Integrated Care Webinar series 2023-24

The role of integrated care systems in developing and delivering virtual wards

Thursday 1 February 2024

NHS England in partnership with the Social Care Institute for Excellence (SCIE)

Your panel today

- **Steph Somerville**, Director, Community Transformation and Virtual Wards Community Health Services, NHS England (chair)

- **James Benson**, Chief Executive of Central London Community Healthcare Trust and UEC Appointed Special Advisor to Virtual Wards

- **Steph Wedmore,** Clinical Service Manager – Virtual Wards, Rapid Response & SPR, Shropshire Community Health NHS Trust

- **Darin Halifax**, Lead for the Voluntary, Community and Social Enterprise, Integrated Care System for Devon

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Agenda

What we will discuss today

#	ITEM	TIME	FACILITATOR(S)
1	**Welcome and introduction**	10 minutes	**Steph Somerville** Director of Community Transformation and Virtual Wards Community Health Services, NHS England
2	**Role of ICBs in developing and delivering virtual wards**	20 minutes	**James Benson** Executive of Central London Community Healthcare Trust and UEC Appointed Special Advisor to Virtual Wards
3	**System approach to working with care homes**	15 minutes	**Steph Wedmore** Clinical Service Manager – Virtual Wards, Rapid Response & SPR, Shropshire Community Health NHS Trust
4	**System approach to working with VSCEs and carers**	15 minutes	**Darin Halifax** Lead for the Voluntary, Community and Social Enterprise, Integrated Care System for Devon
5	**Questions and answers**	25 minutes	**All led by Steph Somerville**
6	**Reflections and close**	5 minutes	**Steph Somerville**

Virtual wards provide hospital level care at home

virtual ward

ˈvəːtʃʊ(ə)l wɔːd

A virtual ward is a safe and efficient **alternative to NHS bedded care**.

Virtual wards support patients who would **otherwise be in hospital** to receive the acute care and treatment they need in their own home.

This includes either **preventing avoidable admissions** into hospital, or **supporting early discharge** out of hospital.

- **The acuity and complexity of the patient's condition differentiates virtual wards from other community and home-based services**
- It provides **urgent access to hospital-level diagnostics** (such as endoscopy, radiology, or cardiology) and may include bedside tests such as **point of care (POC) blood tests**
- It provides **hospital-level interventions** (such as access to intravenous fluids, therapy, and oxygen)
- It requires **daily input from a multidisciplinary team**, either in person or enabled by technology e.g. virtual consultation, and sometimes **multiple visits and provisions** for 24h cover with the ability to respond to urgent visits.
- It requires **consultant practitioner specialist leadership** and **clear lines of clinical responsibility**
- **Defined inclusion and exclusion criteria**, with defined target population and deliver a **time-limited short-term intervention** of 1–14 days.
- **Virtual ward patients have equity of access to other specialty advice as though an in-patient**.

NB: A virtual ward **is not** a mechanism intended for OPAT, enhanced primary care programmes; chronic disease management; intermediate or day care; or pro active deterioration prevention. Wider virtual care supported services (including NHS@home) are scaling to enable these cohorts to be increasingly supported at home / in the community.

Progress so far

The NHSE virtual wards programme launched in April 2022. Since then, the number of virtual wards has grown rapidly, with a focus on the priority pathways of frailty, ARI, heart failure, and children and young people. In September 2023, the target of 10,000 beds was met.

Over 317,000 people have been treated on a virtual ward since April 2022

Over 11,800 VW ‘beds’ in place currently

14,300 people were treated on a VW between 23 Nov-7 Dec 2023

The benefits seen in existing virtual wards

Virtual wards evidence and evaluations

Research and studies are providing strong evidence for the benefits of virtual wards.
* The data below is based on observations from single site analyses relating to frailty.

Patient choice and preferences

>99% **Over 99% of patients on existing virtual wards would recommend the service ***

Treatment and care in a more comfortable home environment.
Keeping patients in a place where they would prefer to be cared for in future
23% of patients treated in a virtual ward achieved a more independent social care outcome than they would have in an acute setting.*

Reducing health inequality

Development of virtual wards offers opportunities to address healthcare inequalities in target areas including COPD and frailty.

Patient wellbeing and safety

5x **Patients are five times less likely to acquire an infection *** when treated on a virtual ward compared to an acute setting

8x **Patients are eight times less likely to experience functional decline *** whilst in a virtual ward compared to equivalent treatment in an acute setting

Avoiding potential harms in a hospital setting, such as falls and delirium

More holistic assessment in home circumstances

Capacity and productivity

2.5x **Two and a half times fewer patients treated on a virtual ward are readmitted *** to frailty beds than the national acute benchmark

Frees up physical beds for other patients who require an in-patient admission

Improves integration between hospital and community services

Improved staff experience and opportunities

Enabled by technology including remote monitoring

Role of ICBs in developing and delivering virtual wards

James Benson
Chief Executive Officer
Central London Community Healthcare NHS Trust (CLCH)
and
UEC Appointed Special Advisor to Virtual Wards

Critical success factors when designing and scaling virtual wards across ICS footprints

Virtual ward services should be developed across systems and provider collaboratives, rather than individual institutions. Services can be based on partnership between secondary, community, primary, social care and mental health services and in many cases partnerships with the independent sector.

Appropriate **clinical leadership and governance** in place at a system and provider level

A **competency-based approach**, avoiding assumptions about professional boundaries and early investment in workforce development and training

Integrated ICS and place based working across health and social care considering use of provider collaboratives

Remote monitoring technology and **wider digital platforms** to deliver effective and efficient care

An **incremental approach to improvement** and growth

Integrated workforce

Appropriate **clinical leadership and governance** is mandatory for virtual wards. ICB level clinical leadership should reflect the diversity of clinical and care professions across the wider ICS partnership.

Virtual wards are **most effective** when delivered by **integrated multidisciplinary teams (MDTs)** who work beyond the boundaries of an acute hospital setting. ICBs having a significant role in **facilitating integrated working** across established teams and **aligning virtual wards to other services** such as UCR and SDEC.

To support having an integrated workforce, a **competency-based workforce model** should be used. Commissioners and providers should ensure that they have the **appropriate workforce and skill mix** in place to deliver virtual wards and meet their local population needs.

Virtual Ward and Urgent Community Response Capabilities Framework

Virtual Ward and Urgent Community Response Capabilities E-Learning Module

RELATIONSHIPS WITH EXISTING HEALTH AND CARE ORGANISATIONS

A virtual ward will need to draw **on clinical services** provided by **existing health and care organisations**, particularly in the delivery of **face-to-face care**. These could include:

- Acute Providers
- Primary Care
- Community Providers & Services
- Therapies
- Diagnostics / Pathology
- Out of hours care
- Personal Care
- Pharmacy
- Social Care
- Pathology

Virtual wards enabled by technology

The ambition is to ensure that virtual wards enabled by technology are sustainably embedded across all Integrated Care Systems in England. All virtual wards should have the capability and capacity to use technology enabled monitoring, where appropriate, to improve access to information that supports clinical decision making.

Providers should consider the technology partnerships and platforms already in place across their ICS in alignment with their digital strategy to support future scalability. Once the clinical and business needs are determined, a local requirement specification for the use of technology in a virtual ward can be developed. This should ideally be completed at an ICS level even if different technology platforms are in use in the short term to facilitate an ICS level solution longer term.

A virtual ward enabled by technology, as per the national definition, consists of (as a minimum):

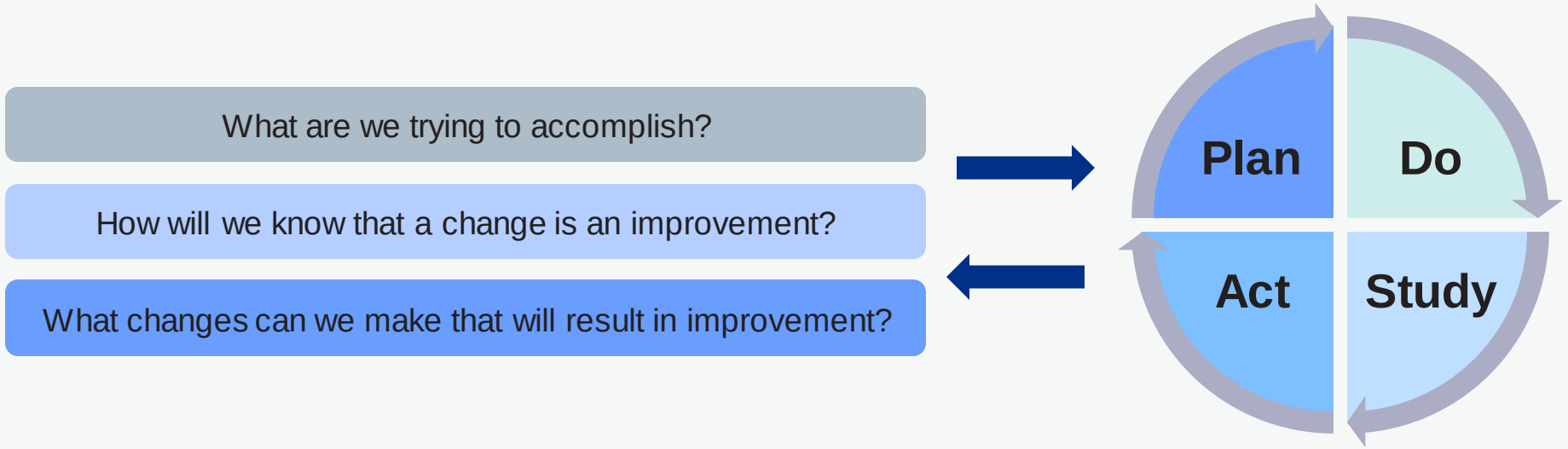
1. The ability for patients, and/or their carers, to measure and input agreed health data (for example, vital signs) into an app or website. This may also be done automatically, for example with wearable / bluetooth technology.
2. Data feed into a digital platform / dashboard which is reviewed remotely by a clinical team.
3. The clinical team are alerted when a patient moves outside of agreed parameters, or fails to enter data, so they can take appropriate and timely action.

Incremental approach to improvement and growth

Systems should be aiming to offer **consistent VW services and pathways across the whole system.** At a minimum, ICSs should ensure that **frailty and ARI** pathways are developed with both **step-up and step-down access**. System level **demand and capacity planning** should be undertaken to understand the needs of local population and to determine:

- ❑ Type of pathways needed e.g. frailty, respiratory, heart failure
- ❑ Total ICS scale required
- ❑ Workforce requirements
- ❑ Location / distribution e.g. do different places in ICS require differing saturation of capacity, alignment with major hospital patches for step down
- ❑ Step up / down required

ICBs and providers are responsible for monitoring and evaluating the implementation and effectiveness of their services. ICBs should use **quality improvement principles and methodologies** - such as Plan, Do, Study, Act cycles - to deliver the optimum model of care and incrementally increase overall system capacity.



Prioritising virtual wards

Virtual ward funding for financial year 23/24 was part of £1bn of UEC capacity funding, of which **£590m has been allocated on a recurrent basis to ICBs**. ICBs have local determination over their allocation of funding for both general/acute and virtual ward beds.

In 24/25, **systems are expected to maintain the increase in core UEC capacity** established in 2023/24 and continue to make progress on the 10 high impact initiatives outlined in the UEC Recovery Plan which includes **expanding virtual wards**.

IBCs should work with providers to **scale capacity and increase utilisation** of virtual wards across the system **investing in workforce and wider enablers** such as technology and diagnostics.

Benefits Mapping

Benefits mapping can be used to capture anticipated benefits, provide evidence-based demonstration of impact and provide assurance of investment. It also provides an easy way to track progress against anticipated benefits.

Benefits mapping can be undertaken at a system level to support discussions around funding and system wider virtual ward planning.

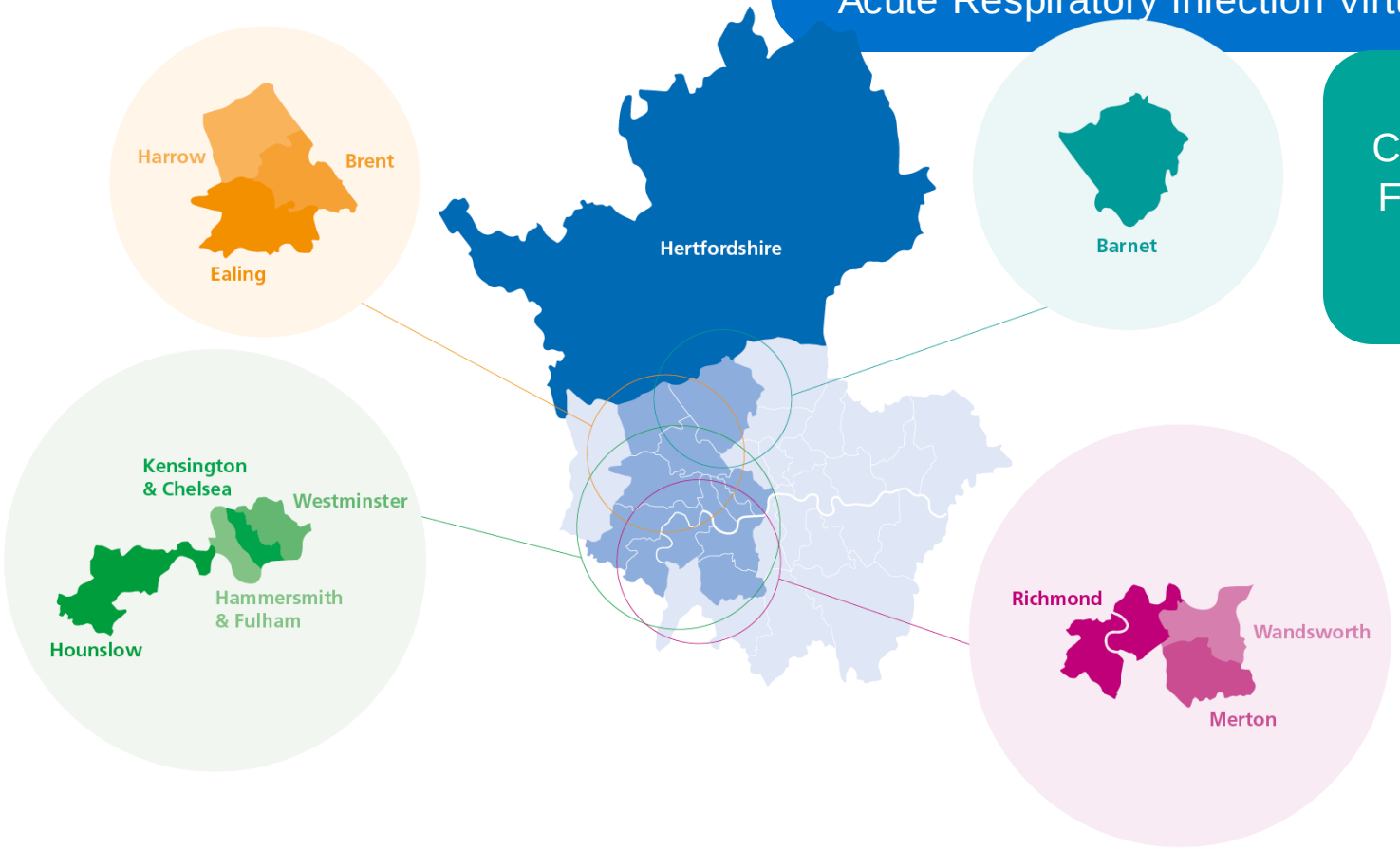
Lancashire and South Cumbria have developed a bed benefit model to support thinking around workforce and support wider estimates of bed impacts and potential social care implications which **can be accessed here.**

Innovation Collaborative: Benefits & Health Economics

Case Study: Virtual wards in CLCH

South and West Hertfordshire
CLCH lead provider
Frailty Virtual Ward

South and West Hertfordshire
Collaboration with West Herts Hospital NHS Trust
COPD Virtual Ward
Heart Failure Virtual Ward
Acute Respiratory Infection Virtual Ward



Barnet
Collaboration with Royal Free London NHS Trust
Delirium Virtual Ward
Frailty Virtual Ward

Wandsworth and Merton
CLCH Lead provider
Frailty Virtual Ward
Technology enabled Virtual Ward

CLCH virtual ward utilisation (to end of December 2023)

Virtual wards in CLCH have supported over 2,200 people to leave hospital sooner and over 600 people to receive care at home and not be admitted to hospital.

2860 patients supported on virtual wards

2221 patients supported to leave hospital earlier

639 patients supported to avoid an admission

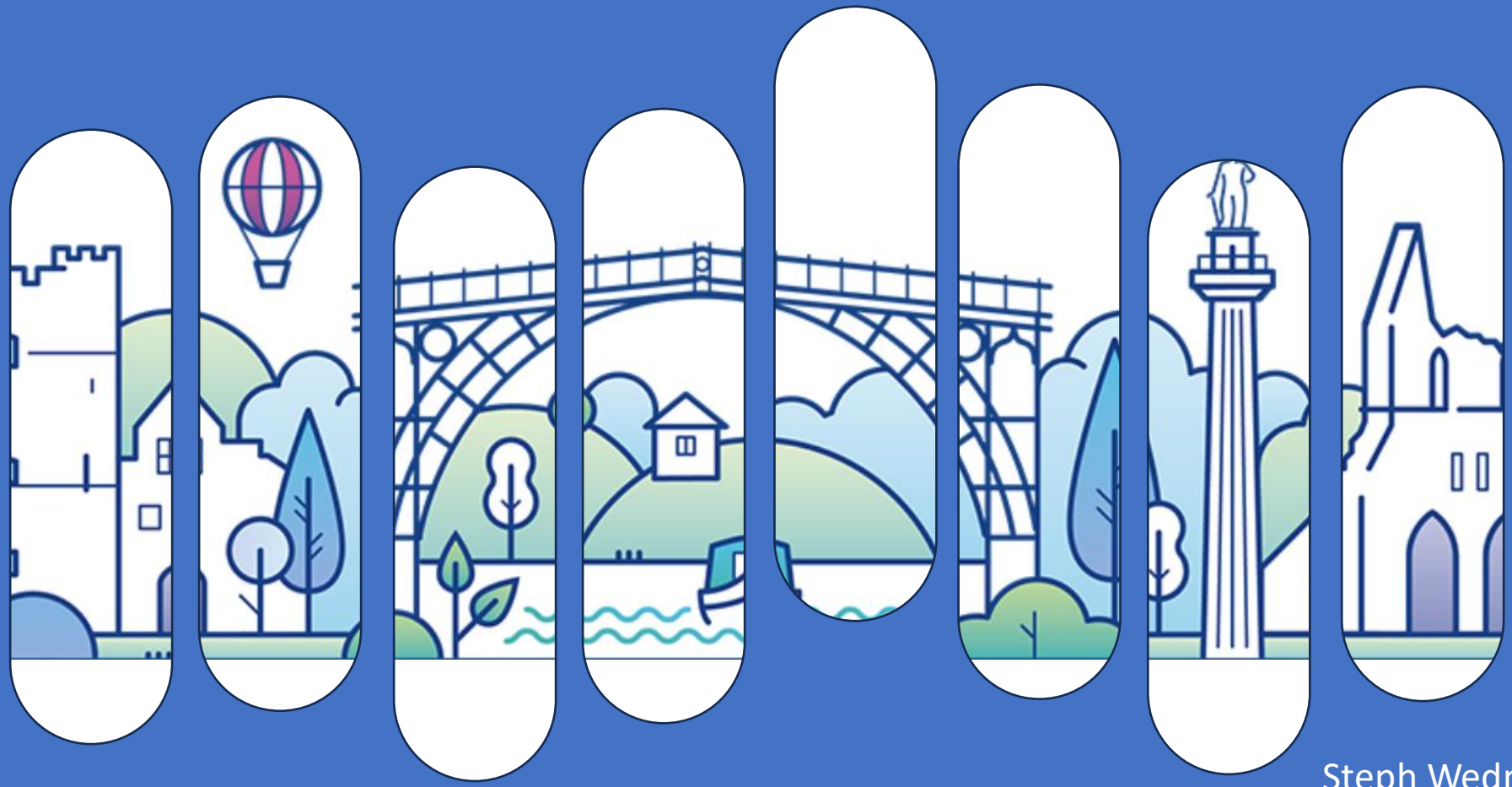
Frailty	WHHT & CLCH Heart Failure	WHHT & CLCH COPD	Delirium	Tech Enabled	WHHT & CLCH ARI
1292 patients	**534** patients	**474** patients	**65** patients	**121** patients	**374** patients
951 ESD	455 ESD	405 ESD	65 ESD	49 ESD	296 ESD
341 Step Up	79 Step Up	69 Step Up		72 Step Up	78 Step Up
December 2021	**October 2022**	**October 2022**	**May 2022**	**February 2023**	**March 2023**

Impact on Acute bed utilisation (109 Virtual ward beds) Dec 2021 - Dec 2023

Frailty **1292** patients	**Heart Failure** **534** patients	**COPD** 474 patients	**Delirium** 65 patients
4.1 bed days saved per patient	**3.3** bed days saved per patient	**2.2** bed days saved per patient	**4** bed days saved per patient

8366 Acute bed days saved through virtual wards

System Approach to Working with Care Homes



Shropshire, Telford & Wrekin ICS

Steph Wedmore
Clinical Services Manager
Jan 2024

System Approach to Working with Care Homes

Planning

- Early integration with system partners key
- Involvement on project workstreams
- Clinical Reference Group
- Utilising knowledge from pre-existing services

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Early Implementation

- Frailty at Front Door
- In-reach model
- Step-up from Care Home ward rounds
- New PW3 Reviews
- Daily Calls to Care Homes
- Advance Care Planning

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Analysis

- Working closely with informatics
- Feedback
- Key performance indicators
- Quality Performance Indicators

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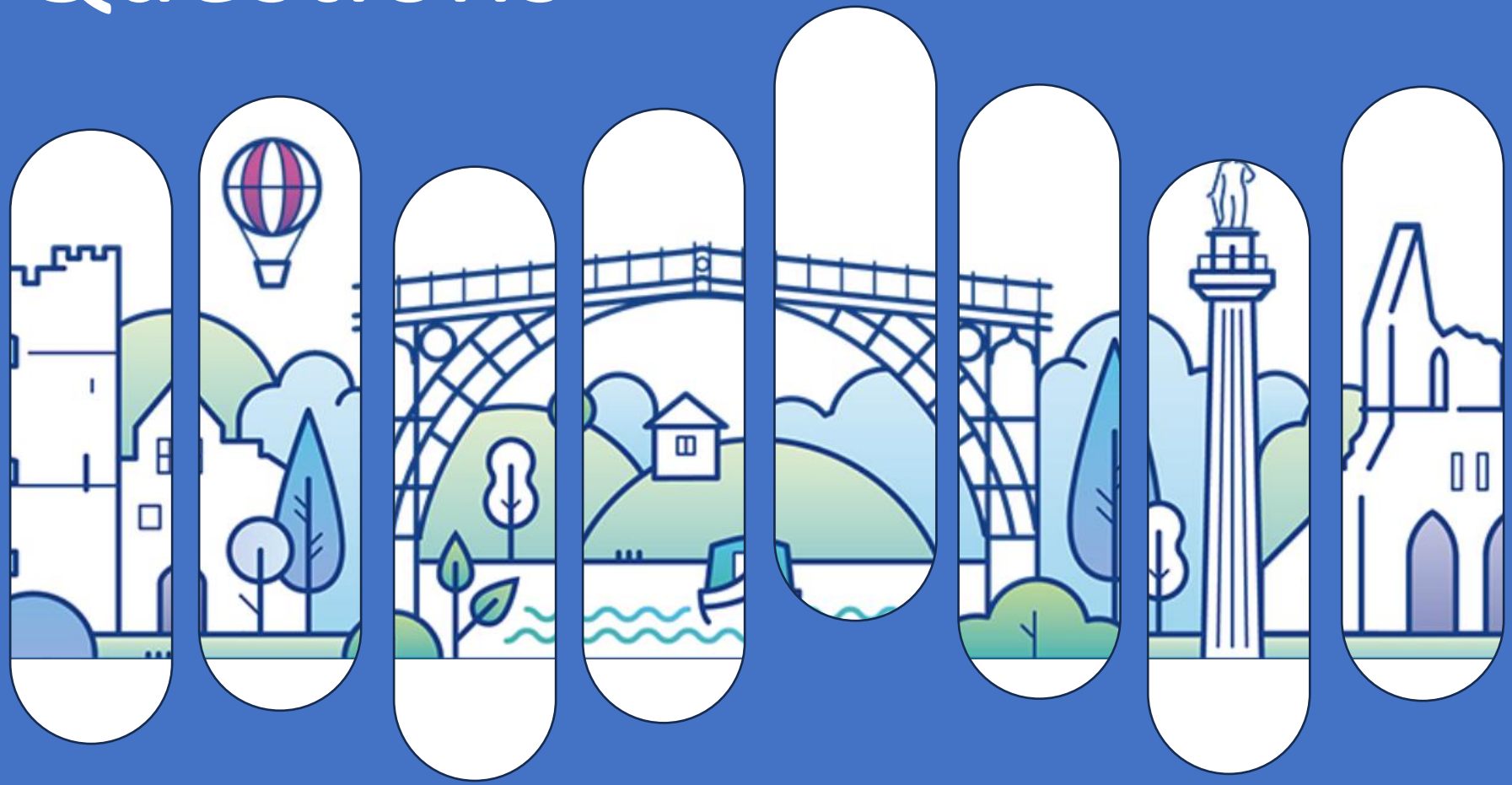
Further Implementation

- Communications
- Centralised Clinical Triage
- Integration with wider system partners

Questions



VIRTUAL WARD (VCSE PILOT – NHS Devon

#OneDevon

WHY DID WE DO IT?

- To reduce health inequalities potentially associated with virtual wards, such as digital exclusion and social isolation.

- To further develop our relationship with the VCSE in Devon.

- To give patients and their carers an even more positive experience of being on a virtual ward.

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BACKGROUND

- Appropriate patients were identified by VW staff at RDUH(E) and referred to the VCSE. Patients gave their permission to be contacted.

- Dependant on patient need, face to face VCSE support was offered to patients to help them with the digital aspects of their care, wrap around support and/or transport of equipment.

- Support was provided to 46 patients in their own home over a three-month delivery period.

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WHAT WAS OFFERED?

- **DIGITAL SUPPORT** – Assisting and advising the patient in the use of digital tech to support remote monitoring of patients care while on the VW in their usual place of residence.

- **WRAPAROUND CARE** – Provide non-medical general wellbeing support for patients as part of their VW offer and beyond. This could include signposting to local services, reducing loneliness and isolation, support for unpaid carers etc.

- **EQUIPMENT TRANSPORT** - Support with collecting and returning the digital equipment for patients who could not get to the hospital independently.

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HOW WAS IT COORDINATED?

- A county wide VCSE organisation acted as the hub for contact from the Virtual Ward.

- They developed a network of local delivery working with local community based VCSE organisations.

- This included training VCSE staff on how to use the digital equipment.

REFERRALS

Referral	Number	%
Digital support	14	30%
Digital support and equipment transport	10	22%
Wraparound care	7	15%
Equipment transport only	5	11%
Wrap around and equipment transport	3	7%
Digital and wrap around	1	2%
Digital, equipment and wraparound	1	2%
No support needed after initial referral	5	11%
Total	46	100%

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WAS IT SUCCESSFUL?

- 46 patients were transferred to a virtual ward who might not have been without this intervention.
- Clinicians reported that the service did help to ease pressures experienced by staff delivering the VW.
- They also reported fewer patient enquiries for help with digital equipment for those that were referred to the VCSE. This impacted positively on clinical capacity and reduced the need to bring patients back to the hospital for digital support.
- Of those that responded,
  - 81% of patients said the overall VCSE experience was excellent
  - 100% of patients said that they were treated with care and respect
  - 81% of patients said they had excellent access to VCSE staff.

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MID PROJECT LEARNING

- Initially, referrals were slow.

- The VCSE offer was misunderstood by clinical staff.

- We developed a MDT approach to address this including training clinical staff on what the VCSE could offer.

COST

Resource	Unit Cost	Total cost
0.6 WTE central co-ordination hub management	£1,050	£12,600
0.WTE data management and administration support	£750	£9,000
VCSE Partnership Steering Group monthly meetings backfill (Three meetings)		£1,000
40 VW patients digital/ local support for up to 2 weeks each	£600	£24,000
Total cost		£46,600

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CONCLUSIONS

- People’s home circumstances were not always as expected e.g. lack of basic facilities or equipment.
- Support for the unpaid carer was often as important as support for the patient.
- Community support is vital post virtual ward discharge to potentially avoid readmission.

POTENTIAL OPTIONS FOR THE FUTURE

- Each of the VW providers to be responsible for developing provision to support patients with technology within their existing funding allocation, utilising their own clinical/non-clinical staff.

- The overall budget for financial year 2024/25 is top-sliced and held centrally to support a combination of digital support, wraparound support and equipment transfer and offered to each provider as an option to decide what they need for their service.

- Each provider is advised that a specific ringfenced VW VCSE funding pot from the 2024/25 budget allocation is needed from which they can make individual decisions on how best to use it in partnership with the sector.

- We explore how we could make best use of existing VCSE capacity in each locality and what the gaps would be to enable a county wide offer similar to the pilot provision?

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POTENTIAL CHALLENGES FOR THE FUTURE

- No specific funding stream
- Difficulty in measuring return on investment
- Better understanding of the gaps in existing VCSE provision (are there already similar commissioned offers in communities that could be adapted e,g, discharge support)
- How do we get the patient/carer voice to influence development of the service
- Is there a danger of a postcode lottery?

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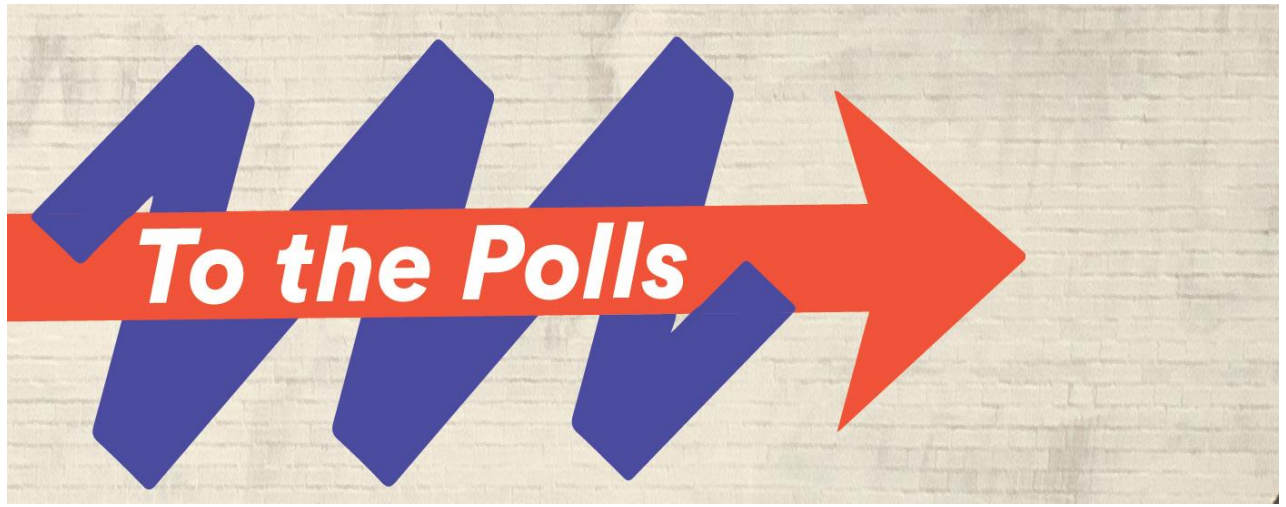

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Poll 1

How much would you say this webinar has increased your understanding of ICSs and virtual wards?

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Poll 2

How much would you say this ICS webinar met your expectations?

Integrated Care Webinar series 2023-24

A recording of the webinar, slides and resources will be shared on the Integrated Care Learning Network.

To join the network email **integratedcare-manager@future.nhs.uk**

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