations.
5.2	When tasks are delegated to non-NHS staff, including social care, local services should ensure sufficient funding arrangements are in place.
5.3	A record of interventions and treatments should be accessible to all appropriate professionals involved in a patient's care.
6	**Hospital-level diagnostics**
6.1	All HaHs should ensure patients have access to tests and urgent diagnostics as they would in a hospital (for example, blood tests, CT scan, X-ray and MRI) to allow for responsive and timely decision-making, in line with national guidance on access to diagnostics on HaHs.
6.2	When setting up pathways to access tests and urgent diagnostics, services should work closely with local pathology networks to ensure appropriate clinical governance, and to avoid hospital admissions for the sole reason of accessing a test. HaHs may partner with care settings such as SDEC and community diagnostics centres.
6.3	HaHs should work with ICB transport leads to ensure patients can access transport to and from these settings as required. They should also consider how samples taken at home will be transported to the laboratory.
6.4	HaH staff kit bags should include portable medical devices, such as in vitro point of care testing and point of care ultrasound devices, to enhance assessments and accelerate clinical decision-making.
7	**Hospital-level interventions/treatment**

7.1	HaHs should offer in-person visits to a patient's usual place of residence in conjunction with care management and monitoring, which can be technology-enabled.
7.2	Appropriate in-person therapies should be available, such as intravenous therapies (diuretics, fluids, antibiotics as a minimum), subcutaneous fluids, nebulisers and oxygen. The MDT may also provide at home services, such as physiotherapy, occupational therapy, assessment and delivery of equipment to improve independence and reduce risk of harm.
7.3	There should be access to advice and guidance from other specialists, consultant-level reviews and medicines management and optimisation.
8	**Technology-enabled care, including remote monitoring**
8.1	All HaHs should have the capability and capacity to use technology-enabled monitoring, where appropriate, to improve access to information that supports clinical decision-making, and support remote consultation and connections between the patient and their care team. Technology should not be used to deliver virtual care where face-to-face care is required. Services should be able to support patients, carers and care home staff with the use of technology and offer alternatives to prevent digital exclusion.
8.2	Electronic patient record (EPR) configuration should support delivery of HaHs by enabling access to information across all delivery partners. This should also provide read/write functionality and enable the flow of clinical information from referral, assessment, admission, care delivery (including visibility of remote monitoring data) and discharge or ongoing transfer of care.
8.3	Where EPMA and e-prescribing systems are not integrated with provider EPRs, these should be optimised to reduce the risks of medical error; support process improvement; and enable integration across service partners.
9	**Pharmacy, medicine reconciliation and optimisation**
9.1	There should be equitable access to pharmacy, with dedicated pharmacy professionals involved in daily board rounds and MDT meetings as required, and in the delivery of comprehensive assessments.
9.2	HaHs, particularly their step-up functions, should have access to medicine 'grab bags' to ensure timely access to appropriate treatments.
9.3	Processes for prescribing and deprescribing, dispensing and delivering medicines should be clearly defined and signed off by the organisation's chief pharmacist or equivalent. Where possible, medicines should either be delivered to the patient's usual place of residence or e-prescribing used to dispense medicines to a local pharmacy to limit travel.
9.4	On discharge from a HaH, relevant information about changes to a patient's medicines should be shared with the patient's GP and community pharmacy. This could be shared via a summary care record.
10	**Clear discharge processes, including monitoring of length of stay**
10.1	HaHs should agree the estimated discharge date for a patient on admission based on clinical judgement and in discussion with the patient and/or their carer. Patients should be discussed daily to identify whether they still require acute care or should be discharged. Decisions should support the safe and timely discharge of people in line with the Hospital discharge and community support guidance.
10.2	The length of stay can differ for each person, but is expected to be short (especially where a HaH admission for diagnostics and rapid treatment replaces an ED attendance) and up to 14 days. Services should monitor length of stay to ensure it is appropriate for both patients' needs and local demand and capacity considerations.

10.3	Services should ensure early discharge planning, including early referral to transfer of care hubs for anyone likely to require an additional package of support on discharge. Suitable arrangements should be made for transferring care from the HaH to alternative pathways, including those led by primary, community or social care. This includes rehabilitation and reablement services as outlined in the Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge; long-term condition management services (including NHS @home services); and EoL and specialist palliative care services.
10.4	There should be appropriate communication with patients and carers to ensure they understand the discharge process and are aware of onward referrals or required further management by other services.