Virtual Wards

Part of the IHSCM
Power-Hour
Series

The NHS went into the Corona Virus pandemic with fewer staff per head of population and fewer beds, than most similar healthcare systems across Europe and OECD countries.

Emerging from the pandemic and faced with an overwhelming number of patients on waiting lists, the NHS is turning to efficiency gains and innovative treatment options.

One innovation, not entirely new, but about to be implemented at scale is the virtual ward. Introduced in response to Covid, NHSE now seek to introduce them as a step-down/step-up response as part of admissions avoidance.

With the help of remote treatment options and supported by technology, patients are monitored and cared for, in their own homes.

Is this an advance or a risk?

The IHSCM, as part of its Power Hour series, invited a panel of experts to discuss the possibilities. Chair, Roy Lilley was joined by;

- Professor Alison Leary,
- Elaine Strachan-Hall,
- Steph Lawrence,
- Alexandra Evans
- Dr Elaine Maxwell

… who shared their insights and experiences.

The discussion may be viewed here, listen here.

The main learning points are summarised to inform your own decision making. We hope they help.

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Chief Executive
IHSCM
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VIRTUAL WARDS - POWER HOUR

The following 28 points are taken from comments, discussion and questions arising from the Power Hour. They represent the key topics that were emphasised, explored or challenged.

They are collated here to promote discussion and thoughts for managers working on virtual ward projects.

1. Digital is fine but success demands great people to support it. Virtual wards are not a substitute for hospital wards – they are different entities.

2. One size doesn't fit all. There are a number of models already in use from Kaiser Permanente to CV-19 remote monitoring, post discharge and the Stephanie Laurence nurse model in Leeds. The trick is to determine what problems need solving and then design digital solution to suit.

3. District and community nurses have huge and increasing demands placed on them for out of hours and domiciliary care, virtual and physical, so simply loading their jobs further, through an ill-planned commitment to virtual wards isn't the answer. Virtual wards must come with a workforce solution.

4. Following-on from this, the imperative is a really sound, integrated workforce model, combined with mature leadership able to ignore the fashionable pressures to implement virtual wards, without thorough planning.

5. The IT element of virtual wards is only a tiny part of the whole. Clinical-care excellence must still be the priority, wrapped around basic elements such as care and advice available by telephone.

6. IT is absolutely important for a key element; record keeping of the care prescribed and delivered, including access to guidance and an understanding of escalation protocols .

7. IT must be very robust have high levels of reliable connectivity. Data collection and systems must be interoperable with the hospital EPR system and local community nursing and primary care systems.

8. A great example of critical decision making best practice in setting up virtual wards is Croydon PCT's ward rounds.

9. Virtual wards cannot be achieved, safely, without the availability and expertise of multi-disciplinary teams, based on the format of regular ward rounds.

10. It is not a Hospital at Home (HAH). Virtual wards require critical decision making and the availability of senior and expert professionals. This means a real investment in time and systems to get right.

11. The priority at first must be deciding on the key clinical objectives and then determining the best structure of virtual ward to match the needs of the patient.

12. Workforce is at the absolute root of success. There must be proper and diligent assessment and design of capability and capacity, particularly in respect of monitoring and escalation – especially night, weekends and other periods of 'out of hours'.

13. Clear protocols, arrived at by thinking through 'gone wrong' scenarios and how to respond, is an essential element.

14. Any virtual ward needs as much clinical governance and Standard Operating Procedures (SOPs) as an acute hospital. System relationships are key.

15. Focus on right service / right wards / right system for the right time in a patient journey. This typically means having skilled and able people available for assessment, including a willingness to ask secondary questions.

16. Virtual wards don't prevent emergency admission but the MDT model including full nursing assessment do impact non-urgent admissions positively.

17. The key question; Is it OK and safe to keep someone at home and care via a virtual ward? The answer is; its all about decision making and quality of assessment.

18. By way of example, Stephanie Laurence's model is a nurse-led approach with a multi disciplinary team including geriatricians, pharmaceutical / medicines assessors, physios and more.

19. We need to shatter the myth that virtual wards are somehow about saving money. They are NOT a cheaper model when done properly and if the objective is about saving money it won't work.

20. Virtual wards should be about improving outcomes for patients, eg reducing re-admission, as well as helping the patient to feel safe and well. There must be patient involvement in any decision to treat via virtual ward.

21. If the virtual ward will involve technologies such as wearables, they must each be regulated and compliant.

22. Before even starting to plan a virtual ward, conduct a proper and detailed workforce impact assessment.

23. **The first question to ask when considering a virtual ward is 'why are we doing this'**. One of the motivators will probably be concern about hospital bed capacity but this alone doesn't provide or inform a workforce capacity solution.

24. Virtual ward capacity and capability must be constantly monitored. Virtual is not a proxy for limitless. As an example, the Stephanie Laurance virtual ward, paused admissions over Christmas because capacity had been reached.

25. Q: What's the most effective means of providing care when we have workforce capacity issues? A: it's not virtual wards.

26. Back to the point that patient safety must be the foundation – which demands supervision intensity.

27. Don't confuse delivery of care with management of care.

28. A good virtual ward will be:

    a. Well resourced
    b. Risk managed
    c. Well led
    d. Multi disciplinary
    e. Run like a real ward
    f. With a fundamental systems approach

In summary, the key conclusions and discussion points emerged as; virtual wards are not a cheap option. They require a multi-disciplinary team approach and are not a way to 'de-skill' care.

If anything, overall, higher skill levels are needed, often with consultant level involvement.

Remote decision making requires experience and confidence and patients in 'virtual wards' will still require regular face-to-face visits.

Out of hours support is vital, as is the smooth transfer to inpatient care should the need arise.

Virtual ward staffing should be self-sufficient and not depend on community services stepping-in, to fill gaps or provide emergency cover.

Paramedic and ambulance support protocols should be established, in advance, to avoid unplanned admissions adding to the pressures on A&E.

Thorough patient assessment to establish OT needs, adaptations and so-on, along with pharmacy, chiropody and other needs, is basic, as are social care packages that are agreed, flexible and fully funded.

Nutritional assessment may be part of the package, along with community support for 'meals on wheels' services, as required.

Where treatments are required at home, staff used to providing hospital care may find a domestic environment challenging and difficult. Proper training is vital.

Where patients are dependent on technology, for monitoring or to raise alarms, they have to be confident how to use it and links, wifi and so on, have to be dependable.