FORUM

The Academy of Medical Sciences

Hospital at home fit for the future

Monday 20 January 2025

Academy of Medical Sciences' FORUM workshop, held in partnership with the British Geriatrics Society

BGS

British Geriatrics Society
Improving healthcare for older people

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Executive summary

In January 2025, the Academy of Medical Sciences and the British Geriatrics Society jointly organised a FORUM workshop in Edinburgh on 'hospital at home', through which hospital-level care is delivered to patients within their own homes or care homes. The workshop involved approximately fifty participants including clinicians, academics, patients and carers, industry representatives and policymakers. The day opened with a speaker and panel session involving world-leading experts, who summarised the evidence base for hospital at home. Discussions then focussed on the components needed for the hospital at home as an intervention to avoid initial hospital bed admission, future opportunities, and knowledge gaps.

Participants agreed that there is strong evidence that hospital at home can deliver outcomes as good as in-hospital care and reduce demands on hospital services. With many hospital at home services being developed as independent schemes across the UK, the priority should be to systematically assess existing models of hospital at home care. This will in turn help identify best practice, optimise existing hospital at home services and support wider rollout.

Discussions highlighted several core considerations:

1. **Mapping the landscape** to create a framework or set of criteria for characterising and comparing hospital at home services. Structured comparisons could identify variations that are warranted, and those that appear to be inconsistent with best practice and evidence. Participants suggested that the analysis should include an equity dimension to explore barriers to using hospital at home and how these barriers might be overcome.
2. **Building a core data set and evaluation framework** for hospital at home could help assess the performance of different services, build a stronger evidence base and underpin benchmarking, monitoring of performance, and quality improvement. This should take a whole-system perspective to capture social care and health care resourcing impacts, and patient and carer experiences. Patients, carers and finance officers should be involved in developing metrics to ensure that the evidence-needs of decision makers are met.
3. **Core aspects of hospital at home service design and delivery:**
    - Rigorous eligibility mechanisms, to ensure hospital at home services are reserved for patients specifically needing hospital-level care.
    - Strong clinical leadership to manage risks in referral and discharge.
    - Communication, coordination, and multidisciplinary teams.
    - A flexible patient-centred approach that considers which aspects of hospital care can appropriately be shifted to the home or care home, and which could be adapted and dropped if they are unable to feasibly be delivered.
    - Patient and carer involvement in hospital at home design and operations, to ensure that hospital at home care is accessible and beneficial to patients and carers.
    - Training and support for carers, while considering the impact of services on carers.
    - Using technology to improve care, e.g. point-of-care diagnostics and monitoring.
    - Embedding research into services to support quality improvement and evaluation.
4. **Workforce and training** should account for the greater flexibility required to deliver efficient hospital at home services. Role blurring is required for hospital at home care delivery, and breaking down silos across disciplines and teams could improve staff recruitment and retention. Specific education and training programmes can prepare clinical leaders and staff for the delivery of hospital at home services and build the skills necessary. New career opportunities for a wide range of health and social care workers could arise from wider rollout of hospital at home services.
5. **Communication** to the public, patients and health and care professionals about hospital at home services could improve awareness and roll out. Participants felt that awareness should be raised among the public so that they know hospital at home is an option, and health professionals so that they feel confident about the quality of care provided.
6. **Learning from pioneering activities** and local innovation (which is currently driving the development of many hospital at home services) could help optimise existing services and inform the development of new services. Patient experience and improvement in health outcomes are also the strongest drivers of this new model of care.

Introduction

The UK has an ageing population, and the number of people in the UK aged over 80 is projected to double to 6 million in the next 20 years.[1] Nearly two-thirds of people admitted to hospital are over 65 and an increasing number are living with frailty.[2] Frailty refers to a decline in a person's mental and physical resilience, making them less able to recover from illness or injury. Despite these pressures, the number of hospital beds in the UK is a third lower than 25 years ago, and the number of beds per 1000 population is among the lowest in Europe.[3]

Although many older people with acute illness often require in-patient hospital admission, for some patients there are risks - particularly for people living with frailty. Hospitals can expose patients to infection and can lead to a decline in mental and physical function ('deconditioning').[4] Studies suggest that avoiding admission to a physical hospital by using a hospital at home service increases the chances of people living at home six months after discharge and may be less expensive than in-patient hospital care.[5] In addition, people may prefer to access hospital care in a familiar setting.

A variety of 'hospital at home' services have been launched to provide an alternative to physical hospitalisation. Patients receive the same standard of specialist hospital care, but at home or in a care home. These services have become increasingly relevant to the current UK Government and the plan to reinvent the NHS with a shift from hospital to the community and build an NHS 'fit for the future'.[6]

In January 2025, the Academy of Medical Sciences and the British Geriatrics Society jointly organised a FORUM workshop to discuss what is needed to deliver an admission-avoidance model of hospital at home for adults living with frailty. The consensus among workshop participants was that **a convincing case had already been made for the hospital at home approach,** but that the priority now is to understand the **most effective ways to deliver hospital at home services**, drawing upon the pioneering services that have already been established.

The workshop involved a balance of perspectives from across sectors and professions, including people with lived experience of hospital at home (as patients and carers). The workshop was developed with input from an expert steering group and co-chaired by **Professor Gillian Mead FRSE FMedSci**, Professor of Stroke and Elderly Care at the University of Edinburgh, and **Professor Andrew Farmer**, Professor of General Practice at the University of Oxford. The event opened with an introduction to the opportunities of hospital at home from **Professor Graham Ellis**, Deputy Chief Medical Officer at the Scottish Government. Professor Ellis then joined an expert panel discussion, involving:

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[1] Centre for Ageing Better. (2025). *State of Ageing 2025*. https://ageing-better.org.uk/our-ageing-population-state-ageing-2025

[2] See https://www.ndph.ox.ac.uk/longer-reads/hospital-or-2018hospital-at-home2019-2013-what2019s-best-for-older-people and NHS Confederation. (2024) *Supporting people with frailty.* https://www.nhsconfed.org/publications/supporting-people-frailty

[3] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-hospital-beds-data-analysis

[4] C. Welch et al. (2024) *New horizons in hospital-associated deconditioning: a global condition of body and mind.* Age Ageing. **53(11).**

[5] S. Sheppherd et al. (2024). *Admission avoidance hospital at home*. Cochrane Database of Systematic Reviews. **3(CD007491).**

[6] UK Government (2025). *10 Year Health Plan for England: fit for the future* https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future and https://labour.org.uk/change/mission-driven-government/

- **Mr Gareth Hooper,** Analytics Manager, The Strategy Unit and past Senior Scientific Advisor to the National Institute of Health and Care Research (NIHR)
- **Dr Shelagh O'Riordan,** National Clinical Lead for Hospital at Home, NHS England and Community Geriatrician, Kent Community Health NHS Foundation Trust
- **Mr John Tippett,** Patient Partner and Research Champion, University of Coventry and Warwickshire Healthcare Trust
- **Mr Steve Wightman,** Healthcare Director, The Access Group.

Following the panel discussion, workshop participants then discussed different case studies of hospital at home models for people living with frailty in different parts of the UK.

What is a hospital at home?

'Hospital at home' services provide time-limited hospital care for people with 'acute' conditions (a short-term and severe episode of illness or injury) in an individual's own home or care home. The term 'virtual ward' is sometimes used synonymously - although this term can lead to confusion about the level of technology required and the types of services offered.

Hospital at home services include diagnosis, treatment and observation, with the technologies used ranging from a phone call to point-of-care diagnostic testing and remote monitoring. They involve health and care professionals from various disciplines, including nurses and allied health practitioners, and usually require the oversight of a specialist doctor or consultant. Hospital at home delivery requires collaboration between primary, community, and secondary care services, as well as voluntary services.

Diagram by Professor Graham Ellis, Deputy Chief Medical Officer, Scottish Government.

Hospital at home for people living with frailty

In his introduction, Professor Graham Ellis, Deputy Chief Medical Officer for the Scottish Government and founder of the UK Hospital at Home Society, summarised how the Scottish Government is strengthening hospital at home provision for people living with frailty. In 2020, hospital at home services were available in 7 out of 31 Scottish Health and Social Care Partnerships (HSCPs). By 2024, they were being offered in nearly all HSCPs. Between April 2021 and October 2024, the number of people treated through hospital at home services per month rose by 397%.

Professor Ellis explained that in 2024, hospital at home services for older people in Scotland had saved an estimated 570 hospital beds at the cost of approximately £15 million, as well as 430 additional care home places.[7] In addition, hospital at home care had saved an additional estimate of £36 million in health and social care costs. Evidence also suggests that, when delivered appropriately, hospital at home services have equivalent or better outcomes than hospitalisation.[8] A randomised controlled trial involving 1055 patients from 9 centres across the UK, found that hospital at home services were cost-effective, safe, and preferred. The trial showed that hospital at home services were associated with a higher likelihood of living at home long-term, a lower risk of admission to residential care and lower incidents of delirium.[9] The cost per admission to a hospital at home was also significantly less when compared to on-site hospital admissions.[10]

The trial also showed that patients were often more satisfied with hospital at home care. Hospital at home services enable people who need hospital care to remain in a familiar environment, where their everyday lives are not so disrupted.

Professor Ellis explained that the ambition now is for hospital at home to become the biggest hospital in Scotland. He detailed how hospital at home services present an opportunity to move towards a more prevention and community-based health and care system. Achieving this system transformation will require retooling the workforce, assessing the role of technology and digital care, and overcoming access challenges such as those presented by rural geographies.

[7] Also see Health Improvement Scotland. (2025) *Older people/acute adult hospital at home services.* https://www.healthcareimprovementscotland.scot/wp-content/uploads/2025/07/Hospital-at-Home-Annual-Report-July-2025.pdf

[8] K. Edgar et al. (2024) *Admission avoidance hospital at home*. Cochrane Database System Review. **3(3).**

[9] S. Shepperd et al. (2021) *Is Comprehensive Geriatric Assessment Admission Avoidance Hospital at Home an Alternative to Hospital Admission for Older Persons?: A Randomized Trial.* Annals of Internal Medicine. **174(7).**

[10] S. Singh et al. (2022) *Is comprehensive geriatric assessment hospital at home a cost-effectivealternative to hospital admission for older people?* Age Ageing. **51(1).**

Mapping the landscape

Multiple hospital at home services have been developed in different parts of the UK, typically driven by the local efforts of healthcare professionals. Although these services share many features, there are also variations in how they operate and deliver care. There are now opportunities to systematically analyse existing hospital at home services to assess their effectiveness and generate a **framework or set of criteria** establishing best practice. Participants at the workshop emphasised that **rigid standardisation was not desirable**, and that justifiable variation (for example, to meet local needs and contexts) needed to be distinguished from approaches inconsistent with best practice.

> I've had very different experiences of hospital at home. One left much to be desired, while the other was excellent.
>
> **Patient Partner**

During discussions, it was recognised that a 'one-size-fits-all' approach was not appropriate, and that services need to be tailored to local contexts. For example, services will need to account for differences between urban and rural or coastal communities, and the challenges travelling between remote communities. Coastal communities often have low life expectancy and higher rates of major diseases, resulting in greater dependency on local health and care services.[11] Some participants suggested that remote monitoring technologies could help support services covering rural or high dependency geographies. Any framework setting out standard 'best practice' models or principles will need to include guidance for adapting to different contexts and populations.

Participants emphasised the need to embed **equity, diversity and inclusion** into any landscape mapping exercise. This should include assessing whether certain populations are under-represented in the use of existing services, and what the reasons for this are. For example, people who are socioeconomically disadvantaged may not be able to access hospital at home if they lack a suitable environment, including access to internet, heating, or carers. Funding or the provision of additional services may be needed to overcome access barriers. Hospital at home services also need to be sensitive to cultural differences and the needs of minority populations, including impact on multigenerational houses. Standard 'best practice' frameworks should set out the most effective methods for overcoming access barriers, and ensure hospital at home services are equitable.

[11] See Department of Health and Social Care (2021) *Health in Coastal Communities – Summary and recommendations.* Chief Medical Officer's annual report. https://assets.publishing.service.gov.uk/media/60f98769e90e0703ba3c9f25/cmo-annual_report-2021-health-in-coastal-communities-summary-and-recommendations-accessible.pdf

Knowledge and research gaps

- What are the core foundational components of hospital at home services, and what variations in service provision are acceptable (and when)?
- Can technology help address the challenge of geographic remoteness and areas of high dependency?
- What are the barriers limiting equitable access to hospital at home services for different populations? How could these access barriers be overcome?

Principles of service design and delivery

As an initial exercise to investigate models of best practice, participants at the workshop were split into six groups to discuss different hospital at home case studies. Participants then identified a range of key principles critical to the development of effective and efficient hospital at home services for older people. As a wider connecting theme, participants agreed that research and innovation needed to be embedded throughout hospital at home services to support continuous improvement and roll-out.

Core to hospital at home services is the ability to achieve an **equivalent level of care and health outcomes** to a physical hospital. However, participants emphasised that the care provided by a hospital at home does not need to exactly match that provided by a hospital. Healthcare professionals seeking to set up a hospital at home have an opportunity to critically consider current hospital processes. This includes assessing which processes could realistically be shifted into the home (or care home) and which could be adapted or dropped if they are unable to feasibly be delivered at home (or in a care home).

> “
>
> You need to maintain standards of care, but you don’t need to replicate everything from a hospital.
> **Professor Graham Ellis, Deputy Chief Medical Officer, Scottish Government**

Patients and carers should also be involved at every stage, from the design of hospital at home services to their evaluation and improvement. It will be important to understand what patients and carer expect and require from hospital at home services. Some hospital at home services have established methods such as patient and carer advisory groups, to help shape their delivery. Continuous **feedback from patients and carers** is valuable, to assess and improve the quality of services according to their experiences and needs.

Understanding the experiences of carers involved in hospital at home services could clarify the potential burden being placed on them and **the support carers need.** A carer in attendance at the workshop, who has lived experience caring for her husband in a hospital at home, highlighted how such services can be demanding for carers. Supporting a patient in a hospital at home, particularly as an unpaid carer, can require additional time and responsibility and be a significant source of stress. Some carers are older themselves or have their own health challenges, and may find it difficult to undertake the physically demanding tasks or increased support a hospital at home may require. Carers will require clarity about their responsibilities, and may need access to training and guidance, such as on using remote monitoring technologies. Additional support for carers will be needed, so that they are able to access resource, staff and services when required.

> When I was caring for my husband at home, I found the extra demands very stressful. I don't think impacts on carers are given the attention they deserve – it can be very difficult for us.
> **Carer and expert by experience**

Hospital at home services need to be **flexible and adaptable** to a range of settings and patient needs. Standard operating procedures are important for assuring quality care, but flexibility is needed to accommodate the practicalities of delivering care in different environments. Hospital at home services need to be adaptable to the different care needs of patients, some of whom may also have multiple conditions. **Portable and simple to use technologies** were seen to be key enablers for supporting the running of hospital at home services. Remote-monitoring and point-of-care diagnostic technologies including wearables and point-of-care ultrasound can help enable staff to make clinical decisions quickly. Hospital at home services should consider what existing and emerging technologies could help enhance and potentially expand the care they provide – particularly for services operating across rural areas or areas with high dependency. The introduction and use of technology into hospital at home services will also require continuous evaluation, to ensure that any issues are recognised and solved quickly.

Communication and coordination across the health and social care system is crucial to hospital at home delivery. Participants also highlighted the critical role of effective **clinical leadership,** to support coordination and ensure an appropriate management of risk. In addition to specialist secondary care, patients may require care from different care teams including allied health professionals and social care workers. Opportunities also exist to integrate hospital at home services with **care homes.** Care home staff could be trained to support hospital at home care, for example by administering intravenous medication and fluids. Care homes will also need to be aware of hospital at home services and referral processes. Effective coordination be needed for streamline **systems of referral**. **Primary care professionals** such as general practitioners may be partially responsible for referrals and for patients following discharge. Integration with ambulance services will be essential, so that they can refer patients and respond to emergencies.

A critical component of hospital at home services is effective and accurate **triage systems**, that enable a senior clinical leader to decide and prioritise when to admit a patient into a hospital at home service instead of an on-site hospital. The preferences of patients will also need to be accounted for, as some patients might prefer one system of care over another. Discussions with patients and carers about admission should carefully spell out the benefits and drawbacks of hospital at home services and physical hospitals. It should be explicit that recommendations for hospital at home care are not based on saving cost and resource. Potentially, there could be different preferences between patients, their families, and/or their carers, and these disagreements would need to be handled sensitively.

Knowledge and research gaps

- How can hospital at home services embed and facilitate research activities alongside service delivery?
- What elements of hospital care can be transferred to the home or care home? Which processes could be adapted or dropped if they are unable to feasibly be delivered?
- How can patient and carer involvement and feedback be embedded into hospital at home design and delivery?
- What are the experiences of carers (particularly unpaid carers) supporting hospital at home patients? What training and support do they need?
- How can existing and emerging technologies support the delivery and expansion of hospital at home services?
- What are the most appropriate and effective approaches to hospital at home referrals and triaging?

Workforce and training

Expanding hospital at home services could have major implications for the health and social care workforce. A level of system transformation may be required to retool the workforce to meet the needs of patients and expand hospital at home delivery. Hospital at home services are delivered by **multidisciplinary teams**, with each patient having a senior clinician responsible for their overall care. There is a need to identify models that are effective and efficient and allow hospital at home services to be delivered at scale without compromising on quality of care. This includes exploring collaborative care models that integrate secondary care, primary care, and community services while maintaining a strong focus on acute care. Modelling the current and future health needs of local population groups, and relevant workforce and resource implications, will also be key for delivering an effective hospital at home service. The use of routinely collected data, such as the electronic frailty index, could help support this modelling.

Clarifying what skills are required, and how to balance different roles and expertise, is critical to hospital at home delivery. For example, there is a need to define the scope and roles of allied health professionals in hospital at home services. Understanding what skills are necessary could inform training and identify staff who could transition into hospital at home roles. Potentially, remote working in a hospital at home could be an option for staff who might find the demands of day-to-day care challenging but have valuable experience. Placements and hospital at home rotations could expose staff to hospital at home services and develop their skills. General practitioners could be exposed to hospital at home services through rotations during foundation years or after qualification.

Building the skillset to support a hospital at home could also be achieved through **blurring staff roles**. Breaking down silos across disciplines and teams can enable smoother coordination and bring **career development opportunities** by expanding skills or responsibilities. Clear opportunities for autonomy, training, and career development may be central to staff satisfaction and retention and could attract new recruits. For example, if hospital at home services embed research opportunities into their structure, staff could also develop valuable research skills.

Some workshop participants suggested that a **competency framework** could be developed, to identify the skills required to run a hospital at home service. This framework could include virtual working opportunities, cross-skilling, and an interdisciplinary approach that promotes shared ownership of patient care. A competency framework could also enable services to understand what **training is required**, including for clinical leaders looking to establish, develop and manage services. This training could provide guidance on hospital at home components, risk management, and how to adapt services to socioeconomic and cultural contexts. Workshop participants also discussed whether there should be a **distinct 'qualification' for hospital at home,** or whether it should be integrated into undergraduate and postgraduate curriculums and wider training. Potentially, a diploma or other qualification in hospital at home could recognise and legitimise the development of relevant skillsets.

Additional research may be needed to explore the experiences of the hospital at home workforce, and how to support recruitment, retention and overcoming potential burdens. Measuring the long-term impact of hospital at home services on the workforce will also provide valuable insights into what skills are needed to deliver an effective and efficient hospital at home model.

Knowledge and research gaps

- What are the most effective hospital at home workforce models for collaboratively delivering hospital at home services at scale? How can we support the current and future health needs of local population groups?
- Which skills are required to deliver hospital at home services, and how can services take advantage of the opportunities of role blurring? What evidence is needed to develop a competency framework?
- What are the training needs for the different professionals working in a hospital at home, including leaders looking to set-up and run services? Would a qualification help recognise and legitimise the specific skills needed for hospital at home delivery?
- How can the hospital at home model be leveraged to provide additional career development opportunities and improve recruitment and retention?

Evaluation and metrics

Participants emphasised the need for **a core dataset, standardised metrics and an evaluation framework** to assess hospital at home services and ensure comparability and consistency across services. Participants felt that research had already demonstrated that hospital at home services were associated with improved outcomes for people living with frailty.[12] They suggested that the next step should be to routinely collect data across sites to support research into the factors associated with good outcomes and quality of care. Increased funding may be needed to undertake this research and conduct investigations into what makes a successful and effective hospital at home service. A core dataset could help establish consensus on national priorities for evaluation, and the creation of a set of metrics. **Standardised metrics** for hospital at home services could be used to track and evaluate performance, benchmarking, and to support continuous quality improvement.

> We need to develop systems across the four nations but also ones that have research and innovation baked in.
> **Professor Andrew Farmer, Professor of General Practice, University of Oxford**

Hospital at home outcomes must clearly capture impact on patients' quality-of-life, including recovery and mortality rates, length of stay and readmission rates, levels of physical deconditioning, and long-term access to social care services. This data should be gathered through patient and clinician reported outcome measures and carefully monitored and compared with physical hospital admission. Participants emphasised that these comparisons should also account for the difficulties of directly comparing hospital at home and in-hospital cohorts.

It will also be vital to directly and accurately capture the perspectives of **patients and carers** when evaluating hospital at home services. Evidence on carer burden, burnout, and satisfaction is vital to ensuring that hospital at home services have positive health outcomes and are sustainable. The perspectives of patients and carers should feed into the development of evaluation frameworks, to ensure that measurements of service quality and outcomes are relevant to their experiences.

Evaluation frameworks will need to consider whether hospital at home services effectively manage demand on secondary care services, while also considering whole-system outcomes. There is evidence that hospital at home services reduce deterioration in patients compared to the physical hospital, and may lead to long-term resource savings for social care services.[13]

[12] S. Shepperd et al. (2021) *Is Comprehensive Geriatric Assessment Admission Avoidance Hospital at Home an Alternative to Hospital Admission for Older Persons?: A Randomized Trial.* Annals of Internal Medicine. **174:7.**
[13] Ibid.

> We hardly ever discharge someone with a bigger care package. That often happens after a patient has a hospital stay.
> **Consultant Community Geriatrician**

A **longer-term and whole-system perspective** needs to be applied to financial planning and evaluation. Setting up new hospital at home services involves high upfront set-up costs, but longer-term savings are generated.[14] Quantifying these savings and matching them to sustainable funding streams can be challenging. A longitudinal view of funding and resource allocation is needed to ensure hospital at home services can grow and deliver lasting benefits. **Sustained, long-term investment** over shorter term contracts and annual funding bids will be required to support the sustainability of hospital at home services. Decision makers require comprehensive cost–benefit analyses to inform resource allocation for investment in hospital at home services. Cost-benefit assessments should consider how resource savings can take time, and the potential savings in other parts of the system. As well as incorporating long-term cost-benefit analyses, participants also proposed that **finance officers should be engaged in the development of evaluation metrics**. This would ensure that evaluations accurately provide the information needed for financial decision-making.

Knowledge and research gaps

- What should be included in the core dataset for evaluating hospital at home services?
- What standardised metrics to track and evaluate performance are needed? Who should be involved in the development of these metrics?
- What patient-centric outcome measures should be included? What impact does hospital at home care have on deconditioning? How can quality of life be assessed?
- How can the experience of patients and carers be accurately captured and incorporated into evaluation frameworks?
- What is the impact of hospital at home services on the whole system - what are the long-term benefits for both patients and the whole system?
- What are the optimal metrics for assessing the cost-effectiveness of hospital at home care? What is the optimal timeframe for evaluating cost-benefit?

[14] S. Singh et al. (2022) *Is comprehensive geriatric assessment hospital at home a cost-effective alternative to hospital admission for older people?* Age and Ageing **51:1.** Also see: https://clch.nhs.uk/about-us/news/hospital-home-evaluation-reveals-huge-cost-savings-better-outcomes-and-sky-high-patient-satisfaction

Building awareness and understanding

Hospital at home services are generally not well known by health and care professionals, patients, carers and the public. **Increasing awareness and understanding** of the hospital at home model could help build acceptance, trust, and support for the development of services at scale. Raising awareness among patients, carers and the public could also empower patients to ask whether hospital at home care is available and appropriate. Patients, carers and the public will also need clear communication on the requirements of hospital at home services, what this model of care delivery may look like, and the support available.

Accurate and positive messaging around hospital at home services was also felt to be important. Workshop participants felt that the expansion of hospital at home services should not be seen as driven by cost-savings and hospital bed shortages. Hospital at home services should instead be associated with positive health benefits and improved patient experience, and an understanding that these services can sometimes be more appropriate than physical hospital admission.

Participants also proposed that more could be done to **increase awareness of hospital at home among health and care professionals**. It is critical that general practitioners and other relevant health and care professionals are aware of what hospital at home services are, and of their availability. Clarity on hospital at home eligibility criteria will also be needed so that health and care professionals understand when referral is appropriate. Health and care professionals should also be aware of hospital at home outcomes, so that they are able to feel confident when discussing the service as an option with patients.

Knowledge and research gaps

- What is the current demand for hospital at home services? What do patients want out of hospital at home services and hospital-level care?
- How can awareness and understanding of hospital at home services be increased amongst patients, carers, the public, and health and care professionals?
- What are the assumptions being made about hospital at home services?
- What do health and care professionals need to know to feel confident referring patients to a hospital at home?

Annex 1: Attendee list

Co-Chairs

Professor Andrew Farmer, Professor of General Practice, University of Oxford
Professor Gillian Mead FRSE FMedSci, Professor of Stroke and Elderly Care Medicine, University of Edinburgh

Participants

Dr Firdaus Adenwalla, Consultant Geriatrician, Cardiff and Vale University Health Board
Alan Bellinger, Healthwatch Representative, Hertfordshire Hospital at Home Steering Board
Dr Katharine Bhatt, GP Clinical Lead, Torbay and South Devon Foundation Trust
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Dr John Dean, Clinical Vice President, Royal College of Physicians
Professor Jugdeep Dhesi, President, British Geriatrics Society
Dr Greg Edwards, Chief Medical Officer, Doccla
Professor Graham Ellis, Deputy Chief Medical Officer, Scottish Government
Professor Adam Gordon MBE, Professor of Care of Older People, Queen Mary University of London
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Dr Latana Munang, National Clinical Lead for Hospital at Home, Healthcare Improvement Scotland
Dr Shelagh O'Riordan, National Clinical Lead for Hospital at Home, NHS England and Consultant Community Geriatrician, Kent Community Health NHS Foundation Trust
Poonam Parmar, Carer and public contributor
Gordon Paterson, Director of Social Care, NHS Education for Scotland
Iain Ramsay, Professional Social Work Advisor, Scottish Government
Professor Sasha Sheppherd, Professor of Health Services Research, University of Oxford
Professor Susan Shenkin, Professor of Healthcare for Older People, Ageing and Health, University of Edinburgh
Suzanne Smith, Frailty Nurse Consultant, NHS Ayrshire and Arran
Dr Claire Steel, President, Hospital at Home Society and Consultant Geriatrician, NHS Lanarkshire

John Tippett, Patient Partner and Research Champion, University of Coventry and Warwickshire Healthcare Trust
Steve Wightman, General Manager – Health and Integrated Care, The Access Group
Lynne Wright, Expert by Experience

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