

# Making virtual wards for frailty work better: guide for commissioners

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## The problem

- People with frailty are at risk of their health deteriorating unpredictably
- Frailty is increasing in the UK's ageing population and acute hospital admissions are high, which is becoming increasingly challenging for the NHS

Frailty is a state of increased vulnerability. Patients can be highly dependent on others for basic care.

Severe frailty is characterised by crises such as severe falls, delirium and sudden immobility, and patients can 'tip' into a frailty crisis after a minor event, such as a mild infection.

Frailty crises often lead to acute hospital admissions and poorer outcomes – from which patients do not fully recover.

However, such crises and frailty deterioration can be mitigated and in some cases prevented with the right management.

NHS England has recently tasked local health and care systems (ICSs) with introducing short-term 'virtual wards' across England.

These aim to treat patients experiencing a frailty crisis for a few days at home and then discharge them back to GP care, thus avoiding acute hospital admission.

Because this approach is relatively new, there is a need to learn about how and why such virtual wards can work to help people with frailty, their carers, and the health system.

## Optimising virtual wards as part of the solution

Our research explored:

- how to run virtual wards effectively and sustainably
- how virtual wards may prevent frailty crises
- the value of a whole system approach

It applies to virtual wards for people with frailty and may also be useful for other multidimensional conditions.

## Summary Recommendations

- Aim to implement four building blocks at set-up and operation of the virtual ward – common standards agreements, information sharing inside and outside the virtual ward, appropriate multidisciplinary team (MDT) composition and meetings, good co-ordination in the virtual ward
- Ensure patient and carer involvement and empowerment – communication via a known point of contact, shared decision making, awareness and prevention of carer stress or burnout, and empowered to manage their own care
- Consider how to motivate professionals to work together – for example a 'team-of-teams' providing mutual support; trust in shared goals; reciprocal learning through the MDT meetings
- Aim to achieve buy-in of professionals – importance of patient safety and benefit; starting small; taking time to introduce formal agreements and learn new ways of working
- Work with primary care and integrated neighbourhood teams (INTs) on a whole-system approach through population health management: to select patients at high-risk of a crisis as well as those in-crisis, and coordinate their care
- Work with primary care and INTs to ensure effective continuity of care on discharge from the virtual ward in a whole-system approach
- Emphasise the need for proactive and anticipatory care to reduce the risk of future crises as part of a sustainable long-term view of frailty management. Prevention better than cure
- Consider sustainability as frailty increases in an ageing population, alongside possible re-admissions to virtual wards if people with frailty are not stabilised, and the potential benefits of transitioning to the proactive care of those at high risk of a crisis

## About the Research

We conducted a rapid realist review of frailty virtual wards and examined 28 documents (published and web-based articles) predominantly from the UK, to determine what works for whom, how, and in what circumstances.

As well as analysing and interpreting this evidence, we consulted with stakeholders (patients, carers and clinicians) at various stages of the research process.

Based on the literature, we used a broad definition of multidisciplinary virtual wards, limited to three essential components:

- Care is provided to the patient in their own home in the community
- A multidisciplinary team makes decisions and plans care remotely from the patient
- The MDT provides oversight of patient care

'Virtual' refers to the way MDTs plan each patient's care, remote from the patient - as opposed to remote patient monitoring.

From the evidence, we identified two main virtual ward models (but note that patients at high risk of a crisis can easily 'tip' into a frailty crisis):

- Longer-term, proactive care wards admitting high risk patients before (but close to when) they experience a frailty crisis, and which offer and establish preventative (proactive) care
- Short-term wards in which mainly reactive care is offered to people already experiencing a frailty crisis

In contrast to virtual wards for simpler conditions, there was very little evidence available on the use of remote monitoring for people with frailty, where face-to-face care was common.

Type 1 (prevention of frailty crises)	Type 2 (treatment of frailty crises)
More than 3 weeks, typically 3-7 months in a virtual ward	1-21 days
Patients at high risk of a frailty crisis or high risk of hospital admission	Patients with frailty in-crisis
Avoids escalation to acute hospital care	Alternative to acute hospital care
Mainly proactive care to prevent a crisis and stabilize frailty	Mainly reactive acute care, then if time start proactive care
Discharge to GP: when frailty is stable with no events for 4-6 weeks	Discharge probably when crisis resolved. Continuity is essential (to start/continue proactive care)

### Further information

Westby M, Ijaz S, Savović J, McLeod H, Dawson S, Welsh T, Le Roux H, Walsh N, Bradley N. Virtual wards for people with frailty: what works, for whom, how and why – a rapid realist review, *Age and Ageing* 2024

<https://academic.oup.com/ageing/article-lookup/doi/10.1093/ageing/afae039>

A presentation summary is also available [here](#)

[Geriatric Medicine, GIRFT Programme National Speciality Report, 2021](#) (whole system approach to frailty management)

[Making the most of Virtual Wards, including Hospital at Home, GIRFT/NHS England, 2023](#) (short term virtual wards)

### Contact the researchers

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## What makes a frailty virtual ward effective?

- A multidisciplinary approach. Frailty is a multidimensional condition and each patient requires multidisciplinary care, tailored to their needs
- Virtual ward 'building blocks' – underlying structures essential for virtual ward operation
- Enabling effective and timely delivery of the frailty patient pathway and ensuring a whole system approach
- Involving patients and carers in decision making, and empowerment for self-managing after discharge

## Virtual Ward 'building blocks'

- Common standards agreements formalising collaboration amongst different providers (e.g. for patient eligibility, care documentation, discharge)
- Information sharing processes within and external to the virtual ward (e.g. out-of-hours, emergency services; IT integration)
- Multidisciplinary team composition appropriate to local patient needs (e.g. primary and community care, clinical specialisms, mental health, social workers, the voluntary sector)
- MDT meetings ('virtual ward rounds') for planning patient care, with decisions enacted by community teams
- A virtual ward co-ordinator facilitating teamwork, liaising with patient/carers and external organisations
- Discharge from the virtual ward and continuity of care: proactive care may take up to six months to establish, so if not started/established in the virtual ward, must be initiated/continued by working with primary care and INTs.

## Patient and carer involvement

- Improved communication via a known point of contact (the co-ordinator)
- At home instead of hospital (patients/carers feel supported and safe in a familiar environment; access to existing routines and support network; smoother discharge transition)
- The carer as an essential partner for the virtual ward (especially since most are not 24h).
- Awareness that carers/families of people having frailty crises (e.g., delirium) may not cope, leading to carer burnout and patient hospitalisation, such that hospital may be the best place (especially outside virtual ward hours in short-term virtual wards).

## Enabling the patient pathway and ensuring a whole system approach

- Selection of patients appropriate to the type of ward (e.g. those in-crisis or close to crisis). Working with primary care and integrated neighbourhood teams (INTs) to identify patients with severe frailty who are 'wobbling' and in need of virtual ward care to arrest a frailty crisis
- A well-informed MDT which plans individualised care, is responsive to patient needs, provides timely access to specialists and services, and determines discharge
- Comprehensive assessment, planning and evaluation, including face-to-face assessments
- Medication management optimised through the virtual ward
- Intensive case management, including stratification by severity/risk and rapid response to changing needs
- Proactive care such as: support for hydration, nutrition, and personal care; self-management strategies; advanced care planning; mental health; falls prevention; occupational health; physiotherapy and social support.

## Based on our research

- Virtual wards should be used before people with frailty experience a crisis, offering preventative (proactive) care for people near to a crisis
- Virtual wards should also be used for people having a frailty crisis, offering acute reactive care, then proactive care to prevent future crisis
- A combination of virtual ward models may be optimal – admitting people in-crisis and those at high risk of a crisis –within a whole system approach to frailty care

## Full Recommendations

### *'Prevention better than cure' and the 'right' patients*

1. Consider prioritising a sustainable virtual ward strategy of proactive care for people with deteriorating frailty near to a crisis, with as-needed reactive treatment for those already in-crisis: seeking to prevent new or further crises.
  - Admit to virtual wards all those with severe frailty who are acutely unwell: those at high risk of a frailty crisis and those who present with frailty crises.
  - Consider a combined approach to acute reactive care and proactive care; for example, red/amber/green wards within one virtual ward, sharing the same staff and MDT, potentially as a more efficient use of resource.
2. Use the processes and functions of the virtual ward to deliver tailored frailty management under one 'virtual roof': providing multi-disciplinary and multi-agency solutions for planning and delivery.

### *Virtual wards within a whole system approach to frailty management*

3. Integrate virtual wards within a whole system approach to frailty management, involving primary care and integrated neighbourhood teams (INTs), encompassing all stages from patient selection to post-virtual ward discharge care.
4. In primary care, consider monitoring people at high risk of a frailty crisis (optionally through GP schemes) to detect deterioration of their frailty, and if this occurs, admit them to a virtual ward before they reach a frailty crisis.
5. Ensure that all virtual wards
  - Initiate, and preferably establish, proactive care (e.g. comprehensive geriatric assessment or similar) before discharge from the ward, AND
  - Work with primary care and INTs to achieve effective continuity of care on handover (including starting proactive care if not done in the virtual ward).
6. Consider the optimum length of stay in a virtual ward to avoid occurrence of (further) frailty crises

7. Produce formal discharge criteria from the virtual ward, and standardise the nature and operationalisation of continuity care.
8. Consider whether a 24-hour virtual ward service is feasible and/or the provision of night sitters for patients with frailty crises.

### *Management of change*

9. Consider ways to manage change and achieve buy-in of staff: importance of patient safety and benefit (saving lives not costs); starting small; allowing time to introduce formal agreements and learn new ways of working

### *Set-up and operation of virtual wards*

10. Include the following 'building blocks' at set-up of a frailty virtual ward:
  - Common standards agreements,
  - Information sharing within and external to the virtual ward
  - Appropriate multidisciplinary team (MDT) composition
  - MDT meetings ('virtual ward rounds'), for planning patient care
  - Virtual ward co-ordinators linking and liaising with people and groups
11. Motivate the virtual ward team to work together through:
  - Providing mutual support (consider a 'team-of-teams' approach)
  - Trust in shared goals,
  - Reciprocal learning through the MDT meetings.
  - Acknowledging perceptions of patient safety and benefit

### *Patient and carer involvement*

12. Ensure patient and carer involvement and empowerment and be aware of their role as partners in care: e.g. communication via a known point of contact, shared decision making, prevention of carer stress and burnout, and empowered to manage their own care
13. Consider whether the patient would be safer in hospital rather than in a virtual ward, depending on the safety of their home environment, availability of carers, and the patient's condition (e.g. people with delirium or dementia).

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