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Guidance note

Frailty virtual ward (Hospital at Home for those living with frailty)

22 December 2021

Definition and background

Frailty virtual wards, otherwise known as Hospital at Home, provide a safe alternative to hospital for patients living with frailty through community-based acute health and care delivery.

Central to this approach is services working towards providing a model that is patient centred, and in which home is an option for care. This is part of the shared decision-making process, in line with personalised care principles.

A Hospital at Home for frailty should be available as an option for clinicians to refer adults (aged 65 or over) who have an acute exacerbation of a frailty-related condition. The concept of a Hospital at Home or virtual ward for frailty is well established.

Note for the purpose of this guidance the terms Hospital at Home and frailty virtual ward are used interchangeably. We acknowledge Hospital at Home is used more widely in practice and therefore its definition may differ outside a virtual ward context.

Recommendation to systems

Systems are asked to make plans to expand virtual ward capacity as fast and safely as practicable, taking account of local circumstances, workforce availability and existing services, and building on existing virtual wards and digital platforms where these are established.

Systems should consider establishing a Hospital at Home model, where they have not already done so, to support the provision of this safe and supported alternative to hospital admission and earlier safe and supported discharge from hospital for patients with acute exacerbations of conditions related to frailty.

Hospital at Home is underpinned by close partnership working across health and social care and through integrated community teams. Implementation should be led by the integrated care system (ICS) and delivered by appropriate secondary care, community health services and primary care working collaboratively. This guidance

note aligns with guidance on urgent crisis response (UCR), same day emergency care (SDEC) and acute respiratory infection virtual wards.

This guidance note sets out a minimum requirement for Hospital at Home and should supplement existing arrangements where these are already established and working, including alternative pathways to admission, integrated pathways and/or condition-specific pathways.

Overview

An overview of Hospital at Home for people living with frailty is set out in the table below.

	Hospital at Home
WHAT	Technology-enabled remote monitoring and in-person care/treatment.
WHO	People aged 65 or over with frailty-related illness. Higher acuity patients who would otherwise be in hospital because they require in person monitoring/treatment.
WHEN	Admission alternative and early discharge.
WHERE	In the patient's own home or usual place of residence, such as a care home.
WHY	Improved patient experience and outcomes. Shared decision-making. Improved patient hospital flow. Reduced nosocomial transmission of infections. Home First as a principle.
HOW	In-person and/or technology enabled care from a multidisciplinary team. Early deterioration recognition and appropriate clinical input. Proactive monitoring/escalation.

A full list of virtual ward core principles is available in the supporting guidance on virtual wards.

Inclusion and exclusion criteria

Services will need to develop their own admission and discharge criteria for acute level care in line with their population needs, available workforce and competencies.

Subject to the patient's choice and clinical judgement, the following criteria can support identification of patients suitable for admission to the frailty Hospital at Home.

Inclusion criteria

- Aged 65 or over, has been assessed to be frail and is in a crisis that requires acute level care.
- Where a person is living with dementia, this should not exclude admission to the Hospital at Home service. Best practice is for the virtual ward team to treat acute conditions with support/advice from older peoples' mental health teams.
- Expected required treatment time is short-term intervention of 1 to 14 days.

Exclusion criteria

- Is injured, eg long bone fracture, and requires emergency care intervention and an admission into a secondary care bed.
- Is experiencing a mental health crisis and requires referral/assessment by a specialist mental health team that cannot be supported in the community.
- Needs acute/complex diagnostics and/or clinical intervention that can only be offered in hospital. This can become a shared risk with the patient if they do not wish to be admitted.
- For safeguarding reasons, it is not safe for a person to remain in their home or usual place of residence.

Staffing and oversight

The Hospital at Home should be led by a named consultant practitioner (including a nurse or allied health professional (AHP) consultant) or suitably trained GP, with access to timely specialist advice and guidance. The multidisciplinary team should include other relevant professionals where required, including pharmacists, GPs, nurses, other NHS specialty consultants, social care teams, mental health and voluntary sector organisations. This is especially important for Hospital at Home services, to ensure that a personalised approach to care can be delivered in partnership.

Hospital at Home staff should have access to rapid telephone/digital/video specialist advice and guidance (eg acute medicine, emergency medicine, respiratory, cardiology or other specialist clinicians) in and out of hours.

Clear pathways for referral and escalation should be developed collaboratively with SDEC, emergency department (ED), primary care, community health services, NHS 111/999 and UCR.

System-wide approach

There should be a system approach, ensuring collaboration to share workforce skills and expertise in the best interests of system-wide change; for example, making senior frailty clinicians and pharmacists available to provide expert clinical support and pharmacy reviews to Hospital at Home patients.

Commissioners and providers should ensure they have the appropriate workforce and skill mix in place to deliver Hospital at Home, meet local population needs and that teams have the skills, training, tools and support required to deliver care. They should also support newly qualified professionals, students and higher education institutions to develop the necessary skills needed for a career in community services.

Governance

Responsibility, including for ensuring appropriate clinical governance, remains with the relevant provider. Each system should have a named person responsible for the establishment of the service in their area. Clinical, governance and administrative

responsibilities across the pathway can be provided by any appropriately trained person and best use of resources should be made.

Staffing

Different models are used for acute level frailty Hospital at Home. Typically, provision includes the use of a flexible workforce that is deployed according to each person's needs. The virtual ward workforce commonly consists of:

- consultant geriatricians (hospital or community based)
- advanced clinical practitioners
- pharmacists
- nurses
- AHPs
- GPs with specialist interest
- health and care support staff
- social care workers
- operational support
- third sector organisations.

To provide a safe and robust virtual ward staffing is required for a minimum of 12 hours a day (8am–8pm), seven days a week, with locally arranged provision for out-of-hours cover, enabling flexibility of service provision as determined by local need.

Further support

For further guidance on implementation of virtual wards please see the supporting guidance note.

For further information and to access digital tools, resources and ongoing updates, visit the virtual ward NHSFutures page. If there are any issues accessing the site or further queries, please email england.virtualward@nhs.net

Appendix: Patient pathway

The patient journey can be split into the following stages:

Stage 1: Clinical assessment

- Clinical assessment before entry to Hospital at Home should be carried out in a person's usual place of residence and in person by a registered professional from community urgent crisis response, same day emergency care, emergency department, or where already admitted to hospital in a ward setting.
- As part of the wider assessment, the following tools and assessments should be used to identify deterioration and support clinical management decisions, which could include intensifying treatment at home (escalation in place) or, if appropriate, transfer to hospital for further intervention. Assessments should not be used exclusively to exclude a person from Hospital at Home admission.
- Assessment should take into account personalised care principles, including 'what matters' to people and their individual strengths and needs.
- Assessment should also include:
  - clinical observations, such as blood pressure and oxygen saturations
  - calculation of National Early Warning Score (NEWS2)
  - frailty screening, with Clinical Frailty Score (CFS)
  - delirium, eg 4AT (rapid test for delirium)
  - assessment of the safety of the person and their family or carers, and the family's or carer's ability to provide support. Consider any capacity, consent or safeguarding concerns, referring to appropriate services
  - review of clinical records and relevant investigations to understand medical history, presenting complaint and usual level of functioning
  - blood, urine and point of care testing/diagnostics
  - assessment and provision of equipment to keep the person safe at home and support/maintain independence.

Stage 2: Admission

- Assessment and delivery of required interventions, including pressure area care, nutrition, hydration, personal hygiene, continence, wound care, mobility

and rehabilitation to regain or optimise functioning to reduce the risk of deconditioning.

- Nutrition assessment, eg Malnutrition Universal Screening Tool (MUST).
- Risk of developing pressure sores, eg Waterlow or Braden score.
- Assessment and provision of equipment to keep the person safe at home and support/maintain independence.
- Prescription and/or administration of medication for pain or symptom relief.
- Rapid access to appropriate medical treatments, including ability to deliver via parenteral routes (subcutaneous and intravenous), as required.

Stage 3: Assessments and monitoring

The following assessments and interventions should be carried out, or started while the person is admitted to a Hospital at Home:

- start Comprehensive Geriatric Assessment for CFS ≥5
- medicines optimisation assessment
- review recommended summary plan for emergency care and treatment (ReSPECT), treatment escalation plan (TEP) and do not attempt resuscitation (DNAR) forms. This should also include a conversation about advanced care planning and treatment escalation, with appropriate plans completed where they are not already in place
- develop personalised care and support planning. Planning document is updated at every point of care/intervention and regularly reviewed so that it includes all the assessment and intervention information, ideally in one place.

Stage 4: Discharge and transferring care

- The discharge criteria from acute level Hospital at Home wards are expected to be in line with the Hospital discharge and community support: policy and operating model, which sets out the hospital discharge model for all providers of NHS-commissioned hospital and community beds, community health services and social care in England.
- A daily review of every person on the virtual ward to make decisions, informed by the criteria to reside, as with all acute care.

- Suitable arrangement should be made for transferring care from the Hospital at Home ward to alternative pathways, suitable for a person's care needs. The need for a timely discharge should never result in discharges that are unsafe, such as without adequate support, or lead to people not being fully informed as to the next stages of their care.
- Care could be transferred to primary care, community or social care-led services such as:
  - discharge to assess
  - community nursing team
  - rehabilitation
  - anticipatory care teams
  - primary care provider
  - end-of-life care
  - GP.
- Where a Comprehensive Geriatric Assessment has been started, this must be clearly communicated to the services taking over a person's care to enable continuity of care and completion of assessment as part of ongoing care within a primary or community care setting.
- When developing services, transitions of care between Hospital at Home services and end-of-life services should be a high priority, with clear pathways between services and agreed care planning to ensure high quality end-of-life care delivery.