British Geriatrics Society
Improving healthcare for older people

# Bringing hospital care home: Virtual Wards and Hospital at Home for older people

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#BGSVirtualWards

# Contents



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# 1 Introduction

**In recent years, healthcare professionals have been considering new ways to respond to the acute care needs of older people with frailty and other long-term conditions. Urgent care is needed but hospitals bring risks for older people as well as benefits, and community-based alternatives are increasingly being explored. This has resulted in a shift in focus within the NHS and internationally towards providing hospital-level care in a person's home environment.**

While these services are traditionally referred to as 'Hospital at Home,' a broader programme of work has recently been introduced by NHS England using the term 'Virtual Wards'. This includes models based on remote monitoring and advice as well as the face-to-face care provided by Hospital at Home models. The different models have the same aim – to provide a safe, effective and person-centred alternative to hospital inpatient care.

Hospital at Home is the most commonly used term to describe these services, both in the UK and overseas. Hospital at Home is delivered as a time-limited face-to-face service by healthcare professionals visiting patients at home. The term 'Virtual Wards' can cause some confusion as many people assume the word 'virtual' to mean 'remote' or 'online'. Virtual Wards have also been treated separately from Hospital at Home by health researchers. However, within the NHS England model, Virtual Wards for older people operate in a similar way to Hospital at Home, with the vast majority of care being face-to-face.

For many older people, hospital admission presents a risk of harms such as deconditioning, delirium and hospital-acquired infections. Receiving treatment and rehabilitation at home may be beneficial, and preferable to hospital admission or to a longer inpatient episode.

Many BGS members have been involved in providing an urgent community response and intermediate care services at home for some years, as described in our *Right Time Right Place* publication.[1] These are time-limited multidisciplinary services that offer urgent community assessment, treatment, rehabilitation and support as 'step up' or 'step down' from acute hospital care. Specialist practitioners working in intermediate care services often provide some short-term intensive hospital-level care too.

In many parts of the country, health and care systems are actively encouraged to establish services that provide hospital-level care to people in their homes. Yet some BGS members have told us that it is unclear how Virtual Wards and Hospital at Home services are being funded and introduced in England. They have asked for information on how these new models of care are being implemented in different areas and how they can be developed in a way that adds value to established intermediate care and urgent community response services for older people.

This paper will summarise the current landscape from the perspective of healthcare for older people and provide some advice to BGS members looking to set up Virtual Wards for older people living with frailty. It is important to note that Virtual Wards and Hospital at Home are not exclusive to older people and can be used to care for a range of population groups with different health conditions. As the BGS is solely concerned with older people's healthcare, this paper discusses Virtual Wards and Hospital at Home within that context only.

While there are many different names for these new services, for the purposes of this paper, we will use the term 'Virtual Wards'.

# 2 About Virtual Wards

## Definitions

**We have heard from BGS members that there is a great deal of confusion around Virtual Wards and that the term means different things in different parts of the country. This section will endeavour to provide an explanation of the terms currently in use by different healthcare providers.**

There are two main types of Virtual Ward that are eligible for funding from NHS England: Acute Respiratory Infection (ARI) Virtual Wards and frailty Virtual Wards (otherwise known as Hospital at Home for Frailty).[2]

**Hospital at Home** is not a new concept – it has been operating successfully in many parts of the country for years. The UK Hospital at Home Society describes Hospital at Home as providing 'intensive hospital-level care for acute conditions that would normally require an acute hospital bed, in a patient's home for a short episode through multidisciplinary healthcare teams.'[3] A Royal College of Physicians (RCP) Wales document defines Hospital at Home as providing short-term, intensive, hospital-level care for acute medical problems in a patient's home.[4] This care is provided by multidisciplinary healthcare teams led by a senior clinician. The team can offer urgent access to relevant blood tests, ultrasounds and hospital-level diagnostics and interventions and give access to the same specialty advice as would be provided for any hospital inpatient.

A **Virtual Ward** is a time-limited service enabling people who have an acute condition or exacerbation of a chronic condition requiring hospital-level care to receive this care in the place they call home, either as an alternative to hospital admission or by facilitating an earlier discharge from hospital.

The Virtual Ward delivers a variable combination of remote monitoring and face-to-face treatment in the person's normal place of residence (at home or in their care home). Virtual Wards applying for NHS England funding will include an element of technology to help staff to monitor patients remotely. The type of technology used will vary between systems. Treatment is provided by specialists from hospital and community teams working alongside other healthcare professionals from community or primary care.

Virtual Wards are not intended for the ongoing management of a long-term health condition. Chronic care and end of life care that would normally be provided by primary care or community health services are not considered to be part of a Virtual Ward. Virtual Wards do not provide social care for patients who require support to return to their normal place of residence.

## Four nations context

Provision of hospital-level care at home varies considerably between the four nations of the UK and also within each of the nations themselves. All four nations of the UK have services providing hospital-level care at home but this is far from universal. Some services have been operating successfully for many years while others are just getting started. The availability of funding for these services varies between different parts of the country.

In England, £200 million is available nationally to support the setup and development of Virtual Wards in 2022/23. In 2023/24, a further £250 million will be available on a match-funded basis. From 2024/25, there is to be no ringfenced recurrent funding for Virtual Wards.[2] As such, systems will be required to build Virtual Wards into long-term strategies and operational budgets to ensure they can be sustained after the ringfenced funding has come to an end. It is important to note that this funding from NHS England is not restricted to frailty Virtual Wards – systems are being asked to prepare their plans for Virtual Wards which can include Virtual Wards for frailty, ARI Virtual Wards and Virtual Wards for other conditions such as heart failure.

Integrated Care Systems (ICSs) have been asked to plan for 40 to 50 virtual beds per 100,000 population by December 2023.[2] A full breakdown of funding allocations by ICS is available in the letter to systems from NHS England dated 19 April 2022 which can be accessed through the NHS Futures platform.

**NHS England[5] have identified nine principles upon which a Virtual Ward should be built. These principles state that Virtual Wards should:**

1. Provide acute clinical care delivered by a multidisciplinary team (MDT) if clinically appropriate, led by a named consultant practitioner (including a nurse or AHP consultant) or suitably trained GP with relevant experience and training, with clear lines of clinical responsibility and governance.
2. Have clearly defined criteria to admit and reside, supported by daily clinical review, by an MDT if clinically appropriate, to provide a safe and robust service.
3. Ensure that patients are given clear information on who to contact if their symptoms worsen, including out of hours. There should be clear pathways to support early recognition of deterioration and appropriate escalation processes in place to maintain patient safety. Training on escalation processes should also be provided to carers, staff, the MDT, etc as necessary.
4. Provide patients (and/or their carers) with adequate information to allow informed consent and understanding of their care, and to support the use of equipment or digital technology such as mobile phones, apps, web-based tools or wearables.
5. Have access to specialty advice and guidance/diagnostics equivalent to acute hospital access as appropriate to enable timely clinical decision-making.
6. Deliver time-limited interventions and monitoring based on the clinical need for a secondary care bed.
7. Be fully aligned or integrated with other service development programmes, including urgent community response (UCR), same day emergency care (SDEC) and unscheduled care across their systems.
8. Be developed for a range of conditions/symptoms/settings and should track specific metrics that measure appropriate outcomes to demonstrate patient safety and sustainability.
9. Ensure that the use of digital technology does not exclude any patient group, and offer alternatives should patients lack the ability to fully use the technology.

The Scottish Government has recently announced additional investment of £3.6 million with the aim of doubling Hospital at Home capacity by the end of 2022. The Scottish Government has invested £8.1 million in Hospital at Home services since 2020.[6] Health Boards in Scotland are required to provide Hospital at Home services and many services have been operational for several years. BGS members in Scotland have suggested that the majority of the successful Hospital at Home services are operating in cities and urban areas. Providing Hospital at Home for Scotland's significant rural and island population is a greater challenge. The ambition of doubling capacity by the end of 2022 may not be realistic.

Hospital at Home and Virtual Ward services have been operational in Wales for several years but are not as widespread as in other parts of the UK. There is also no central support from Government to increase the provision of hospital care closer to home. The RCP have called for additional investment in Welsh health and care services closer to home.[4]

Hospital at Home services have been operating in Northern Ireland for some time with the Department of Health hosting and chairing a project conducting quarterly reviews of regional activity such as patient numbers and time to assessment by Hospital at Home teams. This aims to support a common approach to language and metrics and enable the sharing of progress and good practice.

# 3 What is the evidence?

**A recent rapid synthesis[7] of existing systematic reviews identified 32 papers relating to Virtual Wards, Hospital at Home or remote monitoring as alternatives to inpatient care or admission. While these reviews were not limited to studies of people with frailty, many participants in the included primary studies were older and/or had one or more chronic conditions. The most mature evidence base to inform design of Virtual Wards is from reviews of Hospital at Home.**

The synthesis found some evidence that providing hospital-level care in an individual's home environment can improve their care experience and outcomes and deliver benefits for patients, carers and health and care systems.

## Clinical effectiveness

There is a substantial evidence base on the clinical effectiveness of Hospital at Home – both admission avoidance and early supported discharge models. Multiple Cochrane reviews exist which suggest that most outcomes, including mortality, are probably at least equivalent to those of inpatient care, while subsequent admissions to residential care may be lower. The evidence on length of stay is mixed, with some studies showing that step up models of care can increase length of stay. This is likely to indicate identification of unmet need in patients who otherwise would have received less comprehensive care, and it should not necessarily be seen as a negative. While systematic reviews of COVID-19 Hospital at Home services exist, these primarily focussed on respiratory and mortality outcomes. Because of the very specific context of COVID-19 care, these should not be conflated or combined with the broader literature on Hospital at Home for older people with frailty.

Recent evidence syntheses identified aspects of patient selection as important factors in the success of care involving remote monitoring at home, but also elements of organisational and staffing structures and provision. The review also highlighted the need for guidance on multiple aspects of service design and provision, including staff competencies and data protection. These factors are reflected in, and supported by, research on staff views of Hospital at Home, where concerns centred on unclear and underdeveloped workflows, difficulties identifying patients who would be suitable for Hospital at Home, and increased staff burden.

It is important to recognise that all studies of Hospital at Home have used clinician judgement to select patients for the service. The choice of selection criteria has not been extensively researched and further evidence will be required around this if services are to be delivered in a consistent and effective way. Hospital at Home services which were simple and easy to use, relevant to the patient, and which supported patients' self-management were more likely to be successful. Co-development of remote interventions with patient groups was identified as a factor in success, while reviews in COVID-19 patients identified use of telephone-based interventions as more inclusive for people who lacked internet access or digital literacy.

## Cost effectiveness

In terms of cost-effectiveness there is uncertainty about the extent to which Hospital at Home is cost-saving, with a recent review finding that most primary studies were designed and conducted in a way that made them likely to over-estimate such savings. Research to date has also been mainly conducted from a health service rather than a societal perspective, and has excluded costs to patients and their families; where these were included, they were found to be substantial.

## Patient satisfaction

Cochrane reviews of Hospital at Home found that patient satisfaction may be greater than for inpatient care. This was supported by a recent meta-synthesis which highlighted positive aspects such as more comfortable and patient-centred care and greater family engagement. It is important to realise that satisfaction data come from a highly selected patient group who were not blinded in the context of clinical trials and this should not be taken as evidence that all patients would prefer Hospital at Home. The literature also raises concerns about increase in caregiver stress and burden and concerns about lack of round-the-clock input from healthcare professionals. The meta-synthesis identified the need to involve caregivers throughout the process, including when patients are being admitted into Hospital at Home services, in order to mitigate the impact on them. It is important that Hospital at Home should work for both patients and their caregivers.

## System benefits

Hospitals and integrated systems may benefit from reduced emergency bed days and improved flow. Hospitals are under pressure to catch up on the elective backlog that has developed during the COVID-19 pandemic. Virtual Wards may release inpatient capacity that will help with achieving a reduction in elective waiting times.

The above conclusions are highly caveated, because of the limited way in which Hospital at Home services have been deployed in clinical trials. The implementation of such models at scale in a health service with finite staff resource and which is already operating at maximum capacity remains uncertain. Careful evaluation of the service impacts of Hospital at Home should be part of implementation.

# 4 Top tips for getting started

## Understand your local population and geography

Virtual Wards can take a number of forms and treat a variety of patient groups in different geographies. A coastal, rural or island area will have different needs to an urban centre and it is important that these differences are recognised and accounted for when developing a service. A more geographically dispersed service will need to account for travelling time between patients and therefore may not be able to take on as many patients as an urban service, or may need more staff to care for the same number of patients. Conversely, an urban service will face different challenges, including traffic and parking difficulties when visiting patients at home.

## Be clear about the care you provide and for whom

It is important for Virtual Ward teams to be clear about who they treat and, specifically, who they do not treat. A lack of understanding of the purpose of Virtual Wards among healthcare colleagues means that Virtual Ward services can sometimes be considered a backstop for all other services. Virtual Wards should not be used to treat patients who can be more appropriately cared for by another service. Once your Virtual Ward is established and ready to admit patients, make sure your colleagues know about your service and the population you care for.

It is important to discuss with patients and carers what their wishes and preferences are. If a patient expresses a preference for receiving treatment at home rather than being admitted to hospital, efforts should be made to enable this. However, it is important to note that this type of care will not be suitable for all patients and not all older people with acute conditions will want, or be able, to be cared for in such a service. For some patients, hospital will be the safest place for them to be. This may be because of their medical condition or because they do not have the support they need to stay at home. In many cases, older people will have family members who can support them to be at home.

BGS members who have been operating Hospital at Home services for some time tell us that an older person living alone with no family support is not necessarily excluded from being cared for by the Hospital At Home team, but their situation does make things more challenging. It may be helpful to think of the acronym DOT[†] when considering whether a patient is suitable for Hospital at Home:

- **Drink** – can they get a drink on their own, or do they have someone who can get it for them?
- **Once a day** – can they cope with a visit from the team only once a day?
- **Toilet** – can they get to the toilet on their own, or do they have someone who can help them?

If a patient meets all three of these criteria, they are more likely to be suitable for Hospital at Home care.

[†] *The DOT acronym was created by Dr Patricia Cantley and is reproduced here with her consent.*

It is also important that patients and families are not pressured into receiving care at home if this is not their preference. BGS members tell us that when a patient is admitted to the Hospital at Home service and they or their family are not happy about this, they may call an ambulance once the team has left the house. This can be avoided through honest communication with patients and families about how the service works and what to do if the patient's condition deteriorates. If a patient does need to be admitted to hospital after assessment by a Hospital at Home team, this may assist staff at the hospital as a Comprehensive Geriatric Assessment and diagnostics may already have been carried out.

## Visit other services

Services providing hospital-level care to people in their own homes have been operating successfully for several years in parts of the country. In establishing your own service, there is no need to reinvent the wheel. You may find it helpful to make contact with colleagues elsewhere who are already delivering the type of service you are aiming for. You could visit other services to help you understand how you might want to develop your local model. The UK Hospital at Home Society (**www.hospitalathome.co.uk**) will be able to put you in touch with an appropriate service who would be happy to host visitors and share business cases.

## Start small and learn as you go

For services struggling to start providing a Virtual Ward, it may be easier to begin with a limited service, such as providing support to enable people to be discharged from hospital earlier rather than launching a full Hospital at Home service from the outset. This will still have an impact on patient experience as patients will be able to recover in their own homes with the support of the hospital team. It will also help to relieve pressure on hospitals as beds will be freed up sooner.

NHS England guidance advises Virtual Wards to provide a service 12 hours a day (8am until 8pm), seven days a week. This may not be achievable for many services, at least to start with, and some may prefer to start with a 9am-5pm service, moving to longer hours once established. Virtual Wards do not tend to be a 24-hour service and it will be important to ensure there are clear processes for patients who require support outside of the normal hours of the service. This is likely to be through routine out-of-hours GP services or advice to contact 111 or 999 services. Treatment escalation plans and advance care planning conversations are an important aspect of Virtual Wards, to help ensure the right decisions are made if a patient deteriorates out of hours.

## Build on and integrate with the services and workforce you already have

Consider the services that you already have before trying to implement something new. It may be that you have an existing rapid response service that could form the basis of a Virtual Ward or Hospital at Home service.

Workforce will be a key consideration and it will be important to understand whether a Virtual Ward can be staffed by those already in post or whether you will need to recruit to new roles. The available workforce (or funding, if new roles need to be recruited) will play a big role in determining the level of service you can offer.

The NHS is experiencing a workforce crisis and it is understandable that the workforce requirements of providing hospital-level care at home may seem daunting to those who are struggling to fill rotas in hospitals. In order for systems to provide hospital-level care at home for older people with frailty, it will be important to invest in the skillset of the community workforce and to enable senior clinicians to remain in clinical roles as they progress rather than being obliged to move into purely management positions. Advanced Clinical Practitioners (including both nurses and allied health professionals) should be included in workforce models to ensure that services have capacity at a senior decision-making level.

Many healthcare professionals are accustomed to working in relatively predictable environments such as hospitals or clinics where they have direct support and supervision from colleagues. Going into someone's home, perhaps alone, is a different experience as one can never predict what one will find. Virtual Wards teams should be supported to develop the confidence to work in this setting. Indeed many teams benefit from clinicians with prior experience in community and primary care.

The evidence around optimal workforce for Virtual Wards is still evolving. However, NHS England have published five good practice recommendations[2] for Virtual Ward workforce models:

1. Appropriate clinical leadership and governance in place.
2. A competency-based approach, avoiding assumptions about professional boundaries and early investment in workforce development and training.
3. Integrated working across health and social care.
4. Appropriate use of technology with training and supervision.
5. An incremental approach to improvement and growth.

### Develop good relationships

The success of providing hospital-level care at home will depend on strong relationships between services to ensure that patients receive the best care for them in the most appropriate setting. Some patients may be admitted to a Virtual Ward service and deteriorate, necessitating admission to hospital. Systems must be in place to enable this to happen quickly without hospital admission being seen as a failure by any party. Good relationships between services and with social care providers will be essential and these will take time to develop and build.

### Invest in leadership and governance

Guidance from NHS England states that Virtual Wards must have appropriate clinical leadership and governance and should be clinically led by a named registered consultant practitioner. This individual can be a doctor, nurse or allied health professional and they should have knowledge and capabilities in the relevant specialty or model of care. When planning Virtual Wards it will be important to establish where the governance and accountability lies. In some areas Virtual Wards may be led by and report through the acute hospital while in other areas they may be led and governed through community services.

### Explore technology-enabled care

Part of the appeal of the Virtual Ward model is the ability to monitor patients remotely using day-to-day technologies and wearables. Healthcare professionals could monitor patients and provide advice without visiting them (if no other processes of care are required in person) without the need for patients to attend a hospital or clinic.

However, in contrast to the evidence for remote monitoring of chronic conditions, evidence on how best to implement remote monitoring for acutely ill patients at home or in care homes is currently lacking. It may be that the use of technology in Virtual Wards is greater among younger patients with acute respiratory illness. Many BGS members who have delivered hospital-level care at home for some years have told us that the use of remote monitoring for older people with frailty and other complex conditions is limited. While patients may be issued with a pulse oximeter or asked to monitor their weight, other remote monitoring devices are not routinely used in this population.

It is important to ensure that older people with frailty who may not be confident using technology are not excluded from using technology likely to be beneficial to their care.

While many patients on a Virtual Ward may have help from family or formal carers, some will not, and it is important that this group is not excluded. Ideally, equipment should be simple enough for patients to use independently, without the help of healthcare professionals, family members or carers. Consideration should also be given to those with cognitive, hearing or visual impairments and tools should be developed with this group in mind.

Clarity on what technology is available and for what purpose will be essential if services are to be successful. It is also important to ensure services have ongoing funding for this equipment and that the supply is stable.

## 5 Conclusion

**The BGS welcomes the focus across the UK on providing hospital-level care for older people at home. We know that many BGS members have been providing these services for years with good outcomes. We also know that many patients speak very highly of the care they have received in these services and are very grateful to have been able to stay at home rather than be admitted to hospital. Sustained increased funding for older people's care closer to home can only be a good thing.**

However, it must be acknowledged that not all systems are ready to adopt this model of care. For instance, if services in England are struggling to provide Urgent Community Response, as they have been required to do since April 2022, they are probably not ready to provide hospital-level care at home. Systems should be realistic about whether they can provide this new model of care without a detrimental impact on the quality of care in hospital and in the community if staff are spread too thinly. We are also concerned about the non-recurrent nature of the funding available from NHS England for these services. Funding is only available for the first two years of operation, with the second year required to be match-funded by systems. BGS members who have been involved in establishing these services have told us that pump-priming funding is required for at least the first four years of operation.

It is also important to be realistic about the number of people who can be cared for through providing hospital-level care at home. These services will not be appropriate for all, or even the majority of, older people. For some people, hospital will remain the most appropriate and the safest place to be, at least for initial assessment and rapid diagnostics.

Much of the rhetoric has been about significantly increasing the number of Virtual Ward 'beds' and, in turn, closing wards in acute hospitals. In a system that is under extreme pressure in terms of workforce and finances, providing hospital-level care at home for a select group of older people may release valuable inpatient capacity that can be used to address the elective backlog.

Commissioners face a dilemma when making the decision to set up these services. There is always an opportunity cost of providing any service, particularly when systems are already resource-depleted. For many, deciding to establish new services will mean deciding not to advance or further develop existing services. Local systems will need to make

evidence-informed and data-driven decisions when deciding which services are likely to add value to care provision in their area and be of the greatest benefit to the population they serve. In particular, they will need to carefully consider the balance between short-term intensive Virtual Ward capacity and other evidence-based community interventions such as intermediate care, reablement and rehabilitation that enable independence and reduce future demand for health and social care. To reduce duplication and fragmentation of services, commissioning for these new models of care should consolidate and strengthen existing intermediate care and urgent community response services.

Across the UK, local partners in integrated systems are charged with working together to make best use of the available funding and the workforce capacity from all sectors in order to improve population health. To enable more people to receive treatment, care and rehabilitation at home, healthcare staff must be prepared to work more flexibly between hospital and community in nimble teams that have the appropriate skill mix and with adequate social care support. BGS calls for system-wide and sustainable plans to provide safe, effective and person-centred care for all older people in the most appropriate place at the right time. That means carefully balancing resources for Virtual Wards with strategic investment across the whole continuum of care from prevention and proactive anticipatory care to hospital inpatient care and, critically, other evidence-based models of community assessment, response, rehabilitation and support. Commissioning decisions must also address the root cause for our current gridlocked system – long-term underfunding of social care and a critical shortage of carers, as highlighted in the BGS's *Timely Discharge* series.[8]

Bringing hospital care closer to home for older people with frailty is likely to have benefits for selected patients for whom this is appropriate. We know that BGS members who have been involved in providing these services for some time are convinced of their value. However, we also know that for those healthcare professionals looking to establish Virtual Wards from scratch, it can seem daunting. We hope that this document has provided some pointers that help them as they set up Virtual Wards for older people living with frailty.

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