Older People and Unpaid Carers' Experiences of 'Hospital-at-Home'

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Abstract

Hospital at Home (HaH) is designed to provide acute care for unwell individuals within the comfort of their homes, be it their own home or a care home, mirroring the level of care found in hospital settings. This model is specifically tailored for older people living with frailty, who may be adversely affected by traditional hospital stays. It aims to conduct assessments and interventions at home by healthcare professionals equipped with the necessary training, diagnostic and treatment tools. This approach seeks to avert unnecessary transfers to emergency departments by facilitating early access to senior medical intervention and evaluation, especially for those who may later require enhanced care. Such a strategy is expected to enhance outcomes for those accessing acute care, enrich patient experiences, and alleviate crowding in emergency departments.

This initiative is part of a broader research programme deeply influenced by individuals with firsthand experience of the system. It incorporates a panel comprising individuals who have received adult social care and their supporters, guiding the methodology for public and patient engagement. The goal of the study was to learn about the perspectives of older people who receive HaH, their unpaid carers who are involved in their relatives' HaH, and health and social care workers who provide HaH, as well as the challenges and opportunities for effective collaboration between social care and health care workers.

The study involved 43 participants in a qualitative exploration using a phenomenological framework, encompassing older people, unpaid carers, and health and social care staff. Purposeful sampling was used to identify and select information-rich cases related to the phenomenon of interest: older people, their unpaid carers accessing HaH, and the professionals delivering it. Each participant participated in a semi-structured interview lasting up to 60 minutes, allowing them to respond in their own words. This contrasts with previous HaH studies in the United Kingdom (UK) that rely on fixed yes or no responses in surveys or questionnaires. Inductive thematic analysis was used to analyse the data.

The findings may create learning opportunities for an international audience, for example, concerning effective interprofessional working and person-centred care in HaH. Key discussion areas include the importance of the carer role in HaH, the influence of environment and place on care experiences, and the need for better integration across statutory, private, and third-sector services. Many of the themes discussed relate to different dimensions of quality of care, particularly how it is perceived and delivered. Notably, communication emerged as a critical concern, especially regarding the transition from HaH to general practitioner (GP) care, an area requiring more effective systems and protocols.

This study also explored both expected and unexpected results and their significance for shaping future health and social care policy and practice. The discussion connects research findings to existing literature while identifying study limitations and suggesting additional research questions that address the complex and evolving nature of HaH. Future directions include exploring new avenues for improving person-centred delivery, carer support, integrated care pathways, and communication strategies in community-based services.

The following steps will be to give feedback to the local site in England where the research has taken place and to the Applied Research Collaboration (ARC) that has funded the study. This will highlight ideas and improvements for the future of community-based health and social care for older people and their carers.

Key Words

‘HaH’ – The term ‘HaH’ relates to Hospital at Home.

‘OLDER PERSON’ – It can be generally stated that anyone who is over 65 years of age is considered an older person, as defined by NHS England. It is also important to note that all the individuals who participated in the study were over the age of 65, unwell, and had various health conditions impacting their daily lives at the time of the study.

‘UNPAID CARER’ – The term ‘unpaid carer’ refers to someone who supports a family member who would not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems. All the care they give is unpaid.

‘PAID CARE WORKER’ – The term ‘paid care worker’ refers to a care worker in a community setting, i.e., home care service or a care worker working in a residential home. They are paid to assist older people with personal care tasks such as showering and dressing, meal preparation, medication management, and administration.

‘HEALTH PROFESSIONAL’ – The term ‘health professional’ is someone who provides HaH medical interventions to an older person in their own homes. This could be a doctor, an advanced nurse practitioner or a healthcare assistant.

‘SOCIAL CARE PROFESSIONAL’ – The term ‘social care professional’ is someone who provides support in a professional capacity to the older person or their carer. This could be a social worker or a home care manager.

‘INTERVENTION’ – The term ‘intervention’ relates to a professional, care worker, or the older person’s carer intervening at a point in time. For example, a nurse needs to intervene and take a set of observations during a HaH intervention.

‘EXPERIENCE’ – The term ‘experience’ relates to something that has happened or is due to happen. For example, an older person has received HaH treatment, and they have been asked about their experience after it.

Order of Information in the Thesis

This thesis consists of eight chapters. The first is the introduction, the second is the literature review, the third is the methodology, the fourth, fifth and sixth are the findings, the seventh is the discussion, and the eighth is the conclusion. Each section is broken down below, and there is a brief description of what is included within each chapter.

Introduction – Chapter One includes the background to the study, including the ageing population, rising health and social care pressures, and limitations in existing HaH research. It outlines the case for change, the impact of the COVID-19 pandemic on HaH, and the rationale for this study. The chapter also discusses the researcher's positionality, research aims, objectives and questions, theoretical framework, expected contributions to knowledge, and the potential benefits of the research.

Literature review – Chapter Two is structured around key themes. It begins by examining health conditions associated with ageing, alongside relevant policy, reform, and legislation. It then presents a discussion of existing HaH research, with a focus on its relevance, limitations, and gaps. These gaps are organised thematically around three areas central to this study: patient and carer evaluation, effectiveness and patient outcomes (HaH versus inpatient care), and the cost of HaH.

Methodology – Chapter Three includes the outlines of the method I chose. There is a section on how I reached these decisions regarding the methodology. It also includes what, when, where, how, and why I did what I did to get my results.

Findings – Chapters Four, Five and Six outline what I found from the interviews with older people, unpaid carers and health and social care professionals. It contains facts about my research and a brief comment on the significance of key results, with some generalised comments about results being made within the discussion section.

Discussion – Chapter Seven includes comments on my results, an explanation of what my results mean, an interpretation of my results in a broader context, an indication of which results were expected or unexpected and reasons for the surprising results. There is a discussion on the ‘impact’ of informing future health and social care policies. There is a link to previous HaH research and studies. There is also a discussion about the limitations of my research and any questions that remain unanswered. Moreover, there is a discussion about future research relating to HaH.

Conclusion – Chapter Eight discusses whether I achieved my aims and objectives. It also reveals the most significant results and limitations while suggesting further research.

Chapter One – Introduction

In the introduction chapter, I explore the broader theme around the concept of HaH why it is essential, and how it is paving the way for future streamlined medical treatment away from the acute hospital. I draw on relevant research and studies from national and international sources and key authors who have written about HaH. Additionally, I provide an overview of the HaH model. I explain my research interest and reasons for undertaking this PhD. Moreover, I describe my position as a PhD student. Finally, the research questions and objectives are clearly stated to give the reader an idea of what I aimed to achieve and answer.

Background of the Problem

According to the World Health Organization (WHO), the global population is experiencing increased longevity. From 2015 to 2050, the percentage of the worldwide population aged over 60 is expected to rise from 12% to 22%. This rapid acceleration in the ageing population is unprecedented in recent history (WHO, 2020). Consequently, nations worldwide face significant challenges in adapting their health and social care services to accommodate this demographic shift (WHO, 2020). During the pandemic, health and social care systems in the UK and globally faced severe hospital bed shortages. Acute Hospital Trusts up and down the country were under increased pressure with overwhelming admissions and growing A&E waiting times, contributing to higher mortality and morbidity and further reducing available acute beds (The King's Fund, 2024). In February 2024, 177,805 patients in England waited 12 hours or more to be seen in accident and emergency departments (Gregory, 2022). Older people are awaiting social care assessments in hospitals and communities. According to the King's Fund (2023), in 2020/21, there were 1.92 million new requests for support, which increased to 1.98 million in 2021/22.

Among these, the number of new requests from working-age adults saw a 5.8% increase, rising from 578,000 to 612,000. Meanwhile, requests from people aged 65 and over increased by 2.2%, from 1.34 million to 1.37 million during the same period (The King's Fund, 2023). Even before the COVID-19 pandemic, older people were frequently re-admitted to hospital over short periods due to falls, infections, or illness (NIHR, 2021). Hospitals and communities face strained resources, staff shortages, and budget cuts. Furthermore, hospitalisation isn’t always ideal for older people. This contributes to a care crisis. Skills for Care released its yearly overview regarding the condition of the adult social care workforce in England, revealing a critical situation (Allen et al., 2023). Workforce shortages remain above pre-pandemic levels, despite a decrease in the job vacancy rate from a record high of 10.6% (2021/22) to 9.9% (2022/23) (Allen et al., 2023). Older people admitted to the hospital frequently face adverse outcomes. These include health-acquired infections, increased delirium, and repeat admissions for acute issues such as falls or infections.

Health-related conditions and our ageing population

According to the World Health Organization (WHO), global life expectancy is rising, and between 2015 and 2050, the proportion of the population aged over 60 will nearly double from 12% to 22%. This demographic shift is occurring more rapidly than in previous decades, presenting significant challenges for health and social care systems worldwide. Advances in medical treatments, drug therapies, and specialist equipment mean that most people, even in many developing countries, can now expect to live into their sixties and beyond.

By 2020, for the first time, people aged 60 and over outnumbered children under five, signalling a broader trend towards increased longevity. This shift presents opportunities for older people to remain active and independent for longer. For example, life expectancy for individuals diagnosed with HIV increased from 59 years (2000 - 2003) to over 80 years today, largely due to medical advances. Similar progress has been made in managing chronic conditions such as COPD, cancer, and heart disease through therapies like oxygen treatment and community respiratory care. However, despite increased life expectancy, there is limited evidence that older people are experiencing better health outcomes than previous generations. Ageing remains closely associated with disability, frailty, and social isolation, emphasising the importance of effective, home-based care models that support independence and quality of life. As global ageing accelerates, health and social care systems must adapt to deliver person-centred services that address these increasingly complex needs.

This challenge was further compounded by the COVID-19 pandemic, which significantly disrupted both health and statutory social care services (Jeffery et al., 2020; BMA, 2021; CQC, 2021; GAVI, 2021; Hiam et al., 2023). Social care systems experienced increased delays, reduced access to assessments, and mounting pressure on staff (Shoosmiths, 2020; GAVI, 2021). Similarly, urgent medical services faced prolonged waiting times, delayed discharges, and increased mortality due to disrupted care pathways (BMA, 2021; CQC, 2021). These disruptions disproportionately affected older people, both physically and emotionally, underscoring the urgent need for better preparedness and targeted protections for this vulnerable group.

While the COVID-19 emergency was unprecedented, its consequences revealed long-standing structural weaknesses. A case study by Age UK (2023) highlighted that many older people admitted to the hospital lacked family members to advocate for or support them during their care. There is also evidence of fragmented care pathways for older people living alone, particularly those with dementia, who may lack support between care visits or struggle to attend health appointments unaided. In such cases, carers, when present, often escalate concerns to general practitioners or emergency services, leading to unplanned hospital admissions. These gaps underscore the need for more coordinated, community-based support to prevent avoidable admissions and ensure older people can safely remain at home (Age UK, 2023).

Integrated care in HaH could help to overcome such issues. Based on the literature, this could be where we consider the option of people remaining at home, receiving medical treatment in their home environments: a place they know well and feel safe. This highlights the value of integrating HaH services that are closely aligned with local authority social care services as well as primary and secondary services. For example, in cases where older people live alone without support from family when receiving HaH, such integration may help professionals to identify additional concerns, such as loneliness, social isolation or cognitive impairments. A collaborative working relationship with social care may also help identify the need as early as possible, rather than older people needing to be re-admitted to hospital when concerns are raised at home. Evidence suggests that the more an older person is admitted to the hospital, the more it affects their memory and cognition (Alzheimer's UK, 2017). Not only this, but older people are also more susceptible to acquiring health-related infections, such as urinary tract infections – many are sent home after treatment with short-term services that end with no formal follow-up because the older person has been 're-abled' and is 'back to baseline'. The older person's long-term emotional and psychological well-being needs may be unmet. There is also the concern about older people's reluctance to return to the hospital if required because of poor past experiences. Early identification of health needs, together with timely access to hospital-based care, where necessary, may help in addressing the issues identified. This consideration should form a key topic of ongoing evaluation and service planning in HaH.

Pressure on the NHS and Social Care

The human population is ageing in a way never seen before; meeting the needs of older people living with multiple health conditions is a significant challenge facing the NHS and Social Care in England (Stafford, 2018). This adds substantial financial pressures to the NHS (Lafond et al., 2016; Murray et al., 2016). Older hospitalised patients are often deprived of sleep. During 2006/07, 1 in 10 older people admitted to acute hospitals as emergency admissions had 5+ health conditions – applying pressure to the ambulance services (Health Foundation, 2024). Physical and mental health issues, chronic pain, sensory impairment, and substance misuse are examples of such conditions. In 2015/16, one-third of older people experienced these symptoms (Steventon et al., 2018). The data shows high rates of multi-morbidity among older hospitalised patients (Stafford, 2018). Research shows a correlation between socioeconomic status and health in older people. Those from poorer backgrounds experience illness and health conditions much earlier in life (Stafford, 2016).

Evidence from the National Institute for Health and Care Excellence (NICE) (2018) highlights the issue of prescribed medications. NICE (2018) reports that, on average, older people with four or more health conditions taking part in the study (out of 300,000) receive 20.6 daily medications or other therapies from their GP. Older people may benefit from independently managing their health via oral medication. However, taking multiple medications increases the risk of adverse effects and drug interactions, according to NICE (2018). Older people managing multiple medications, including for mental health, face increased risks of adverse drug interactions (NICE, 2018). This increases the likelihood of hospital admission if, for example, the medication causes drowsiness or proves ineffective.

In social care, millions of older people and unpaid carers continue to struggle to access the support they need (Butler, 2025). While recent policies are important, they have not significantly reduced waiting times or eased pressure on carers, many of whom manage alone (Age UK, 2022). This highlights the need for more integrated and streamlined health and social care services, such as holistic HaH models. The financial burden of social care also remains a pressing concern. Strict eligibility criteria and increasing financial thresholds in England have led to a rise in self-funders—older people who must pay for their care without local authority oversight (Tanner, 2022). In response, the UK Government introduced a Health and Social Care Levy and proposed a care cap (Oliver, 2022). However, these measures offer little immediate relief to older people and unpaid carers. The government's Build Back Better: Our Plan for Health and Social Care (2021) was widely criticised for failing to deliver meaningful reform (Oliver, 2022), and little progress has been made since its publication.

However, The King's Fund (2023) recently reported that adult social care teams have significantly reduced waiting lists. In April 2022, the waiting list stood at 542,000, but by the end of March 2023, it had been reduced to 430,000. This reduction can be attributed to local authorities' efforts to assess individuals' needs early on and utilise available resources to provide support rather than waiting for situations to worsen. Skilled practitioners are now more aware of community resources that can proactively help individuals, addressing their needs and challenges (The King's Fund, 2023). Moreover, local authorities have extended the responsibility of initial assessments and triage to skilled social care practitioners, not just social workers, to expedite the process and ensure timely support. This approach helps prevent crises by using community resources proactively rather than depending on formal services later (LGA, 2023).

According to Age UK (2021), 1.4 million requests for care from older people were turned down since the PM promised to "fix care, once and for all" (Age UK, 2021, p. 1). As a result, 24% of older people were found ineligible and received no help, while 26% were referred to other services like Age UK. A recent study published by Age UK (2021) found that being stuck at home for an extended period, often immobile and without company, accelerates and intensifies some older people's need for care. It is clear from existing research and HaH studies that older people's health and quality of life depend heavily on when and how they are discharged from hospitals and supported in the aftermath (Age UK, 2021). Media reports frequently mention the issue of 'bed blocking' and older people staying in hospitals when they do not need acute medical care

(Age UK, 2021). ‘Bed blocking’ also brings about a financial burden for local authorities when discharges are delayed by social care. The NHS has the power to issue fines to councils, and since 2016, NHS Trusts have issued fines of up to £280,000 as a result of social care delays (Mithran, 2017), which ultimately takes away money from social care services and the people they intend to serve: the public.

The limitations of current HaH research

Currently, HaH research in the UK is limited regarding the lived experiences of older people and their unpaid carers, and this study aims to fill this gap. Moreover, this study will provide insights into how professionals can manage health conditions outside of hospitals more effectively by integrating with statutory services, such as social services. The study’s findings might allow health and social care services to implement better home-based care strategies. These strategies may help practitioners develop the expertise needed to reduce hospital admissions. Despite some research focusing on patient satisfaction with older people, there is little information about unpaid carers from a socioeconomic standpoint. The data from Rossinot et al. (2019) and Mäkelä (2020) show some impact on a carer, but they are brief and lack in-depth experiences regarding their role and HaH's impact. Other literature addresses the lack of inclusion of carers and older people in assessments, such as those assessing physical and cognitive impairments.

The literature is heavily focused on the medical model, why older people are ill, what HaH can do to treat away from the acute hospital and what it can do to reduce emergency department overcrowding (Leong, 2021; Kanagala, 2023; Arsenault-Lapierre, 2021). Additionally, HaH has a cost component in the literature, but this is from an international perspective. When 'cost' is considered, it is based on a non-state-funded system, e.g., costs to older people. In contrast, UK literature rarely addresses cost-effectiveness, given that the NHS provides free care to older people. Furthermore, there is little evidence regarding the post-discharge process from HaH, once treatment has ended. It remains unclear whether the older person gets referred back to their named GP. Also, there is limited information on the involvement of social care provision. Consequently, questions persist around who is responsible for referrals for daily living support, how service costs are determined, and who makes final decisions in the process.

As noted earlier, most HaH research originates internationally, with minimal focus on in-depth UK-based experiences. This gap in research is urgent, as it directly impacts the lives of older people and their carers. The current research landscape primarily emphasises the need to explore the experiences of unpaid carers and the impact this has on them. However, new studies still fail to recognise this, likely due to a predominant clinical lens, with many researchers coming from medical backgrounds. The health and social care crisis is well-known within the NHS and social care sectors in the UK, affecting older people and their carers. As evidenced below, despite efforts to prevent older people from being admitted to hospitals, the NHS bed crisis is looming, and older people are often left waiting days, if not weeks, to be discharged.

A Case for Change

Before the global emergency, the NHS struggled with admissions and discharges due to the number of older people admitted to the hospital. Chirgwin (2018) highlighted that readmissions for older people are happening every 90 seconds. The global pandemic significantly disrupted health and social care services but also exposed long-standing systemic issues. The COVID-19 pandemic increased the demand for HaH programmes as hospitals were overwhelmed with patients infected by the virus, especially during the first wave (Leong, 2021).

During the January surge in 2021, more than 100,000 patients were admitted to hospitals in England, with almost 40,000 patients admitted in a single day across the country (NHS England, 2021). To relieve pressure on overstretched emergency departments, the government quickly implemented HaH initiatives, which proved highly impactful and rapidly scalable during the crisis (NHS England, 2022). Recent research suggests that COVID-19 HaH initiatives rapidly increased across the UK during the pandemic, with early feedback showing positive results. The government's primary aim was to free up beds in acute hospitals, ensuring those patients with the most urgent acute needs received it promptly.

NHS England produced a report in 2022 named 'Virtual Ward including Hospital at Home'. They state that patients can receive the care they need at home, including in care homes, safely and conveniently, rather than in hospitals with virtual wards (NHS England, 2022). Providing an alternative to admission and early discharge also allows systems to narrow the gap between demand and capacity for secondary care beds (NHS England, 2022). This aligns with the earlier 2013 government initiative announcing a £3.8 billion Better Care Fund (BCF), aimed at integrating health and social care services. Using the BCF, local health and social care services can work more closely through a single pooled budget (NHS England, 2013).

There is also a wider concern about healthcare accessibility in deprived areas of the UK, where residents already experience poor health, further highlighting the need for HaH services. Thirty per cent of people in England's most deprived areas depend on emergency care, according to the Office for National Statistics. This includes 999, 111, emergency departments, and walk-in centres. This is often because these people cannot access a GP appointment, compared to just 10% of people in the least deprived areas of the UK (ONS, 2023). It is also important to note that over 20% of the UK population is over the age of 60, and this number is expected to rise from 14.9 million in 2014 to 18.5 million in 2025, according to the Office for National Statistics (Office for National Statistics, 2015). More concerning is that 75% of 75-year-olds in the UK already have more than one long-term health condition, a figure expected to increase to 82% among 85-year-olds (Barnett et al., 2012). Moreover, NHS England data reveals that the number of individuals over the age of 60 increased by two-thirds between 2007/08 and 2013/14 — a steeper increase than initially predicted by demographic change alone.

The Acceleration of HaH during the Coronavirus Pandemic

The coronavirus pandemic has significantly impacted our health and social care services, both for those receiving statutory social care services and those providing them. Social care workers faced a real risk of catching COVID-19. The sector experienced some of the highest mortality rates in recent history, with sickness absences doubling between February and October 2020. This severely affected service delivery and caused a mass shortage of skilled staff (Shembavnekar, 2020). The coronavirus emergency was sudden, and many lessons had to be learned from those on the frontline, those living with the disease, those isolated, and those who tragically lost their lives.

More specifically, there has been increased attention on how to better support older people and carers within the NIHR, paying particular attention to the development of HaH delivery. Since

2018, this has included contributions from the public, which has led to the need to explore this area in greater detail. It includes older people, health and social care professionals and relevant networks of regional NIHR centres relating to HaH. It has provided significant insights from older people and their carers who have been treated through HaH treatments. During this time, it was unanimously agreed that the development of HaH was essential and timely; even before the coronavirus pandemic, hospitals and social care sectors were exposed to delivering high-quality care in a timely manner. HaH can benefit older people and those with co-morbidities, including reduced stress of being in their own surroundings, travelling costs, and stress on relatives (Paling, 2020). There are also systemic benefits for health and social care services, including shorter A&E waiting times, reduced hospital stays, lower NHS costs, fewer delayed discharges ('bed blocking'), and decreased reliance on GPs and other frontline services (Paling, 2020).

The reason for undertaking this research

I was interested in researching this topic because I wanted to understand the experiences of older people and their unpaid carers when receiving HaH, whether good or bad, and the perspectives of health and social care colleagues who provide this treatment. The research has gained significant importance because of the coronavirus pandemic and the increasing question about the shortage of acute beds in hospital settings in the UK and abroad. The pandemic significantly impacted health and social care services, affecting both recipients and providers of statutory care. More than 30,500 deaths occurred in care homes, and more than 4,500 deaths occurred in people receiving home care support during the first pandemic wave (Deeny, 2020). These figures are significant to the HaH model because the pandemic has strengthened the need for this research. It has also emphasised the need to explore alternatives to hospital care and to better understand the experiences of those receiving and providing such care.

In my experience on the frontline, especially in one team where I have recently worked, more people are talking about it, and older people and their families want it. Based on my experience and the results of the study, there is significant potential for its development and delivery in a more integrated, personalised approach to health and care planning, both in people's own homes and in community settings such as care homes, rehabilitation centres, and beyond. With over a decade of experience in health and social care, I have witnessed the impact of poor collaboration on short- and long-term care planning. A lack of collaboration while making short and long-term care plans (including social care and health), whether in the community or at the time of the person's departure from the hospital, can be damaging. I know from my experiences as a social worker working in 65+ Older People’s Teams and Hospitals that older people want to be treated in a way that considers all their views and wishes in a personalised, organised, and humanistic manner by all professionals involved in this process. When this fails, the older person and their family become understandably frustrated and lose confidence in us as professionals. This narrative needs to change.

When I talk to older people about how we can best enable them to meet their ongoing care needs, they frequently tell me they want to remain at home for as long as possible, with minimal support, so long as they feel it is safe for them to do so. Many older people I have met refuse to be admitted to a hospital for fear of not being discharged or being sent to a location other than their home, such as a nursing home. I have discovered that older people can often clearly explain their needs with the help of family and friends. However, the practitioner needs to be patient and understand their situation. Older people know what they want, and I always see it when I meet them: to be treated and cared for at home if that is an option. They do not want to be transported in an ambulance to a hospital, separated from their comforts and loved ones, only to wait hours to be triaged. This often leads to further deterioration in their health and well-being. Also, older people do not always feel that being in the hospital is very coordinated and have voiced concerns that they do not always feel included in discharge planning, often sensing decisions are being made without their knowledge.

Older people might feel against receiving care at the hospital because research shows that older people who get admitted to a hospital are often at risk of experiencing a significant decline in their functional abilities and reduced ability to complete daily living tasks (Weng et al., 2024). Upon discharge, older adults face heightened risks of falls, reduced independence, repeat hospital admissions, and unplanned transitions to residential care (Glans et al., 2020). Due to these reasons, some older people may choose to be treated away from the acute hospital site based on past negative experiences. These experiences may motivate them to opt for home-based care programmes, such as HaH or virtual wards. I cannot blame them; having seen the benefits of HaH, I too would prefer treatment at home rather than in a hospital. What is better, staying at home or being in a strange and loud environment that would only cause me anxiety and distress? I believe it is clear which choice I would make, which is one of the driving aspects that led me to choose this study topic.

Therefore, it is essential to consider several factors to ensure a smooth discharge process for patients and their families, to ensure a holistic approach. Detailed assessments and reviews of patients' progress throughout their hospital stay are crucial for understanding their needs when discharge discussions begin (Waring et al., 2014). Involving the patient and their family members in multi-disciplinary discussions is essential to address ongoing needs as soon as they are well enough to participate. This can include considering different social care options based on prior discussions about the patient's ongoing health and care needs and any goals they have on discharge. This approach could address issues early in the discharge planning and alleviate problems and potential delays. Patients and their families can be informed of the following steps by ward staff, including assessing their comprehensive needs by a social care practitioner and potential timelines for this process.

Positionality as a PhD Student

Researchers must demonstrate reflexivity because it is essential (Gilgun, 2011), and I needed to make myself aware of my position within the research context. 'Positionality' refers to how a researcher's background influences their approach and interpretation of data, shaping both the conduct and outcomes of research (Gilgun, 2011). As a qualified social worker, my PhD research critically examined the experiences of older people and unpaid carers in HaH. Drawing on my hospital-based social work experience, I gained firsthand insight into the challenges older people face when transitioning from hospital to home or 24-hour care environments. This raised significant questions about how such transitions affect well-being and daily living needs. The impact of this research is significant, offering hope for improved care and well-being by potentially identifying areas for improvement and best practices. It also explored how social care interacts with health services in the planning and implementation of hospital-to-home transitions, especially as these services scale up for the future.

While my professional background may have offered valuable insight, it also risked shaping my interpretations. I was aware of the need to avoid letting preconceived ideas influence how I interpreted participant data. For example, although I understood that many older people prefer to remain at home rather than in hospital due to discomfort with institutional settings, I remained vigilant against projecting this belief onto my research. I knew that my view of health care professionals' willingness to collaborate with social workers could also bias my interpretation. However, even though I held these perspectives, it did not necessarily mean that the research would reflect the same narrative. According to Finlay (1998), I needed to remain aware of my assumptions and try to suspend them. This was difficult, given the volume of information participants shared. Most older people discussed their dissatisfaction with hospital treatment and expressed relief at returning home with HaH. These narratives constantly challenged my neutrality, making it difficult at times to maintain complete detachment. I was mindful of this throughout my engagement with participants and ensured I kept an open mind, allowing the data to speak for itself rather than fitting it into pre-existing frameworks. I remained committed to objectivity by challenging myself when confronted with findings that deviated from my expectations and critically examining why this might be the case.

I also knew that not all older people enjoy speaking to social workers. I had to face the fact that some participants might hold suspicions, associating social workers with institutionalisation (Curryer et al., 2020). Indeed, a report by the Care Quality Commission (CQC, 2012) noted that older people sometimes avoid contact with social workers due to fears of being "taken away." Over the years, I often heard comments such as, "I thought you were going to put me into a home," reflecting a widespread fear that can hinder open dialogue. In reality, social workers aim to empower and advocate for individuals to remain living independently for as long as possible. Maintaining the integrity of the research required me to clearly distinguish my role as a doctoral researcher from my professional identity, ensuring trust and openness during interviews.

This dual identity also presented practical and ethical challenges during the research process. If participants requested help or advice about social care, I explained that I was acting in a research capacity and would only respond with their explicit consent, according to ethical protocols. I also anticipated that interviews might include emotional disclosures or safeguarding concerns. This occurred when a patient raised such a concern, and I responded appropriately, in consultation with my lead supervisor and the NHS Trust. Through my adaptive approach, I applied my social work training to navigate these moments while protecting participant autonomy and confidentiality. I provided full information about the study, participants' rights, and safeguards for their safety and privacy.

Overall, maintaining a balance between my professional expertise and research responsibilities demanded constant self-awareness. Although participants may have withheld information out of concern for possible intervention, I was transparent about my ethical responsibilities and the boundaries of confidentiality. By engaging in continuous self-reflection, I navigated these complexities in a way that respected and upheld the voices of older people and unpaid carers. My research was grounded in ethical principles and transparency, which I demonstrated through my commitment to open communication and integrity.

Research Aims

The study aimed to explore the experiences of older people, unpaid carers, and professionals involved in a HaH service in a deprived, diverse urban area in England. It also aimed to examine how HaH interacted with local authority social services and how professionals, particularly those new to HaH, perceived delivering care through this model.

Research Objectives

- Encouraging greater awareness of older people's and unpaid carers' needs and preferences within HaH interventions.
- Contributing to a better understanding of when and how HaH can be a suitable alternative to acute hospital care.

- Providing insights into the practical and emotional impact of HaH on unpaid carers to inform future support approaches.
- Highlighting opportunities to strengthen interprofessional collaboration between health and social care staff involved in HaH.

Research Questions

There are three main research questions:

Q1 – What are the stakeholders' experiences who have directly received and/or delivered HaH interventions, and how has this impacted them?

The term 'stakeholders' will include: older people receiving HaH; unpaid carers supporting the older person; professional staff involved in providing HaH or other health and social care that interfaces with HaH; and care workers providing paid front-line care.

The term ‘impacted’ refers to the impact HaH may have on residents, relatives, care workers, managers, and health and social care professionals within a residential or nursing home or providing health and social care support within the older person's own home. For example, what implication does HaH have on residents receiving treatment in their own homes? How does HaH impact an unpaid carer?

Q2 – How does HaH coordinate with other statutory, private and third-sector health and social care services?

The terms 'third, statutory’ and ‘private sector' may include services (but are not limited to) Age UK, Dementia UK, Parkinson’s UK, Alzheimer's Society, the Carers Trust, local authorities, and private services within and outside of the NHS.

Q3 – What can be learned from the findings regarding future health and social care policy and practice?

The contribution to knowledge

It is hoped that this thesis will contribute to the body of knowledge regarding HaH experiences when older people access this type of treatment alongside the experiences of their carers and health and social care professionals. Existing research does not focus much on the in-depth experiences of older people, carers and professionals. Although some of the studies highlighted in the literature review consider feedback or responses from these groups of people, there is not much evidence about how HaH has impacted them in detail. For example, little is known about how HaH interacts with secondary services when an older person is discharged back to the care of their GP. Although it is clear that older people prefer to remain at home, it is unclear whether this is because they prefer to receive HaH treatment or whether there are other reasons. Little is known about the impact HaH treatment has on unpaid carers. Although some research considers carers, not much attention is given to them in broader HaH research.

There is a need to investigate these issues through in-depth interviewing, which will enable these groups of people to expand, in their own words, the impact HaH has had on their daily lives. It is also important to note that this research design, in terms of qualitative methods, has not been considered in the studies already highlighted in the literature review. There has been no scope for these groups of people to give feedback in the spoken word, only in yes and no responses following their HaH treatment, and this has been in the form of a survey or questionnaire. I believe this removes the opportunity for in-depth conversation, whereby crucial feedback can often be missed. Therefore, by meeting these aims and objectives, this research will contribute significantly to what is already known about HaH among these groups of people. For example, evidence might highlight a disconnect between referring an older person back to the care of their GP after HaH treatment. This creates an opportunity for developing a communication system whereby a smoother process is embedded within the discharge pathway. The study results will also give scope for broader research to be conducted in this area.

Who will benefit from this research?

Experiences of Older People receiving HaH

Older people who choose HaH will gain insight into this care model and its benefits, which will ultimately help them decide whether to choose HaH should they become unwell and need treatment in the future. HaH will also identify the social care needs of the older person. Health professionals can then point older people in the right direction for ongoing social care support in these instances.

Experiences of Older People’s Unpaid Carers

This research will provide good insight to those carers who might support the older person during and after their HaH treatment as it begins to scale up for the future. The study will assist in capturing the needs and expectations of carers, as they are often disregarded within already completed studies. HaH will also identify ongoing support needed for a carer. They can point the carer in the right direction of continuing support, i.e., to their local authority, so they can access a carer's assessment.

Experiences of Health and Social Care Professionals

This research will help to identify the strengths and weaknesses, such as integrated working, as the service scales up. It will also identify gaps in processes, i.e., how a professional might identify other needs, such as an occupational therapy need and how this would need to be embedded into a process and followed through. Moreover, it will identify the need for increased staffing capacity in the future and how a more collaborative approach may be needed, i.e., to include social care professionals and not just health professionals within the service.

Future research and practice

It is anticipated that this research will provide results and conclusions that will evidence positive paradigms and areas for future research. It is also expected that the study will reach conclusions about its integrated approach to health and social care services and how this might also need further exploration in the future.

Key points include:

- 1. Resources - It is important to free up acute beds so that they are used for critical care where there is no alternative to hospital.

And

- 2. Older people's welfare – avoidance of hospital-acquired infection, retaining wellbeing by being in a familiar environment.

The theory for understanding lived experiences

A theoretical framework is essential for explaining, predicting, and understanding phenomena in a given field; it provides the foundation for any research study. Grant and Osanloo (2014) argue that all research knowledge is derived from the theoretical framework, which underpins the rationale, problem statement, purpose, and significance of the study. As Abend (2008) notes, it introduces and justifies the theory relevant to the research problem under investigation. Given this study's focus on the lived experiences of HaH, it is necessary to align it with an appropriate theoretical approach. This framework draws on concepts and definitions related to HaH, emerging both from academic literature and practical understanding. A phenomenological approach was chosen due to its emphasis on capturing in-depth human experiences, particularly in areas where empirical research is limited (Creswell, 2009). It is widely used in health and social care research (Moustakas, 1994); for example, Jang et al. (2022) used it to understand nurses' experiences during the COVID-19 pandemic.

While phenomenology is well-suited to understanding lived experiences, it is important to recognise that conceptual frameworks may not always be fully articulated in the literature. As Abend (2008) suggests, researchers must also draw on broader contexts—such as media narratives, daily life, workplace experiences, and global events—to enrich their conceptual grounding. Concerning HaH studies, the key emerging themes from Leff (2005), Shepperd (2011), Messecar (1999), Harris et al. (2005), Rossinot (2019) and Leong et al. (2021) include patient choice, service pressures, financial implications, satisfaction, carer relationships, and the integration (or lack thereof) of medical and social care services. In the main, the theory is that older people receiving HaH treatment opt for it and feel safer and that a more therapeutic relationship is established between them and the HaH professionals providing treatment. While these issues are already emerging, it is essential to note that it will take time to thoroughly familiarise and embed ourselves within the literature, looking for concrete findings and analytic models pertinent to the research we are investigating (Abend, 2008). However, as a starting point, these themes and ideas are a reasonable basis for the theoretical underpinning of HaH, closely aligned with phenomenology, given that there has been a need to understand the 'human experience' of a particular phenomenon. The reason for HaH is that we know from the studies above that there is an increased demand for health and social care services. Yet, little attention is given to the experiences of older people and their unpaid carers when receiving treatment, which is the driving factor for this research. For example, existing research shows that older people report feeling satisfied when receiving treatment at home (Leff, 2005). However, the word 'satisfaction' requires exploration, specifically the context in which such satisfaction occurs. It is necessary to examine whether factors such as remaining in a familiar environment, concerns about being hospitalised, changes in daily routines or fears of deteriorating health in the acute setting contribute to older people being satisfied in HaH. Further attention must be paid to this group of people to better understand HaH's outcomes with older people and their unpaid carers.

It is noticed from the studies outlined above that choice appears to be a driving factor for older people when deciding what they want as opposed to what medical or social care professionals feel is best for them, in terms of hospital or HaH treatment. While choice is essential for older people, there is also a substantial 'financial cost' when older people become unwell and need medical treatment and social care support. It is a given that people in the UK benefit from free NHS healthcare (subject to eligibility criteria). However, when we talk about financial factors, it also means the cost of social care. For example, an older person may need HaH treatment but may also need social care support due to their inability to manage independently whilst unwell. They might not have a close family support network to step in and support them; therefore, they may need a care package to support their daily living tasks alongside HaH treatment. As such, this can be a financial burden to older people as not everyone is entitled to free 'social care support'. It is means-tested, and not all older people will be eligible for support from their local authority. Yes, there is a duty on local authorities to provide a social care assessment. However, they are not duty-bound to provide 'free social care' should the older person exceed the authorities ‘financial threshold'.

Nevertheless, HaH is viewed as a preferred care option for older people needing treatment. The evidence does suggest that increasing the choices of care settings, e.g., HaH as opposed to in-patient hospital care, reduces pressure on the NHS by decreasing the length of stays while avoiding the need for emergency admission to an acute hospital (Messecar, 1999). Therefore, several factors contribute to the delivery of HaH. It includes the abovementioned issues and the link to health and social care integration. The ability of HaH to function in a holistic way may be limited by the potential need for intervention from social care services when treating older people. It is crucial because it raises the question of who identifies social care support as needed, who takes over at this point, and who assesses the costs associated with social care intervention. The phenomenological approach considers these questions within the qualitative methods via interviews with older people, their unpaid carers and professionals. The phenomenological approach seeks to explore these issues through qualitative methods, including interviews with older people, their unpaid carers, and professionals

The next chapter will focus on the literature review. It will summarise pertinent studies on HaH, specifically examining the perspectives of older people and their unpaid carers, alongside aspects of satsifcation, choice, cost and integration. Moreover, it will discuss various HaH studies and evaluations, identifying strengths, areas for improvement, and the gap in knowledge this this study aims to fill.

Chapter Two – Literature Review

In this chapter, I present several elements structured around key themes. I begin by exploring health-related conditions and our ageing population, policy, reform and legislation. This is followed by a discussion and critique of current HaH research, highlighting its relevance, limitations, and gaps. These gaps are organised thematically around patient and carer evaluation, effectiveness and patient outcomes – HaH versus inpatient care, and the cost of HaH, most relevant to this study. The chapter concludes with a discussion and critique of current HaH research, highlighting its relevance, limitations, and gaps.

The purpose of this literature review is to evaluate secondary data relevant to specific research questions, critically assess existing findings, and draw informed conclusions. To achieve this, it is crucial to evaluate both the research value and how the study aligns with current knowledge (McLaughlin, 2007). This review identifies what is already known about the experiences of older people and unpaid carers in relation to HaH, and where gaps in knowledge remain.

Specifically, this study employs a narrative literature review. Narrative reviews represent a distinct form of knowledge synthesis, offering a flexible yet rigorous framework (Sukhera, 2022). As Sukhera explains, narrative reviews are particularly suited to complex and under-researched areas. While a systematic review was considered, it typically follows rigid protocols and may exclude valuable qualitative or experiential evidence. In contrast, narrative reviews accommodate diverse study designs (Greenhalgh et al., 2018) and allow for a more contextual and interpretive analysis. This makes the narrative approach particularly well suited for exploring the lived experiences of older people and topics of unpaid carers, which are not always captured within traditional hierarchies of evidence.

Narrative reviews are also effective for uncovering new insights in emerging or fragmented research areas (Rumrill et al., 2001). This is especially important for HaH, where limited research exists. As Levine et al. (2022) observe, inconsistencies in implementation contribute to the lack of understanding. Sukhera (2022) emphasises that narrative reviews are inherently iterative, involving the ongoing selection, appraisal, and synthesis of relevant literature, guided by researcher reflexivity and judgement.

Introduction to Hospital at Home as a Model of Care

A (2021) NIHR study showed that care at home improves outcomes for vulnerable and older people, easing pressure on emergency departments and hospitals. The study also highlighted that older people in HaH over one month were less likely to develop acute confusion (NIHR, 2021). Caplan's (2005) study showed that HaH treatment resulted in less delirium and fewer related complications than acute hospital treatment for older people. According to the Geriatric Medicine Research Collaborative (2019), Delirium may trigger or worsen dementia and is linked to longer hospital stays. It often leads to people spending a long time in the hospital and eventually ending up in residential or nursing care. Although hospital stays pose health risks to older people, research shows most older people and their families prefer treatment at home when unwell (Shepperd et al., 2021). Longman et al. (2012) suggest older people often fear that hospital admission may exacerbate chronic conditions. Fried et al. (2000), as cited in Pouw et al. (2018), studied preferences among individuals aged 65+ admitted with conditions such as chronic heart failure, COPD, or pneumonia. Over 50% preferred home treatment over hospital care, citing feelings of safety and comfort. Missildine et al. (2010) further highlight that older inpatients are frequently deprived of sleep and confined to bed for up to 20 hours a day, contributing to depression, sensory deprivation, and disorientation.

Wiles et al. (2011) also argue that supporting older people to remain at home helps delay or avoid costly residential care. HaH has also expanded patient choice, enabling older people to receive personalised care at home rather than in acute settings (NHS England, 2021). It has been shown to reduce emergency department visits by delivering timely, multi-disciplinary care, often coordinated by a GP or hospital team (Edgar et al., 2024). This model may be particularly beneficial for patients in deprived areas, where hospital admissions might otherwise be avoidable. As HaH appears to be offered currently at the point of admission to emergency departments or through contact with a paramedic or 111 (NHS England, 2022), this reinforces the importance of broadening access and ensuring the model is embedded consistently across services, so those who do not need a hospital bed can be safely triaged and supported at home. With that in mind, it is essential to establish a common language to ensure that patients, clinicians, commissioners, and policymakers clearly understand the model's purpose. Home based care models differ from other healthcare services due to the complexity and severity of the medical conditions they treat. They care for patients who would otherwise require hospitalisation, although the threshold for hospital admission is not well-defined. It depends on hypothetical thinking about whether the patient would have required hospital assessment. Focusing on the care processes delivered can determine whether hospital-level care is being provided at home or in a care home (Knight and Lasserson, 2021). Again, this reinforces the value of HaH when care is delivered appropriately in a familiar environment, it reduces the risks of hospital-acquired infections and complications that could lead to deterioration.

HaH – A General Introduction

HaH provides a short-term medical intervention in an older person's home or care home, which can be described as equivalent to that provided in an acute hospital setting (Leff et al., 2005). HaH is a new, innovative programme in the part of England, where this study took place, where acute care is delivered outside of the traditional hospital setting. HaH has been expanding for some years, and given the trending theme of 'Admission Avoidance', it is a sought-after service. Indeed, evidence (NHS England, 2021) suggests that it keeps people away from emergency departments and older people in their homes, reducing the pressure on overstretched and scarce NHS resources. Other evidence (Messecar, 1999) also suggests that HaH care is a practical, less costly alternative to acute hospital care for older people. It is similar to the same care delivered at the acute hospital, providing nursing and rehabilitation services in people's homes instead of care at the acute hospital (Messecar, 1999). There is also the pertinent point concerning the care choice for older people, given a global ageing population (WHO, 2023).

HaH services are designed to help patients recover their functionality, but they are not the same as rehabilitation or ‘reablement’ (Legg et al., 2016) or restorative services (Tinetti et al., 2016). Reablement and restorative services provide short-term interventions to improve functional recovery following the resolution of an acute illness. Interestingly, access to home-based care in the UK is not widely accessible to all patients requiring acute treatment, and the quality of service provided by individual HaH services varies widely (Health Innovation Oxford & Thames Valley, 2024). In Scotland, the HaH model is more developed and supported by various government policies and guidelines that ensure consistency in service design and delivery (Health Improvement Scotland (HIS), 2020). However, this approach is less common in other parts of the UK. A recent survey of acute hospitals in the UK showed that only around half of them could refer patients directly to a HAH service (Holland et al., 2019).

Most HaH services mentioned in research by Holland et al. (2019) needed to be able to provide an assessment by a physician at home or access to point-of-care diagnostics. This suggests that the services described were not intended to manage acute illnesses that require hospitalisation. Home-based management of acutely unwell patients requires timely access to diagnostic tests, hospital-level interventions, and clinical decision-makers. This approach is summarised by the UK Hospital at Home Society (2022), as evidenced in Table 1 below. The specifics of each HaH service depend on local needs and infrastructure. Patients can receive ongoing care at home as if they were in a hospital ward. The HaH team provides treatment, monitoring, and clinical review until the patient's condition improves and they are discharged back to their General Practitioner's (GPs) care (Knight and Lasserson, 2021).

Key Features of Hospital-at-Home
The acuity and complexity of the patient's condition differentiates the hospital at home from other community services.
It provides urgent access to hospital-level diagnostics (such as endoscopy, radiology, or cardiology). It may include bedside tests such as point of care (POC) blood tests and point of care ultrasound (POCUS).
It provides hospital-level interventions (such as access to intravenous fluids, therapy, and oxygen).
It requires daily input from a multidisciplinary team and sometimes multiple visits. Provisions for 24-hour cover with the ability to respond to urgent visits are also required.
It requires secondary care level specialist leadership and clear lines of clinical responsibility.

Defined inclusion and exclusion criteria, with a defined target population, for example, for over 18 or over 65.
These programs deliver a time-limited short-term intervention of 1–14 days.
HaH patients have equity of access to other speciality advice like in-patients.

Table 1. Key Features of Hospital-at-Home (Source: Hospital at Home Society, 2022, p.1)

Please note the following information: the diagram below outlines the essential care processes for HaH developed by Knight and Lasserson in 2021. It is important to clarify that this diagram was created for a specific model and may not apply to all HaH services.

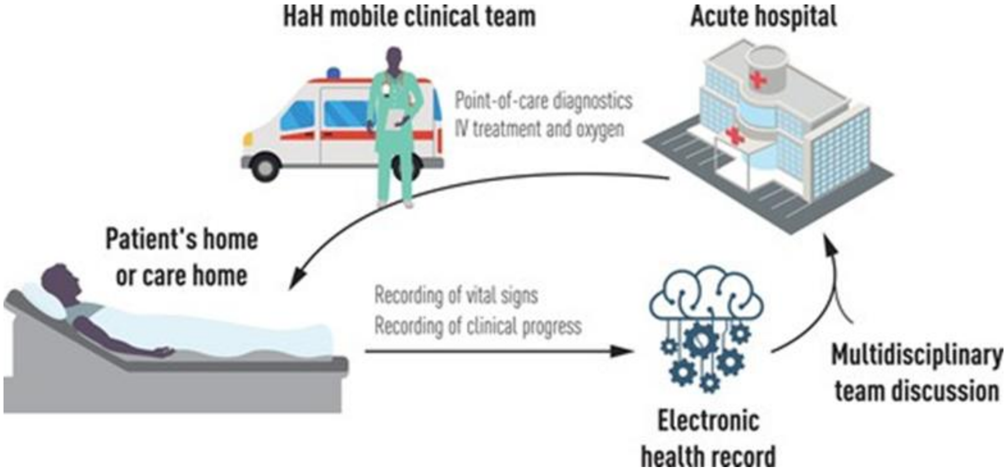

Diagram 1. Essential Care Processes in Hospital-at-Home (Source: Hospital at Home Society, 2022, p.1)

HaH provides urgent access identical to acute hospital-level interventions (such as oxygen, intravenous fluids, and therapy). The multi-disciplinary team includes medical doctors, nurses, and allied health professionals, such as healthcare assistants. It requires several visits to the older person when treated at home. The healthcare provision may sometimes require 24-hour coverage, which allows professionals to respond to urgent visits. There are clear lines of clinical responsibility. For example, a medical doctor would always be on shift and take the lead, and a nurse would deal with triage and admissions. A nurse or doctor will provide medical care to older people in their homes, usually achieved by a rota system. More specifically, this service has explicit criteria with an established target age population of those over 65 years old. The service delivery time is a targeted short-term intervention and can vary from 1 to 14 days. It is expected that a first responder in the community will have assessed all referrals to HaH, and escalation of care deemed appropriate; assessment is likely to have been undertaken by:

- GP
- Ambulance crew
- Integrated Care Services
- Member of the nursing home team

A complete set of physiological observations and NEWS2 score should be obtained before referral.

The HaH registrar will triage referrals. The appropriateness of HaH involvement will be determined on a case-by-case basis based on:

Medical Inclusion

- Need for urgent diagnostics to allow risk-stratification
- Need for urgent treatment not otherwise available in the community (e.g. parenteral treatment)
- Same-day emergency care (SDEC) via ambulatory care unit (AMAA) is impractical/burdensome

Medical Exclusion

- Need for immediate transfer to the emergency department to facilitate lifesaving treatment, for example:
- Septic shock
- Suspected acute myocardial infarction
- Suspected acute stroke
- Urgent need for cross-sectional imaging

A pragmatic approach regarding exclusion criteria is needed for patients with advance care plans. This means considering whether a hospital transfer is appropriate and whether the patient (if capable) would refuse hospital treatment. Whilst HaH would be a targeted healthcare intervention, there is still scope for special medical advice should an older person need this during medical treatment. For example, if a doctor identifies other health-related needs requiring specialist advice or input. The care is designed holistically, ensuring person-centred care planning involves both the older person and their carer/family members. There is a clear pathway from referral to closure, and how this works. For example, HaH colleagues identify an older person who may benefit from the service; they are offered this instead of hospital admission. They sign a disclaimer that explains what will happen at the beginning and end of treatment. Some key facts about HaH include:

- Older people with frailty are at particular risk of being affected by institutionalisation and delirium. Some 30 to 56% have been shown to experience a reduced functional ability between hospital admission and discharge (Health Care Improvement Scotland, 2020).
- HaH has existed in several countries worldwide for 25 years. The first HaH service was introduced in Scotland in 2011 (Health Care Improvement Scotland, 2020).
- HaH works best when implementing an integrated acute and community-based service model to meet local population needs (Healthcare Improvement Scotland, 2020).

HaH is developing, albeit with some initial difficulties, i.e., with medical supplies and the logistics of 'sign-offs', 'professional responsibility regarding who will do what and when' and 'delivery'. However, these difficulties are overcome through good partnerships with allied health professionals, and the model appears to be progressing well. Evidence (Rossinot, 2019; Harris, 2005) also suggests that older people opt for this level of care (through research already carried out) instead of needing treatment in an acute hospital setting. Wright et al. (2013) found that avoiding hospital admissions and using same-day discharge works well for older people. Due to the infancy of HaH within the UK, knowledge regarding older people's rich and detailed experiences within this geographical location is limited. It is important to consider the practicality of HaH and its wider impact on older people and their unpaid carers. Furthermore, it is also important to explore how the presence of medical equipment in the home affects the environment of older people and their unpaid carers – additionally, understanding the experiences of health and social care professionals delivering HaH warrants further exploration.

Policy

Integrated care is all about services, including health and social care, joining up to ensure a seamless experience, combining both services and ensuring people's (young and old) needs are at the centre to reach a common goal of improving the patient experience (Shaw, 2011). Coordinated and person-centred care is at the forefront of healthcare in communities worldwide (WHO, 2016a). Research suggests that older people with multiple health conditions need regular interventions from health and social care services, so streamlining and effectively coordinating services is essential (Goodwin et al., 2010). It aims to ensure quality person-centred care and reduce the risk of older people requiring emergency medical care. Integrated care requires all those (including the older person, their family, and carers) involved in care and support planning to be included at the earliest possible stages (Shaw, 2011). By adopting this approach, a common vision is shared between all involved – ensuring the older person's perspective and voice remains a central principle of wellbeing throughout (Shaw, 2011). Historically, under New Labour, we know agencies were encouraged to work together in many ways between 1997 and 2010 (Miller, 2021). However, the focus on the macro level may have come at the expense of collaboration at the local level (Miller, 2021). Between 1997 and 2010, successive Labour governments proposed policy reforms to increase partnerships within health and social care services (Miller, 2021). After taking over in 2010, the Conservatives implemented a policy of austerity that reduced public spending (Miller, 2021).

Legislation

The Care Act 2014 was introduced to modernise and streamline outdated social care legislation in England, placing duties on local authorities to assess individuals’ social care needs and determine eligibility for publicly funded support (Department for Health and Social Care, 2015). It aims to promote independence and well-being through a person-centred approach, underpinned by six key principles: Empowerment; Protection; Prevention; Proportionality; Partnership; and Accountability. A core duty of the Act is to provide or arrange services that prevent or delay the development or escalation of care needs.

In the context of HaH, this is particularly relevant for older people who may be medically optimised and ready for discharge but remain in hospital settings due to delays in social care assessments. HaH can offer a bridge in such situations by delivering acute care at home; however, when HaH services are unavailable, under-resourced, or unable to meet the individual's needs, discharge may be delayed, or families may feel compelled to seek alternative support. In these circumstances, older people and their families may be required to self-fund care to facilitate discharge and receive adequate support at home. This may involve hiring private carers, arranging interim home care packages, or paying for short-term residential care placements, raising concerns about equity and accessibility in a system intended to be person-centred.

Local authorities are required to provide comprehensive information about all available care options, not just those they directly commission, including reablement, befriending services, personal assistance, residential care, and specialist care such as dementia services (UK Government, 2022). They must also advise on accessing support, obtaining independent financial advice, and reporting concerns regarding the safety or well-being of individuals with care needs (Department for Health and Social Care, 2022). Despite these statutory duties, challenges persist for older people and unpaid carers engaging with HaH or waiting for follow-up care after HaH episodes. Although integrated, person-centred care remains a government priority, delivery is often constrained by funding pressures, workforce shortages, and market instability in the home care sector (Allan, 2015). For example, limitations in available domiciliary care following HaH interventions can lead to reliance on self-funded care or unpaid carers.

In addition to the legislative framework, national initiatives have been introduced to strengthen system integration and reduce unnecessary hospital admissions. These include Integrated Care Systems (ICS), the Better Care Fund (BCF), Primary Care Networks (PCNs), and Enhanced Health in Care Homes. The core aim of these reforms is to encourage closer collaboration between NHS services, local authorities, and community providers to ensure patients receive the right care in the right place. These approaches also attempt to shift care from hospitals to community settings and promote preventative and person-centred care planning. However, while these policy frameworks are ambitious, their implementation has often faced barriers such as funding constraints, staffing shortages, and inconsistencies in local delivery (Goodwin et al., 2012; Miller, 2021).

Reform

In line with the above, in 2010, England introduced significant policy reforms, including many initiatives to integrate health and social care services (Miller, 2021). After all, the government is focused on improving patient and service user experience (Reed et al., 2021). During 2015 and 2019, the government introduced and committed to meeting the objectives of the spending review and autumn statement in 2015, the sustainability and transformation plan in 2015, integrated care systems in 2018, the NHS long-term plan in 2019, and primary care networks in 2019 (Alderwick et al., 2019). By focusing on better partnership working, the government built on previous efforts to achieve similar objectives concerning partnership working (Miller, 2021). It was widely promoted that integrated care benefits the health and social services sectors. However, this ambition was not always realised in practice, and there was a noticeable disconnect between national policy and the experiences of healthcare stakeholders tasked with implementation (Miller, 2021).

Due to concerns about greater competition in public health care in England, the Future Forum was set up to establish integrated care as a priority with specific goals and key messages (Goodwin et al., 2010). As a result, national health and social care bodies made a public commitment to integrated health and social care services (Miller, 2021). One early mechanism was the pooling of funds for nationally set objectives, the creation of local authority-led partnership boards, and high-profile innovation programmes (Miller, 2021). According to Miller (2021), the NHS traditionally coordinates and delivers health care in England through local planning and provider organisations. We know that local authorities follow national policy but have greater autonomy than the NHS in deciding how these are implemented and how funding is allocated. COVID-19 has increased the pressure to integrate health and social care services, yet national responses have tended to prioritise hospital-based services over investment in community and social care structures (Miller, 2021).

Intermediate Care (IC) also plays a significant role in addressing these systemic challenges. Glasby et al. (2008) explore IC's potential to rebalance the UK health and social care system by reducing emergency hospital admissions and resolving delayed transfers of care (DToCs). IC aims to help older people avoid hospital stays when they do not require critical treatment but would benefit from organised assistance. However, research shows that IC often fails to meet its objectives because acute services continue to dominate care pathways, with hospital admission remaining the primary option. The perception of IC lacking credibility among some acute care professionals may act as a barrier to its wider acceptance.

IC also seeks to minimise hospital discharge delays by providing appropriate post-acute care services. However, IC frequently lacks sufficient capacity to effectively address discharge bottlenecks. These services tend to be activated in response to hospital pressures rather than patient needs, resulting in rapid discharges that do not always place patients in suitable settings. The report identifies systemic fragmentation and unclear roles among acute care facilities, intermediate care services, and social services as key obstacles. Patients experience gaps in care, resources are consumed inefficiently, and staff disputes about patient pathway responsibility persist due to a lack of integration. This fragmentation limits IC's ability to realign health and social care systems (Glasby et al., 2008).

The recent approaches to the delivery of Medical Care

In the UK and internationally, many approaches are used to provide acute care to older people at home or in care homes. By bringing hospital-quality diagnostics and treatment into someone's home, HaH or 'virtual ward' initiatives minimise the risks associated with hospitalisation, including infection, mental health deterioration, and loss of physical function. For example, a report by the British Geriatrics Society (2023) highlights the benefits of HaH and virtual wards, noting that such services can reduce the likelihood of delirium and hospital-acquired infections without compromising patient safety. It can be distressing and disorientating for older people living in care homes or their own homes when they need acute hospitalisation, especially if they are living with some form of cognitive decline. HaH services provide face-to-face care at home through a multidisciplinary team (MDT) based in the community. They are provided as an alternative to inpatient care (Shepperd et al., 2016).

It is important to note that there are two distinct differences between a HaH and a virtual ward. HaH care is often delivered in person, with frequent monitoring by a healthcare professional visiting during the patient's treatment (Kelly, 2024). A virtual ward is similar in that treatment is delivered at home, but patient monitoring may be remote rather than face-to-face (Geddes, 2024). Often, this is achieved remotely from a distance on a patient-facing app or website associated with medical devices and a digital platform for healthcare professionals (NICE, 2023). Vital signs such as temperature, blood pressure, oxygen saturation, heart rate, and respiratory rate can be monitored remotely, with data automatically sent to clinicians. Some platforms also include patient questionnaires that can be fed back to clinicians (NICE, 2023). There is no distinct difference in what HaH aims to deliver versus a virtual ward, regardless of which option is decided. Indeed, both aim to provide safe, effective, and person-centred care to people instead of them needing to be taken to a hospital for treatment (British Geriatrics Society, 2022).

Literature Review Methodology

To ensure a comprehensive and conceptually grounded review, I included well-referenced studies that directly explored the experiences of older people and unpaid carers within HaH (Sukhera, 2022). Following the structured yet flexible approach described by Sukhera, I conducted a broad search across both academic and grey literature databases, including FindIt@Bham, Google Scholar, ResearchGate, PubMed, CORE, JURN, Refseek, and NIHR. This inclusive strategy facilitated the identification of key themes, gaps in the literature, and international perspectives on HaH.

To guide the search process, I developed a list of search terms informed by preliminary scoping, existing literature, and the conceptual focus of the study. These terms were grouped thematically to target different aspects of HaH:

- **Patient and carer perspectives:** *Experiences of HaH*, *Patient satisfaction HaH*, *Unpaid carers' experiences of HaH*, *Patients' understanding of HaH*

- **Processes and delivery:** *Hospital discharge and HaH*, *HaH structures and delivery*, *Virtual wards*
- **Theoretical and policy framing:** *What is HaH?*, *Policy and Legislation*, *Person-centred care in HaH*, *Integrated care*
- **Outcomes and impact:** *Effectiveness of HaH*, *Impact of HaH*, *Professionals' perspectives*

This structured approach enabled a thorough exploration of both conceptual and practical elements of HaH while ensuring alignment with the study's aims.

Main Author & Date	Study Focus	Context	Methods	Key Insights
Shepperd et al. (2016)	Admission avoidance via Hospital at Home	International (Systematic Review); mixed settings; older adults	Systematic review of RCTs	HaH can reduce admissions and readmissions; outcomes vary
Caplan et al. (2005)	HaH impact on cognitive and physical function	Australia; older adults post-discharge; home-based care	Randomized controlled trial	HaH improved cognitive and physical outcomes post-discharge
Mendoza et al. (2009)	HaH for decompensated heart failure	Spain; patients with chronic heart failure; acute substitution	Comparative study	HaH is effective and safe for managing chronic heart failure
Leff (2005)	Feasibility of HaH for older adults	USA; older adults; community-based HaH model	Pilot study	HaH feasible; reduced hospital stay and high satisfaction
Levine et al. (2019)	Pilot RCT of HaH for acutely ill adults	USA; adults with acute illness; pilot trial setting	Pilot RCT	HaH was safe, feasible, and cost-effective in early testing
Facultad & Lee (2019)	Patient satisfaction with HaH	UK; patient satisfaction in HaH service;	Survey	High satisfaction due to care personalisation

		community setting		and convenience
Harris et al. (2005)	Cost and acceptability of HaH	UK; older adults; HaH vs inpatient care (RCT)	Randomized controlled trial	HaH as effective as inpatient care, with cost and acceptability benefits
Rossinot et al. (2019)	Experiences of patients and carers	France; patients and caregivers; qualitative HaH experience	Qualitative interviews	Carers appreciated home care but faced organisational challenges
Klein (2016)	Case study on HaH implementation	USA; national-level case study on HaH design and rollout	Case study	Scalable model showing benefits in quality, cost, and satisfaction
Mäkelä et al. (2020)	Work of patients and carers in HaH vs hospital	UK; older adults and informal caregivers; qualitative study	Qualitative comparative study	Care work burden shifted to patients and carers in HaH setting

Table 2. Outlines the ten studies selected for detailed analysis in this review

The studies in Table 2 were selected for their conceptual relevance to understanding the lived experiences of patients and carers within HaH. In particular, they address clinical outcomes, emotional and relational aspects, and service design. Although several lacked in-depth qualitative detail or were based outside the UK, they offered valuable insight into the real-world application of HaH models and the implications for those receiving care at home.

Some of these studies were based in international contexts, including the United States, Australia, and Spain - regions where HaH services are more established. While the studies varied in methodology and focus, they collectively informed the review's central themes and highlighted cross-national similarities and limitations. Notably, evidence from the UK on the personal, relational, and logistical dimensions of HaH remains limited.

Accordingly, these articles inform the three thematic areas developed in the remainder of this review:

1. Patient and Carer Evaluation
2. Effectiveness and Patient Outcomes – HaH versus Inpatient Care
3. Cost

Each theme is discussed in detail below.

Patient and Carer evaluation

These studies are significant because they show that HaH is effective, well-accepted by patients, unpaid carers and health providers, and can improve quality of care for older people and those approaching the end of their lives. The studies provide strong evidence of patient satisfaction, emotional benefits and how feasible HaH is in different countries.

A growing body of literature highlights both the potential benefits and limitations of HaH from the perspective of patients and unpaid carers. Several studies emphasise that patient preference and satisfaction are important, yet often influenced by factors such as perceived safety, the availability of social support, and the burden on unpaid carers. For instance, while Leff (2005) found that HaH was preferred by 69% of patients across two sites, those who declined participation cited concerns related to safety, comfort, and caregiver strain. These concerns were echoed in other studies. Collins et al. (2004) reported mixed patient satisfaction, with some participants preferring the reassurance of hospital-based care for complex conditions, while others valued the face-to-face, personalised attention received at home.

A recurring theme across studies is the variability in how patients and carers experience support during HaH. Rossinot et al. (2019) highlighted the need for greater recognition and assistance for unpaid carers, a gap also noted by Shepperd et al. (2016), who found that while home-based end-of-life care increased the likelihood of dying at home, it lacked data on how this impacted family caregivers. Similarly, Facultad and Lee (2019) documented high satisfaction levels in a UK-based HaH model, with 97% of participants recommending the service, although the reasons behind this satisfaction were not clearly explained. Together, these studies illustrate that while HaH can offer a more personalised and potentially preferred alternative to hospital care, concerns around caregiver burden, support systems, and service responsiveness remain critical to its broader implementation and acceptance.

The studies highlight interesting knowledge about patient care transformations outside traditional hospital settings. The primary objective in these studies remains to improve patient satisfaction and health outcomes through the implementation of individualised services based in home settings. Patient preferences in healthcare delivery have become more recognised as essential elements which demonstrate a move towards personalised care models that respond effectively to individual needs.

At the core of these studies is the shared understanding that many older people and unpaid carers prefer receiving care at home. HaH and home-based end-of-life care demonstrate that this preference contributes significantly to overall satisfaction. While Leff (2005), Rossinot et al. (2019), and Collins et al. (2004) address acute medical needs, Shepperd et al. (2011) study end-of-life care model focuses on ensuring comfort and dignity in the final stages of life. This distinction illustrates how care needs adapt along the continuum of illness, yet both approaches foster a sense of security and personal connection that patients value (Collins et al., 2009, & Facultad et al., 2019).

Safety concerns consistently appear as a central theme throughout the studies. Across all the studies, participants revealed doubts about the quality of medical care they might receive at home compared to care at the hospital. Patients who received end-of-life care at home showed greater comfort levels with their dying process, which indicates stronger acceptance of home-based care settings (Sheppherd et al., 2011). The assessment of safety seems to change depending on the specific healthcare needs being addressed. More specifically, clinical safety was a central theme in the study by Leff (2005) and included concerns about adverse events such as delirium, medication errors, but also the comparison of mortality and re-admission rates to traditional care at the hospital, and concerns clinicians had about the adequacy of emergency response in the home. In terms of the other studies highlighted, Lemelin et al (2007), Collins et al. (2004), Shepperd et al. (2011), Rossinot et al. (2019) and Facultad and Lee (2019), they often overlook safety concerns as a central theme or interpret them through the lens of satisfaction of comfort rather than safety concerns. The studies also identify existing deficiencies in knowledge regarding the effects on unpaid carers. The impact on carers' daily lives and mental health from home-based healthcare models needs more research to understand their impact on those who support older people.

Each study has various methods, ranging from mixed to quantitative and qualitative data, to examine patient experiences. Collins et al. (2004) and Sheppherd et al. (2011) were the only studies that used mixed methods. In contrast, Leff (2005) and Facultad and Lee (2019) used quantitative data, whereas Lemelin et al. (2007) and Rossinot et al. (2019) adopted a qualitative approach. The distinction highlights different research methods for collecting knowledge. The studies highlight the critical requirement for detailed qualitative data to improve our comprehension of older people and unpaid carers participating in Hospital-at-Home programmes.

The international relevance of these findings remains unclear for healthcare systems in different countries. Studies by Collins et al. (2004) and Shepperd et al. (2011) were carried out in the UK. Whereas the studies by Leff (2005) were carried out in the US, the study by Lemelin et al. (2007) in Canada, the study by Rossinot et al. (2019) in France and the study by Facultad and Lee (2019) in Australia. As such, the findings from the research highlight additional local research to confirm their validity because of how different healthcare systems operate across the globe. The research by Shepperd et al. (2011) offers a more solidified understanding of home-based end-of-life care because it is a systematic review, compares both home-based care to inpatient or hospice settings, has an explicit focus on end-of-life care and addresses clinical and human aspects, effects, but indicates a need for further supporting evidence. The other studies by Leff (2005), Lemelin (2007), Collins (2004) and Facultad and Lee (2019) focus on patient satisfaction, and Rossinot (2019) offers detailed experimental data.

The combination of HaH and home-based end-of-life care research demonstrates how personalised care can lead to better patient satisfaction outcomes. The studies demonstrate the urgent need for continuous research that examines safety issues while exploring unpaid carer roles and the special requirements of diverse patient groups to achieve a comprehensive hospital-at-home model beyond standard acute care environments.

Effectiveness and Patient Outcomes – HaH versus Inpatient Care

Studies on the effectiveness of outcomes are significant because they show that HaH can improve and maintain patients' cognitive and physical functions, and effectively manage more complex chronic health conditions like heart failure in the home. The studies also highlight HaH's potential to reduce costs and support a more patient-centred approach to healthcare delivery.

The results from the Caplan et al. (2005) study showed that older people in HaH with limited cognitive and physical abilities faced more significant mortality and morbidity rates. Mendoza et al.'s (2009) study showed that heart failure patients who received home treatment maintained the same health outcomes as hospital-treated patients while enjoying lower medical costs. The HaH programmes show possible benefits for patients with confusion and bowel/bladder problems, but demand further research to determine their precise effects on physical and cognitive abilities. Klein et al.'s (2016) study demonstrated that collaborative care models produced reduced time spent in the acute hospital and financial benefits while underscoring the need for social workers and rehabilitation specialists in home care settings

Mäkelä's study (2020) brings attention to the critical yet frequently ignored contributions of older people and their unpaid carers who choose home health services instead of acute care at the hospital. They found that older people and unpaid carers were actively involved in decision making with regards to HaH though unpaid carers often had to take on caring responsibilities during the period the older person received HaH and this was mainly down to the older person's cognitive impairment or confusion due to a delirium at the time the person was acutely unwell.

The studies demonstrate that HaH services offer advantages for both older people and their unpaid carers. Studies by Mendoza et al. (2020) and Klein et al. (2016) highlight reduced hospital costs during acute care periods while maintaining patient outcomes and quality of life that match standard inpatient care levels. Hospital at Home (HaH) has emerged as a potentially economical substitute for conventional hospital admissions. By alleviating pressure on acute care facilities, it supports a more strategic allocation of healthcare resources, with the possibility of reinvesting in preventive care and local community health services—an approach that may appeal to those shaping policy. Mäkelä's (2020) qualitative study shows that many older individuals express a clear preference for receiving treatment at home. This preference is often attributed to the familiarity of the home environment, which offers emotional stability and comfort. These insights stress the importance of placing patient preferences at the centre of care design and delivery.

There is still little research about unpaid carers who may be performing essential tasks within HaH, which poses a significant problem. The research highlighted that HaH affects unpaid carers' daily lives but often neglects to understand their emotional, physical and financial struggles. Unpaid carers face challenges as they handle complicated care tasks alongside emotional stress management. There remains a clear need for more detailed research to gain a fuller understanding of the experiences of older people and unpaid carers within Hospital at Home settings.

Future studies should explore a range of factors, including the psychosocial elements that shape these experiences, as well as the ways in which HaH integrates with broader medical and social care systems. It is equally important to investigate the emotional and relational dynamics that occur within this model of care. Examining these dimensions becomes essential because it enables the creation of customised interventions that improve patient experience and outcomes and provide better support for unpaid carers, giving researchers a sense of purpose and motivation.

Cost

Studies that investigate the costs of HaH are significant because they show that HaH is a safe, effective and cost-efficient alternative to care at the acute hospital, offering similar or better outcomes and higher patient satisfaction, sometimes at a lower cost.

Harris et al. (2005) and Levine et al. (2019) highlight that HaH can significantly reduce health care-related costs. Together, the two studies offer valuable insight into hospital-at-home care models for individuals experiencing acute illness. They indicate that Hospital-at-Home programmes not only help reduce healthcare expenditure but also maintain high standards of care, generating financial benefits for both patients and health systems. The consistent preference shown by patients and their families for receiving care at home further reinforces the case for wider adoption of these models within health services.

More specifically, the study by Harris et al. (2005) aimed to assess hospital-at-home services by comparing them with traditional inpatient acute care across dimensions of effectiveness, patient satisfaction, and financial impact. According to this key research study, patients treated in their homes showed clinical results comparable to those treated in hospital settings. The home-based care model produced health results that were equal to those of hospital treatment, yet it delivered cost savings (once operating a full capacity), which presents significant economic advantages for healthcare systems. Patients' positive experiences in hospital-at-home demonstrate its effectiveness for those who want medical treatment in their home setting. The research also highlights that the hospital-at-home can be seen as a legitimate and economical choice for certain patients who need acute care services, instilling optimism about its economic benefits.

Building upon Harris et al.'s (2005) foundational research, Levine et al. (2019) focused on the cost-effectiveness of providing HaH to older people. This study assessed the safety and economic viability of delivering intensive medical care through home-based intravenous treatments and continuous patient monitoring. The results also highlighted that HaH helps reduce acute hospital stays and re-admission rates, and lowers financial costs by minimising infections often associated with inpatient stays for older people. The studies also demonstrated that financial costs could be reduced by successfully managing complex medical conditions in patients' homes beyond traditional hospital environments.

Both studies examine hospital-at-home care advantages yet reveal significant disparities. Harris et al. (2005) broadened their research to cover multiple acute conditions treatable at home to lay the groundwork for the hospital-at-home model. In contrast, Levine et al. (2019) investigated complex medical conditions that demand hospital-level treatments like intravenous medication and continuous patient monitoring, which can prove more costly. The studies show that home-based hospital care exceeds expectations by being efficient and cost-effective. The study results demonstrate multiple advantages of expanding these programs across different regions. Home care transfers lead to substantial hospital resource demand reductions, which help prevent facility overcrowding and decrease operational expenses.

The findings about cost in HaH demonstrate that high-quality medical care can be provided successfully in home environments, providing patients with the benefits of familiar surroundings during treatment and recovery at a lower cost. The findings also collectively reveal that HaH must be acknowledged as essential in a developing healthcare framework. Healthcare providers and patients benefit from home care models, which offer solutions to current system challenges like increasing expenses and the demand for patient-centred care. Hospital-at-home services help healthcare systems deliver enhanced care quality through greater efficiency and expanded patient access. Transitioning to home-based hospital care ensures long-term sustainability and efficiency in healthcare delivery and offers future security. Maintaining these models is critical to developing healthcare systems that provide better patient care responses but are also cost-efficient.

Conclusion

The evidence to date suggests that older people prefer to be treated at home rather than being treated in a hospital. Some older people and their carers do not always feel included in assessment processes such as cognitive and physical assessments; therefore, a more integrated approach is needed to ensure there is a more holistic approach in HaH. Internationally, it appears HaH can be more cost-effective compared to care at the acute hospital; however, this depends on several factors such as the onset of acute illness and the complexity of health conditions. However, it is difficult to say if this would be the same in the UK. There appears to be some data regarding the impact on the carer role, although there is a lack of sufficient detail to understand how this impacts daily life and relationships. There is also little evidence of what might happen once HaH has ended. More specifically, questions remain concerning the extent of unmet social care needs, such as home care and necessary equipment. Furthermore, there is a lack of around which agencies are responsible for addressing these needs, how eligibility is assessed and who makes the final decision in these scenarios. Many of the studies are international, and research is limited concerning older people and their carers' hospital experiences at home in the UK. Most of the studies highlight the need to further explore the experience of older people's unpaid carers and the impact HaH has on them. It is crucial to conduct further research to fill these gaps. Most HaH research is outdated; there is only one piece of ongoing research in England, "Comprehensive Geriatric Assessment, Acute Care at Home Trial", led by Prof Sasha Shepperd at the University of Oxford.

There is no current evidence of the experiences of older people and their unpaid carers when receiving HaH treatment in the community. As this particular HaH site is developing, albeit with some initial difficulties, they are being overcome through good working partnerships with allied health professionals, and the model appears to be progressing well. Evidence suggests older people are opting for this level of care (through research already carried out) instead of the need for treatment in an acute hospital setting. Evidence also suggests 'admission avoidance' is working, and older people do not need to go to the hospital because they can be safely treated at home (NHS England, 2020). Due to the infancy of HaH, where this study took place in Birmingham, knowledge regarding older people's rich and detailed experiences within this geographical location is limited.

The issues highlighted above may be overcome with better-equipped medical care services for older people, such as HaH, as it would provide an effective alternative to inpatient care for older people and their carers (Shepherd, 2016). Despite HaH's early implementation in this region, there is significant potential for its development. We know HaH has been an accepted alternative to inpatient hospital-level care in several countries (the United States of America (USA), Italy and more recently, the UK) (Shepherd, 2016). Still, for its successful implementation within the West Midlands, the model should integrate with other services such as (but not limited to) social care, occupational therapy, and physiotherapy. This would ensure a streamlined service that identifies and meets the medical and social needs of an older person and their carer. Recent studies show the model works well, and hospital admissions are avoided. However, there is little evidence to suggest the vital link between statutory social care services and how these work with one another. Therefore, throughout this research, I interviewed both older people, their carers, and professionals. This enabled me to gather a rich, detailed account of how the service progresses and interacts with other vital services and how it impacts daily routines from an older person's and their carer’s point of view.

The next chapter will discuss the methodology and will detail my selected approach. Towards the conclusion, a reflective segment will discuss the rationale behind my methodological choices. It will cover the specifics of what I did, the timing, location, procedures, and the reasons behind my actions to achieve my findings.

Chapter Three - Methodology

This chapter outlines the research methodology employed in the study, providing a comprehensive overview of the chosen approach. It details the specific steps taken, including the timing and location of the research, the procedures followed, and the rationale underpinning these decisions. The chapter concludes with a reflective discussion that offers insight into the methodological choices made and how they were designed to support and achieve the study's overall objectives.

Study Context and Background

As this was an ARC-funded project, I started at a stage where the shape of the studentship had been discussed by professionals directly involved in the service. The ARC funding, which supports innovative and impactful research in the healthcare sector, was instrumental in initiating this project. The need for this research output was readily understood, given the strong relationships between Hospital-at-Home (HAH) professionals, academics, and a previous supervisor. The studentship fell within the West Midlands Acute Care research theme. The initial focus was on a new community-based service in Birmingham that provides HaH to older people in their homes and care homes, avoiding unnecessary hospital admissions. There was scope to develop a proposal aligned with the successful student's specific interests.

As such, and given my background in social work with older people, I wanted to provide qualitative insight into the overall experiences of Older People and Unpaid Carers in HaH. I had some prior knowledge of HaH, given my strong background as a hospital social worker in another part of the country, and older people often spoke about wanting to be discharged home with alternative care, if possible. However, HaH was not well known where I previously worked, and my understanding of the model was limited. The studentship was an ideal opportunity to develop a study that better understood HaH and the experiences of older people and unpaid carers. Therefore, I influenced the research by designing questions and methods to achieve these outcomes, an area that has historically been under-examined.

The process of developing these questions and methods involved a thorough review of existing literature, consultation with my supervisors and experts in the field, and consideration of the

ARC's research priorities. I was in an advantageous situation and was able to write a research proposal that assisted with this approach; I was able to identify gaps in knowledge around HaH, past experiences of HaH with older people and unpaid carers, the concerns around the lack of acute NHS beds, the shifts from acute care to more community-based care, and the need to look at alternative approaches to acute level care for older people away from the hospital, which often poses risks. With that being said, given the demographic group of proposed participants, the challenges in recruiting older people with cognitive impairments added a layer of complexity to the process, highlighting the collaborative nature of the research. Because of my social work knowledge and skills with older people and unpaid carers, I felt these were assets in contributing successfully to these processes.

Two health professionals actively involved in HaH introduced me to the HaH team in the early months. Their insights and experiences were invaluable in shaping the direction of the study. I spent time sitting with the team, explaining who I was and my position as a PhD student at the University of Birmingham. I saw how the team dealt with initial triages, the types of professionals that made up the team, and how people were seen and treated from the start to the end of their HAH treatment. It was interesting to see the vast array of professionals that made up the service, given that it was in its early stages of development. There was always a consultant on duty who took overall responsibility for the day-to-day running of the service. Nurses often triaged patients referred by general practitioners or hospital consultants who felt the older person could be discharged home with HaH instead of remaining in the hospital, usually posing risks. Alongside the medical staff, HaH had access to a temporary home care service that would provide immediate social care support during the person's HAH treatment, if necessary. This service is free of charge, provided by the NHS, and not financially assessed.

Patients also had access to occupational therapy and physiotherapy as part of their treatment, which included physiotherapy exercises and equipment provided free of charge. However, one significant challenge identified during the study was the absence of integrated social work involvement. Where social care needs were identified, referrals had to be made by nursing staff at the point of HaH intervention. This placed additional strain on nurses, particularly given the short-term nature of HaH services. In many cases, patients completed their medical treatment but were discharged with unmet longer-term social care needs.

Nurses often expressed that managing and following up on social care referrals was outside their clinical remit, yet they were frequently contacted by patients seeking updates on pending assessments or care packages. In practice, this created difficult conversations, with nurses having to explain that once medical treatment had concluded, it became the patient’s responsibility to pursue social care support from the local authority. Exceptions were made only in cases where the NHS Trust continued temporary home care due to unresolved safety concerns, pending a full social care assessment. These operational barriers highlighted a lack of coordination between health and social care systems, reinforcing the need for a more integrated model of care. These observations informed the direction of this study, particularly in examining the relationship between HaH and social care, an area notably underexplored in existing literature.

Spending time with the HaH team allowed me to emphasise the significance of my research and how it could help me recruit participants to achieve my intended aims and objectives. Building rapport took time, particularly during the height of the COVID-19 pandemic. To help me, the two doctors involved in the early stages of the studentship played a crucial role in advocating for my research study. They not only facilitated the process of gaining access to the HaH team but also highlighted the importance of the study to both patients and professionals. The Trust's medical director, who worked closely with the HAH team, was also entirely on board and believed in the research, which also appeared to influence the motivation of the health professionals to recruit patients receiving HaH.

I made sure to underline the vital role the HaH team's insights would play in shaping the study, making them feel valued and integral to the research process. Their contributions, from sharing their experiences to providing feedback on the research design, were invaluable. Coming from a social work background and the challenges of practice helped me to develop a good rapport with the nurses who voiced concerns about delays from a social care perspective. When I explained my role from a practical point of view as a social worker and the challenges we face on the frontline, they showed some understanding and empathy for the difficulties in social care, something they had not heard articulated in that way before. As time passed, I gained the trust of practitioners, and some were forthcoming about being interviewed.

The importance of research methodology

Any researcher must design a robust research methodology framework for the problem area that requires further exploration, as without doing so, the likelihood of achieving poor results, a lack of depth in the findings (Grossoehme, 2014), or not meeting the aims and objectives is almost inevitable. It is also crucial to note that even if the researcher is exploring more than one problem, the research methodology might be different. Therefore, researchers must remain flexible in their methodological approach and tailor it to the specific research problem (Creswell, 2007). For example, a researcher may want to investigate why so many older people are attending emergency departments and why many older people often wait in acute beds for long periods after their medical treatment has finished. In these cases, both quantitative and qualitative methods are appropriate. The researcher must turn their mind to which is the most suitable method for the chosen problems, the order of accuracy of the result of a method and the efficiency of the methods (Goundar, 2012). Considerations of these aspects constitute the research methodology. When exploring this in more detail, research methods assist us in uncovering new information or creating a better understanding of a topic. On the other hand, a robust research methodology is essential to assist with rigour and logical consistency, including how the researcher will gather HaH data and specific methods employed (Creswell, 2004). With these considerations in mind, a qualitative research methodology was selected as most appropriate for this study.

What is qualitative research, and why was it used for this study?

Qualitative research is undertaken where there is a need to understand people's experiences, attitudes, beliefs, behaviour, and interactions (Busetto, 2020). Strauss and Corbin (1990, p.11) state, "By the term qualitative research, we mean any research that produces findings not arrived at by statistical procedures or other means of quantification." In simple terms, when the research goes beyond merely presenting statistical data like numerical figures, graphs, and bar charts, it must dive deeper, especially when the aim is to explore the complex, lived experiences associated with a specific phenomenon. The study investigated the experiences of HaH participants during medical treatment, whether in their home or a care home, how they came to know about HaH and the processes they have encountered throughout their journey. The motivating factors for adopting a qualitative lens to this research were that existing HaH studies (Leff, 2005; Shepperd, 2011; Harris, 2005; Rossinot, 2019; Leong, 2021) followed this approach when the subjects studied relate to personal experiences of a particular phenomenon. However, many of these studies lacked thick descriptions, a gap that this study aimed to address. Nevertheless, the studies provide data about individual experiences of HaH treatment with older people and unpaid carers, which are relevant to this study, albeit with a lack of thick descriptions.

Secondly, qualitative research describes participants' opinions, feelings, and experiences. It also interprets the meaning of their actions, e.g., the reasons they said or did something (Denzin, 2011) in a particular environment, for example, a care home. Indeed, Bogdan (2007) suggests interviews are incredibly beneficial when the researcher needs to gather detailed, in-depth descriptions of a complex phenomenon and when thick descriptions are needed, often referred to as 'phenomenology' (Bogdan, 2007). For example, how an older person felt before, during and after their HaH treatment, how this may have impacted their daily routines and the potential impact on their relationships with others, such as their unpaid carer. This method can be seen as giving voice to individuals whose views are not often considered in research (Sofaer, 1999), e.g., an unpaid carer.

Although some positive aspects of qualitative research are evident, there are also some challenges to adopting this design. For example, the time and effort a researcher must invest in unpicking and understanding the phenomenon in question (Patton, 2002). Secondly, qualitative data is seen as a perspective-based method, for example, the individual viewpoint of a participant receiving HaH. The responses cannot be measured or compared with other data (Malterud, 2001) because they relate to the individual experience of HaH and cannot be generalised.

Thirdly, it can be difficult for a researcher to 'engage' participants in the interviewing process (Malterud, 2001). Participants might view this as time-consuming or not want to divulge too much about their individual experiences. Despite these challenges, a qualitative approach remained the most appropriate choice for this study. Any issues uncovered during the interviewing process will be dealt with sensitively, following strict ethical guidelines. In terms of engagement, there is confidence that older people, their carers, and stakeholders will want to involve themselves in this research because it is a growing model of care. Regarding the time needed to analyse the data, I was confident there was enough of it in this stage of the research process. However, if any difficulties had arisen, the organisational research plan was in place to refer back to and follow. Given the emphasis on lived experience and the need for in-depth insight, a phenomenological approach was selected to frame the study.

What is Phenomenology and how does it apply to HaH?

Kafle (2013) explains that phenomenology has roots in philosophical traditions that have developed over centuries. However, Edmund Husserl is widely credited with formalising phenomenology in the 20th century (Kafle, 2013). It can be described as a way of thinking about our own experiences, what we hear, feel, and see from our own personal pespective. In the context of this study, phenomenology enabled an exploration of how older people and unpaid carers personally experienced HaH services, not just what happened, but how it felt and what it meant to them. For example, a participant's HaH experience might include how an older person feels receiving treatment at home, or a relative's understanding of HaH discussed during an interview after care is delivered. Phenomenology is typically experienced from a first-person point of view, though this is not always the case. It is a research approach that seeks to describe the essence of a phenomenon by exploring it from the perspective of those who have lived it (Neubauer et al., 2019). According to Welman and Kruger (1999, p. 189), "phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved."

This approach was particularly relevant in this study because HaH involves complex interactions between the home environment, healthcare professionals, and informal support networks. Understanding how participants made sense of these interactions in real time, and in reflection, allowed deeper insight into the personal and emotional dimensions of receiving or supporting care at home. Phenomenology can be interpreted in many ways, but it generally refers to the appearance of experiences as they are lived, or how things present themselves in our consciousness. As Smith (2005) summarises, whatever we experience holds meaning, whether before, during, or after the event. For example, an older person might reflect, “I want my hospital-at-home treatment to be a comfortable experience, as last time I had this treatment in hospital, it made me feel uncomfortable” (Unknown). Such reflections were central to this study’s objective to access not just practical feedback, but the felt and remembered experience of care.

The main reason for adopting phenomenology in this study is its flexibility, which allowed space to explore participants' perspectives in depth during interviews (Jacobs and Furgerson, 2012; Miles et al., 2014). As a qualitative design, phenomenology offers strong foundations for social science researchers to explore lived experiences (Kafle, 2013). This was essential for a study like this, which sought to uncover how older people, unpaid carers, and healthcare professionals perceived and interpreted the relatively new HaH model of care. This approach closely aligned with the study’s aim of capturing meaningful, first-person accounts from those directly involved in HaH.

Potential Outcomes

The study aimed to achieve several outcomes through the qualitative lens. These included: 1) making HaH interventions more responsive to the needs of older people and unpaid carers; 2) improving support for unpaid carers; and 3) promoting better interprofessional collaboration. Reaching these outcomes required a carefully considered and logically structured research design that could support exploratory depth and methodological rigour. Lane (2018) defines research design as a study with strong scientific foundations to effectively address the intended research goals and objectives. It should offer a logical framework for investigating the research questions and testing hypotheses while minimising ambiguities and biases. Additionally, it should provide compelling evidence to support the argument (Lane, 2018). As seen in foundational social research methods (Bryman, 2016), the basic structure of a research design is the blueprint for carrying out an investigation directed by a research question. This structure is particularly evident in an inductive approach, where the design emerges from data rather than from a prior theory (Charmaz, 2014).

Whilst the basic structure of a research project is essential, it is crucial to note that the organisational element is also vitally important. For example, how decisions have been reached and the design of the research, including the development of clear aims and objectives, the underlying philosophical position, the chosen methodology, and the step-by-step research processes. Gorard (2013, p.8) suggests, "A way of organising a research design is to maximise the likelihood of generating evidence that provides a convincing answer to the research question". Gorard's guidance was particularly relevant for this study as it was essential to ensure the question is answered and relayed articulately to generate new knowledge and evaluate the effectiveness of the intended research aims and objectives. Therefore, I had to have a robust organisation plan to ensure tasks were completed on time concerning a qualitative research project, for example, finalising the overall research design, refining the methodology, addressing ethical considerations, identifying participants, conducting interviews, and analysing the data gathered.

Research Design

The overall study used a qualitative design underpinned by phenomenology, chosen for its focus on understanding the lived experiences of older people and their unpaid carers receiving HaH An inductive thematic analysis was employed for its flexibility and suitability in exploring diverse perspectives across participant groups (Jacobs and Furgerson, 2012).

Three participant groups were each invited to take part in a one-off, 60-minute interview, conducted either face-to-face or virtually:

- Older people interviewed in their own homes or care homes;
- Health and social care professionals (e.g., nurses, doctors, occupational therapists, and social workers) interviewed in NHS settings;
- Unpaid carers interviewed in their own homes, their relative's home, or a care home.

Purposeful sampling was adopted to identify information-rich cases, focusing on individuals who had recently accessed HaH services in the community rather than being admitted to the hospital. Participation was voluntary, with older people given the opportunity to reflect before deciding whether to take part. To be eligible, they must have received HaH treatment for up to one week. Some individuals were not recruited due to the brief nature of their involvement with the service.

Selection of qualitative methods

For this study, interviews were considered the most appropriate method to gather the data. Interviews are often the most used methodology in research that involves conversation or interaction with another to gather the data (Young et al., 2018). Interviews are flexible, allowing for in-depth analysis from often smaller-sized samples and placing the focus on the views of participants (Young et al., 2018). Given the study's emphasis on lived experience, interviews were well suited to capturing personal narratives and rich detail across participant groups. However, there are many types of qualitative methods. Therefore, it is important to establish the best type when research questions relate to specific aims and objectives. Having identified interviews as a potential primary method, I carefully considered alternative qualitative approaches to ensure the most suitable and rigorous option was selected for this study.

Methods Considered

Interviews

It is important to note that various types of interviews are used in qualitative research. In this context, three main types are explored. The first is the structured interview, which uses a fixed set of predetermined questions in a specific order. These are typically closed-ended or multiple-choice and allow researchers to identify patterns and compare responses easily. However, they may feel overly formal and lack flexibility (Nor Rashidi et al., 2014). The second is the unstructured interview, one of the most flexible formats. Questions are not fixed in order, allowing the interview to proceed spontaneously based on participants' responses. While this flexibility can enrich the data, it also poses challenges. Interviewers must avoid leading questions to reduce bias, which can affect reliability and compromise the study (Jamshed, 2014). The third is the semi-structured interview, which blends the structure of predetermined topics with the flexibility of open-ended questions. Although there is a general guide, the order of questions is adaptable. This format suits exploratory research and enables researchers to probe more deeply into participants' responses. It is often used when researchers have some interviewing experience and want to allow participants' insights to inform future inquiry (DeJonckheere, 2019).

Observation

Observation through participant monitoring is a valuable method. The primary goal of observation is to capture specific characteristics and behaviours of an individual (or group) at a particular time, for example, within a care home or a person's own home (Mulhall, 2003). However, evidence suggests that observation, particularly in medical and nursing fields (both covert and overt), when investigating the complex health conditions of older people, can pose challenges for the researcher and be more time-consuming (Mulhall, 2003). Observation is epistemically linked to perception what we observe is shaped by our prior frameworks and interpretations (Hanson, 1958; Hammersley, 2008), which supports Shapere's earlier discussion of perception's role in knowledge construction. For instance, older people receiving HaH may have varying perspectives and opinions as they witness real-world events, which contrasts with feedback gathered through a post-treatment questionnaire or structured interview. As Spilsbury et al. (2024) explain, non-participant observers in UK care homes must carefully manage their 'observational gaze' - choosing what to record and sometimes refraining from intervention. The methodical and ethical challenge of including or excluding sensitive or potentially damaging observations raises critical concerns about bias and missing context.

Documentary Analysis

Documentary analysis was another valuable method that might assist in gathering the much-needed data – it is quite popular within public health research (Robson, 2011). I had an idea that data could be obtained by reading the older persons' health records, e.g., HaH have documented (on their system) that they have seen an older person, treated them and closed the referral. However, after spending time with the team, I also concluded that documentary analysis was not possible because information on the system was limited in how the older person felt during or after treatment. It was a case of the health professionals triaging the referral, treating the older person, and closing the referral or following up if needed. There is also the issue of what would be documented in the person's records and whether this is written in an objective or subjective fashion, so the information might be fully accurate from the participant's own voice rather than the voice and interpretation of the professional writing it. Therefore, I did not feel I would be able to obtain rich, in-depth experiences via this method.

Rationale for the choice of methods

While each method presented distinct advantages, careful consideration of ethical, practical, and methodological factors ultimately guided my decision. I concluded that semi-structured interviews were the most appropriate method for collecting data, offering a balance between structure and flexibility. This approach offered clarity and practicality, particularly compared to observation or documentary analysis, which raised ethical and logistical concerns, for example, obtaining verbal consent for observation without prior contact, or the challenge of explaining my positionality as a PhD researcher.

Interviews with older people and unpaid carers were conducted face-to-face, following the easing of COVID-19 restrictions, while interviews with professionals were carried out remotely via Microsoft Teams to accommodate work schedules and ensure safety. This flexibility enabled broad participation and minimised disruption. Semi-structured interviews allowed for a structured yet open exploration of experiences, aligned with the study’s aim of understanding how participants experienced HaH before, during, and after treatment (Thomas, 2006). They enabled me to probe participants’ beliefs, attitudes, and perceptions, and to capture sensitive and nuanced accounts, especially important given the personal and emotional nature of the topic (Jacobs & Furgerson, 2012; Miles et al., 2014).

This method is widely used in health and social care research (DeJonckheere, 2019; Magaldi et al., 2020) and is particularly suited to capturing lived experiences (Cohen, Manion, and Morrison, 2011). Other studies on HaH (Leff, 2005; Shepperd, 2011; Harris, 2005; Rossinot, 2019; Leong, 2021) also employed interviews, but often lacked in-depth accounts. These studies focused primarily on treatment outcomes or efficiency, rather than the full scope of emotional and relational impacts.

Unlike questionnaires or observational methods, interviews gave participants the freedom to reflect and speak in their own words. This was particularly important for exploring the roles of unpaid carers and professionals, whose experiences of delivering and receiving HaH are often overlooked. Studies such as Rossinot et al. (2019), Facultad and Lee (2019), Collins et al. (2004), and Lemelin et al. (2007) largely overlooked these richer perspectives, instead favouring immediate treatment observations or outcome data. Despite the benefits, semi-structured interviews are not without limitations. They require significant preparation, interviewer skill, and the ability to avoid leading questions or researcher bias (DeJonckheere, 2019). Additionally, while the method provides depth, it does not allow generalisation across all HaH participants, given the diversity of individual needs and experiences.

Remote Methods

It is essential to note that remote methods need to be considered due to the ongoing coronavirus pandemic. However, it is important to note that a significant proportion of older people have never used the internet, or indeed a computer (Beswick, 2021), which leads me to think very carefully about the most appropriate remote method for participants. For example, where face-to-face contact was not possible, interviews were planned to be conducted either by telephone or via Microsoft Teams provided by the University of Birmingham (UoB). When interviews were conducted via Teams, it was recorded. If it was conducted over the telephone, the call was placed on speakerphone and recorded with the use of an encrypted audio recording device. The approach taken depended on the participant's needs and preferences, and whether they felt comfortable and able to participate remotely. This was not the only issue relating to remote methods; according to the Office for National Statistics (2019), 25.9 million rely on expensive pay-as-you-go data services, meaning a substantial cost to the individual should a remote interview take place, given how much data this might take up for the older person, their carer or even stakeholders (ONS, 2019). Therefore, it was important for me to discuss this with the participants before arranging a remote interview. If they felt comfortable and provided consent, the interview proceeded using the agreed remote method. It is important to note that all interviews with older people and unpaid carers took place face-to-face. The interviews with professionals all took place via Teams due to another COVID-19 lockdown and professionals' preferences at that time.

Recruitment of Participants

Concerning the identification of participants in more detail, I created an appropriate research tool: a participant information sheet (PIS), which provided information about HaH and what would be involved if the participants wished to take part. The HaH direct care team identified older people and unpaid carers during the older person's treatment. I distributed information leaflets to health professionals, who then provided a copy to older people and carers during their treatment. My contact details were at the bottom of this, and if they wished to participate, they could get in touch with me, or they could ask their health or social care worker to contact me on their behalf. I then contacted them to arrange a suitable time to conduct the interview. All participants read, understood, and signed the consent form. I only received personal details once individuals had expressed interest and agreed for their information to be shared with me. The HaH consultant and lead doctor identified health and social care professionals. I then contacted them via email and provided them with a copy of the information leaflet and consent form for them to sign and email back to me if they wanted to take part. All interviews with professionals were completed via Microsoft Teams, mainly due to the coronavirus pandemic and also because of staff availability and scheduling considerations.

Sampling

The sample for this study included older people receiving HaH, their unpaid carers, and stakeholders providing care (e.g., doctors, nurses, social workers, and paid care workers), with a total of 43 participants. This semi-fixed sample size was chosen to allow flexibility while ensuring adequate representation across the three groups. Creswell (2007) recommends a sample of 5 to 25 participants for in-depth qualitative research, although larger samples can become time-intensive to analyse (Kuzel, 1992, cited in Saunders, 2012). Given the inclusion of multiple participant groups, a larger sample size was considered appropriate for this study. While Creswell (2007) provides helpful guidelines, Nowell (2017) argues that qualitative research does not require a fixed number of participants, particularly in studies involving complex data or novice researchers. This flexibility was important to accommodate potential withdrawals or limited availability during the study.

This flexibility was important to accommodate potential participant withdrawals or limited availability during the study. In practice, no changes were needed. The decision to adopt a semi-fixed sample was also influenced by Crouch and McKenzie (2006), who suggest that working with fewer than 20 participants in a single case study facilitates rapport and encourages open dialogue, benefits that applied to each participant subgroup. This approach aligns with Rossinot et al. (2019), who used similar sampling methods in their HaH research. The use of purposeful sampling enabled the selection of information-rich cases based on relevance to the study aims. However, such an approach is not without limitations; it carries the risk of researcher bias and participant self-selection, both of which must be carefully managed (Sharma, 2017).

Ethical Considerations

When designing a qualitative study, other elements of methodology and design should be considered to meet the aims and objectives, including ethical considerations and positionality (Newman et al., 2021). It is important to remember that the researcher's and the participants' identities can influence the research process. Therefore, establishing clear expectations and boundaries from the outset is essential (England, 1994). As Kezar (2002) discussed, positionality theory emphasises that researchers and participants can have multiple overlapping identities. As a result, individuals draw from various aspects of their identity to adapt to certain situations (Kezar, 2002).

All participants should engage voluntarily (Holloway, 1997; Kvale, 1996) and should not feel in any way under duress to take part. As previously highlighted, all participants received a participant information sheet and consent form, which needed to be read, understood and signed, all of which form part of informed consent. I was fully aware of the appropriate tools that needed to be created, and these included consent forms, recruitment invitations, participant information sheets and interview schedules. The formal ethics committee procedure (sponsorship) was pursued in compliance with the policy of the UoB. Participant details were kept confidential and not exchanged with others (e.g., supervisors) until the respondent gave informed consent. For purposes of consistency and validity, I ensured to: 1. Advise the participants that they were giving informed consent to take part in this study; 2. Explained the purpose of this study; 3. Explained the analysis methods and, ultimately, 4. Advised on the advantages of the study.

I was also aware of safeguarding and protocols that needed to be adhered to in the circumstances relating to 'disclosure', as these are parallel when considering the overall approach to ethical considerations. I added a disclaimer to the participant information sheets. The interviews, whether face-to-face or via other virtual means, must be straightforward, sensitive, and well-articulated, and data collection methods must be relevant and rigorous (Angen, 2000). Before the interview, I had to be mindful of sensitive topics that may come to light during the interview process, so the approach had to be conducted respectfully and honestly (Angen, 2000; Altheide, 1994). I also had to be aware of the risks associated with research that involves vulnerable people. Concerning this project, the following risks were identified early in the process.

There was a risk of psychological and emotional distress. For example, participants might have discussed personal issues, such as how their caring role impacted them or whether they were satisfied with their experiences. Participants could also have chosen to speak about unrelated personal topics, which might have evoked emotional responses. If this occurred, I was prepared to ask whether they wanted to take a break or stop the interview, with the option of rescheduling at a more convenient time. However, this was not necessary, as none of the participants expressed distress during the interviews.

There was a risk of participants feeling uncomfortable discussing their experiences with professionals who had provided direct medical care. Participants might have also felt uncomfortable discussing their experiences in the environment they live in, for example, a care home. Participants might have also felt uncomfortable discussing their experiences in front of paid/unpaid carers. I ensured the participants chose where they would like the interview to take place - for example, a private room.

There was a risk of older participants becoming fatigued or unwell during the interview, depending on their health conditions and general frailty. Therefore, I was mindful of this before and during interviews. I offered breaks throughout the interview. I also offered shorter interviews over a period (for example, 30 minutes one day and 30 minutes the day after). I had planned in advance to terminate any interview if the older person felt unwell. However, no older people voiced that they wanted to terminate the interview at any point during the process.

There was a risk of catching COVID-19; however, I had been vaccinated to lower the risk. I used lateral flow testing weekly when visiting care homes or people in their own homes. I wore appropriate PPE. I was DBS checked and did not have any pre-existing/current/pending criminal convictions. Where psychological distress was identified, I was prepared to seek support from my supervisors for guidance. However, no concerns arose during the interviews in this case.

There is also the issue of the researcher having a thorough understanding of the topic area they wish to explore and the awareness of the phenomenological approaches to research concerning lived human experiences (Neubauer et al., 2019). To ensure the research is trustworthy, it must demonstrate value, integrity, and methodological rigour. This is essential for establishing research credibility and ensuring that findings reflect participants' realities. I was confident that not all issues would be challenging because the participants' data was factually sound. After all, interviewing enabled the participants to respond in their own words; this also ensured that the data corresponded with the 'real world' as participants would be experiencing a phenomenon by having medical care interventions at home.

I was aware the sampling needed to be logical and purposefully drawn, e.g., the sample and access to participants (older people in care homes and their own homes having HaH treatment) and what was expected from both the participants and me. Another vital point is that research cannot simply identify an area for exploration; any researcher needs to be deeply engaged with the already existing data via reading, reflective writing, re-reading, and re-writing (Neubauer, Witkop and Varpio, 2019). Indeed, in Moustakas's (1994) approach to transcendental phenomenology, data is read, and this data is reduced to meaning units; information is often re-read, and the data is compared and so on in the ongoing process of engaging with the data to describe the lived experience of another.

Concerning data protection and patient confidentiality, I stored personal data on university computers (BEAR - more specifically, 'BlueBEAR'). I used my laptop to connect to the UoB's secure server. Importantly, no data was stored locally on my personal computer. The interviews were audio-recorded on an encrypted Dictaphone. The recording was transferred securely within 48 hours from the device to the UoB BEAR system. I deleted the recordings from the UoB BEAR system once I had transcribed them due to the number of anticipated recordings; deletion took 4 weeks. They needed careful transcription, which was time-consuming. UoB has invested in a central Research Data Store (RDS), which provides an integrated and secure service available to researchers from all disciplines to store working data cost-effectively and link it efficiently to all BEAR services. On request, a default allocation of up to 3TB of space per project for five years is allocated to the principal investigator (PI), funded by UoB for the project's duration (whichever is the shortest). To facilitate large data transfers, we can use BEAR data transfer. However, from January 2022, I no longer used BEAR data share to share/transfer data. I ensured I adhered to UoB's storage of research data policy. Microsoft OneDrive or Teams are recommended as per UoB's ICT Guidance.

Research data needs to be stored securely for ten years as per UoB policy. I kept files (consent forms and audio-recorded interviews) saved to the university hard drive, with one backup sent to Microsoft OneDrive. As I stored my files, I applied consistent file naming to keep the data organised. For example, 'Older Persons Interview Recordings'. These were password-protected. I securely stored files on the UoB server BlueBEAR by logging on remotely. I deleted any identifiable information after transcription. I used anonymised identifiers (numbers) and removed other people's names and places from the transcripts. Document linking identifier and name were stored securely separately from other research data (insecure files on the UoB BEAR system). Participants' personal data was only seen by me, my supervisors, and the examiners (although this was not requested). I deleted personal data once transcription had taken place. This data was then stored on the UoB BlueBEAR system. I was the only person who had access to this data unless shared with my supervisors for comment. However, I did not need to share any of this data with them. Once the data was securely stored and anonymised, I proceeded to the analysis phase of the findings.

Consent and involving people with Dementia

Informed consent is widely regarded as the cornerstone of research ethics, ensuring that all participants voluntarily engage with a clear understanding of their involvement (Xu et al., 2020). However, obtaining consent becomes more complex when involving individuals with dementia or cognitive impairments, requiring significant ethical reflection (Diaz, 2025). Challenges may include difficulties in processing study information, weighing risks, and making autonomous decisions (Appelbaum, 2007). In England and Wales, the Mental Capacity Act 2005 provides the legal framework for such situations. It requires researchers to presume capacity unless proven otherwise and outlines safeguards for involving those who may lack capacity, including guidance for intrusive research (Sections 30–33) (Department of Health, 2005). If a participant is deemed to lack capacity, researchers must act in their best interests, considering their values, beliefs, risks, and potential benefits of taking part (Dixon-Woods et al., 2004). The Act also stresses the importance of involving the consultee's family members or close contacts, who can advise on the individual's likely wishes. Researchers should make every effort to support understanding and communication throughout the consent process. To assess capacity, researchers must apply the two-stage test outlined in the Mental Capacity Act (2005), ensuring consent is specific, supported, and lawful (Health Research Authority, 2021). If a person objects or has previously expressed a wish not to participate, consent must not be pursued, even if inclusion appears beneficial.

Initial plans to involve people who lacked the mental capacity to give consent to participate

During my early research, I was able to establish excellent rapport with HaH professionals, and this topic emerged as a critical area of discussion. HaH professionals indicated that they frequently received referrals from hospital settings seeking to discharge patients to their homes with HaH, where Dementia or cognitive impairments were apparent. Including people with cognitive impairments in this HaH research was essential, as they are often excluded from studies despite being among those most likely to receive HaH services and whose experiences are critical to shaping inclusive, person-centred models of care

I planned for the lead doctor or consultant on shift to evaluate medical records to identify whether cognitive impairments existed at the point of triage. Subsequently, I intended for the doctors to engage patients in a dialogue (once ethical approval was granted) regarding my intentions as a researcher, providing an informative leaflet about the study and scheduling a follow-up discussion during subsequent HaH visits. If the doctors determined that the participant retained this information, they would have facilitated the exchange of contact information.

For each participant who had the mental capacity to consent to take part, I planned to call them to introduce myself. I would have then arranged a face-to-face visit, ensuring that participants had read and understood the participant information sheet and consent form. These documents outlined the benefits of participating, potential risks and safeguarding issues. I would have given participants a week to decide if they wanted to join the study, allowing them time to consult with their relatives or unpaid carers.

When there were uncertainties about a participant's mental capacity to give informed consent, and if doctors assessed them as incapacitated, I planned to seek the views of consultees and make a decision based on this advice. This was a particularly important part of the ethical standpoint, ensuring inclusion of participants who may lack the mental capacity to take part in research (Kim, 2010). Indeed, research with human participants requires researchers to understand ethical principles and prepare documents that comply with legal standards before presenting their study to an ethics committee for approval (Kim, 2010). The role of the ethics committee in maintaining ethical standards of research practice is pivotal (Kim, 2010). Having completed all the necessary preparatory steps for my study, I presented it to the ethics committee.

Presentation to the ethics panel and their feedback

During my presentation, the ethics panel of approximately twenty experts raised questions about including older people who may lack the mental capacity to participate in the study. The panel expressed concern that insufficient attention had been given to the involvement of participants with Dementia and other associated cognitive impairments. More specifically, the panel required more robust thinking around how to carefully include these groups of participants, as approval for research involving adults without the mental capacity is contingent on the research, which is discussed in more detail below. It is important to note that these were the conditions I considered when preparing my ethics application, as they are the requirements for including people who lack mental capacity to consent as set out in the Mental Capacity Act 2005.

1. **The research not being able to be carried out as effectively on exclusively those with capacity** - Understanding the experiences of older people with Dementia could be seen as contributing to a more 'dementia-friendly' approach within HaH, particularly given that people living with Dementia are often excluded from research (Diaz-Gil et al., 2023). Including their perspectives is essential to capturing the full scope of HaH experiences. However, in the context of this study, including participants who lacked mental capacity would likely not have met the conditions set out in the Mental Capacity Act 2005, as it may have imposed an undue burden due to participants’ ill health at the time, combined with cognitive impairment.

2. **Having the potential to benefit the participant without disproportionate burden and being intended to provide knowledge of the causes or treatment of, or of the care of persons affected by, the same or a similar condition** - Understanding how older people with Dementia feel about the presence of health professionals in their home through interviews could lead to better training for staff to reduce distress and improve relationships. Older people may also experience improved interpersonal interactions during HaH treatment, as is evidenced in the Olsen et al. (2021) study. However, it is important to be mindful of the potential burden imposed on involving people with cognitive impairments in research. According to Hellström et al. (2007), involving older people with cognitive impairments may limit an older person’s ability to fully understand the research process, which might lead to confusion or anxiety. Examples of this might include repeated questioning, changes in routine or interactions with people the older people are not familiar with, leading to distress or disorientation.

3. **If without the potential to benefit, the risks are negligible and anything done to, or in relation to the participant will not— i) interfere with their freedom of action or privacy**

in a significant way or ii) be unduly invasive or restrictive – This criterion refers to studies where there is no potential benefit to participants, but also no risks or burdens. This would not apply to my study, as there may have been some risks or burdens involved, for example, having a stranger in the home asking questions about potentially upsetting experiences. I did consider observation with older people in their environments while receiving HaH, which may have helped to yield positive results (Baker, 2006). However, I discounted observation as a method because I did not feel it would yield the in-depth experiences of older people, unpaid carers, and health and social care professionals, given that I would only be observing older people receiving HaH at that moment. There is also the issue of privacy, as entering people’s homes involves accessing a private space, which could risk violating their right to privacy.

Although these points were considered as part of the research design, the research ethics committee decided against allowing me to include people who lacked the mental capacity to consent to participate in my study without revision of the methodology and resubmission of the ethics application. The panel felt more clarification was needed about how the MCA 2005 conditions were met. The panel were primarily concerned with two points: i) how people who lacked the capacity to consent would be involved in the process, and ii) whether unpaid carers would act as Consultees, as well as being interviewed as participants in their own right. As unpaid carers are often also the next of kin or closest relative, the panel felt it was unclear whether they would serve both roles or whether only the carer would be enrolled, in which case the MCA 2005 would not have applied. After reviewing the committee's decision, I revisited my strategy and discussed my options further with my supervisors and the HaH medical team. Given the urgent timeline of my research, I would have needed to rethink my processes and create new documents, and I was nervous about whether the ethics panel would still find this acceptable, given the time pressures, I decided not to take the risk.

Final action taken following the ethical panel’s decision

As a result, I decided to limit my inclusion criteria to participants without cognitive impairments who could provide informed consent to participate in the research. I subsequently submitted a revised application to the ethics committee, which received approval. Further conversations with my supervisors and the HaH team indicated a shared consensus that future studies involving this population could be reassessed when ample time is available to thoroughly explore the complexities associated with mental capacity and consent for potential research involving older people and unpaid carers in HaH. Nevertheless, it has made me think of the impact I might have had on my findings if the board had granted me approval. People with cognitive impairments might have shed light on tailored HaH treatments as opposed to those with the mental capacity to consent to take part in the research. Excluding these participants raises questions about equity in research, such as contributing to systematic inequality and discrimination (Dewing, 2007). Including these participants might have also enhanced my findings' validity and applicability, such as real-world relevance and improving research through the involvement of people with cognitive impairments.

My research is not just a professional endeavour, but a profoundly personal mission. It upholds social work values by amplifying the voices of those with cognitive impairments and representing their best interests. This mission, which is deeply ingrained in my professional obligations, is a testament to my commitment to equality, inclusion, participation, and the voices of older people and unpaid carers, which has directed most of my work. Throughout my research journey, I have better understood the distinctions between practical and theoretical approaches to mental capacity assessments. As part of my social work practice, I conduct assessments through structured best-interest pathways where quick decision-making takes precedence. However, this journey has made me more aware that moving into academic research demands that I must adjust my perspective to meet new requirements. Participants who lack the mental capacity to consent to take part in research require researchers to adopt a detailed and reflective approach when engaging with them – it is not simply a clear pathway, which I have often experienced in hospital discharge settings. The shift to research work has empowered me to tackle future design challenges that respect and include people with cognitive impairments. Standard protocols alone do not meet research requirements, as I need to examine the ethical aspects of research choices and their effects on participants.

Learning from the process

Through the ethics review process, I recognised the importance of designing more adaptable methods to support the inclusion of people with cognitive impairments. Although my study did not initially incorporate these features, I have since learned the value of using accessible tools such as information sheets and visual aids to make participation more inclusive. I also came to appreciate the importance of co-production and now advocate for the involvement of older people living with Dementia and their unpaid carers in the design of future research. Research participants with Dementia would benefit from a deeper understanding of existing protocols and guidelines through this approach. The findings of Tanner (2012) show that including older people with Dementia as co-researchers produces more meaningful participation and richer insights. Building on this, Campbell et al. (2022) demonstrate how visual and participatory methods, such as home tours and co-designed materials, can support people with Dementia to engage on their own terms. Their work highlights the value of flexible, relational approaches that centre the lived experiences of participants, offering both ethical and practical strategies for inclusion. In future research, I would aim to promote inclusive research networks and develop relationships with academic peers and partnerships locally and internationally, drawing on what I have learned about the value of collaboration in designing inclusive studies.

My recognition of these research challenges has shown me the importance of collaboration. Moving forward, I feel that connecting with experts who have effectively managed comparable obstacles is crucial and advantageous. Such collaborative efforts reveal how sensitive research frameworks can be developed to meet ethical standards while ensuring participants are both protected and empowered. As researchers and practitioners, we have a profound responsibility to ensure our work accurately represents the voices and needs of research participants, particularly those who are vulnerable or underrepresented (Wood et al., 2024). This aligns with the principles of social justice and respect for persons, which underpin ethical research practice (Beauchamp et al., 2019). I am now more critical of the researcher and practitioner roles while maintaining a commitment to continuous reflection to ensure my research respects participant dignity and amplifies the voices of older people and unpaid carers (Manthorpe et al., 2010). This reflective stance also influenced how I carefully developed inclusion and exclusion criteria to ensure that participants' experiences were authentically represented.

Inclusion and Exclusion Criteria

Concerning inclusion and exclusion, there were three sets of criteria for each participant group. The main eligibility criterion was that older people must have been receiving hospital care at home. Once this criterion was met, additional inclusion criteria also needed to be met.

Inclusion Criteria for Older People:

- They must have been 65 years old or over (this is an older person's study, so we set this age as a person over the age of 65).
- They had mental capacity – the direct care team confirmed if the older person had the capacity to consent to take part.
- They must have been receiving HaH treatment for at least one week (this would have given them time to reflect and decide whether they wanted their views and experiences analysed in this study)
- They must have been living in the specified geographical location in either their own home or a care home.

Inclusion Criteria for Health and Social Care Professional Workers:

- Health and social care professionals/workers must have had some role in providing or coordinating the older person's HaH care.
- Paid care workers must have been directly involved in the older person's HaH care and support needs, whether this was in a care home or in the older person's own home.

Inclusion Criteria for Unpaid Carers

- They must have been over 18 and have the mental capacity to consent.
- They must have been an unpaid carer to the older person who was receiving HaH and who was included in the study.

- They did not need to live with the older person.
- Unpaid carers must have been providing support to an older person when taking part in the study.

Exclusion Criteria

- If older people did not meet the criteria, they were excluded from the study.
- If health and social care professionals were not providing medical or social care intervention, they were excluded from the study.

Below is a flow chart of how participants were identified and recruited, which was discussed above.

How were participants identified and recruited?

Participants were identified through stakeholders providing HaH treatment.

⬇

Health and social care professionals were identified via the weekly Microsoft Teams EPI-Centre meetings. Paid care workers and home managers (in care homes) were also be sent an email if HaH professionals were providing care to older people in care homes.

How many participants were recruited?

I interviewed older people and unpaid carers (if the older person had one), and stakeholders.

11 older people.

11 unpaid carers.

21 stakeholders.

⬇

When potential participants indicated a willingness to take part, I arranged a suitable time and date to meet them.

⬇

What happened once consent had been obtained?

⬇

Once a participant had read the PIS and signed the consent form, they were contacted by me.

⬇

I then arranged a suitable time and date to meet the older person / unpaid carer by telephone / virtually, or a face-to-face visit. The interview took place in the older person's / carer's home or in a care home, depending on their current location at the time.

The Interviews

I recorded the interviews on a secure recording device. The interview questions were presented to older people, so they had the scope to tell me their thoughts and feelings in their own words. Another point worth noting is how the older person or their unpaid carer generally communicates. For example, there may have been communication or sensory impairment, so reasonable adjustments may have needed to be made, i.e., pictures, charts, and audible equipment. I intended to include older people living in care homes and older people living in their own homes. However, no reasonable adjustments needed to be made among all the participants.

Analysing the Data

Regarding the analysis stage of this project, I used inductive thematic analysis to analyse the interviews with older people, unpaid carers, and stakeholders. However, I also considered alternative methods, including grounded theory and interpretative phenomenological analysis (IPA), to ensure that the chosen method best aligned with the study's aims.

Grounded theory (GT) is an approach to developing theory from collected data. This method involves systematic data gathering and analysis to generate a new theory rooted in the data set (Chapman, 2015). It is also relevant because of its inductive nature (Glaser and Strauss, 2017), where the researcher sets aside any pre-existing knowledge and allows the theory to 'emerge' from the data. It is suited to areas where very little is known, such as the experiences of people in HaH. However, given my knowledge and experience, it would have been difficult for me to analyse in this way and from a different perspective, it can be argued that the lenses I brought were very useful in helping me make sense of the data. Also, unlike thematic analysis, grounded theory uses selective coding phases, each with a distinct purpose to build a concrete theory (Tie et al., 2019). The process follows specific, systematic steps and procedures to guide the research process towards theory generation (Tie et al., 2019). However, it may be less adaptable to different kinds of research questions or objectives, as it can involve changes in the interviews and the questions being asked throughout the process.

Interpretative phenomenological analysis (IPA) is an approach that focuses on understanding the subjective individual experiences of how people personally perceive and process things (Smith, 2015). IPA is particularly suitable for studying small samples of participants and involves a detailed examination of individuals' experiences (Eatough et al., 2017) within a specific phenomenon, such as understanding the experiences of individuals living with speech impediments or exploring how individuals navigate life following traumatic domestic abuse. In contrast to other analysis methods, IPA emphasises studying the elements important to the participant during the interviewing process rather than focusing on common themes that emerge during interviews (Noon, 2018). Additionally, IPA often involves cross-case analysis, where the researcher completes a case study of each participant, while thematic analysis treats all cases as one data set from the beginning (Noon, 2018).

Thematic analysis (TA) is a widely used method in qualitative research that involves identifying and interpreting patterns of meaning across a data set (Braun and Clarke, 2006, 2022). There are multiple approaches to TA, with two common ones being inductive and deductive (Nowell, 2017). An inductive approach allows themes to emerge from the data without pre-existing theoretical assumptions, while a deductive approach applies a predefined framework to guide coding (Braun and Clarke, 2006; Nowell, 2017).

For this study, an inductive approach was most appropriate because existing literature lacks in-depth accounts of older people’s experiences of HaH. More specifically, I employed a reflexive thematic analysis, which allowed codes and themes to evolve throughout the analytical process in response to the data. This approach does not rely on predetermined codes or themes; rather, it constructs themes by interpreting and organising codes around central, recurring ideas (Braun and Clarke, 2019). According to Braun and Clarke (2019), reflexive TA is shaped by the interplay between three elements: the data set, the researcher’s theoretical assumptions, and their analytical skills and positionality. This interpretative process enabled me to remain open to unexpected patterns and to reflect on how my own background as a social worker influenced the interpretation of the data.

Thematic analysis was conducted using Braun and Clarke’s (2006) six-phase process: (1) familiarisation with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. I read and re-read transcripts in an active and immersive manner, seeking patterns of meaning and significance across participants’ accounts.

The flexibility of TA, combined with its accessibility, made it well-suited to this study. It enabled a nuanced exploration of older people’s, unpaid carers’, and professionals’ experiences with HaH without requiring alignment to a particular theoretical framework (Braun and Clarke, 2022; King, 2004). I refrained from coding until I had completed an initial read-through of the entire dataset. First, I read all the professional transcripts, followed by the older people’s and unpaid carers’ transcripts. Each set was reviewed twice to ensure I fully understood participants' perspectives. During the second read, I highlighted repeated words and phrases, which helped generate initial codes. These were transferred into a Word document for further analysis, where emerging themes were identified. These main themes were then further developed into sub-themes. For example, the concept of person-centred care emerged as a key theme encompassing multiple dimensions explored in the findings chapter. This process was applied across all participant groups. I then reviewed and refined the emerging themes to ensure alignment with the research questions, which helped to make concrete patterns emerge. Once the themes and sub-themes were clearly established, I began writing up the findings.

Additional insight was gained by examining participants' experiences over time, particularly how their care interacted with statutory social care services. A rigorous thematic analysis can produce trustworthy and insightful findings (Braun and Clarke, 2022), especially when exploring lived experiences in depth. It also enables the researcher to compare differences, identify similarities, and explore trends across participant groups. Braun and Clarke (2022) note that digital tools such as recording devices and transcription software have transformed qualitative research. Recording interviews enables the researcher to revisit the data accurately, without the pressure of taking notes in real time, thereby reducing the risk of missing important insights (Roulston, 2010). These recordings can then be transcribed manually or via a transcription service.

For this study, I used NVivo to organise and code data from the audio-recorded interviews. After reviewing the transcripts, I identified initial codes and grouped the data into themes. NVivo supported the structuring of these codes into tables, facilitating deeper analysis. As Gibbs (2018) notes, coding involves identifying and categorising patterns and relationships in the data, for example, understanding why HaH was chosen over inpatient admission. These codes were later refined and consolidated into broader themes to build a cohesive narrative.

While thematic analysis was well-suited to this project, there are limitations to consider. One major challenge was managing the large volume of data, which reinforced the value of using NVivo. Additionally, not all themes applied equally across all participants, and the findings cannot be generalised to all HaH users nationally or internationally. As Creswell (2014) and Patton (2002) emphasise, qualitative findings must be interpreted within their specific context. Similarly, Maxwell (2008) highlights the importance of considering the conditions under which data is collected when drawing conclusions.

Another consideration is the influence of the researcher. As Anderson (2010) explains, qualitative analysis is shaped by the researcher's background, positionality, and analytical skill. While my professional experience as a hospital social worker provided prior insight into patient preferences for home-based care, I was careful to bracket these assumptions during analysis. Themes and sub-themes were developed solely from the participants’ own words, ensuring that findings reflected their lived experiences rather than my pre-existing knowledge.

Conclusion

In summary, the chosen methodology allowed me to gather in-depth experiences from older people, unpaid carers, and professionals regarding those receiving HaH and those delivering it. In the UK, the HaH model has not always fully captured the participants' perspectives, including older people, their unpaid carers, and stakeholders. There was also limited evidence on how this model communicates with statutory social care services. Much of the existing research has been international and heavily medically focused. It is also important to note that this care model has yet to be widely practised across England and represents a modern approach to delivering acute care to older people in their homes. Therefore, the underlying philosophical and methodological stance has allowed me to examine and address the research questions in detail via this methodology.

The next chapter will detail my findings from the older person interviews. It will provide a concise analysis of the most important outcomes, along with some overarching remarks on the results, which will be elaborated upon in the discussion section.

Chapter Four – Findings from the Older Person Interviews

This part of the thesis will cover the findings from the interviews with the older people. The findings link directly to the original research questions. The main one for this findings chapter is "What are the stakeholders' experiences who have directly received and delivered HaH interventions and how has this impacted them?" Within this part of the findings chapter, there will be several sections. In the coding part, themes and subthemes were identified during thematic analysis. Therefore, the section will include the following themes and sub-themes:

- Theme one: Past experiences of Hospital Care versus HaH – with three sub-themes: quality of care in hospital, feeling listened to, and respected, and the environment.
- Theme two: Features of HaH valued by older people – with four sub-themes: communication; quality of clinical care; being given time; and being at home.

The table below shows the older person participants with an identifier. The identifiers will be placed after the quote.

Identifier	Gender	Ethnicity	Living situation
Older Person 1	Female	White British	Lives with husband
Older Person 2	Female	White British	Lives alone
Older Person 3	Female	White British	Lives with husband
Older Person 4	Male	White British	Lives with wife
Older Person 5	Female	White British	Lives alone
Older Person 6	Female	White British	Lives with husband
Older Person 7	Female	White British	Lives with husband
Older Person 8	Male	African British	Lives with wife
Older Person 9	Female	Asian	Lives with grandson
Older Person 10	Male	White British	Lives with wife

Table 3. Older Person Identifiers

Theme One – Past experiences of Hospital Care Versus HaH

From the older person interviews, it was evident that there were varying degrees of experience when older people were treated in the hospital prior to returning home with HaH. The experiences captured range from older people feeling unheard to the impact a hospital environment has on them. It is important to note that it does appear older people's views about HaH are heavily influenced by comparison with their experiences of hospital care.

For the purpose of this theme, below is a diagram of the main theme and its branches of sub-themes.

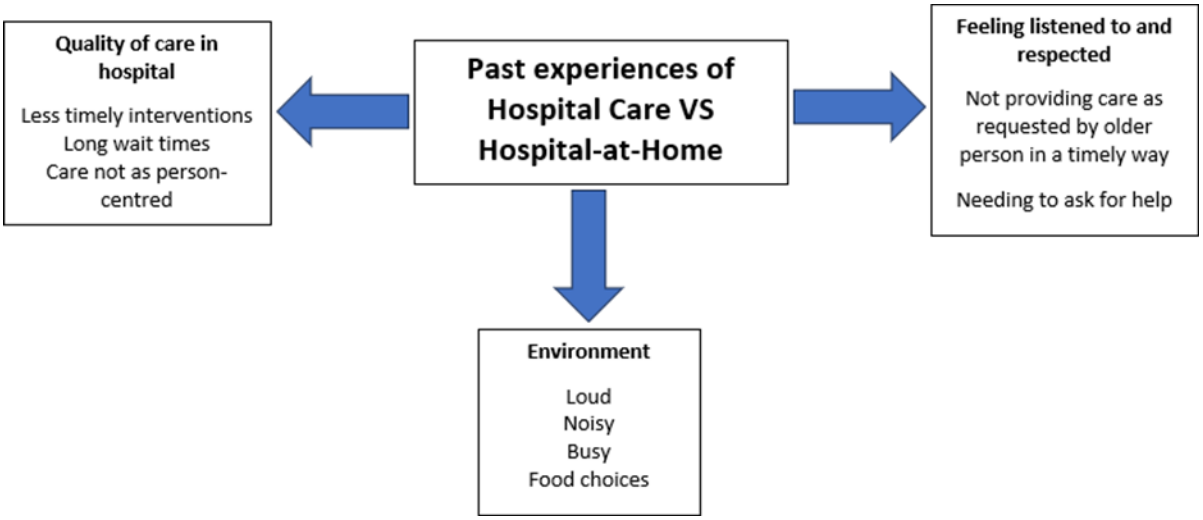

Table 4. Past experiences of Hospital Care versus HaH

Sub-theme – Quality of Care in Hospital

This sub-theme covers help in the sense of what older people experienced when they were in the hospital and asked for help with something related to their needs at that time.

The mention of lying in bed for 22.5 hours without attention indicates a lack of adequate care and monitoring. This brings about a negative view of quality care at the hospital. Therefore, it is better to receive treatment at home because the quality of care might be better.

> *"I went into A&E and I were there about four, four or five hours, then they moved me up to (a hospital ward). I were lying on (the bed) for 22 and a half hours. My daughters and my husband came to see me the next morning. I was still in the same bed. I was red raw on my back and my bottom. I said to one of the nurses 'Can you just check my catheter to see...?' I said, 'It seems a bit full to me.' Nobody had been round to see me to change it. I'm not going in there again." (Older Person, 1)*

There is an issue where the older person felt they needed intervention, but the doctor did not feel it necessary, which the older person feels led to a poor experience. The final part of the quote suggests a broader critique of care at the hospital. The older person seems to suggest a trend of negligence or a lack of care in hospitals:

> *"I couldn't say it was that good because when I was in that hospital that week, I said to the doctor there, I says, 'Would you please examine my chest?' He said, 'You don't need it'. I don't know. I don't think they seem to bother so much today." (Older Person, 2)*

The delay in responding to the older person's needs highlights how lapses in care can leave patients feeling neglected. While one nurse's dismissive response suggests a lack of urgency, another's prompt and compassionate action shows how care quality can vary even within the same setting:

> *"I said can you just check my catheter to see...?' I said, 'It seems a bit full to me.' Nobody had been round to see me to change it. Erm, she sort of... said 'Yeah, that's alright,' and walked off and then one of the other nurses obviously must have overheard me say, so she come. She said, 'Don't worry, I'll do it'. She emptied it for me." (Older Person, 1)*

Humanising the experience of being a patient illustrates the emotional and physical toll that waiting for care can impose on older people. It serves as a reminder that healthcare is not just about diagnoses and medical procedures, but also about the human experience. It also highlights systemic issues within hospitals, such as understaffing, inadequate communication, or the need for improved protocols to ensure timely care for older people:

> *"When you could get the nurse there, I have got no argument, they were brilliant, but when I asked them to empty a bag as an example, I asked them to empty that and they said, I had to use my frame to get to them, I went back to the bed, this is only one example, I went back and they said, 'lie on your bed and we'll come over', three hours later I was still waiting, that's just one. I am not knocking them down for everything, but that was one." (Older Person, 2)*

The older person appeared to need help with eating and drinking when in the hospital, but it appears they had to manage without support. This raises questions about the effectiveness of care practices at the hospital and the importance of understanding individual patient needs:

> *"I was left to try and feed myself, I couldn't feed myself, I couldn't even hold a spoon, knife or a fork. I couldn't even have a drink, they kept bringing me water, but I couldn't hold it because I was shaking, I had to wait for my husband to come to feed me or give me something to drink and yet, they told me I have got to drink, how was I supposed to drink when I couldn't even hold a cup?" (Older Person, 3)*

Sub-theme – Feeling Listened to and Respected

This sub-theme covers listening and respecting what they have to say because older people raised this concern when they were treated in the hospital, which impacted their overall experience and view of a hospital setting.

The older person did not feel listened to regarding how they were feeling, and the treatment given hurt them when this was promised otherwise. It sheds light on the often complex and sometimes confusing experience older people have when dealing with medical professionals in hospitals:

> *"When I went to hospital before all this lot, I says, 'Doctor, could you tell me what's the matter with my stomach?' I said, 'I can't eat.' He says, 'You can't?' I says, 'No.' I said, I've got a cramping in my stomach pulling my muscles and, and I feel within my muscles aching into my ribs here.' He says, 'These antibiotics are for your stomach.' Well, I had a bit of a*

> *water trouble. And they says erm, 'Take it – er, take the six. These won't hurt,' but they did." (Older Person, 4)*

The importance of communication in maintaining personal relationships is strong, especially in scenarios where older people may be feeling vulnerable or anxious, such as in a hospital. It also raises questions about the efficiency and attentiveness of health care delivery in hospitals:

> *"I mean, I asked for a telephone for two minutes so, that I could phone my wife and tell her I am going to be late coming out. Two hours later, I still hadn't got one. I had to ask about three or four nurses. I did phone in the end, but it was about two hours later." (Older Person, 5)*

There are long wait times to receive help from staff in the hospital, leaving the older person feeling they have not been listened to. It serves as a reminder that older people are not just cases or numbers; they have feelings and needs that should be acknowledged in hospital settings:

> *"I mean, it get you a little bit irate when you are waiting, keep waiting in the hospital and I don't like to get funny with anybody, but I just said to the nurse, 'What about this bag if it overflows? I've been waiting nearly three hours', 'We'll be there in a minute', but it wasn't a minute, it was a long time." (Older Person, 7)*

Sub-theme – Environment

This sub-theme covers the environment because older people highlighted that this can impact how they feel when receiving treatment in a hospital, and any factors that might lead to a poor experience.

The environment of a hospital impacted the older person due to the heat on the wards and how this caused their eyes to feel drier. The mention of not wanting to go to the hospital suggests a fear of losing independence or facing an environment that feels hostile or alienating:

> *"'Well, when the heat comes up, I can hardly, hardly see you.' He says, 'Oh, dear. Oh, and that's why I don't want to go in hospital because I can't see. You see, my eyes are very, very dry. They get that dry and they make me that I can't see properly." (Older Person, 8).*

Older people reveal the impact the environment had on them when they were in hospital – moving wards, to the facilities, noise and food. They highlight that a positive experience at the hospital is not solely determined by the skill of the medical staff but is also heavily influenced by the surrounding environment and amenities:

> *"The nurses, the staff were absolutely excellent, but the ward was bad. I think it was because it was one of the oldest parts of the hospital, the toilets didn't flush and you know, there was quite a lot of people in the ward, it wasn't good and the food was, they've got a lovely kitchen, but they didn't use it, it was all microwave horrible stuff." (Older Person, 10)*
>
> *"I don't like the hospital. I just don't like it". (The older person then refers to being moved around different wards and that there no communication between them). "The food, yeah. It's vile. Some of the nurses were nice, but there were a few, who were quite rude." (Older Person, 6)*

Conclusions of Past Experiences of Hospital Care Versus HaH:

- Older people do not like being in the hospital, and some reasons why this might be are highlighted in the data above. These views were very strong throughout the interviews, and it was clear that older people were unsatisfied with the quality of care they received.
- Their views about HaH are heavily influenced by comparison with their hospital experiences, which were largely negative. Overall, it is not clear that there are any positive aspects to being in the hospital when these older people are unwell.
- Key concerns included not always feeling listened to and respected during treatment, delays in receiving help, often leaving family members to provide care during visits and environmental factors that made them feel uncomfortable, contributing to poor experiences and negative perceptions of hospital settings.

Theme Two – Features of HaH Valued by Older People

From the older person interviews, it was evident that person-centred care led to older people feeling respected, valued and listened to. It ranged from older people to being told what treatment was due to be delivered to a much better service because older people felt professionals were spending the right amount of time with them to provide the treatment required.

For the purpose of this theme, below is a diagram of the main theme and its branches of sub-themes.

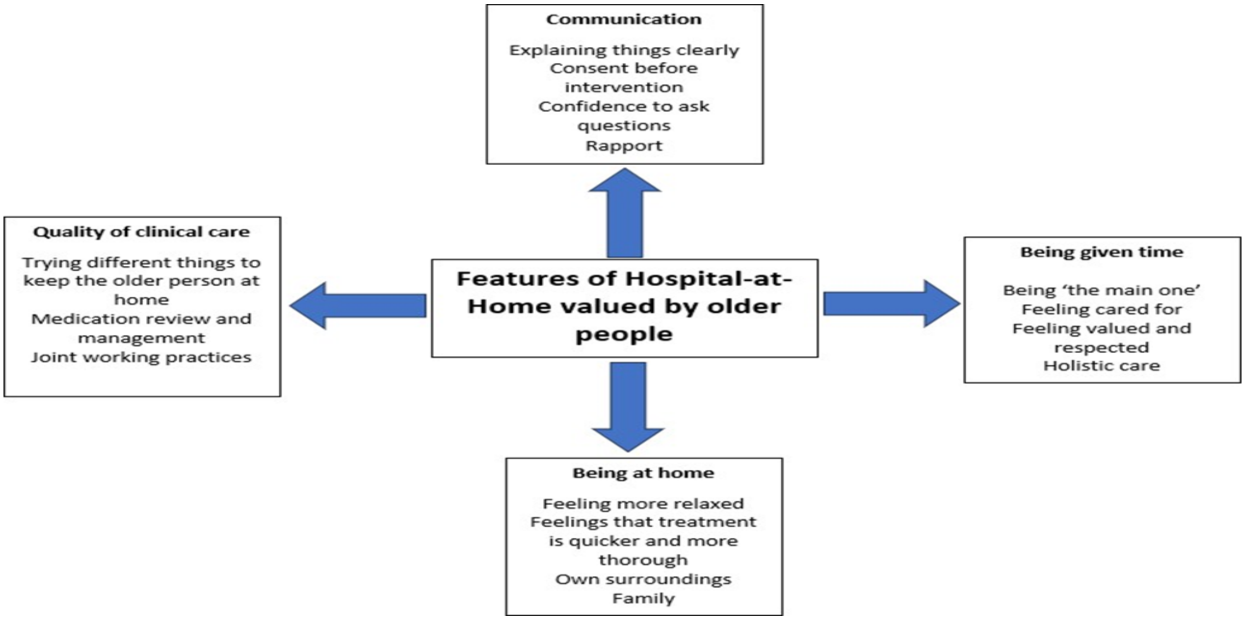

Table 5. Features of HaH Valued by Older People

Sub-theme – Quality of Clinical Care

This sub-theme covers factors that led older people to be satisfied with HaH. Older people felt very satisfied overall due to a number of factors, such as things being explained in detail to the quality of clinical care provided.

The actions of the doctor and nurse illustrate a blend of professionalism (the doctor’s scanning and administering antibiotics) and compassion (the nurse's concern for the patient's condition), reflecting the importance of both in HaH:

> *“I think they were very, very good. If I could write down and give him a good name, I would. I mean I’m 97 and for what they did for me is wonderful. He was the best doctor. He saved my life. He saved my life and the nurse. The nurse what came says, ‘You’re ever so poorly.’ She said, ‘I’ll get a doctor in here to you,’ and he came and he scanned me all over. He put the two antibiotics in my veins. Yeah, he come for three or four days and then the nurse finished it off. There was nothing else they could have done.” (Older Person, 7)*

The mention of the professional's demeanour being “really nice,” “very professional,” and “very helpful” points to the importance of interpersonal skills in HaH. This highlights the impact that a compassionate and skilled professional can have on a patient's experience:

> *“No, she said it’s wonderful, she really loved it and didn’t need to go anywhere. She didn’t need to go to hospital, and she found him really nice, and he was very professional, and he was very helpful to her, and he has kind of sorted her out.” (Older Person 9 – Grandson speaking on behalf of his grandma as she did not speak English. Grandson was translating)*

The importance of compassionate care in HaH is strong. There is a suggestion that even potentially uncomfortable medical procedures can be made more bearable by the kindness and professionalism of medical staff:

> *“They put stuff in me to make me wee even more which I did (it wasn’t pleasant) but erm, no, it – honestly, they were fantastic. They were absolutely fantastic. I can’t fault any of the doctors and nurses that have come in here. I cannot fault them. They’ve been so, so nice.” (Older Person, 5)*

Sub-theme – Communication

Older people feel communication is important between them and their treating clinicians. It is clear that older people felt there was better communication when receiving HaH, which led to a positive experience:

> *“Hospital at home was brilliant. He is a good doctor. I called him Dr Thumb when he first came because I couldn’t remember his name, don’t you tell him. He told me what he was going to do before he did it and asked me how I was before, if I was okay for him to do it, if you can understand what I mean because I had only got my nightie on and yeah, he was brilliant, brilliant doctor.” (Older Person, 10)*

> *“Yeah, at least you can get something done (when receiving treatment at home). But if you missed anything, you could always ask them again. Whereas in hospital they are quite busy, and they haven’t got that sort of time, have they really to stop.” (Older Person, 10)*

> *“They were excellent, they told me everything I wanted to know well, everything I could think of. Anything we didn’t understand, they explained. They did a scan of my chest and stomach and the heart and basically, I just can’t fault them.” (Older Person 6)*

Sub-theme – Being Given Time

There is a crucial aspect of patient care in HaH: the quality of attention and the relationship between patients and HaH professionals. The older person’s experiences may resonate with many who have felt overlooked in a busy hospital setting, highlighting the need for models of care, such as HaH, that prioritise individual patient needs:

> *“Having said that, when the nurses come here, there is only me they are looking at, when you are in hospital there is about 20 (patients) waiting for care so, one thing against the other. Whereas here, I am the main one, you know, that’s what they have come for.” (Older Person, 3)*

> *“They were absolutely brilliant because I came out of the hospital and they gave me an examination here you know, they brought all the stuff with them, and it was brilliant. It was like people who were coming in to look after me. I have just been satisfied with everything, all the treatment I have had yeah, it couldn’t have been better”. (Older Person, 1).*

> *“They have really done me well, sorted me out. And kept me well with medication, trying different things if something hasn’t worked. One was doing my kidney, I don’t know what*

> *it means, the count or something, had it gone down? Yeah, it went right down, and they halved the tablet, and it was giving me really bad back pain for some reason, and they have sorted that out, they have been great." (Older Person, 10)*

Sub-theme – Being at Home

This sub-theme covers being at home because from the interviews, older people highlighted this as a very important part of their recovery.

The older person felt the care was more personalised to them and their needs, which led to a positive experience:

> *"Everything was better. You know, everything was better. It was ... how can I put it? It was ... intimate isn't the word, is it? But it was so – I don't know, it was just so nice to be at home. Okay, they came in, they used the table to do whatever. It were absolutely lovely." (Older Person, 5)*

Some older people would prefer more home visits when they are not well, which implies that these interactions are more comfortable and less stressful for the older person compared to other forms of engagement. This could suggest a preference for a personal and intimate approach in care or support:

> *"They truly have been good so, there is nothing I can fault them on, absolutely nothing. The only thing I would like is more home visits, one, because I am more relaxed and two, I don't get hemmed up and out of breath". (Older Person, 3).*

There is a positive interaction between older people and HaH professionals. This duality highlights the complexity of patient experiences, where one can appreciate the quality of care while simultaneously feeling dissatisfaction with the logistics that occur in hospitals (wait times / in own room, isolated):

> *"Well, anybody who has come here has done what they have come for. They have done bloods. I mean, I wouldn't have to wait three hours for a start. Very caring the nurses, very caring. I like to be at home, yeah." (Older Person, 8)*

> *"Well, you can do as you want, can't you. I think at the hospital you're either in a room on your own or you are with other people who you don't know." (The unpaid carer who was supporting the older person explained her mother likes to be her own surroundings). The older person agreed with this stating "It's better here." (Older Person, 1)*

Remaining at home would be the older person's preference and might lead to positive experiences, given that it might be where they want to remain when unwell. Furthermore, having family around was a factor:

> *"I think we ought to have a service like this because I was talking to my neighbour who lost her husband last year and she said, 'Wouldn't it have been nice if [undisclosed] would have had this care at home instead of being in hospital?'" (Older Person, 4)*
>
> *"The thing is, treatment at home you're going to have person you know, what you like and what you don't like. In the Hospital at Home, people are more friendly so, you know, they kind of understand you more. So, I like the treatment at home. Because people in their own surroundings you know, they are quite likely to explain what they like and what they don't like." (Older Person, 11)*
>
> *"It's private, if, if you understand me. I mean, okay, you've got curtains round you (in hospital) everybody can hear what's going on, you know. But here, it's private. You've just got your immediate family if you want them with you. He (husband) was always here anyway because he's like – you're like my spare rib, ain't you, love? Er, but apart from that, no, it's, lovely. I'd recommend it to anybody. I couldn't (say) there's nothing I could improve. Honestly, it were wonderful. If it wasn't, I'd tell you." (Older Person, 3)*

Conclusions of Features of HaH Valued by Older People:

- It is very clear from the interviews that HaH is the preferred option for older people. It appears older people's generally positive experiences of HaH are often framed by poor experiences of hospital care.
- Older people feel their care is more suited to their needs and they feel valued and respected.

- Older people do not feel like a number and instead feel they are treated as human beings as opposed to when they are in a hospital where they feel they are just another number.
- There appears to be a better relationship between the older person and the professional – this is likely due to the quality time professionals have spent getting to know their patients and their condition during treatment.
- Professionals do well in explaining things to older people in a way they understand, which helps them feel satisfied with the quality of care they receive.
- Older people prefer to be in their own homes – this is because they feel more relaxed, and their families are often always present during professional visits.

The following chapter will consider the findings from the unpaid carers' interviews.

Chapter Five – Findings from the Unpaid Carer Interviews

This chapter of the thesis will cover the findings from the interviews with the unpaid carers. The findings link directly to the original research questions. The main one for this findings chapter is "What are the stakeholders' experiences who have directly received and delivered HaH interventions, and how has this impacted them?" For example, additional unpaid carer duties such as personal care tasks, emotional, psychological and financial impacts when older people have received treatment. There will be several sections to the chapter. In the coding part, themes and sub-themes were identified during thematic analysis. Therefore, the section will include the following themes and sub-themes:

- Theme one: Becoming aware of HaH, with three sub-themes: assistive technology, support in place, and primary care.
- Theme two: Impact on the Unpaid Carer – with four sub-themes: physical impact; impact on work and home life; emotional impact; and appropriateness.
- Theme three: Features of HaH valued by carers – with two sub-themes: holistic care, and communication.
- Theme four: Joined-up care.

Below is a table which shows the unpaid carer participants with an identifier, with a column for the nature of the relationship. The identifiers will be placed after the quote.

Identifier	Gender	Ethnicity	Relationship to older person
Unpaid Carer 1	Female	White British	Wife
Unpaid Carer 2	Female	White British	Friend
Unpaid Carer 3	Female	White British	Wife
Unpaid Carer 4	Female	White British	Wife
Unpaid Carer 5	Female	White British	Daughter
Unpaid Carer 6	Male	White British	Daughter
Unpaid Carer 7	Female	African British	Daughter
Unpaid Carer 8	Female	White British	Wife

Unpaid Carer 9	Male	Asian	Grandson

Table 6. Unpaid Carers Identifiers

Theme One – Becoming Aware of HaH

From the unpaid carer interviews, it was evident that participants had varying degrees of knowledge from various sources about HaH via equipment, support in place and primary care.

For the purpose of this theme, below is a diagram of the main theme and its branches of sub-themes.

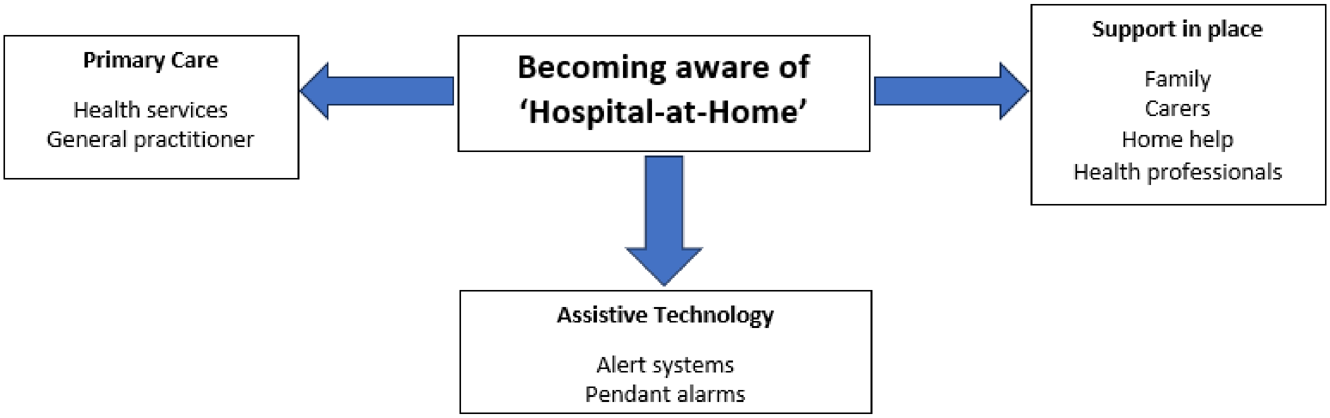

Table 7. Becoming Aware of Hospital at Home

Sub-theme – Assistive Technology

This sub-theme covers assistive technology in the sense of pendant alarms and fall detectors, which alerted wider services that then led to HaH intervention.

The carer found out about what had happened when the older person pressed their pendant, which triggered communication between emergency care and HaH. However, what is not necessarily clear is if the unpaid carer understood what HaH entailed and what was to be expected:

> *"She pressed her pendant and then 111. Then the next thing I know is a doctor phoned me and he said he'd done a scan and her lungs were filling up with fluid. He said, 'We've give her intravenously like the medication and there'll be someone coming the next day.' Then*

> *the next day, I came and another doctor and a nurse came while I was there. The nurse did the procedure. They said she'd be on tablets for her water." (Unpaid Carer, 6)*

Sub-theme – Support in Place

This sub-theme covers support in place, for example, services already providing support, such as specialist teams, for example, heart failure teams, to emergency services.

The carer had details about HaH because of a service their relative was receiving, which was already providing support:

> *"We've got a card off the heart nurse for the emergency numbers. So, I was so concerned about him that I rang that number." (Unpaid Carer, 1)*

The carer became aware of HaH through social care because the carer wanted to request more home care for his grandmother:

> *"It (HaH) came through social services, that's right because I called the social services for more care for my granny and from there, it came along from that, yeah." (Unpaid Carer, 9)*

The hospital made the unpaid carer aware of what was going to happen once the older person got home (HaH treatment and support from their carers):

> *"It must have been the hospital sorted it out. The hospital said you've got to have carers three times a day and they put it into place, I didn't have nothing to do with that, they did it. It must have been the hospital, and the social worker. She said you're having them morning, dinner time, teatime and supper time, but that was all in place because they wouldn't let him out until it was all in place for him to come home. ALSO, because I think he (treating consultant) was tending to (the older person) while he was in the hospital."(Unpaid Carer, 3)*

There is an indication that the unpaid carer became aware of HaH following intervention the older person had from heart failure specialists already involved in their care:

> "*I was pre told that the avoidance team would be in contact via the heart failure team. When they did come out, they didn't actually explain who they were, they were just saying, if they had mentioned they were the avoidance team then, I would have been aware because I was expecting them to come so, when they were saying they were from the I am thinking the virtual team or something, but I knew that the other team was coming. But anyway, I came and they were here when I got here." (Unpaid Carer, 2)*

The unpaid carer became aware of HaH during an emergency services visit by the ambulance. It is interesting because it appears some emergency services have knowledge of the service:

> *"The ambulance lady when she came a week Sunday gone. She did it all for me, the ambulance girl, yeah. They had only come to put him back in bed for me because he kept falling out. As soon as she told them, we had somebody here the next day, it was wonderful." (Unpaid Carer, 4)*

Sub-theme – Primary Care

Some unpaid carers found out about the service through communication between their GP and HaH:

> *"Only what (daughter said) they heard it off the GPs as they was coming out. When the doctors and the team came out, they explained things more thoroughly so you kind of knew where you stood and what was happening." (Unpaid Carer, 8)*
>
> *"Well from the GP coming in to getting in touch with the nurses and it all came together. If it hadn't have been for this GP speaking to (the HaH doctor) to find out what was going on (the HaH doctor) wouldn't have come in would he? So, it was all done and it was very professional how it was done, it was lovely, all very helpful." (Unpaid Carer, 4)*

Conclusions of Becoming Aware of HaH:

- There are several ways unpaid carers were made aware of HaH.
- The knowledge of the service is not necessarily in the public domain because unpaid carers only became aware that HaH was available when older people became unwell. For example, an emergency, such as rapid deterioration of the older person.

Theme Two - Impact on the Unpaid Carer

From the interviews with unpaid carers, it became clear that carers experienced various impacts when older people underwent treatment at home. These effects spanned several areas, including physical demands, work and home life balance, emotional well-being, and the suitability of the treatment.

For the purpose of this theme, below is a diagram of the main theme and its branches of sub-themes.

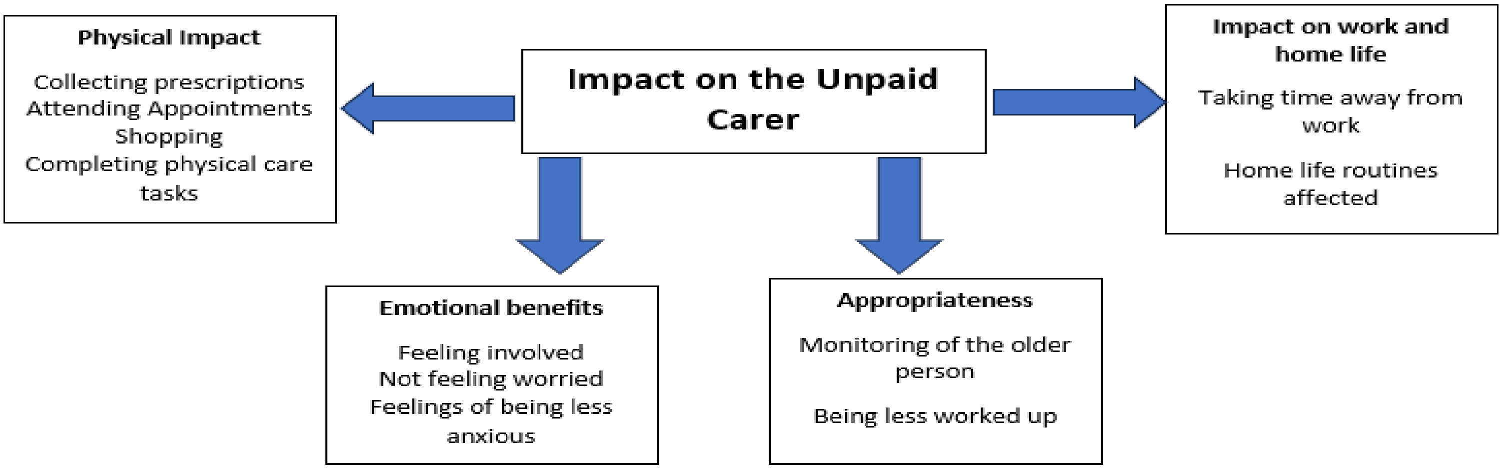

Table 8. Impact on the Unpaid Carer

Sub-theme – Physical Impact

This sub-theme covers the physical impact on the unpaid carer when the older person was receiving HaH treatment. It ranged from doing more in the sense of practical tasks to monitoring the older person.

Some unpaid carers felt the need to do more when the older person was unwell and receiving treatment, and sometimes after treatment had finished. It meant that when the older person was receiving treatment, the physical burden increased. For example, doing more care tasks than they are used to:

> *"I was here more because of the way she was. I suppose it was more monitoring really than anything. I do Sunday … I do her a cooked dinner and one for Monday. I don't come on a Monday but I come Tuesday with another dinner. Wednesday I come. I don't come Thursday. I come Friday and Saturday but I have to take her back to mine. Them days I came, I used to take her back to mine. She'd have fresh salmon, cod, fish, you name it. She had it and I do all the washing. I do her cleaning. I do her shopping. I just take care of her. She has a carer in three days." (Unpaid Carer, 2)*

> *"The thing is, I oversee, as I am next of kin and I know about dad's condition, I am the one that has to push things through, if I am not happy with whatever, I chase that, if I am not contented with what has been given, I chase it so, I am the main port of call so, the only thing that's happened differently is that I have been given a lot of numbers to call as support." (Unpaid Carer, 5)*

> *"I have to make sure that appointments are met, feedback is given or if I need to chase anybody for any extra information, call the doctor and whatever so, I am still that port of call because I just have to make sure that what they say they are going to do, they will do and if I don't think they are doing it good enough I will, they'll know." (Unpaid Carer, 4)*

Some unpaid carers felt their caring role became more intense in the sense of supporting the older person with their personal care needs. What we can see from the first quote is a sense of acceptance (I wouldn't have it any other way), and in the second, a development of learning and confidence (I am on the mark now):

> *"It's got a bit more – work to do like with helping and that It's just one of those things. I've got to do it. I wouldn't have anybody else to do it for her. I've been showering her and putting cream on her and everything. It's been quite a lot and you're getting up in the middle of the night and doing it, but you know, it's getting better." (Unpaid Carer, 6)*

> *"I've had to do everything for him. Everything. To washing him down to changing him, to not feeding him but medication, I've took over all his medication because I never touched his medication, but now, this sounds awful, but I couldn't trust him now with his medication because if he couldn't find them he'd say oh forget it, that sort of thing. "Well, I've got it all written down and I am on the mark with it, I really am on the mark with his medication now." (Unpaid Carer, 1)*

In HaH, there appears to be a family approach to providing care to the older person. Therefore, there is an impact on family members to provide care tasks between HaH treatments. Whilst a family approach is evident from these two quotes, we don't necessarily know whether or not this was down to the fact that they wanted to provide care or whether they had to:

> *"Yeah, we do it (care) between us. There's three – two daughters and – I mean my son's even offered to help us. She wouldn't want carers coming in." (Unpaid Carer, 6)*

> *"I have got two sons, but my one son lives in [confidential] and my other son only lives down the road, but since [the older person] has been poorly, he is here every day after work. He finished at 1 and he has been stopping here, but he's on work at 2 o'clock in the morning so, he needs his rest, but I said to him, I don't need you to stop and then, we got these carers at night and at least it's a bit of a respite for [the son] you know, but he is looking after all the medical side of it because I haven't got a very good memory." (Unpaid Carer, 8)*

Where the older person and the unpaid carer are unwell at the same time, this caused some concerns; nevertheless, the unpaid carer remained the primary carer alongside some temporary support. It is important to note that the implications are for carers who are themselves older people and in poor health:

> *"But why they give me care to start with because my son was there and he said, you do realise my mum's a poorly woman as well? Because I've got bad lungs and that and osteoarthritis, so I'm no spring chicken, and they said well, she needs some help, she does need help at home with him but I have persevered and I have coped." (Unpaid Carer, 1)*

When home carers don’t turn up, it leaves the unpaid carer to support the older person with care tasks, but this can be problematic if the unpaid carer is unwell or has additional needs:

> *“Because the carers, now this is what I was told, aren’t allowed to bath them. I don’t know why. Because I said I’ve got a bath for myself because I can't get in and out of the bath so I bought a chair myself, I said can he have a bath by sitting on this? She says, no, because it’s not one we have supplied. I understand that. Well, the one day the carers they’d stopped coming in for some reason, it was bad weather and they couldn’t get here and I said I’m going to have a go at bath.” (Unpaid Carer, 1)*

The burden was left to the unpaid carer to help the older person if they fell at home or needed to get help from a neighbour. It is not clear whether there was formal help made available or whether HaH advised what help could be available in these circumstances, e.g. calling them for assistance / out of hours support:

> *“There was just nothing, you know, and all she done like was fell over and I was picking her up, there was no, I couldn’t call anybody, I couldn’t phone because nobody would come. And then after three weeks they started bringing all this stuff, and I thought it’s a bit late, if it had been here you know. I mean years ago I was built like a brick outhouse, but not anymore, I couldn’t pick her up and I had to go and get the chap next door, he’s a young body builder, he was okay.” (Unpaid Carer, 6)*

Sub-theme – Impact on Work and Home Life

This sub-theme covers the impact on work and home-life and how when the older person was receiving treatment, it had a knock-on effect on their work.

When older people become unwell, unpaid carers are impacted in various ways, such as their home, work and financial situations. It remains unclear whether HaH offered to provide interim support to alleviate these issues for unpaid carers, e.g., referrals to appropriate help and support services:

> *“Yes (my caring role has changed), because at least like when she first came out, well now, when she had UTI (urinary tract infection), because originally she was upstairs, she used*

> *to just do her own thing our mother did, she never had a bed down here or anything, but then she's had this UTI and had a fall and I stopped the night because I thought she's got a UTI she was all over the shop and got no underwear on or nothing, she walking round here with no underwear on, so I stayed the night and I couldn't go to work because I work nights I do and I couldn't do my job, so that had a knock on effect at work." (Unpaid Carer, 6)*

Sub-theme – Emotional Impact

This sub-theme addresses the emotional impact of HaH on unpaid carers of older people. All the unpaid carers interviewed reported feeling positively impacted, with no emotional negatives identified. As a result, unpaid carers feel less anxious and stressed when older people receive HaH.

When older people receive HaH, unpaid carers feel less stressed and anxious. It is evident that HaH has a clear emotional impact on the unpaid carer, lessening the factors that contribute to their feelings when older people receive treatment elsewhere, such as at the hospital:

"I don't have to listen to him getting all worked up to go into hospital because he can't walk when he gets there and if he has to park and walk a long way, he's upset before he even gets there because he can't breathe. I was doing more (when he was having treatment at home) because he couldn't do anything but once he's had the infusions, he's able to do more for himself." (Unpaid Carer, 1)

> *"I was so worried, they decided that they would send a nurse out because he couldn't go to the walk-in centre, so they decided to send a nurse to the house. They were really helpful." (Unpaid Carer, 7)*

> *"I think it has helped me out, it has got better more and we know where we stand and it kind of yeah, it has made it less in the sense of you know, look, I still have to do what I have to do, but they have made it easier with how quick everything has worked [right] and how they have just tried to get her back on her feet as quickly as they can so, that's a good*

> *thing for her and her health and get her back to better, doing what she should be." (Unpaid Carer, 9)*

The inconsistency in post-discharge not only impacts the older person who may feel confused or unsettled by having to adjust to new carers, but also the unpaid carer who must repeatedly explain the older person's history and needs:

> *"Sometimes I think the problem is, when our mother goes in hospital she comes back out and then her care starts all over again, because after three days they have to re-start the care, so then it's all different people again who come in, like it's all different district nurses, it's all different OTs, so then you're just facing the same thing again like what you're going through again." (Unpaid Carer, 5)*

The unpaid carer's responsibilities had a significant impact on their home life, leaving them feeling exhausted. The introduction of professional help from home carers alleviated some of the burdens placed on them while the older person was unwell:

> *"My home life was impacted as well because of having to do more, I was just so tired, constantly tired I was. So, once the carers were in place it was great because I could go home." (Unpaid Carer, 5)*

Sub-theme – Appropriateness

The sub-theme covers appropriateness because this was highlighted by unpaid carers during the interviews. It ranged from ensuring the right equipment was in place to monitoring the older person during treatment.

The unpaid carer is worried about the older person being left alone for long periods if HaH treatment is offered. Therefore, it would appear that HaH is only beneficial when there is somebody in the home to monitor the older person's condition in between visits from health care professionals (should the older person not be able to do this themselves):

> *"The trouble is though they can't do that much treatment here, it's like the doctor said, if he could put a canular in and IV fluids he would have done it here but he couldn't because*

> *we can't leave her, you know what I mean. So, there's nobody here to do that (monitor)." (Unpaid Carer, 2)*

There is concern around whether it was appropriate for the older person to be treated at home due to a number of provisions and equipment not being in place. Therefore, in order for HaH to be appropriate, it is important the basics are in place for it to work effectively:

> *"The trouble with the hospital they sent her out without it (carers) being in place. She had no hospital bed. What we'd done, we had to bring the bed down and put it there and then when the carers did come, they couldn't do anything with her because she weren't on a hospital bed." (Unpaid Carer, 5)*

There is indication that the team found it most appropriate for the older person to be treated at home, and the unpaid carer felt this was suitable because their relative was more relaxed at home:

> *"They said they are the avoidance team preventing him from going into hospital and it would probably be in his best interest if they could avoid him going into hospital. So, the treatment that they gave was better for dad being at home because he was more relaxed, rather than being rushed to hospital on numerous occasions and going into all that atmosphere, he was more relaxed at home to get the treatment." (Unpaid Carer, 7)*

Conclusions of the Impact on the Unpaid Carer:

- Several factors impact unpaid carers when older people are unwell, ranging from physical, emotional, home and work.
- It is not necessarily clear what support or advice is provided to the unpaid carer when they are impacted.
- Unpaid carers did more for the older person when they were unwell and receiving treatment. Tasks ranged from personal care to meals and medications.
- The need to monitor or oversee care duties of the older person is strong and it is not necessarily clear if professionals provided oversight or advice on what to look out for.

Theme Three – Features of HaH Valued by Unpaid Carers

From the unpaid carer interviews, it was evident that carers felt reassured when the older person was receiving treatment. It ranged from keeping carers informed, quality assessment, to good communication between carers, the older person and professionals.

For the purpose of this theme, below is a diagram of the main theme and its branches of sub-themes.

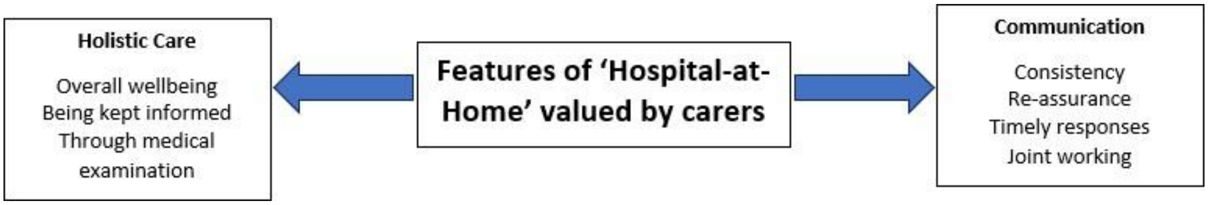

Table 9. Features of Hospital at Home Valued by Carers

Sub-theme – Holistic Care

This sub-theme covers holistic care because it was evident from the interviews that unpaid carers felt reassured by a number of holistic factors, such as examinations, equipment, keeping them informed and overall wellbeing of the older person.

The unpaid carer mentions they were "put at rest that day," indicating that the care provided alleviated their worries. This suggests the context might involve health care or emotional support during a challenging period:

> *"They were 100 or a million percent (great). You couldn't fault whatever. You couldn't do any better than what they did because they checked everything and we were put at rest that day because he'd been not well for about three months but going down and down and downhill." (Unpaid Carer, 8)*

The exchange between the older person and the doctor also highlights the dynamic of communication in HaH. The older person seems concerned about the findings and seeks reassurance, which speaks to the anxieties patients often feel regarding their health:

> *"I tell you now, he has never had an examination like they did it, never. They brought a little portable machine with them and looked at all his kidneys, one kidney is a little bit*

> *smaller than the other, but nothing to worry about he said, but his bladder, he has never seen a bladder so huge, he said, 'in all the years I have been a doctor' and I said, 'well, is it dangerous?', he said, 'no, but it is large, he's full of something' he said, and until he gets these drinks down him, we have got to wash it straight the way through.'" (Unpaid Carer, 4)*

The comparison between the efficiency of HaH and the perceived shortcomings of GPs may point to broader issues within the healthcare system, particularly regarding the challenges faced by primary care in addressing complex cases, especially in older people:

> *"I think number 1, you know she is 101 years old now and number 1, she doesn't need to go to the hospital, it was done very efficiently, it was done very quickly, really quickly I mean, what GPs couldn't do in a year they did it like in one day, they looked at her medication, they sorted her medication out, they did the bloods, like I said, what a GP can't do in one year they did it in one day and that's quite amazing actually. I mean, I've never heard of anything like this so, I was really shocked, like so professional, so good." (Unpaid Carer, 9)*

Timely investigation is important, highlighting the importance of diagnosing the specific reason for the older person's condition:

> *"They checked everything with the scan thing, and they could tell his heart was working fine. Erm, his liver was fine. His kidneys were fine but they just needed to know why his blood was dropping down so quick with the – forgot what it's called now – yeah, the iron, iron levels had dropped dramatically and that's why they was doing all the tests which was fantastic." (Unpaid Carer, 1)*

The nurse is concerned, prompting further investigation by the doctor, which emphasises the importance of attentive healthcare, which ultimately reassures the unpaid carer:

> *"They did his blood pressure and looked at his eyes and everything and the nurse was concerned, so she got the doctor to come back and he came to the house and tested his heart, his liver, his kidneys with the jelly and the scan thing and put our minds at ease that*

> *his heart that was making him feel so ill and they'd got to get to the bottom of it. So, then he sent him for a scan, an X-ray and then we've been to – he's been to see a specialist and he's had the all clear that there was no cancers or anything because of the weight loss and that was in – within three weeks." (Unpaid Carer, 4)*

The mention of "personal private service" suggests that HaH can feel more individualised and attentive than hospital care, where older people may feel like just another number:

> *"I mean if you've got treatment that you've got to be in hospital for fair enough, but if all your bloods and that and all you're practically doing is bed blocking and they can come in and treat you at home and you're getting like personal private service, aren't you? It ain't like you're just a number. I mean they came and they sat there, talked to her like she was normal, even though she was going mad at them." (Unpaid Carer, 6)*

The phrase "I never thought I could get help like this" reflects the unpaid carer's surprise at the level and quality of care provided. It suggests that they had not previously recognised the extent of support available to the older person:

> *"They came and explained all of the care and what they were going to do. I never thought I could get help like this. I have been nursing him myself for four years [right], I mean, I have heard of home helps you know and people going in taking them meals and that, but I mean, regarding the care that he's had well, I just haven't got words to say. It's taken a hell of a lot of pressure off me. I knew if he needed hospital, they would have taken him to hospital, I was quite happy." (Unpaid Carer, 4)*

The unpaid carer felt more reassured, albeit by the presentation of the older person, because they were in their own home and the carer could provide support. It appears the narrative was different, though, when the older person had to spend time at the hospital:

> *"When she was in hospital it was just like she was a lump of meat. Here, I mean I know she ranted and raved a bit, but she felt at home. And then when like the doctor (HaH) come she was okay with him. She used to go a bit funny of an afternoon but me daughter said that's normal. She improved more after, within a couple of days after the urgent*

> *response team (HaH) come than all the three weeks before that she had come out of hospital, because she was in her own environment and that was it. If she wanted a cup of tea I made her a cup of coffee, if she wanted a meal I used to go and cook her a meal and feed it her, and she felt lovely." (Unpaid Carer, 6).*

Sub-theme – Communication

This sub-theme covers communication as a factor in what made unpaid carers feeling re-assured. It includes professionals being clear from the onset to delivery of care and discharge from the service.

There is a positive attitude within HaH, suggesting that a cooperative atmosphere is beneficial not only for older people but also for the professionals involved:

> *"Well, they must all talk to each other because one person knows what the next person is doing and the respiratory get involved with the heart nurse and the heart nurse gets involved with the respiratory. So, they're our heroes" AND "I think they work very well (together)." (Unpaid Carer, 5)*

There appears to be a broader movement in healthcare towards patient-centred care, where the emotional and psychological aspects of patient care are prioritised alongside physical health:

> *"They kept me informed as well – well informed as well with everything. When the doctor came out, he phoned me right away. He told me all what he's done and I couldn't thank him enough. More of a personal thing. The patient wasn't a number; they was a person. Whereas, in hospital sometimes, okay you're there but sometimes when I've – when she has been in hospital odd occasions, it's though like she's been a number there." (Unpaid Carer, 4)*

The older person reflects on an experience where they received unexpected promptness and high-quality treatment. They emphasise that the service exceeded their expectations and highlight the professionalism of the care provided. The use of phrases like "absolutely fantastic" and "very professional and very good" highlights a positive evaluation of the treatment, regardless of the scale of the care (small or big):

> *“I never expected them to send somebody out straight away. Nothing could have been done better. I’ve never known treatment like it. It was absolutely fantastic. All the treatment he’s had at home, whether it be small or big, it’s been very professional and very good.” (Unpaid Carer, 8)*

The older person emphasises that the treatment they received at home was exceptionally professional and effective, suggesting that HaH can rival or exceed traditional hospital care:

> *“Because although it (treatment) was done at home it was very, very professional, very, and I don’t care where he’d have gone, he wouldn’t have got no better treatment anywhere to what he had here because it was absolutely brilliant. I can't fault the heart nurses, the virtual whatever you call them, nurses, everybody. The carers have been absolutely wonderful, they have honestly, they have gone out of their way to help, really out of their way.” (Unpaid Carer, 1)*

The mention of a doctor and a trained nurse working alongside each other emphasises the importance of teamwork in HaH. It suggests a holistic approach where multiple professionals contribute to quality patient care:

> *“I mean, the doctor was supported by a trained nurse so they worked alongside each other, and they explained the steps beforehand and prior and after as to what treatment they would be giving him. Giving the treatment in their home surroundings and technology has gone really far because they were able to do an ultrasound at home rather than being admitted into hospital and having that wait time and being anxious so, yeah, the treatment was good.” (Unpaid Carer, 5)*

The phrase "everybody is singing off the same hymn book" suggests that there is a shared understanding and coordinated effort among HaH professionals. This implies that the team is aligned in their goals and practices, which is crucial for effective patient care:

> *“I think everybody is singing off the same hymn book because sometimes, I will get a call from the GP to say, ‘are you aware that this team are doing x, y and z?’ And I said, ‘yes, I am aware’. The heart nurse, especially the heart team, are very good, getting feedback*

> *and coming back with blood results and giving me an update and things like that." (Unpaid Carer, 2)*

The importance of professionals keeping to their word and keeping unpaid carers updated was evident. Therefore, communication is classed as a positive factor when carers provide feedback. It is also important that when professionals kept to their word, it appeared to strengthen the benefits of the service:

> *"Oh, that was like, what he said was done. He turned round and said he was coming on a certain day, he came on a certain day, and he said, I'll see you on the Monday, and I think that was about December 5th or something. It's alright, I haven't got a good memory, I've got it written down and they came at 6 o'clock on the night, which surprised me, and they came out and they said, doctor said we'd got to come, we've got to come. You don't get that treatment like that, that's five star." (Unpaid Carer, 3)*

> *"He (the doctor) explained everything. If he needed further treatment, they would have given him another pump, but after that treatment they kind of signed him off so, they were happy with the treatment, I was happy with what the findings were and what they gave and then, there was a follow on from the heart failure team so, yeah." (Unpaid Carer, 5)*

Conclusion of Feeling Reassured:

- Several factors reassure unpaid carers, from communication to holistic care for older people.
- The most crucial point is that unpaid carers feel reassured by the timely interventions from HaH professionals and the good communication between all parties.
- One communication issue was highlighted between home carers involved during the older persons' treatment; however, this did not impact the care delivered to the older person.
- Overall, unpaid carers only spoke in positive terms about how HaH professionals deliver care.

Theme Four – Joined-up Care

From the unpaid carer interviews, joined-up care was evident in the sense of when positive and negative experiences happened. The issues highlighted were mainly around the disconnect between GPs, care providers and the HaH service. However, it is acknowledged that there are good relationships between internal colleagues such as HaH, physio and occupational therapy.

Joined-up Care

There are issues when there is a lack of joined-up care with professionals, such as HaH, care services and GPs and how, at times, some professionals will send the older person to the hospital without considering other services, such as HaH. It also highlights issues around when changes are made, such as medication management:

> *"The trouble is that like I say you've got all different ones, you've got everyone's different, every time she comes out of hospital there's someone different, and now like I phone my mom's doctor and I say to her, well, what's going on at the hospital? You know, like what's going on at the hospital like? What's with this discharge? And they said, I can't understand it, the discharge letter. And I say well, or what? Because nobody's saying anything." (Unpaid Carer, 5)*

> *"Because what they say is, instead of trying to keep mum at home they'll say oh if she's ill, send her to the hospital, you know what I mean, instead of coming out and seeing her." (Unpaid Carer, 5)*

> *"I was in contact with his GP anyway because they were looking to change his water tablets so, the doctor from the GP on that same morning said she would send the medication to the GP, sorry, to the pharmacy and the doctor said, well, this was the medication that is going to have the avoidance team, but when I went to the GP, it wasn't done so, I had to well, I went to the pharmacy, it wasn't done, I had to call the virtual team and make them aware that it hadn't been done because the medication had changed and the doctor said he needed that changing. So, I had to do a lot of things after that to get*

> *the virtual nurse to come out and change his meds because the carers wouldn't tamper with the medication so, there was a lot of steps that I had to do after that still to make sure everything was in order." (Unpaid Carer, 7)*

Joined-up care between HaH and other disciplines, such as physiotherapy and community nurses, was good. There appears to be a better joined-up approach from the perspective of the unpaid carers because evidently, when issues arise, care is provided in a streamlined way and any issues are dealt with swiftly:

> *"I mean they (HaH) came, I've got it all written down on the calendar see because I've got a terrible memory, and they just said, we've come. We'll come, whatever day it was, and they was here, and then in between the physio, and then they sent the physios in and she was giving the physios a right rollicking, because they turned round, they got her about and give her the exercises to do and they was like some kind of routine they got into and then they turned round and said, oh we'll take you outside, you know, with the snow on the ground, and get you to walk down the steps and up the path. And she soon told them what to do. She said, I haven't been able to walk now for about five or six weeks, she said, and I'm not going outside in the snow. But it was alright." (Unpaid Carer, 3)*

The unpaid carer mentions an "integrated system", which suggests that there are effective communication and coordination mechanisms in place among healthcare professionals. This is significant as it implies that the healthcare system can share information and collaborate effectively, which is crucial for patient outcomes:

> *"Well, initially, when one of dad's legs badly needed changing, I had to get, I had to call the community nurse, luckily, the person who took the call because dad was unwell that day, luckily, whoever took that call came out to check dad to do his observations to make sure that things were what I said they were and then, from that, she said she had picked up something on, because I think, there must be an integrated system where they connect to each other so, she was able to pick the obs up, come back and then, come back again and do the dressing. So, yeah, I think they do work well together." (Unpaid Carer, 7)*

Conclusions of Joined-up Care:

- Joined-up care internally between HaH and other ‘in-house’ disciplines such as physio and occupational therapy was good.
- There is sometimes a disparity in what some professionals feel is best for the older person. For example, some might feel hospital is the best option, whereas others might disagree and find HaH is the most suitable.
- There appears to be a system in place because the professionals involved are up to speed when they arrive to see older people and know what they are there to deliver.

The next chapter will cover the findings from the interviews with health and social care professionals.

Chapter Six – Findings from the Health and Social Care Professionals Interviews

This chapter of the thesis will cover the findings from the interviews with health and social care professionals. It is important to note that the findings are from a professional viewpoint, not an older person's viewpoint. The findings link directly to the original research questions. The main particular one for this chapter is "What are the stakeholders' experiences who have directly received and delivered hospital-at-home interventions, and how has this impacted them?". Within this chapter, there will be several sections. In the coding part, themes and subthemes were identified during thematic analysis. Therefore, the section will include the following themes:

- Theme one: Decision making about risk, with five sub-themes: responsibility; taking the risk; weighing up the risk; deterioration of an older person; and escalation and uncertainty.
- Theme two: Communication – with two sub-themes: barriers and relationships.
- Theme three: Person-centred care – with two sub-themes: feeling in control, and family involvement.
- Theme four: Service Provision – with three sub-themes: absence of social care, training, and equipment.

Table 10 below lists the participating health and social care professionals along with their assigned identifiers, which are used to reference their quotes in the text.

Identifier	Profession	Job Role
Professional 1	Doctor	Acute Medical Registrar
Professional 2	Doctor	Acute Medical Registrar
Professional 3	Doctor	Acute Medical Speciality Doctor
Professional 4	Nurse	Advanced Clinical Practitioner
Professional 5	Nurse	Advanced Clinical Practitioner
Professional 6	Nurse	Advanced Clinical Practitioner
Professional 7	Nurse	Advanced Clinical Practitioner
Professional 8	Nurse	Advanced Nurse Practitioner
Professional 9	Nurse	Advanced Nurse Practitioner
Professional 10	Nurse	Community Case Manager
Professional 11	Doctor	Consultant (Acute)
Professional 12	Doctor	Medical Registrar
Professional 13	Doctor	Medical Registrar

Professional 14	Doctor	Medical Registrar
Professional 15	Doctor	Medical Registrar
Professional 16	Therapist	Occupational Therapist
Professional 17	Doctor	Palliative Medical Registrar
Professional 18	Doctor	Palliative Registrar
Professional 19	Trainee Nurse	Trainee Advanced Clinical Practitioner
Professional 20	Trainee Nurse	Trainee Advanced Clinical Practitioner
Professional 21	Nurse	Clinical Practitioner

Table 10. Health and Social Care Professionals Identifier Table

Theme One – Decision Making about Risk

For the purpose of this theme, below is a diagram of the main theme and its branches of subthemes.

Table 11. Decision-making about risk

From the professional interviews, decision-making about risk was evident, e.g., between the older person and the professional, about having treatment at home or needing treatment at the hospital.

Sub-theme – Responsibility

This sub-theme covers responsibility in several forms, such as taking sole responsibility, sharing responsibility, feeling confident in liaising with colleagues, and the number of patients the professional is responsible for.

Sole responsibility is strong, which might differ in a hospital setting. It highlights the complex ethical considerations involved when weighing the risks and benefits of different treatment options. Nonetheless, the doctor feels the risk is shared between them and the older person:

> *"I'm on my own, so I'm taking the decision either to treat in the home or send to the hospital. So that was a little bit more responsibility but it's usually like a shared risk because the patient is happy to take the risk and to receive treatment in his home rather than go into the hospital" (Professional, 12).*

The doctors feel confident in their duties and responsibilities around signposting the older person to other colleagues where necessary:

> *"Everyone knows that different role and a lot of people are happy to signpost to each other rather than – in a positive way rather than a – trying to shirk responsibility. Everyone is very keen to try and direct responsibility to the right department and the right person". (Professional, 2).*

Some HaH professionals had concerns about access to resources, therefore, it was important that they had the right access to resources in a timely manner, otherwise, it causes worry for the professionals when treating people at home versus treating them in the hospital:

> *"So then to come into a department (hospital-at-home) that does house visits in a community setting only with more acute medical flavours, it's quite unnerving because you don't have access to blood tests, the imaging – a lot of the same crutches that you rely on when you're in a hospital setting you don't have access to. I think that's really kind of disconcerting for a lot of the doctors that come into it at the beginning." (Professional, 2)*

> *"Our service is 8am to 8pm so, there is that gap there where there isn't the resources available if we need to escalate something that's a bit too complex for our service" (Professional, 4)*

Practising HaH for the first time can be anxiety-provoking. It appears professionals felt more comfortable when treating people at the hospital because they had a team at hand. However, this doesn't seem to be the case here:

> *"Absolutely (worried about treating at home as sole clinician), I think (when) people are in hospital, it's very easy to get a second opinion because there are lots of members of the team around and I can always ask a senior, whereas in their own home, for one thing, the level of monitoring is a lot lower so, there's more risk involved, I think. Obviously, I could phone a consultant at city for advice if I needed it but it's not really the same as being able to take someone to see the patient with you so, it is quite isolated and that was a cause for concern" (Professional, 14).*

The mention of "anxiety" and "nerve-racking" indicates that there was a level of apprehension regarding potential adverse reactions and contraindications that might occur in HaH, which might otherwise be better controlled in the hospital:

> *"I think when you're first initiating treatment, so I know that's something that the advanced medical practitioners (AMPs) in particular are looking into at the moment, initiating like IV antibiotics for example, I think there is that sort of element (anxiety), so at the moment we're not doing that, we're not doing the first doses because there is that sort of worry that if patients are having this drug for the first time and are there going to be any reactions or contraindications, and that is a little bit nerve racking, but overall I think it's a really good thing (hospital-at-home). I think it's the way forward and I think it's safer in some respect for patients to be in their own environments and not be exposed to the risks of hospital waiting times, but yes there is that element of fear that, not fear, but I think you're always nervous that things could go a little bit wrong and then you're on your own, but you get that with anything I think." (Professional, 5)*

COVID-19 was a significant challenge, but nursing staff felt that responsibility was shared with their senior colleagues rather than being left alone to take sole responsibility:

> *"I came into this role just over two years ago. I'd always worked in an acute Trust prior to that (HaH), in a very specialist area rather than generalist, and started this role as we hit the COVID pandemic, so it was quite a challenge, but we were always very well supported with our clinical lead." (Professional, 7)*

Some professionals felt it might have been helpful to have a process to follow, some training or an introduction that might have helped them establish their roles and responsibilities and increase confidence in certain aspects of HaH:

> *"It would have been nice to have some written confirmation from the hospital about what it was exactly that they were allowing and expecting us to do (when delivering HaH) because some of it felt a little bit risky, not risky in the sense that it was carelessly done, but it's just the nature of an appropriate at home patient is that if it's just bloods you they never needed to be in hospital in the first place." (Professional, 13)*

The plan for professionals is to upskill them. However, it doesn't seem to be the case in this scenario. Responsibility, in the sense of equipment, seems to be in the hands of doctors rather than the nursing staff:

> *"The plan was, and still is as far as I'm aware, to upskill us. So, although I personally (don't feel confident in certain pieces of equipment), and I don't think any of my other colleagues are either, we're not trained to be able to do the ultrasound within their own home of the patient. The Epicentre doctors tend to do that, but I think that the plan is that we are still going to be upskilled at some point (which will make us more confident)." (Professional, 9)*

Despite the uncertainty surrounding the operational aspects of HaH, the nurse expresses confidence in their ability to provide care to patients. This indicates a strong foundation in their clinical skills and a commitment to patient well-being in HaH:

> *"I would say I (wasn't confident) at the beginning. I was confident in terms of the care I would be able to provide in the community. The only bit I was not confident or rather I was not very clear about was the set-up of the Hospital at Home system because we have kind of piggy-backed onto [CONFIDENTIAL] which is a system already functioning in the community here. It wasn't a lack of confidence but rather just not having a clear idea of how the two systems, which is essentially Hospital at Home and [CONFIDENTIAL] erm, co-function." (Professional, 3)*

Professionals feel it is important for older people to take responsibility for their health and what signs to look out for when receiving HaH treatment instead of just relying on presenting to the hospital:

> *"I think it's really important that we ensure people are kept at home if they can and people take responsibility for their health and are taught what to look out for and to help maintain their own health as well, rather than just relying on the hospital." (Professional, 5)*

There is uncertainty about the unknown and not knowing what the nurse may be presented with. The nurse is optimistic in taking on the challenge around responsibility in the sense of upskilling, only enhancing what they already know from their previous areas of expertise:

> *"I think there's always an element of the unknown and you're not quite sure what your kind of walking into. But that in a way only enhances your skills further. On paper it may say a chest infection query, but you go in and it's quite something else because you're kind of taught to do like a head-to-toe assessment anyway and do a systematic approach to your assessment. I think if anything it just kind of skills us up a little bit. But confidence can be up and down at times just basically because you don't quite know until you get there what you're going to be faced with." (Professional, 19)*

There appears to be a reduction in the number of older people to see, treat and review. We also see the doctor highlighting the responsibility of investigating themselves, whereas in the hospital, somebody else might share or complete these tasks:

> *“It felt a little bit strange to me that I was only seeing very few patients in a day and, you know, I was having to do quite a lot of the investigations and so by myself, whereas in hospital you’d normally request somebody else to do the bloods and the observations and so on. So, it was, it was a little bit alien to me.” (Professional, 15)*

There is more responsibility in treating older people with complex conditions, but it is seen as an opportunity to upskill, so it’s worth it:

> *“I think what we’re seeing is a lot more acutely unwell patients, a lot more complex patients, sort of several co-morbidities where the GPs haven’t been going out, we’ve been going out for them as the project’s (hospital-at-home) got moving. If we’re concerned, we can have that discussion (with registrars). They will come with us and see a patient, so we’re learning from them. It’s all moving in the right direction I think to upskill as ACPs” (advanced nurses).” (Professional, 4)*

The nurse outlines various options available when dealing with complex cases in HaH, seeking advice, requesting a specialist's presence, or hospitalising the patient if necessary. This indicates a thoughtful, patient-centred approach to HaH:

> *“If there were things that you felt that if you went to a poorly patient and the patient was quite complex in terms of medical conditions, you would refer back to the epicentre doctor just to get some advice, or ask them to actually come out to review the patient, or you always had the option of sending the patient in if they were at the stage where you felt they needed to be in hospital anyway.” (Professional, 5)*

Some professionals had received sufficient training that made them feel confident in their abilities. Some professionals had previous experience practising medicine in the community, which also contributed to their confidence in delivering HaH care and taking responsibility for patients. For those who were new to HaH care, having experienced colleagues helped them build their confidence:

> *“The department and the doctors that were helping to set up the Epicentre service created a couple of induction programmes to run through and er, how the system works both for*

> *the doctors involved and the departments that we touched on peripherally, such as emergency departments and the erm, hospital avoidance erm, nursing staff as well, just so that we can kind of get an idea for how the team should interact at their interface. Erm, so there was a one- day induction erm, given to, given to the participants of Epicentre throughout the year, run at different times." (Professional, 7)*

The nurse has a wealth of experience in acute and community-based care. Therefore, the transition to delivering HaH appeared to be straightforward, and the nurse felt confident treating people in HaH. Therefore, taking on training did not seem to be an issue in this scenario, given the expertise of the nurse:

> *"I have extensive acute background because I have worked in cardiology, stroke and with medical assessment units, so, I kind of worked a little bit all over so, I think for them, that was quite good because I have got that experience of working with the poorliest patients and also, you know, I went to rehab as well so, I have kind of gone the whole circle. So, my last place of work in a hospital was actually a rehab ward which then kind of follows on from, we would normally probably send patients out from the rehab ward which these guys were picking up if they were becoming unwell so, in that sense, it was just a kind of the you know, the right progression (what to do in hospital-at-home)." (Professional, 10)*

There is a need to advocate for and educate older people receiving HaH. It stresses the importance of a collaborative approach to delivering care and professionals stepping up to the challenge:

> *"Yes, I think so (was confident). Like I said my role is split a little bit so yes, I do the hospital at home, but I think a lot of that is the teaching side of it and the education and the advocacy, so yes, I was confident. I think more stuff is coming out now that they want to change things or things are changing and developing and it's something that you just move with the times don't you, so forever changing, forever getting my head around new things. I think sometimes when you work in the community there's people have different opinions and views on things and how you manage your own patients, or how you manage*

things, I like the idea of this coming in (HaH) we'll work at the same thing and all support each other in the same sort of ways with the doctors as well." (Professional, 6)

Summary of Responsibilities:

- Some clinicians felt it was solely down to them to assess and manage risk, whereas others felt able to call on their health colleagues if there was any slight deterioration or uncertainty about an older person's condition or treatment.
- Some professionals highlighted their responsibility in completing investigations themselves, whereas in a hospital, other professionals might have done this on their behalf, e.g., blood tests and following up results.
- Some professionals felt they were up-skilling when providing treatment, assessing risk and reviewing older people's conditions.
- Some professionals, especially doctors, noted the difference between being accountable for a smaller group of patients in a HaH compared to managing a larger caseload of patients in a hospital setting.
- Some clinicians felt education was paramount when it came to HaH treatment. Hence, the older person can spot signs of deterioration, for example, and how best to manage this rather than presenting to the hospital.
- Training for professionals was also raised as a tool to increase confidence in taking responsibility.
- Some clinicians felt a standard operating procedure would have been helpful, as this would have made them feel more confident in their responsibilities as HaH practitioners.

Sub-theme - Taking the Risk

This sub-theme covers taking the risk in several forms, from feeling uneasy initially to feeling more comfortable as time progresses, assessing and managing risk, a new way of working for some professionals, to team spirit and support from colleagues.

There is a feeling of awkwardness when first delivering HaH to then realising that, from observation, older people are happier and have family around; therefore, it is worth taking the risk because of the wishes of older people to wanting to remain at home:

> *"They (older people) want to be in the comfort of their own home. Initially, it felt a little bit awkward for me, to be honest, like to go to the patients' houses and like seeing them there ... but when I have noted that patients when reviewing them, some of them feel better, and the family and even the patient are so grateful for not sending them to the hospital and giving the treatment in their homes." (Professional, 2)*

There appears to be an element of taking risks, but HaH professionals are willing to take the risk of treating older people at home:

> *"I am a little bit apprehensive, um, because even with whether it was medical oversight, or whether it's, er, a well-trained, rehearsed ACP, there is always what if something goes wrong when there's nobody with the patient at that particular time? And I think no matter what safety precautions, safety netting you give to your patients and the family, there is always that tiny little element of risk. I think we're prepared to take on that risk, um, by carefully selecting the right patient at the right time, in the right place, really." (Professional, 16)*

The feelings of the unknown are highlighted when providing HaH due to the difference in approach to medical care. However, what seems to be clear is that staff feel more comfortable over time with additional training and exposure. Therefore, it's worth taking risks:

> *"It's the unknown, providing hospital care in the community is very, very different but with some directions and online training and face-to-face training and courses, the confidence and competence comes with it." (Professional, 4)*

It feels important to take risks. For example, continual assessment and management of risk make professionals more confident, such as gaining prior experience and becoming familiar with new conditions and community management:

> *"I think at the back of our minds there's always that element of risk. I think that comes with experience, but you get used to managing or being comfortable with a certain amount of risk. We talk about low thresholds or high thresholds for admission (if it's decided the person needs to go to hospital). Depending on the older persons past medical history or the recent history, and their story so far, would determine whether you would have a low threshold or a high threshold." (Professional, 19)*

There is a greater consideration of risk when an older person is receiving HaH due to the difference in approach to risk-taking:

> *"It's quite daunting taking a patient who you would treat in hospital. I suppose the whole premise is that these are patients that are unwell enough to require hospital treatment and treating them at home. So, it can be quite daunting. I certainly sometimes think about the patients that are at home a little bit more than say I would when I was on the acute take, just because on the acute take you've got a bit more of a safety net really." (Professional, 1)*

All conditions/symptoms are different with each patient. Where there might be some anxiety in taking new risks around HaH, it is clear there is a need for team support and advice from colleagues where there might be uncertainty or query:

> *"Every day you're going to get somebody different and some different symptoms that sometimes you might not know what to do with so, you're going to have to you know, refer back to our epicentres (HaH) like doctors there so, we can refer to them as well." (Professional, 10).*

The approach to taking new risks in HaH is unnerving for some clinicians. Therefore, what is evident is the readjustment to a new way of working away from the hospital environment and thinking differently about the approach to medical care in the community:

> *"Our hospital physicians find it to be quite unnerving, I guess. Some of the stuff that we manage in the community (HaH treatment) is – when you mention that to other hospital physicians, they kind of look at you aghast to think that that's the kind of stuff you could manage in someone's living room as opposed to blue-lighting them into a – an emergency department or an acute medical unit in a secondary care setting." (Professional, 1)*

> *"I think medicine is about managing worries, isn't it? Your own and the patient's. I think it could work, I think that especially if patients are extremely keen to be at home, and maybe would have even intended to go to hospital or wouldn't have agreed to stay in hospital, I think that having an agreement with them that they understand that there's a certain element of potential, theoretical enhanced risk of having certain things managed in the community, I think that's a perfectly logical thing to do and a perfectly sound approach to those patients." (Professional, 14)*

Despite the uncertainty of delivering care at home, it's worthwhile to take the risks because it enables people to remain at home, which is better for older people:

> *"I didn't know what to expect entirely. House environments are obviously different, and they are not ideal in terms of a place where you can provide care but balancing that out against ... preventing a hospital admission helps me approach that with a bit more positivity. I have had very few situations where I was essentially not in a good environment when visiting home but I'm always supported by a ACP, a AMP or a member of the team and because they have been doing this a lot longer than us, they're quite confident in going into the community and seeing patients, so that is an advantage to be able to go with one of those team members, which makes me feel more safe and secure in the environments." (Professional, 3)*

There is more concern when it comes to treating older people at home instead of at the hospital. However, it's worth taking risks and involving other services because it is what older people want, as long as treating them at home is safe:

> *"It is always a worry when you are in the community, because in hospital when you move you know, you need the shifts and the nurses coming, but in community you have to check*

> *all the aspects before you leave the home. It's very different from acute and it could be worrying so, you know, safety netting, try everything possible, get other services involved. It's more worrying than working in hospital, BUT it is best to keep them (older people) at home as much as possible as long as it's safe to avoid delirium or worsening of their cognition." (Professional, 8)*

There is a need for additional training in addressing various risks when providing HaH, given the distinct difference from working in an acute hospital setting:

> *"There's different risks that come with that and particularly, you know like I say, we've not been given extra training for how to do that or a sort of awareness of what services are available erm so, yeah, I suppose, there were some concerns about what that would look like. It felt very different to my normal work (in the hospital)." (Professional, 17)*

Summary of Taking the Risk:

- There is a need for additional training regarding a new way of working, especially if the clinician has yet to practise this model of care routinely.
- New approaches can be unnerving for some clinicians, and the need for colleague support is strong.
- Ongoing exposure to this new way of working may increase clinicians' confidence, with some feeling they are upskilling as time progresses.
- Clinicians feel it is worth taking the risk at times because older people feel happier at home, surrounded by their loved ones.
- Clinicians feel more comfortable and competent when additional training is offered when there is a new way of working, especially when taking unknown risks, e.g., treating older people at home versus treatment at the hospital.

Sub-theme – Weighing up the Risks

This sub-theme covers weighing up the risks, for example, not wanting to go to hospital, preference and choice, being happy about taking the risks, appropriateness of HaH, environmental factors and whether or not support is in place.

There is a feeling of worry when the older person or relative makes decisions; however, they are happily taking risks because they don't want to attend the hospital:

> "*They (older person) don't want to go to the hospital, so most of them like are happy to take that risk and ... the most worrying bit for me is the decision, with the patient or the relative." (Professional, 12)*

It makes sense to take the chance of staying at home, as there is a lesser risk of catching infections, which is what older people prefer (staying at home):

> *"They (older people) want to stay at home. In terms of honouring patient preference, keeping patients' content and happy and safe, I think it's a brilliant thing to do. It's also safer in their own homes, they're not as exposed to hospital acquired infections or risks of falls,* trips, confusion and delirium that they normally get in hospital." *(Professional, 18)*

Shared decisions are evident between the older people and professionals when weighing up the risks of attending hospital; the older person's preference is strong and accepted in these instances:

> *"It's like the patient's preference, so I can say it's a shared decision between me and the patient because usually, most of the patients we go and see, they refuse to attend the hospital. They don't want to go to the hospital, so most of them like are happy to take that risk." (Professional, 13)*
>
> *"Hospital at Home is to not take that risk purely upon your own shoulders and try and share it out and make a shared decision with the patients about whether they do or don't want to be in hospital. And I often leave hospital admission as an option. You know, I say that there is a way to treat at home, it comes with these risks and benefits. The other*

> *option is hospital admission that comes with these risks and benefits and we come to a decision down the middle. And I would say I've not come across a patient yet that their choice has been to receive care in hospital as opposed to at home. So, I think that does share a bit of the risk out." (Professional, 1)*

There is a difference in how professionals weigh risks and available options. Through consultation with HaH colleagues, they could keep the man at home, avoiding the need for an unnecessary admission, which would have been the case without intervention from them:

> *"We had a gentleman a while back where the GP just wanted to send him into hospital. He'd got cellulitis, an injury, broken area. It was quite clearly cellulitis; elevated CRP, elevated white cell count – neutral count but his vital signs were stable. On the news, he was scoring zero. So, the GP, because of the, the, the blood tests, wanted to send him in but with (support from) our consultant microbiologist, we actually kept him at home." (Professional, 8)*

When weighing up risks, it is evident that the environment is considered. For example, is the home safe to deliver HaH treatment? If it is, then proceed, but if not, this will need further consideration:

> *"You have also got to make sure that that patient, it's appropriate for them to stay at home and that they're safe and that the care that you want to deliver in that environment is safe." (Professional, 4)*

There is an indication that there are differing levels of risks and that some professionals feel more comfortable than others. Regardless of this, the aim is to keep people at home, so it's worth taking risks if it's safe to do so:

> *"I think we're all at different levels with what we're comfortable with managing (risk). I certainly get senior advice when I feel a little bit unsure, even if that is running past a medic, but I think generally as a team or a group we are a little less risk averse, just because of our mission really to try and keep that person at home. I think we're pretty*

> *good at weighing up whether someone should go in, they should really just go in and we've done all we could, you know." (Professional, 20)*

The aim seems to be to keep an older person at home if it is safe. However, should this not be a safe option, the power dynamic would change, and the professional would be assertive in highlighting the risks of remaining at home to the older person:

> *"I think that our aim as a team is anything that can be done to keep someone at home, safely, then that's the main thing for us. Obviously if people need to go in then we encourage them to go in but if it's just for a scan or just for a set of bloods and we can do it at home, then that's the best place for them. People are always happier in their own homes anyway." (Professional, 9)*

There is a strong feeling about the older person's environment, but it is important to weigh up the wrap around support when HaH is being delivered, for example, support from family:

> *"Being able to provide safe care – in an environment that patients are familiar with. So, we're not causing worsening of delirium and getting them to very clinical environments where they maybe haven't got that support (family/environment/advocate)." (Professional, 5)*

Summary of Weighing up the Risks:

- Professionals considered several factors when weighing up the risks of delivering HaH treatment, for example, the older person's environment and wrap-around support, e.g., family members.
- Weighing up the risks consisted of ensuring the appropriate treatment was available for safe delivery in the home.
- It is important to weigh the risks together and ensure positive risks are taken instead of being risk-averse, as the aim is to keep people at home, and it is what older people want.
- Professionals felt the decision around weighing up the risks of receiving HaH treatment versus hospital care was shared between them and their patients and

family members. Whilst it was evident this did make some professionals feel worried, patient preference superseded this worry, and the older person took the risk.

Sub-theme – Deterioration of an Older Person at Home

This sub-theme covers deterioration at home, for example, the support network around the older person, access to necessities, integrated working with professionals, the older person's environment, refusal of care, power dynamics, safety netting of the older person and the reliance on the older person to monitor their condition.

It is important to work closely with health colleagues when an older person's health worsens. It shows that swift action is taken to meet the deteriorating needs of the older person, with assistance from the pharmacy, district nurse, and the 'kit bag':

> *"Because the patient's showing signs of distress and that's where we really pull our teams together then. We get a prescriber to do the prescribing, we run it down to the pharmacy and we get the medications, we run back to the family then we get a kit bag from the district nurses and make sure everything's in the house in terms of giving them medication and do the referrals." (Professional, 17)*

It can be challenging when older people do not want people coming into their homes. Therefore, discussions should take place about the best way risk transmission of COVID-19 can be kept to a minimum:

> *"You have also got the patients that, especially with COVID, they don't want people in their house so, they don't want to have anything, you know, they don't want you to come in and invade their space." (Professional, 10)*

There is a holistic approach to delivering HaH that includes thoughts about safety netting if deterioration occurs. The ultimate goal is to ensure that the dying process is as peaceful and pain-free as possible, allowing the older person to pass away at home:

> *"That (MDT response) enables the family to have a complete safety net blanket of support for the up and coming hours or days where their loved ones going to be able to die at home in comfort, with no distress." (Professional, 18)*

There is thinking behind leaving someone receiving HaH alone, and how they might manage if they do not have wrap-around support in place. There is a reliance on the older person to report any deterioration if their condition worsens:

> *"When you're leaving someone at home, sometimes they've got carers, sometimes they've got family members but sometimes they don't have anyone else and you're really reliant on that person knowing when they're getting worse, and that leaves a lot of room for things to go wrong." (Professional, 2)*

Summary of Deterioration of an Older Person at Home:

- Integrated working is essential when an older person deteriorates at home. For example, professionals will work together to ensure the older person's wishes to remain at home are respected.
- Professionals will work together to ensure the older person is comfortable and their family are supported by a multi-disciplinary team (e.g., district nurses, HaH colleagues, consultants and therapists).
- There is thinking around safety netting for older people, should they have nobody to support them if deterioration occurs. For example, professionals rely on the older person to understand deterioration and to self-report if their condition worsens. Where needed, they will provide temporary home care until treatment is finished.
- Some older people do not always want people in their homes due to the risk of COVID-19 transmission, which can be problematic. Therefore, it is important to discuss with the older person what actions will be taken before offering treatment at home (in terms of reducing/managing the risk of transmission).

Sub-theme – Escalation and Uncertainty

This sub-theme covers escalation and uncertainty, for example, what steps to take, being faced with an unknown situation alone, escalating to multi-disciplinary colleagues, honouring and outweighing the older person's preference.

Power dynamics play a part here, and it could be viewed as the professional having the power to send the older person to the hospital, which might outweigh what the older person feels is best for them:

> "*There's always that element of what to do in this situation, should we really send them (the older person) into hospital? And you do feel a little bit like you've failed I guess when they have to go in, but there is also that safety line as well." (Professional, 19)*
>
> *"We were able to have a chat with the patient and come to a shared decision that the patient should go to hospital and get the treatment to get better. And again, yeah so, we really gave the patient hope and I think we did the right thing for the patient." (Professional, 11)*
>
> *"They have been used to going into hospital and having the 24-hour care there so, yes, we have challenges, and it takes a lot of some, for those people it takes a lot of convincing and sometimes you can't always win so, it's the patient's choice, you might still have to send them in." (Professional, 4)*
>
> *"At times, if it was a situation which wasn't suitable to be dealt with at home or the the situation had escalated to a level that they needed admission, then sometimes we were admitted into hospital, and there was also, some involvement of referring to other community teams as well." (Professional, 15).*

There is anxiety about what happens when someone might deteriorate at home because immediate help may not always be available. Therefore, risk management is approached differently than in a hospital setting:

> *"You're taking a different approach to risk management. A lot of people (older) come into hospital and you get regular observations and if anything happens or anyone gets sicker, you've got people around you to tell you that someone's getting sicker." (Professional, 2)*

The older person's choice is respected even when they deteriorate at home. Again, integrated working is evident in the sense that HaH professionals will call on multi-disciplinary colleagues to ensure the older person can remain at home during the end of their life:

> *"I saw a patient other day that is quite poorly near end of life, but you know, even if he deteriorates, he is determined that he doesn't want to go into hospital and we obviously respect that and keep him at home and just try and keep him as comfortable so, we're able to get the relevant service in to make sure he is looked after in his own house." (Professional, 10)*

Some older people do not always feel that HaH is right for them because they are so used to receiving treatment in a hospital rather than in their own homes:

> *"Some people will be very acceptive of it and you know, they will be thankful that you are coming and doing this at home, but the second there will be people in my experience, that they want to be in hospital. They don't consider it as the right way as they have been used to going into hospital and having the 24-hour care there." (Professional, 7)*

It is important to check documentation and seek advice to ensure that the treatment is correct and will benefit the older person:

> *"There was a palliative patient where I was asked to prescribe quite a high dose of a controlled drug, which was a lot higher than I had prescribed before. The documentation was in the patient's home, but for me, I needed to actually speak to one of the consultants that was on call to verify it. Because it was my signature, it was a controlled drug and it was high enough that if that dose was incorrect, it could very easily have killed the patient,*

> *but the downside of that one was the family weren't very happy with all the checking I was wanting to do." (Professional, 6)*

The unknown could be uncomfortable when it is not known what the clinician might be faced with:

> *"The referrals come from lots of different places, some of them have been seen before, some of them not. You often don't know how ill they are until you've seen them. Often the decision to get involved at the start can be a little bit difficult. So, there's a huge amount more uncertainty around even accepting the referrals to start with in hospital at home." (Professional, 2)*

Professionals would appreciate covering potential scenarios in their induction to understand the processes to follow. It contrasts the supportive team available in a hospital with situations where a lone practitioner might need to urgently call for help:

> *"You get that little bit of anxiety thinking well. What if you go to somebody's house and they are lying on the floor and you know, but I suppose, that's something that would be discussed with you during your induction period and you kind of know, you have this lone working device that you can call for if you need any help erm and but you know what you need to do." (Professional, 1)*

There is a lack of awareness of what HaH does, which might lead to uncertainty regarding professionals deciding whether to refer the older person for HaH treatment:

> *"Not everybody's aware of the service and how to refer in, but once they do sort of come into contact with us, quite often we're the first point of call before the GP, which is nice because they trust us to be responsive and go and review the patient in a timely fashion. But it's just getting the word out there about the project (hospital-at-home) with acute medical registrars." (Professional, 5).*

There is some anxiety about the reliance on escalating to community services if an older person deteriorates at home. The professionals feel more comfortable treating people at a hospital due to the vast array of professionals and equipment around them than in a HaH environment:

> *"Obviously, in a hospital, you've got the crash team and you just call them and they're there, but in the community, you're relying on the ambulance services so, it means that you may have to stay with the patient you know, you might have gone over your fifth time to make sure that patient is alright." (Professional, 10).*

Summary of Escalation and Uncertainty:

- When deterioration does occur, professionals take prompt action by liaising with their health colleagues to manage the older person's condition at home. Where this is not possible, other options need consideration and discussion with the older person. The older person's preference to remain at home is respected even when they might be approaching the end of their life.
- Where there is uncertainty, professionals act by double-checking records and liaising and, where needed, escalating to senior colleagues for advice.
- A lack of awareness of what HaH can provide might lead to uncertainty in professionals referring older people for HaH treatment; therefore, educational understanding is crucial.
- There is some anxiety around health professionals practising HaH in some scenarios. For example, what to do when finding somebody on the floor, what services can help and how long this might take to arrive. Whereas in a hospital, help is available immediately from the multi-disciplinary team.

Theme Two – Communication

For the purpose of this theme, below is a diagram of the main theme and its branches of sub-themes.

Table 12. Communication

From the professional interviews, the term communication is evident from analysing the professional interviews, including how communication impacts service delivery, older people receiving treatment, and how it can enhance positive relationships between older people and professionals taking a holistic approach to delivering care.

Sub-theme – Barriers

This sub-theme covers barriers to communication when delivering HaH, for example, communication between health and social care professionals, delays in following up on necessary tests, following older people up at the point of discharge from HaH to identifying support from a social care point of view.

It is a challenge when support is needed from the GP, which is a barrier to effective communication between HaH colleagues and the older person's GP:

> *"We might have a difficulty to contact the GP – like calling them – so, calling the GP just to update them and tell them what happened, and what we have done, and what the patient needs." (Professional, 13)*

There are difficulties between HaH and GPs over the weekend that can be problematic, as GPs are unavailable to sign necessary documents:

> *"Where it doesn't go well, is when we have had patients who the communication between all the services hasn't been on point. So, (when a) patient was end of life and the end of*

> *life treatment plan wasn't in place via the GP and trying to get that put in place over a weekend can be really difficult." (Professional, 6)*

There is a challenge between HaH and social work and highlighting long delays and the need to continually follow up on necessary requests for social care intervention and support:

> *"I've spoken to social workers before and they've promised to come back to me within a few days with a plan or what they can offer and there's always a delay." (Professional, 5*

Decisions are made at senior levels, but there is a lack of communication with front-line practitioners, which makes them feel undervalued and uninformed:

> *"I think it's easy sometimes to get lost in that they make decisions and plans up above and sometimes I don't feel like it's properly passed down (Communicated to us) as it should be." (Professional, 5)*

There is an indication of a lack of communication channels between HaH colleagues and social care and GPs. There seems to be no clear process when it comes to getting all around the table when this is needed:

> *"It tends to be people like outside of the Trust (communication difficulties), so the social workers or the GPs are people that we don't work closely with, or if I'm trying to arrange an MDT meeting sometimes that can be a little bit difficult to pull everyone together." (Professional, 7)*

A lack of knowledge about HaH operations can impact effective communication channels. There is no awareness of the benefits that HaH can provide to older people in the community:

> *"I think the stereotype for community is district nurses and that's it. I don't think they realise we (HaH) have occupational therapies, physiotherapists, speech and language, advanced clinical practitioners, community matrons, we have a whole host of health professionals. I think there needs to be more communication and education on all the services that are out here in the community to keep patients at home." (Professional, 6)*

There is a challenge in getting hold of GPs who have referred older people to HaH for treatment. This can be problematic if further information is needed from them:

> *"There's quite often inability to access a GP for a lot of our patients who have been referred which, to be honestly – I think is because of the burden on them. I do think there is a low threshold at times to call 111 for patients who are not able to get to their GPs which, might not always be the right step." (Professional, 3)*

There are difficulties with communication between HaH and social care, for example, contacting and requesting support from them to progress with assessments for help at home:

> *"The case managers can pick up that sort of thing (when help is needed at home) and refer to social services or for care packages and what not as needed. But yeah, maybe just from a social point of view." (Challenges of communication) (Professional, 8)*

There is a lack of communication when reviewing results and liaising with the team delivering HaH:

> *"With GPs it's sometimes challenging because you know, the patient is still in the community, the GP might receive the odd blood test and things that they're not sure of. No one's known about the patients under our care and the GP has seen the blood test and just rung an ambulance to take them in. So that communication with primary care sometimes can be challenging." (Professional, 1).*

Summary of Barriers:

- From the professional interviews, it appears communication is a crucial part of the older person's journey from triage to treatment and discharge from the service. Without effective communication, this can impact the delivery of care in some regard.
- Clinicians sought advice from their colleagues for further guidance or input from health disciplines (e.g., occupational or physiotherapy, specialist input from consultants, heart failure, frailty, stroke and COPD), but at times, the response was not always timely enough.

- There were areas in which communication was a barrier to the effective implementation of care outside of HaH. For example, when practitioners identified social care needs and referrals were completed to the local authority social care, there were delays, which led to the health professionals needing to chase up the referrals for assistance on several occasions.
- Clinicians raised concerns regarding GPs blue-lighting older people to A&E after analysing blood tests (for example) without effectively communicating with HaH clinicians. It raised the question regarding the overuse of emergency services and when an ambulance should be called. For example, in these instances, HaH clinicians explained that admission could have been avoided if primary care had used their service. This would have kept the older person at home and away from the emergency department.

Sub-theme – Relationships

This sub-theme covers relationships and how communication has impacted these with professionals, older people and their carers.

There is a moment of reflection by the doctor in that some people do not always feel listened to, and how important this is, as it can only strengthen the relationship between the older person and the professional:

> *"The initial conversation between the doctor and the patient was really good, rather than just taking the information second hand. And I think she actually said that it was nice to actually be heard, is what she said, which was a little bit sad because everyone should be heard shouldn't they when they speak to us." (Professional, 17)*

There is an open dialogue between multi-disciplinary colleagues, and they feel confident in approaching one another to seek advice and support:

> *"There are physios and occupational therapists that are linked to the service and we all communicate really well and they come and ask us questions and we can ask them to come and see a patient." (Professional, 18)*

Feeding back problems are acted on, and there is confidence in reporting concerns to seniors, highlighting the relationship between senior managers and front-line practitioners – they feel listened to:

> *"I have fed that (areas of concern) back to them (senior management) and they always are really good at listening to the feedback and then sort of making changes." (Professional, 5)*

Good communication and awareness of individual roles and responsibilities are highlighted as key to the successful and safe service delivery:

> *"What makes hospital at home work well were the good communication, I think that's the key thing, and understanding of each other's roles, people knowing their boundaries around their ability to actually deliver care and what and be done in the home." (Professional, 7)*

There is a better relationship established due to communication over a period as opposed to communication with an older person in a hospital:

> *"I think you also have because it tends to be a smaller number of patients, you tend to have a bit more interaction with the number of days rather than just a one-off set piece and acute take and then somebody else looks after them the day after. There's a little more continuity." (Professional, 2)*

There is a wealth of knowledge of what's available, community-wise, that can make a person a more confident and effective practitioner. Therefore, educational awareness of what is out there is key:

> *"What I actually have found over the years is that being an effective hospital at home practitioner involves having a good grasp of what community networks are available and who does what. So, you become a sort of a consultant for all other community workers in terms of reaching out to other services. You get used to the web of what is available and erm know about the services that exist." (Professional, 16)*

Having good relationships with older people by getting to know them as opposed to being a number, evidences the personalised care of HaH and how this person felt listened to:

> *"He didn't feel like he was being ignored (following open communication with him and his family from HaH professionals) by busy hospital staff but instead, getting personalised care from his family and from people that were coming into his house who knew him." (Professional, 1)*

Strong relationships between HaH colleagues and their confidence are evident in escalating concerns or when needing to seek advice:

> *"We all sit together in the office and we're very keen to communicate to each other. I think as a service we do that well that we involve each other and share our concerns and escalate our concerns and adjust interventions and seek advice or consultation where we don't know enough in a particular area of practice." (Professional, 4)*

Summary of Relationships:

- There are good, strong relationships between HaH colleagues because they are established now and are aware of each other's roles and responsibilities.
- Within HaH, there is an open culture in the sense of speaking up and raising concerns, which senior leaders act on.
- There are clear links with HaH colleagues in terms of whom to contact for advice if necessary, e.g., if they identify the mobility needs of an older person. For example, they will link with their physiotherapy and occupational health colleagues.
- Relationships between older people and their health professionals are positive. Older people feel their voice is heard, and a more therapeutic relationship is established due to the holistic nature of HaH.
- Where relationships are affected, it is clear this is a breakdown in communication from the external side (for example, when practitioners refer to a GP and social care). This leaves practitioners with the burden of chasing up the initial referrals. This causes frustration, which may lead to negative relationships with external partners.

- Where relationships are affected currently, a better understanding and a joint working approach to strengthening these relationships is needed. External support, such as primary and social care, is necessary for the older person and unpaid carer (if they have one) because if ongoing support is needed, it is not assessed and delivered promptly.

Theme Three – Person-Centred Care

For the purpose of this theme, below is a diagram of the main theme and its branches of sub-themes.

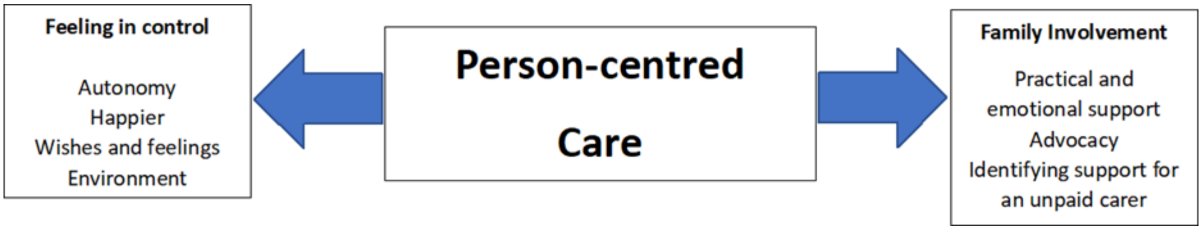

Table 13. Person-centred Care

From the professional interviews the term person-centred care is evident from analysing the professional interviews, including feelings of autonomy, being happy to the expressed wishes and feelings of older people, environmental factors, and the involvement of family members, which included providing practical and emotional support, advocacy and identifying the support for unpaid carers.

Sub-theme – Feeling in Control

This sub-theme covers feeling in control; for example, older people felt able to decide about their treatment options (e.g. HaH versus hospital care), a more holistic approach to care delivery, a frank discussion about their condition in their own home, an environment which the older person feels is familiar, and including their family members in discussions.

There are benefits of keeping people at home from a holistic perspective, e.g., when people are in their own home, they have their family around them and feel more in control, as it’s convenient for the older person:

> *"The older people were very happy to receive the treatment, in their like home with the family around. It was more convenient for them and some of them felt like they already have had enough of hospital admissions. Some (older people) feel better, and the family are so, so grateful for not sending them to the hospital and giving the treatment in their homes." (Professional, 13)*

There is an indication of the benefits of holistic, person-centred care; older people feel better in their own environment and avoiding necessary trips to hospital is of great importance – they are in control as they decide:

> *"I think the big thing from the patient perspective is just being in their own home. The comfort of having family around them, erm the setting of care. You know, avoiding transfers to the hospital and long hospital admissions, where actually the things that make a difference are at the start." (Professional, 1)*

Older people do better in their own environment, and seeing fewer patients might improve person-centred care:

> *"I would say that communication with the patients tends to be much – they tend to be better actually in the hospital at home environment. It's fewer patients, it's less confused. So not only have we prevented an admission, but we've also tremendously improved the patient experience because we're essentially going out to them in their houses, so that's quite rewarding." (Professional, 2)*

Professionals feel older people feel in control of their own treatment options and their preference is to stay at home:

> *"It (HaH) prioritises patient autonomy, often people are 'Well, I don't really want to go to hospital,' or 'I, I feel well enough. Is there anything that can be done at home?', and especially for patients in, in – as they get more frail and elderly." (Professional, 2)*

HaH is brought to older people, and they can decide what happens next as opposed to sitting in A&E, whereby they might be sent home because they aren't unwell enough to need inpatient care:

> *"The impact of the Hospital at Home service means that people come to them. They don't have to sit in A&E for 12-14 hours to have a first assessment and then end up being told that – 'Actually, you're well. You can go home.'" (Professional, 1)*

There is a comparison between HaH and a hospital setting. Therefore, it seems HaH is better because it is more person-centred and older people do far better than they would in a hospital:

> *"Older people seem to sleep better, eat better, drink better when they're at home. It's reassuring for people around them that they can actually be with them and keep them company and they're not affected by their anxiety and isolation that hospitals bring. What I've also encountered is across acute and community clinicians is that it's very easy for people to get lost in the system in hospital and not necessarily receive patient-centred care. There's no institutional sort of override of who they are and what they need." (Professional, 16)*

There is a more holistic approach to care in the community as opposed to in a hospital. Older people feel they get what they need in their own environments, and relationships are stronger:

> *"They (older people) feel that we're more comprehensive than their own GP, they get that face-to-face contact a lot of the time where they haven't been having it with the pandemic as of late. They feel that we build up a bit more of a rapport with them. We have certainly more time than a GP ten-minute slot to kind of go through their health, issues or needs. And we kind of look at the patient a bit more holistically." (Professional, 20)*

Summary of Feeling in Control:

- From the professionals' viewpoint, overall, older people felt listened to and respected. They felt their needs and wishes were respected, allowing them to decide for themselves. Doing so gave them a sense of feeling in control from a professional point of view.
- Professionals felt that older people did better at home. They felt happier, got more sleep and assessments of their health needs were more holistic.

- There was a better sense of autonomy, leaving it up to the older person to decide what is best for them once they have weighed up the two treatment options. Where this might not be possible, professionals explored other options, such as care at the hospital.
- From the professionals' viewpoint, older people felt content at home; there was evidence that it was more convenient for them and that they had their loved ones around them to provide support if needed.

Sub-theme – Family Involvement

This sub-theme covers family involvement, for example, involvement of family members from the onset, support family members were providing to the older person, the family members viewpoint in terms of options for treatment, and support for the family member in the short and longer term.

The importance of older people having their family around them when receiving treatment at home is strong:

> *"I think providing the treatment in their home we were able to like maintain their like – you know, having the support from the family around them, being able to stay in their familiar zone and place and still be able to move around in their house, having the family around them". (Professional, 2).*

There is a need for holistic thinking, which might not be considered in a hospital setting until at least the discharge stage. Therefore, there is a need to upskill in this area of medical practice:

> *"I am very aware of the limits of my knowledge when it comes to holistic thinking with particularly older patients. You had to think about support for the family and things like that, that you need a whole team to be aware of." (Professional, 18)*

There is an indication that family plays a big part in decision-making because older people want to stay home surrounded by their family:

> *“On the whole, most of our patients who have this model at home prefer the model to stay at home with their family.” (Professional, 7)*

It is important to have family around older people, and being surrounded by their comforts is strong for older people:

> *“The comfort of having family around them (was important to them), the setting of care. You know, avoiding transfers to the hospital and long hospital admissions, where actually the things that make a difference are at the start.” (Professional, 5).*

The family were supportive of the decision made by the older person. However, little attention is given to how much input the family provides during the treatment of the older person and what support is given to the family member:

> *“She (older person) lived with her family, and they were all very supportive. She was able to continue having physio and OT (occupational therapy) at home with the support of her family without needing to be admitted to hospital and the family were really, really thankful.” (Professional. 15)*

There is a reliance on family members or carers to report deterioration. However, what is unclear is what process should be followed to avoid hospital admission:

> *“If he became more unwell, family members or the carers would phone the ambulance only for the family members to try and say, ‘No, keep him out of hospital.’” (Professional, 2)*

The presence of family helps the older person feel better, and the older person feels they were listened to – family involvement may play a large part in advocacy:

> *“It (HaH) meant that the family especially during COVID, weren’t deprived of being able to visit (hospital), being able to have a hand in the care of their dad, meaning that he felt better. He didn’t feel like he was being ignored by busy hospital staff but instead, getting personalised care from his family and from people (HaH) that were coming into his house.” (Professional, 1)*

There is a reliance on the family to intervene because they were present, but it is not clear what support is provided to the family member:

> *"He had an amazing supportive family who were able to keep an eye on him and feedback any issues, of which I think the only one, that his cannula came out a little bit earlier than expected." (Professional, 21)*

Summary of Family Involvement:

- It was clear from the majority of the professional interviews that family involvement was prevalent in treating an older person receiving HaH care.
- There were varying degrees of involvement from family members in the sense of providing practical support (such as personal care), advocating for their loved one and enforcing what they wanted. It was also evident that when an older person may have been impacted cognitively due to an infection, the family member advocated for what their loved one would have wanted, which was to receive HaH.
- There was little evidence of how HaH professionals supported the unpaid carers' needs. Whilst it is acknowledged that they provided both practical, emotional, and advocacy support, it is not clear if they were offered any ongoing support in their caring role or support/advice during HaH treatment.
- Where support has been provided to an older person by the unpaid carer, where is the evidence to show further, on-the-spot or ongoing support was offered to them? For example, in the sense of a referral to adult social care for an assessment of both the older person and carers' needs. There appeared to be an acceptance by HaH staff that the unpaid carer would support their relative as they lived with them.

Theme Four – Service Provision

For the purpose of this theme, below is a diagram of the main theme and its branches of sub-themes.

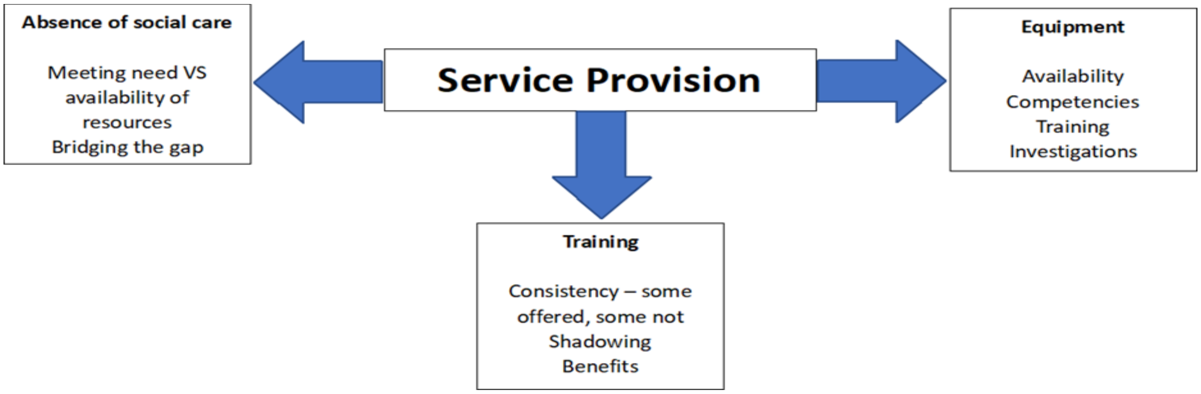

Table 14. Service Provision

From the professional interviews, it was identified that there was a gap in service provisions. This included the absence of social care, equipment and training, as highlighted in the diagram above.

Sub-theme – Absence of Social Care

This sub-theme covers the absence of social care provision, for example, when social care needs are identified during HaH treatment, long wait times before social care takes on the assessment and implements a care plan to meet the social care need, and how staffing problems are affecting service provision.

There is a thought process when treating older people in their environments; if the older person does not have additional social care support, who picks up the burden – that is, social care, but this is not always timely:

> *"Thinking have they got relatives; do they live alone? Do they have carers? Have they got access to food? Can they do this independently? Erm, do they have access to telephones? Do they know how to contact us if something is not right?" (Professional, 7)*

There are long wait times for social care, leaving the older person without care unless HaH can temporarily bridge the gap. We also see the advantages of having a social worker on board linked directly with the service, which might improve long wait times for assessment:

> *"The patient then tends to have to wait, whether it's just a few days or up to a week, before someone from the social aspect will make contact. So, it would be ideal if we could have a social worker who could just pick up referrals a lot quickly and sort that side out for us." (Professional, 19)*

The absence of care provision can be problematic, for example, older people waiting until care becomes available. Therefore, the older person has to wait until something is organised, but then it is just a case of taking whatever the older person is offered:

> *"I think sometimes provision of support at home can be a little tiny bit slower sometimes. In terms of if we do a referral for package of care, sometimes there might be a little bit of a wait or, er, only get one visit for a week or two until something comes up." (Professional, 17)*

There are delays in social care support, and it might help if there were a social care presence as part of HaH:

> *"It's that link in with social services sometimes, many a time we go out to a patient and kind of sort out the medical need, health need. And then it may be that they need some carer support or funding or some further support around medication or just sorting out the daily things for a patient that really, they're unable to do because of their health. And we do have access into reablement packages of care, but there's still that missing link sometimes, there's not someone sat in the office with us, there's not someone physically able to be there face-to-face with a patient." (Professional, 20)*

The absence of social care presence in the team is strong, as they have no control over how fast social care gets involved:

> *"The social care side of it does impact our role in quite a large way. Sometimes we don't have full control over the social side of it. You know that can probably be a little bit*

> *frustrating when we're ready to move now, but we've got to wait for something that we can't control (a care package)." (Professional, 17)*

There is frustration due to a lack of available care for older people. If care is not commissioned quickly, the older person may need to be admitted to the hospital for social reasons because there is no care in place to ensure their safety:

> *"I guess it's (lack of care) down to staffing, I don't ask the reasons why, it's just a frustrating situation and care quite often as well when we've been trying to put care packages in place to avoid an admission." (Professional, 5)*

Summary of absence of social care:

- The absence of social care concerns HaH practitioners.
- Whilst the team can tap into a temporary home care, this is only meant to be a temporary arrangement until the designated local authority can assess the person's needs and identify an ongoing care package – this can cause problems.
- Thought is given to family members who can provide interim support as unpaid carers. However, little attention is given to the burden placed on family members when there is a lack of social care provision. There appears to be an acceptance that they will manage as they live with the older person, not that they are actually providing support that a paid care worker would do.
- When older people did not have family members to support them, this raised concerns among health practitioners regarding what actions should be taken next to help meet their needs, even if this was a temporary arrangement.
- There does not appear to be a straightforward process for when HaH staff feel an urgent care package is needed, e.g., to support older people's ongoing social care needs. Who takes overall responsibility, who pays and who decides? Moreover, it is important to note the availability of resources when need has been identified.
- There is no direct link between HaH and the local authority in which the person is receiving treatment. HaH professionals appear to follow the standard route like a member of the public – this needs to be included in the model.

Sub-theme - Equipment

This sub-theme covers equipment, for example, ensuring equipment is readily available and training for staff, to specific staff only having the privileges to carry certain pieces of equipment, which impacts service delivery.

Equipment is needed in a timely fashion, but it can be problematic in HaH, whereas equipment is readily available in an acute ward:

> *"Getting equipment in a timely fashion so, in hospital you just call someone, and someone will bring a Zimmer frame or oxygen or whatever. Whereas it's a bit more difficult in someone's home so, that's a challenge." (Professional, 18)*

Not all HaH staff are trained to use all equipment; therefore, this can be problematic if an older person needs investigation, which the professional might not be trained in:

> *"Sometimes it's (difficulties) depend on the equipment that's available. We've now got point-of-care blood testing that makes it a bit more safe and makes expeditious in getting blood results, but those are user-dependent as not all users can use them." (Professional, 2)*

Service provision may improve if further training is provided to staff, alleviating the need for escalation to the hospital if the professionals on shift cannot identify or investigate symptoms at home:

> *"There was probably additional (training) to use the equipment, and I know that we're looking at possibly doing more things just like the IV's which would require extra training. But we will be doing as Advanced Nurse Practitioners (ANP's) possibly in the future so there will be further training required for the role." (Professional, 20)*

Only some professionals have the privilege to carry certain pieces of equipment around; doctors might not always be on hand to support the practitioners on site. Therefore, an investigation may need to be postponed, or the person needs to go to the hospital:

> *"Because having their (HaH doctor) equipment, the cannulas and the fluids is not something that we carry round as nurses so having (HaH doctor) with us he was also able to do a scan which he connects to his phone, so the equipment that was available that wouldn't have been previously gave the expertise to be able to deliver the care at home." (Professional, 5)*

Summary of Equipment:

- Equipment was only sometimes readily available. For example, it all depended on who was on shift at the time and who was trained to use the equipment.
- Some professionals were trained and knew how to use ultrasound scanners, whereas others did not. Where this was the case, it made HaH professionals think carefully about what needed to happen next. In instances like this, it was common practice for the professional to admit the older person if the equipment could not be used by the professional on shift.
- Where an older person's needs might be more complex, e.g., needing several tests, investigations or scans, or where equipment is unavailable, the recommendation would be for the older person to receive treatment in a hospital.

Sub-theme – Training

This sub-theme covers training of practitioners, for example, training on equipment, competencies of what each provider can provide, some professionals can prescribe, some can't, additional training of staff might be helpful, expectation versus reality when faced with HaH scenarios, and training sessions on specific pieces of equipment.

Training was provided on specific equipment to spot particular conditions in the community that could be treated instead of admitting the older person to the hospital:

> *"There was some training in how to use the portable ultrasound and the Butterfly to look for any like pneumonia like lungs or effusion on the lungs." (Professional, 2)*

Debate amongst colleagues around competencies and skills is strong; raising the issue of who is best trained:

> *"There's also a sort of a constant debate as to what competencies and skills we can provide, what governance is available for the range of medical interventions that we can provide." (Professional, 1)*

Some professionals are trained, and some aren't. Therefore, there's some disparity in who's being offered training and who is not:

> *"Some (HaH professionals) can prescribe, some can't, some can work the point-of-care blood test machine, others can't, some can put in cannulas, others can't, and it really depends on the luck of the draw on the day as to who you've gone out with." (Professional, 2)*

It was important to get to grips with a new system when working in the remit of HaH:

> *"I had to learn the non-clinical side of the role which was system one which is a system that we use to communicate with other services and the GPs." (Professional, 17)*

A number of training sessions were delivered, and 'all' is referred to, but this is not the case from the professional interviews:

> *"We had quite a few sessions actually. We had a session which told us – which gave us all the information about what we expected, what's your expectation and what you're supposed to do in the community." (Professional, 11)*

There is disparity in the training offered to professionals – who gets and who doesn't:

> *"No (didn't receive any training) and I think a lot of people had received additional training and I didn't. I did ask for it but, in the end, it never happened." (Professional, 2)*

The importance of training and direction is strong in the sense of the equipment and clinical direction in HaH. The mention of "specific policies or guidelines" highlights a lack of structured protocols to inform decision-making about patient care in HaH. This absence might lead to confusion and inconsistency in how care is provided:

> *"So, training around erm how to use pieces of equipment, yes. But not training on how to deliver what is a relatively novel type of care delivery. And especially without any specific policies or guidelines to dictate who should come and who we should see and who we shouldn't. It really is quite light in terms of operating procedures. So no, not that much specific training." (Professional, 1)*
>
> *"It's the unknown, providing hospital care in the community is very, very different but with some directions and online training and face- to-face training and courses, the confidence and competence comes with it." (Professional, 6)*

It seems that there are no set expectations, but one might hope that there would be, considering the responsibilities and expectations involved in delivering HaH:

> *"I did have an expectation that we'd get a lot more (training), for want of a better word, medical training, from ultrasound training, diagnostic training, blood interpretation." (Professional, 21)*

Summary of Training:

- There were varying degrees of training, from medical to system training. Not all HaH professionals had the same training as others.
- It appeared training was based on skill set and the practitioner's role (e.g. doctor or nurse).
- Some professionals who were new to HaH initially felt they would receive more comprehensive training relating to equipment to help them in their roles. Those who did not receive this could pick this up by liaising with colleagues and asking questions.
- Some HaH professionals had training followed by shadowing a professional who knew how to use the equipment. However, this approach was only sometimes consistent and appeared different from the expectation.

To summarise the end of this findings chapter from the health and social care professional interviews:

- The decision-making process concerning risks can be divided into several sub-themes. These include taking responsibility for individual risks, considering risks from a professional or older person's perspective, assessing the risks of deterioration at home should an older person become more unwell during treatment, escalating risks to more senior staff and specialist clinicians, and dealing with uncertainty amongst individual practitioners.
- Communication also branches into several sub-themes, from barriers to effective communication and relationships. If good communication is established early, this will contribute to a better working relationship between professionals, older people and their carers.
- Person-centred care also branches off into several sub-themes, from older people feeling more in control in deciding what is best, to the involvement of their family members, to ensuring older people’s wishes are respected. Wherever possible, professionals do what they can to keep older people in their homes, if it is safe.
- Service provision also branches into several sub-themes, from the absence of social care and how this impacts older people and ultimately HaH as a service, to training and how this impacts individual practitioner duties, but also how lack of training might lead to hospital admission and equipment. Where equipment is not readily available, this can be problematic as the person is left waiting and needs would be unmet for a period.

The next chapter will discuss my findings, their meanings and broader implications, expected versus unexpected results with explanations, and their impact on future health and social care policies. It will connect to previous HaH research, address limitations and unanswered questions, and outline directions for future research.

Chapter Seven – Discussion

This chapter discusses my research findings, examining their significance and broader implications for health and social care. Key themes include person-centred care, the role of carers, communication, environment and place, integration, and perceived quality of care in HaH. The analysis addresses both expected and unexpected outcomes, offering detailed interpretations and their relevance for future policy. I also compare my findings with existing HaH literature, highlight study limitations, and reflect on the complexities of researching this topic. Finally, I propose directions for future research to deepen understanding of HaH.

This study has examined the experiences of Older People and Unpaid Carers' experiences of HaH using a qualitative research design. More specifically, the research has answered the following research questions:

1. What are the stakeholders' experiences who have directly received and/or delivered HaH interventions, and how has this impacted them?
2. How does HaH coordinate with other statutory, private and third-sector health and social care services?
3. What can be learned from the findings regarding future health and social care policy and practice?

Many of the themes discussed relate to quality of care, and the following sections examine in more detail these different dimensions of quality. As per the World Health Organization (WHO) (2023) "Quality of care" refers to the degree to which healthcare services enhance the likelihood of desired health outcomes for both individuals and. HaH aims to align with this narrative by providing an integrated and personalised approach to HaH (Burton, 2022); however, it must be noted that the service is not universally available. According to a study (Vindrola-Padros et al., 2021), patients receiving HaH care have reported positive feedback on the quality of care they have received. This suggests that HaH is providing patients with a choice and a personalised approach to care, enabling older people to receive treatment in a familiar environment. The results from this study highlight that several factors contribute to the quality of care for older people and unpaid carers, including person-centred care planning, effective communication, feeling valued, strong relationships, time, and a comfortable home environment.

Previous research (Makela, 2020; Leff, 2005; Klein, 2016; Rossinot et al., 2019) on this topic did not explore why people were satisfied with the care they received and what it meant for both the older people receiving it and the health professionals delivering it. Older people have reported that HaH was more personalised and therapeutic (Collins et al., 2004), but provided little evidence as to why this might be. Leong (2021) suggest that people receiving HaH are showing better clinical outcomes, but as is evident, this is medically focused. However, there is little evidence in terms of why this might be or the overall experiences from the first-hand voice of participants. However, the findings of this study help to fill this gap in knowledge. The study's findings now provide much-needed insights into the quality of care in HaH, such as what personalised and therapeutic care might mean to the HaH experience for older people, their carers, and the professionals delivering it.

The following seven themes have been identified as significant areas for discussion: 1. The comparison of Quality of Care in HaH among participants. 2. Hospital Care Versus HaH: Insights from Older People 3. Person-centred care in HaH; 4. The importance of the carer's role in HaH; 5. Communication in HaH; 6. The environment and place in HaH; and 7. Integration in HaH. These discussions have been derived from the results of this study, which followed a rigorous process of thematic analysis. Themes were selected based on their recurrence across participant groups, their relevance to the study's research questions, and the depth of insight they offered into participants' lived experiences. Initial codes were grouped and refined into broader patterns, with some themes emerging early during analysis and others becoming clearer through repeated engagement with the data. The discussions aim to generate a deeper understanding of how each theme contributes to the overall quality and delivery of HaH care.

The comparison of Quality of Care in HaH among participants

There are key differences when comparing family involvement from the perspectives of professionals, older persons, and unpaid carers in HaH. Older people tend to be in their familiar environments, surrounded by their family members, neighbours or friends, and this appears to be key when looking at what makes up good person-centred care for older people when receiving

HaH. This sense of comfort, familiarity, and autonomy was viewed by older people as enhancing the overall quality of care.

When comparing this to unpaid carers, the findings suggest they prefer the older person to receive treatment at home, as they feel the quality of care is better than that delivered in hospital settings. They can keep an eye on things – something they can't necessarily do when older people receive treatment in the hospital. In turn, this alleviates the psychological distress unpaid carers experience when older people need medical treatment because they are certain of the older person’s clinical outcome in HaH because they are present (Azoulay et al., 2014).

When comparing this with the professionals' views, they feel this person-centred approach creates a better relationship between the older person and their unpaid carer. This might be because when professionals deliver the care needed, there is always somebody present in the household or who lives close by, so they are actively involved when treatment is delivered. Information is provided during visits so unpaid carers are fully informed of the next steps. This ongoing communication fosters a sense of transparency and trust, contributing to a perception of higher quality care compared to care at the hospital, where carer involvement is restricted by visiting policies. Professionals also emphasised the importance of communication skills and relational training in building trust and delivering high-quality, person-centred care. As such, empathy and relationational training might strengthen trust and improve experiences of older people and unpaid carers in HaH. As highlighted by McCormack et al. (2011), training can be viewed as a response to systemic and cultural barriers. Therefore, training should be about technical skills but also about fostering inter-professional collaboration to break down communication barriers and creating a culture of learning and adaptability where HaH professionals feel confident and supported.

The data from the results of this thesis highlights the importance of relationships between professionals, older people, and their carers. There was a strong focus on professionals’ relationships between carers and the older people receiving treatment, such as keeping them informed. The data does show that there is a more holistic approach to the delivery of HaH, such as thinking about the environment and what support might already be in place (support from a family member or friend or not). However, one might argue that although there might be a better sense of relationships between professionals, older people and their unpaid carers, this might be because all are present in the same household during treatment. Alternatively, professionals might feel more comfortable providing care at home, which helps them build a better relationship between older people and unpaid carers – an area that would benefit from further investigation. It is evident that unpaid carers are a crucial part of the care that older people receive in HaH, unlike in hospitals, where around-the-clock care is provided by staff. This shared responsibility and collaboration within the home environment may further enhance the perceived quality of care by all involved.

Hospital Care Versus HaH: Insights from Older People

Although exploring hospital care experiences was not an explicit aim of this study, these insights emerged strongly during the interviews. Although older people appreciated HaH, they identified multiple shortcomings when receiving care at the hospital. The positive reception of HaH appeared to stem largely from the negative experiences people had with traditional hospital treatments. Older people's experiences provide important information about the benefits of HaH and demonstrate the pressing need to improve care at the acute hospital. These accounts are consistent with findings from Leff et al. (2005), who found that HaH participants reported higher satisfaction, more comfort, and a greater sense of control than those in inpatient care.

Older people frequently described their hospital experiences as impersonal and frustrating. Many reported long delays in receiving basic care, a lack of communication from staff, and feelings of being disregarded. These accounts reflect common challenges in acute hospital environments, where overstretched staff and system pressures can contribute to lapses in compassionate, timely care (Griffiths et al., 2021). For example, participants spoke of waiting hours for assistance with toileting, not being helped to eat or drink, and feeling invisible to medical staff. In contrast, HaH services were often characterised as more attentive, personal, and responsive qualities that seemed to restore a sense of dignity and autonomy during treatment. These perceptions align with findings from Levine et al. (2022), who showed that patients receiving HaH care experienced lower rates of complications and higher satisfaction, especially regarding timely care and communication.

Older people preferred HaH not just because of home clinical care but also due to their past hospital experiences. The favourable assessments of HaH services resulted partially from negative experiences during hospital stays. These findings suggest that older people value respect, personalised attention, and comfort in HaH, which they felt was often missing from inpatient experiences. Importantly, this comparison between HaH and hospital care provides a dual insight. First, it confirms the value of HaH as a model that may be more compatible with the needs and preferences of older patients. Second, it presents a critique of inpatient care by pinpointing particular aspects that require improvement. Research by Burton et al. (2022) reinforces this by showing that patients with access to HaH reported significantly better experiences in communication and care continuity.

The areas for development identified include enhancing staff communication, ensuring basic care needs are met quickly, and improving physical environments. Participants experienced disorientation and distress due to environmental discomforts like extreme heat, loud noises, and regular ward relocations. Environmental aspects, often overlooked in hospital design, played an essential role in shaping negative patient experiences - a finding echoed in a study by Rivas et al. (2022), which explored the impact of hospital environments on older patients' emotional well-being. Such experiences further shaped participants' preferences for receiving care at home, where familiar and calmer settings offered greater emotional comfort.

Person-centred Care in HaH

Person-centred care, with its focus on personalisation and coordination, aims to empower patients to take an active role in their treatment (Health Foundation, 2024). This study shows examples of older people being involved in decisions, such as choosing HaH over hospital care. However, access to HaH was shaped by professionals who assessed eligibility, meaning some older people may not have been offered it. This raises questions about how much real choice existed. Since all participants had used the service, it's unclear how those denied access or unaware of HaH might have viewed it. While patient involvement was evident, it appeared dependent on both professional judgment and awareness of the option. These examples illustrate how personalisation in HaH is shaped not just by patient needs but also by professional discretion, which underscores the complexity of delivering truly person-centred care.

These decisions come as a result of a detailed and cautious assessment of the related risks, showing the thorough and diligent approach applied in the process. This aligns with the broader view that personalised care should encompass not only medical needs but also holistic well-being (Johnson et al., 2023). Professionals demonstrated an awareness of the individual's environment and personal circumstances, including the need for paid carers, suggesting a commitment to care that extends beyond clinical tasks. This was evident in professionals developing a deeper understanding of the older people they supported, factoring in their home environment and social context.

A person-centred approach also aims to help practitioners recognise the advantages of person-centred care for patients, communities, and the broader health and social care system (Johnson et al., 2023). Coulter (2016) makes a good argument for this - doctors often reach their medical recommendations based merely on the person's physical condition at that time (Maslow, 2017). In contrast, a person-centred approach to the care of older people should consider them beyond their illness, age or frailty (Starfield, 2014) and consider the socioeconomic determinants that may have led to the health deterioration of the older person. This includes taking into consideration the person's environment, cognition (Brooker, 2007), involvement of family members, and shared decision-making (Kitwood, 1992) with the overall aim of maximising choice and autonomy whilst ensuring relationships are maintained and ongoing care needs are met. These perspectives support the need for HaH services to be grounded in a broader understanding of the person, not just their medical condition

Professionals believed that older people had more autonomy in making decisions about their treatment, such as choosing between HaH and traditional hospital care and evaluating potential risks. This is supported by studies that have a strong desire for older people to maintain their autonomy and remain active participants in decisions regarding their care (Hvalvik & Reierson, 2011; Breitholtz et al., 2013). However, the results from this thesis suggest professionals felt older people wanted to remain at home, and the decision came down to weighing up various factors such as risk and whether it was feasible to treat the older person at that time. For example, professionals were considering the increased risk of exposure to infections if admitted to the hospital, as well as remaining at home where this risk is less, having family by their side at home and older people being in their own environments – all of which contribute to older people’s overall quality of care and emotional wellbeing. These findings also align with the findings of Shepperd et al. (2006), who reported higher patient satisfaction among older people receiving HaH, with particular attention in areas such as comfort and convenience. The study by Harris et al. (2005) showed that older people reported high satisfaction levels, but did not explain why until this thesis identified factors like remaining in their own environment and having closer contact with family as explanations for professional views on older people's choices to receive HaH. Hedman et al. (2015) noted that professionals often navigate ethical dilemmas to support older people's preference to remain at home, even when safety concerns arise.

A scoping review conducted by Sheridan et al. (2011) provides support for this statement, as it revealed that individuals with low health literacy experienced greater confidence and empowerment in managing their health when healthcare professionals used plain language and gave clear, thorough explanations of diagnoses and treatment plans. Similar observations have been made in studies involving older adults. McGilton et al. (2012), for instance, observed that individuals in continuing care facilities felt more confident and satisfied when nurses communicated in a clear and easily understood manner tailored to their needs. Similarly, Fetherstonhaugh, Tarzia and Nay (2015) highlighted that older people, including those with cognitive impairment, felt more empowered and central to their care when they were included in decision-making processes and given understandable explanations. These studies suggest that effective, person-centred communication contributes meaningfully to perceived quality of care in older people.

There was a sense from professionals that when people feel safer, for example, in their environment, they do better than when they receive treatment in a hospital. These results are supported by Levine et al. (2021), who found that patients receiving care had better sleep quality and lower mortality rates, as well as fewer medical complications and increased physical activity compared to patients treated in hospital settings. According to Gorman (2016), about one-third of patients over 70 years old and more than half of patients over 85 leave the hospital more disabled than when they arrived. Similar conclusions have been drawn in studies such as those by Helvik (2013), who noted functional decline in older people post-hospitalisation. Interestingly, the results from this study do not highlight that older people declined during their HaH treatment. Indeed, professionals feel older people do better at home.

Professionals also highlighted that older people receiving HaH treatment slept better, felt safer, and had the support of loved ones around them. A systematic review by Qaddoura et al. (2021) supports these findings as patients receiving HaH reported higher satisfaction with home comfort and family support, along with decreased anxiety when compared to hospital stays. Some of the older people who participated feel safer at home because they have somebody to advocate for them where needed, such as an unpaid carer, friend, or neighbour. Professionals considered family involvement more, identifying the unpaid carer, neighbour, and friend and including them from the onset, which, from speaking to older people, they did not feel was the case when they were hospitalised. This is supported by Wong et al. (2024), who found that patients and carers appreciated their involvement in care decisions during the initial stages of HaH treatment because it differed from their prior hospital experiences.

This emphasis on person-centred care in HaH should reassure the audience of its effectiveness. However, it does raise questions regarding the equality of HaH and how this might affect the equity of access, highlighting the concern around universal healthcare delivery for all people needing medical treatment, given that there appears to be somebody present during all participants' treatment who participated in the study. There is no evidence about participants who may live in inadequate housing or have nobody to support them, such as family members, friends or neighbours.

The data suggests that professionals feel older people have a sense of value because they are empowered to decide on the available options and risks, which are all part of the quality of care they deliver. Overall, professionals feel that older people have a perception of control – that they are making the decision because they are given clear information, even if this is the professionals' decision about what should happen. However, it is important to distinguish between expressing a preference and making a final decision. While older people may articulate their views, the ultimate decision about the treatment pathway often remains with professionals, shaped by clinical judgement and service availability. It is a collaborative one because professionals, older people and unpaid carers work together to assess the risks and decide the best option. For example, not just looking at the illness or disease but the bigger picture, such as the environment, support in place and the older person's wishes. This thinking or consideration by professionals can be closely linked to the theorist George Engel, who first conceptualised the biopsychosocial model in 1977. He suggests that to understand a person’s medical illness, it is not just the biological factors to consider but the social and psychological factors (Engel, 1977).

Indeed, HaH by way of delivery is not just treating a medical need because the data show that professionals think in a more person-centred way when delivering it. For example, professionals highlight other factors when treating older people in their own homes, such as family circumstances (whether there is somebody present, for instance, husband or wife, daughter, or son at home during treatment), the environment and risks (whether it is safe to treat, whether there is sufficient space), whilst considering the social care needs of the older person. Many factors are all part of what quality care might mean for the professionals delivering HaH compared to care in a hospital setting. Therefore, the biopsychosocial approach to what involves the thinking behind person-centred care is evident from the data. The environment is crucial because professionals see older people in their homes rather than in an anonymous hospital bed. HaH also highlights the vital role of unpaid carers, who support and sustain person-centred care in HaH.

Importance of the carer role in HaH

It is crucial to note that unpaid carers play a pivotal role in maintaining person-centred care for older people receiving HaH, often acting as informal social workers, health aides, and advocates (Kim, 2024). Their presence helps ensure continuous observation and timely communication of concerns to healthcare professionals, potentially improving both the effectiveness and safety of care. In contrast, the absence of an unpaid carer introduces uncertainty. Without this support, it may be more difficult to monitor the older person's condition effectively, increasing the risk of delayed interventions or missed changes in health status. Relying on older people to self-monitor can also pose risks, particularly where cognitive impairments are present and professionals deem this arrangement unsafe. Overall, unpaid carers appear to play a vital role in supporting older people during HaH treatment. All the older people interviewed in this study had an unpaid carer, which may reflect an implicit requirement for accessing HaH. As such, the findings offer limited insight into the experiences and challenges of those without this support - highlighting a critical area for future research.

It is important to recognise the difficulties some unpaid carers face and the tasks they take on, such as washing and dressing, collecting prescriptions, and helping older people with their mobility needs during their HaH treatment. These care tasks go beyond helping somebody to have a shower or bath, helping them to get dressed, or just preparing meals and drinks. The Care Act 2014 also sets out clear eligibility criteria for unpaid carers. A carer is eligible for support if their caring responsibilities have a significant impact on their wellbeing and they are unable to achieve key personal outcomes, such as maintaining relationships, engaging in work or education, or looking after their own health. This highlights the need to recognise and support unpaid carers, and to ensure professionals are trained to identify and respond to their needs appropriately.

It is essential to consider the ongoing effects on unpaid carers should the caring role continue after treatment has finished. This includes psychological morbidity, social isolation, risk of health deterioration, and financial hardship (Brodaty et al., 2009). Unpaid carers may already be managing these challenges when they begin their role in HaH care. Therefore, although unpaid carers state they prefer HaH as it eases their anxieties and worries, they must also consider their health conditions and the potential for deterioration of their health and well-being without the appropriate support in place, as evidenced earlier in the thesis. According to a recent Carers UK (2022) analysis, 60% of unpaid carers had a long-term health condition, disability, or illness, and 64% of unpaid carers reported that their condition impacts their ability to carry out day-to-day activities. This is likely to affect their ability to care for older people receiving HaH treatment. Careful attention must be given to unpaid carers taking on a formal caring role who already have their own health conditions. Supporting this is a study by Greenwood et al. (2019), who found that older spousal carers often face additional difficulties, including reluctance to seek support, social isolation, and concerns about the future care of the older person, often spouses. These difficulties can be exacerbated by deteriorating health and reduced energy levels, making it a significant note for both health professionals and social care practitioners to ensure support and assistance in planning for the future care needs of both the unpaid carer and the older person. The findings from this thesis do not highlight that this is already happening, so ongoing training might be needed to overcome this issue, which would also acknowledge the unpaid carer being tasked with formal care duties, ensuring that support is implemented alongside the assistance they provide to the older person.

Additionally, it is important to consider the eligibility criteria for unpaid carers under the Care Act 2014, which establishes the need for support if caring responsibilities significantly impact their wellbeing. However, this thesis does not address those carers who may not meet the eligibility criteria, which could mean they do not receive the support they require to manage both their own health and their caregiving duties. This gap in support should also be considered in future research and practice.

Effective communication was key in delivering HaH to older people and their unpaid carers. The data indicates that this was achieved through open and honest communication among everyone involved, which helped strengthen the relationship between older people, their carers, and healthcare professionals. In turn, this might also strengthen the relationship between HaH professionals and external partners. It might also help to raise the profile of HaH and create greater interest in it. It should be noted that unpaid carers did not disclose the additional care duties they were responsible for during interviews. It is unclear why this was, but it could be because the interviews were conducted in the presence of the older person, limiting the carers' ability to express their true feelings. However, there was no indication that unpaid carers wanted to speak without the older person present.

As highlighted earlier in the thesis, this reinforces the importance of planning for carer support not only during HaH but also in the transition phase after formal services are withdrawn. Ensuring continuity of support and recognising carers' evolving needs are critical to preventing carer burnout and maintaining the sustainability of home-based care models. It is also crucial to note the evolving gender roles in caregiving. According to Barzallo et al. (2023), two out of three family caregivers are female. However, current trends show an increasing number of men undertaking caregiving duties, a shift from the traditional gender roles, yet female caregivers continue to report a higher burden (Barzallo et al., 2023). Interestingly, from the results of this thesis, most unpaid carers were female, but there were also male unpaid carers who assumed this role. Both male and female carers were often spouses, which is an intriguing observation. However, it is crucial to highlight that this study did not find evidence suggesting that burdens differed based on gender roles.

In summary, as highlighted above, caregiving is not just about the apparent tasks (washing, dressing) that often come with a caring role. It extends far beyond these duties, encompassing emotional, social, and practical support that can be both physically and mentally demanding. As discussed earlier, unpaid carers often face significant challenges, including social isolation and psychological strain, as well as concerns about the future care of the older person (Greenwood et al., 2019). Moreover, the eligibility criteria under the Care Act 2014 clearly acknowledge the impact that caregiving responsibilities can have on the well-being of unpaid carers, yet many carers may still fall outside the scope of formal support, which raises concerns about gaps in the system. Therefore, it is clear that more can be done to support unpaid carers in their roles, not just through the recognition of the tasks they perform, but by addressing the broader aspects of caregiving, especially those that affect their emotional and physical wellbeing, and ensuring that support mechanisms are in place to help them manage these responsibilities. Effective communication among HaH professionals plays a key role in providing this support, facilitating coordinated care that considers both the older people and unpaid carer’s needs.

Communication in HaH

The communication between HaH professionals was evident from the initial triage to treatment and discharge. Open communication helped professionals to look at things more holistically instead of just treating the medical need, for example, ensuring the home is safe for the older person and finding out if there was a relative, neighbour or friend to liaise with professionals in their department should they need further advice or support. Whilst communication was effective amongst HaH colleagues, there was evidence of barriers when it came to professionals needing to discharge the older person back to the care of their GP. When comparing this to hospital discharge, evidence suggests that poor communication with GPs can risk patient safety and continuity of care (Boddy, 2022). These 'discharge' tasks are usually done by a junior doctor, who will complete the discharge summary, which will then be seen by the GP admin and passed to the GP (Boddy, 2022). However, several concerns are often raised, and further questions are needed. This results in GPs needing to follow up on information that might not be thorough or where ongoing tests are unclear. In HaH, there appears to be some difference in that when clinicians refer to the care of the person's GP, they often must telephone through the information several times, which takes time away from clinical practice.

This issue came to light during the interviews with the professionals who found this to be a lengthy process, as there was no direct communication channel to pass the information over – they had to follow the queue process like members of the public. There is a similarity in both processes in that they are one-way communication structures – administrative staff will take down the information, and only if the GP has any queries will this be followed up. There appears to be no direct contact between hospitals, HaH and GPs. A recent study by Hockley et al. (2021) focused on using communication devices like iPads and smartphones in care homes during the COVID-19 pandemic when visits were restricted. The study found that older people could communicate with their loved ones and healthcare professionals through various video calling apps such as WhatsApp, Zoom, Skype, and Teams. It may be suggested that these devices could also be used to communicate between HaH professionals and practice following the older person's period of HaH treatment. So, a shared record system would also be helpful in this case.

Professionals could update their systems, sending the information directly to the patient's clinical notes or the practice for a clinician to follow up with the patient.

Furthermore, concerns were raised regarding communication between HaH and adult social care and how it impacts people waiting for social care assessments. Waiting for input from social care impacts the HaH temporary care service. Therefore, there are times when this service is blocked, and further referrals cannot be taken because older people are receiving temporary care from the trust while waiting for adult social care to complete an assessment of their needs and implement the necessary care. This was highlighted by HaH professionals as a key communication challenge between departments. However, there is no evidence of this impact on older people and carers, and it only became apparent during interviews with professionals. The only conclusion could be that this delay contributed to a delay in social care allocating the referral for assessment because of a backlog in people already awaiting a social care assessment. Indeed, as of 31st March 2023, 434,243 people in England were waiting for assessments, care packages, direct payments, or reviews by local authorities. The Association of Directors of Adult Social Services (ADASS) recorded at the end of August 2022 that this number is down 12% from the 491,663 (Samuel et al., 2023).

It is clear from the data that communication between professionals is impacted. However, the data also suggest that HaH professionals are aware of the challenges external services, such as GPs and adult social care, face. Sheehan et al. (2021) highlight that effective communication between hospital allied health and primary care practitioners can enhance the quality and continuity of patient care. While HaH aims to achieve this objective, patient experience can suffer when there are communication barriers with other services that older people depend on. The UK government's significant policy reforms in 2010, which included numerous initiatives to integrate health and social care services (Miller, 2021), particularly in streamlining personalised health and social care services for older people, are of great importance. However, the study's findings also highlight barriers to communication between professionals that hinder the realisation of this goal, making the findings from this study even more crucial.

More specifically, these findings demonstrate potential enhancements for service delivery and planning processes in HaH. The need to improve interprofessional communication in HaH arises from professional reports of barriers between GPs and adult social care, which can result in poor patient experiences. These challenges underscore a broader issue: professional barriers between policy goals and practical application in real-world practice reveal a disconnect. This research by Miller (2021) regarding the UK's major policy reform demonstrates that achieving integration between systems, especially in the sense of communication, remains an unattained goal. The lack of shared digital records and dependence on indirect or one-way communication methods still impacts coordinated patient care across HaH professionals, GPs and adult social care services. The stoppage of HaH services due to social care assessment delays demonstrates the gap between intended seamless care delivery and current operational practices. Systemic and technological limitations obstruct practical implementation even though policy frameworks exist. The gap in care delivery can only be bridged through co-located services, joint training programmes, interoperable digital systems, and communication protocols between agencies. HaH could become more capable of providing high-quality care that is coordinated and centred around the person when these areas are addressed. When these systemic factors are addressed, HaH can provide care that is both coordinated and truly centred around the person, including the critical role of environment and place in older people's wellbeing.

Environment and Place in HaH

Environment and place have been significant driving factors for older people when it comes to receiving treatment at home. According to Stones and Gullifer (2014), citing Hearle, Prince and Rees (2005), home provides older people with "a sense of autonomy and independence… control over daily activities and events, body, individuality and social status". Older people also feel more able to be themselves in their familiar environments (Stones and Gullifer, 2014). Wilson (2013) highlights the importance of the environment for older people when they are medically unwell. Most of the older people commented on how important it was for them to remain at home in their familiar environments, and this is something they valued. Indeed, a pilot study in North Lanarkshire supports this argument because older people who are sick do better in their familiar environments, appear happier at home, and often recover better because they are at home with their family (Wilson, 2013). Another study also focused on space beyond the windows, which highlighted the emotional attachment of being at home, that being at home was multifaceted and is strongly influenced by a personal connection to place and relationships (Cristoforetti et al., 2011). The study also brought to light the cultural expectation of maintaining one's independence for as long as possible.

Bigonnesse et al. (2014) also found that personal belongings that hold memories at home bring comfort to older people and are extremely important to them when considering their environment and place, such as when receiving HaH. This goes hand in hand with maintaining relationships older people have in the places they live, for example, their communities, which can bring a sense of meaning to the home or an environment that provides older people with feelings of security and comfort (Gillsjö et al., 2011). Bove et al. (2022) highlight this in their most recent study of patient experiences of HaH in Denmark. Older people felt they were at the centre of the health professionals delivering support, that their family relations and roles were maintained and that they were able to maintain a meaningful everyday life within their communities (Bove et al., 2022).

Having family at the bedside can promote recovery by providing emotional support, affection, and active involvement in medical treatment (Piat et al., 2016). However, there are several drawbacks to this practice. One notable issue is overcrowded rooms, which can increase stress levels for the older person, family members, and healthcare professionals (Ciufo et al., 2011; Gray et al., 2001). Additionally, constant family presence may lead to a lack of privacy for both the patient and other hospital visitors, further contributing to feelings of discomfort or stress. Moreover, family members often feel the pressure of taking on caregiving responsibilities while balancing their own emotional needs, which can cause burnout or increased anxiety (Skwarska et al., 2000).

In a hospital setting, there may also be restrictions on the types of care that family members can be involved in, potentially leading to a disconnect between the patient's care needs and the family's involvement. While these drawbacks are commonly observed in hospital care, some of them are also relevant to HaH services. For example, although HaH allows for a more intimate, home-based setting, the pressure on family carers to assume responsibility for medical care can increase stress levels, particularly if they feel unprepared or unsupported. Moreover, the dynamics of caregiving within the home may also lack the privacy or respite provided by a hospital setting, where care is provided by professionals. Therefore, while HaH can mitigate some challenges associated with overcrowded hospital rooms, it presents its own set of issues related to caregiving pressure and the potential for insufficient support for family members.

Additionally, health professionals may have to answer medical questions and address concerns from patients' unpaid carers, which can increase stress on staff and take them away from direct treatment for a period (Bishop et al., 2013). Nonetheless, these exchanges are often facilitated by the home environment, which supports more natural and informal interactions, thereby enhancing communication

In summary, the environment and place of care strongly shaped older people's preferences and recovery experiences. Familiarity, control, emotional connection to surroundings, and proximity to relationships made HaH not only clinically beneficial but also deeply meaningful to those receiving it. These findings underscore how place is not merely a backdrop to care but a dynamic contributor to the quality and experience of care itself.

Integration in HaH

During the interviews, it became clear that collaboration between professional groups involved in HaH was inconsistent. In certain cases, participants described positive examples of joint working, especially during times of crisis, when district nurses and doctors became involved in managing home-based care, sometimes for the first time. However, this was not always the case. A number of older people and unpaid carers said they had never heard about HaH from their GP, raising questions about whether GPs are sufficiently engaged in the referral process. In fact, GP involvement overall appeared limited, both in introducing the service and in ongoing support. Social workers were also largely absent, even when older people had clear social care needs. These gaps in multi-agency collaboration may reduce the visibility and accessibility of HaH and suggest that stronger integration is needed if the model is to meet its full potential.

Integrated care is often seen as the way forward for developing health systems globally (Zonneveld et al., 2018). This theme emerged clearly from the findings of this thesis. As people are living longer and experiencing more chronic health conditions, the demand for integrated approaches to health and social care is increasing (WHO, 2015). This raises the question of how effectively this need is being addressed through integrated models such as HaH. People with complex needs often require input from multiple disciplines, including primary care, secondary care, and social care (Zonneveld et al., 2018), and this was evident in HaH, where older people frequently relied on input from occupational therapists, social care practitioners, and specialist clinicians.

Indeed, the WHO (2015) defines integrated care as an approach that strengthens people-centred health systems through the coordinated delivery of quality services across the life course. These services should reflect the multidimensional needs of individuals and be delivered by multidisciplinary teams working across different care settings and levels. It should be effectively managed to ensure optimal outcomes and appropriate resource use, based on the best available evidence, with feedback mechanisms to drive continuous improvement, address upstream determinants of ill health, and promote well-being through both intersectoral and multisectoral action (WHO, 2016).

To ensure the effective implementation of HaH for older people, it is important to establish common standards agreements, implement information-sharing processes, and have an MDT plan for older people's care remotely and in person. This is supported in the study by Sage et al. (2021), who showed that sharing information effectively by using shared electronic health records helps to coordinate care and improve communication between healthcare providers who deliver HaH. The NCBI (2020) study also demonstrated that multidisciplinary teams (MDTs) are vital for HaH because precise identification of responsibilities leads to thorough evaluations and coordinated treatment while addressing difficulties from informal role definitions in community environments. These factors are evidently needed, as highlighted by the results of this thesis, because professionals didn't always feel that common standards and sharing processes were clear or evident in the initial stages of HaH. However, the linchpin to good quality care in HaH is the coordination among all professionals involved, including social care (Westby et al., 2023).

Improved healthcare collaboration has been cited as a key healthcare reform strategy (Romanow, 2002). More simply, collaboration is a mutually beneficial and well-defined relationship between two or more organisations to achieve common goals (Green et al., 2015). To be more specific, examples of good collaboration can include but are not limited to role clarity – professionals are relied on to perform their unique role (Bosch, 2015), such as a doctor, nurse or advanced nurse practitioner in HaH, all bringing specialist skills and knowledge to the team; trust and confidence; professionals should be confident in their abilities to develop team trust (Bosch, 2015). This could include additional training needed for professionals as highlighted in the early findings of this research, and collective leadership, also known as a philosophy, that distributes the pressure away from any one individual and shares it throughout the team or group (Bosch, 2015), could be the guiding principle for the consultants leading HaH services in this specific geographic area.

The collaboration between GPs and social workers is also particularly promising because both professions have the potential to offer accessible, person-centred support (Löwe et al., 2022), often achieved through multi-disciplinary design by daily and weekly meetings with the relevant disciplines. Like medicine, social work is based on the interaction of individuals and organisations dedicated to the welfare of the state and society. Social work, grounded in human rights and anti-discrimination, serves a political function by enhancing social justice (McPherson & Abell, 2020; Lundy, 2011). There is a well-established history of collaboration between social workers and medical professionals, especially within hospital environments. This dynamic has been explored in studies such as those by Glasby and Miller (2015) and Mangan, Miller and Ward (2015), which reflect on how these working relationships have developed in general practice and social care. Their findings point to a mix of sustained cooperation and persistent challenges, suggesting that while joint working has deep roots, it also continues to face structural and professional barriers. This tradition of partnership can reassure us of the potential for successful collaboration between the two professions. However, although HaH models depend on multidisciplinary collaboration, existing research provides minimal direct evidence about the relationship between GPs and social workers in these settings (Leff et al., 2005; Shepperd et al., 2016).

Research on integrated care shows that professional collaboration improves outcomes and care coordination for older people who have complex needs (Reeves et al., 2017; Kodner & Spreeuwenberg, 2002). Challenges such as unclear roles, combined with fragmented communication, create barriers to integration, indicating gaps that require attention in HaH practice (Curry & Ham, 2010; Glasby & Dickinson, 2014). NHS England (2022) has made it clear that virtual ward and HaH models require better collaborative efforts. The results of this thesis highlight these very challenges in HaH, particularly in referring people back to the care of their GP and social care for ongoing support or advice.

Indeed, recent reports have highlighted that for services to work together better, the workforce needs to build integrated links and partnerships with other services rather than functioning solely as a single service (NHS England, 2022; Health and Social Care Committee, 2023). For change to be effective, it is essential that healthcare professionals themselves engage with external partners, professional bodies, and patient groups to build collaborative relationships and co-design services, as Bate, Bevan and Robert (2004) argue in their work on experience-based design. This rule should also apply to those on the front line, who can help enhance the patient experience by taking on board policy-led changes.

Lewis et al. (2015) highlight the importance of integrated care delivery in HaH. Indeed, older people who need emergency hospitalisation are more at risk of fragmented integrated care. They suggest that the virtual ward model attempts to address this by offering a multi-disciplinary approach to delivering HaH to reduce the risk of unplanned hospitalisation. This included several disciplines around the table when treating older people at home, where meetings were held regularly. Interestingly, this included physiotherapists, community clinicians, social workers, district nurses and matrons. However, this was soon disbanded following the pilot, as some staff felt this integrated approach was less important than directly providing ‘clinical’ HaH care. This is significant because the data from this study highlights the need for this approach, given that there is an absence of social care input and the difficulties that arise as a result. Therefore, one might suggest that all disciplines should be considered when designing HaH services as it scales up for the future to include those professionals who can help to make the service more streamlined and provide better outcomes for older people and their carers.

The final chapter presents the conclusion, evaluating whether the study's aims and objectives were achieved. It also summarises key findings, acknowledges limitations, and suggests directions for future research.

Chapter Eight – Conclusion

HaH is increasingly popular, offering benefits for older people, unpaid carers, and professionals by providing better home recovery (Ore, 2024). It is important that we try to find new approaches to support older people that are integrated in nature. Integrating health and social care services for older people is critical to the UK government's agenda, and HaH is a crucial healthcare model that can develop into an integrated health and social care model for older people. Indeed, the effects of an integrated care system are perceived to improve the quality of care, increase patient satisfaction and access to care for older populations (Karacsony, 2022), and the popularity of HaH is gaining momentum both in the UK and internationally (Patel et al., 2021). However, the results from this thesis at the one case study site highlight a need for further development into an integrated care model. This approach, which should encompass not just medical care but also the skills of social workers, occupational, and physiotherapists, has promising potential for improvement. It is a collaborative effort to address medical and social needs, enhancing the care for older people and their carers without hospital visits. The next part of this thesis will address the research questions in detail, offering hope for the future of integrated HaH care.

‘What are the stakeholders' experiences who have directly received and/or delivered HaH interventions, and how has this impacted them? – There has been a vast array of data that evidences a great deal of experience from the three groups of participants included in the research. These three groups include older people, unpaid carers and health and care professionals.

Experiences of older people who have directly received HaH

A significant point to highlight from the results in this thesis is that older people and unpaid carers evaluated HaH with reference to their experiences and expectations of hospital care. This study stands out because participants independently drew these comparisons - an approach not extensively documented in previous HaH literature. This comparison brings a vital element to current research by illustrating how people naturally assess care environments based on person-centredness, responsiveness and autonomy (Shepperd et al., 2009; Davis et al., 2019). The results highlight that older people feel clinical interventions at the hospital are less timely compared to those interventions provided in HaH. Older people feel that there is a better focus on person-centred care in HaH. Older people felt a need to ask for help at the hospital, instead of help being readily available. This does not appear to be the case in HaH as help was readily provided – support from family and equipment from occupational therapy in some scenarios, and temporary free home care if needed. They felt the hospital environment was detrimental to their well-being, and several factors contributed to this, including loud and noisy wards, the busyness of an acute ward and the food choices on offer, which older people were not used to when compared to the food they would have been eating at home. All these factors contributed to the quality of care that older people received at the hospital. In conclusion, overall, older people did not like hospital-level treatment and preferred remaining at home, if possible, with HaH treatment.

When examining these hospital experiences with HaH, the data differ significantly but are original and substantial. Older people expressed greater confidence in asking questions to clinicians when receiving HaH care. This research offers valuable information that bridges a gap in the literature regarding communication patterns between home-based and hospital care while showing that the home environment enables older people to engage more actively in their healthcare, according to Nunes et al. (2021). Open communication and trust were more evident in HaH, whereas in hospital, participants described negative experiences such as delays in care and the need to repeatedly ask for assistance. More significantly, older people valued being given the option to decide on whether they felt treatment could be safely delivered at home, which formed part of weighing up risks – a dynamic not typically present in hospital care. This finding contributes new knowledge by proving how vital perceived autonomy is for healthcare decisions, something that is underrepresented in previous HaH research (Leff et al., 2005; Conroy et al., 2012).

Older people overall felt joint working was good between health professionals delivering HaH, and this was achieved through good and clear communication and an established rapport over time. Overall, older people felt the quality of clinical care they received was very good. The main factors that led to such satisfaction were their feeling more relaxed in their familiar environments, feelings that treatment was more thorough and timely and the fact that they had family members by their side, as all older people had a family member present with them during treatment. The qualitative data strengthens the evidence base for HaH by highlighting how familiarity with the environment, emotional support systems, and relationship development lead to positive care experiences while enriching past studies focused on outcomes (Shepperd et al., 2016; Levine et al., 2020). These factors all contributed to these experiences from the older person's viewpoint. However, beyond the older person's experiences, an important aspect emerged regarding how unpaid carers initially became aware of HaH, a question that past research has not adequately addressed.

Experiences of unpaid carers

A significant point is how unpaid carers initially became aware of HaH. As evidenced in the data, unpaid carers made it clear they had not heard of HaH before. Previous research does not answer this question, and it has remained unclear how either family members or older people become aware of the service. This finding addresses a gap in existing literature by shifting focus from clinical outcomes of HaH to awareness and access pathways for families (Gonçalves-Bradley et al., 2017; Shepperd et al., 2016). There were several ways in which this service became known. This included assistive technology, such as fall pendant devices, which alert emergency and health services. These alerts often led to a conversation about the option of receiving HaH instead of treatment in the acute hospital. It was also clear that this service only became known if family or carers were concerned about the older person's condition. For example, when they contacted services like a GP or NHS 111, it was only at that point that unpaid carers became aware HaH was an option. This highlights that HaH does not feature prominently in public-facing health communication, and awareness often arises through reactive triggers—a point previous research has not sufficiently examined (Leff et al., 2005). Therefore, the data suggest that HaH was not public knowledge.

The results highlight the significant implications of the HaH model for unpaid carers, especially when older people require treatment. The study delves into various contributory factors that influenced the overall effect on the unpaid carer. These factors encompass the physical and emotional impact, the appropriateness of HaH, and its impact on the work and home life of unpaid carers. Current studies on HaH prioritise system efficiency and patient outcomes, yet omit a detailed examination of the carer’s role and experience (Jeppesen et al., 2012; Carers UK, 2022). The findings of this thesis contribute to filling that gap.

This analysis provides a comprehensive understanding of the multifaceted significance associated with implementing HaH services for older people and unpaid carers. Based on my observations of the data, it is evident that unpaid carers were frequently taken for granted, as professionals did not appear to consider or discuss the additional care and monitoring they provided during the treatment period. No thought was given by professionals to what support unpaid carers might need, despite the tasks they took on. My interpretation is that although unpaid carers did not make this explicit, their physical impact increased in the sense of having to 'do more', such as completing personal care tasks, collecting prescriptions, shopping tasks, and supporting the older person with follow-up health appointments. There were also concerns about the impact on the unpaid carers' home and work lives. Unpaid carers had to take time away from work to either provide care or oversight to the older person during treatment, leading to a financial loss in some cases, as the carer had to take unpaid leave. This highlights the urgent need for support for unpaid carers.

However, while these challenges were evident, there were also positive emotional impacts when older people received HaH. This meant unpaid carers felt less anxious and more relaxed because they felt professionals took their time and included them in ongoing discussions during visits to the older person. Where temporary home care was needed, this was provided by the Trust to alleviate any difficulties the unpaid carer experienced in providing care tasks. However, it is important here to note that this was a short-term service and any ongoing care needed to be assessed by social services, but this led to delays.

In conclusion, unpaid carers valued the support provided by HaH professionals. Contributing to these positive experiences were consistent visits and communication, timely responses from health staff, joint working between colleagues, and thorough medical examinations during triage and treatment. Sadly, this contrasted with unpaid carers’ experiences of hospital discharge, where older people were often sent home without the necessary equipment or care—a concern given the availability of short-term discharge support schemes such as rapid reablement or equipment provision.

It can therefore be assumed that unpaid carers and older people perceived HaH as better resourced due to its interdisciplinary approach and stronger coordination. The HaH service examined in this study was in its early stages and experienced low referral rates, which may have impacted the allocation of resources. As the service grows and referrals increase, the challenges identified in this research may become more apparent. Previous studies on HaH (Kinosian et al., 2021; Alexander et al., 2018) have highlighted issues such as limited resources and challenges with discharge planning, which could potentially arise as the service evolves. While the service has shown positive results, it is important to interpret these findings within the context of an emerging service model, with the likelihood of new challenges as the service develops over time. Understanding these challenges from the perspective of the professionals directly involved in delivering HaH provides valuable insight into the operational realities of this evolving model.

Experiences of professionals who have directly delivered HaH

In the service I have researched, several disciplines made up the HaH team, including consultants who took the lead, junior doctors, nurses, occupational therapists, and physiotherapists. A significant finding of my research was the need for more input from social care professionals in the medical treatment process. This highlights the potential for my work to reshape current practices. It was only at the point professionals felt ongoing care might be needed that a referral was completed to the local authority. There was a great deal of thinking around risk and decision-making from all the professionals who participated in the interviews. This included some professionals, mainly doctors, having to think 'outside the box' when treating older people at home. As evidenced in the interviews, this caused some concern to the doctors, as all had no substantial experience practising medicine in the community - almost all had only practised in acute hospitals. Therefore, it was not just thinking about medical risks but also environmental risks that they had not encountered before. With this came added responsibility, so a consultant, for example, who took the lead would be the one to make tough decisions alone without a team around them in the hospital, which would usually be the case, but not always in HaH.

Some professionals felt uncomfortable with this, but again, this appeared to be because it wasn't 'the norm'. However, these anxieties faded with time, and professionals felt more confident as they became familiar with this new way of working. They also felt risk was shared between them, the older person, and the unpaid carer, which is not something that might usually happen in an acute hospital. Lundell et al. (2020) found that risk-sharing and relational decision-making are key components of HaH care, with both professionals and patients actively involved in care decisions. The findings from this thesis demonstrate that HaH professionals share responsibility with patients and carers during HaH, which aligns with Lundell et al.’s (2020) research but has not been fully explored in previous HaH studies. Professionals did feel that people recover better in their familiar environments, but that came with some challenges. For example, results from tests at the time of delivering HaH didn't always come back fast enough and involved several follow-ups with other departments (such as blood or imaging). Another point professionals made was about what was expected of them when delivering HaH, as this wasn't always clear. Again, this caused some unnerve with professionals, given it was venturing into the 'unknown'. The evidence indicates a training and role-definition gap for HaH clinicians, especially when doctors move from hospital settings, which current systematic reviews (such as Gonçalves-Bradley et al., 2017; Shepperd et al., 2009) have not thoroughly examined. Professionals also felt uncomfortable with going into people's houses, as this was not the norm for professionals more used to working in a hospital environment. Some (mainly doctors) felt uncomfortable going in alone, whereas others felt comfortable, so this varied greatly. It was noted in the interviews that this was often overcome by shadowing other colleagues initially or completing training, which increased professionals' confidence in delivering HaH. These findings further highlight insight into HaH workforce development: While some nurses may utilise prior community work experience, medical staff generally require structured training to boost their confidence and readiness in a home-based setting. Existing literature primarily examines patient outcomes and system-level efficiency (Shepperd et al., 2009; Gonçalves-Bradley et al., 2017) but fails to thoroughly explore how HaH professionals adjust to new environments or gain clinical confidence.

Some professionals felt they didn’t have the necessary training to provide person-centred care at home initially. This included no training to use specialist pieces of equipment and a lack of knowledge about delivering care to an older person in their own environment. They also did not know what to do if they had concerns about the person’s living environment. This problem seemed to be more common with doctors and less so with nurses, who were skilled and had experience delivering community nursing care over long periods of their careers. Where doctors felt less knowledgeable and where there was a lack of training to use equipment needed in the home, they often had no option but to admit the older person to the hospital for ongoing treatment. Pieces of equipment that hindered some professionals were the point of sound ultrasound (POCUS) – some professionals were trained to use this, whereas others were not. This is an area that would benefit from further exploration.

Another critical point was around the awareness of services available to professionals; for example, when deterioration might occur, who to call and when. Almost all the professionals felt comfortable asking colleagues for advice when unsure what action to take or who to contact. Nurses, in particular, felt more confident in managing risk and seeking specialist advice from the consultant on duty in consultation with the older person and the unpaid carer. However, social work and social care were not part of the network of professionals to contact for advice, which seems to be a gap in the system. It appears at the forefront of professionals' experience around risk in HaH was the importance for them to ensure older people remain at home in their familiar environments as admission to the hospital would increase the risk of exposure to acquired infections, delirium, or COVID-19, given it was the height of the pandemic at the time.

Some professionals found this challenging to deal with and felt emotionally attached, given the time spent with older people, treating them if the decision was made for them to need hospital treatment. However, even with these feelings, professionals had to best judge the condition at the time (deterioration) and consult with senior clinicians for advice, which would ultimately require admission to the acute hospital. A more important point raised was the concerns professionals had when older people had nobody with them at home, meaning it was ultimately up to the older person to alert professionals if they felt their symptoms were deteriorating. This created a sense of heightened anxiety and was not always easy for them to accept. It is important to note that all participants had the mental capacity to make these decisions and judgments. Some professionals found it emotionally challenging to treat older people in HaH, especially when hospital admission became necessary. Despite these feelings, they had to carefully assess deterioration and consult senior clinicians to decide on admission. A key concern was when older people were alone at home, relying on themselves to recognise worsening symptoms, which caused anxiety for professionals. All participants had mental capacity to make decisions, but this raises broader questions about empowerment in HaH particularly for those who might struggle to know when hospital care is needed.

The data show that professionals were willing to take positive risks in consultation with patients and unpaid carers to keep older people in their familiar environments. This reflects findings by Lundell et al. (2020), who describe nurses managing risks in home care to benefit patients. However, unlike Lundell et al., this research highlights formal collaborative decision-making among doctors, nurses, patients, and carers, and frames risk-taking explicitly as a positive, strategic practice. Initially, doctors sometimes felt isolated when starting HaH, but confidence grew with experience. Nurses generally felt more prepared, given their background managing complex older patients. These experiences influence how HaH teams coordinate and communicate with other health and social care services to ensure seamless patient care.

How does HaH coordinate with other statutory, private and third sector health and social care services?

HaH in this geographical location coordinates with other services. For example, the team liaise closely with their colleagues in occupational therapy and physiotherapy. There also appears to be a communication channel between the Trust’s temporary home care provider that is put in place when social care need is identified during the older person’s period of treatment. When looking more closely at health and social care services, there is also a link between the HaH team and the local authority adult care services. It appears this link is triggered at the point when staff feel the older person may need ongoing home care support from a long-term package of care. The process for this means the nurse in charge will make the referral to the named local authority’s social care department, using the same referral system as any other member of the public. There have been some problematic delays, though, in social care picking up the initial referral, completing the assessment and implementing the ongoing care needed. Given these delays, it would be beneficial to have a direct link between HaH and a duty social worker at the local authority who could prioritise HaH referrals. Without a better system in place, such delays affect the Trust's ability to discharge older people from its free temporary home care services.

At times, this can block the Trust from offering this free temporary home care to other older people who might need it during their period of treatment in HaH, and the Trust continues to offer people the free service until adult social care steps in. It comes with the question of who is offered help and who is not. There appears to be no clear pathway around the eligibility criteria for this free temporary home care. It's important to note that while older people may receive free HaH social care, they might not be eligible for ongoing adult social care via the local authority (LA). This means they could be required to self-fund their care after the HaH services end, unless they are assessed and deemed eligible for further support. Another concerning point to note is around the advice and support provided to the unpaid carer who is present with the older person at home during treatment.

Another concerning point to note is around the advice and support provided to the unpaid carer who is present with the older person at home during treatment. At times, health professionals appeared to take for granted the presence of unpaid carers, who often assumed caring roles without prior warning - this seemed to be the norm among carers in the study. It remains unclear what support mechanisms exist for unpaid carers in these situations. There needs to be a clear link between carers taking on responsibilities and the support they receive, such as access to a social worker within HaH who can offer advice and referrals, including for carer assessments by local authorities to determine eligibility for long-term support like personal budgets. This finding reveals a critical gap in HaH service design: unpaid carers play a vital role in home-based care but are often excluded from formal care planning and support. While Nunes et al. (2021) highlight the autonomy older people gain through HaH, my research adds important insight into the unmet physical, emotional, and financial challenges unpaid carers face, frequently without consultation or assistance. What distinguishes my findings is the focus on the specific demands on unpaid carers during HaH treatment and the urgent need for proactive engagement and formal assessments, an area overlooked in previous research. This underscores the necessity of more integrated support pathways for carers throughout the HaH process.

These challenges reflect wider coordination issues within the HaH model, particularly when it comes to working with GPs. For example, professionals who took part in interviews voiced concerns about the time it was taking to pass over information to GPs when discharging older people back into their care. This process was not always easy, and HaH professionals had no direct communication links to do this. As such, they were following the same processes as a member of the public would have to do - phoning the surgery using the main contact number. The information would then be passed over to them, and any queries would be passed on from the GP to the HaH team should they have any queries about the discharge summary and its content. Therefore, it is clear that communication is not always easy for HaH professionals, and a more streamlined approach is needed to enable smoother communication between the services that HaH coordinates with. This issue represents a significant operational barrier in HaH implementation. While previous research, such as Davis et al. (2019), addressed professional uncertainty and role ambiguity in HaH models, it did not focus on communication breakdowns between HaH professionals and GPs during patient transitions. The requirement for HaH professionals to use public-facing processes like calling surgeries through standard numbers to share vital clinical information reveals systemic inefficiency. This insight extends the current literature by exposing how administrative barriers can compromise continuity of care and create delays in post-discharge planning for older people in HaH. Addressing these systemic challenges is essential to ensuring timely, coordinated care and improving outcomes for both older people and their carers.

What can be learned from the findings regarding future health and social care policy and practice?

Most older people prefer to be at home in their familiar environments, but more training is needed for professionals who have recently started practising in this area of health and social care. Without adequate training, there are concerns that professionals may not be fully equipped to manage the complexities involved, such as identifying social care needs, assessing the feasibility of care delivery in the home environment, and evaluating the living conditions of older people. The delivery of person-centred care can also be negatively impacted by concerns around workplace culture, learning culture and the physical environment (McCormack et al., 2011).

Some professionals reported a lack of clear policies and procedures in the early stages of HaH implementation. While paperwork was not raised as a concern in this study, other studies have identified documentation and compliance processes as barriers to efficient HaH delivery (Levine et al., 2018; Kinosian et al., 2021). This highlights the need for national guidance, infrastructure support, and regulatory alignment to ensure that HaH can operate at scale . Moreover, training, education, commissioning, and service reconfiguration are necessary to ensure good quality person-centred care in HaH (Coulter et al., 2016). In the absence of these supports, the delivery of person-centred care may be compromised. Given that older people prefer this form of treatment, HaH should be expanded countrywide, in partnership with social care, to ensure an integrated approach that supports both older people and unpaid carers.

It is also important to note concerns around 'weighing up risks' and 'who decides.' While most older people felt comfortable weighing risks alongside health professionals and family members, it remains unclear how those without family support would approach these decisions. This raises important questions about equity of access to HaH, warranting further research. A significant issue is the lack of a clear definition of who might benefit from HaH but lack the necessary support to manage their health conditions and treatment. The research highlights that all older people in the study had someone with them during treatment, observing, advocating, and monitoring their health. This raises a serious question about those who may not have the support to 'self-monitor,' potentially leading to their exclusion from HaH. It also prompts consideration of whether HaH is currently accessible to all.

There is a growing understanding of the effects of HaH treatment on unpaid carers, who experience both positive and negative impacts. For example, unpaid carers recognise the emotional benefits for older people receiving care at home rather than in a hospital. However, concerns remain about the physical, emotional, and financial toll that caring duties can have on carers themselves, as evidenced by the study results. It is crucial to clarify the role of unpaid carers in HaH, as they provide not only emotional support but also practical care responsibilities.

Awareness of HaH services among both older people and healthcare providers remains limited. Many older people were unfamiliar with the concept until emergency situations, such as ambulance callouts or alarm activations, introduced them to the service. This thesis reveals a critical gap in how HaH is communicated, particularly to GPs, who act as gatekeepers. The limited visibility of HaH may contribute to unnecessary hospital admissions and delayed access to care (Shepperd et al., 2009; Davis et al., 2019).

Several participants expressed that if they had known about HaH earlier, they would have preferred it over hospital treatment. It is unclear how information about HaH is disseminated to communities and services, and some providers appear better informed than others. Whether GPs are fully aware of HaH and its benefits is unknown, raising questions about the potential to reduce emergency admissions, a pressing concern. This lack of clarity may reduce referrals, delay clinical decisions, and diminish trust in HaH as a safe and effective alternative to hospital stays. Consequently, services may be underutilised, care becomes fragmented, and opportunities to prevent unnecessary admissions are missed, particularly when professionals are left to decide if concerns arise around the safety of the patient in HaH, potentially leading to delays or missed opportunities for intervention (Smith et al., 2021; Jones & Patel, 2020; NHS England, 2022)

Intermediate Care (IC), which is discussed in Chapter Two, is intended to help reduce hospital admissions and address delayed transfers of care, faces its own difficulties. These include challenges like a lack of integration, limited resources, and poor communication between healthcare providers. Both IC and HaH seek to fill the gaps left by conventional hospital care by offering more flexible and patient-focused alternatives, allowing individuals to receive care in the comfort of their homes. However, just like with IC, if HaH services are not widely recognised or properly understood by crucial healthcare professionals, such as GPs, or if there are barriers in terms of access or referral processes, the opportunity to prevent unnecessary hospitalisations may be lost. The fragmentation seen in the IC system, where roles are unclear and resources are stretched, reflects similar challenges that HaH encounters. Without improved integration and greater awareness, HaH may continue to be underutilised, preventing the delivery of more efficient and person-centred care.

To improve HaH further, clear and specific information for older people and their families is crucial. This should include details about the treatment plan, potential side effects, and the role unpaid carers may play. Providing such information at the start of treatment helps patients understand what to expect and highlights additional support options, such as home care, equipment, or ongoing assistance after treatment concludes. Leaflets for unpaid carers would also be beneficial, informing them about accessing support through local authorities, including carer assessments to aid them during treatment and in any ongoing care.

An integrated care system would benefit HaH, GPs, and social care alike. HaH services would gain from integrated systems that enable real-time communication and coordination with social care. The findings of this thesis go beyond general calls for integrated care (Gonçalves-Bradley et al., 2017) by suggesting practical improvements such as automated alerts to local authorities and direct referral channels to increase HaH’s effectiveness and timeliness. For example, if HaH professionals identify a need for long-term social care, the system could automatically notify the local authority to request a social care assessment or advice on housing, community services, or benefits maximisation. Of course, this requires sufficient capacity in the relevant services to be effective.

Moreover, an integrated care system could greatly enhance HaH by providing clear care pathways indicating who to contact and when, an area professionals identified as a concern during early findings. Inclusion criteria for HaH also need to be more flexible, as the current strict criteria may exclude some older people. This may be due in part to a lack of awareness and education among health professionals, which could be addressed through further training and improved understanding.

Taken together, these findings illustrate that while HaH has demonstrable benefits for patients, carers, and professionals, its sustainability and equity hinge on improved training, stronger integration with social care, clearer referral pathways, and recognition of unpaid carers' roles. Addressing these gaps will be vital for expanding HaH as a safe and person-centred alternative to hospital care

The next part of the thesis will be recommendations for future policy, practice and research.

Recommendations for Future Policy, Practice and Research

Policy and Practice

Mandate Comprehensive Training for HaH Staff

- Implementing more comprehensive training for all staff involved in HaH has a multifaceted impact. Firstly, it ensures that care is consistently patient-centred, acknowledging and addressing the unique needs, preferences, and values of older people. This type of care fosters a more holistic approach, potentially improving patient satisfaction and outcomes. Secondly, training in support for unpaid carers equips staff with the knowledge and skills to effectively engage with and support family members or friends who are providing 'unpaid' care. Such training should be made mandatory. By providing them with adequate support, it can help to alleviate challenges they might face. Lastly, understanding wider services that can assist older people and their families allows staff to offer more comprehensive support beyond immediate medical needs. This could include linking older people and unpaid carers with community resources, social services, or other forms of support.

Provide Coping Support for Unpaid Carers

- Coping strategies should be offered to the unpaid carers to help them manage the situation better. This is not just a suggestion, but a crucial need, as it is unclear precisely from this thesis what support is being provided. The unpaid carer plays a crucial role in the older person's treatment. If the carer becomes ill, there would be no one to provide the necessary care, increasing the risk of hospital admission for the older person, especially if they cannot monitor their condition. For example, if the unpaid carer usually supported the older person with washing and dressing, meals and drinks or medications at home during the treatment, but the carer suddenly became unwell, this could lead to unavailability of care and further increase the risk of hospital admission.

Integrate Social Care into HaH Delivery

- The design of HaH must include the presence of social care as it scales up. The tasks that unpaid carers undertake during an older person’s treatment highlight the need for further research. Social workers, with their unique ability to assist older people and unpaid carers, are not just instrumental but crucial in addressing concerns such as poor housing conditions, completing referrals to occupational and physiotherapy where such need is identified, connecting individuals with community support services like daycare provisions and respite care, completing carers assessments, optimising income through access to benefits, and advocating more generally for both older people and unpaid carers to improve their overall health and wellbeing.

Improve Interprofessional Communication Channels

- There needs to be a clearer and more direct communication channel between HaH and other services such as GPs and the local authority adult social care department. This might be achieved by a direct line or shared record for professionals to refer patients back to the care of their GP. In terms of social care, it would be helpful for a social worker to be part of the multi-disciplinary team. This might help alleviate the long delays older people face waiting for an assessment when the HaH team has already identified ongoing social care needs.

Increase Community Awareness of HaH

- There needs to be more educational awareness of HaH in communities, as not all participants had heard about it before. It seems the service is only discussed and offered during an emergency health episode, such as an ambulance call out or when somebody has fallen at home and pressed their emergency falls pendant alarm. This might be achieved by providing GPS with some training about HaH, how to access it, and the patients it can treat at home without the need for emergency admission to a hospital.

Address Social Care Delays in Ongoing Support

- While temporary home care is available, the absence of social care presents a significant barrier for professionals in planning person-centred care. Although temporary social care is accessible through the health service, long wait times often leave older people waiting for an ongoing assessment from the local authority for potential ongoing homecare support. To address this, a dedicated social care professional should be included in the HaH team. This professional would intervene and assess when HaH professionals believe long-term home care may be necessary post-discharge. Currently, HaH is dependent on the local authority to assign a social care professional for the assessment; a process that often leads to delays in discharging older people from their Trust home care service, which is currently free of charge.

Recognise and Support the Role of Unpaid Carers

- Thought needs to be given to the roles of unpaid carers in HaH given the nature of care tasks they take on board. This could be addressed by professionals familiarising themselves with The Care Act 2014, particularly section 10 (The Care Act, 2014). In this way, professionals can review the needs of the unpaid carer at the time of treatment for the older person and identify if the carer needs ongoing support. This would then lead to the professional completing a referral to the local authority for a carer's assessment to determine the level of support the unpaid carer would benefit from.

Research

Enhance Understanding of Multidisciplinary HaH Models

- Future studies should look at models with different professional make-ups, including social workers, GPs, and community partners, as this is an area that needs further exploration to help us better understand the links between such services and HaH.

Evaluate HaH Effectiveness against Hospital Care

- This research has explored the experiences of older people who are receiving or have recently received HaH. What we don’t know is how far it contributes to their recovery outcomes compared with hospital care. Therefore, this is an opportunity for further research.

Explore Unpaid Carers’ Perspectives in Greater Depth

- While unpaid carers expressed a preference for the older person to be present during the interview, it is worth considering that conducting separate interviews in a future study could yield different results. It is possible that unpaid carers have contrasting experiences when not in the presence of their loved ones. Nevertheless, the findings of this study offer valuable insights into the challenges that unpaid carers face, underscoring the need for additional support and resources. The data also suggest that relationships were of utmost importance, which could be another reason unpaid carers did not discuss the additional care duties placed on them.

Limitations of the Research

There are limitations to this research, which are discussed below.

Equality and Diversity (EDI)

The study, which investigated the experiences of older people and unpaid carers during their HaH treatment, can be criticised for lacking equality and diversity data. The majority of participants were from white ethnic backgrounds, leaving a significant gap in terms of representation from other ethnic groups. As such, it is unclear why this was and how the findings would differ if participants from other ethnic backgrounds were involved in the study. Another limitation of the study is that all participants had a spouse or family member with them during treatment, which is not always the case for older people. It is not known how the findings would differ if older people did not have family support during their treatment, as not all older people have supportive relationships. This has been highlighted by the results and raises questions about the effectiveness of treatment for older people without the support of family members. Furthermore, the study also lacks information about same-sex couples, which further highlights the lack of diversity in the study. It is unclear how the results might differ in this scenario, and this is an area that requires further research. Addressing these limitations is crucial to ensuring that future research can better reflect the diverse experiences of older people.

Concerns about Cognitive Impairment(s) and Mental Capacity

During the study, all of the older people and unpaid carers who participated had the mental capacity to consent to take part in the study. The health professionals confirmed that none of the participants showed any evidence of cognitive impairment. However, the study's results could have been influenced if individuals who lacked the mental capacity to consent to take part in the study were included. I carefully considered this issue during the study's design and ethics process. However, due to time constraints, there was not enough time to fully evaluate how mental capacity would be assessed and by whom, in the event that questions were raised about an individual's ability to consent. Although I attempted to address this issue, the study began later than anticipated, leaving little time to consult with experts and think through this matter thoroughly. As a result, there is some uncertainty about whether the study's results would have differed if individuals who lacked the mental capacity to participate had been included.

Sample Size, Time and Roles

The research also has some limitations around sample size and time constraints. Despite the participation of 42 older people, unpaid carers, and professionals in the study, the results might have differed had the sample size been larger. Also, some topics had not yet reached saturation. However, due to the COVID-19 pandemic, recruiting more participants was challenging, as some participants were hesitant to allow a researcher into their homes for interviews. The fear of contracting the coronavirus was prevalent among many individuals, and this likely deterred involvement. Therefore, only a small number of older people and unpaid carers agreed to participate, and this was highlighted by professionals during the discussions about patient numbers in HaH.

Moreover, the study was conducted by only one person, which may have further limited the scope. With a larger research team, it might have provided more time to increase the sample size and allow more time for recruitment. However, I was working under time constraints, and engaging additional researchers may not have been feasible. It is also worth noting the absence of social worker perspectives in this study. Future studies with larger sample sizes and more diverse populations, including a wider range of professionals, would help validate these findings and strengthen the evidence base.

In total, twenty-one health professionals agreed to take part in the study. Even though I built trust with many, some remained sceptical about providing honest feedback via Microsoft Teams, as face-to-face research interviews were prohibited at the time due to a spike in COVID-19 infections. Nonetheless, the remote interview format allowed for a broader geographic reach and may have improved participant diversity. Certain professionals asked for information about whether their identities would remain protected throughout the recording process. I reassured them that details such as names and workplaces would remain confidential.

Interestingly, almost all professionals chose to keep their cameras off during interviews. Only two (whom I had met during my time with the team) out of the twenty-one were willing to turn them on. This makes me wonder whether responses might have been different had cameras been on, especially since I did not have the chance to meet most of the professionals during my time with the HaH team. It may reflect a lack of privacy in clinical settings, such as other professionals seeing them taking part in interviews in a large area, raising confidentiality concerns. It may also be that there was no opportunity for me to build relationships and trust with all professionals in person, which might have discouraged some professionals from using their cameras.

Region

The study in question was conducted solely in one particular area of England. It is uncertain whether the results can be generalised to other areas of the country. If the study had included a wider geographical area, it might have increased the number of participants and allowed for a more diverse pool of individuals with varying backgrounds, including black and Asian participants, as well as those who identify as LGBTQ+. It is also worth noting that the model of HaH service that was being practised in the area during the research period was still in its early stages. As such, healthcare professionals had a limited understanding of how best to deliver this service. This lack of familiarity could have impacted the study's results if the service had been more well-established, with professionals having a greater understanding of the service and how to deliver it. Whilst HaH is one specific model, there are others to highlight, such as ‘virtual wards’, which may have generated different results.

Patient Public Involvement (PPI)

Ensuring that patients and the wider public are involved in the activities undertaken within this research project is a key priority for the ARC, which funded this research. Patients and the public bring a wealth of experience and provide valuable perspectives on the way that research is designed and delivered. The design of the public and patient involvement activities within this project was supported by the NIHR ARHC West Midlands Acute Care Interfaces Patient and Public

Involvement and Engagement (PPIE) group. The group had numerous discussions about HaH models and expressed a concern for how the services are developed. They designed a project that will help us understand the overall experiences of patients, their unpaid carers and health and social care workers. However, it is important to note that I was not included in the PPI prior to me starting the research, so it is unclear exactly what was discussed and who was involved in this process. There were also no funds available to me for this purpose. Therefore, there is a limitation in this regard. I made an effort to utilise the available mechanisms. I consulted with the Adult Social Care Lived Experience Panel to gain further insight into the panel's general opinion about HaH, as the importance of older people's involvement in research is evidenced (Goodwin et al., 2023). Indeed, the Adult Social Care Lived Experience Panel was valuable, as it provided insight into the service's awareness among a diverse group of people with lived experience and how they feel about HaH.

Methods

The research study in question utilised semi-structured interviews with all of the participants who provided their consent to take part. The design of the research project considered various methods to gather in-depth information about the participants' experiences. After careful consideration, it was concluded that this approach to interviews would be the most appropriate method for this study. This method allowed for flexibility in the questioning process, which enabled the participants to provide detailed information about their experiences. I considered using observation as a method to gather information, but ultimately decided against it due to ethical concerns. The older people in the study were undergoing treatment and at times very poorly, and it was felt that observing them and asking questions during this time would not be appropriate. Additionally, given the heightened anxiety of the COVID-19 pandemic, it did not feel appropriate to observe the professionals delivering treatment. I felt that this could have added to the anxiety that these professionals were already experiencing. However, the research team recognised that observation may be appropriate in certain circumstances. For example, observation could be considered for future studies when older people are approaching the end of their treatment and feeling better in their familiar environments. In such cases, observation may provide valuable insights into the experiences of the participants.

Reflection

This research has been an exciting piece of work for me as the primary investigator. I came directly from social work practice into a PhD with limited knowledge of the requirements and expectations of a PhD student. Whilst I completed both a bachelor's degree in social care and a master's degree in social work, the level of critical thinking in a PhD is much different. I had to adapt quickly to the role of a PhD student and further enhance my knowledge of social science research methods. While I completed modules in research at the undergraduate and master's levels, I needed to have a solid understanding of different methods and research designs to fully appreciate which method and design were most suitable for this research.

It was hard initially to adapt to an academic environment, given that I had spent nearly five years working as a hospital social worker. However, the support provided by the university and supervisory team has been excellent, and whilst I have faced difficulties adjusting alongside dealing with grief and loss, I have persevered with the support from the department. Throughout this process, I have learned that I am very resilient. As I reflect on this journey, I am filled with a sense of joy and satisfaction. I have thoroughly enjoyed my time as a PhD student and am proud of the research I have completed. I feel that I have been able to examine a topic that is very relevant in health and social care, and have been able to contribute to this crucial area in several ways. Therefore, I would say I have achieved my aims and objectives and hope that the findings will have a lasting positive impact on practice and policy in health and social care.

Appendices

Ethics Approval Letter: 22.NW.0084 299850
Letter_of_HRA_Appr

Ethics Acknowledgement Letter: 22-NW-0084
Acknowledge docu

S&WB NHS Approval Letter: RESEARCH AND
DEVELOPMENT APP

Participant Information Sheets: PIS+1.docx PIS+2.docx PIS+3.docx

Participant Interview Questions: IQ+1.docx IQ+2.docx IQ+3.docx

Participant Interview Letters: IL+1.docx IL+2.docx IL+3.docx

Sources of Support Letter Older People: Sources+of+Suppo
rt+for+Older+Perso

Consent Forms for Participants: Consent+Form+for
+Interviews.docx

Research Protocol: Protocol+Final+V1
0+Final.docx

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