An Evaluation of Fife’s Integrated Community Assessment & Support Service (ICASS)

FINAL REPORT: EXECUTIVE SUMMARY

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Authorship & Acknowledgements

This is the final in a series of reports detailing the findings from the evaluation of Fife’s Integrated Community Assessment and Support Service (ICASS). It summaries findings from previous evaluation reports and reports on new findings from more recent evaluation work.

In terms of the evaluation tasks:

- Mhairi Gilmour was lead investigator for the evaluation and carried out the review of evidence on Hospital at Home models of care, the initial scoping interviews to establish what ICASS is, designed and piloted the electronic surveys of staff and undertook the subsequent analyses of the data and interpretation of the findings. MG also wrote the first and subsequent drafts of previous evaluation reports, with the exception of the report detailing patient and carer experiences of Hospital at Home which was written by Anala Gossai. MG wrote the first and subsequent draft of the final evaluation report.

- Dr Gordon McLaren chaired the ICASS Evaluation Group, provided detailed comments on the evaluation proposal and all subsequent evaluation reports and provided input and support to the work throughout. GMcL also interpreted the findings of the quantitative analysis of the impact of Hospital at Home on acute activity in Fife.

- Bryan Archibald undertook all quantitative analysis around Hospital at Home and contributed to discussions around the interpretation of the findings of the analysis of the impact of Hospital at Home on acute activity in Fife. Stephen Halcrow undertook this role until July 2013.

- Jan Carter undertook the analysis around financial sustainability of Hospital at Home in Fife.

- Dr Angela Wilkinson undertook the audit and case review of a cohort of Hospital at Home patients.

- Anala Gossai & Alice Wright carried out the work around patient and carer experiences of Hospital at Home in Dunfermline & West Fife.

- The ICASS Evaluation Group provided guidance and advice on the evaluation work throughout. This included commenting on the various evaluation reports, including this final report. Membership of the ICASS Evaluation Group (past and present) is as follows:

  Current members
  - Dr Gordon McLaren (Chair) Consultant in Public Health Medicine, NHS Fife
  - Jan Carter Finance Manager, NHS Fife
  - Claire Dobson Clinical Services Manager, K&L CHP, NHS Fife
  - Mhairi Gilmour Public Health Research & Development Officer, NHS Fife
  - Yvonne McCallion Reshaping Care for Older People Lead, NHS Fife
  - Brenda McFall Improvement Programmes Manager, NHS Fife
  - Liz Mitchell Fife Health & Social Care Partnership Coordinator
  - Dr Sue Pound Consultant Physician, Care of Elderly Medicine, NHS Fife
  - Dr Angela Wilkinson Lead Consultant, Hospital at Home, NHS Fife

  Past members
The author would like to thank all those groups and individuals who contributed to the evaluation work since it began in 2011.

In particular, thanks are given to the patients and carers who gave up their time to be interviewed on their experiences of Hospital at Home.

Thanks are also given to the various staff members who gave up their time to contribute to the evaluation work, in particular those who agreed to be interviewed in order to explain the development and implementation of the various aspects of ICASS; those who gave time to comment on draft versions of the electronic staff surveys and especially those who took time to participate in the electronic surveys to capture experiences of ICASS as a whole and subsequently of the Hospital at Home component of ICASS.

Finally, thanks are given to those who provided comments on previous versions of this final ICASS Evaluation Report.
1. Executive Summary

Introduction

A proportion of Change Fund monies from The Scottish Government’s Reshaping Care for Older People Programme have been used to develop and implement a new Integrated Community Assessment and Support Service (ICASS) in Fife since November 2011. Anticipated outcomes include:

- Providing an alternative to emergency hospital admissions for older people but will progress to also reduce the number of people requiring long term institutional care.
- A reduction in the length of stay will be facilitated for those who require hospital admission.
- Enable older people who are maintained at home to achieve and sustain their maximum potential.
- Providing care and support that is both financially and practically sustainable.

A programme of evaluation has been ongoing since December 2011 in order to determine whether Fife’s ICASS service is achieving these outcomes. Work has also been undertaken to understand the structure and processes of ICASS in order to establish what ICASS is, how it works and how it compares to previous ways of working.

A number of methods have been used in evaluating ICASS, a summary of which are provided below. NB: In order to place the various strands of evaluation work in the appropriate context in terms of timing of implementation of Hospital at Home, Figure 1 shows the timeline of evaluation activities in relation to the timeline for implementation of the Hospital at Home component of ICASS. This timeline should be taken into account when considering the findings from the various evaluation strands.

1) A review of key documentation along with a series of qualitative interviews with key ICASS stakeholders and attendance at relevant meetings in order to determine how ICASS is structured and how it compares to previous ways of working;

2) An electronic survey to find out what health care staff know and understand about ICASS and whether they feel it is meeting its original anticipated objectives;

3) A review of published and grey literature to identify and provide background knowledge to other Hospital at Home models of care;

4) A series of Case Studies of Hospital at Home patients, involving a review of case notes and qualitative interviews, in order to capture their experience of Hospital at Home and seek their views on the extent to which the objectives of the service are being met;

5) An electronic survey of medical staff to capture their experiences of Hospital at Home and their views on the extent to which the objectives of the service are being met;

6) An audit of a cohort of Hospital at Home cases to determine whether Hospital at Home provides care for patients other than those who would otherwise have been admitted to an acute hospital setting;
7) An analysis of quantitative data recorded at both local patient administration system and national SMR01 level, in order to:
   a. describe the Hospital at Home activity and
   b. assess the impact of Hospital at Home on acute hospital activity;

8) A financial evaluation to assess the financial sustainability of Hospital at Home.

This report is the final ICASS Evaluation Report and summarises the findings from previous reports as well as highlighting new areas of learning.

NB: Although the original evaluation protocol included ways in which Fife Council’s Homecare Reablement Service would be evaluated, these were superseded by a Review of the service, the results of which have not been formally announced.

As such, this report only identifies the learning from the Intermediate Care and Hospital at Home aspects of ICASS.
Figure 1: Timeframe of ICASS evaluation work in relation to timeframe of Hospital at Home implementation

- Scoping interviews/attendance at meetings
- DWF H@H service starts
- DWF H@H Case note review
- Initial review of literature
- DWF H@H Patient/Carer Interviews
- Initial Evaluation Findings published
- DWF H@H Patient/Carer Report published
- K&L H@H service starts
- Audit of DWF H@H patient cohort
- Quantitative analysis of impact of H@H
- GNEF H@H service starts
- Healthcare staff survey - perceptions of ICASS
- Report on healthcare staff perceptions of ICASS
- Medical staff survey - perceptions of H@H
- Update of literature review
- Final Evaluation Report
Key Findings

What is ICASS and how does it compare to previous ways of working?

ICASS is the overarching term used to describe a group of services whose aim is to improve the quality of care and outcomes for older people with the intention of allowing them to remain independent within their own homes or communities.

Documentation describes ICASS as comprising three key component parts available in the three geographical areas of Fife: Hospital at Home, Intermediate Care and Homecare Reablement (which was subsequently re-named Home Care following Fife Council’s review). Each locality also has a single point of access where all referrals for Hospital at Home and Intermediate Care Services are routed. Access to Home Care is through a single point of access Contact Centre provided by Fife Council.

In addition to the core ICASS services listed above, each area has local variations such as Community Hospital Inpatient Beds, Intermediate Care Housing and Integrated Services for Dementia & Frailty.

ICASS is different to previous ways of working primarily through:

- Co-location of teams
- Implementing new ways of working
- Implementing new models of care such as Hospital at Home

Examples of new ways of working include the ICASS Assessment Model which identifies and assess older people who, with the right support and rehabilitation, could be discharged at the earliest opportunity and the Discharge Hub at VHK to improve discharge planning and take a proactive approach to complex cases.

As ICASS constitutes new ways of working in relation to caring for older people, one strand of evaluation focused on gathering NHS staff perceptions of ICASS through an electronic survey. **NB: This work took place between July and September 2013 and feedback provided by respondents reflects experiences at that point in time.**

Health staff knowledge, understanding and perceptions of ICASS

Of the 214 staff members who participated in the electronic survey the majority were Nursing or Allied Health Professional staff. The vast majority of respondents were aware of ICASS having either referred to or worked within the service.

The majority of respondents felt ICASS had a positive impact on patients, benefited carers and was meeting the majority of its originally anticipated outcomes although only 33% of respondents agreed that ICASS helps reduce the number of people requiring long term care.

In terms of understanding ICASS, only 25% reported ICASS as including Hospital at Home, Intermediate Care and Home Care whilst other respondents reported District Nursing Services or Fife Falls Response Service being part of ICASS. Some respondents commented on the confusion around roles and responsibilities of different components of ICASS.
The majority of respondents felt ICASS had changed the way health care staff work together although this was not always in a positive way with referral processes and impact on existing services being highlighted as areas of concern.

Only 5% of respondents to the survey were medical staff, leaving a gap in understanding how medical staff, GPs in particular, perceive ICASS. In addition, Hospital at Home is a new model of care implemented as part of ICASS, representing a significant investment in terms of both money and new ways of working. Taking this into account, subsequent evaluation work focused more specifically on the Hospital at Home aspect of ICASS.

**Hospital at Home in Fife**

The Hospital at Home model of care in Fife is Consultant-led with specialist Nurse Practitioners assessing and admitting, with medical support, patients to the Hospital at Home "Virtual Ward". Referrals are received for Alternative to Admission to an acute setting or Step Down Care following a time in hospital.

Conditions accepted by Fife’s Hospital at Home are varied with only a few exclusions (cardiac event, stroke, lower leg fracture, GI bleed, head injury or acute abdominal pain). Whilst the service is aimed primarily at people aged 75 and over, people younger than 75 who are deemed "frail" can be accepted by the service.

Three Hospital at Home teams exist, covering Dunfermline & West Fife, Kirkcaldy & Levenmouth and Glenrothes & North East Fife with the service being implemented incrementally across the three areas.

A total of 1317 patients of all ages have been accepted to the service between April 2012 and end of March 2014. Of these, 1015 (77%) of accepted referrals were for Alternative to Admission and 302 (23%) were for Step Down Care.

Patients accepted to the service were aged between 23 and 102 years with the average age being 79 and the median age being 81. 972 (72.5%) patients accepted to Hospital at Home were aged 75 or over. It should be emphasised that only this activity will impact on acute hospital activity for people aged 75 and over.

Patients stay in the service for an average of 9 days and the majority of conditions cared for are respiratory conditions e.g. asthma, COPD, influenza, pneumonia or problems relating to the circulatory, genitourinary or digestive systems.

**Patients and carer experiences of Hospital at Home**

A series of case studies of a group of Hospital at Home patients and carers were undertaken in order to capture their experiences and establish how the service had met their needs. The work took place in Dunfermline & West Fife where Hospital at Home was implemented first and interviews took place between May and July 2012 - approximately three months after the service started and the feedback provided by respondents reflects their experiences at that point in time.

A total of five patients and three carers took part in semi-structured, qualitative interviews and key themes were identified.

Patients:

- Valued the opportunity to be in familiar surroundings when ill and believed the home environment provided a better setting for returning back to good health. Being able to maintain daily routines and having more support and social
contact with their family and friends were reported as being especially important.

- Reported feeling safe being cared for at home - having Hospital at Home nurses explain what was happening and being available when needed contributed to this.

- Repeatedly spoke of their apprehension for being admitted to hospital, especially given the recent centralisation of acute services in Fife which meant visitors would have to travel further. The negative media coverage around the new wing at VHK contributed to this apprehension. However, those patients who had been admitted to VHK praised the service they received.

- Had no suggestions on how the Hospital at Home service could be improved.

**Carers:**

- Reported they appreciated their family member receiving hospital level services at home, although this depended on how severe the disease was.

- Reported that being able to maintain their own daily routine was important, especially those with grandchildren.

- Echoed the feelings of the patients in terms of apprehension of admission to hospital, for the same reasons – having to travel further to visit and negative media coverage around the new wing of VHK.

- Only one carer suggested communication could be improved between carers, GP’s and the Hospital at Home service.

In interpreting these findings, it is acknowledged that this work took place in the very early stages of Hospital at Home being implemented in Dunfermline & West Fife and, as with all new services, the Hospital at Home service was still refining processes in identifying patients who would benefit most from such a service.

It is also acknowledged that it is possible that the patients who contributed to this work might be less dependent and less frail than the subsequent patients accepted by Hospital at Home as the service has grown in confidence. It is therefore possible that this cohort of Hospital at Home patients were not all typical of the Hospital at Home target group.

**Medical staff perceptions of Hospital at Home**

Given that Hospital at Home represents a significant investment in terms of both Change Fund monies and also of new ways of working, it was felt to be beneficial to capture the views of medical staff potentially affected by the service being implemented. This was done through an electronic survey of all GPs in Fife and medical staff in NHS Fife’s Operating Division, focusing on knowledge and experience of Hospital at Home and its perceived impact on patients, carers, staff and services.

A total of 49 medical staff took part in the electronic survey and responses were analysed on a Fife-wide level. *NB: This work took place in February 2014 and responses reflect the experiences of respondents at that point in time.*

The majority of respondents were GPs and all were aware of Hospital at Home with the majority having referred to the service at least once. Respondents covered all three areas of Fife. The remaining respondents were hospital based doctors.
The majority of respondents reported positive experiences of contacting the single point of access to make referrals and felt they (medical staff) were aware of the conditions Hospital at Home could support at home. However, a substantial number of comments related to not receiving enough information on the outcome of referrals or feedback on why referrals were not accepted, especially in areas where the service is still in its infancy.

Respondents reported that information provided on discharge from Hospital at Home was poor in terms of level of detail and format. GPs reported having to follow up with Hospital at Home staff to clarify information in the discharge documentation, thus increasing workload.

Hospital at Home was felt to reduce the need for hospital admissions by the vast majority of respondents although the impact on the length of hospital stay, reducing delayed discharges and especially helping to reduce the number of people requiring long term care was less clear.

Just under half of respondents felt Hospital at Home had adversely impacted on their workload either by them having to query discharge information or, in the case of hospital based staff, answering queries from Hospital at Home staff out of hours.

The vast majority of respondents felt that patients and carers had benefited from Hospital at Home with the service reported to help older people be maintained at home, improve their care experience and enable older people to maintain their independence. Some respondents noted that by admitting a person to hospital, carers might get some reprieve from their caring role.

One respondent queried whether Hospital at Home was caring for patients who might previously have been cared for at home under primary care i.e. does Hospital at Home deal with patients over and above those who would have previously been admitted to hospital? To assess whether this was the case, the findings from a previous audit of a cohort of Hospital at Home referrals were considered.

**Does Hospital at Home care for patients other than those who would have otherwise been admitted to a hospital setting?**

An audit of 52 consecutive referrals for Alternative to Admission was carried out by the Hospital at Home Consultant in order to identify whether any of these patients could have been cared for by other existing services.

*NB: The audit took place in July 2013 and findings reflect services at this point in time.*

Of the 52 referrals, a total of ten patients were aged under 75. Of these, nine would have been admitted to hospital prior to Hospital at Home being in place, one would have been directed to an urgent Outpatient Department or Assessment at VHK.

Of the remaining referrals included in the audit i.e. those aged 75 or over, ALL would have been admitted to an acute hospital setting prior to Hospital at Home being in place. This was due either to no other appropriate service being in place or to existing services, *at that point in time*, not having the appropriate skill mix/level of training relating to, for example, administering subcutaneous or intravenous therapy to enable that patient to be cared for at home.

Of interest is the anecdotal evidence from two Hospital at Home Consultants which suggests that, even though the patients included in this audit would all have been admitted to an acute hospital had Hospital at Home not been in place, there is still a
proportion of Hospital at Home patients who could be cared for by other existing services.

In order to quantify this proportion, it would be helpful to repeat the audit work.

**Impact of Hospital at Home on acute hospital activity**

In order to estimate the impact of the service on acute activity in Fife, for people aged 75 and over, an analysis of quantitative data was carried out using two methods: Trend Analysis and Point in Time Analysis.

The Trend Analysis followed on from a previous analysis of trends in emergency activity rates for people aged 75 and over and compared acute activity in Dunfermline & West Fife where Hospital at Home was implemented first and K&L where Hospital at Home had not been implemented at that point. This methodology was based on the assumption that trends in emergency activity in these two areas were likely to have mirrored each other and thus expected acute activity (based on K&L data) could be compared to actual activity (based on DWF and Hospital at Home data).

Results from this analysis showed that the trends in the different areas do not mirror each other after 2009/10, with K&L admissions increasing between 2009/10 and 2012/13 whilst DWF admissions remained relatively static.

Based on this analysis results, it was felt the trend analysis method was no longer appropriate to use to estimate the impact of Hospital at Home on acute activity for people aged 75 and over.

The Point in Time analysis calculated the proportion of acute activity attributable to Hospital at Home at a particular point in time. August 2013 was chosen as the point in time as this was the most up to date validated data available.

The proportion of acute activity attributable to Hospital at Home was calculated as the difference in emergency admission and emergency bed day rates per 1,000 people aged 75 and over including and excluding Hospital at Home activity. The analysis focused on the Dunfermline & West Fife area as the Hospital at Home service had been implemented first there and good quality, validated data was not available for the other areas.

NB: Whilst referrals for both Alternative to Admission and Step Down Care contribute to emergency bed day activity, only referrals to Hospital at Home for Alternative to Admission contribute to emergency admission activity.

The analysis showed that in Dunfermline & West Fife:

- Acute activity attributable to Hospital at Home reached ~8% for emergency admissions and ~7.5% for emergency bed days in February 2013 for people aged 75 and over and remained at approximately these levels until August 2013.

- In August 2013, 8.5% of emergency admissions and 8% of emergency bed days for people aged 75 and over were attributable to Hospital at Home.

However, given that anecdotal evidence from the two Hospital at Home Consultants suggest there is a proportion of activity that could be dealt with by existing services; these figures are likely to be an overestimate. Repeating the audit work would assist in more accurately quantifying the acute activity truly avoided by Hospital at Home.
Sustainability of Hospital at Home

In evaluating the financial sustainability of Hospital at Home, the cost per bed day for a patient being cared for in Hospital at Home as opposed to an acute hospital setting was compared. This was calculated based on the cost of running Hospital at Home and the number of people being cared for by the services.

As of March 2014, the service at a Fife level was working at approximately 70% occupancy levels (based on original calculations that the service could care for 60 patients per day).

At a continued occupancy level of 70%, Hospital at Home at a Fife level would deliver 15,330 bed days per annum - equivalent to 1916 patients, using an average length of stay of 8 days - equivalent to an average cost per bed day of £170 in Hospital at Home compared to an average cost per acute bed day of £267.

In these circumstances, Hospital at Home would be £97 (36%) less expensive per bed day than if the patient was being cared for in an acute setting.

Whilst the above analysis recognises the difference in direct costs, it does not take into account the significant overheads associated with caring for a person in a bed in a physical hospital setting. The non direct costs associated with caring for a person in VHK would add 47% to the direct costs mentioned above.

Therefore, investing in providing hospital level care in the community would negate the need to increase Hospital Wards, saving both the difference in direct costs and the additional overheads associated with caring for a person in a hospital ward.

In terms of whether Hospital at Home is sustainable from a practical point of view, staff opinions gathered via the staff surveys were mixed with concerns raised around recruiting lower band staff without enough width and depth of experience to effectively provide hospital level care at home.

The evidence base for Hospital at Home

A review of published and grey literature was undertaken to provide background knowledge to the different existing models of Hospital at Home and their relevance to the Fife scenario. The key findings were as follows:

- The Hospital at Home model in Fife is quite unique. Other models of Hospital at Home exist but differ in a variety of ways:
  - Many are targeted at specific conditions such as chronic obstructive pulmonary disease or chronic heart failure
  - Many, such as the Croydon model, identify patients “at risk” of hospital admission and focus community based services on providing care via a “Virtual” or “Community Ward” to prevent these people subsequently being admitted to hospital. Other models identified patients currently in a hospital setting who can continue to receive hospital level care but in their own home.
  - Many include Allied Health Professional and/or Social Care staff

- Evidence on other models of Hospital at Home suggests that Hospital at Home models of care improve patient experience. Other outcomes such as readmission
or mortality rates differed according to the model of care and the condition being cared for.

- A paper published in 2009 by Young commented on promoting Hospital at Home services on the basis they may reduce health-care costs by reducing the demand for acute hospital care. The author urged "caution" stating:
  
  "The proportion of older people for whom Hospital at Home is suitable might be too small for genuine economies to be realized"

  "The service may simply respond to a proportion of patients with hitherto unmet needs"

- Availability of care at home, either by informal carers or by home care services, is important to the success of a Hospital at Home episode of care and also impacts on analyses of cost of Hospital at Home models of care

- The model of Hospital at Home most similar to Fife’s reported in the published literature was the ASSET model in Lanarkshire, although only one conference abstract was identified. This abstract reported on the 30 day outcomes of the first 1000 patients finding that, for those maintained at home, 18.7% had been re-admitted once or more and 8.5% of patients had died within 30 days of being discharged.

- In terms of “grey literature”, the majority related to the Scottish Government’s Press Release in 2013 stating that models of Hospital at Home similar to the Lanarkshire (ASSET) model detailed above were being rolled out across Scotland with key results from a clinical audit quoted.

- No updated information relating to the Torfaen Hospital at Home model of care was identified although further reports on Hospital at Home models in other areas of the UK were found but the information provided was very brief.

Conclusions
In interpreting the findings from the various strands of evaluation, the following conclusions were drawn:

- The Intermediate Care and Hospital at Home components of ICASS have introduced new ways of working which have helped achieve, to an extent, ICASS’s overall aim of allowing older people to remain independent within their own homes or communities.

- This has been achieved by providing an Alternative to Admission to hospital in the case of Hospital at Home and both Intermediate Care and Hospital at Home providing Step Down Care thus helping reduce the length of time an older person remains in hospital. It is acknowledged that ICASS is one part of a larger body of work in changing the way older people are cared for in Fife.

- In the case of Hospital at Home, patients and carers like the service and it accounted for ~8% of acute activity for people aged 75 and over in Fife in August 2013. However, this figure is likely to be an overestimate, based on the anecdotal evidence of two Hospital at Home Consultants.

- It should also be noted that, in accepting referrals for people aged under 75, Hospital at Home is not achieving its maximum potential in terms of the impact
on acute hospital activity for this age group and also in terms of cost-effectiveness.

- It is too early to estimate the longer term impacts of Hospital at Home. One of the originally anticipated outcomes of the service was to reduce the number of people requiring long term institutional care and only longer term monitoring of care home admission rates or re-admissions to hospital will help quantify whether this has actually happened.

**Recommendations**

In considering the findings from the various strands of evaluation work, a series of recommendations are presented.

*NB: It is acknowledged that the recommendations below are based on the findings of evaluation work undertaken at a specific point in time and that these may already be taken into account in work currently underway around ICASS.*

**Recommendation 1**

To facilitate better understanding of ICASS and its component parts by service providers, both in health and social care, and by service users, all ICASS staff should consistently use the same terminology:

- ICASS is the acronym used to describe a group of services, the key components of which are Hospital at Home, Intermediate Care and Home Care. Interchanging the term ICASS with Intermediate Care has the potential to confuse both service providers and service users.

**Recommendation 2**

To continue improving the Intermediate Care and Hospital at Home components of ICASS, work to resolve any outstanding perceived issues or barriers to good working partnerships identified through the staff surveys should be considered for inclusion as part of the Community Flow Improvement Group work plan.

**Recommendation 3**

At a strategic level, the importance of including Home Care Reablement as a component part of ICASS is acknowledged. Evidence on the impact of this service on people aged 75 and over in Fife should continue to be sought.

**Recommendation 4**

To impact most on reducing the rate of emergency hospital activity for the oldest, frailest members of our community, the acceptance criteria for Hospital at Home should be applied more rigorously, especially with regard to age and level of need. This will also help NHS Fife in achieving the vision of Reshaping Care for Older People which relates to people aged 75 and over.

**Recommendation 5**

To maximise potential cost savings associated with the Hospital at Home model, consideration should be given to whether the original capacity levels for the service are still valid. Applying the acceptance criteria regarding age more rigorously would also assist with this.
Recommendation 6
To assist in identifying those frail patients who would benefit most from the Hospital at Home service, Hospital at Home should consider ways of quantifying the levels of need of potential patients, at the start and finish of an episode of care. This would and also assist in quantifying any changes as a result of receiving the service.

Recommendation 7
To ensure Hospital at Home accepts referrals for the most appropriate patients, and does not deal with patients that could/would receive other services, Hospital at Home clinicians should consider undertaking a second audit of a cohort of Hospital at Home cases. This would also help accurately assess the percentage of emergency hospital activity truly avoided by Hospital at Home.

Recommendation 8
To identify any longer term changes that could be, at least in part, attributable to Hospital at Home, rates of emergency hospital admissions and readmissions for people aged 75 and over should continue to be monitored.

Recommendation 9
To identify any longer terms changes in the number of people requiring long term institutional care that could, at least in part, be attributed to Hospital at Home or Intermediate Care, longer term trends of institutional care should be monitored.

Recommendation 10
To improve partnership working between services, Hospital at Home should consider how best to provide feedback on both outcome and appropriateness of referrals to referrers, especially in areas where the service is still in its infancy. Hospital at Home should also consider how best to provide information on discharge from the service.

Recommendation 11
To facilitate a successful outcome of an episode of Hospital at Home care, the service should continue to consider the circumstances of both patients and their carers.

Recommendation 12
To facilitate improved service user satisfaction, Hospital at Home and Intermediate Care services should consider was of collecting feedback from service users, both patients and carers on an ongoing basis.