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Supporting information for ICS leads
**Enablers for success: virtual
wards including hospital at
home**

Version 1, 25 April 2022

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Introduction

A virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital.

NHS England and NHS Improvement are asking all integrated care systems (ICSs) to extend or introduce for the first time the virtual ward model. This document supports ICSs with their strategic and financial decisions on virtual ward planning and implementation. The content is positioned at ICS leadership teams but will be helpful for provider organisations as they plan together to implement this model.

This guidance starts a two-year funded transformation programme to support the development of virtual wards, operating to standardised clinical models, across every area of England. Further clinical guidance is being developed to support local organisations to operationalise virtual wards and will be made available on the [FutureNHS website](#).

Ambition

ICSs have been asked to deliver virtual ward capacity equivalent to 40 to 50 virtual ward 'beds' per 100,000 population (equivalent to the delivery of up to 24,000 virtual ward beds), by December 2023. This has been outlined in the [2022/23 priorities and operational planning guidance](#). In doing so, additional 'bed' capacity could be created as a result of efficient and productive use of resource and management of patients.

At a minimum, we expect each system to implement virtual ward models for the two pathways (acute respiratory infection, frailty) defined in the previous [supporting information](#). Depending on the starting point and maturity of services within each system, systems may wish to expand and develop other pathways in addition.

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.

Virtual ward services should be tech-enabled to maximise the opportunity they offer for patients, carers, and staff. Technology enablement means the management of patients via a digital platform managed remotely by a clinical team.

Virtual ward services will only be successful if they combine all the above in creating an integrated care model. Hence it will be the first test of ICSs, as they are established, to deliver a new multi-agency approach to supporting people to be cared for in their own homes or usual place of residence.

In order to achieve scale, systems will need to think about virtual wards on a whole system basis and whether they are best delivered on a whole ICB footprint or in partnerships with other ICBs.

Available funding and recommended use

Funding available for 2022/23 and 2023/24

£200 million of funding is available from the Service Development Fund (SDF) in 2022/23. This a major contribution to the set up and development of virtual wards. A further contribution of £250 million, on a match-funded basis, will be available in 2023/24. This temporary national funding will provide significant financial support to systems for the establishment of virtual wards but is not intended to cover the ongoing cost of the service. No ringfenced recurrent funding will be made available from 2024/25. Systems will therefore need to ensure virtual wards are built into long term strategies and expenditure plans.

For further information on funding available for virtual wards and conditions and caveats of funding refer to [SDF planning requirements: Virtual wards that deliver hospital at home care letter](#).

Planning for funding

ICSs will need to develop and submit two-year comprehensive rollout and delivery plans up until April 2024. As part of this they will be expected to create detailed financial plans which include projected workforce staffing and expenditure. A template for plans will be made available on FutureNHS.

Additionally, as part of their articulation of benefits, ICSs must share their understanding of expected ‘bed’ capacity benefits, namely the ‘net bed benefit’. This is the net comparative ‘bed’ benefit of using workforce in a virtual ward compared to using workforce in a secondary care bed setting. To support with this analysis a [Bed Benefit Tool](#) has been made available on FutureNHS.

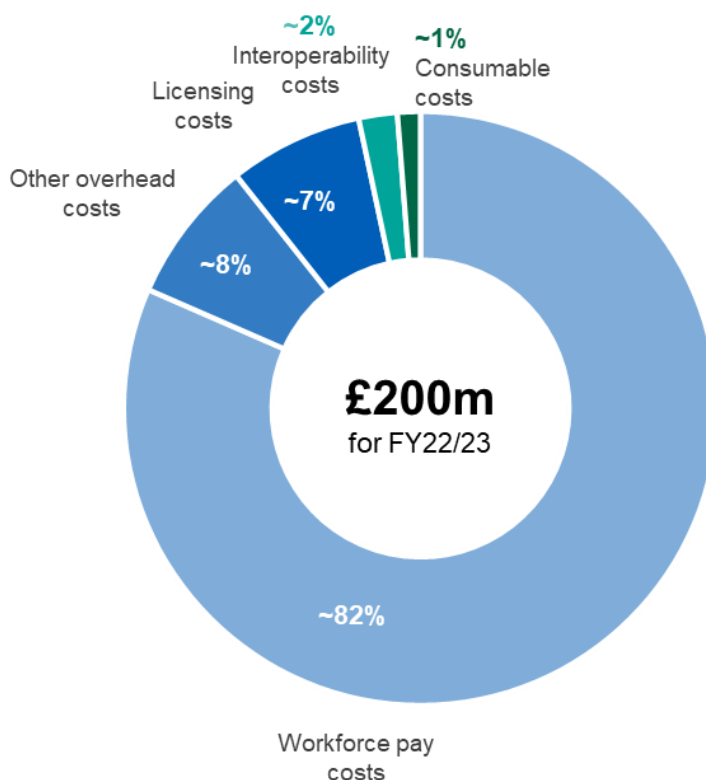
Funding suggestions

ICSs will have local determination over their allocation, provided that it relates directly to the development of virtual wards.

However, it is expected that most of the funding allocation is spent on workforce pay costs (including clinical, operational, administrative and programme delivery resource) to fund the staffing models required for virtual wards.

In addition to workforce pay costs, ICBs should use this funding to pay for enabling technology. It is recommended that the funding is spent on licensing, software and/or platform costs, kit required for the virtual ward, and ensuring interoperability between chosen systems to enable effective data sharing, aligned to the ICS’s digital, data and technology strategy.

Figure 1: Indicative breakdown of virtual ward costs



Further resources available for 2022/23

In addition to SDF monies, there is a separate allocation of Regional Scale Programme (RSP) funding from NHSX, with up to £6.3 million available nationally. This additional funding is designated for ICS technology implementation support (eg information governance compliance, clinical safety relating to technology, project management support). This includes, but is not exclusive to, the technology enablement of virtual wards.

System-level reporting and data requirements

ICSs must fulfil two different reporting asks as a condition of receiving and using funding.

Virtual ward SitRep

From April 2022, lead providers of virtual wards (acute trusts, community trusts/social enterprises or any other organisation leading the service) will need to submit a fortnightly 'SitRep' with a minimum data set of aggregate information relating to usage, type and configuration of the virtual ward itself and data on patients' ethnicity, gender and age.

Further details on the purpose, approach and specific data parameters of the virtual ward SitRep is provided in [Virtual ward sitrep technical guidance](#).

Financial plan and reporting

From the second half of 2022/23, there is an expectation that ICSs will commit to quarterly financial updates as part of their regular assurance meetings. Local colleagues may be asked to provide information on the following datapoints once they have decided how to spend their allocation:

- year-to-date spend and forecast out-turn on workforce pay costs (eg staff pay costs by banding and discipline)
- year-to-date spend and forecast out-turn on technology non-pay costs (eg costs for licensing, interoperability)
- year-to-date spend and forecast out-turn on other non-pay costs (eg consumables).

We will nationally monitor ICS rate of allocation via the ledger (ISFE) using the mandated A3 code for virtual wards.

This information will be used to provide better insight on where money is being spent, and where future resource could be prioritised to support further service development.

Monitoring and assurance

From July 2022, regular assurance and reporting processes will be stood up between ICSs, regions, and the national virtual ward programme team. The intention is to provide regional and national visibility and assurance on delivery, expenditure, and benefit. It will also help identify where targeted support and improvement interventions would be valuable for ICSs. Where feasible, this assurance will draw on existing processes and governance structures.

To support initial assurance at a local and regional level, we are proposing that the following reporting processes are stood up:

- monthly regional assurance sessions (at a minimum; more frequently if necessary)
- monthly sessions with ICSs at a region level – the SitRep data and financial data will be made available to facilitate these discussions.

These assurance meetings will also gather information from ICSs and regions about the level of spending of their allocations.

Assurance and monitoring metrics

To ensure that the virtual ward programme meets its objectives, it is important that we monitor and evaluate key metrics to measure success. At a minimum, progress will be assessed by the metrics and data given in Table 1 below:

Table 1: Data and metrics for progress assessment

Metric		Data source
1	Number of virtual ward beds per 100,000 population	Calculated from fortnightly virtual ward SitRep and population date
2	Virtual ward utilisation	Calculated from fortnightly virtual ward SitRep
3	Number of patients admitted	Fortnightly virtual ward SitRep
4	Rate of ICS allocation spend	Set up on ISFE of new A3 ledger analysis code called 'Virtual Ward' to monitor what has been allocated to, and spent by, systems
5	Whole Time Equivalent (WTE) increase	Detailed financial plans/quarterly financial reporting

While we recognise the importance of monitoring patient and staff experience, these measurements will not be included in the initial, aggregate SitRep. We will be scoping the potential for a national clinical audit cycle which could include these metrics over the next few months as a priority.

The national programme team will develop a framework for assessing the holistic impact of virtual wards, supported by common metrics. This framework will be co-produced with regions and systems.

Reporting of SitRep data

As well as being used for assurance, the SitRep will be necessary to ensure that robust and consistent data is available to report progress of scaling virtual ward services and build evidence about effectiveness to support continuous improvement.

In collecting data nationally, we will provide rapid reporting capability that can be used for national stakeholders and disaggregated for regions, ICSs and at provider level.

Rapid local evaluation

We have begun working with 10 existing virtual ward providers on rapid local evaluations to understand virtual ward models and share implementation experiences to benefit ICSs and providers who are at an earlier stage of

development. In the longer-term, we will work with NIHR as part of a national evaluation of virtual ward provision.

Workforce recommendations

Virtual wards present an opportunity to develop flexible and new ways of working that may attract new staff, retain existing staff, improve staff satisfaction, and enhance health and social care integrated multidisciplinary team working. Clinical and non-registered professionals across care settings and providers will need to work together to deliver virtual wards.

At the most fundamental level, workforce models and staffing should be determined by local need, joint health and social care system planning, clinical need (including admission and discharge criteria), robust clinical and professional judgement and aligned to the [National Quality Board](#) and [Developing Workforce Safeguards](#) recommendations.

While evidence on optimal workforce models is still evolving, to support systems to plan their workforce with the right capabilities, we have collated key considerations and learnings from existing practice. Examples of current virtual ward staffing for remote respiratory virtual wards and frailty virtual wards (Hospital at Home for those living with frailty) can be found on [FutureNHS](#). These examples demonstrate the variation in staffing of virtual wards and highlight the need for local decision making based on the safer staffing principles and quality assessments.

Building on the [principles](#) of virtual wards, good practice recommendations for virtual ward workforce models include:

1. appropriate clinical leadership and governance in place (mandatory requirement)
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.

1. Appropriate clinical leadership and governance (mandatory)

- A virtual ward should be clinically led by a named registered consultant practitioner i.e. doctor, nurse, or allied health professional (AHP) or primary care general practitioner with knowledge and capabilities in the relevant speciality or model of care (or access to specialist medical advice).
- Operating procedures should be in place to ensure support is available out of hours to manage deterioration and maintain patient safety 24 hours a day. In many cases this will involve integration with existing procedures and may involve ICSs reviewing provision and formalising additional provision where demand exists for cohorts of patients with highest needs.
- All staff should have the knowledge, experience, and skills to ensure that patient safety and quality is maintained.
- A quality impact assessment should include digital clinical safety in order to inform a workforce learning and development plan.

2. Competency-based approach, avoiding assumptions about professional boundaries and early investment in workforce development and training

- A competency-based workforce model, using an agile, multiprofessional response, based on holistic person-centred needs should be used. Employing the skills of the full multiprofessional team will support the virtual ward environment to be as safe as it can be for all; patients, staff, and their respective families/carers.
- Involve trainee grades such as general practitioner trainees, specialist registrars, advanced practice trainees early and as part of their curriculum of training with medical consultant supervision.
- Invest in advanced practice including community nursing and advanced clinical practitioners (ACPs).
- Consider pooling relevant consultant resource across different trusts and across the system to provide a joint on-call rota for seven day a week working.

3. Integrated working across health and social care

- Ensure integrated working with established teams as appropriate. For example, matrix working with urgent care response teams, primary care, community nursing teams, rehabilitation and enablement teams and trusted assessors for care homes.

- Build on existing and emerging integrated health and social care models that reflects the diversity and care needs of the population served for example, enable capacity in existing out-of-hours services, including community night nursing team services or general practitioner out of hours service where appropriate.
- Consider collaborative models with the voluntary community social enterprise sector to enable people to be cared for at home with support for provision of meals, social and wellbeing, companionship, and advocacy.

4. Appropriate use of technology, supported by training and supervision

- Apply technology to support workforce productivity and to provide more flexibility for the clinical workforce in terms of blended roles of face-to-face and virtual care.
- Define and collect data on clinical and workforce outcomes from the start to support future business cases and the development of workforce models.

5. Incremental approach to improvement and growth

- Use quality improvement principles to ensure a progressive approach to successfully test new ways of working to deliver the optimum model of care.
- Consider developing capacity incrementally. Review patient numbers, associated staffing model and requirements, patient and staff outcome and quality metrics prior to increasing patient numbers.
- Co-produce flexible workforce models, which consider community (place based) and population need, geography and workforce supply.

A workforce planning considerations checklist to support ICS leads in thinking about workforce, along with guidance on delivering safe and effective virtual ward care once the workforce is in place, can be found in the appendices.

A core capabilities framework for virtual wards is currently being developed. This will help inform the development of staff across these clinical services and other related workforce teams and will set out the standards for education and training. This document should be published in Q1 22/23 and aims to identify and describe the skills and knowledge which the healthcare workforce needs to deliver high quality, compassionate, personalised care in a virtual ward environment.

Virtual wards and carers

Third sector groups, carers and carer groups should be involved from an early stage in design of virtual wards, the technology and what support and care will be offered. Carers are a real asset and often know the patient the best, so their involvement is vital. ICSs need to engage with carers and carers groups to help shape virtual wards to ensure they fully consider the needs of carers, as well as the person with care and support needs.

To support carers and mitigate any potential risk associated with virtual wards that unpaid carers will be asked to pick up more caring responsibilities, virtual wards must be designed in such a way that enables professionals to:

- identify unpaid carers
- signpost carers to carers' assessments and further support, such as advocacy and respite care
- involve carers as equal and expert partners in care
- be aware of carer rights under the Care Act, and young carers' rights under the Children and Families Act. These pieces of legislation work together so that carers of all ages, and the people they support, can get the assessment and support they need
- have informed discussions with carers about the choices available for care including having the right to choose the level of care they can provide, including the right not to provide care if they are unable or unwilling to do so.

The delivery of virtual wards must consider the needs of carers. Those delivering virtual wards should:

- recognise unpaid carers as equal partners in care who can provide vital information about the person with care and support needs
- Include unpaid carers in all aspects of the virtual ward care – from discharge planning and support, to whether the person with care and support needs should remain in a virtual ward if situation changes
- respect carers' wishes in terms of which aspects of care they are able and willing to provide, if any
- make carers aware of their rights
- ensure that carers have access to information about what to do if:
 - they are no longer able to provide care on a virtual ward

- their needs have worsened
- the needs of the person receiving care have worsened.

Local carer support organisations can be a vital source of support for many carers and can bring a voluntary, community and social enterprise (VCSE) service perspective to system and service design. Local carer support organisations will also be well placed to support unpaid carers, and many – if commissioned – will also be able to provide vital respite breaks that so many carers need.

Technology enablement

Technology enablement of virtual wards is necessary to maximise workforce benefits. Guidance on how to set up a technology enabled virtual ward is [available](#).

Guidance for selecting and procuring a technology platform

This step-by-step [guidance on selecting and procuring a technology](#) platform has been produced to support ICS and provider leads to consider key requirements in relation to selecting and procuring a technology platform for virtual wards. Based upon the clinical model and vision for the service, it includes key questions in relation to what the technology platform is required to do, clinical and electronic equipment required and information governance considerations.

When you know what technology you require, the guide contains information in relation to the procurement process and supports the development of a technology specification. It includes an example specification that can be adapted to meet local needs.

Information governance guidance

The virtual wards service is likely to be delivered by teams from different organisations across the ICS and relevant patient information will need to be available to all those involved. Organisations have a duty to share information to support individual care – information governance guidance and templates have been designed to be used by ICS leads and providers to support this. The [information governance guidance](#) relates to:

- IG professionals setting up virtual wards in a lawful and secure way and sets out the actions required by the lead commissioning organisation and all organisations that are part of the virtual ward.

- Patients and service users receiving care in a virtual ward.
- Healthcare professionals working in a virtual ward.

The templates included can be adapted for local use and include:

- a data processing impact assessment (DPIA)
- a data sharing agreement (DSA)
- a data processing agreement (DPA)
- a privacy statement.

There is also a suppliers checklist which can be used to support working safely and in partnership with the NHS to deliver virtual wards.

Developing data flows for reporting and evaluation

Manual data reporting of virtual ward data from the SitRep

In collecting data through the SitRep, we will be looking to provide timely reporting back to national stakeholders that can also be disaggregated for regions, ICSs and at provider level. Through engaging with stakeholders at various levels, we will provide data and reporting functionality that minimises duplication and ensures consistency of metrics wherever used.

There will be a core dataset required that includes:

- virtual ward capacity – defined as the number of patients who can be simultaneously managed by virtual ward services
- flows of patients in and out of virtual wards, including the admission routes in and discharge destinations after discharge off a virtual ward
- length of stay in a virtual ward, based on categorised aggregate data in the interim and admission and discharge dates in the patient level data
- understanding of patient demographics and clinical pathways/services for those using virtual wards which will illustrate the breadth and variety of service models in place.

Moving to automated, patient level data collection

There are a range of data collection models in place with different systems and approaches to coding used to manage them. In the short term, an aggregate data collection across providers will be used to establish a baseline position for virtual

wards. With the support of national teams, we will be working to implement automated patient level data flows through the 22/23 financial year. Once the necessary data infrastructure is in place across all virtual ward providers, this will enable a switch from manually submitted aggregate data collection.

The aggregate data submitted by providers initially will act as the basis for the patient level minimum data set. The definitions relating to virtual wards, including hospital at home, will be incorporated into the NHS Data Model and Dictionary. There will also be consideration of how existing data sets such as ECDS can be utilised to record virtual ward activity alongside Same Day Emergency Care (SDEC) activity, mitigating the current issues of how activity can be coded to avoid impacting on reporting of inpatient metrics.

Working with the independent sector

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

When making commissioning decisions for new services it is important to consider what is needed from a health care provider and technology supplier; the independent sector plays a role in both.

Given the independent sector is already a valued partner in many local health and care systems, as providers of a range of NHS healthcare services, the delivery of virtual wards is an opportunity to build on these relationships. Partnerships with independent sector healthcare providers (ISHCPs) may expand local capacity and enhance capability through strong local partnerships with existing acute and primary care providers.

The independent sector also comprises important innovators and suppliers of technology. Ensuring virtual ward services are enabled by technology may also mean building on existing and new relationships with independent sector technology suppliers (ISTs). Partnerships will support designing technology enabled pathways that improve care experience, provide clinical teams with the technology to work efficiently, and improving clinical decision making by having the right data available for their patient at the point they are delivering care.

The national programme is conducting market engagement to support the development of independent sector capacity for virtual wards considering partnerships across ISHCPs and ISTSs.

Equality and health inequalities

Virtual wards must support patients by bringing the healthcare system to the patient, providing tools to support people to manage their health in their own homes or normal place of residences. Additionally, virtual ward services aspire to improve healthcare for all through ensuring equitable access, excellent experiences, and optimal outcomes. They could provide huge benefit to those who have most difficulty accessing healthcare. However, if tools are distributed without a real focus on them reducing health inequalities, then they are likely to widen the gap further.

There is a risk that the use of digital technologies will disproportionately exclude people from certain groups, including older people, those in social housing, those on lower incomes, the unemployed, those with disabilities, rural populations, traveller communities, homeless people, those with no recourse to public funds, and young people not in employment, education or training (NEETs).

The NHS Long Term plan commits to more NHS focus on health inequalities, recognising that while the roots of many health inequalities lie in wider social/societal determinants, the NHS can and should do more by helping people to lead healthy and active lives (through both direct treatment and preventative healthcare).

Therefore when considering priorities for intervention, ICS leads should be driven by the needs of people and communities as an integral part of their work and ensure that work is co-produced with wider partners in health and social care, including the voluntary sector including inclusion health groups as well as other groups whose voices are not being heard. An equality and health inequalities impact assessment must be conducted to ensure ICSs are fulfilling their obligations under the PSED and the health inequalities duties.

As virtual wards will utilise technology, consideration should be given to digital exclusion as part of implementation. This could include:

- provision of necessary equipment (including adaptations to overcome barriers eg visual impairment): this could be in the patient's home or in another location that is readily accessible
- support and training: this should be designed with and driven by the needs of users; based in spaces that are easy to access; involving peer support and VCSE organisations
- support for ongoing use including mobile data/access to WiFi.

The Health Inequalities Improvement Planning [Matrix](#) has also been developed for regional, system and provider service leads to understand the key areas for consideration as health services are designed, implemented and evaluated, to ensure that the health inequalities gap is not inadvertently widened.

Green considerations

Embedding the response to climate change into core NHS business is highlighted in the operational planning guidance. Keeping people healthy throughout their life course and providing care closer to home, such as that provided in virtual wards, has great potential for [carbon reduction](#).

Trusts and ICBs, once established, are expected to have a board-level net zero lead and a Green Plan, and are asked to deliver carbon reductions against this, throughout 2022/23.

Consideration should be given to how virtual ward plans fit and contribute into carbon reduction of models of care in the ICS [Green Plan](#) and the environmental sustainability of [digital technology](#) from the outset.

Appendix 1: Example virtual ward staffing models

Examples of staffing virtual wards with face-to-face care including Hospital at Home for those living with frailty

Please note: These examples have not been quality assured by NHS England and NHS Improvement and are for illustration purposes only.

Further research is required to develop an evidence based safer staffing tool in line with NQB recommendations.

The examples demonstrate both mostly face-to-face models, often used in frailty hospital at home services (Sites 1-3) and mostly remote models, commonly used for acute respiratory services (Sites 4-6).

Where services are expected to deliver a higher proportion of face to face care, including personal care or rehabilitation, the reported staffing numbers are greater and are often integrated with existing teams. Allowance for travel time is not known.

Some of the examples below demonstrate how virtual ward services have been integrated into systems which results in flexibility of workforce from other existing services.

Site 1: North East and Yorkshire

The virtual ward service is embedded into integrated neighbourhood teams which include local authority and third sector services.

A workforce of 54.71 WTE (including pharmacists and pharmacy technicians) provide the virtual ward service as part of community services. There are 50 beds and the virtual ward operates a 24/7 service with overnight support and access to the on-call out-of-hours registrar if needed as

part of our deteriorating patient standard operating procedure.

Neighbourhood teams developed effective collaborative models with the voluntary community social enterprise sector, this has enabled people to be cared for at home with support for provision of meals, social and wellbeing, and companionship and advocacy.

Whole time equivalents (WTE)									
Leadership		Registered nurses/ AHPs		Healthcare support workers		Specialist input		Administrative support	
Community matrons	8.67	Registered nurses	14.74	Healthcare assistants	7.3	Consultant	1.7	Admin assistant	1.0
		Night nurses	1.73	Nursing clinical assistants	10.84	Pharmacists	3.0	Night admin assistant	1.0
		Triage nurse	1.0			Pharmacy technicians	3.0		
	8.67		17.47		18.14		7.7		2.0

Site 2: South East

The virtual ward for those living with frailty has a workforce of 30.59 WTE identified from the frailty service locality teams, community rapid response, therapies and outpatient parenteral antimicrobial therapy (OPAT) services.

They have also used rotational posts to cover the service and develop workforce roles.

There are 25 beds and the virtual ward operates a 12-hour day-and-night service.

Out-of-hours overnight cover is provided by linking with general practitioner services.

Whole time equivalents (WTE)									
Leadership		Registered nurses/AHPs		Healthcare support workers		Specialist input		Administrative support	
Consultant	1.0	Registered nurses	8.19	Nurse associates	3.0	Frailty nurse	1.0	Admin manager	1.0
Clinical service manager	1.0	AHPs	3.0	Assistant practitioners	4.0			Administrators	2.0
Advance level practitioners	6.4			Healthcare assistant	1.0				
7.4		11.19		8.0		1.0		3.0	

Site 3: South East

The virtual ward for frailty has a workforce of 7.0 WTE. The service is also integrated with the urgent care response (UCR) service which provides further multidisciplinary team (MDT) support.

The virtual ward is part of a wider community frailty team with flexibility as all team members rotate and assist at times of surge in-demand.

Out-of-hours cover is provided by linking with general practitioner services.

There are 12 beds and the virtual ward operates a 10-hours a day service.

Whole time equivalents (WTE)									
Leadership		Registered nurses/ AHPs		Healthcare support workers		Specialist input		Administrative support	
Consultant geriatricians and MDT support from UCR	1.0	Advanced level practitioners	3.3	Healthcare support worker from urgent community response service	1.0	Specialty medic	1.0	Administrator	1.0
Service lead/ advanced practitioner	0.3					Pharmacy technician	0.4		
	1.3		3.3		1.0		1.4		1.0

Examples of staffing mostly remote virtual wards including respiratory virtual wards

Site 4: North West

The acute respiratory infection virtual ward has 9.74 WTE and is an integral part of the community respiratory service.

Patients are triaged onto one of three pathways from the emergency department, two of which lead to admissions to the virtual ward.

There are 25 beds and the virtual ward operates a nine-hours a day service.

Out-of-hours cover is provided by existing services.

Whole time equivalents (WTE)							
Leadership		Registered nurses/AHPs		Healthcare support workers		Specialist input	Administrative support
Advanced level practitioner nurse/AHP	0.96	Nurse/AHP	4.5	Assistant practitioners	0.56	n/a	n/a
Senior nurse/AHP	3.72						
4.68		4.5		0.56		0	0

Site 5: Midlands

The mostly remote virtual ward service has 10.7 WTE which support respiratory and cardiac teams which provide community service.

Patients input their vital signs and series of disease specific questions on a daily basis which is reviewed by a clinician.

Any patient data which triggers alerts resulting in patients being contacted via telephone or video call on the same day by a clinician.

The site reports access to 100 beds and the virtual ward operates eight hours a day service.

Whole time equivalents (WTE)									
Leadership		Registered nurses/AHPs		Healthcare support workers		Specialist input		Administrative support	
Consultant	0.2	Nurse/AHPs	4.2	Healthcare assistants	2.5	Highly specialist AHPs	1.5	Administrators	1.3
Nurse/AHPs	1.0								
1.2		4.2		2.5		1.5		1.3	

Site 6: East of England

The mostly remote virtual ward has 16.8 WTE.

The service started with respiratory conditions, but has grown and evolved to include other pathways, including gastroenterology.

Eligible patients are admitted directly from the emergency department or acute medical unit (AMU) as well as from wards.

Patients are contacted via daily phone or video calls during virtual ward rounds.

There are 40 beds and the virtual ward provides 24-hour cover.

Whole time equivalents (WTE)									
Leadership		Registered nurses/ AHPs		Healthcare support workers		Specialist input		Administrative support	
Consultant	0.8	Deputy virtual wards managers	2.0	Physicians associates	2.0	Doctors	2.0	Administrators	2.0
Clinical operational lead	1.0	Registered nurses	6.0						
Virtual ward manager	1.0								
2.8		8.0		2.0		2.0		2.0	

Appendix 2: Considerations checklist for staffing levels

Minimum criteria for systems to consider have been pulled out of feedback from sites. Note that this checklist is non-exhaustive and should be read with in conjunction the [ICS people function guidance](#).

Criteria	Comments
Systems leadership	
<ul style="list-style-type: none"> Develop collaborative and transparent arrangements for domestic and international recruitment across the system, including attracting local people into virtual ward. 	
<ul style="list-style-type: none"> Enable a systems leadership approach supported by robust clinical leadership, working in an integrated way across organisational boundaries and all sectors to support the expansion of virtual ward and safe discharge arrangements. 	
<ul style="list-style-type: none"> Enable strategic planning, commissioning, delivery and oversight of virtual ward workforce growth commitments across sectors to expand services, particularly in nursing, allied health professions ie consider healthcare support worker pipeline. 	
<ul style="list-style-type: none"> Establish a culture where learning and continuing professional development of all virtual ward clinical and non-registered staff across the system is actively encouraged, and barriers are identified and removed. 	
<ul style="list-style-type: none"> Complete a full quality impact assessment including a workforce impact assessment, as per the CQC Well-Led framework requirement and comply with National Quality Board and Developing Workforce Safeguards recommendations. 	
<ul style="list-style-type: none"> Where relevant, social care must be compliant with health and safety regulations;¹ safe practice includes assessing risk and ensuring a person is kept safe in accordance with their human rights. 	
<ul style="list-style-type: none"> Identify the relevant requirements to ensure the workforce operates within their respective Professional Regulatory Standards, code of practice, good medical practice principles and social care practice. 	

¹ See SCIE reference page: <https://www.scie.org.uk/key-social-care-legislation/health-and-safety>

Transformation	
<ul style="list-style-type: none"> • Enable teams to innovate and transform virtual ward service and multidisciplinary workforce models, using quality improvement methodology and maximising the use of digital and technology, and supporting the spread and adoption of new roles and new ways of working. 	
<ul style="list-style-type: none"> • Embed a systematic approach for listening and acting upon the views of staff working across the integrated system and ensuring their involvement in the development, communication and delivery of virtual wards. 	
Data and intelligence	
<ul style="list-style-type: none"> • Provide virtual ward workforce data to regional and national workforce teams to support aggregated workforce planning, and to inform prioritisation of workforce initiatives and investment decisions. 	
<ul style="list-style-type: none"> • Workforce outcomes should focus on staff experience, access to development and clinical supervision and retention. 	

Appendix 3: Delivering safe and effective virtual ward care

In order, to deliver safe and effective virtual ward care consideration should be given to:

- The principles of the [NHS Patient Safety Strategy](#) and the principles of the [NHS People Plan](#).
- Delivery of successful personalised care approaches to integrated working and ensuring staff have a robust understanding and delivery of personalised care, holistic health and social care needs assessment including shared decision-making. This will result in care for people that considers their strengths, needs and assets and can help them return home or stay at home.
- Clear clinical pathways and unambiguous contractual relationships and obligations.

- Clinical responsibility must be explicit in care pathways, including out-of-hours arrangements.
- To support quality of care and professional development, all registered practitioners require regular clinical supervision. For nurses this is access to a professional nurse advocate.
- Support and mentor the development of non-registered staff to ensure continuous standards of care and recognition that teams are working in new ways.
- Ensuring consideration is given as to how the use of technology can improve staff experience and enable more efficient ways of managing direct and indirect care.
- Positive and transformational leadership is needed to give confidence to staff working in new ways and encourage behavioural and cultural change. This includes meaningful engagement with clinical teams and clinical leads to inform the establishment of clear clinical governance and reporting structures, clinical responsibility, and ways of working.
- Virtual ward organisation must ensure all staff comply with the intercollegiate standard for safeguarding at the appropriate level.

The first of a number of e-learning sessions is [available](#) to support clinical staff to better understand who the patients are, how they are admitted, why monitoring is important, their role in monitoring, remote assessment and escalation. ICSs will adopt their own approaches to the delivery of care and this learning should be used in conjunction with local training, guidance and policies.

Appendix 4: Narrative workforce case study

Reducing the attendance to hospital, with staff supporting people at home through a virtual ward in Croydon

Up to 40 patients a day are supported on the virtual ward. Remote monitoring is provided for people with heart failure and respiratory conditions at home. The virtual ward is integrated into existing neighbourhood teams.

Service hours are 8-8pm, after which usual out of hours general practitioner, community nursing and 111/999 respond to patients.

Once admitted to the ward, patients are supported by daily interventions. Patients are monitored on telehealth devices set up in their own homes and patient observations are monitored by a nursing team, supported by a rapid response general practitioner.

“The [GP] role is different to a surgery-based GP, as the patients have a high acuity than most GP surgery patients. The [GP] role consists of MDT review and leadership, reviewing patient telehealth results, managing patients escalated by GPs or virtual ward nurses and community consultations with patients.” *GP in Croydon*

Following discharge, patients can be referred to the personal independence co-ordinators, who help people identify their own goals to regain independence and live the life they want to live.

Croydon’s workforce top tips:

- Tolerance for risk is managed well by community clinicians but this often requires experience to build this as the virtual ward matures
- Identify what skills and training are needed for your virtual ward patient cohorts. For their virtual ward they recommend non-medical prescribing, recognising deteriorating patient and sepsis
- Consider how the workforce is grown and which teams/specialties require more capacity to support virtual ward growth based on patient types being referred
- Integrate your virtual ward into other services, such as heart failure nurses working within the virtual ward or part of virtual ward caseload being managed within specialty.

Overcoming workforce challenges at Frimley Health NHS Foundation Trust

A frailty virtual ward (hospital at home service) was set up in April 2021 by Frimley Health NHS Foundation Trust.

As a combined acute and community provider they have been able to work alongside hospital discharge teams and community nursing to deliver person-centred care to patients.

They are currently looking to providing wider service coverage, 8am-8pm seven days a week by March 2022 but sufficient workforce is a challenge.

Currently, out of hours patients are managed by their existing business as usual pathways. If there are serious concerns, the service handover any patients to the community or night nursing services.

To extend the virtual ward service coverage, the trust is making the most of existing teams, for example utilising acute frailty advanced nurse practitioners and other staff from existing intermediate care services. They plan to pool geriatrician consultant resource from different trusts across the system to provide a joint on call rota for the virtual ward.

The trust acknowledges that while using flexible existing resource is helpful in the short-term, longer-term workforce solutions are needed to deliver their planned service coverage alongside a sustained positive cultural shift to support this way of working.

“It’s ok to start small – you can achieve a lot with a small team and then build up.

There’s a lot to think about in terms of kit, policies etc, so important to run all of your processes with small numbers of patients first. It is also important to set up clinical governance structures and take a QI approach with tackling issues as they come up. There’s a lot of work being done already in community, so important to enhance this rather than replace or disrupt.”

Dr Lucy Abbott, Consultant Geriatrician and Chief of Service for Community Services and Older people’s medicine

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This publication can be made available in a number of alternative formats on request.