

Neonatal and paediatric hospital at home

Guiding principles for service development

August 2025

Acknowledgements

We would like to thank professionals from hospital at home services across Scotland, and beyond, for their valuable contributions and comments. In particular, boards that have contributed information.

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Key points

- This is part one of Healthcare Improvement Scotland's guiding principles for service development for neonatal and paediatric hospital at home services. An extended version of this document will be available in the spring of 2027 and will include learning from services across Scotland.
- 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 for neonatal and paediatric patients has differences from adult services but key principles remain. Some services in Scotland are still developing and defining their scope. Thus, the definition and features are subject to change as they evolve.
- We conducted a literature search in January 2026 on the effects of hospitalisation on neonatal and paediatric patients, and their families. The evidence suggests that hospitalisation can be stressful for babies, unwell children, and their parents, siblings and grandparents. Stressors include the hospital environment, family separation and disruption to routines, amongst others.
- We conducted a separate search on the effects of hospital at home for neonatal and paediatric patients, and their families. The available evidence suggests that hospital at home is a safe and effective alternative to hospital care for babies and children with certain conditions. There is also evidence of positive impacts on patient and family experience.
- Neonatal and paediatric hospital at home is an initiative which aligns with several policies and standards. These include Scottish Government's Operational Improvement Plan (2025), the Health and Social Care Service Renewal Framework (2025) and the United Nations Convention on the Rights of the Child (Incorporation) Scotland Act (2024).
- Healthcare Improvement Scotland supports a national improvement programme which is supporting various health boards across Scotland to implement neonatal and paediatric hospital at home services. The programme's learning system also provides resources, learning and networking opportunities.
- There are more resources available to professionals involved in the design and delivery of hospital at home services. Sources include the UK Hospital at Home Society, the World Hospital at Home Community and the Paediatric Hospital at Home Network.

Contents

Key points	1
Contents	2
1.0 Purpose of the guiding principles	3
1.1 Note on purpose of this document	3
1.2 Further iterations	3
2.0 Neonatal and paediatric hospital at home: definition, rationale and context.....	3
2.1 What is neonatal and paediatric hospital at home?	3
2.1.1 Definition	3
2.1.2 Key features	4
2.1.3 Case study from NHS Greater Glasgow and Clyde’s neonatal team	5
2.2 Evidence	8
2.2.1 Why is an alternative to hospital care needed?	8
2.2.2 Safety and effectiveness of hospital at home.....	10
2.2.3 Patient and family experience	11
2.2.4 Staff experience	12
2.2.5 Cost-effectiveness.....	13
2.2.6 Evidence excluded from our summary	13
2.3 Health and social care policy landscape.....	14
2.3.1 Public Bodies (Joint Working) Scotland Act 2014	14
2.3.2 Scottish Government Operational Improvement Plan	14
2.3.3 Health and Social Care Service Renewal Framework	15
2.3.4 Realistic Medicine and Value Based Health & Care	15
2.3.5 United Nations Convention on the Rights of the Child (UNCRC) (Incorporation) (Scotland) Act 2024	16
2.3.7 The Best Start: Strategic Plan for Maternity and Neonatal Care	17
2.3.8 Other related policies and guidelines	17
3.0 Next steps	19
3.1 Other tools and resources	19
3.2 Can you help us?	19
Bibliography	20

1.0 Purpose of the guiding principles

1.1 Note on purpose of this document

This version of the guiding principles is the first publication by Healthcare Improvement Scotland specifically designed for neonatal and paediatric hospital at home services. It is intended to be an introduction to the underpinnings of neonatal and paediatric hospital at home as well as an overview of the current policy context in Scotland and the evidence base.

1.2 Further iterations

Healthcare Improvement Scotland intend to publish an updated and expanded version of this document in the spring of 2027. This update will be developed by drawing on the experiences of Scottish neonatal and paediatric hospital at home services, sharing their learning around what works and what does not.

In the meantime, we encourage professionals involved in the design and delivery of these services to consult the evidence in section 3.0 of this document, as well as the [guiding principles for adult hospital at home services](#) published by Healthcare Improvement Scotland in 2025.

2.0 Neonatal and paediatric hospital at home: definition, rationale and context

2.1 What is neonatal and paediatric hospital at home?

2.1.1 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 for older adults has been developed over the course of the last 14 years in Scotland, with Healthcare Improvement Scotland supporting a national programme since 2019.

For many years before the national programme was established, various health boards in Scotland made progress in the implementation of neonatal and paediatric hospital at home services. However, there were significant barriers to some services being sustained and scaled. 2025/26 saw the first round of Scottish Government funding for the roll out of neonatal and paediatric hospital at home services, with funding for implementation and improvement support from Healthcare Improvement Scotland. It is hoped that national coordination and funding will facilitate the implementation of new services and the further establishment of new and existing services

into the healthcare system. A paediatric hospital at home network has also been active in recent years, which meets regularly to connect clinical teams across Scotland interested in developing, or currently developing, neonatal and paediatric hospital at home services.

Hospital at home for neonatal and paediatric patients has differences from adult services, but key principles remain and are discussed in 2.1.2. Globally, adult hospital at home services tend to be more widely available and more established. Not all NHS Scotland health boards are currently planning to deliver neonatal and paediatric hospital at home services. Of those that are, some are still developing and defining the scope of their service. The way hospital at home services operate is influenced by the geography and demographics of an area. Thus, the definition included above, and any descriptions of its features below, are subject to change as they evolve.

2.1.2 Key features

- 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 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.
- Paediatricians and neonatologists act as senior decision makers and responsible medical officers (RMOs), sometimes with the help of other grades of medical staff.
- Care is provided by multidisciplinary teams (MDTs) 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, oxygen or phototherapy 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).

2.1.3 Case study from NHS Greater Glasgow and Clyde's neonatal team

This case study covers the experience of NHS Greater Glasgow and Clyde's (NHSGGC) neonatal hospital at home team since enrolling in the national neonatal and paediatric hospital at home programme with Healthcare Improvement Scotland. NHSGGC also have a paediatric hospital at home service however that is not the subject of this case study. We are also aware that NHSGGC and other health boards have implemented neonatal and paediatric services akin to the definition of hospital at home prior to the establishment of this programme.

In November 2025, NHSGGC launched the current model of their neonatal hospital at home service. At the time of writing, their team consists of:

- four neonatal nurses,
- a service improvement manager, and
- clinical oversight from a hospital consultant neonatologist.

Service parameters

- The team currently provides home phototherapy to clinically eligible newborn babies. Phototherapy is provided via the [BiliCocoon®](#) device which delivers 360° light exposure to the baby.
- Hospital at home staff train parents to use the device. They then visit the family at home daily to assess the baby's progress. This means that families can settle into their new routines with minimal disruption. The device can also be used while feeding the baby.
- The service operates within a 15-mile radius of the Queen Elizabeth University Hospital.
- The working hours of the service are 8am to 8pm, 7 days a week.

Barriers and facilitators

The team reported what they considered barriers and facilitators to implementing their service. The following items may be helpful for other teams to consider when developing a service.

Barriers included:

- Getting confidence and buy-in from teams can take time.
- Some colleagues may be sceptical about big investment for little gain at first.

Facilitators included:

- Engaging with maternity colleagues early, speaking at team meetings and visiting teams. This included explaining what the service offers and what it does not. It also included reassuring them that their workload will not increase.
- Referral pathways operating "business as usual". All babies being seen by referring teams before contacting hospital at home to ensure clinical safety.
- Lone worker status alarms.

- Parking permits for the hospital are essential to ensure staff can make visits to the wards and laboratories. Permits ensure staff can find parking in a timely fashion, increasing efficiency.
- Engaging with laboratory staff early. Smooth laboratory processes, and processes to share abnormal results, are important.
- Collating family and patient feedback continuously. Their voice is the most powerful feedback so important to ensure it is collected, reviewed and acted on.
- Collecting data on numbers and days of care re-aligned. This information is important to managers along with family feedback.
- Sharing your experiences widely.
- Involving partnerships as they can be a great support.

Staying committed and positive. Your team and your positivity will make great things happen for families.

Service activity to date

Figure 1.0 NHS Greater Glasgow and Clyde neonatal hospital at home admissions

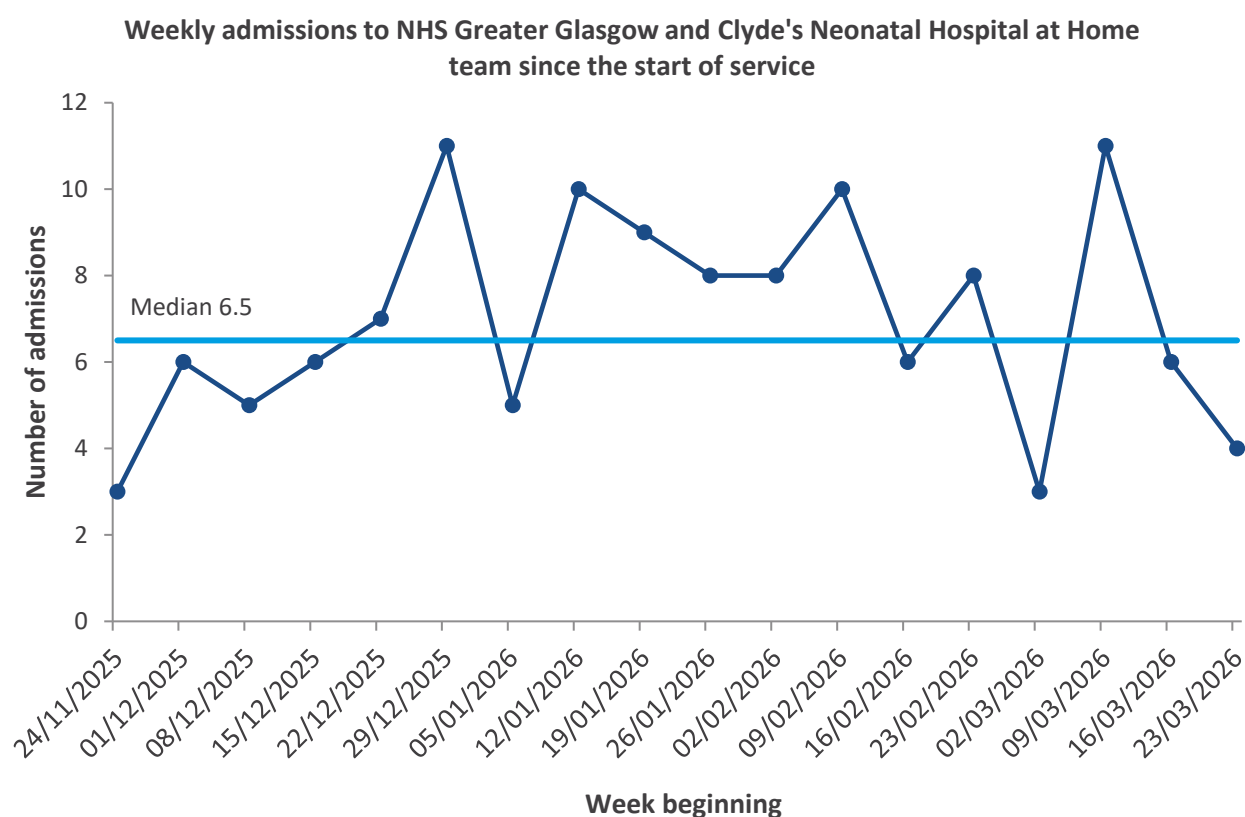


Figure 1.0 shows that the number of admissions per week to the service have fluctuated since its launch, with a median of 6.5. This is to be expected from a new service whilst processes are developed and refined. As the service develops, it will be more appropriate to look at monthly admissions. Weekly admissions data such as the chart above is useful but is sensitive to week-by-week variations such as sickness absence in the team.

Impact

Feedback from parents has been positive and points to parents feeling well supported and comfortable at home.

"I can care for my kids at home no need to worry about my son when my newborn needs the neonatal care."

"Returning to the hospital right after delivery can be overwhelming, but being able to stay at home in a familiar, comforting space made everything so much easier."

"The nurses were great at explaining everything and really helped with my anxiety surrounding treatment. I am so grateful and felt extremely supported throughout."



"It was very special to have babies managed at home over the festive period...it's a fantastic service. Appreciated by both the NHS and service users."

"Being able to visit and manage a 'well' baby who requires additional support at home as well as seeing parents relax in their own environment whilst caring for their baby is so rewarding."

"Knowing what I do supports people during important moments in their lives gives me a strong sense of pride, purpose and great job satisfaction."

Feedback from staff is also positive and points to them finding the work rewarding.

2.2 Evidence

In January 2026, we conducted two literature searches to identify evidence for this document. For both searches, results were limited to papers in English and published after 2005. Other restrictions were also applied where necessary.

The first search was to identify evidence about the effects of hospitalisation on neonatal and paediatric patients. This was needed to provide the background context of the traditional model of care. It was also to identify areas where a shift to providing hospital care at home could be beneficial. We searched for research papers focusing on babies, children of all ages, adolescents and their family or carers. Databases searched were Embase, Ovid MEDLINE, ERIC, APA PsycInfo and NHS Scotland Journals. A review of the citations within these papers identified more sources.

The second search was to identify evidence about the impact of hospital at home on the same groups. Databases searched were Medline and CINAHL. Through review of abstracts, papers commenting on four key topics were prioritised. The topics were:

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

Please contact Healthcare Improvement Scotland if you would like to see the search strategies used.

We noted that there was a smaller evidence base than for adult hospital at home, with fewer high-quality papers available. Many of the findings below were based on small sample sizes. Readers should keep this in mind when interpreting findings.

2.2.1 Why is an alternative to hospital care needed?

The rationale for paediatric hospital at home services is rooted in the desire to improve patients' and families' experiences of healthcare. It seeks to remove some of the stressors associated with hospitalisation. We identified evidence about the experiences of children in hospital spanning several decades, countries and clinical indications for hospitalisation. Thus, the results from individual studies were difficult to generalise. The following summary describes the key findings that were present across a range of contexts.

Hospitalised children

Children of all ages find hospitalisation a stressful experience. However, the reasons can vary depending on developmental stage¹⁻⁴. In self-report survey studies, children often have both positive and negative things to say about hospital. Negative experiences often relate to the treatments and procedures they receive in hospital¹⁻³ but they also commonly mention the following factors.

Separation. Children describe experiences of isolation or separation from family and friends¹⁻³.

Lack of normal activities. Children often feel negative about the lack of normality during a hospital stay. This may include being away from their own toys, TV and school^{2,3}.

The physical environment of the hospital. Children express discomfort with the hospital environment. Examples include noise while on the ward¹⁻³, lack of privacy^{1,2}, poor food^{2,3}, and uncomfortable furnishings².

Researchers suggest that children's negativity about hospital could be due to separation from familiarity¹⁻³, causing them to seek continuity between home and hospital life³. As far as possible, researchers suggest that maintaining familiarity, normal activities and communication with friends and family could make a positive difference^{1,2}. The European Association for Children in Hospital (EACH) charter also advocates for keeping children in their own environment if care can be equally well provided there⁵.

Parents

Parents experience emotional, physical and financial pressures when their child is in hospital⁶. The main stressor for parents is often their child's illness and the uncertainty surrounding it. However, they also commonly mention the following factors.

Logistics of being present for their child. Parents often must navigate logistical barriers to be close to their child during a hospital stay. They overcome this by seeking accommodation nearby, travelling back and forth, or staying in the hospital when possible^{6,7}.

Obtaining necessities. Parents have trouble obtaining the necessities of daily living whilst staying with their child. This includes food and access to shower facilities^{6,7}.

Financial burden. Hospitalisation can have financial implications for families. This may be due to nonmedical costs or taking time off work which leads to loss of earnings^{6,8-11}. Nonmedical costs include food, accommodation, travel and parking, amongst others.

Isolation. Some parents report feeling isolated from their social networks whilst their child is in hospital^{6,7}. This may include their friends, family and work colleagues.

Balancing home and hospital life. This is particularly prominent amongst parents who have other dependents which can mean they are separated from their other children^{4,6,7}.

The hospital environment. Like the children, parents also express negativity towards the hospital environment. They mention noise on the ward^{6,12} and the emotional impact of seeing other children and families⁶.

The effects of hospitalisation on parents are, like the patient experience, extremely nuanced. Parents report many positives of hospitalisation which sometimes overlap with the negatives. For example, new parents might worry about no longer having nurse support when they are home

from the neonatal intensive care unit (NICU)⁶. However, they may have conflicting concerns around ability to bond in the hospital setting, valuing being able to care for their baby at home⁶.

Siblings and grandparents

Siblings and grandparents of hospitalised children also experience physical and mental burden^{6, 13}. Siblings often experience:

- significant disruption to their own routines^{6, 13} including missing school¹⁴,
- less time with their parents which leads to feelings of anxiety^{6, 13, 14}, and
- a feeling of responsibility to alter their behaviours to ease the strain on their parents^{6, 12, 15}. Parents sometimes note that their well child(ren) seem emotionally withdrawn^{6, 14}.

Siblings often say they would be less anxious if they knew what was happening with their sick sibling and long for more open communication^{6, 13, 15}. They also report that things are better when there is normality and familiarity¹³.

It should be noted that well siblings sometimes report positive experiences when their sick sibling is in hospital. This is often due to spending more quality time with other caregivers^{6, 13, 14} or connecting with other children who have sick siblings¹³.

Grandparents experience a phenomenon known as “double concern”. This refers to their worry for both their grandchild and their child (the parent). They often take on more responsibilities when their grandchild is in hospital, such as caregiving for the well sibling(s)^{6, 14, 16}.

Ultimately, experiences of a child’s hospitalisation differ between groups (patient, caregivers, siblings) and within groups. The experience is partially dependent on factors such as age, socioeconomic status and gender. Therefore, there is no “one size fits all” approach that will eliminate all negative experiences during a child’s illness⁶. Hospital at home seeks to remove some of the stressors for people affected by a child’s hospitalisation, but it may not be the right fit for every family. Being treated at home may reduce some of the illness burden for patients and their families but the worries surrounding the illness and treatments are likely to remain.

2.2.2 Safety and effectiveness of hospital at home

Safety and effectiveness are key concerns for all healthcare services. Hospital at home’s initial investment is made with the assumption that services will match or exceed hospital care on safety measures and prove more cost-effective. There is also an expectation that services will offer efficiencies by reducing readmissions and length of stay in hospital. Length of stay is a two-fold measure. A service may work to reduce:

- **Length of stay in the hospital.** For example, by facilitating early supported discharge from the hospital. This does not necessarily mean the total period of care is shorter but frees up bed spaces in the hospital and may still be more cost-effective.
- **Total length of stay.** This can be defined as the total period of acute care, including days in hospital plus days under care of hospital at home.

The evidence in this section suggests that neonatal and paediatric hospital at home can meet these expectations. However, due to a limited amount of available evidence, the age of the available evidence, and the wide variety of service models that are studied, we cannot draw firm conclusions.

Several systematic reviews were identified that met our criteria for quality and relevance. Non-systematic reviews are cited where appropriate. When compared to conventional hospital, paediatric hospital at home services were not associated with more adverse events^{17, 18}, less favourable clinical course^{17, 19, 20} or more readmissions^{17, 21}. However, some systematic reviews identified a study by Bajaj et. al (2006) which found that hospital at home resulted in a higher level of clinical complications and total days of care required for treatment^{20, 22}. Another of the included studies, by Sartain et. al, agreed that the average total length of care was longer in hospital at home²³.

Sartain et. al's study was a randomised controlled trial conducted in 2002 in England. The study compared an acute paediatric hospital at home ward with conventional hospital care. The authors found no differences between the two groups in presentation to the emergency department or readmissions to hospital within 90 days after discharge. However, when the authors assessed readmission rate by cause, they found readmission for breathing difficulties was twice as high in the hospital at home group than the hospital group. They argued this increase could be reflective of increased parental confidence in identifying exacerbations in the hospital at home group. Increased parental coping skills were also put forward to explain the lower first week readmissions in the home care group²³.

Several studies of neonatal hospital at home were identified which reported positive findings for safety and effectiveness. The authors found equal or lower readmission rates^{24, 25}, length of stay (in hospital and hospital at home wards)^{20, 24, 26, 27}, and comparable weight gain across hospital at home and control groups^{20, 26}. This weight gain was sustained at 6- and 12-months post-discharge in the case of Garcia-Ortega et. al²⁶. A 2025 systematic review by Spaan et. al assessed 31 studies of home phototherapy for neonatal hyperbilirubinemia. They found that home phototherapy was safe and effective for low-risk, near-term or term neonates. However, they rated the quality of evidence as low-very low²⁸.

2.2.3 Patient and family experience

As per the evidence in 2.2.1, there are several opportunities for improvement of the patient and family experience in neonatal and paediatric hospital-level care. Evidence suggests that patients and their families face issues relating to the logistics of hospital life, separation, and the physical hospital environment. The evidence relating to hospital at home services for babies and children suggests that this service model could relieve some of the stressors for children, their parents and other family members.

A 2024 systematic review by Pinheiro et. al found that the provision of hospital care at home promotes children being more involved in their own care²⁹. This improved patient confidence and

autonomy, ultimately improving joy and satisfaction. They also found that the parent-professional relationship was improved in hospital at home, along with parental confidence in caring for their unwell child. This was contingent on training being given to parents before leaving the hospital, to allow them to competently care for their child. Pinheiro et. al described a “partnership” which develops between parents and healthcare professionals when care is delivered in the home. Spaan et. al also highlighted the importance of parental education and good communication between parents and professionals in home phototherapy initiatives to reduce parental insecurity²⁸.

Pinheiro et. al also found positive effects of hospital at home on the family system. They found that it promotes normalisation and maintains family unity. The review concluded that hospital at home “improves the affective bond, the sense of security, comfort, tranquillity, relief, confidence, and autonomy” whilst “reducing stressors such as anxiety, nervousness, uncertainty, and fear”. One study included in the review assessed the impacts of hospital at home for siblings of ill children. They found that support from home care nurses helped their psychosocial coping. Siblings reported positive experiences of the service because it kept the family together and they could be more involved in their sibling’s care³⁰.

We identified two other experiential studies which met our criteria for inclusion in this summary and were not part of the Pinheiro et. al (2024) review. One was a 2017 evaluation of a pilot hospital at home service for children in England. This study found that hospital at home promoted a better patient experience of hospital-level care and improved parental confidence in caring for their unwell child³¹. Less recently, Sartain et. al (2002) conducted interviews with participants of a randomised controlled trial comparing hospital and hospital at home care²³. Most patients, and their parents, expressed a preference for hospital at home. The main reasons for this preference were comfort, freedom and less disruption to normal family routines.

2.2.4 Staff experience

There was limited evidence available on staff experience for paediatric hospital at home. A 2002 study of a Norwegian hospital at home service compared the experiences of parents and community nurses. In the study, the nurses were not permanently attached to the hospital at home service. This explained why they reported finding it challenging caring for children and completing procedures in front of parents. They felt the scrutiny of the parents yet also felt appreciative after gaining their trust. They also described forming a partnership with the parents, similarly to the findings of Pinheiro et. al^{29, 32}.

A 2024 study by Heimdal et. al assessed a NICU hospital at home service. The study shows broad similarities with the previous articles. Initially, nurses in the service felt uncertainties around responsibilities and procedures. They also found it challenging to get enough time with parents to provide what they felt was enough education. After some time, they recognised the quality-of-care hospital at home provides and were able to adapt to effectively supportive parents. The nurses also expressed positivity about in-hospital education. They observed that starting parental education in the hospital improved the functioning of the family when patients were discharged

into hospital at home³³. Spaan et. al found similar patterns in the views of healthcare professionals providing home phototherapy for neonates. They stated that healthcare professionals' concern was a barrier to implementation²⁸.

2.2.5 Cost-effectiveness

Cost-effectiveness of a health service can be assessed from two points of view. That is, benefit for the healthcare system and benefit for the service users. Our search returned four systematic reviews which assessed the evidence for the cost-effectiveness of hospital at home services, conducted in 2013²⁰, 2023¹⁷ and 2025^{28, 34}.

Parker et. al (2013) noted that there was some evidence of reduced costs for families. Based on weaker evidence, they stated that paediatric home care could also reduce costs for healthcare services²⁰. Two reviews found most studies showed significant cost savings for paediatric hospital at home services^{17, 34}. Dick et. al (2025) specified that cost savings were for both families and the healthcare system³⁴, but the Detollenaere et. al (2023) review did not make any delineation between the two¹⁷. The remaining review by Spaan et. al (2025) stated that only five of the included studies compared costs for home phototherapy regimes versus hospital phototherapy. However, all five of those studies reported lower costs per day for the home regime²⁸. All reviews reported limitations in that the methods of cost analysis were heterogeneous and often not well reported. It was therefore difficult for reviewers to draw strong conclusions on the cost-effectiveness of hospital at home despite the results appearing positive.

There is a need for more evidence in this area with robust, consistent methodologies. Cost-effectiveness also varies according to country as costs for the system and its users are dependent on local policies, financial support initiatives and whether the health system is private, public, or a mixture of systems.

2.2.6 Evidence excluded from our summary

Due to the heterogeneity of "hospital at home" service models across the world, some of the evidence reviewed was not aligned to the Scottish definition. As a result, we wanted to clarify what is outwith the scope of the definition of neonatal and paediatric hospital at home in Scotland at present. The evidence may also be of value to services attempting to define disease-specific pathways, despite being weak evidence due to the differences in service delivery.

Tiberg et. al have a comprehensive series of research papers published from 2012-2015 which assess "hospital based home care" (HBHC) for paediatric patients newly diagnosed with Type 1 diabetes. In the HBHC group, patients received care in a home-like environment, not their actual homes, and were supported by nurses in the facility. Still, the studies showed equivalence between hospital and HBHC for metabolic control and insulin dose at 6- and 12-months after diagnosis. Parental satisfaction and social functioning after diagnosis were also improved with HBHC.³⁵⁻³⁷

Other excluded evidence included papers assessing palliative care at home, mental health care, chemotherapy or any service models which required the patient to attend outpatient clinics as an alternative to hospital admission. For example, to receive antibiotic therapy. The definition of hospital at home in Scotland does not encompass outpatient parenteral antibiotic therapy (OPAT) but does include where antibiotic therapy is delivered in the patient's home.

2.3 Health and social care policy landscape

2.3.1 Public Bodies (Joint Working) Scotland Act 2014

The Public Bodies (Joint working) Scotland Act 2014 identified four key objectives.

- Health and social care services should be firmly integrated around the needs of individuals, their carers and other family members.
- Health and social care services should be characterised by strong and consistent clinical care and professional leadership.
- The providers of services should be held to account jointly and effectively for improved delivery.
- Services should be underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve, rather than the organisations through which they are delivered.

Under the act, unscheduled care is delegated to integration authorities which comprise of local authority and NHS board decision makers. Agreement from relevant integration authorities is therefore key to the acceptance and funding of hospital at home services in regions across Scotland.

2.3.2 Scottish Government Operational Improvement Plan

In March 2025, Scottish Government published their Operational Improvement Plan (OIP). This builds on NHS boards' individual delivery plans and lays out commitments and actions for NHS Scotland to deliver against the vision for NHS renewal and improved experience for patients. The plan focuses on four key areas:

- improving access to treatment
- shifting the balance of care
- improving access to health and social care services through digital and technological innovation, and
- prevention of illness by working with people to proactively meet their needs.

Shifting the balance of care is a term used to describe the alleviation of pressures on acute hospitals, by caring for more people in the community. Hospital at home helps deliver on this in two ways, via admission avoidance and early supported discharge pathways.

The OIP clearly states the government vision for the expansion of hospital at home services by December 2026. This includes the broadening of pathways beyond the traditional remit of older adult acute care, to include paediatric services.

2.3.3 Health and Social Care Service Renewal Framework

Alongside the Operational Improvement Plan, Scottish Government published the Health and Social Care Service Renewal Framework in June 2025. This lays out changes required to improve how people experience health and social care in Scotland. The framework explicitly states that it can be applied to care of people of all ages in Scotland. The changes are underpinned by five key principles: prevention, people, community, population and digital.

Hospital at home delivers against the people and community principles which focus on person-centred, 'value based' healthcare. This approach empowers patients and promotes the shift from hospital-based models to a higher proportion of care delivered in the community.

The framework also states that, as part of its commitment to shifting the NHS towards people-led and value-based health and care, local areas should be empowered to embed Getting It Right For Every Child (GIRFEC) and the Team Around the Person Toolkit, to develop a model which fully supports families.

2.3.4 Realistic Medicine and Value Based Health & Care

Realistic Medicine puts the person receiving health and social care, and their priorities, at the centre of decisions made about their care, recognising that a one size does not fit all, and moving away from a 'doctor knows best' culture. It advocates for shared decision-making about treatment in line with the patient and family wishes. It also takes a healthy approach to risk, and is open with patients and families, allowing them to decide what is best for them. It aims to reduce overtreatment and unnecessary medical interventions. It also encourages innovation and improvement, while recognising that excessive variation in the outcomes of care can be service-driven and potentially harmful.

Value Based Health & Care (VBH&C) also advocates for person-centredness. It focuses on treatment that is of value to the patient personally, not just in terms of cost. VBH&C is about healthcare providers working in partnership with patients and their families and understanding what matters most to them. This approach is intended to promote the sustainability of NHS Scotland services. It looks to do so by optimising the use of healthcare resources where they are needed most, reducing harm and waste in the process.

The principles of Realistic Medicine and VBH&C should thread through all healthcare provision, including for children. This includes delivering care in the most appropriate setting for the patient and involving them as key stakeholders in this decision. Hospital at home can provide an alternative care setting for children and families who would prefer to avoid a hospital admission. This is possible providing they have an appropriate home environment, and the child's care can be safely delivered there. As per the United Nations Convention on the Rights of the Child (UNCRC),

children capable of forming their own views have the right to express them freely in matters affecting them. This includes in relation to their healthcare. The UNCRC is described in more detail in the next section of this document. Scottish Government have published guidance for professionals relating to children and young peoples' participation in decision making³⁸. Being cared for at home can also provide patients with more choice about how care is delivered, compared to the options in hospital. For example, a parent or their child may prefer the parent to provide non-clinical aspects of care. The home setting could facilitate this as an option.

2.3.5 United Nations Convention on the Rights of the Child (UNCRC) (Incorporation) (Scotland) Act 2024

The UNCRC was incorporated into Scottish law by the UNCRC (Incorporation) (Scotland) Act 2024. Thus, the UNCRC is now interpreted as law in Scottish courts. This highlights Scotland's commitment to putting the rights of children and young people into law and to applying the convention. Not all rights in the convention are relevant to hospital at home. However, some have a clear link to how services should be designed and delivered. These include:

- Right 3 (Best interests of the child),
- Right 9 (Keeping families together),
- Right 12 (Respect for children's views), and
- Right 24 (Enjoyment of the highest attainable standard of health), among others.

Paediatric and neonatal hospital at home services should ensure that their service considers and adheres to the Act. This can be done through completing and reflecting on the 54-article checklist often included as part of an equality impact assessment (EQIA). Hospital at home as a model of service delivery can contribute positively to several of the rights.

2.3.6 Getting it right for every child (GIRFEC)

GIRFEC is Scottish Government's commitment to supporting children and young people to reach their full potential, by ensuring that they and their families and receive the right support when they need it. GIRFEC has its roots in various reports and plans from the early 2000s.

GIRFEC provides a consistent approach to using and promoting various wellbeing indicators combined under the acronym SHANARRI. The SHANARRI indicators are used to understand a child or young person's wellbeing and respect their rights. GIRFEC is not exclusive to healthcare but expects all practitioners supporting a child or young person's wellbeing to respect its principles and values. Key aspects of SHANARRI that relate to paediatric hospital at home include:

- "Healthy – having the highest attainable standards of physical and mental health, access to suitable healthcare, and support in learning to make healthy and safe choices."
- "Nurtured – growing, developing and being cared for in an environment which provides the physical and emotional security, compassion and warmth necessary for healthy growth and to develop resilience and a positive identity."

- “Respected – being involved in and having their voices heard in decisions that affect their life, with support where appropriate.”

Hospital at home can support babies, children and young people to live healthy lives by offering safe and effective care in their homes. At home, they can receive treatment in an environment less disruptive to development and they can be supported more easily by family. Hospital at home also seeks to respect children and young people, as well as their families. It does so by offering them choice, where possible, about where and how they would like to be treated.

Scottish Government reaffirmed their commitment to GIRFEC by embedding it in law via the Children and Young People (Scotland) Act 2014.

2.3.7 The Best Start: Strategic Plan for Maternity and Neonatal Care

This review, announced in 2015, was conducted as part of the Scottish Government’s Transformational Change Plan. It made recommendations for a Scottish model of maternity and neonatal care that would contribute to the Scottish Government aim to deliver person-centred, safe and effective care. The review process involved engagement with service users, staff and service providers, as well as an assessment of the currently available evidence and data.

Hospital at home was not an established model at the time so was not suggested in the plan for neonatal care. However, one of the main findings following neonatal staff engagement was that better facilities for parents to be with their babies were needed, as well as additional support for early discharge home. Hospital at home has the potential to keep families together and supports them to return home at an earlier opportunity.

2.3.8 Other related policies and guidelines

The [Patient Rights \(Scotland\) Act 2011](#) set out new rights for healthcare patients. The act is primarily a vehicle for introducing the patients’ rights charter. The charter sets out rights and responsibilities for patients. This includes both what patients should expect, as well as what is expected of them. There are many links to hospital at home, without any explicit mentions of the service. The act gives all patients the right that the health care they receive will consider their needs and encourage and enable them to take part in decisions about their health and wellbeing. These are components of hospital at home. In neonatal and paediatric hospital at home services, parents or carers are more likely to make decisions. However, patients should be involved in decision making as much as possible.

[Keeping the Promise](#) (2022, updated 2024) is a commitment by Scottish Government to implement over 80 recommendations made by the Independent Care review in a 2020 report. The ‘promise’ is “that all Scotland’s children and young people will grow up loved, safe and respected so they can realise their full potential.”

The Promise looks to support care experienced children. It makes few references to healthcare and hospitals. It does mention the importance of health service reform and of shifting the balance

of care closer to home. Hospital at home offers an alternative to traditional hospital-based care by moving care into the home.

The [national health and wellbeing outcomes framework \(2015\)](#) applies across all integrated health and social care services. It ensures that they are clear about their responsibilities for shared priorities. Integration authorities are required to publish annual performance reports setting out how outcomes are being improved. There are nine outcomes specified in the framework, including that “People who use health and social care services have positive experiences of those services, and have their dignity respected.”

The outcome states that people should expect to have their views listened to, and services will respond to their suggestions. Hospital at home services are an example of giving patients the choice about where they are treated. There are no specific references to neonatal or paediatric services, or hospital at home, in the framework, as it applies across the health and care sector.

The National Institute for Health and Care Excellence (NICE) guideline [Babies, children and young people’s experience of healthcare \(2021\)](#) sets out recommendations for babies, children and young people (aged 17 and under) accessing health services. The guidelines apply to the target population regardless of the acuity of their health needs. The guideline offers information for healthcare professionals, children, young people and their parents or carers.

Sections 1.8 (on the healthcare environment) and 1.9 (on maintaining usual activities) are particularly relevant to neonatal and paediatric hospital at home services. Section 1.8 highlights that babies, children and young people should receive their healthcare in an environment that suits their (or their parent or carer’s) preference about place of care. For some, this might mean that receiving hospital care at home is the best option. Services such as hospital at home allow the NHS to respond flexibly to the desires and needs of patients. The home may not meet all criteria set out in the guideline. For example, the guideline suggests the healthcare environment should be “calm, with as little disturbance from background noise as possible” and with “separate treatment areas from those for play and recreation”. This may not be possible in every home. Patients, parents or carers, and hospital at home staff must be responsive to their own context.

[Facing the Future: Standards for children and young people in emergency care \(2025\)](#) sets out standards for children and young people in emergency departments. Standards 1 & 3 call for an integrated whole pathway approach, the provision of alternative care pathways, and that the needs of children and young people are met at the right time and in the right place. The standards note the dangers of crowding in emergency care departments. They then go on to suggest that hospital at home can offer an alternative model of care which could help manage emergency department overcrowding.

3.0 Next steps

Healthcare Improvement Scotland is supporting a national programme for the roll out and improvement of neonatal and paediatric hospital at home services in Scotland. If you would like to learn more about the programme and how your service could be involved, please contact us at his.communitycare@nhs.scot.

3.1 Other tools and resources

A UK-wide Hospital at Home Society launched on 5 March 2020. The Society supports the development of specialist acute care through hospital at home, shares best practice and contributes to the evidence base. Their website is available at www.hospitalathomeuk.org.uk.

Resources are also available on the World Hospital at Home community website <https://whahc-community.kenes.com/>.

Healthcare Improvement Scotland operates a national learning system for all involved in the design and delivery of hospital at home services. This learning system includes the production of resources, hosting of in-person and virtual networking events, webinars and learning sessions. A selection of resources are shared on the Healthcare Improvement Scotland [website](#).

There are additional resources available upon request via email or via our Microsoft Teams community channel. The Microsoft Teams channel also allows you to chat with neonatal and paediatric hospital at home colleagues across Scotland and share learning and insights. You can request to join our [Microsoft Teams channel](#).

3.2 Can you help us?

To help us develop the next iteration of the neonatal and paediatric hospital at home guiding principles for service development, we need the input of hospital at home professionals across Scotland. We plan to develop the next iteration of this document using the real-world experiences of the teams we work with. Using such examples, we will be able to provide evidence for what works, and what doesn't, when implementing services.

We would also like to continue to develop case studies with neonatal and paediatric hospital at home teams across Scotland. This will help us, and you, to demonstrate the impact hospital at home is having on this patient population. We have developed resources to help teams write case studies which we can share with you.

If you think you could help us, please get in touch at his.communitycare@nhs.scot.

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