British Geriatrics Society
Improving healthcare for older people

Hospital At Home

BGS

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Hospital at Home for frailty: Current situation and future potential

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Foreword

This paper lays out the current situation, the evidence base and the potential future for Hospital at Home services - provided we get them right. Money is tight, and there is a risk these relatively new services will be cut, rather than further developed. The current pressure on emergency services and long waiting lists for elective care will never be resolved without a focus on community alternatives, especially for those living with frailty.

As a Consultant Geriatrician I have been running a Hospital at Home service for people living with frailty since the early days of COVID. Our Hospital at Home now sees around 3,500 patients each year with a service running 12 hours a day, seven days a week. Our service takes direct referrals from primary care and directly from ambulance paramedics and I see every day how effective this can be. Most of our patients stay at home for the entirety of their illness with the service making use of point of care testing, rapid investigations including point of care ultrasound, intravenous treatments, oxygen and much more. The service is consultant and GP led and has a blended staffing model across the full multidisciplinary team, including Advanced Clinical Practitioners and SAS doctors. The service is incredibly popular with patients who value the option to have hospital-level care at home. I can't tell you how often I am hugged by a patient or their family as I leave!

While there are risks associated with being at home, for older people there are also considerable risks associated with going to emergency departments and staying in hospital, sometimes for a very long time. Providing care through Hospital at Home is not about restricting access to hospital when there is a medical need for it and when the individual is likely to benefit. Hospital at Home is simply about identifying people who could receive hospital-level treatment in their home environment and offering that alternative to admission.

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1. Terminology

The NHS in England uses the term 'virtual ward' to describe an acute clinical service with the staff, equipment, technologies, medication and skills usually available in a hospital delivered to selected people in their usual place of residence, including care homes. Health systems in most of the rest of the UK and the world use the term 'Hospital at Home' to describe the same service.

The Royal College of Physicians, British Geriatrics Society and UK Hospital at Home Society issued a statement in 2024 advocating for 'Hospital at Home' as the preferred term.[1] We will therefore use the term 'Hospital at Home' throughout the paper. This is because the use of the word 'virtual' can imply or be understood by patients as care that is only provided virtually. All patients being treated through Hospital at Home should have access to both face-to-face visits, remote consultation via video or telephone and remote monitoring if needed.

2. What is Hospital at Home?

Hospital at Home is a safe and effective alternative to acute hospital bedded care for people who are sick enough to be in hospital. There are generally two models of Hospital at Home:

- Alternative to admission: where patients can be directly admitted to Hospital at Home and receive all their care at home.
- Early supported discharge: where patients who are admitted to hospital are discharged earlier than they otherwise would be, to complete their treatment at home under the care of a Hospital at Home team.

Patients being treated by a Hospital at Home team will need hospital-level assessment, investigations and interventions, all coordinated and supported by consultant level staff. Advance care planning is crucial for patients being treated by Hospital at Home to ensure the circumstances in which a patient might wish to be admitted to hospital are clear. Anecdotal feedback from clinicians suggests that it is easier to focus on what is important to the patient when these conversations are undertaken in the individual's home environment rather than in hospital.

Comprehensive proactive care for people living with frailty and multiple long-term conditions, soon to be formalised in England through Integrated Neighbourhood Teams, provides an opportunity to document what a patient would want if they were sick enough to require hospital-level care. Clinicians working in Hospital at Home have found that documenting these conversations in advance can significantly increase referrals to Hospital at Home services.

3. What is currently happening across the UK?

England

In England, there are currently around 35,000 patients being treated on a Hospital at Home service every month. The average length of stay varies depending on the type of ward but is around four days for a frailty ward and seven to ten for a respiratory and heart failure ward. The 10 Year Health Plan for the NHS in England commits to expanding Hospital at Home programmes over the next three years.

Case study: A patient's perspective

Joan* is 90 years old and lives alone with a carer coming in daily. One morning she was found by her carer more confused than usual and unable to get out of bed. The carer called 999 and paramedics attended. Joan was unwell with evidence of significant infection in her leg. She was offered the choice of hospital admission or to receive care through Hospital at Home.

Joan really wanted to stay at home, so a referral was made to the local Hospital at Home team and an advanced clinical practitioner visited within an hour. An assessment was made including history, examination and point of care testing. Joan's NEWS2 score was 7 and a diagnosis of delirium secondary to cellulitis and postural hypotension was made. Antibiotics were given, initially intravenously, and Joan's medication was adjusted. The team also supplemented her usual care package by increasing the frequency of carers visiting while she was unwell. She was reviewed by a consultant over a video call and advance care planning was completed and recorded.

Joan recovered after three days. She was back to her usual self, able to walk and be as independent as she wanted to be. Joan was delighted that she was able to receive the care she needed and recover in the comfort of her own home.

**This anonymised case study was gathered through interviews with the patient and staff.*

Scotland

There have been Hospital at Home services in Scotland for frailty as far back as 2011 and currently up to 578 patients on any one day are under the care of a Hospital at Home team. There is a lot of work being done by Healthcare Improvement Scotland, and Scottish Government support plans to expand Hospital at Home across all of Scotland. The majority of Heath Boards either have a Hospital at Home service or are looking to develop one. Currently frailty has been the main specialty relating to Hospital at Home services in Scotland but chronic obstructive pulmonary disease (COPD) and heart failure Hospital at Home services are being developed.

Northern Ireland

In Northern Ireland, Hospital at Home services are often called 'Acute Care at Home' and the first service was established in the Southern Trust in 2014. There are now Hospital at Home services for patients living with frailty in four of the five Health and Social Care Trusts, with plans for the remaining Trust to follow suit.

Wales

In Wales, Community Resource Teams work in each Health Board area providing care at home for people living with frailty.[2] Models vary across the country with some Teams providing acute level care at home while others are providing support for both short- and long-term care. There is however a lack of Welsh Government support and sustained funding for such services and many teams are under-resourced and under-appreciated.

3. What is the evidence base?

There is strong evidence for the clinical and cost-effectiveness of Hospital at Home in the UK. This section sets out evidence from large single provider sites, an Integrated Care Board (ICB) and an evaluation across the South East of England. Single site evaluations are the norm because of the heterogeneity of provision and complexity of multiple service evaluations. We have focused here on the impact of Hospital at Home on service delivery and the cost-effectiveness of these services.

A. Impact on service delivery

An evaluation of a Liverpool heart failure virtual ward compared healthcare utilisation within 30 days for patients receiving care on the virtual ward to a control group receiving inpatient care. The service supported a 36% absolute reduction in A&E activity and an 11% absolute reduction in NHS 111 activity for patients receiving virtual ward care.[3] Mortality and readmissions were significantly lower for those treated on the heart failure virtual ward compared to inpatients at one, three, six and twelve months. The virtual ward cohort also experienced a reduction in hospital-related adverse outcomes such as hospital-acquired infections, adverse drug reactions and falls.[4]

West Hertfordshire have conducted a large-scale evaluation of their virtual ward, accepted for publication in summer 2025, which has analysed data from 2,966 virtual ward admissions and compared patient activity and outcomes with a matched control group. Patients entering the virtual ward through early supported discharge have inpatient admissions which are, on average, 2.8 days shorter than comparable control groups.

An evaluation of 29 virtual ward pathways across South East England, encompassing 22,000 virtual ward admissions, found that virtual wards providing an alternative to admission are associated with a positive impact on avoidable non-elective hospital activity. On average, one non-elective admission 'avoided' was shown to be correlated with 2.5 virtual ward admissions, with some more mature virtual wards achieving a 1:1 association between the 'avoided' non-elective admissions and virtual ward activity. This evaluation shows that virtual wards are a clinically- and cost-effective alternative to hospital admission and they become more cost-effective as they mature as they are more able to identify patients who would otherwise be in hospital and gather the skills to manage them.[5]

Unpublished analysis has been undertaken comparing predicted non-elective admissions in East Kent to actual number of admissions since the introduction of the frailty Hospital at Home service. There has been a significant drop in the number of non-elective admissions against predicted which is similar to the number of patients admitted to Hospital at Home. Data demonstrates that for every 1.03 patients treated in the Hospital at Home, one non-elective admission to the acute hospital is avoided. This research was presented as an abstract at the World Hospital at Home Congress in 2025.[6]

In addition, a meta-analysis and systematic review published in Age and Ageing shows that people cared for in Hospital at Home may have improved cognitive and functional outcomes when compared to hospital admission.[7]

B. Cost-effectiveness

A National Institute of Health Research (NIHR) randomised control trial of admission avoidance Hospital at Home services with Comprehensive Geriatric Assessment (CGA) for patients over the age of 65 concluded that Hospital at Home is a cost-effective alternative to hospitalisation for selected older people. The evaluation looked at costs for six months following the patient receiving treatment and found a mean difference of -£2547 for Hospital at Home patients, compared to those receiving inpatient care, due to the higher cost of hospital admission, reduced length of stay for Hospital at Home patients, and reduced need for residential care.[8]

The National Institute for Health and Care Excellence (NICE) conducted an economic evidence review of virtual wards as alternatives to hospital care. The review found that most virtual wards are reported as cost-saving, although methodologies vary between studies and have some limitations.[9]

An evaluation of Cheshire and Merseyside heart failure virtual ward identified a substantial net cost benefit of £1,135 per patient per episode, with modelling indicating that with increased capacity and higher throughput, net cost benefit will grow. This cost benefit is driven by reduced hospital stays, fewer ED visits, and lower readmission rates.[10]

The West Hertfordshire virtual ward evaluation (currently unpublished but accepted for publication in summer 2025) has identified significant cost savings. The virtual ward costs around £118.49 per bed day, compared to £569 for inpatient care. As such, savings are estimated at £486 per early supported discharge patient and £3,652 per admission avoidance patient. Between December 2021 and May 2024, the virtual ward supported 2,966 patients, with estimated cost savings of £3.83million over 33 months.

It is important to note that Hospital at Home services have ongoing costs and some evidence suggests these can initially be more expensive than inpatient care. An evaluation of Wrightington, Wigan and Leigh virtual ward found that virtual wards were more expensive than inpatient care in the first year. However, as staff became used to new ways of working and capacity and occupancy increased, the cost of step-down virtual ward care decreased to become in line with inpatient care.[11] The study highlighted that virtual wards, as with any service, take time to established and become cost-effective with scale and maturity.

5. Patient perspective

Research published in June 2025 by the Strategy Unit, Midlands and Lancashire showed that for most patients, virtual wards provided a more comfortable and flexible alternative to hospital care. The ability to remain at home while receiving professional medical support was a significant advantage, particularly for those with previous negative hospital experiences. Patients also appreciated the reassurance provided by regular check-ins and remote monitoring devices, which helped them feel in control of their health and safe at home.[12]

The same research said carers reported that the home-based nature of virtual wards reduced the logistical and emotional strain of frequent hospital visits. Many expressed relief at the professional healthcare support provided at home, which helped improve their loved one's condition. However, many carers also said that that they felt their own needs were overlooked, particularly during admission. This is particularly important, given many carers for patients on virtual wards are spouses who will also be older and have their own health needs. A lack of communication and involvement in care decisions were their main concerns. Carers emphasised the importance of being seen as active partners in care delivery, with tailored support and regular updates to help them manage caring responsibilities.

It is important to note that people receiving care from a Hospital at Home team must be able to manage at home without support or have family or friends around who can help them to carry out daily activities such as preparing food, washing and dressing. Some Hospital at Home services have access to urgent personal care services that can support people who cannot manage on their own and do not have family to help them. If this support is not available through the Hospital at Home team or through the individual's own family or friends, Hospital at Home may not be suitable for this individual and they may need to be admitted to hospital.

6. The future of Hospital at Home

Safe, effective care for many people living with frailty and multiple long-term conditions can be provided at home with outcomes similar to or better than in hospital, and at lower cost in the long-term. Acute-level care in the community is already being delivered through Hospital at Home services, presenting an opportunity to expand this programme across the UK.

Any expansion of Hospital at Home services must be supported by adequate investment and staffing resource. Despite commitments from across the UK to scale up Hospital at Home services, the NHS is being asked to make significant reductions in running costs. In England alone, all ICBs have been asked to reduce running costs by 50% by the end of 2025. These financial constraints present a significant risk for the NHS to roll out Hospital at Home services nationally.

The NHS must look at the current provision of urgent care, including Hospital at Home services, and determine how this could be streamlined in a local context. For example, England's urgent community response (UCR), Hospital at Home, and ambulance teams are independent from each other, despite providing similar services to often the same patients. Through combining these teams to create a Single Point of Assessment (SPoA),[13] this could be an enabler for offering more patients alternatives to hospital admission. This model of care could also free up ambulance crews to attend emergencies where hospital admission is likely to be lifesaving.

For many in the NHS, Hospital at Home will be a new way of working and delivering care. This means that adequate training must be provided to providers and staff to ensure they are equipped to work with patients and deliver this model of care.

The British Geriatrics Society and the UK Hospital at Home Society call on Governments to:

- **Roll out Hospital at Home services across the UK with adequate investment and resource.**
- **Streamline community care delivery by combining urgent community response, ambulance and Hospital at Home services to create a Single Point of Assessment.**
- **Support systems to provide early supported discharge to a Hospital at Home service.**
- **Support providers and staff to adopt Hospital at Home as a new model of care.**

7. Conclusion

While Hospital at Home and virtual ward services will not single-handedly save the NHS from the difficulties facing it over the next 10 years, they can form part of the solution. People living with frailty are more at risk of infections and deconditioning when admitted to hospital. This population has also been proven to benefit from an alternative to hospital admission, provided at home. Hospital at Home services are an important part of healthcare provision. They are valued by patients and have been proven to be cost and clinically effective. They are not replacing hospital care across the board but, for appropriate patients, they provide a safe and clinically effective alternative.

The provision of a real alternative to hospital admission for appropriate patients, supported by shared decision-making to ensure that the individual's preferences are taken into consideration is an important component of patient-centred care and should be available to more people.

As the evidence builds, now is the time to encourage and support the staff running these services and to advocate on behalf of our patients. This requires investment in finances, supported by ongoing research and evaluation. Now is not the time to pull back from something that could be a crucial part of the Government's 'left shift' from hospital to community.

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