Hospice at Home TOOLKIT

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One Page Summary for:

Health and Social Care Commissioners and Integrated Care Boards

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Research into hospice at home services

Hospice at Home services support people towards the end of their life, to live at home for as long as possible and to die at home if that is their preference. We undertook a research project (2017-2020) to understand how to get the best performance from hospice at home (HAH) services in England, to optimise patient care and outcomes. We carried out a national survey and then looked into 12 services around the country in detail. We recruited 339 patients and their family/friend carers and interviewed 85 professionals.

What did the research show?

- Hospice at home (HAH) services overall provided care that was likely to deliver 'a good death' and 73% of patients died in their preferred place.
- Patients admitted to HAH services were much less likely to die in hospital than the general population (9% vs 46% [2017 data]).
- All HAH services offered care which was highly rated by family/friend carers.
- The majority of HAH services were being delivered to patients dying of cancer (77% of patients admitted to HAH had main diagnosis of cancer).
- Two-thirds of HAH services reported charity donations as the main source of funds.

What does this mean for you when commissioning Palliative and End of Life Care services?

N.B. There were considerable variations in the detailed operations of hospice at home services from one locality to the next, so it is important to find out about your local service (Hospice Care Finder, Hospice UK).

1. Commissioners could utilise some of their budget effectively by funding HAH and achieving objectives enabling choice about place of care and reducing acute hospital pressures.

2. As significant funding for HAH across the country comes from charitable sources, commissioners who spend NHS funds on HAH are likely to get good added value, *however* ⇨

3. As many HAH providers are small charities, there is a tension for them in terms of integration with other providers, which they fear may impact on their specialism and charitable fundraising.

4. Commissioners should consider the sustainability of HAH when determining the amount of funding and the duration of contracts (which are often too short to provide adequate stability).

5. Commissioners have important responsibilities for the equity of service availability. With the pressure to provide equitable services, some of the key features of HAH that drive better outcomes cannot be compromised, in particular: the elements of time, expertise and relational care which engender trust and confidence; agility of the service to respond to changing needs; identifying and addressing the needs of family carers as well as the patient at home.

6. Commissioners may also want to consider how to work with HAH providers to extend their services to more people, and particularly to address the inequities of provision for those with diagnoses other than cancer.