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Virtual Wards for *people with frailty* in the community

Rapid realist review findings and implementation ideas

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Westby M, Ijaz S, Savović J, McLeod H, Dawson S, Welsh T, Le Roux H, Walsh N, Bradley N.
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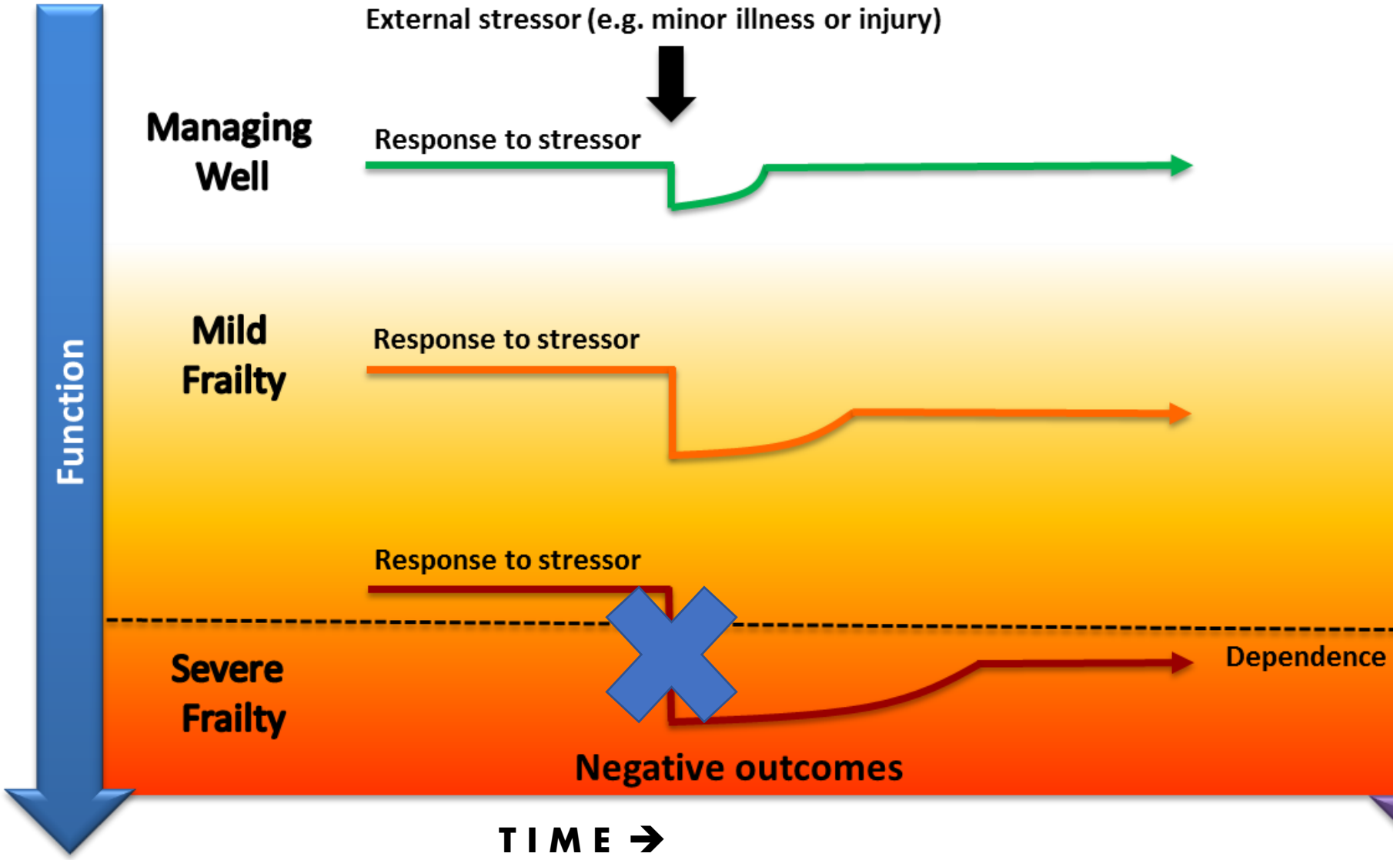
Content

- Frailty and its management, and NHS problems
- Virtual Wards – what are they?
- Our realist review project
- Findings 1 – types of virtual ward
- Findings 2 - Components of Virtual wards and how they work
- Issues and solutions
- Summary recommendations

People with frailty are at risk of unpredictable deterioration in health



Where people have severe frailty, even 'minor' stressors (e.g. UTI, constipation) can tip over into a frailty crisis (e.g. fall, delirium, sudden immobility)

⇒Hospital admission

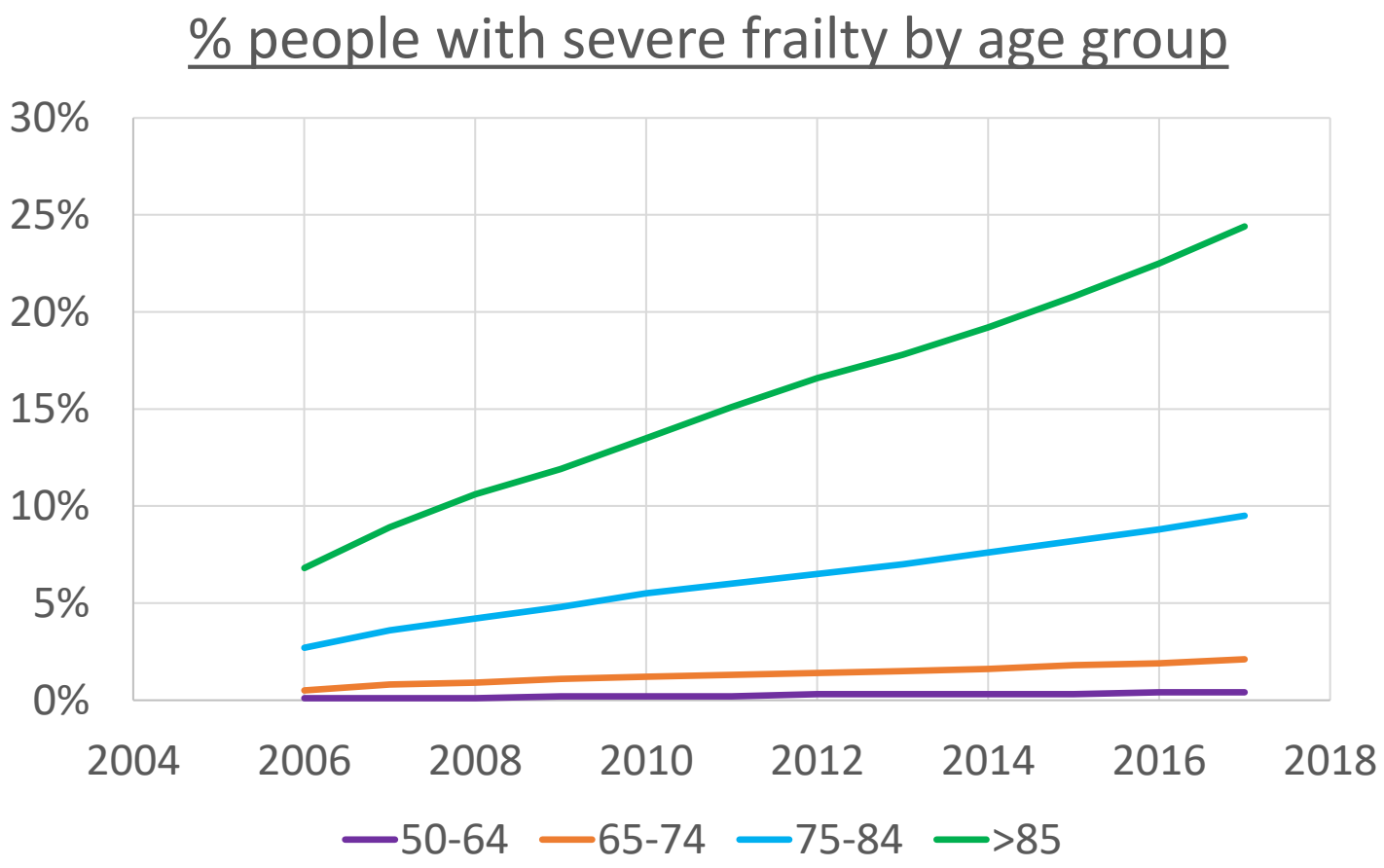
Current management of frailty

- Diagnose and assess frailty severity in primary care
- As appropriate, refer for assessment / Comprehensive Geriatric Assessment: stabilise frailty, & prevent frailty crises (‘*proactive care’*)
- If people have a frailty crisis, intervene to treat the crisis and also the trigger *(‘reactive’ acute care* – usually in hospital)
- GIRFT recommendations† include:
  - Integrate frailty care across health systems (secondary care, primary care, care homes, community services, ambulance services and paramedics, local authorities and the voluntary sector)
  - Prevent moderate frailty from becoming severe
  - Implement safe and effective discharge and reduce *re-admission* rates

† https://gettingitrightfirsttime.co.uk/wp-content/uploads/2021/09/Geriatric-Medicine-Sept21h.pdf

The problem for the NHS

Frailty prevalence is increasing with time and hospital admissions are high



Pre-COVID, 5-10% of those attending A&E and 30% in acute medical units were older and living with frailty

https://gettingitrightfirsttime.co.uk/wp-content/uploads/2021/09/Geriatric-Medicine-Sept21h.pdf

Data from Walsh et al. Age and Ageing 2023: 52. 1-9

Part of the solution is Virtual Wards

- Virtual Wards (VWs): model for delivering multidisciplinary care *at home* to people with frailty *at high risk of a crisis or in-crisis ("acutely unwell")*
- Aim to prevent hospital admission – by preventing a *crisis* or preventing the *admission*
- Current state of play is that NHS England guidance has been issued - but what do virtual wards for frailty care look like? What are the must-have components? And how can research help us implement Virtual Wards?
- Evidence of effectiveness is limited and inconsistent – we wanted to understand why and how – so needed a different sort of evidence review…
- …and therefore, we conducted a rapid realist review to understand how and why Virtual Wards may (not) work within their specific contexts.
  And what could improve them.

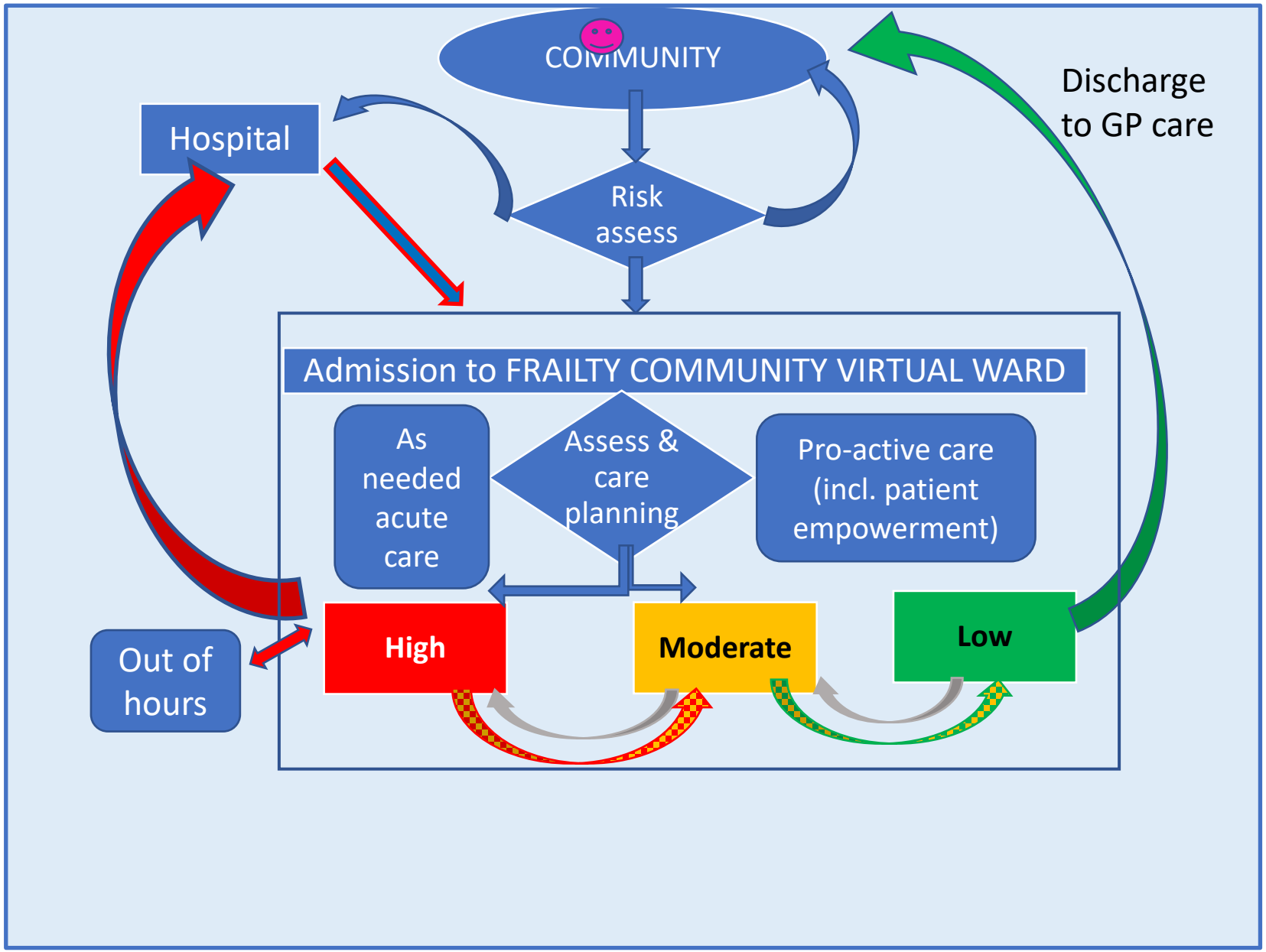
What we did

- Searched (in 2 rounds) the published literature and Google search for NHS documents on virtual wards for frailty in the UK
- Worked with stakeholders at two stages (clinicians, patients, carers)
- Iterative data extraction from 28 studies

=> Three main themes

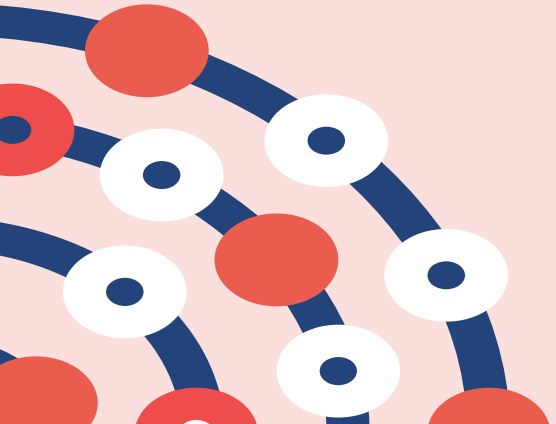
  - Virtual Ward building blocks
  - How Virtual Wards enable delivery of frailty interventions
  - Patient and Carer involvement and empowerment

STARTING POINT FOR VW PATIENT PATHWAY – FROM THE LITERATURE



FINDINGS

Types of Virtual Ward
Themes, components and implementation



Types of Virtual Ward

Type 1 – longer-term Virtual Wards

(17 studies)

- > 21 days (avg. 3-7 months in VW)
- High risk of a frailty crisis or high risk of hospital admission
- Avoid escalation to hospital
- Mainly proactive care to prevent a crisis and stabilize frailty
- Discharge to GP: when frailty stable with no events for 4-6 weeks

Type 2 – Short term Virtual Wards

(12 studies)

- 1-21 days
- Frailty in-crisis
- Alternative to hospital care
- Mainly reactive acute care, then if time start proactive care
- Discharge probably when crisis resolved. Continuity is essential (to start/continue proactive care)
- NHS ENGLAND GUIDANCE

Implementation question

- If we are tasked with rolling out short-term virtual wards for people with frailty in-crisis, can we learn anything from the more established longer-term virtual wards?
- Yes – we can learn from both longer-term and short-term VWs

Evidence Theme 1 – VW building blocks

Frailty – multidimensional needs of patients – requires multidisciplinary care

- **Common standards agreements**
  - e.g., patient eligibility, assessment procedures, discharge, care documentation
  - Formalises collaboration amongst the different providers and specialities involved.
- **Information sharing processes**
  - IT integration and trust amongst providers, incl. out-of-hours, GPs, emergency services
- **Multidisciplinary team (MDT) composition and co-ordination**
  - Service delivery requires an MDT to provide a tailored, whole-person approach to diagnosis, assessment and treatment
  - Multiple teams work together across primary care, community care, speciality frailty clinicians
  - VW co-ordinator: facilitates teamwork, liaises with patient/carers & external organisations
- **MDT meetings**
  - MDT meets to discuss patients and plan their care, remote from the patients.
  - Forum for communication between hands-on team and specialist clinicians

Evidence Theme 2 – VWs delivering frailty management

Virtual Ward components combine to ensure the Virtual ward *as a whole* can deliver interventions to people acutely unwell with frailty

- **Patient selection into the VW**
- **Comprehensive assessment, planning and evaluation**
  - VW co-ordinator, face-to-face and consulting with MDT
- **Medication management** optimised through VW
- **Intensive case management**
  - Stratification by severity/risk (RAG) and rapid response to changing needs.
  - Monitoring
- **Proactive care** facilitated, patients / carers empowered in their own care

Evidence Theme 3 – patient and carer experience

- [Limited evidence on this section and none on social inequalities]
- **Improved communication** via a known point of contact (the VW co-ordinator)
- **At home instead of hospital** (patients and carers feel supported and safe)
- **Carer experience**

  Including shared decision making and being valued and listened to. Carer is an essential partner for the virtual ward (especially since most VWs are not 24h)

  BUT

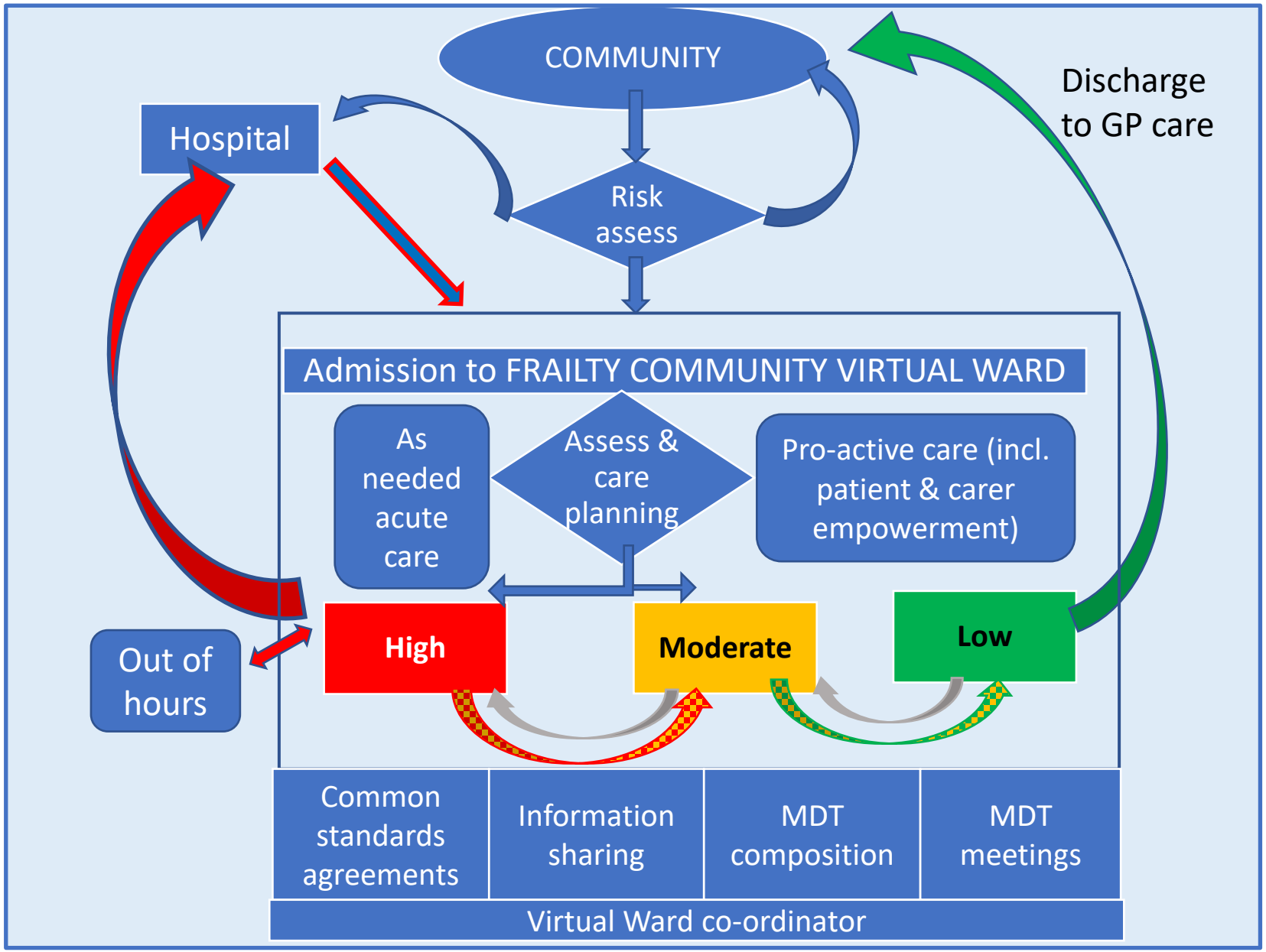
  Carers of people in-crisis (e.g., delirium) may not cope (especially out-of-hours) => carer stress and burnout. Hospital may be the best place.

  More likely when patients are in-crisis (i.e., mainly short-term VWs)

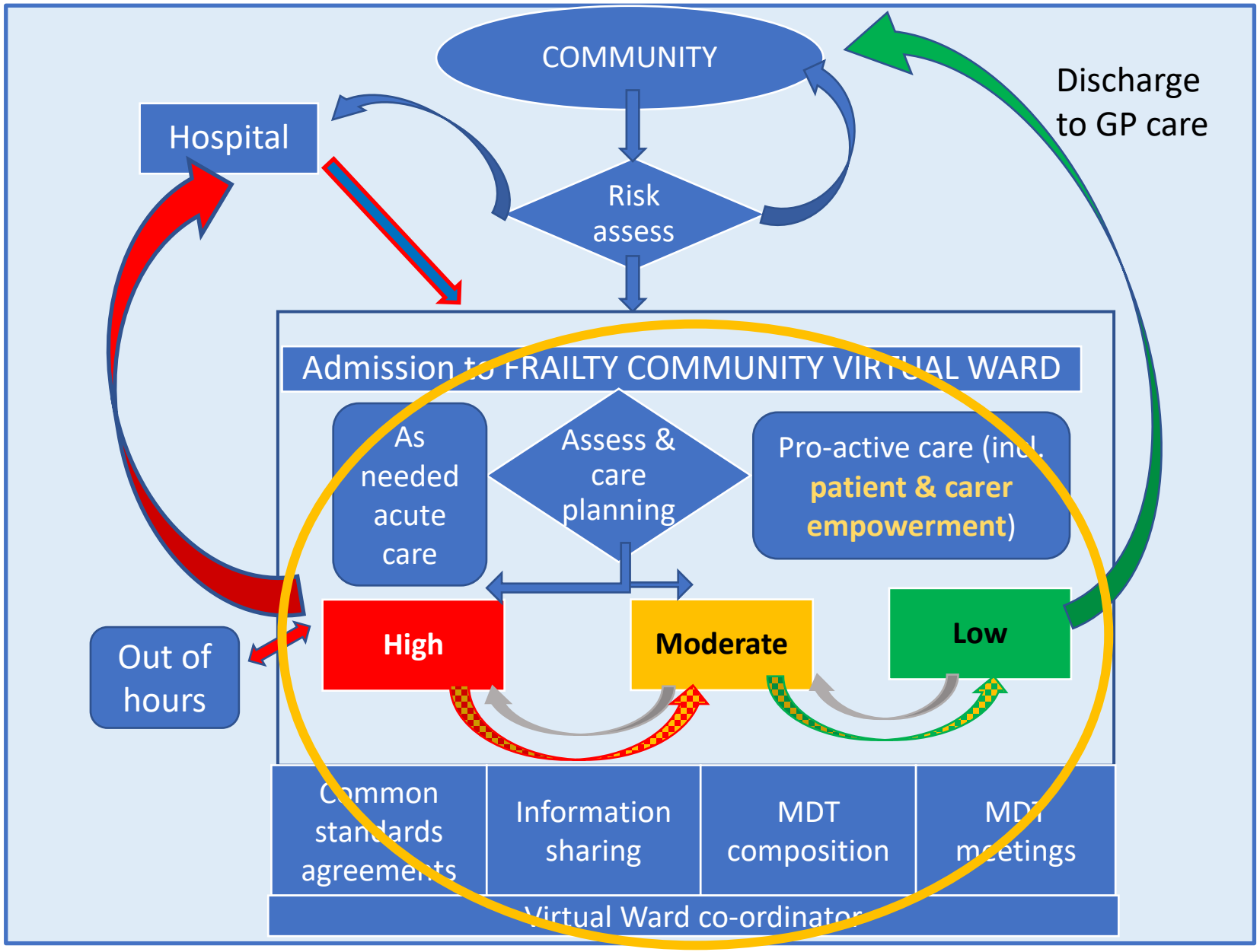
Mechanisms

- Professionals motivated to work together (and their ability to do so) - ICBs
- ‘Team-of-teams’ provides mutual support
- Trusting in shared goals, reciprocal learning
- Buy-in of professionals is aided by:
  - perceptions of patient safety and benefit (saving lives not saving costs)
  - starting small
  - taking time to introduce formal agreements and learn new ways of working
- Good communication between patients, carers and staff
- Patients feel safe at home, supported and empowered to manage their own care
- Carers supported, valued, burden reduced

VIRTUAL WARD DELIVERING FRAILTY MANAGEMENT



VIRTUAL WARD DELIVERING FRAILTY MANAGEMENT



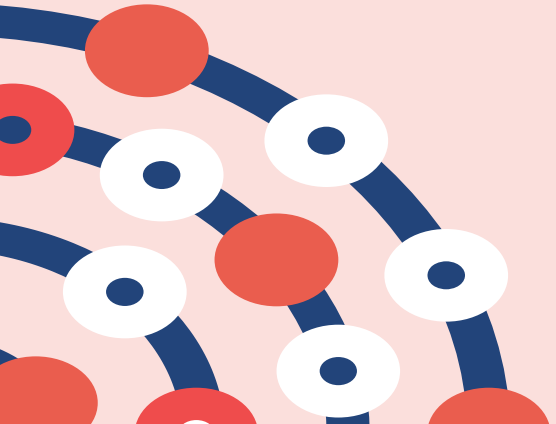
AND INCORPORATING PATIENT AND CARER EXPERIENCE

COMMUNICATION

AT HOME INSTEAD OF HOSPITAL

CARER EXPERIENCE

A couple of important issues…



Issues I – delivering proactive care

The Issue

- Treatment of frailty requires
  - Reactive care to treat a frailty crisis if needed AND
  - Proactive care to prevent future crises and stabilise frailty – using the Comprehensive Geriatric Assessment (or similar)
- But the CGA can take up to 6 months to be established – *so there is insufficient time in the short-term virtual wards.*
- Without proactive care, risk that further crises occur => VW re-admittance
- Limited evidence suggests discharge to GP* can be uncoordinated / unpredictable

Potential solutions

- Proactive care – if not delivered in a longer-term virtual ward - must be initiated/continued by the GP* after discharge from the virtual ward,
- i.e. continuity of care is essential.

=> requires good communication, involvement of patients/carers, and systems in place

(i.e. a whole-system approach is needed – see also below)

* Integrated neighbourhood teams, incl primary care, community care, dementia services, social care, 3rd sector, pharmacy

Issue 2 – selection of patients and strategy

The issue	Potential solutions
• Short-term virtual wards treat at home patients who are in-crisis => Frees up some <u>hospital</u> beds BUT Acute care at home may be difficult/unsafe. • Virtual wards not 24 hours: rely on carers/ families, *who may not cope with frailty crises* e.g. delirium – may lead to carer burnout and hospital admission for the patient • Concern that there are too few <u>virtual ward</u> beds, as prevalence increases, as well as the risk of re-admittance *=> potential overload of Virtual Wards and risk of system collapse*	• A combination of short-term and longer-term virtual wards could work (probably not practical yet) • Rather, in the context of effective mid/long-term frailty management, we should try to *prevent high risk patients reaching a crisis* • So identifying the patients *at high risk of a crisis* or who are "wobbling" – and they may wobble for a few days before tipping over – and offering them proactive care in the virtual ward • Initially, this would be alongside those in-crisis • *Again a whole-system approach is needed to, and from, primary care*

RECOMMENDATIONS from the review

1. Aim to implement the four building blocks at set-up and operation of the virtual ward – common standards agreements, information sharing within and external to VW, appropriate MDT composition and meetings, good co-ordination in the VW
2. Ensure patient and carer involvement and empowerment - communication via a known point of contact, shared decision making, awareness & prevention of carer stress/burnout.
3. Empower patients and their carers to self-manage after discharge from the virtual ward
4. Consider how to motivate professionals to work together – e.g., a 'team-of-teams' providing mutual support, trust in shared goals, reciprocal learning through the MDT meetings.
5. Aim to achieve buy-in of professionals – importance of patient safety and benefit (saving lives not costs), starting small, taking time to introduce formal agreements and learn new ways of working
6. Work with GPs* on a whole-system approach to select patients at high-risk of crisis as well as those in-crisis
7. Work with GPs* to ensure effective continuity of care on discharge from the VW and a whole-system approach
8. Emphasise the need for proactive care to reduce risk of future crises as part of a sustainable long-term view of frailty management. Prevention better than cure.
9. Consider sustainability as the prevalence of frailty increases in an ageing population, and potential benefits of transitioning to the proactive care of those at high risk of a crisis

* and Integrated Neighbourhood Teams