

Hospital at home services

Report of the national programme 2025/26

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Summary

This report summarises the impact of the national hospital at home programme for the period April 2025-March 2026, delivered by Healthcare Improvement Scotland.

Healthcare Improvement Scotland have been delivering a national improvement programme to support hospital at home services since 2019. In line with Scottish Government's Operational Improvement Plan 2025, we supported the expansion of hospital at home in 2025/26. The expansion included roll out to new localities, addition of new disease pathways and the addition of neonatal and paediatric services to the national programme.

Key information

Definition of hospital at home

Hospital at home is a service that provides acute hospital-level care by healthcare professionals, in a home context, for a condition that would otherwise require acute hospital inpatient care.

Impact of hospital at home

- In 2025/26, over 17,000 people aged over 65 avoided spending time in hospital because of hospital at home services.
- The median number of admissions to older/acute adult hospital at home services per week rose by 27% during 2025/26, to 378 admissions.
- According to national data, 340 babies and children avoided time in hospital between November 2025 and April 2026 due to hospital at home services.
- An estimated £18.8 million in healthcare costs were avoided in 2025/26 because hospital at home admissions cost less than traditional geriatric hospital stays.
- An estimated £44.3 million in healthcare costs were avoided due to reduced healthcare usage in the 6 months following discharge from older/acute adult hospital at home.

2025/26 national programme objectives

The programme objectives for the 2025/26 period were to:

- share evidence and best practice
- increase the pace of implementation through tailored improvement support
- enable measurement of progress and evaluate impact, and
- facilitate learning and connections both locally and nationally.

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Background: hospital at home

1.1 Definition

Hospital at home is a service that provides acute hospital-level care by healthcare professionals, in a home context, for a condition that would otherwise require acute hospital inpatient care.

Hospital at home has traditionally been delivered to older people over the age of 65 in Scotland who required acute care, to avoid admission to hospital or to support early discharge from hospital. In 2025, Scottish Government provided funding for the expansion of hospital at home in Scotland to include respiratory, heart failure, neonatal and paediatric treatment pathways. Individual NHSScotland boards applied for funding to support the pathways suited to their local needs and capacity. Therefore, there is some variation in the pathways delivered across different areas of Scotland.

The term hospital at home is sometimes used to describe a broader remit of services, which include outpatient parenteral antimicrobial therapy. Some hospital at home services in Scotland include OPAT within their remit. This report focuses on the hospital at home services delivered in patients' places of residence, not those requiring attendance at outpatient clinics.

1.2 Key features

The key components of Scottish hospital at home services are as follows.

- Unscheduled care is delivered within a same-day response time.
- Clinical services are delivered in the patient's home, in place of inpatient admission, but not preventing access to hospitals where required. 'Patient's home' may include their care home, a relative's home, or other homely settings.
- Patient care is mainly conducted in-person, with additional remote monitoring offered by some services. Remote monitoring, independent of face-to-face care, is not considered hospital at home.
- Secondary care specialists act as senior decision makers and responsible medical officers , sometimes with the help of other grades of medical staff. For paediatric and neonatal services, the responsible medical officers are consultant paediatricians and neonatologists respectively.
- Care is provided by multidisciplinary teams of healthcare professionals, which include nurses, allied health professionals (AHPs) and other doctors, complying with current acute standards of care
- These professionals deliver short, time-limited, acute episodes of care. This can be for the entire acute episode, as an alternative to hospital admission, or at the end of the episode to support early discharge from hospital.

- Teams have access to hospital-level diagnostics, such as endoscopy, radiology or cardiac diagnostics where necessary.
- Professionals administer secondary care level interventions above those that can be delivered by other community services, such as intravenous fluids and oxygen, where required.
- Services complement other community-based health and care initiatives that support patients to remain in their own homes. They provide a level of care that no other service in the locality, other than acute hospital, can provide.
- Services do not cover chronic disease management (other than during acute exacerbations).

Although all hospital at home services across Scotland have these key components, there is variation in how services are designed and delivered. Variation exists because hospital at home is designed to interface with the existing services in an area, to accommodate local context and population needs.

Some NHS boards in Scotland are still in the process of developing and defining the scope of their neonatal and paediatric hospital at home services. Therefore, the definition and key features above are subject to change as they evolve.

1.3 Objectives for the national programme 2025/26

Healthcare Improvement Scotland have supported a national improvement programme for hospital at home since 2019. The programme objectives for the 2025/26 period were:

- share evidence and best practice
- increase the pace of implementation through tailored improvement support
- enable measurement of progress and evaluate impact, and
- facilitate learning and connections both locally and nationally.

2.0 Sharing evidence and best practice

2.1 Programme structure 2025/26

2.1.1 General programme offering

We work with NHS boards and health and social care partnerships (HSCPs) to design, implement and improve hospital at home services. This includes the following activities.

- Providing in-depth support to model patient pathways from referral to discharge.
- Sharing advice on measuring and evaluating the implementation and impact of services.

- Providing quality improvement (QI) support to help plan, deliver and evaluate tests of change to patient pathways.
- Managing relationships with NHS boards/HSCPs/Scottish Government and other national organisation leaders, to address the infrastructure improvement required to expand hospital at home at a national level.

2.1.2 2025/2026 expansion

Scottish Government's Operational Improvement Plan, published in March 2025, called for the expansion of hospital at home in Scotland. It stated that pathways could *"include older acute adults, outpatient parenteral antimicrobial therapy, respiratory, heart failure and paediatrics"*.¹

Healthcare Improvement Scotland was therefore funded to support adult, neonatal and paediatric hospital at home services within the remit of the national improvement programme in 2025/26. Following confirmation of funding, all NHS boards in Scotland were offered the opportunity to apply to the programme. They had the choice to request support for any of the following pathways:

- acute older adult
- respiratory
- heart failure
- intravenous antimicrobials at home, and
- neonatal and paediatrics.

Applicants were also able to choose from three levels of support, aimed at services in different stages of their journey. The three packages were as follows.

1. Intensive implementation package: For services that either need support with a very new service, need structure to deliver change, are aiming for a high level of innovation, or have little local support.
2. Implementation package: For services that are making significant changes, want some help with structure to deliver this change, and have some local support.
3. Learning package: For services that are well established, are confident about their next steps and/or have strong local support.

Services with hospital at home funding from Scottish Government, as part of the Operational Improvement Plan, were able to participate at any of the three levels. Services without this funding were still able to participate in the learning package. Support was available for services with pathways at any stage of development.

In this summary of our activity for 2025/26, the main distinction will be made between:

- adult hospital at home services, and

- neonatal and paediatric hospital at home services.

2.1.3 Establishment of the neonatal and paediatric hospital at home national programme

Healthcare Improvement Scotland assembled an improvement team for neonatal and paediatric hospital at home following confirmation of the programme scope for 2025/26. We chose for the neonatal and paediatric programme to have separate leadership from the adult programme initially. This was to support the intensive early stages of set-up and planning. However, some staff supported both programmes to promote continuity. Over the 2025/26 period, the programmes experienced some cross-over in decision-making. The teams worked closely to ensure that timelines were harmonious, and learning could be shared where applicable.

Following the application process, support was offered to all six NHS boards that requested it. One service withdrew early in the programme as they did not receive the appropriate funding. Some services that enrolled in the programme had existed prior, whereas others sought support for set up.

2.2 Guiding principles for service development

The first version of the “Hospital at home – Guiding principles for service development”, hereafter referred to as the guiding principles for adult services, was published in 2020. This document was aimed at professionals developing hospital at home services for the older acute adult cohort.

The purpose of guiding principles for hospital at home are to assist in the local and regional planning of specialist services which support people to receive hospital-level care at home. The principles are not intended to be a stand-alone guide to setting up a hospital at home service. Instead, we recommend services use them alongside support from us and the Scottish hospital at home community.

2.2.1 Update to the guiding principles for adult services (October 2025)

Following the Operational Improvement Plan, an update to the guiding principles for adult services was required. This update was needed to encompass new treatment pathways.

We firstly conducted a literature search to identify evidence about heart failure and respiratory hospital at home pathways. The results of this search were summarised and included in the updated guiding principles. Several other updates were made to include learning from the previous 5 years of the programme. This captured insights from the Healthcare Improvement Scotland team as well as professionals working in hospital at home services.

The updated guiding principles for adult hospital at home services were published in October 2025. A copy can be found on Healthcare Improvement Scotland’s website [here](#).

2.2.2 Neonatal and paediatric guiding principles – part one

Following the update to the guiding principles for adult services, priority was placed on developing a similar document specific to neonatal and paediatric hospital at home.

In March 2026, we completed part one of the “Guiding principles for service development for neonatal and paediatric hospital at home services”, hereafter referred to as the neonatal and paediatric guiding principles. This document contained the definition, rationale and policy context for neonatal and paediatric hospital at home.

A literature search was conducted during the development of the document. This search focused on four key areas of evidence:

- safety and effectiveness
- patient experience
- family experience, and
- staff experience.

A summary of the evidence identified in this literature search was included in part one of the neonatal and paediatric guiding principles. The document was shared within the neonatal and paediatric hospital at home learning system which Healthcare Improvement Scotland provides for professionals in the field. An extended version of the document will be publicly available on Healthcare Improvement Scotland’s website in the future, when services have had time to establish and reflect on the process of development.

2.2.3 Evidence summaries

Below are summaries of the evidence identified during the development of the guiding principles. Our previous annual report referred to the evidence about hospital at home which had emerged between 2020 and the time of writing the report. We have identified further evidence which has been published since then and included it in this section.

Heart failure and respiratory pathways

- Systematic reviews have reported positive findings for the effects of hospital at home on the outcomes of heart failure and respiratory patients.^{2, 3} The findings of the reviews were based on randomised controlled trials conducted in the early 2000s.
- More recent observational studies have demonstrated similar readmission⁴ and mortality rates when acute heart failure is treated at home.⁵
- Two 2017 randomised controlled trials showed the importance of face-to-face care. They found that pure remote monitoring models did not improve outcomes for heart failure patients.^{6, 7}
- In an economic evaluation of Liverpool’s heart failure virtual ward, they observed a cost benefit when treating heart failure patients at home. The magnitude of cost benefit was

variable by patient, depending on the severity of their condition. They also reported a reduction in accident and emergency (A&E) activity.⁸

- There is a need for more recent evidence to inform disease-specific pathways in hospital at home.

Neonatal and paediatric hospital at home

- In a range of systematic reviews, paediatric hospital at home services have not been associated with more adverse events,^{9, 10} less favourable clinical course^{9, 11, 12}, or more readmissions^{9, 13} than conventional hospital.
- At the individual study level, higher readmissions for clinical complications have been observed. However, they may be explained by increased parental ability to identify worsening of their child's condition.¹⁴ This is likely due to parental education delivered as part of the hospital at home service.
- Several studies of neonatal hospital at home report positive findings for safety and effectiveness. Researchers have observed equal or lower readmission rates^{15, 16} and length of stay,^{12, 15, 17, 18} and comparable weight gain^{12, 17} across babies treated via hospital at home and conventional hospital.
- A 2024 review found that providing hospital care at home promotes children being more involved in their own care.¹⁹ This was found to improve patient confidence and autonomy, ultimately improving joy and satisfaction.
- The same review also concluded that hospital at home reduces "stressors such as anxiety, nervousness, uncertainty, and fear" for families.
- There is some evidence of cost-effectiveness of neonatal and paediatric hospital at home services.^{9, 12, 20, 21} However, conclusions are weak due to varying service designs which make it difficult to compare study results.

General evidence

- In March 2026, the Journal of Advanced Home Medicine was published for the first time. This journal publishes research relating to all novel acute medical interventions delivered at home but has a specific interest in hospital at home.
- One paper published by the journal was a multi-country study which found that the rates of unplanned escalations back to hospital were consistent across sites in Australia, Singapore, and the USA at around 6-7%.²² The authors suggest that this could be used as an internal benchmark for acceptable risk.

- Patients over the age of 85 were more likely to require escalation than those under 65, as were patients with certain conditions. Intensive care unit admissions and mortality following escalation were rare in the study sample.
- In another study, conducted in Canada, the researchers identified more patient characteristics linked to a higher likelihood of escalation to hospital.²³ The researchers developed a risk assessment tool with their findings.

*Note: Due to the acute nature and complexity of conditions hospital at home treats, there will always be a proportion of patients that could require transfer back to hospital if their condition develops. Hospital at home professionals continuously assess risk and make shared decisions with patients about the most appropriate place for their care.

3.0 Measurement and evaluation of impact

Healthcare Improvement Scotland has traditionally gathered data from hospital at home services nationally. This includes the number of patients in the service at the start of each day, new patients admitted, referrals rejected, patients discharged, and occupied beds per day. A summary of the data from the 2025/26 period is included in this report.

We have balanced the need to capture and report this data with ensuring the process is as efficient as possible, to reduce the burden on hospital at home services. In 2025/26, services continued to submit data to us monthly, whilst also reporting to Public Health Scotland. From 1 April 2026, Public Health Scotland will be the only organisation collecting this data nationally.

3.1 Relieving hospital pressures

Increasing hospital at home capacity directly impacts on reducing hospital pressures. Hospital at home services provide an admission alternative which:

- Prevents delayed discharge, as the patient is already at home. This is important because evidence shows delayed discharges from hospital are associated with increased risk of mortality, hospital acquired infections, mental ill health and reduced mobility for patients.²⁴
- Reduces demand on ambulance services, A&E departments, and wards.

National data for neonatal and paediatric hospital at home was not collected for the full year in 2025/26. Public Health Scotland collected admissions data for these services from November 2025 onwards. Their publications show that 340 babies and children avoided time in hospital due to hospital at home services between November 2025 - April 2026.^{25, 26}

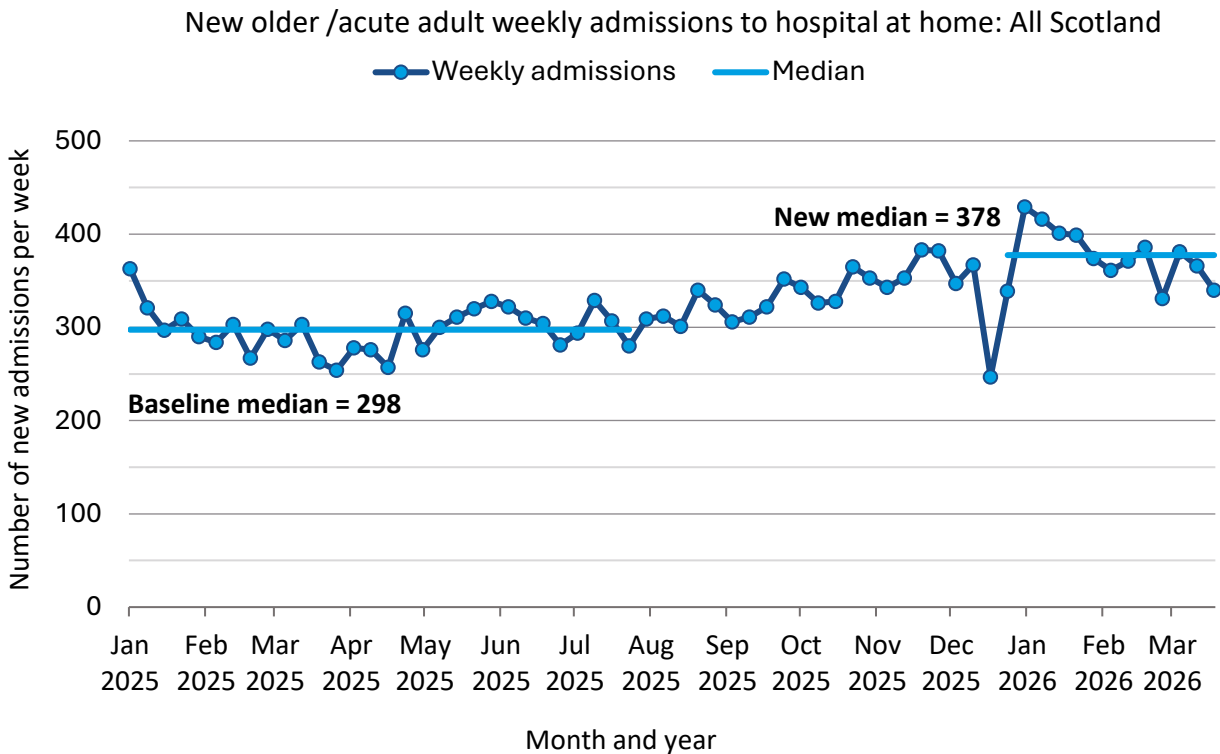
Older/acute adult hospital at home services have been part of the national programme since 2019, and processes for data collection and sharing with Healthcare Improvement Scotland are well established. We therefore have more robust data to share about older/acute adult

services. The data presented in sections 3.1.1 and 3.1.2 therefore relate to older/acute adult hospital at home services only.

3.1.1 National activity – older/acute adult hospital at home

In 2025/26, over 17,000 people aged over 65 avoided time in hospital due to hospital at home. Figure 1.0 below shows the number of admissions to older/acute adult services per week between April 2025 and March 2026.

Figure 1 New admissions per week to hospital at home services in Scotland



The chart shows that total weekly admissions to older/acute adult hospital at home services across Scotland have increased from a baseline median of 298 admissions per week to a new median of 378 admissions per week. This increase coincides with additional investment in hospital at home services to enable expansion during 2025/26. Admissions have remained consistently higher following this investment, apart from one week during December 2025. The decrease in December 2025 was likely due to reduced referrals over the public holidays.

Overnight bed days

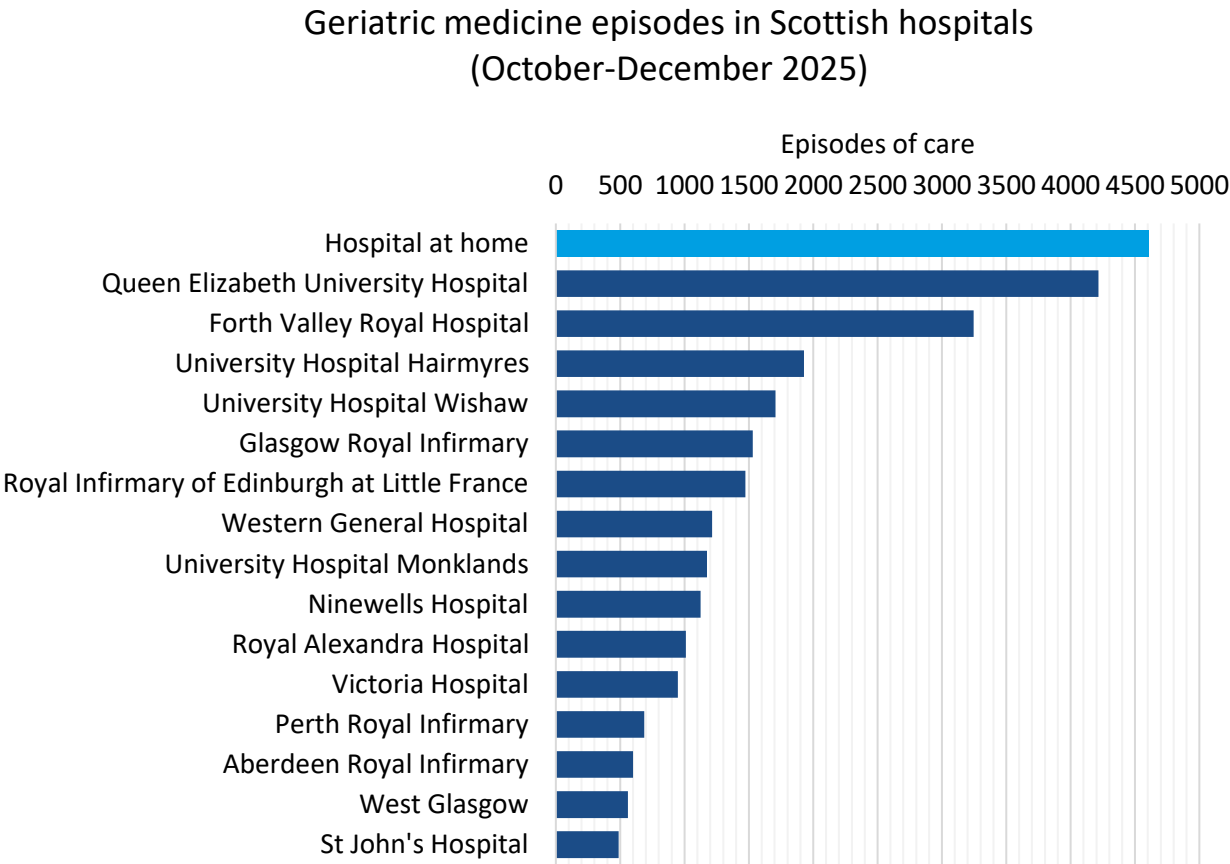
In 2025/26, hospital at home provided over 165,000 overnight bed days for patients that would normally have been in hospital. As hospital at home has a shorter average length of stay than traditional inpatient stays on geriatric wards, the total bed days saved from hospitals is estimated to be nearer 268,000. Hospital at home therefore reduces pressures on the system.

Admissions per hospital

Figure below shows the number of admissions to older/acute adult hospital at home in Scotland, compared with the 15 Scottish hospitals with the most inpatient and day case geriatric medicine episodes during the period October–December 2025.²⁷ This is the closest

comparison that can be made between the hospital at home activity data we routinely collected in 2025/26 and the national statistics for hospital activity.

Figure 2 Geriatric medicine episodes of care in Scottish hospitals October-December 2025

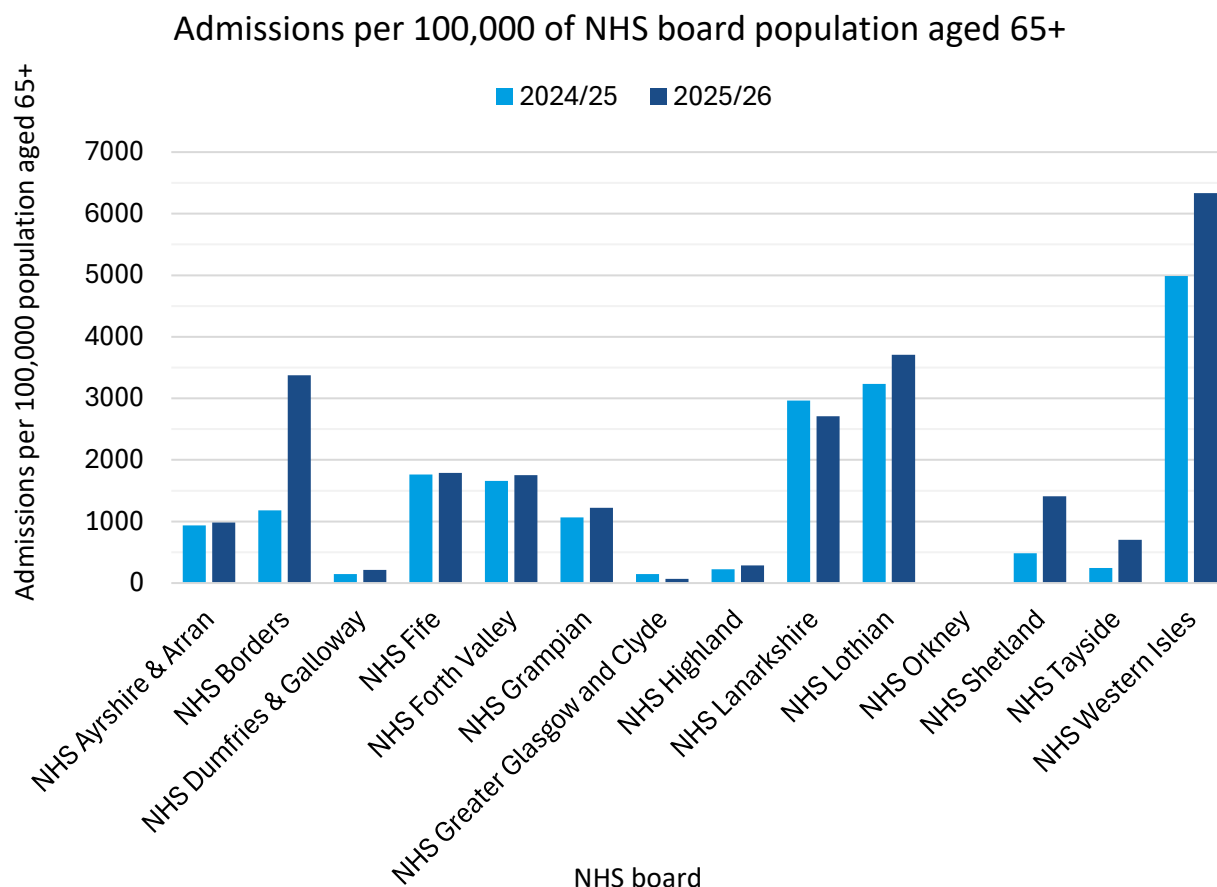


The chart shows that hospital at home provided the most geriatric medicine episodes of care of all Scottish hospitals.

3.1.2 Local access – older/acute adult hospital at home

Admissions to hospital at home may be higher or lower in different NHS boards depending on the size of the population. Therefore, it is important to look at the delivery of hospital at home services within the context of the population size. The chart below shows the admissions to older/acute adult hospital at home services in the 14 NHS boards in Scotland, per 100,000 of the population aged over 65.²⁸ It provides side-by-side comparison of each board’s 2024/25 and 2025/26 data.

Figure 3 Hospital at home admissions per 100,000 of NHS board population over age 65 in 2024/25 and 2025/26



The chart shows that most NHS boards have increased access to hospital at home compared to last year. This is mainly due to the expansion of the hospital at home services, such as increased capacity to see more patients or roll out of the service into new areas. However, fluctuation could also be due to changes in referral patterns, possibly because of referrer education. There are particularly notable increases in service provision within NHS Borders, NHS Western Isles, NHS Shetland and NHS Lothian.

3.2 Financial impact

Based on the overnight bed days saved by hospital at home, it is estimated that over 800 additional staffed hospital beds operating at 90% occupation would have been required to manage the same number of patients in 2025/26 if the service did not exist.

A 2022 randomised controlled trial across nine UK hospital at home services demonstrated costs to be up to 53% less than a traditional hospital admission.²⁹ Based on these findings, we have calculated theoretical costs avoided for the system because of hospital at home.

- An estimated £18.8 million in costs were avoided in 2025/26 based on nationally reported costs for geriatric inpatient admissions.³⁰
- An estimated £44.3 million in costs were avoided in 2025/26 based on estimated reductions in health and social care usage for 6 months after patients are discharged.²⁹

- An estimated 530 care home admissions have also been avoided by providing hospital at home care.²⁹

3.3 Unmet demand

Public Health Scotland have published a hospital at home management information release for the period February–April 2026.²⁵ This report contains data submitted by hospital at home teams across Scotland. As part of their reporting to Public Health Scotland, hospital at home teams input the number of referrals they have to reject and the reason for rejection. Reasons include no capacity; inappropriate referral; patient requires hospital care; referral withdrawn; patient social circumstances unsuitable for hospital at home; duplicate referral; patient sent to A&E; insufficient clinical information; patient/carer refusal; or “other”.

The report for this period shows that the most common reason for rejected referrals was due to capacity issues within services (31%), and the least common reason for rejection was patient/carer refusal. This could indicate that the refusal rate for hospital at home is low, signifying high acceptance from the public. However, referrers may have asked the patient and/or carer about their preferences before making a referral, therefore not making the referral if a patient does not want to be treated at home. This would not have been recorded as part of this dataset.

Capacity issues are a commonly cited issue in hospital at home teams and the data from this report is corroborated by the findings of the Scottish Government’s Evaluation of Hospital at Home in Scotland: Phase 1 Findings Report. The report focuses on the experiences of staff delivering hospital at home services and those referring into the service.³¹ It makes several suggestions for the future of hospital at home, one of which is *“A funding model which supports teams to have greater and more consistent staff resource, facilitating increased capacity to take on referred patients and potentially to implement longer hours of operation and additional geographical coverage.”* More information on the findings is available in [section 3.4.4](#) of this report.

3.4 Patient, carer and staff experience

Although numerical data provides important markers of how well a service is performing, it does not demonstrate the full picture. Qualitative data, such as feedback from those using or delivering the service, is equally important. This type of information describes the real-world experiences of people who interact with the service and provides a deeper understanding of the impact.

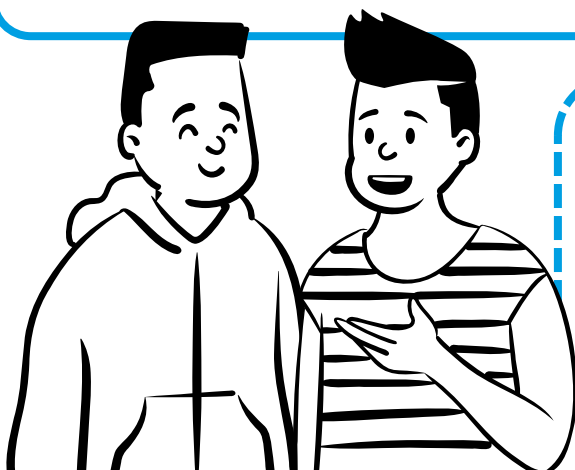
3.4.3 Feedback from Care Opinion

There are national feedback mechanisms in place such as Care Opinion, which is an online platform allowing patients and their relatives to share their stories about the health services they have used. The platform is run and moderated by an organisation independent of the NHS. Below are some examples of feedback received for hospital at home services in 2025/26.

Figure 4 Selection of feedback submitted to Care Opinion for hospital at home services in Scotland 2025/26

"I would promote this service as a great achievement and think there should be more services like this."

Relative of patient, East Lothian Hospital at Home.



"The Hospital at Home service made such a positive difference and meant my mum didn't have to stay in hospital any longer than necessary."

Relative of patient, Forth Valley Hospital at Home.

"This is a professional, person-centred care service which was found to be so beneficial to my mum and family, allowing her to be in her own home with her pet."

Relative of patient, Lanarkshire Hospital at Home.

Quotes from www.careopinion.org.uk

3.4.4 Staff experience of hospital at home

As mentioned previously, the Scottish Government is conducting an evaluation of hospital at home services in Scotland. Phase 1 of this research included a workforce survey as well as focus groups and interviews with hospital at home delivery staff and referrers. The Phase 1 Findings Report³¹ contains the main findings from this phase of the research, which include the following.

- Both referral and delivery staff have a mixed understanding of the scope, principles and practices of hospital at home. As a result, services are delivered in a variety of ways across Scotland and much of the design is up to local decision makers. The confusion is also related to the regularly changing definition of hospital at home which results from funding and other decisions.
- There is clear buy-in for hospital at home from most referrers. They appear to be both willing to refer to the service and confident in the care their patients will receive. However, key issues are apparent surrounding capacity of services to accept referrals, lack of out-of-hours provision and clarity around responsibilities for overall patient care.
- Most delivery staff felt that their team had a strong skill mix. They also often agreed that delivery processes were effective and there was good senior promotion of hospital at

home. However, staff shortages and poor staff retention due to fixed-term funding were highlighted.

The report makes several suggestions for the future of hospital at home. Suggestions to maximise optimal delivery included the following.

- Embedding strong communication between hospital at home teams and local referral pathways.
- Continuing to build teams with diverse experience and specialties.
- Having clear delivery and improvement processes.
- Ensuring strong promotion of hospital at home at a senior level.
- Continuing roll out of point of care testing (POCT) and remote monitoring.

Suggestions to alleviate existing barriers included ensuring eligibility criteria are clear and the referral process is consistently followed; reducing inefficiency through better equipment, processes and funding; and a funding model which facilitates more consistent staffing and resource.

3.5 Measurement challenges in hospital at home

In previous annual reports we have used hospital at home activity data to calculate an equivalent number of beds to compare capacity with physical hospitals. The conversion of activity to beds has become increasingly difficult and is no longer a meaningful measure of hospital at home capacity. We have therefore chosen to count new admissions rather than equivalent bed. This provides a fairer reflection of current activity for several reasons, including the following.

- The capacity of hospital at home services changes daily depending on the condition of patients on the caseload, number of visits needed per patient per day, travel time between patients, staffing levels and skill mix.
- Different pathways and services serve different patient groups with varying levels of complexity and typical lengths of stay. Methodologies for converting activity to beds do not account for this diversity.
- Improving efficiency has enabled services to reduce length of stay. When converted to bed numbers this means they appear to have fewer beds whilst seeing more patients. When this happens, services could be disincentivised from further improvement.

The Scottish Government Operational Improvement Plan¹ aims to expand hospital at home to 2000 beds by December 2026. An alternative aim focusing on the number of people accessing hospital at home (new admissions) would be more appropriate and measurable using the new Public Health Scotland dataset.

4.0 Facilitating learning and connections

We have developed learning systems for professionals working in neonatal, paediatric and adult hospital at home services across Scotland. Learning systems provide professionals with networking opportunities and the chance to share knowledge, create connections, ask questions, and gather insights. The aim is for the learning systems to contribute to the development and maturity of services. This section describes the key elements of the hospital at home learning systems and their activity in the 2025/26 period.

4.1 National learning event

In October 2025 we hosted a joint in-person event for the adult, neonatal and paediatric hospital at home professionals we support. A total of 162 people attended the event, with representation from all 13 NHS boards currently participating in the national hospital at home programme.

Mr Neil Gray, cabinet secretary for NHS recovery, health and social care at the time, attended. Mr Gray gave a speech about the impact of hospital at home and took part in a question-and-answer session with attendees.

4.1.1 Workshops

Attendees participated in several workshops throughout the day with some tailored to specific cohorts. The workshop topics were based on the current needs of the hospital at home community including the current landscape, what hospital at home teams were currently working on and the types of support they were requesting.

Workshop topics were:

- data capture (with Public Health Scotland),
- patient and carer experience,
- improving existing services,
- developing new pathways,
- managing acute heart failure and respiratory conditions in hospital at home, and
- neonatal & paediatric hospital at home.

The neonatal and paediatric session was supported by colleagues from the UK Hospital at Home Society that lead established services in England, Zoe Tribble and Christina Newbould.

4.1.2 Feedback

We asked the attendees to answer a series of evaluation questions at the end of the event. The results of the questions were then collated and analysed.

Feedback was positive overall, with most respondents confirming that the event helped them build upon and create new connections with colleagues across boards. They reflected that the event was “informative”, “inspiring”, “interesting” and “collaborative”.

4.2 Online networking sessions

We facilitated several online networking sessions for hospital at home professionals in 2025/26. This included both informal sessions where participants could bring current challenges for discussion, and more focused sessions where knowledge and information was shared.

4.3 Cross-site visits

4.3.1 Neonatal and paediatric services cross-site visits

In March 2026 we sponsored neonatal and paediatric hospital at home teams to visit established services in England to learn about their development and ways of working. Teams were consulted about their preferences, delivery models and patient groups. They were then matched with English services using similar models or serving similar contexts.

A total of 20 people (from five Scottish NHS boards) including consultants, nurses, AHPs and service managers, visited four NHS England trusts in London and Oxford. Activities during the visits included accompanying staff on home visits, attending team meetings, visiting hubs, attending presentations about host services, and time for discussion. Scottish teams were asked to record their learning from the visits, and this information has been collated to share amongst the neonatal and paediatric hospital at home community in Scotland.

Teams received helpful resources from English teams including standard operating procedures, data collection toolkits, patient engagement tools, and training materials. Teams were keen to adapt some aspects of what they observed for their own local contexts and support was requested from us to translate resources for local use.

All teams strongly valued building relationships with colleagues from further afield and seeing the services in practice. They noted that learning directly from frontline teams and clinicians was one of the most valuable aspects of the visit.

4.3.2 Adult services cross-site learning

NHS Shetland and NHS Western Isles visit

In March 2026, Healthcare Improvement Scotland helped facilitate a site visit between island NHS boards. NHS Shetland’s hospital at home team visited NHS Western Isles and the two boards had opportunities to:

- share practical learning and adaptations
- identify transferable good practice and improvement opportunities, and
- strengthen relationships and peer support across remote and rural services.

NHS Forth Valley learning day

Several services expressed a desire to visit the NHS Forth Valley hospital at home team. In response, we planned a learning day to be hosted in NHS Forth Valley. The purpose was for services to learn about Forth Valley hospital at home's multidisciplinary team skill mix, respiratory hospital at home service, OPAT service and use of electronic prescribing. This event was planned in 2025/26 but took place in June 2026.

4.4 Online community forums

4.4.1 Neonatal and paediatric hospital at home community forum

In November 2025 we launched an online community forum for professionals in Scotland delivering, or interested in delivering, neonatal or paediatric hospital at home. This was designed to complement the existing network meetings for clinicians with an interest in neonatal or paediatric hospital at home. The forum is hosted on Microsoft Teams and allows professionals to share resources, ask questions and learn from other teams across the country.

4.4.2 Adult hospital at home community forum

The online community forum for professionals working in the field of adult hospital at home has been in operation for several years and is also hosted on Microsoft Teams. The forum provides a space for services to share learning, make connections and keep up to date with news from Healthcare Improvement Scotland and the wider hospital at home community. There is a wealth of resources available that have either been designed by us or shared by members. There are now 512 members of the community, from NHS boards and HSCPs across Scotland.

The resources available through the forum cover key aspects of service development and provision, including:

- infrastructure
- workforce
- interventions and care planning
- point of care testing, and
- patient feedback.

4.5 Peer support groups

In 2025/26 we have taken steps to actively promote and facilitate connections between groups of professionals with common challenges or shared interests. We have encouraged connections to be made so that groups can share learning and offer peer support or collaboration where possible.

4.5.1 Remote and rural collaboration

Feedback from hospital at home teams during the early stages of the 2025/26 programme highlighted that remote and rural services needed dedicated opportunities to connect with one another. They expressed a desire to build relationships amongst the remote and rural hospital at home community due to the unique challenges they face in delivering their services.

We have supported the development of a remote and rural network which was co-designed with hospital at home professionals in these regions. To date this has resulted in quarterly online meetings, and a dedicated Microsoft Teams channel, both of which we facilitate. These activities provide opportunities for professionals in remote and rural services to build relationships and share challenges, learning and resources.

4.5.2 Frailty collaboration

Frail people are a principal patient cohort for adult hospital at home services. The Scottish Government's NHS Recovery Plan, published in 2021, advocates for a whole-system approach as a key factor for success.³² Therefore, it is important that services recognise interdependencies with other parts of the system.

Several NHS boards are integrating their hospital at home services with their hospital-based, primary care, and community frailty offerings. This has been particularly important in remote and rural settings where staffing needs to be multi-functional. Our hospital at home and focus on frailty programmes have worked closely over the 2025/26 period to coordinate joint site visits and online meetings with the teams they work with. This promotes collaboration and nurtures the connections between services working towards a common goal of providing timely and quality care for frail older adults.

4.6 Technology

4.6.1 Point of care testing

POCT allows certain diagnostic tests to be performed on site with the patient without the need for sample analysis in a hospital laboratory. This allows results to be received rapidly on site. In hospital at home settings, it means that routine tests can be performed in the patient's home.

Services including NHS Lanarkshire and NHS Lothian have successfully implemented point of care blood testing, which is making clinical decision-making quicker, more effective and safer. This is especially impactful in areas far away from laboratories.

Point of care ultrasound also has the potential to improve clinical decision-making and patient journeys. Some hospital at home clinicians participated in a point of care ultrasound training day, run by the UK Hospital at Home Society, in March 2026. We plan to collaborate with the society to develop a training programme, as there are potentially great benefits to having this as a diagnostic tool, especially in remote and rural areas.

4.6.2 Remote monitoring

Remote monitoring equips patients with devices to upload clinical observations and communicate with their clinical team whilst at home. Several hospital at home teams in Scotland are testing remote monitoring as another tool to improve their service.

Healthcare Improvement Scotland have completed a Health Technology Assessment of virtual ward platform technologies.³³ In the context of the assessment, the term “virtual ward platform technologies” covers technology used to support service models where patients are monitored at home and have minimal face-to-face contact with healthcare staff. Although hospital at home is not truly a “virtual ward” service and staff visit patients regularly in their homes to provide treatment, the findings of this assessment are of interest and relevance to hospital at home.

The assessment identified a limited evidence base for virtual wards. Recommendations from the assessment suggest that remote monitoring should not be used as a standalone method of care and should be integrated as an element of a wider service. The report also suggests that suitability of patients for remote monitoring is circumstantial and decisions to use the technology should be based on informed, comprehensive discussions with patients and carers. Additionally, the report suggests that services using remote monitoring should practice systematic data collection to assess clinical and cost-effectiveness. In 2026/27, Healthcare Improvement Scotland will continue to engage in work to explore the use of these technologies in hospital at home.

4.7 National connections

4.7.1 Hospital at Home Society conference

In March 2026, the UK Hospital at Home Society held a conference in Edinburgh. The conference was for members of the hospital at home community to come together to make connections, share research and learn from each other. We encouraged professionals from Scottish hospital at home services to attend by supplying regular information about the event in the online community forum as well as having discussions with teams during coaching calls.

We prepared a presentation for the conference, which was delivered by a representative of the team. The presentation, titled “Hospital at Home across Scotland” gave attendees an overview of the evolution of hospital at home in Scotland so far, the challenges faced by services, how Healthcare Improvement Scotland are supporting them, and the difference hospital at home is making to the system. Other members of the national team also attended the conference to gather insights about emerging research, build connections with colleagues across the UK and understand how to best support teams in the coming year.

4.7.2 Once for Scotland

In 2025/26 we engaged with other national organisations to explore a “Once for Scotland” approach to infrastructure that would facilitate more efficient working for hospital at home services. The purpose of this kind of approach is to avoid the repetition of work for services

trying to establish processes within their individual boards or HSCPs. Areas of work being considered are POCT (blood testing and ultrasound), electronic prescribing, and economic evaluation. Healthcare Improvement Scotland have contributed the hospital at home perspective to national guidance for domiciliary oxygen developed by National Services Scotland and the National Advisory Group for Respiratory Managed Clinical Networks.

5.0 Tailored improvement support

5.1 Local measurement support

5.1.1 Neonatal and paediatric local measurement framework

In 2025/26 we developed a local measurement framework for services, to be used in addition to the core Public Health Scotland data set. This framework was developed in collaboration with participating NHS boards, using learning from neonatal and paediatric hospital at home services established in NHS Trusts in England.

The framework supports NHS boards to develop a suite of measures that can be used to evaluate their own services and demonstrate impact locally. It includes measures such as the number, source, and outcome of referrals to neonatal and paediatric hospital at home. A sample of the neonatal and paediatric hospital at home services are now testing the template and we expect to gather feedback throughout the programme.

5.1.2 Patient experience

In 2025/26, we committed to providing improvement support for patient engagement and experience.

Offer of support

Early in the 2025/26 programme, a “menu of support” was sent to all services to raise awareness of the range of support we could provide in relation to patient experience. It was also shared to encourage teams to request assistance. The options included items such as evidence searching, conducting patient experience conversations and help designing patient facing materials such as experience questionnaires and information leaflets.

Surveying feedback practices across services

In early 2026, we designed a survey to capture information about the current feedback collection practices of hospital at home services in Scotland. The survey focused on patient and carer feedback, how often this is requested, the frequency of responses, the methods of collection and the barriers services face. The survey was distributed to key contacts in March 2026 and responses were received from 16 services. The key results were as follows.

When asked about the frequency of feedback collection:

- 12 services said they were currently collecting patient and carer feedback, and

- services that asked for feedback at every visit had higher estimated average monthly responses. This can be seen in the table below.

Table 1 Average responses and response rate to service feedback surveys by frequency of

Frequency of requesting feedback	Average monthly responses*	Average response rate*
Every visit	13.6	32.5%
Most or some visits	5.33	42%

*Monthly responses and response rates were reported by teams. If teams did not have this information, they were asked to provide an estimate. Therefore, these figures are approximate.

When asked about what they do with the data after collection:

- nine out of twelve teams share and communicate responses with their staff
- six teams collate and store their data digitally
- six teams share the data with clinical governance teams or use the data for reporting
- three teams use the data in discussions with staff, such as ward or governance meetings, and
- two teams mention using the data for QI work or sharing it with QI colleagues.

When asked about the barriers they face in collecting patient and carer experience data, the most reported barriers were:

- age of patients
- capacity of patients, and
- condition of patients.

Around half of services reported these factors as an issue affecting data collection. Three services also mentioned the digital literacy of their patients, which is related to age, capacity and condition.

5.2 Ongoing coaching support

Each of the teams participating in the national programme has an assigned improvement coach from Healthcare Improvement Scotland. Coaches meet with their assigned teams regularly online, to check in and provide support. This encourages teams to carve out protected time in their schedules to think about service improvement. The content of meetings is tailored to meet the needs, and development stage, of each team. In-person site visits are also carried out if teams would benefit from in-person support, or improvement coaches feel the need to learn more about the team.

5.2.1 Support and advocacy for services

Part of the improvement support offered by us is to advocate for services and raise their profile. In 2025/26 we have supported teams to:

- identify and communicate with senior leaders within their NHS boards
- discuss requirements for data collection and reporting with Public Health Scotland, and
- host visits from elected officials.

We have existing relationships with other national boards and Scottish Government's policy team, as well as regular meetings, which enables us to:

- share barriers faced by teams
- advocate for services to receive funding, and
- raise awareness of (unintended) consequences arising from policy decisions.

In 2025/26 we arranged the Cabinet Secretary for NHS renewal and health and social care's Q&A at our October event. We also advocated for the First Minister to visit NHS Greater Glasgow and Clyde's neonatal and paediatric service to raise the profile of hospital at home for this patient group. Additionally, we facilitated a meeting between the Scottish hospital at home network (neonatal and paediatric clinicians) and Scottish Government's policy team. This gave them the opportunity to share experiences, build shared understanding and agree actions to raise the profile of services.

5.3 Programme drivers

We have developed a programme-level driver diagram which sets out the overall aim for the programme and the requirements to achieve this aim (the "drivers").

The driver diagram can be found in [Appendix 4](#). The overall aim is to "Develop hospital at home models to increase the number of patients managed by services." The following sections of the report are based on each of the primary drivers (the "we need to..." section of the diagram) and provide examples of how services are delivering against these drivers.

5.2.1 Ensure conditions for change

Strong foundations are required to develop and maintain safe and sustainable services. Appropriate funding, leadership, governance structures, infrastructure, workforce planning and system integration are essential. It is also important to ensure alignment of priorities between senior leaders and frontline services. Below are three examples of services work that contributes to creating the conditions for change.

Example: NHS Greater Glasgow and Clyde

Strong leadership and robust governance processes are key to:

- providing clear direction
- managing risk, and

- enabling change to be implemented safely, consistently and at pace.

NHS Greater Glasgow and Clyde has six HSCPs with diverse geographies and populations. Hospital at home services are now active in four of the HSCPs and are testing a shared governance model. They are doing this to support new HSCPs to introduce hospital at home in a phased and supported way. The overall aim of this approach is to deliver a coordinated, whole-system programme.

This new governance structure has been put in place within the NHS board and a hospital at home framework has been approved, with operational oversight routed through the Home is Best group. This group provides system-wide leadership for frailty transformation in NHS Greater Glasgow and Clyde. This means hospital at home is aligned with urgent care, falls, palliative care and whole-system flow. Through the group, and hospital at home integration meetings, there is improved insight, across the HSCPs and the NHS board, into the benefits of shared governance, consistent pathways and multidisciplinary collaboration.

Learning from the initial testing of this model has highlighted the importance of aligning digital processes, reporting requirements and clinical pathways to improve monitoring of activity and outcomes. This supports standardised learning, accelerates early testing in new sites, and enables safe, scalable implementation.

As a result of the model, new services can begin with small test beds, allowing earlier demonstration of impact before scaling. The set-up also allows for sharing of limited resources, for example, pharmacy support. Coaching from Healthcare Improvement Scotland helped the teams to create the right clinical and workforce model by drawing on experiences from other services. We also facilitated peer-to-peer learning and support for the teams, by connecting them with other services in Scotland.

Example: NHS Western Isles

Strong, well-defined relationships and processes with other services, departments, and specialties enable:

- timely coordination
- shared decision-making, and
- seamless patient care across organisational boundaries.

NHS Western Isles adopted a whole-system approach by integrating their hospital at home service with both acute and community care, working closely with frailty colleagues. They are embarking on a transformative cultural shift which takes a home-first approach. This included proactive, preventative work in care homes, work to promote alternatives to admission, and offering effective supported discharge.

Example: NHS Shetland

Safety, effectiveness and positive experience for patients and staff are ensured by a service:

- built on proven practice

- enriched by frontline staff and patient insight, and
- strengthened through active involvement of those delivering and receiving care.

As mentioned earlier in this report, members of our team travelled to Shetland in March 2026 to deliver a workshop on improving patient engagement and experience.

During this workshop and since, NHS Shetland's hospital at home team have demonstrated an enthusiasm to use the views and experiences of their patients, carers and staff to continually improve their service.

We have supported the team with redesigning their patient facing materials. These include their patient information leaflets, patient and carer experience questionnaire, posters and a discharge package to ensure a smooth transition of care, with signposting to third sector services. The team are also embarking on a test of change to implement a comment card system which they hope will make it easier for patients to provide ad hoc feedback and serve as a mechanism for staff to record the informal feedback they often receive verbally.

5.2.2 Establish new services

The hospital at home programme supports the development and implementation of new hospital at home services to meet population need. This includes expansion to new geographical areas and patient groups, to provide safe alternatives to inpatient care that were not previously available.

Below are examples of an expanding adult service and a new paediatric hospital at home service.

Example: NHS Borders adult service

Increasing coverage across a larger proportion of the NHS board or HSCP area improves access and equality of hospital at home services. This includes expanding to provide care, engagement and interfacing with community services in new adult populations.

NHS Borders have expanded the geographical coverage of their service through a hub-and-spoke model. They have taken a phased approach to implementing the "spokes" and learning has been taken from each one. This has required recruitment and workforce planning of medical, nursing and AHP staff. Connections made through the hospital at home programme have provided insight for the team into other workforce models. Significant work has gone into the logistical planning of the service expansion to allow for co-location, which promotes integration with both acute and community services.

They have also improved integration with direct pathways between their Home First service and frailty unit, which enhances flow and discharge coordination. By the end of March 2026 NHS Borders had almost achieved 100% geographical coverage, expecting to reach this target in July 2026. They are now placing focus on pharmacy recruitment, optimisation of their workforce, and expansion to manage more patients.

Example: NHS Lanarkshire Paediatric service

NHS Lanarkshire launched their paediatric hospital at home service in December 2025 with support from us. The board is the 3rd largest in Scotland with a population of over 664,000 people and approximately 15% of the population is aged under 16. Their paediatrics department is based in University Hospital Wishaw, however their patient group live across a large geographical area. The introduction of hospital at home for this patient group provides a safe and effective alternative to hospital care for children. Despite the large area, the hospital at home service is not geographically restricted therefore families across the NHS board are able to access the service and stay at home during a child's treatment.

The team have engaged with the families they support and have received consistently positive feedback. Their early data has shown that hospital at home is providing an acceptable alternative to hospital treatment. So far, the service has been focusing on a few key specific pathways, but they have plans to expand to the treatment of other conditions to allow the service to reach full potential.

5.2.3 Expand condition pathways

Additional defined clinical pathways (for example respiratory or heart failure) enable more patients to receive acute care at home through defined, evidence-based pathways. This means increased access and impact across patient groups.

Example: NHS Forth Valley

NHS Forth Valley's hospital at home respiratory service provides urgent specialist respiratory care at home for patients who would otherwise require hospital admission. Following success managing mainly patients with chronic obstructive pulmonary disease (COPD), the Forth Valley respiratory team piloted an expanded model accepting all respiratory conditions.

They increased their hospital at home respiratory "ward" capacity from 5 beds to 10 beds as a test of change initiative over a 14-day period. They then reviewed feasibility and outcomes. During the test of change, occupancy was 95% and average length of stay was 5.9 days. This was a positive difference compared to an average 8.76 days length of stay in the inpatient ward. A hot clinic (an urgent outpatient clinic for patients at risk of admission) also reviewed 13 patients to avoid hospital admission, providing respiratory assessment, treatment plans, home nebulisers, and oxygen therapy.

The expanded service was delivered by an expanded multidisciplinary team which supported higher occupancy, reduced length of stay, and provided an effective alternative to inpatient care. The pilot demonstrated that a broader range of respiratory patients can be managed safely at home. The NHS Forth Valley team has now implemented the respiratory hospital at home ward into their service and will continue to monitor the impact.

5.2.4 Optimise existing services

Optimising existing, established hospital at home services to improve their efficiency, quality and consistency is achieved through:

- better use of workforce
- streamlining pathways
- developing effective referral routes, and
- enhancing the use of digital and point of care technologies.

Decisions and improvements are guided by evidence, data and shared learning from other services. The following are examples of how hospital at home services in Scotland are optimising services that already exist within their areas.

Example: NHS Tayside neonatal service

Making best use of a skilled workforce by deploying the right staff, with the right skills, at the right time maximises quality, efficiency and service impact.

NHS Tayside's neonatal hospital at home service has demonstrated effective use of a skilled workforce to support babies to return home from hospital more quickly and receive a broader range of treatments at home. For the past 20+ years, NHS Tayside has had a neonatal community outreach team, however there were no professionals other than nurses within the service and patients had to be readmitted to hospital if they required other treatment. There was a desire to AHPs to the team, and efforts had been made in recent years to do this but were not successful in securing support.

In 2025, with funding for neonatal hospital at home, and with support from our programme, NHS Tayside has been able to set up a new integrated service. Their multidisciplinary team now has core input from nursing staff, doctors and AHPs providing care to babies in their home environment. The AHP specialties in the team are physiotherapy, occupational therapy, speech and language therapy, and dietetics. Having a breadth of specialist knowledge means that members of the team can bring unique perspectives to the treatment of a patient, enabling the team to provide more holistic, person-centred care.

Example: Argyll and Bute HSCP

Efficient, clearly defined and consistently applied processes and pathways promote safe patient flow with minimal delay or duplication.

The Argyll and Bute hospital at home team have optimised their service in several ways to increase the number of patients being referred as an alternative to inpatient admission. Approximately 80% of admissions to the service are now via admission alternative pathways. Referrals are primarily received from A&E, but GP and ambulance service referrals are also increasing. The referral pathway is being refined and expanded to include specialist and community nurses, supported by targeted awareness sessions and cross-service shadowing between hospital at home, GP registrars, and paramedics.

Creative problem-solving has been central to maintaining flow through the service. The team ran a test of change using remote clinical pharmacy support from Tiree, supported locally by pharmacy technicians. Alongside this, refreshed flowcharts, standardised electronic documentation, medicines reconciliation templates and discharge letters are being used to

help embed consistent pathways that support timely decision-making and smoother transitions across hospital and community settings.

6.0 Next steps

In 2026/27, our hospital at home programme will focus on providing support through the following key areas of work.

6.1 Direct support to services

We will continue to provide direct improvement support to hospital at home services in Scotland. This includes the following.

- Delivering the national learning systems to promote the sharing of knowledge and evidence across all pathways.
- Providing direct implementation and improvement support to neonatal, paediatric and adult services across all pathways, focusing on expansion to meet the Scottish Government aim for December 2026.
- Advocating for services, especially new neonatal and paediatric services, supporting them to secure sustainable funding models and prioritisation for resource allocation.

6.2 Evidence

We will continue to share evidence and best practice with the hospital at home professional community to promote the continued development of evidence-based hospital at home services. This will include, but is not limited to, the following activities.

- Continuing to identify and summarise the evidence for neonatal and paediatric hospital at home. This includes developing part 2 of the guiding principles for service development, in collaboration with the services.
- Reviewing emerging evidence for best practice in managing infections in the community, including exploring reduced use of intravenous treatments where clinically appropriate, to maximise efficiency of hospital at home services.
- Reviewing recommendations from the Scottish Healthcare Technologies Group (SHTG) on virtual ward technologies. This includes identifying the role of the hospital at home programme in the implementation of the recommendations in relation to remote monitoring.

6.3 Data and evaluation

We will continue to provide data and evaluation support to services to help them understand their impact and drive continuous improvement. This includes the following key activities.

- Supporting services to develop local measurement plans.

- Supporting services to understand Public Health Scotland data reports and use the information to drive continuous improvement.
- Helping services to develop their practices in collecting patient, family and carer experience data so they can understand their impact and use this to inform future improvement work and service design.

6.4 Collaboration with the wider community

We will continue to engage and collaborate with key stakeholders for hospital at home in Scotland. This includes the following.

- Working with national, subnational and local partners to provide greater clarity on definition of hospital at home, and other models of remote hospital care.
- Working with subnational planning groups to understand their priorities and how the hospital at home programme can support them.

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Appendix 1: Breakdown of acute adult services by area

The charts in this section present the weekly number of new patient admissions to older/acute adult hospital at home services between April 2024 and March 2026. Accompanying each chart is a brief narrative highlighting key patterns, trends, and any notable changes observed over the reporting period. Where relevant, additional context will be provided to explain significant increases, decreases, or periods of variation within the data.

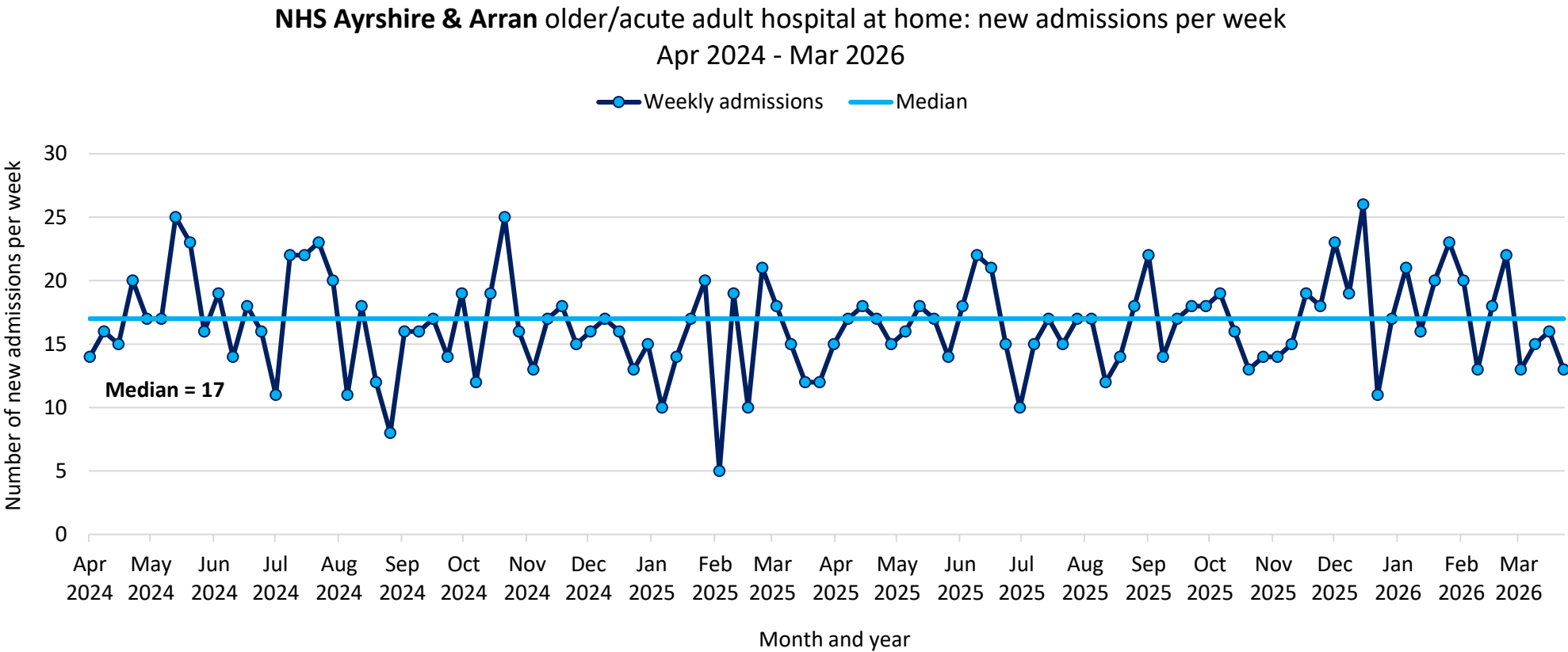
Weekly admission numbers are expected to fluctuate over time and should be interpreted within the wider service and system context. Variations may be influenced by a range of operational factors, including staffing availability, annual leave, sickness absence, vacancies, changes in referral pathways or service capacity. External factors such as periods of increased demand across health and social care services, adverse weather conditions, and local healthcare pressures may also affect admission activity.

Seasonal patterns are commonly observed in hospital at home services. Demand often increases during the winter months when rates of respiratory illness and other seasonal conditions are higher. At the same time, admission numbers may temporarily reduce during festive periods due to the impact of public holidays, reduced staffing levels, changes in referral activity, and patients choosing to delay or decline care where clinically appropriate. These factors can contribute to short-term peaks and troughs within the weekly data and should be considered when interpreting trends.

These charts reflect individual service activity, therefore admission numbers should not be compared between services. Admission numbers for individual services should be considered in the context of the population size in the board. For further understanding of admissions in relation to population aged over 65 per NHS board, please refer to Figure 3.0 in the main report.

NHS Ayrshire & Arran

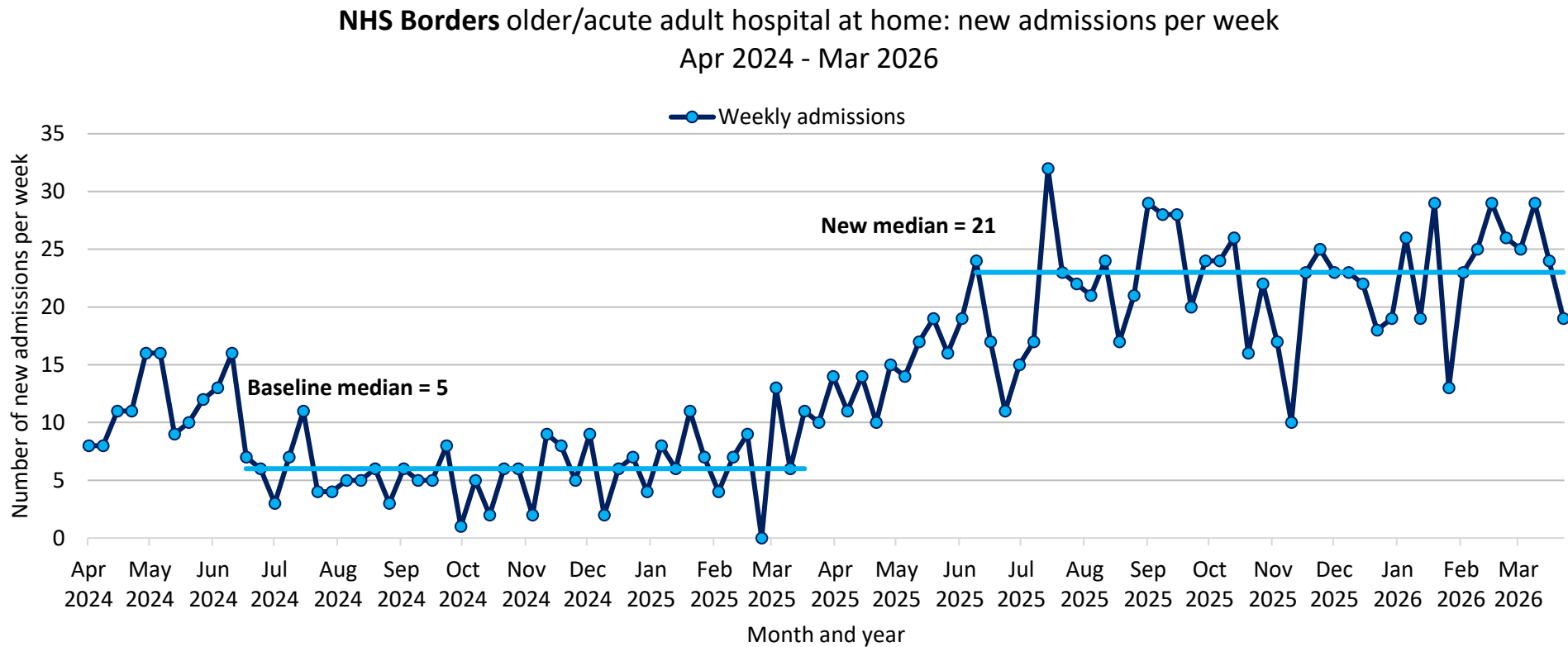
Figure 5 NHS Ayrshire & Arran older/acute adult hospital at home activity April 2024 - March 2026



Admissions to the NHS Ayrshire & Arran older/acute adult hospital at home service have remained stable during 2024/25 and 2025/26 at a median of 17 admissions per week.

NHS Borders

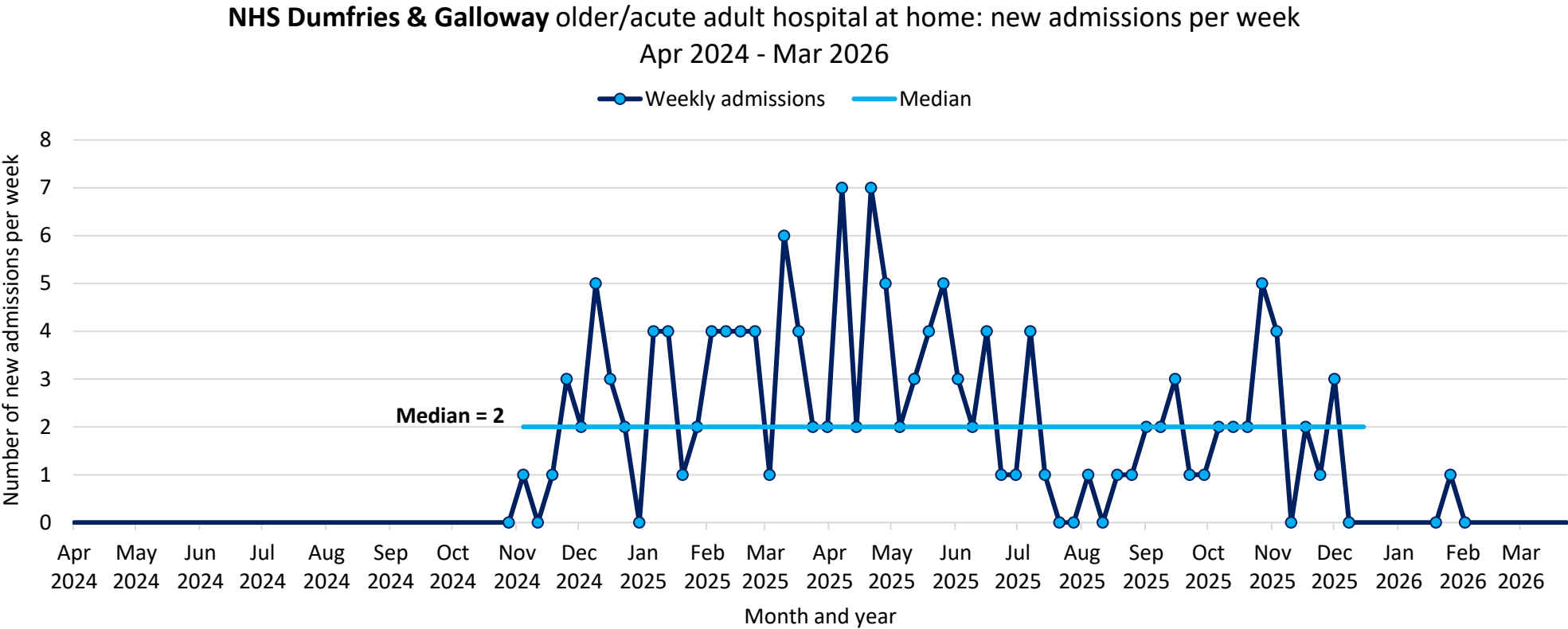
Figure 6 NHS Borders older/acute adult hospital at home activity April 2024 - March 2026



Admissions to the NHS Borders older/acute adult hospital at home service increased in 2025/26 from a baseline median of 5 to a new median of 21 admissions per week. This was likely due to recruitment and geographical expansion of the service.

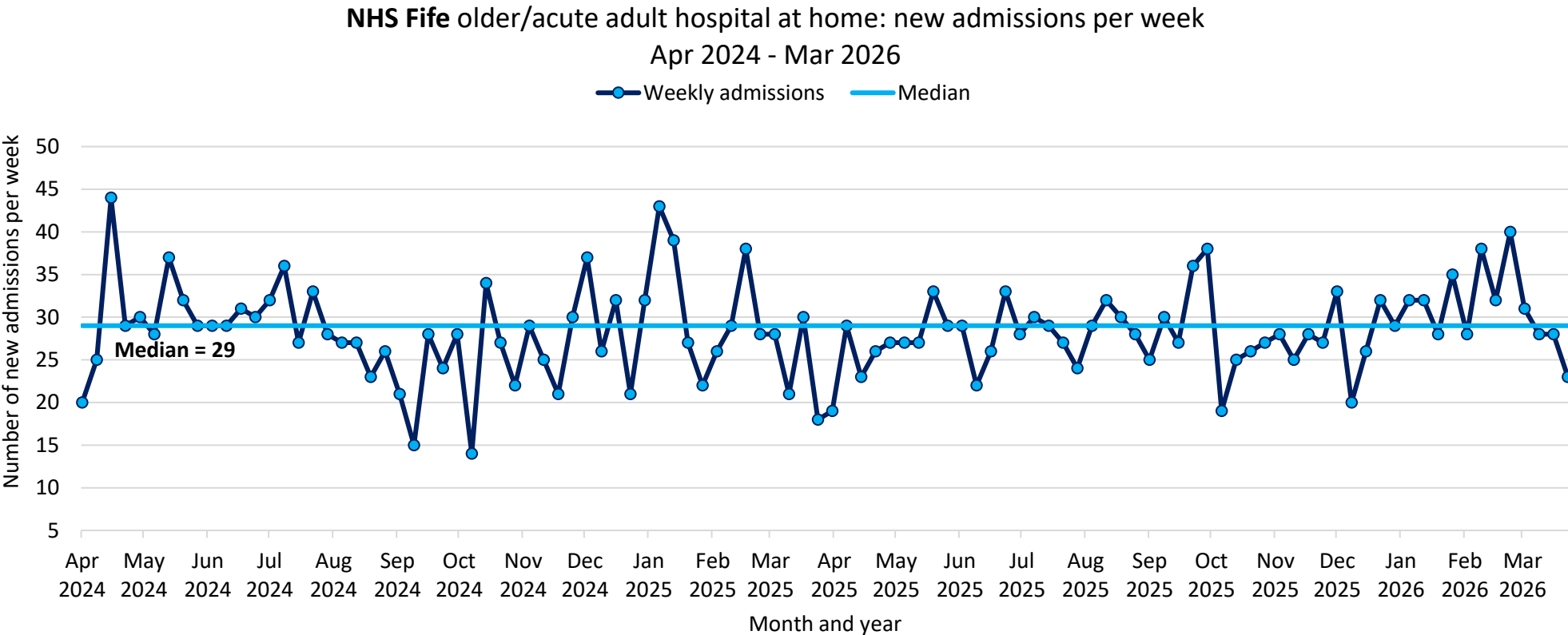
NHS Dumfries & Galloway

Figure 7 NHS Dumfries & Galloway older/acute adult hospital at home activity April 2024 - March 2026



NHS Dumfries & Galloway's older/acute adult hospital at home service commenced in November 2024. Admissions were initially stable at a median of 2 admissions per week, but the service was suspended from December 2025 due to competing priorities. The NHS board are currently planning for relaunch of the service.

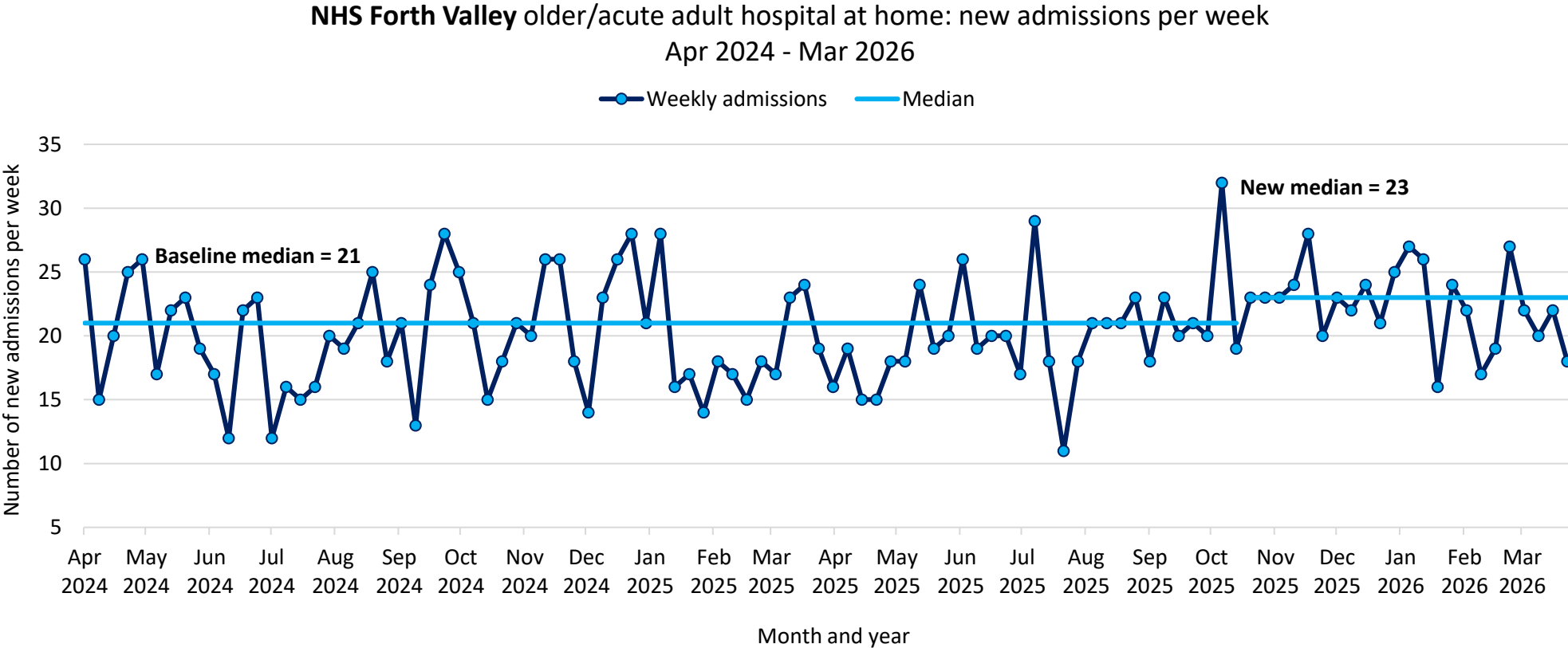
Figure 8 NHS Fife older/acute adult hospital at home activity April 2024 - March 2026



Admissions to the NHS Fife older/acute adult hospital at home service have remained stable throughout 2024/25 and 2025/26, at a median of 29 admissions per week.

NHS Forth Valley

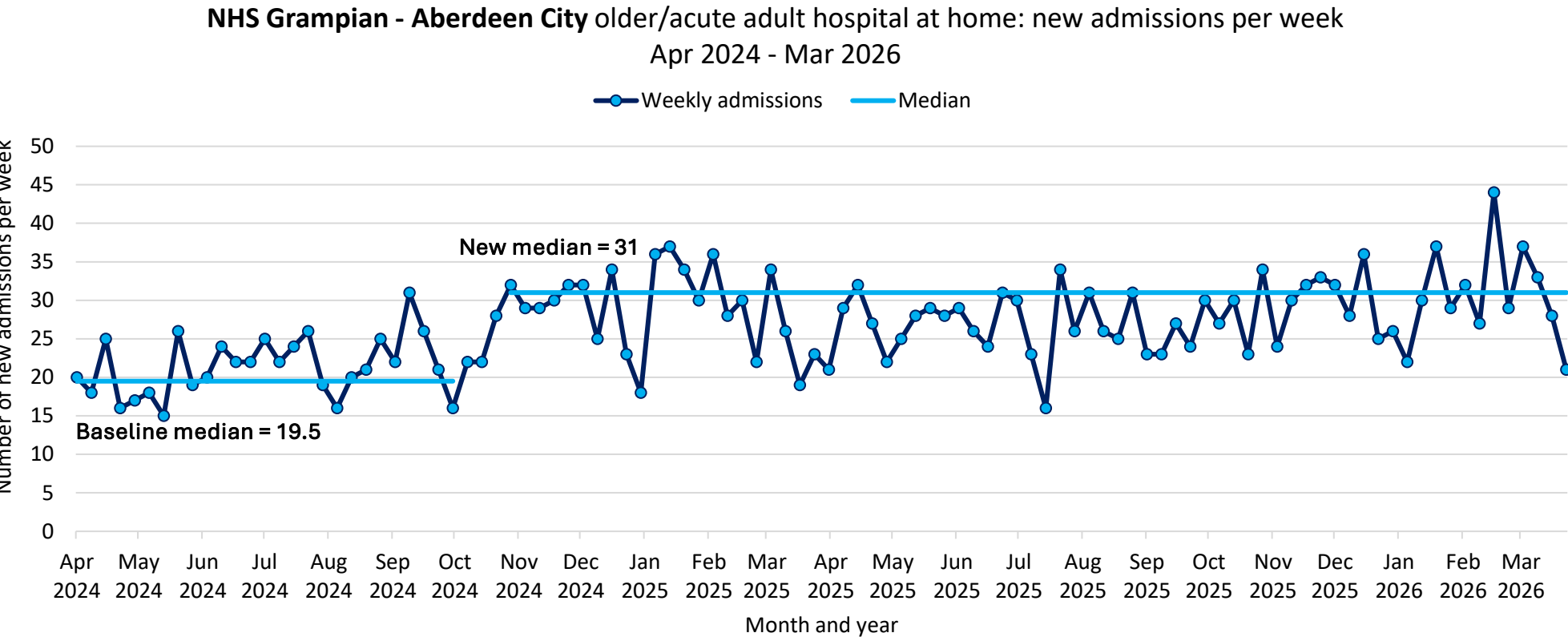
Figure 9 NHS Forth Valley older/acute adult hospital at home activity April 2024 - March 2026



Admissions to the NHS Forth Valley older/acute adult hospital at home service increased from a baseline median of 21 to a new median of 23 admissions per week during 2025/26. The NHS board started testing new respiratory hospital at home pathways in October 2025. They went on to implement this pathway as normal practice in spring 2026.

NHS Grampian

Figure 10 NHS Grampian older/acute adult hospital at home activity April 2024 - March 2026

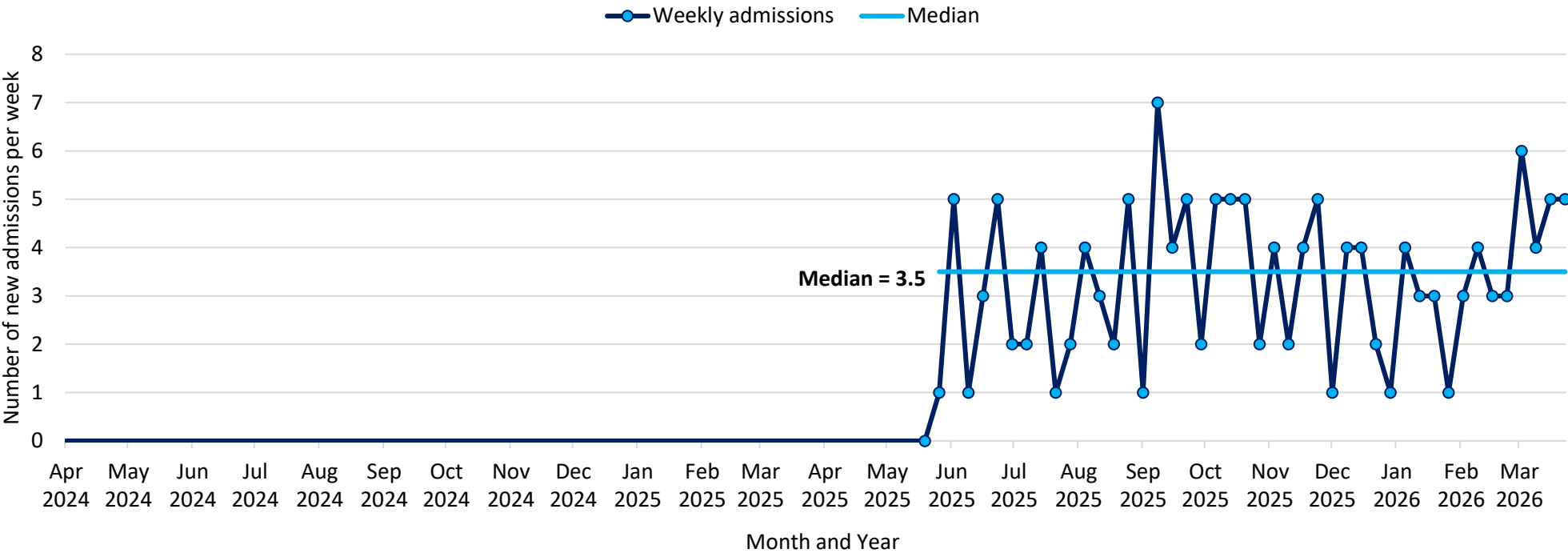


Admissions to the NHS Grampian older/acute adult hospital at home service showed a clear shift in activity during autumn 2024, with the median increasing from 19.5 to 31 admissions per week. In 2024/25 they gained additional GP input into the team, which has enabled them to conduct more engagement with primary care and increase direct referrals into their service. The median weekly admissions remained stable throughout 2025/26.

NHS Greater Glasgow and Clyde

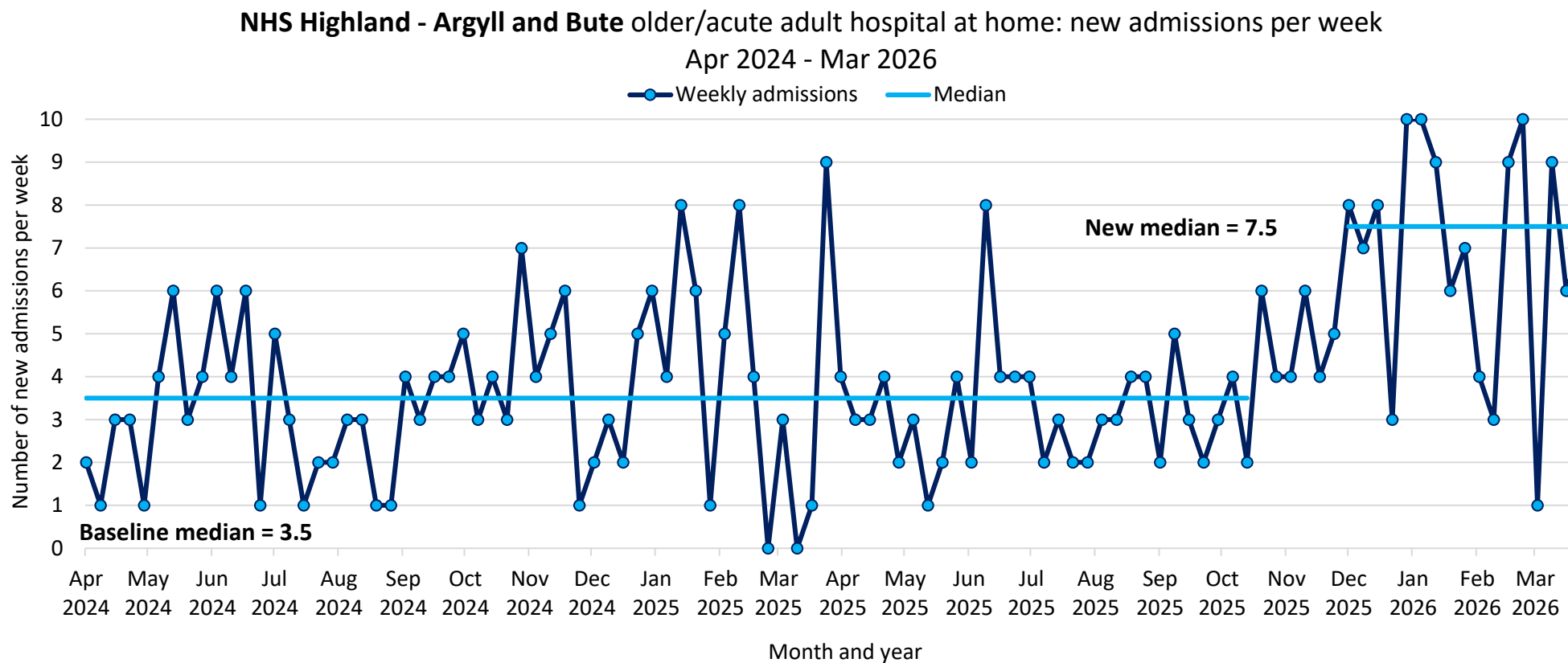
Figure 11 NHS Greater Glasgow and Clyde Renfrewshire older/acute adult hospital at home activity April 2024 - March 2026

NHS Greater Glasgow and Clyde - Renfrewshire older/acute adult hospital at home: new admissions per week Apr 2024 - Mar 2026



NHS Highland

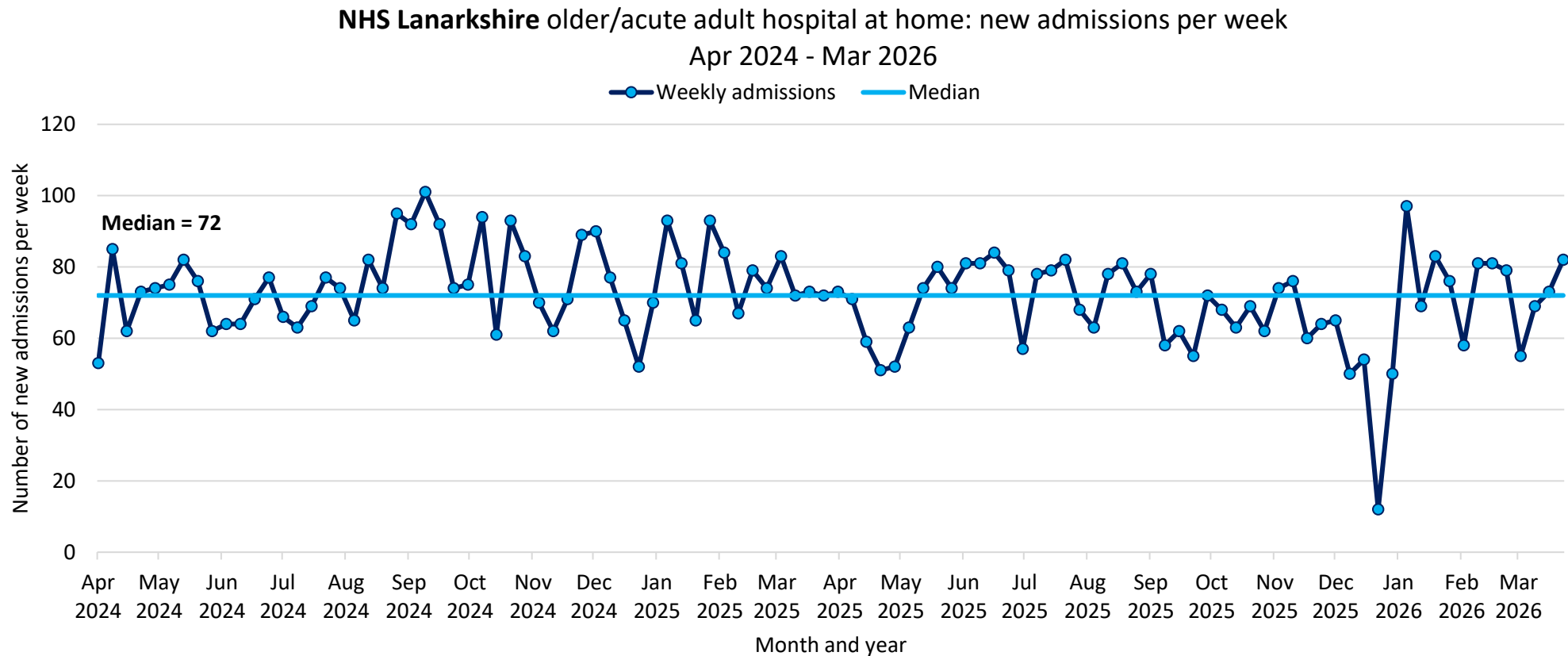
Figure 12 NHS Highland Argyll and Bute older/acute adult hospital at home activity April 2024 - March 2026



Admissions to the NHS Highland's Argyll and Bute older/acute adult hospital at home service increased from a baseline median of 3.5 to a new median of 7.5 admissions per week in January 2026. Funding for this service has allowed for new recruitment, resulting in service provision 7 days a week and thus an increase in admissions.

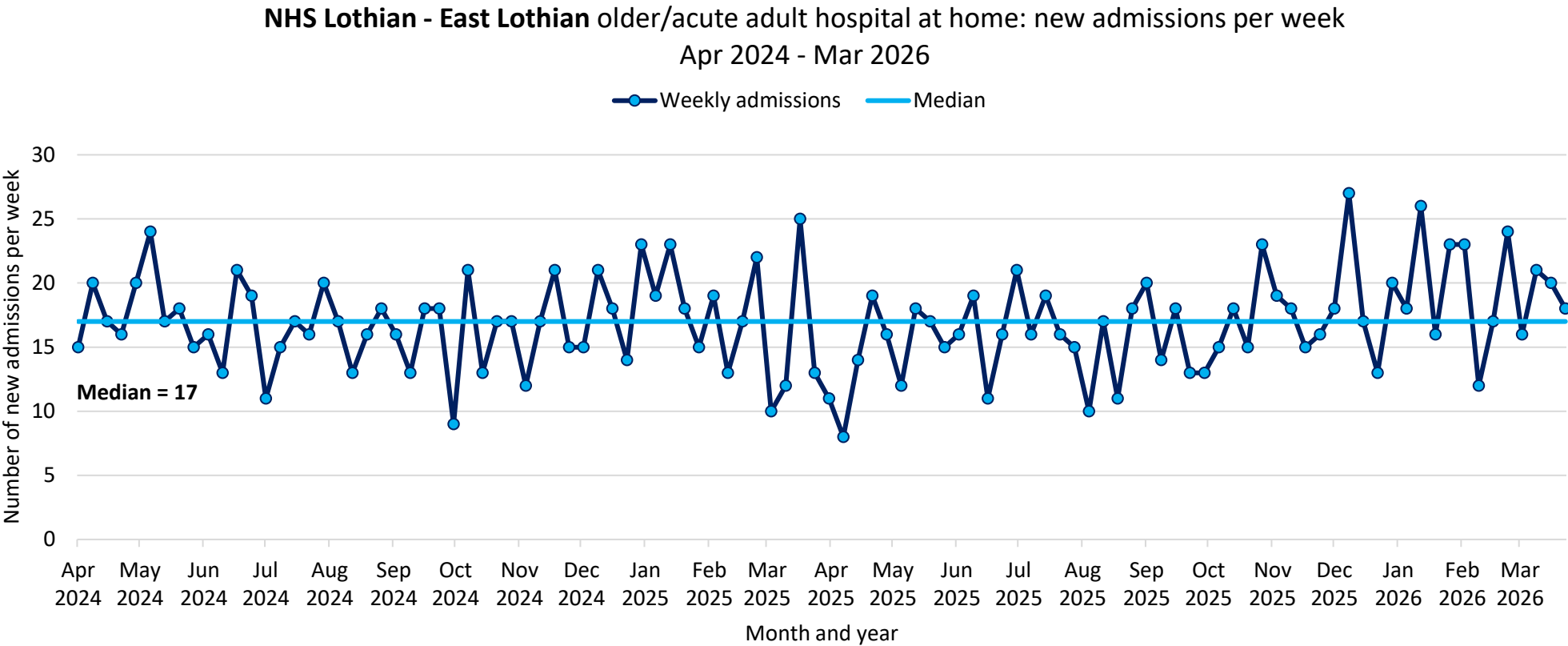
NHS Lanarkshire

Figure 13 NHS Lanarkshire older/acute adult hospital at home activity April 2024 - March 2026



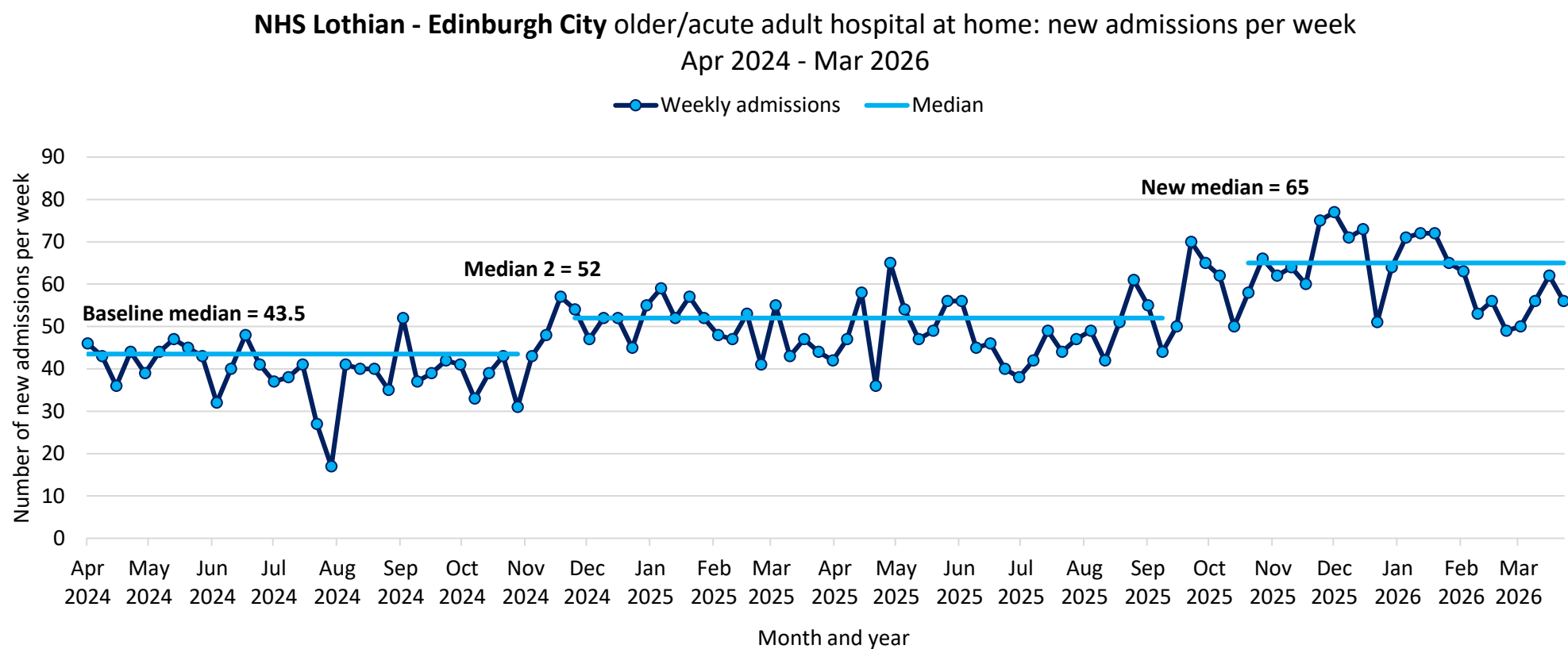
NHS Lanarkshire has a very well established older /acute adult hospital at home service. Admissions remained stable at a median of 72 per week throughout 2024/25 and 2025/26.

Figure 14 NHS Lothian East Lothian older/acute adult hospital at home activity April 2024 - March 2026



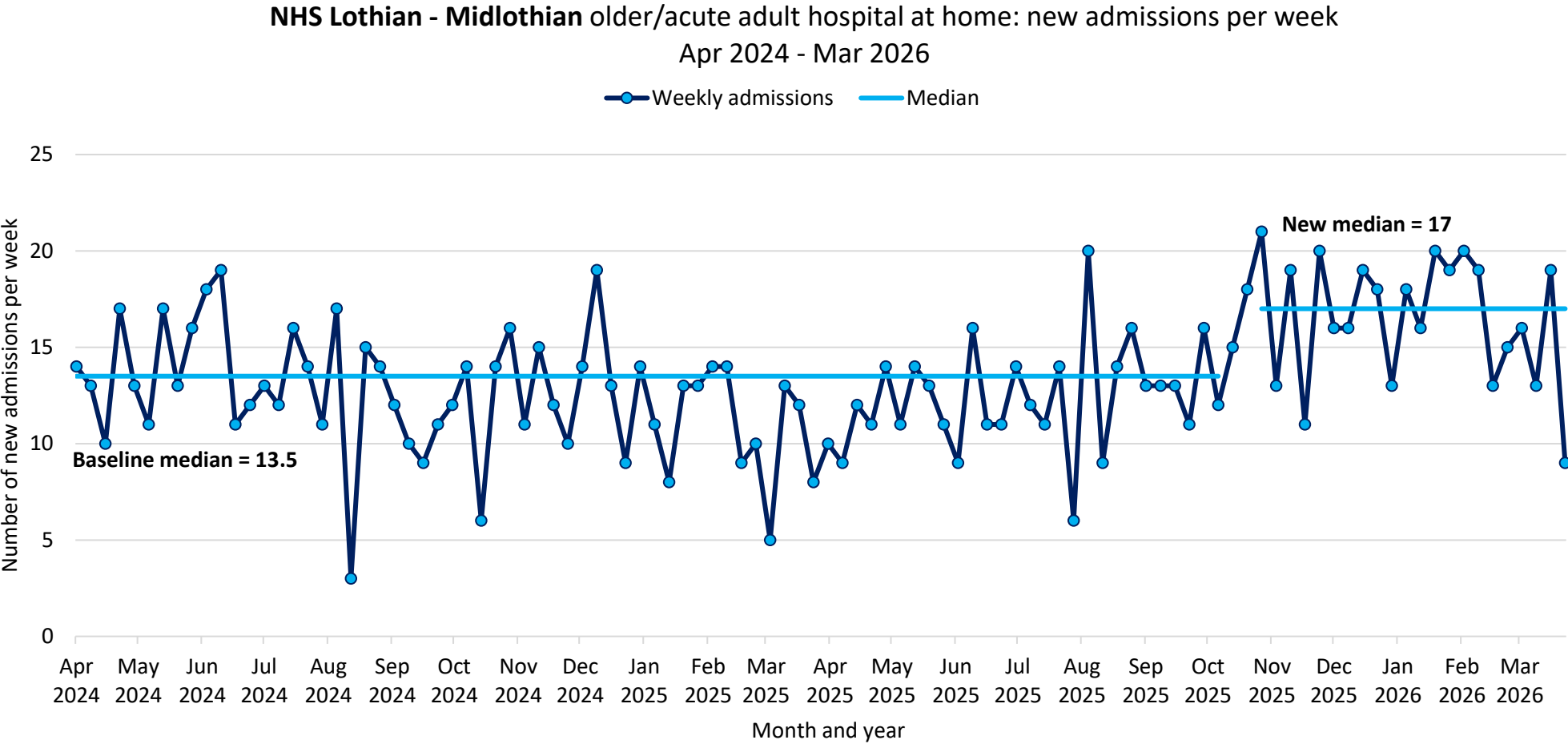
Admissions to the East Lothian older/acute adult hospital at home service remained stable at a median of 17 per week throughout 2024/25 and 2025/26.

Figure 15 NHS Lothian Edinburgh City older/acute adult hospital at home activity April 2024 - March 2026



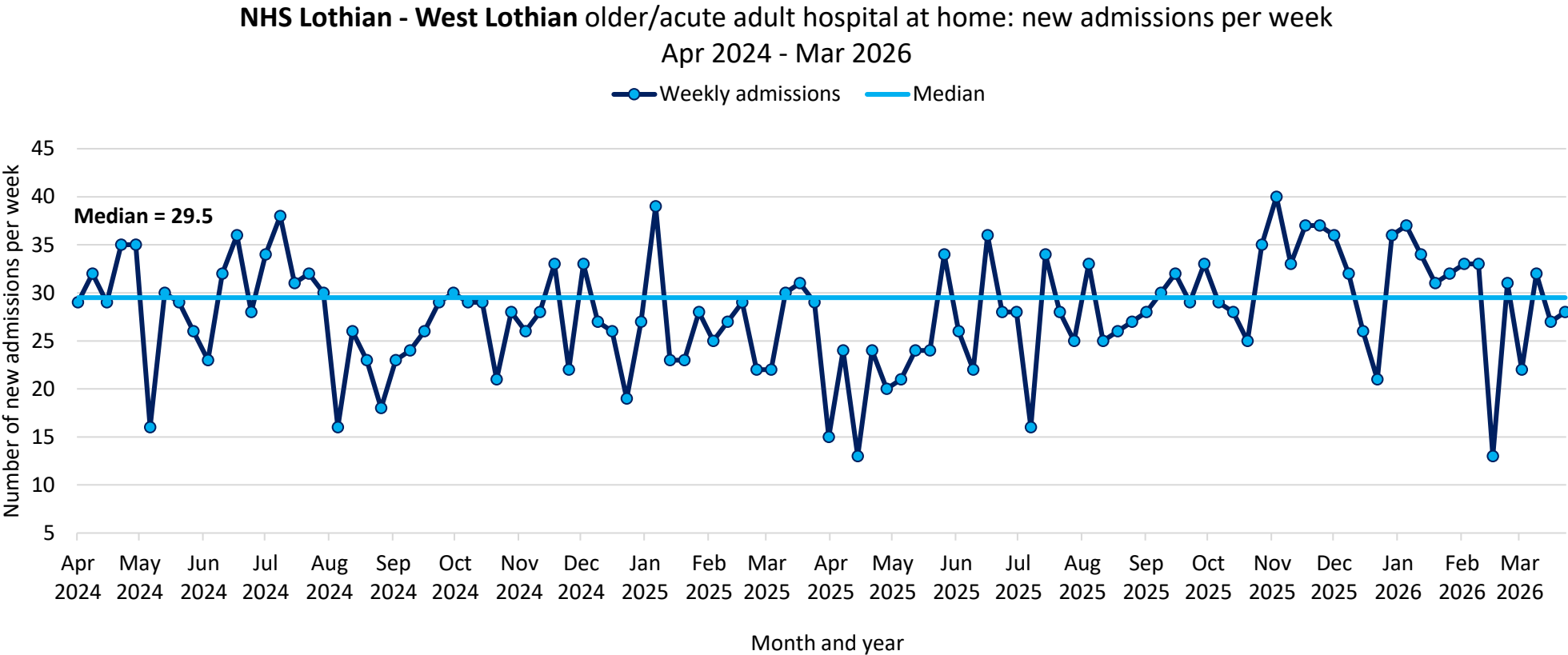
Median weekly admissions to the Edinburgh City older/acute adult hospital at home service increased in two distinct phases. There was a baseline median of 43.5 admissions per week rising to 52 from January 2025. A further increase was seen in 2025/26, following an increase in staffing, with admissions reaching a median of 65 per week.

Figure 16 NHS Lothian Midlothian older/acute adult hospital at home activity April 2024 - March 2026



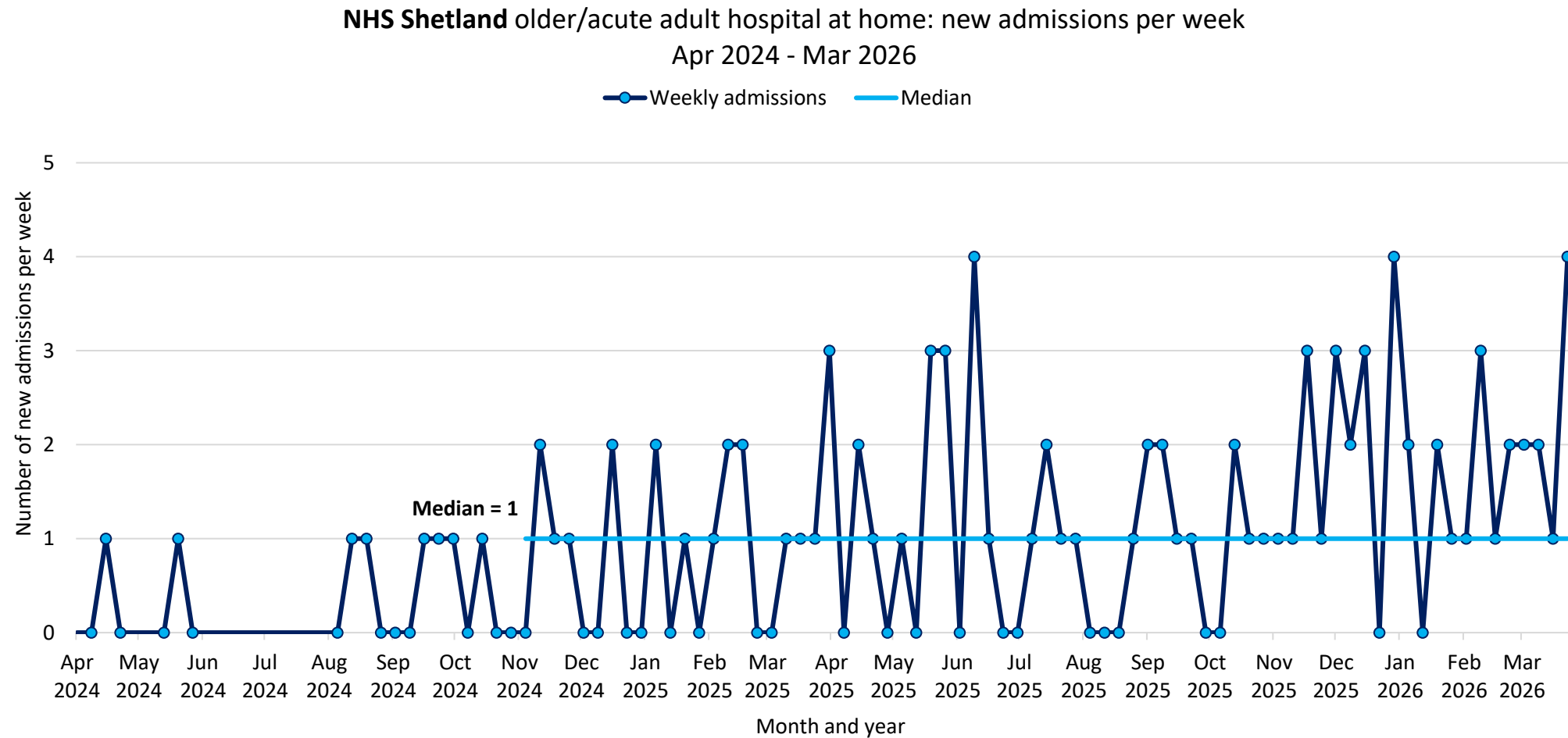
Admissions to the Midlothian older/acute adult hospital at home service increased from a baseline median of 13.5 to a new median of 17 admissions per week in autumn 2025. The service worked with their flow centre to review criteria for referrals and increase the volume of referrals received.

Figure 17 NHS Lothian West Lothian older/acute adult hospital at home activity April 2024 - March 2026



Admissions to the West Lothian older/acute adult hospital at home service have remained stable at a median of 29.5 per week in 2024/25 and 2025/26.

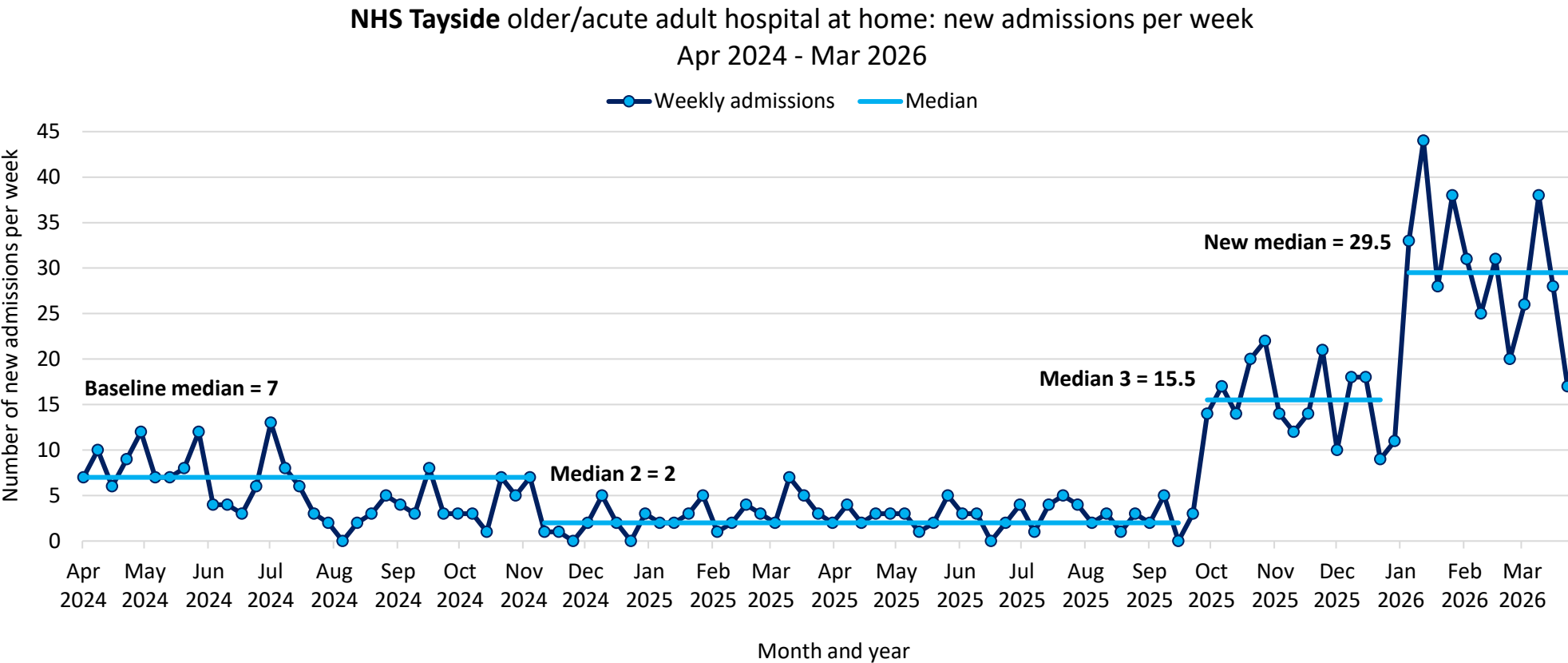
Figure 18 NHS Shetland older/acute adult hospital at home activity April 2024 - March 2026



Admissions to the NHS Shetland older/acute adult hospital at home service have remained stable at a median of one per week in 2024/25 and 2025/26. The team started attending hospital discharge meetings in December 2025 which resulted in an increase in referrals in 2026.

NHS Tayside

Figure 19 NHS Tayside older/acute adult hospital at home activity April 2024 - March 2026

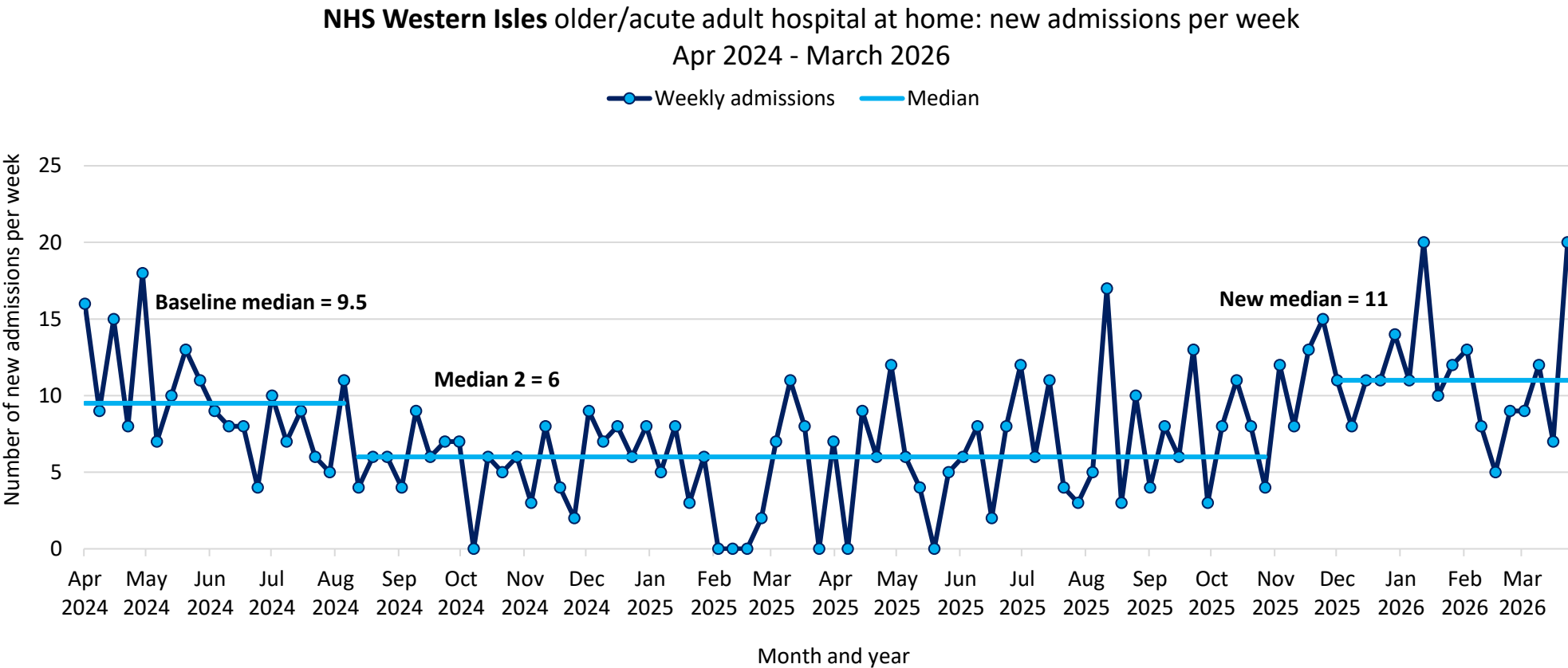


Admissions to NHS Tayside’s older /acute adult hospital at home service reduced from a baseline median of 7 per week to 2 per week in later 2024. In 2025/26, median weekly admissions increased to 29.5 per week.

NHS Tayside has not participated in the national hospital at home improvement programme so contextual information is not available about changes to the median over this period.

NHS Western Isles

Figure 20 NHS Western Isles older/acute adult hospital at home activity April 2024 - March 2026



Admissions to the NHS Western Isles older/acute adult hospital at home service declined slightly during 2024 from a median of 9.5 to a new median of 6 admissions per week. The median then increased to 11 admissions per week from December 2025. Significant work has been ongoing to develop a new integrated approach to care in this NHS board, which is now being reflected in the increased activity.

Appendix 2: Neonatal and paediatric service mapping

The tables in this appendix present the findings of a national mapping exercise undertaken by us in 2026 to identify neonatal and paediatric services across Scotland that meet, or may meet, the hospital at home definition. Engagement was undertaken with all 14 territorial health boards, capturing both current and historical service provision.

This national mapping exercise demonstrated that care is being delivered in patients' homes across all territorial health boards in Scotland that meets, or may meet, the definition of hospital at home. However, this provision is variable in scale, consistency, and degree of formalisation. Healthcare Improvement Scotland will be doing more work in 2026/27 to understand which elements of neonatal and paediatric care currently being provided to babies and children in their homes fits the definition of hospital at home.

Neonatal service mapping

The "Neonatal hospital at home" column in the Table 1A notes whether each NHS board reports having a formalised hospital at home service for neonates. The rest of the columns represent whether they have neonatal outreach teams (NNOT) delivering specific treatments and assessments to babies at home, without being under the umbrella of hospital at home.

Definitions used for this work are:

- Blood sampling: Provision of neonatal blood tests in the patient's home.
- Nasogastric tube (NGT) feeds: Support for nasogastric tube feeding in the patient's home.
- Oxygen therapy: Support for neonatal oxygen requirements in the patient's home.
- Phototherapy: Provision of phototherapy for neonatal jaundice in the patient's home.
- Sleep studies: Provision of overnight sleep studies in the patient's home.
- Warmed cots: Provision of warmed cots in the patient's home to support thermoregulation.

Table 2 Neonatal hospital at home and outreach services in NHS Scotland health boards

NHS Board	Neonatal hospital at home	NNOT: Blood Samples	NNOT: NGT Feeds	NNOT: Oxygen Therapy	NNOT: Phototherapy	NNOT: Sleep Studies	NNOT: Warmed Cots
NHS Ayrshire & Arran		✓	×		×		×
NHS Borders		✓	■	■	×	■	×
NHS Dumfries & Galloway		×	✓	✓	×	✓	×
NHS Fife		✓	✓	✓	D	✓	✓
NHS Forth Valley		✓		✓		✓	
NHS Grampian			✓	✓	✓		
NHS Greater Glasgow and Clyde	✓	✓	✓	✓		✓	
NHS Highland		×	×		×	×	
NHS Lanarkshire		■ /D	✓	✓	D	✓	×
NHS Lothian			✓	✓	✓	✓	
NHS Orkney			×	✓	D	×	×
NHS Shetland			×	×	×	×	×
NHS Tayside	✓	✓	✓	✓	✓	✓	×
NHS Western Isles		✓	×	×	×	×	×

KEY: ✓ There is an established service providing this routinely

× There is no service currently providing this

D There is a service in development planning to provide this

■ This has been offered in the past but is not currently offered routinely

Note: blank entries within tables do not necessarily indicate absence of provision.

Paediatric service mapping

Paediatric services provide care to children and young people, typically aged 0–15, with some services extending to 18 years. These services are delivered across hospital and community settings. The “Paediatric hospital at home” column in Table 2A notes whether each NHS board reports having a formalised hospital at home service for paediatric patients.

Definitions used for this work are:

- Community Children’s Nursing (CCN) team: Team providing care in the patient’s home, often following hospital admission or for long-term conditions.
 - Blood testing: Provision of blood tests in the patient’s home.
 - Urine testing: Provision of urine tests in the patient’s home.
 - Sleep studies: Conducting overnight sleep studies in the patient’s home, providing an alternative to admission for this investigation.
 - NGT or Percutaneous Endoscopic Gastrostomy (PEG) feeds: Support for tube feeding in the patient’s home.
 - Parenteral nutrition (PN): Support for PN feeding in the patient’s home.
 - End-of-life care: Provision of care at the end-of-life in the patient’s home, often in conjunction with children’s hospice.
- Clinical Nurse Specialist (CNS) teams: Specialist teams providing remote monitoring, virtual review, and care in the patient’s home for defined conditions (e.g. cystic fibrosis, diabetes, oncology).
- Child and Adolescent Mental Health Service (CAMHS) intensive home intervention: Provision of intensive mental health support in the patient’s home.
- Home OPAT: Provision of intravenous antimicrobial therapy in the patient’s home.
- Long-term ventilation (LTV) pathways: Provision of care for children and young people requiring long-term ventilation in the patient’s home.
- Rapid response AHP intervention: Provision of intensive AHP input in the patient’s home during acute deterioration.

Table 3 Paediatric hospital at home and other outreach services in NHS Scotland health boards

NHS Board	Paediatric hospital at home	CCN: blood testing	CCN: urine testing	CCN: Sleep studies	CCN: NGT/PEG feeds	CCN: PN feeds	CCN: End-of-life Care	CNS remote monitoring and support ¹	CAMHS intensive home intervention	OPAT	LTV pathways
NHS Ayrshire & Arran	■	✓	✓	✓	✓	✓	✓			✓	
NHS Borders		✓	✓	✓	✓	×	✓	✓	×	✓	✓
NHS Dumfries & Galloway	D	✓	✓	✓	✓	✓	✓	×	✓	×	×
NHS Fife	■			✓	✓			✓		✓	
NHS Forth Valley	D		✓	✓	✓		✓	✓	✓		✓
NHS Grampian				✓	✓	✓		✓		■	✓
NHS Greater Glasgow and Clyde	✓	✓	✓	✓			✓	✓		✓	✓
NHS Highland		×	×	✓	✓	✓	✓	✓	✓	■	✓
NHS Lanarkshire	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
NHS Lothian				✓	✓		✓	✓		D	✓
NHS Orkney								×		×	
NHS Shetland								×		×	
NHS Tayside		✓	✓	✓	✓	■	✓	✓	✓	×	✓
NHS Western Isles		✓	✓	×	×	×	×	×	×	✓	×

KEY: ✓ There is an established service providing this routinely

× There is no service currently providing this

D There is a service in development planning to provide this

■ This has been offered in the past but is not currently offered routinely

Note: blank entries within tables do not necessarily indicate absence of provision.

Appendix 3: Neonatal and paediatric service profiles

In 2025/26 neonatal and paediatric pathways were introduced to our programme as part of the hospital at home expansion. This section presents short profiles of the services in our programme which delivered care in 2025/26 and have continued into 2026/27. A service was also delivered in NHS Fife during 2025/26, but funding was discontinued. Data for neonatal and paediatric services has not been collected nationally by us.

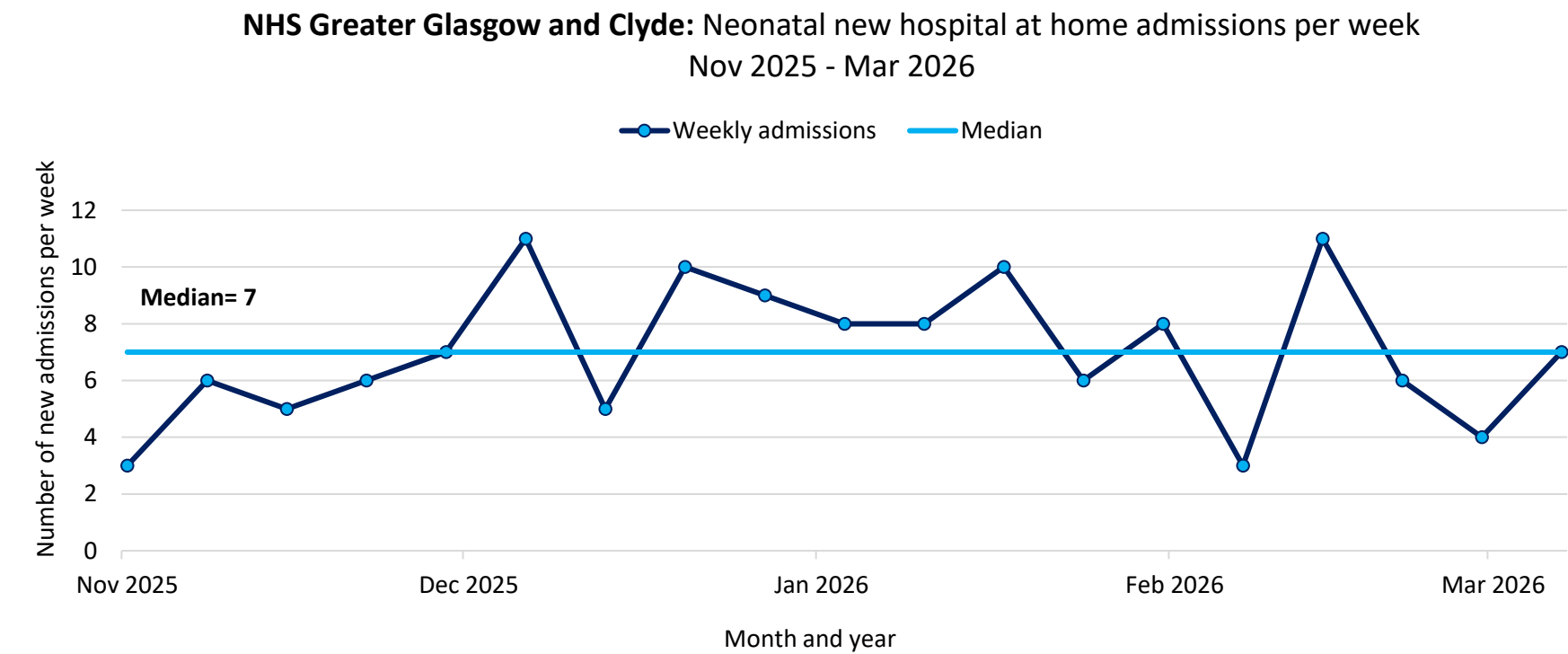
The data shown in this section was collected locally and reflects individual service activity. It cannot be used to draw comparisons between services due to the varying collection methods, contexts and pathways delivered.

NHS Greater Glasgow and Clyde

Neonatal service

NHS Greater Glasgow and Clyde’s neonatal hospital at home service was launched in November 2025 and provides phototherapy at home for babies with jaundice. The service initially became available to families living within a 15-mile radius of the Queen Elizabeth University Hospital. Figure 21A shows that weekly admissions quickly increased to a median of 7 and have been maintained at this level. This suggests steady utilisation as the new service became established. In 2026/27 the service will focus on expanding its workforce, geographical coverage and pathways (including oral antibiotics, tube feeding support and late preterm care), while continuing to gather family, staff and service data to inform future development.

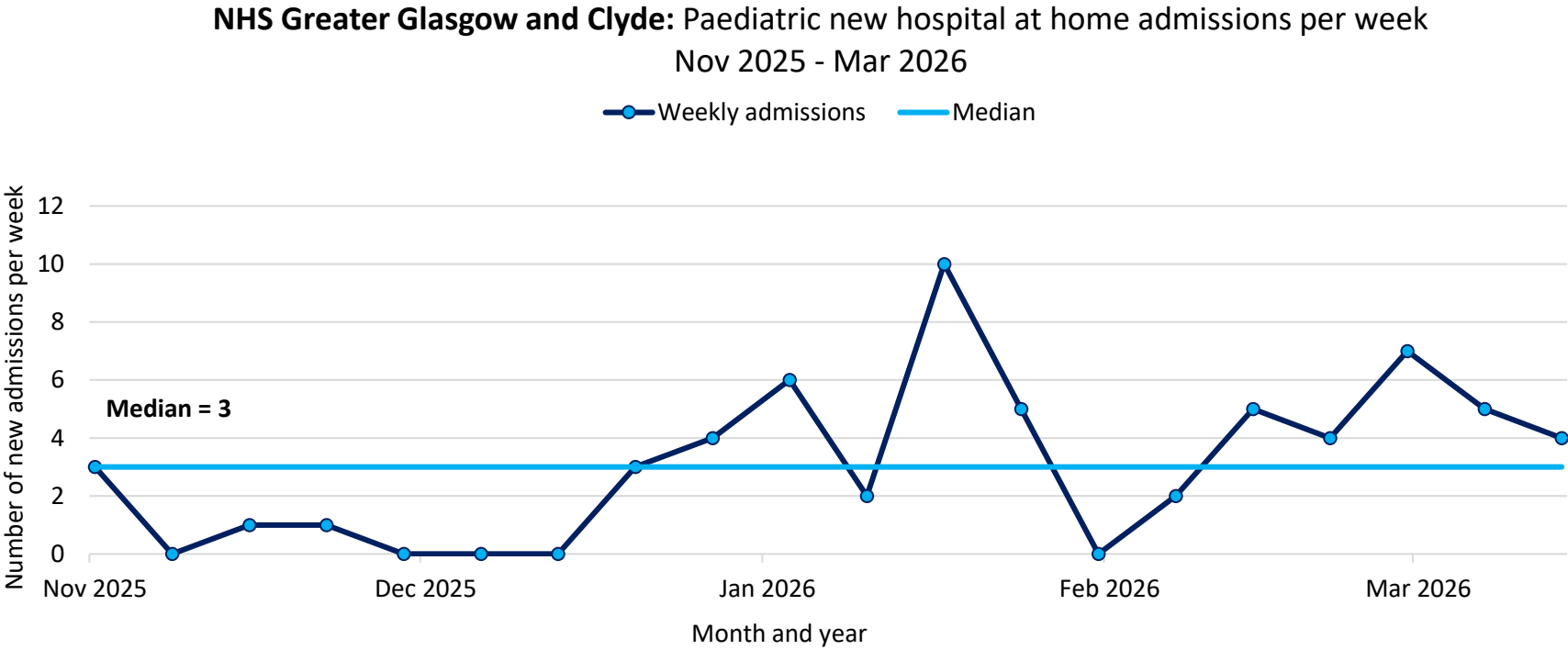
Figure 21 NHS Greater Glasgow and Clyde neonatal paediatric hospital at home activity November 2025 – March 2026



Paediatric service

NHS Greater Glasgow and Clyde’s paediatric hospital at home pathway launched in November 2025, initially as a consultant-led service while nursing recruitment progressed. Early work focused on establishing general paediatric pathways and constipation care. From January 2026, with nursing staff in post, the service transitioned to a nurse-led model and expanded to include paediatric OPAT. Figure 22A shows that the median number of admissions has remained at 3 per week since launch. However, per week activity increased from the beginning of 2026, with the service recording more than 5 admissions in several of the weeks. This indicates increased activity as staff joined the team. In 2026/27 the team aims to scale activity and expand pathways.

Figure 22 NHS Greater Glasgow and Clyde paediatric hospital at home activity November 2025 - March 2026



NHS Lanarkshire

NHS Lanarkshire began seeing patients in their paediatric hospital at home service in December 2025. At the time, they were operating with two paediatric pathways; home IV therapy and constipation care.

Figure 23 NHS Lanarkshire paediatric hospital at home activity December 2025 - March 2026

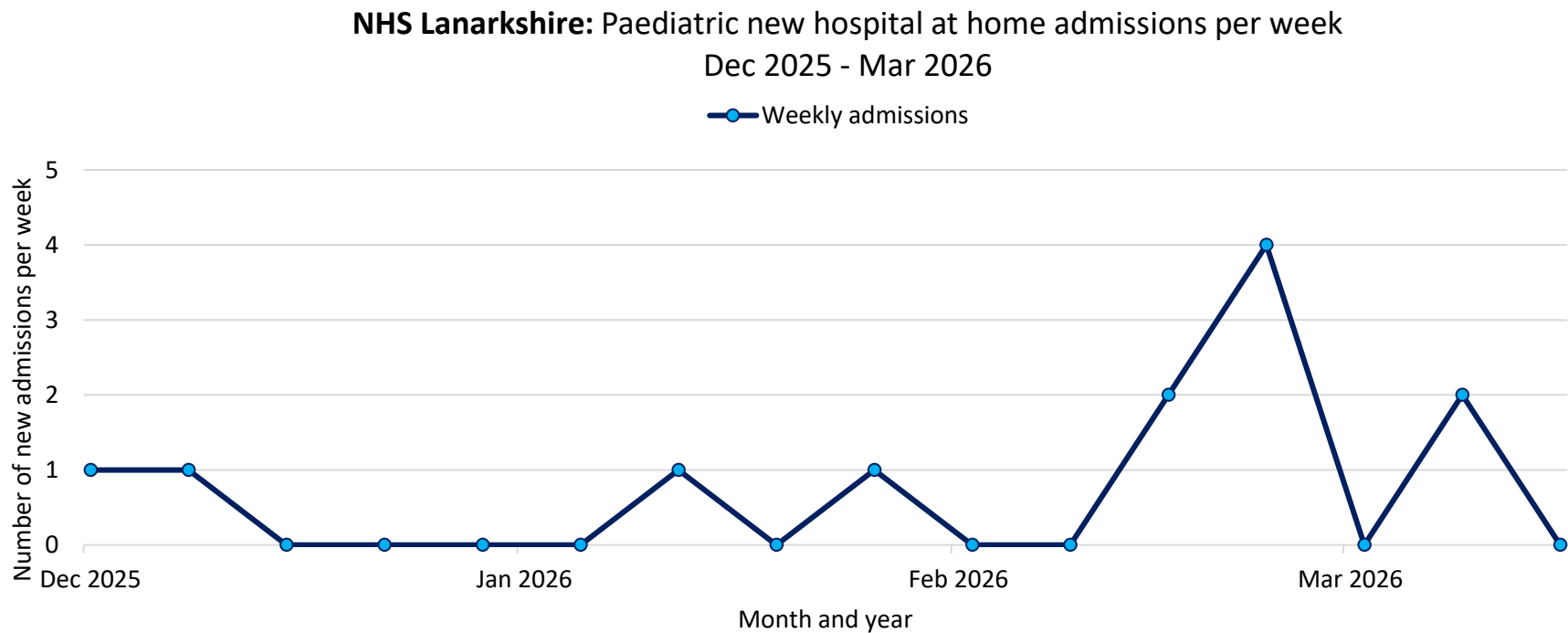


Figure 23A shows variable weekly admissions, with a notable increase in February 2026 to a peak of 4 admissions. During 2026/27, the team plan to expand clinical pathways, extend operating hours and widen referral routes, increasing access to hospital at home for more children and families.

NHS Tayside

NHS Tayside launched its neonatal hospital at home service in January 2026, building on an established neonatal community outreach team that was already delivering some hospital-level care at home, such as tube feeding. The multidisciplinary hospital at home service brings together AHPs, consultants and nursing staff to support earlier discharge from the neonatal unit and provide continuity of care while infants await community developmental services. Through this model, babies and families can access specialist input from dietitians, occupational therapists, physiotherapists and speech and language therapists at home, providing support that was not previously available through the outreach service alone.

Figure 24 NHS Tayside neonatal hospital at home activity January-March 2026.

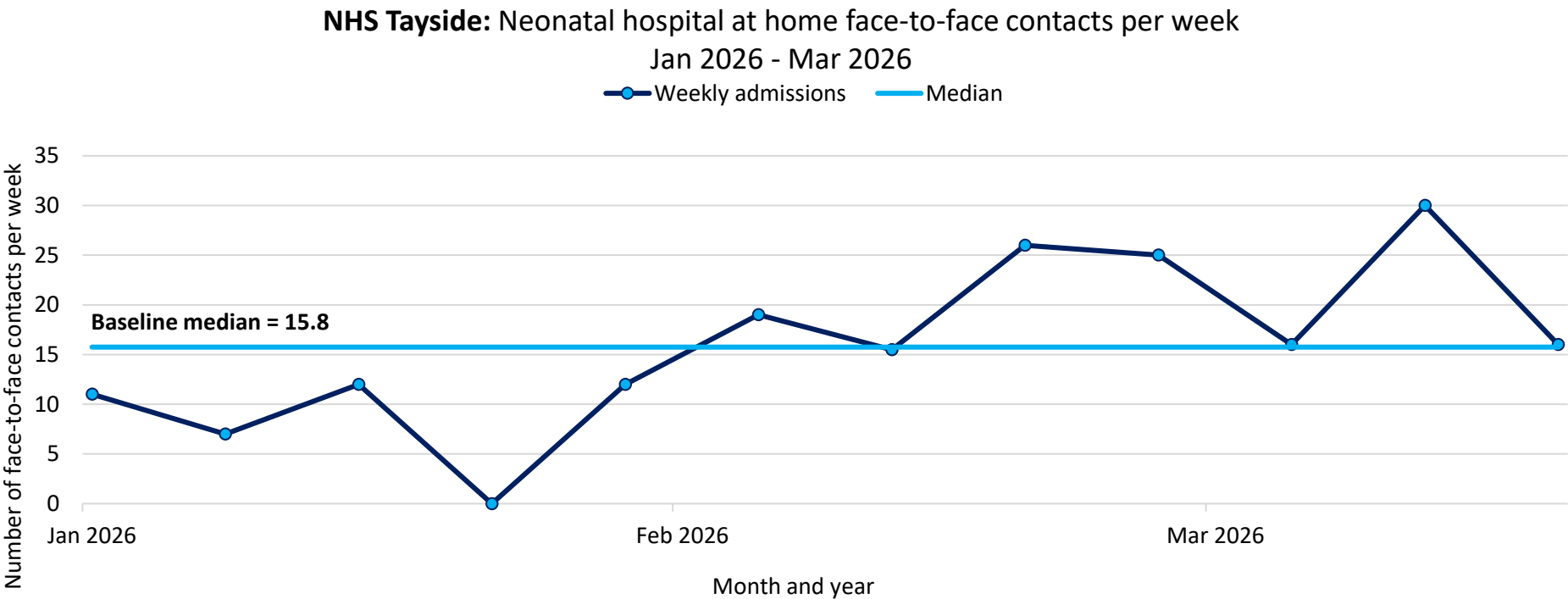


Figure 24 A shows that, since launch, activity within the service has increased steadily. The NHS Tayside neonatal hospital at home service recorded a median of 15.8 face-to-face contacts per week between January and March 2026. Face-to-face contacts represent visits delivered by the service and do not equate to new admissions, as each patient may receive multiple visits during their time on the pathway. The number of contacts increased during February and March, indicating growing service activity.

Appendix 4: Programme-level driver diagram

A driver diagram is a quality improvement tool used to visually display what will drive the achievement of a project's overall aim. The driver diagram below, developed by us, shows how the national hospital at home programme is contributing towards its overall aim.

To...	We need to...	Which requires...
Develop hospital at home models to increase the number of patients managed by services	Ensure conditions for change	• Funding and infrastructure • Workforce planning • Leadership and governance • Interventions and care planning • Integration and interfaces • Evidence, experience and engagement
	Establish new services	• Adult services in new geographical areas • Neonatal and paediatric services • Specialist services for new patient populations
	Expand condition pathways	• Additional defined clinical pathways • Links with appropriate workforce for wider patient cohorts
	Optimise existing services	• Effective use of skilled workforce • Capacity to match activity and demand • Efficient processes and pathways • Referral pathways from new sources • Point of care testing • Digital services

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