Virtual wards – Friend or foe?

Dr Daryl Freeman, *PCRS Service Development Committee*

The transformation of out of hospital services has been identified as a key element of the NHS recovery plan. Patient care delivered closer to or in their own homes was identified as a priority in the NHS Long Term Plan.

It is envisaged that NHS funding will increase to support systems to increase the capacity of community services, address waiting lists and expand models of care in the community to aid hospital discharges.

Virtual wards (VW) have been identified as a potential solution to the bed pressure within the acute sector and as a way of caring for patients in their own communities.

The definition of a virtual ward is as follows:

A virtual ward is a safe and efficient **alternative** to NHS bedded care. They provide acute care, support and treatment to people who would **otherwise be in an acute hospital bed,** and are often enabled by digital technologies.

Virtual wards can support people as an **alternative to admission** into hospital settings, and can also help **support early discharge.**

Following the COVID-19 waves the NHS has had significant success in establishing virtual wards, over 53 VW are providing over 2,500 "beds" nationwide, not just for patients with COVID, but patients with acute respiratory infections, urinary tract infections, frailty and COPD exacerbations.

NHSE has prioritised the roll out of further VW beds to alleviate pressure on the acute sector, free up beds and enable the NHS recovery phase to begin.

The delivery of virtual wards should, according to NHSE, be developed across systems rather than individual institutions, building partnerships between secondary, community and primary care. Where the independent sector can help, further spare capacity should be used.

The aims are ambitious

By December 2023 it is hoped that there will be 40-50 Virtual Ward beds per 100,000 population. The hope is that these beds will be a combination of step-up and step-down beds across a variety of clinical specialties. There is a substantial funding stream associated with this and for primary care there are both threats and opportunities.

Up to £200 million will be available in 2022/23 and up to £250 million in 2023/24 (subject to progress of systems) to support the implementation of these plans. We expect plans to cover two years. The scale of funding awarded in 2022/23 will depend on credible ambition for delivery of virtual wards by December 2022 to provide capacity for next winter.

The concern for primary care is that these services will be designed without consultation from primary, community and social care and without consideration to the potential increased workload when patients are cared for in their own communities. The opportunities are, however, not inconsiderable. Not only are primary care physicians best placed to design and deliver these services; but in addition;

- They are generally less risk averse than their secondary care colleagues
- They know how to access community and social services to improve the care of the patient in their own home
- They have a knowledge of the patients' ability to cope at home before they became unwell.

Arguably of more importance, primary care has, for a long time, had computerised patient records and good links with community and social care, so should consider designing and developing Virtual Wards to enhance funding, staff engagement and retention.

The Development of 2 workstreams are seen as a priority by NHSE at present:

- Frailty
- Acute respiratory infections

Both of these have good guidelines published on the NHSE VW web site

https://www.england.nhs.uk/publication/guidance-note-acute-respiratory-infection-virtual-ward/

https://www.england.nhs.uk/publication/guidance-note-frailty-virtual-ward-hospital-at-home-for-those-living-with-frailty/

More interest is being developed in "step up" virtual wards and it is recognised that primary and or community care may be better placed to deliver this part of the VW pathway than secondary care.

The importance of keeping patients in their own homes is being recognised as more than simple "admission avoidance":

- It reduces the risk of hospital acquired infections.
- It keeps the patient in their own community (especially important for the frail patient, those with learning difficulties, and/or those reliant on formal or informal carers).
- It reduces unnecessary travel to acute hospitals, reducing carbon emissions as well as cost.
- It may be especially important in rural communities with poor public transport links, thus addressing some of the many health inequalities suffered by rural populations.
- It helps patients to retain their own routines, mobility and habits especially important for the elderly e.g. getting dressed, preparing meals etc.

So virtual wards are here to stay – at least for the foreseeable future, they are funded and supported by NHS England, so what are the benefits of being involved as a primary or community care clinician?

- Being involved is a chance to shape the services to benefit local communities and needs, for example a very elderly rural population would benefit from a frailty step up virtual ward. The process of setting up and running the virtual ward may facilitate the development and planning of enhanced services for this group of patients.
- Being involved is a chance to access some development work with real money behind it.
- Being involved is an opportunity work across boundaries and develop new collaborations and pathways.
- Being involved is an opportunity to identify gaps in supporting services (an example would be noting a high incidence of patients with asthma in the virtual ward, and developing an enhanced asthma review service as a result).

Overall, from a primary care respiratory point of view it is an opportunity to improve services.

A patient admitted to a virtual ward requires the same enhanced review as they would need if admitted to a hospital bed or seen in ED. Developing the virtual ward should enable the constructive conversations around whether a community respiratory service is needed, if one needs developing or if a service already exists ensuring that it is an integral part of the VW design process.

In summary, virtual wards may be seen as a threat to primary care, but I believe robust involvement from an early stage can help improve primary care's influence in the development of local services and help to ensure that where virtual wards are developed, they serve to improve the care of patients living in our communities.