Reference: FOI.ICB-2526/172

Subject: Virtual Ward (Adult) Services

I can confirm that the ICB does hold some of the information requested; please see responses below:

QUESTION	RESPONSE
Timeframe: 1 April 2024 – most recent month available (monthly breakdown if possible). Please provide the following at ICB/system level:	
1. Overall configuration a. Which providers in your ICB deliver adult Virtual Ward services. b. Pathways supported across the system.	a. Sirona care and health CiC deliver the VW service and subcontract some of the service to North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). b. The Pathways supported are: • Outpatient Parenteral Antibiotic Therapy (OPAT) • Acute respiratory infection (ARI) • Frailty • Heart Failure • General Surgical and General Medicine. (Includes Infectious Diseases)
2. Activity & Capacity a. Reported VW capacity (beds) and occupancy at ICB level. b. Total admissions and discharges.	The VW Capacity excel spreadsheet is enclosed with the latest ICB level data report. Additional data would need to be requested directly from Sirona care and health - sirona.hello@nhs.net

3. Outcomes & Safety a. Any system-level monitoring of readmissions, escalation rates, or mortality. b. Any evaluation reports commissioned by the ICB.	a. No system level monitoring is undertaken for readmissions, escalation rates, or mortality. b. The Virtual Wards Self-Assessment Tool was completed in October 2024 and is enclosed.
4. Finance & Benefits a. Total system spend on Virtual Ward services in 2024/25. b. Any documented cost-effectiveness or "bed days avoided."	a. £7.275m in 2024/25 b. 6 Months analysis undertaken from January 2025 to June 2025 for cost effectiveness:

Insights and impacts

Month	Av. LOS days	Referrals	Average VW beds delivered	Av. Acute beds saved (VW beds x 0.7 = Hospital bed)	Cost savings (Hospital bed = £345/day)	Cost savings vs. VW av. Monthly budget
January	13.3	321	137.7	96.4	£1,030,998	-£405,998
February	11.5	268	110	77	£743,820	-£118,820
March	9.9	265	84.6	59.2	£633,144	-£8,144
April	12.1	249	100	70	£724,500	-£99,500
May	11.5	293	108	75.6	£808,542	-£183,542
June	11.5	244	93.5	65.5	£677,910	-£52,910

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The information provided in this response is accurate as of 19 September 2025 and has been approved for release by David Jarrett, Chief Delivery Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

Report Period	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Virtual ward occupancy	53%	64%	72%	73%	53%	55%	66%	77%	82%	49%	51%	68%	67%	68%	55%	60%	48%
Virtual ward occupancy - capacity	121	121	121	111	141	141	141	141	141	201	171	171	171	156	156	161	161
Virtual ward occupancy - occupied	64	77	87	81	75	78	93	109	115	99	87	116	115	106	86	97	78

Healthier Together
Improving health and care in Bristol,
North Somerset and South Gloucestershire

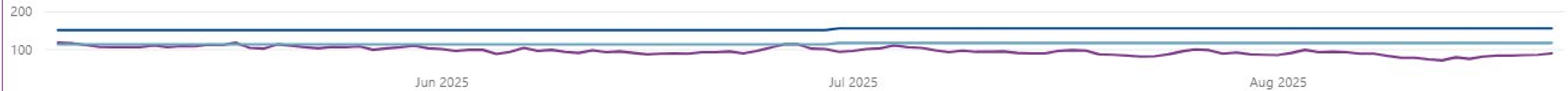
Virtual Wards

Data

Occupancy

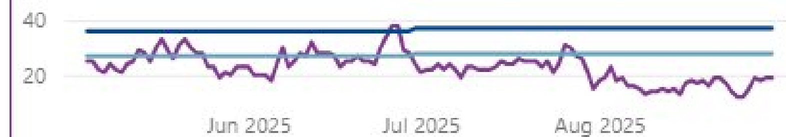
Daily occupancy - all wards

Total number of patients on ward (Occupancy) Capacity Target



Daily occupancy - Frailty

Total number of patients on ward (Occupancy) Capacity Target



Daily occupancy - General

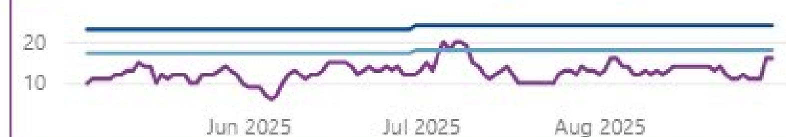
Total number of patients on ward (Occupancy) Capacity Target

Daily occupancy - Heart Failure

Total number of patients on ward (Occupancy) Capacity Target

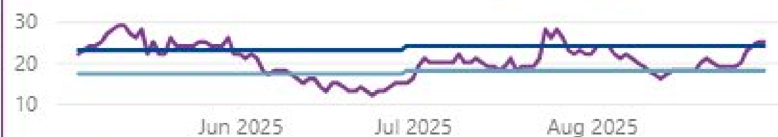
Daily occupancy - Infectious Diseases

Total number of patients on ward (Occupancy) Capacity Target



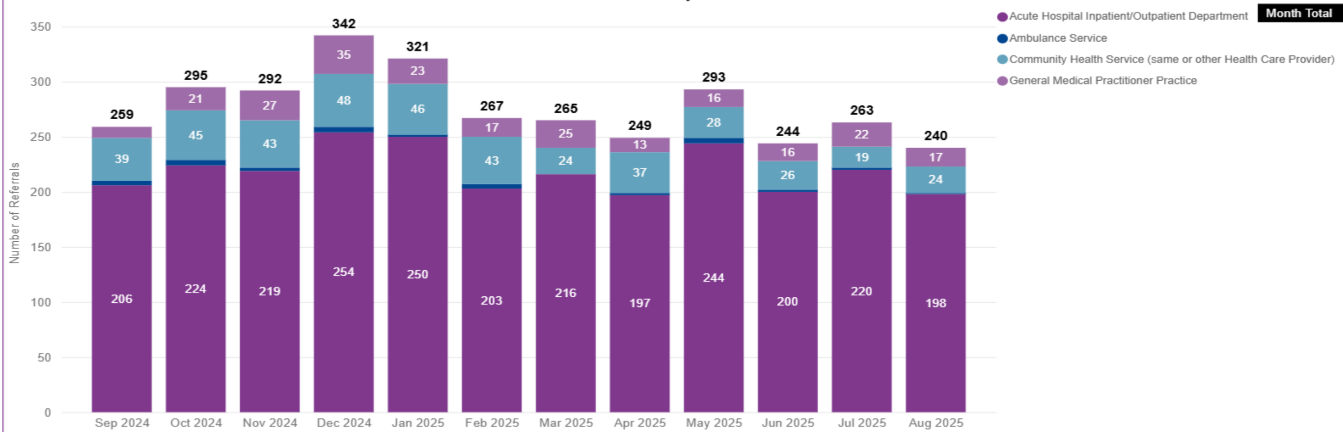
Daily occupancy - OPAT

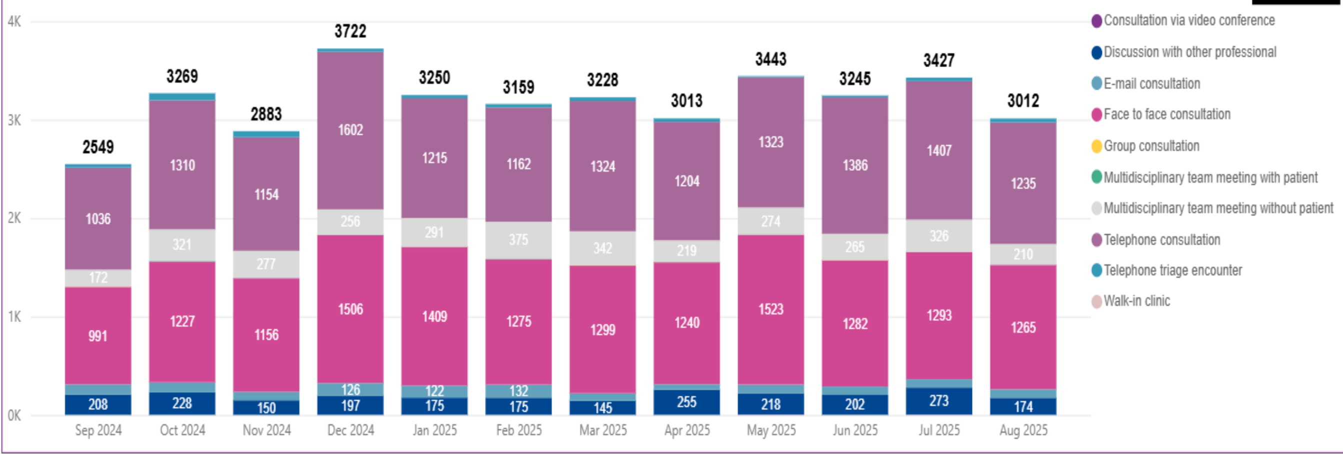
Total number of patients on ward (Occupancy) Capacity Target

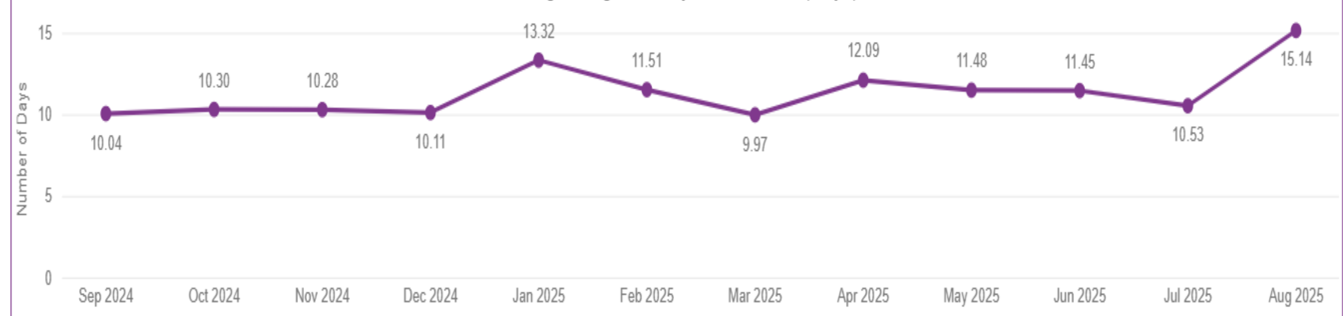


Daily occupancy - Respiratory

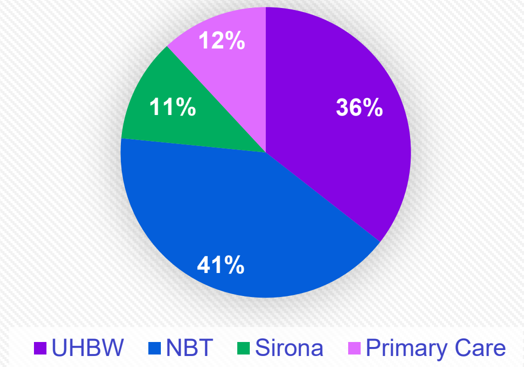
Total number of patients on ward (Occupancy) Capacity Target





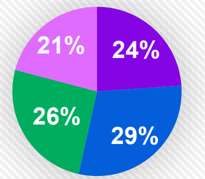


Source of referrals

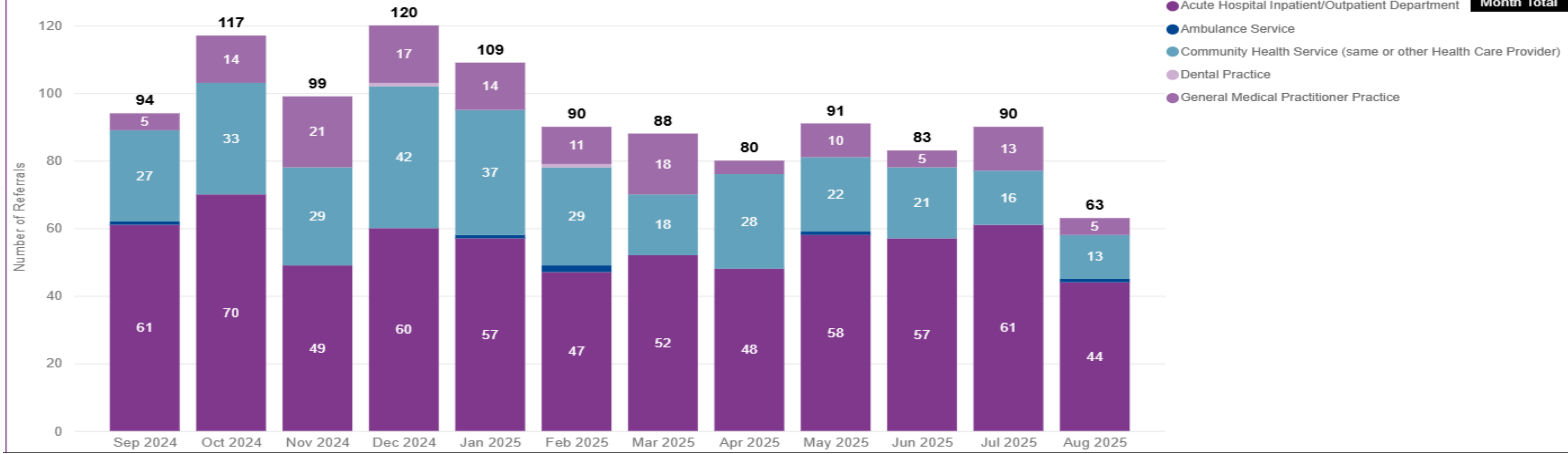


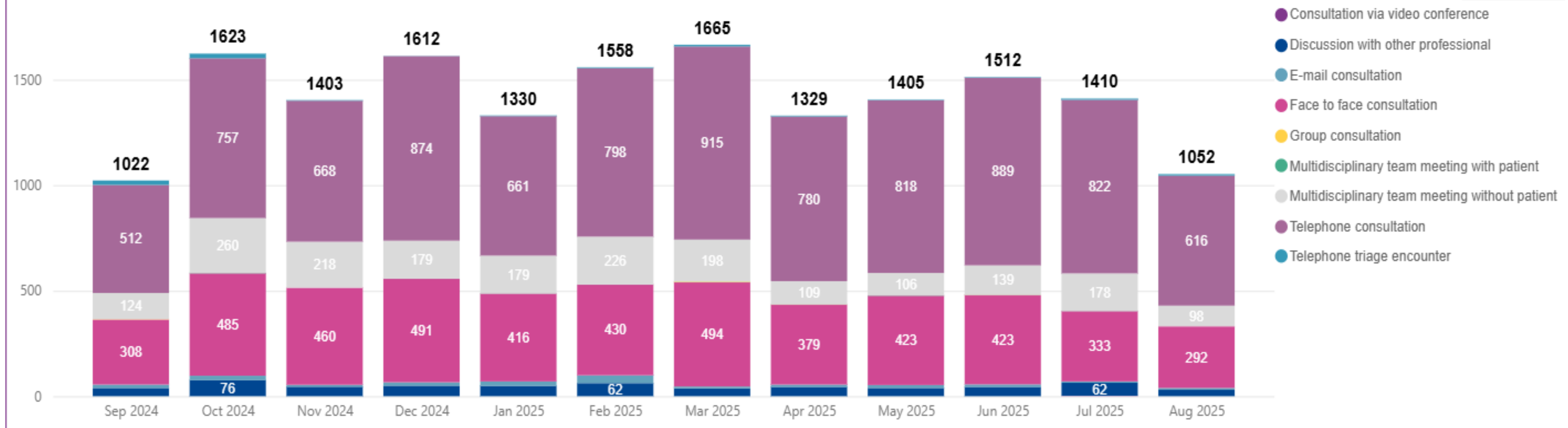
UHBW NBT Sirona Primary Care

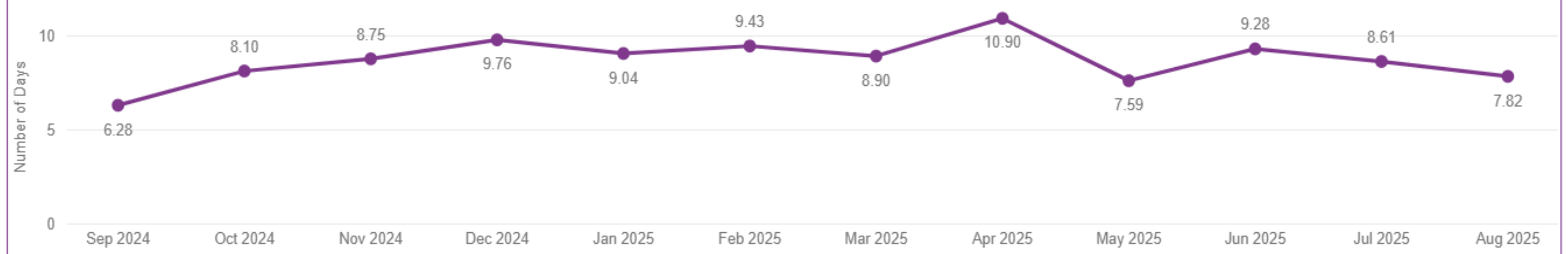
Referrals source

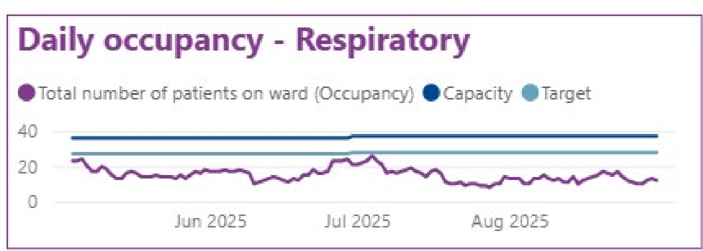


UHBW NBT Sirona Primary Care

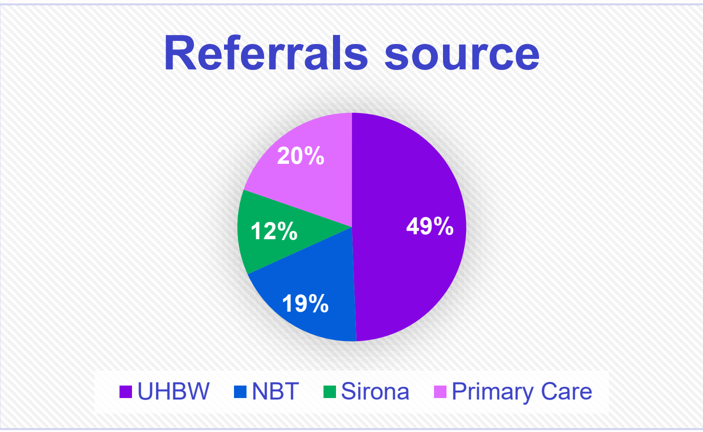




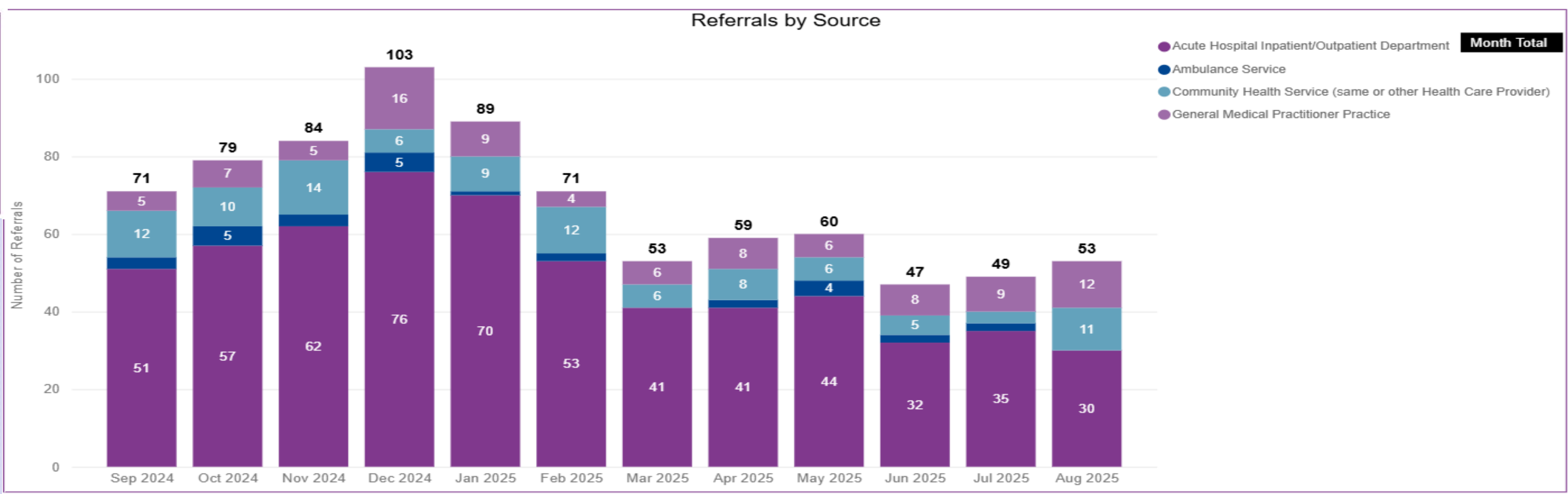




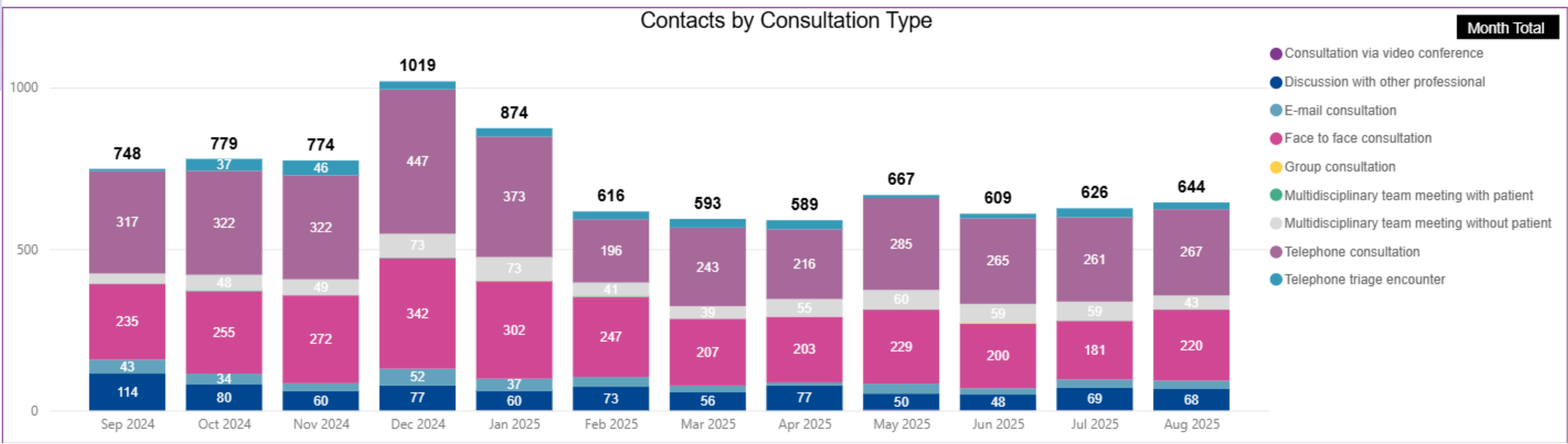
Daily occupancy - Respiratory
Total number of patients on ward (Occupancy)
Capacity
Target
40
20
0
Jun 2025
Jul 2025
Aug 2025



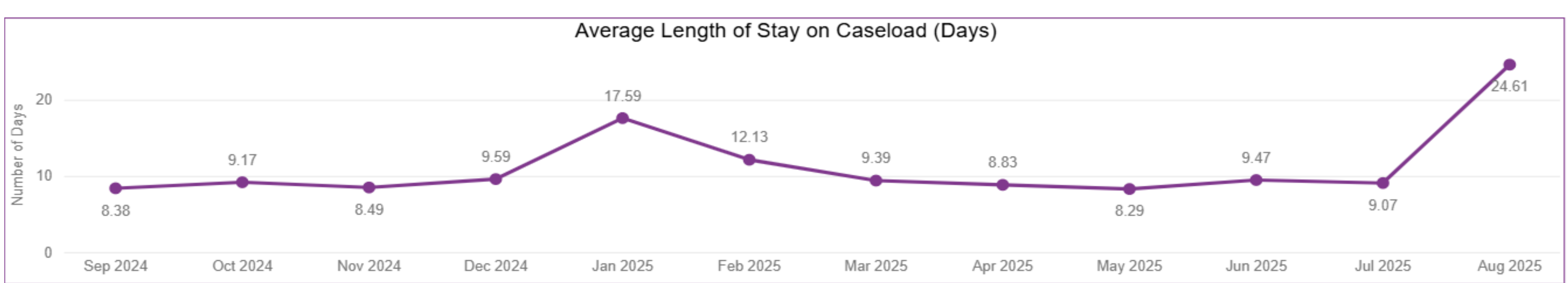
Referrals source
49%
19%
12%
20%
UHBW
NBT
Sirona
Primary Care



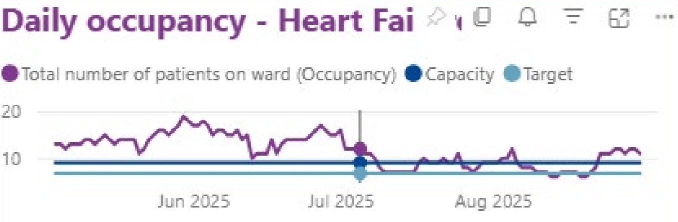
Referrals by Source
Acute Hospital Inpatient/Outpatient Department
Ambulance Service
Community Health Service (same or other Health Care Provider)
General Medical Practitioner Practice
Month Total
Number of Referrals
Sep 2024: 71 (51, 12, 5)
Oct 2024: 79 (57, 5, 10, 7)
Nov 2024: 84 (62, 14, 5)
Dec 2024: 103 (76, 5, 6, 16)
Jan 2025: 89 (70, 9, 9)
Feb 2025: 71 (53, 12, 4)
Mar 2025: 53 (41, 6, 6)
Apr 2025: 59 (41, 8, 8)
May 2025: 60 (44, 4, 6, 6)
Jun 2025: 47 (32, 5, 8)
Jul 2025: 49 (35, 9)
Aug 2025: 53 (30, 11, 12)



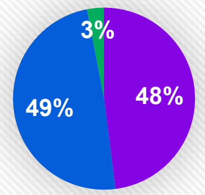
Contacts by Consultation Type
Month Total
Consultation via video conference
Discussion with other professional
E-mail consultation
Face to face consultation
Group consultation
Multidisciplinary team meeting with patient
Multidisciplinary team meeting without patient
Telephone consultation
Telephone triage encounter
Sep 2024: 748 (114, 43, 235, 317)
Oct 2024: 779 (80, 34, 255, 48, 322, 37)
Nov 2024: 774 (60, 272, 49, 322, 46)
Dec 2024: 1019 (77, 52, 342, 73, 447)
Jan 2025: 874 (60, 37, 302, 73, 373)
Feb 2025: 616 (73, 247, 41, 196)
Mar 2025: 593 (56, 207, 39, 243)
Apr 2025: 589 (77, 203, 55, 216)
May 2025: 667 (50, 229, 60, 285)
Jun 2025: 609 (48, 200, 59, 265)
Jul 2025: 626 (69, 181, 59, 261)
Aug 2025: 644 (68, 220, 43, 267)



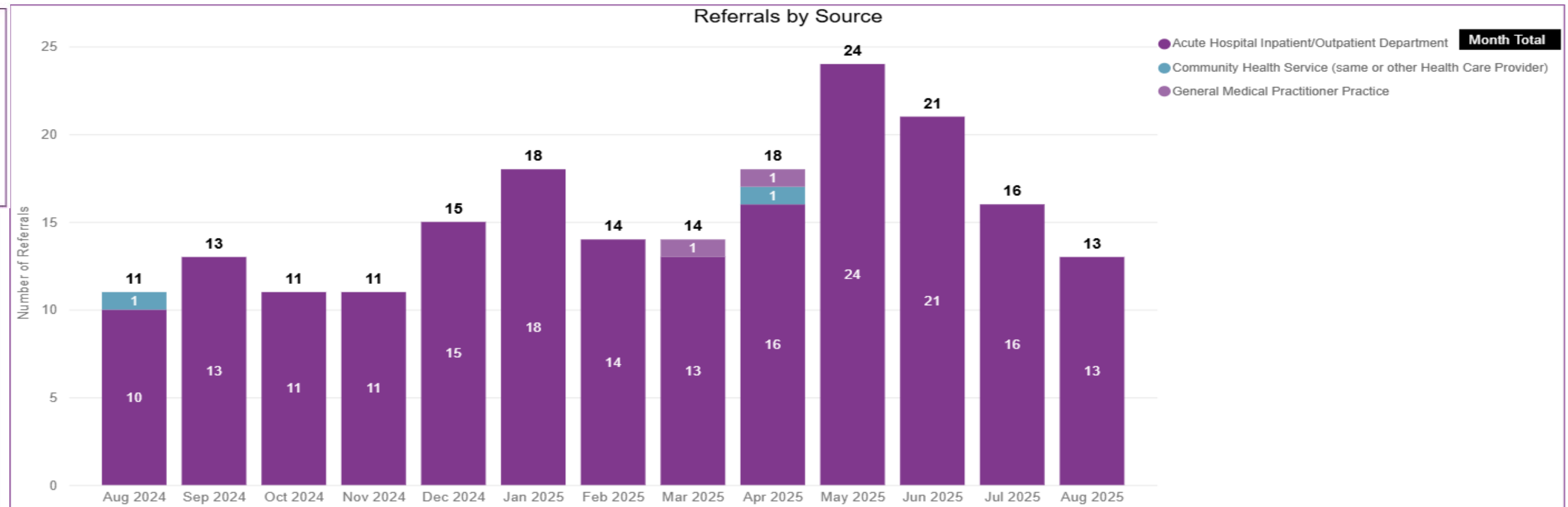
Average Length of Stay on Caseload (Days)
Number of Days
Sep 2024: 8.38
Oct 2024: 9.17
Nov 2024: 8.49
Dec 2024: 9.59
Jan 2025: 17.59
Feb 2025: 12.13
Mar 2025: 9.39
Apr 2025: 8.83
May 2025: 8.29
Jun 2025: 9.47
Jul 2025: 9.07
Aug 2025: 24.61

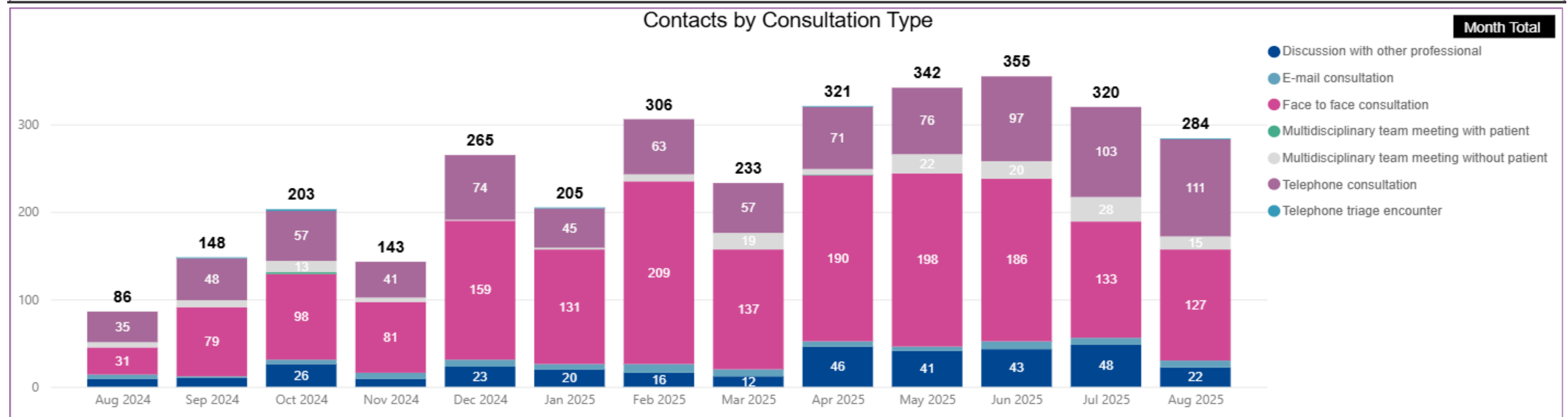


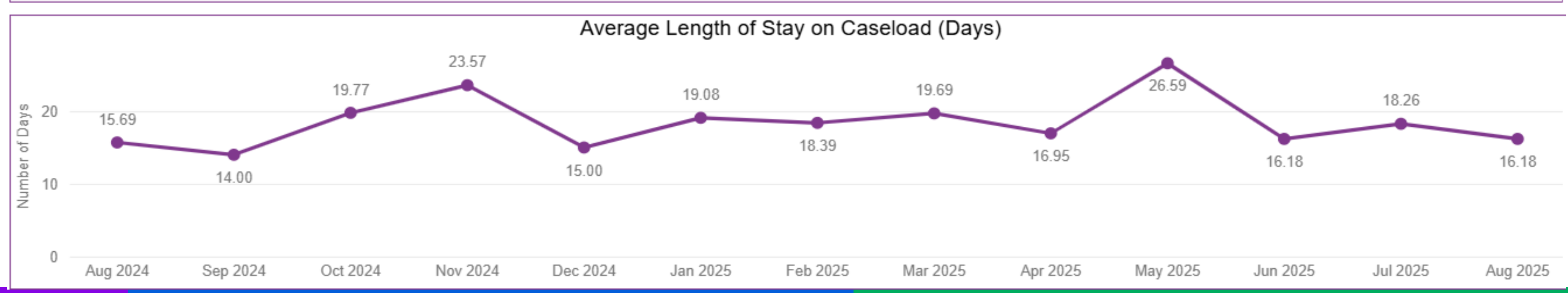
Referrals source



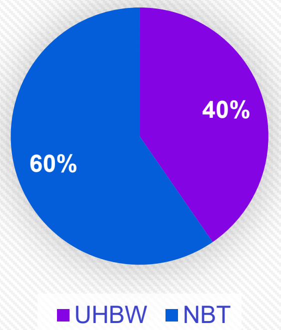
UHBW NBT Primary Care

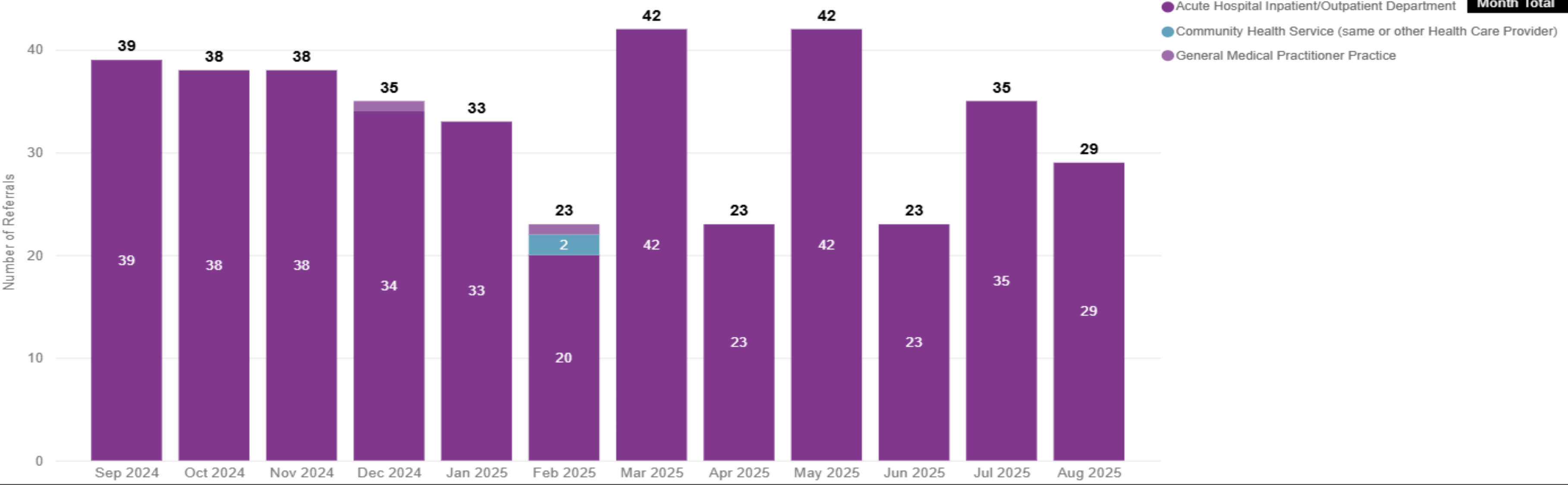


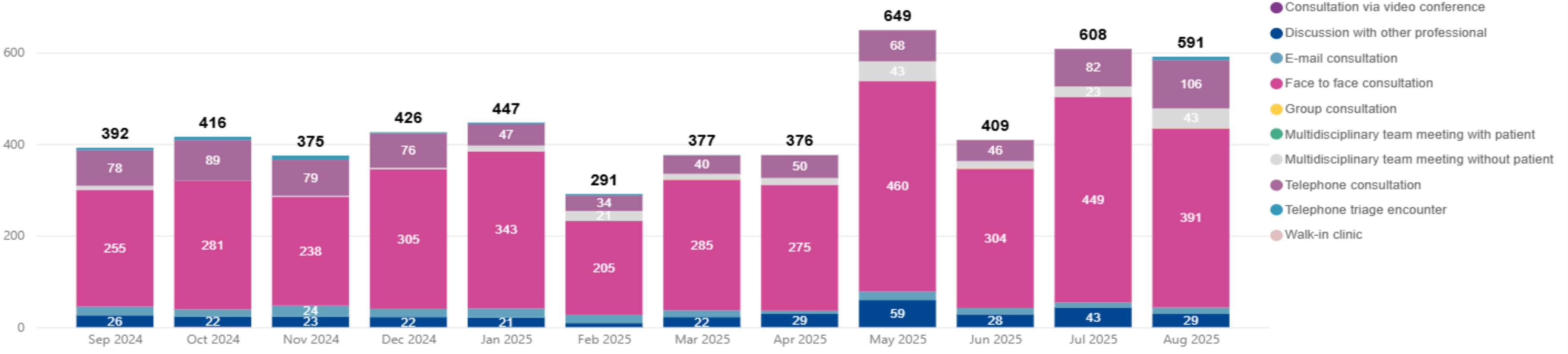


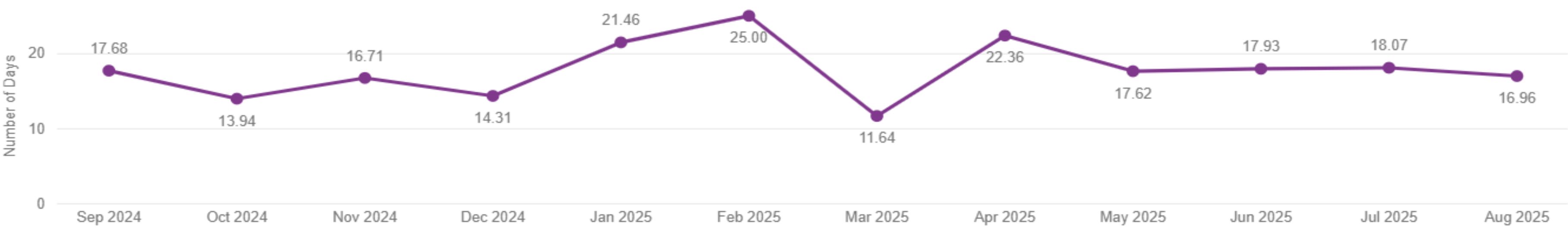


Daily occupancy - OPAT
Total number of patients on ward (Occupancy)
Capacity
Target
30
20
10
Jun 2025
Jul 2025
Aug 2025


Referrals source
40%
60%
UHBW
NBT


Referrals by Source
Acute Hospital Inpatient/Outpatient Department
Community Health Service (same or other Health Care Provider)
General Medical Practitioner Practice
Month Total
Number of Referrals
39
38
38
35
33
23
42
23
42
23
35
29
Sep 2024
Oct 2024
Nov 2024
Dec 2024
Jan 2025
Feb 2025
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025

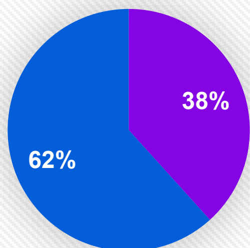

Contacts by Consultation Type
Month Total
Consultation via video conference
Discussion with other professional
E-mail consultation
Face to face consultation
Group consultation
Multidisciplinary team meeting with patient
Multidisciplinary team meeting without patient
Telephone consultation
Telephone triage encounter
Walk-in clinic
392
416
375
426
447
291
377
376
649
409
608
591
Sep 2024
Oct 2024
Nov 2024
Dec 2024
Jan 2025
Feb 2025
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025


Average Length of Stay on Caseload (Days)
Number of Days
17.68
13.94
16.71
14.31
21.46
25.00
11.64
22.36
17.62
17.93
18.07
16.96
Sep 2024
Oct 2024
Nov 2024
Dec 2024
Jan 2025
Feb 2025
Mar 2025
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025

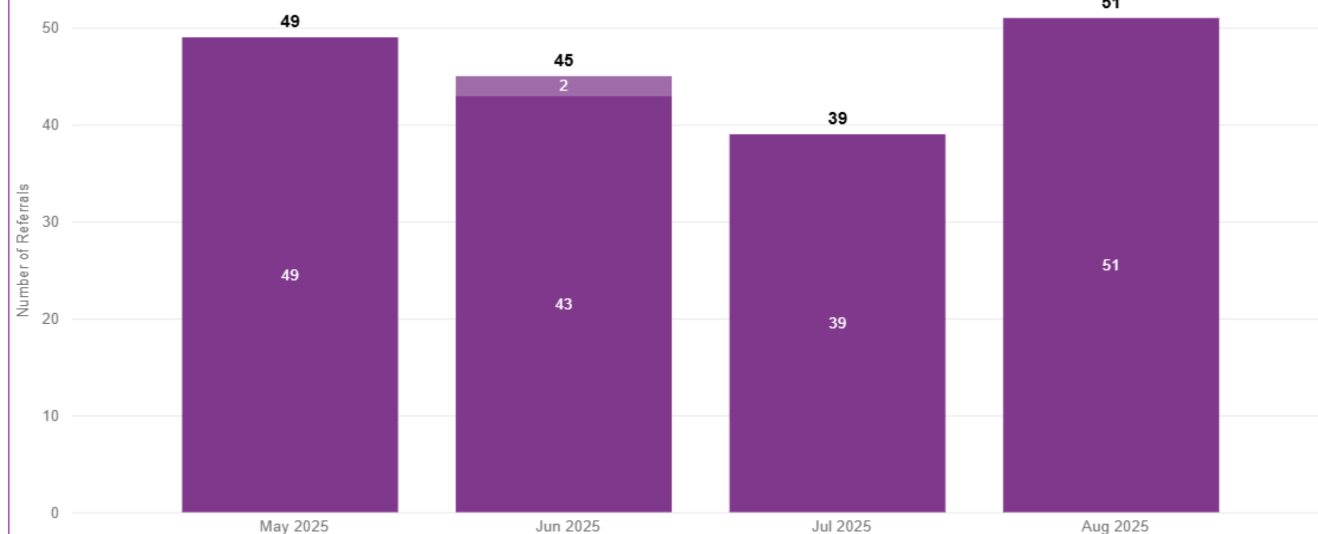
Daily occupancy - General

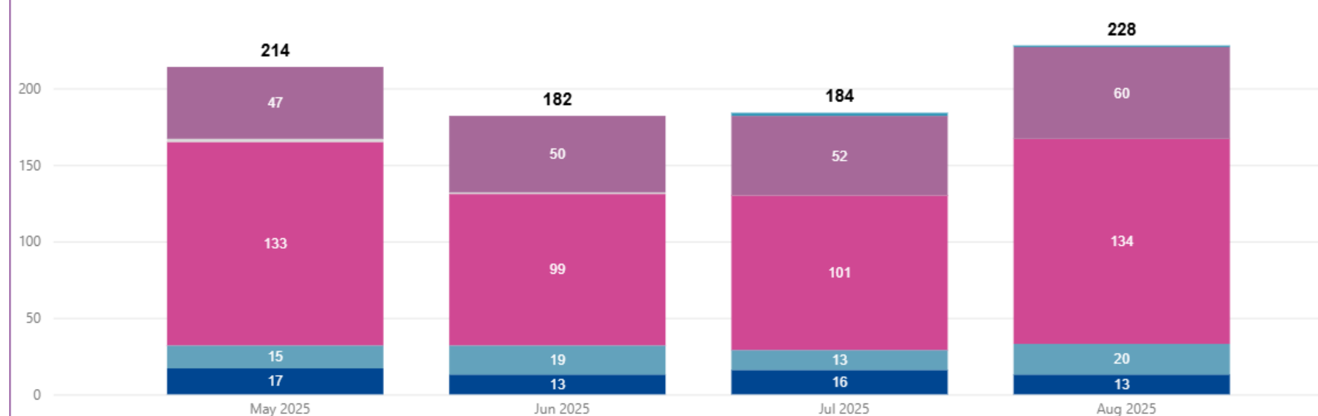
Total number of patients on ward (Occupancy) Capacity Target

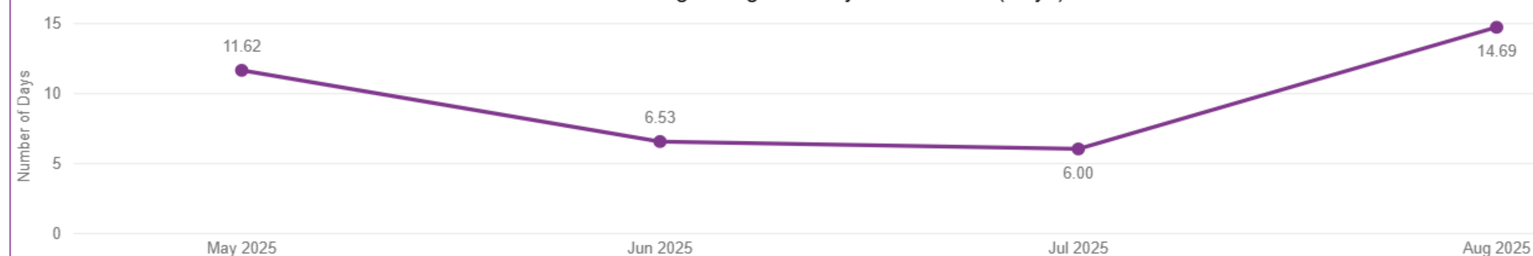
Referrals source

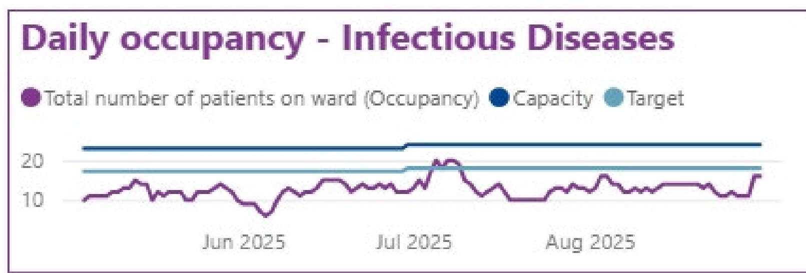


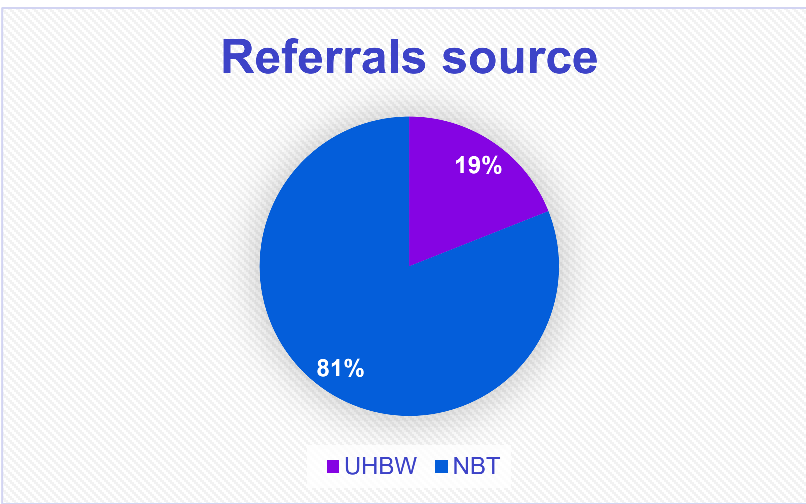
UHBW NBT

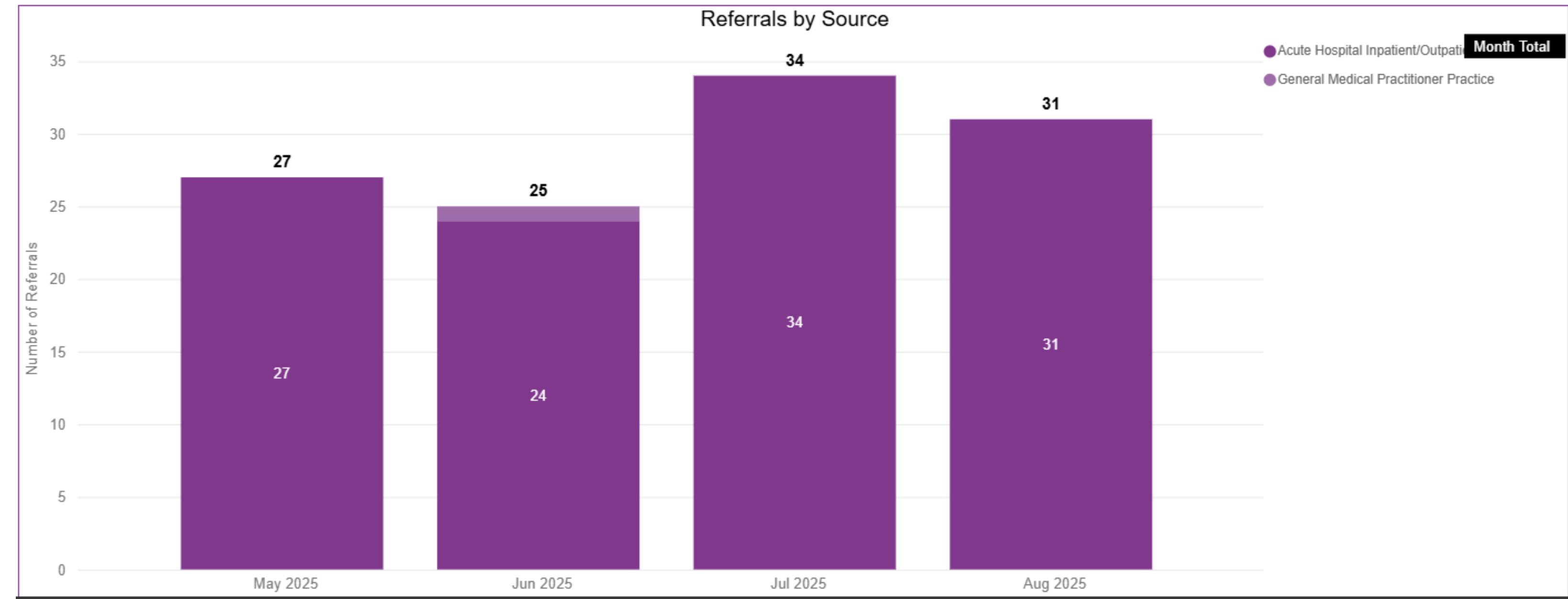


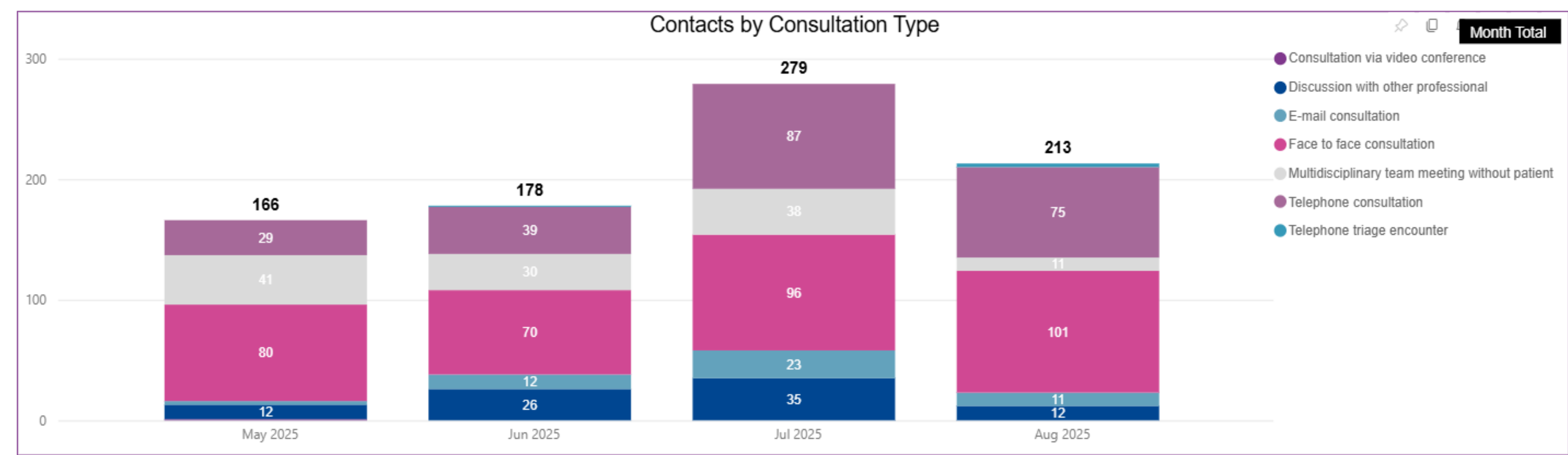


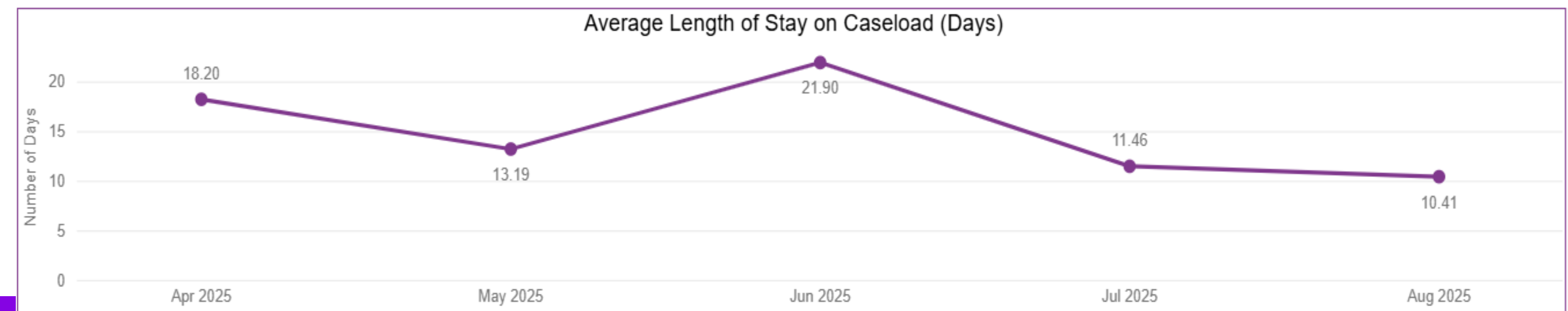



Daily occupancy - Infectious Diseases
Total number of patients on ward (Occupancy)
Capacity
Target
20
10
Jun 2025
Jul 2025
Aug 2025


Referrals source
19%
81%
UHBW
NBT


Referrals by Source
Acute Hospital Inpatient/Outpati
General Medical Practitioner Practice
Month Total
Number of Referrals
35
30
25
20
15
10
5
0
27
27
25
24
34
34
31
31
May 2025
Jun 2025
Jul 2025
Aug 2025


Contacts by Consultation Type
Month Total
Consultation via video conference
Discussion with other professional
E-mail consultation
Face to face consultation
Multidisciplinary team meeting without patient
Telephone consultation
Telephone triage encounter
300
200
100
0
166
29
41
80
12
178
39
30
70
12
26
279
87
38
96
23
35
213
75
11
101
11
12
May 2025
Jun 2025
Jul 2025
Aug 2025


Average Length of Stay on Caseload (Days)
Number of Days
20
15
10
5
0
18.20
13.19
21.90
11.46
10.41
Apr 2025
May 2025
Jun 2025
Jul 2025
Aug 2025

Self-assessment tool for virtual wards / hospital at home services

DRAFT: September 2024

Background and purpose:

This self-assessment tool is designed to support services, providers and integrated care boards (ICBs) in assessing their local delivery against requirements in the Virtual Wards Operational Framework. This tool is intended for local use to support local improvement plans and is not an assurance mechanism. It aims to complement the ongoing programme of Getting it Right First Time (GIRFT) reviews across the country, and to help local services understand their maturity and identify areas for improvement to maximise benefits for patients, carers and the wider system flow.
If following the self-assessment providers and systems are unable to meet the core components, local systems are encouraged to contact their NHSE region to discuss an improvement/implementation plan.

How to use this self assessment tool:

The tool can be used by individual services or provider organisations. Alternatively, this may be completed with all relevant services at provider or system level to provide a provider or ICS-wide pricture. To do so, providers/ICBs can duplicate the core service component sheet to enable each service to complete the self-assessment across their patch. The suggestion is then for local analysts to help link the sheets to generate a cross-provider/cross ICB overall scoring/assessment of the fidelity of local provision against the virtual wards operational framework. The virtual wards operational framework encourages system-level collaboration and this tool can support this.
The core service component sheet aligns with core components for virtual wards/hospital at home services outlined in the operational framework. The ICB recommendation sheet aligns with the requirements for ICBs set out in the operational framework.

Information can be entered about current activity relevant to each key line of enquiry (KLOE), actions needed to meet the recommendation, your deadlines and the names of the responsible leads. Useful documents can be added as hyperlinks as you see fit.

You can adapt the data sheet to suit your own service or organisation's needs, e.g. adapting columns and rows, adding extra sheets for example to provide more operational information or detail on service configuration and activity, linking the data to calculate scores, etc.

The virtual wards operational framework can be accessed here.

This self-assessment tool and other relevant resources, case studies, etc. can be accessed on our FutureNHS pages here.

Service/provider name: NHS@Home BNSSG
Is service step-up/step down or both: BOTH, predominately step-down
Service specialty (e.g. frailty, respiratory, heart failure, etc): Frailty, Respiratory, HF, General and infections
Date of completion of assessment: 01/10/24

KLOE number	KLOE	Does your service or provider meet the recommendation? (yes/no/partial/not applicable)	Evidence of current activity to meet the recommendation (If the recommendation is not applicable to your service or provider please explain why)	If the recommendation is not met, what actions are being taken to support its implementation?	Deadline	Responsible lead	Completed by
1	Effective governance and clinical leadership, with consultant physician/consultant practitioner/GP	Yes					
1.1	A named consultant physician/consultant practitioner/GP for the virtual ward, which could be a doctor (including a medical consultant or a GP with an Extended Role), nurse or allied health professional (AHP) with consultant-level practice and knowledge and capabilities in the relevant specialty or care model, holds accountability for all patients admitted to the virtual ward	Yes	Consultant (s) for all virtual wards who holds accountability for patients within the speciality ward. This is a mix of consultants rather than one named which supports cover across the year				
1.2	Where a patient is admitted from an inpatient ward, the accountability should be transferred before the patient leaves hospital unless the accountable clinician is the same individual in both care settings	Yes	Clear handover of the care from one HCP to another via the single point of referral and treatment plans				
1.3	Patients should be monitored to support early recognition of deterioration and appropriate escalation processes should be in place to maintain patient safety. Training on escalation processes should be provided to carers and staff as necessary	Yes	Remote monitoring in place, clinical team support escalation managed from patient with clear levels of escaltion as part of SOP. All staff undertake trainign on NEWS2, SAFER / deteriorating patint as core	e			
1.4	Virtual wards should have processes in place to monitor clinical safety and incident reporting. This should capture learning on clinical safety, including digital clinical safety across service partners, with a route into system clinical governance. There should be regular monitoring of patient morbidity and mortality for the virtual ward, which should include reviews of clinical incidents and complaints	Yes	All teams utilise electronic systems to report and manage learning events. quarterly collaborative clinical governacne group (CCGG) to support wider dsicussion of learning (including providers and remote tech company representation). Overarching PSIRF plan for collaborative in place. Complaints / concerns managed and reporte through same route. CCGG reports to lead provider quality and outcomes committee as part of goverance approach (committee of the Sirona - lead provider board				
2	Operating hours (8am–8pm, 7 days a week at a minimum) and out-of-hours provision	Partial					
2.1	Virtual wards should ensure staffing for a minimum of 12 hours a day (8am-8pm), 7 days a week	Yes					
2.2	Operating procedures should be in place to ensure support is available out of hours to manage deterioration and maintain patient safety 24 hours a day, with access to specialty advice and guidance as required.	Partial		There is access for patients via 111 / out of hours GP - all patients are advised of this. Out of hours GP has access to maintain safety 24 hours a day with access to A&G. If patient requires visit out of hours there is access to OOH community nursing, Is partial only as access is not provided by the NHS@Home service. No actions being taken at present time other than collating data to capture requirements	31.3.24	JT	
2.3	Virtual wards should ensure that it is clear to patients and carers what support out of hours services are able to provide	Yes	Patient information leaflet for the service as well as infomration in the remote tech includes details on out of hours escalation				
2.4	Virtual wards should continually review out-of-hours contracts to support any additional service demand that might emerge. This is particularly important when proactively identifying step-up demand that could be diverted from inpatient care	No		This would be included as part of the ICB review and Integrated Cordination Centre being developed to include virtual wards. Not provider responsbility currently			
3	Clear admission criteria and assessment processes	Partial					
3.1	For all admissions to a virtual ward, a senior clinical decision-maker, under the oversight of a consultant physician/consultant practitioner/GP, should promptly assess patients to decide whether they should be admitted to a virtual ward. This may be in consultation with other specialty clinicians	Yes	Substantive consultant workforce - Clinical director, frailty, cardiology and respiratory. general medical / ID consultant due to start mid November 2024 as part of planned step up of capacity				
3.2	Assessment may include comprehensive geriatric assessment where indicated, calculation of NEWS2 score, Clinical Frailty Score (CFS) screening and 4AT rapid test for delirium in adults. These assessments may help risk stratify the appropriateness of virtual ward care but should not be used on their own to exclude a person from admission to a virtual ward. PEWS could be used to support admission decisions for CYP	Yes	All patients have a CFS and NEWS2 score on referral. These are monitored in EMIS as part of the VW clinical delivery. Where appropriate 4AT is utilised (and is part of the remote monitoring questions)				
3.3	For patients transferring to a virtual ward from an inpatient ward, hospital staff should proactively identify suitable patients, including during their twice daily ward rounds at a minimum. The decision to admit a patient to a virtual ward will be made in conjunction with the senior clinical decision-maker in the virtual ward	Yes	Hospital staff highlight patients as part of daily BR and inreach staff in hsopital will support admission into the VW as part of a trusted assessment process. Where required A&G sourced from senior clinical decision makers				
3.4	Admission criteria should reflect the acuity of virtual ward patients	Yes	SOP clearly defines inclusion and exclusion criteria and this is communicated with HCPs across the system through intranets and systsem websites e.g. Remedy				
3.5	They should work with care transfer hubs to support discharge to virtual ward care, in line with the Hospital discharge and community support guidance.	Yes	Project group working with D2A and TOCH to facilitate discharge, prevent cancellations, support awareness raising and provide early discharge wtih support				
3.6	An assessment of a patient's holistic needs should be undertaken – or have been undertaken by/jointly with a care transfer hub for patients transferring from an inpatient ward – to ensure that virtual ward care is adapted to the individual patient's circumstances and their wider needs	Yes	Assessment is completed by the NHS@Home in reach team inclduing holistic needs. Where care needs are higher than medical only e.g. P1 this is completed in conjuction with teams in the TOCH				
3.7	Assessment should help recognise when an individual might be in their final days or weeks of life, and occur in line with the Gold Standard Framework	Yes	ReSPECT decisions / discussions key part of assessment and ongoing management process. This includes recognition of individuals in final days / weeks of life				
3.8	An assessment of the needs of a patient's carer should also be undertaken to ensure they are properly supported, for example by reference to the carers' checklist	Yes	carers wishes are included in the VW holisitic assessment. HCPs highlighting any requirements are able to link into designated social prescriber in the team who can support carers assessments and wider				
3.9	There should be policies in place to ensure equity of access in the admission and assessment processes and reduce health inequalities	Partial		There is a policy and aspiration for implementation of this. Current focus on improving data collection to include ethnicity alongside Deprivation index to enable service to evaluate next steps	31/03/2025	Sarah Winter	
4	Personalised care and support planning and shared decision-making	Yes					
4.1	Services should provide patients (and/or their carers) with adequate information to ensure informed consent for treatment on a virtual ward and make any reasonable adjustments required. If an individual lacks capacity to make informed consent, then their representative or a best interests assessor should be involved to advocate on behalf of the individual's interests and needs	Yes	W admission checklist includes consent process for patient / carer that is reviewed individually				
4.2	There must be a documented shared decision-making process with patients and/or carers consenting to admission with full awareness of the benefits and risks. This includes delivery of care in their home environment and carers' circumstances	Yes	documentation of SDM included in clinical records. These are audited quarterly				
4.3	Personalised interventions, including co-produced care and support plans, should be agreed. Advance care planning conversations should occur to ensure what matters to patients is documented in a place that all staff can access and these advance care plans are respected in the event of patient deterioration. Care should otherwise reflect of any previously agreed advance care plan	Yes	All staff have completed ReSPECT training. All referrals include ReSPECT and ACP conversations as a requirement and where these have not been completed they are followed up in the community by the VW team				
5	Daily board rounds involving a senior clinical decision-maker, medical input and the wider MDT	Partial					
5.1	Board rounds should be overseen by a senior clinical decision-maker, occur daily, include medical input and be supported by a dedicated MDT encompassing a variety of disciplines as would be the case in a hospital (that is, consultant physicians/GPs, physicians, registered nurses, AHPs, advanced clinical practitioners, pharmacists). The MDT should include other relevant professionals when required, including social care teams, mental health and voluntary sector organisations	Partial	BR are currently M-F for highest intensity pathways (Gen med, fraily, respiratory). other pathways have acess to senior decision maker twice weekly and daily by phone / email. All BR include the MDT. Currently there is no access in the Vw MDT for social care and this is accessed through Locality model. VCSE is accessed as highlighted via embedded social prescriber in the team	no actions being undertaken at present time to move BR to include weekends.			
5.2	When tasks are delegated to non-NHS staff, including social care, local services should ensure sufficient funding arrangements are in place.	Not applicable					
5.3	A record of interventions and treatments should be accessible to all appropriate professionals involved in a patient's care	Yes	All staff in NHS@Home now complete electronic record in community EMIS; this is shared via ALL RECORDS to GP practice. it can also be seen by other clinicians through connecting care				

KLOE number	KLOE	Does your service or provider meet the recommendation? (yes/no/partial/not applicable)	Evidence of current activity to meet the recommendation (If the recommendation is not applicable to your service or provider please explain why)	If the recommendation is not met, what actions are being taken to support its implementation?	Deadline	Responsible lead	Completed by
6	Hospital-level diagnostics	Partial					
6.1	All virtual wards should ensure patients have access to tests and urgent diagnostics as they would in a hospital (for example, blood tests, CT scan, X-ray and MRI) to allow for responsive and timely decision-making, in line with national guidance on access to diagnostics on virtual wards	Yes	Access to blood tests as urgent in agreement with path labs. Currently expanding to use of POCT for CRP and other bloods. Access to scanning via consultant team in pathways				
6.2	When setting up pathways to access tests and urgent diagnostics, services should work closely with local pathology networks to ensure appropriate clinical governance, and to avoid hospital admissions for the sole reason of accessing a test. Virtual wards may partner with care settings such as SDEC and community diagnostics centres, and should work with ICB transport leads to ensure patients can access transport to and from these settings as required. They should also consider how samples taken at home will be transported to the laboratory	Partial		Some variation in SDEC pathways across the BNSSG area dependent on trust. This includes access to transport; however this is being standardised. NS'Home is aware of the current SDEC provision and accesses this			
6.3	Virtual ward staff kit bags should include portable medical devices, such as in vitro point of care testing and point of care ultrasound devices, to enhance assessments and accelerate clinical decision-making	Partial	All staff have access to vital signs equipment	Scoping requirements for POCT and roll out of CRP testing happening. UCR colleagues have access to POCT for U&E and NHS@Home can access via them. No current plan to utilise hand held ultrasound at the present time			
7	Hospital-level interventions/treatment	Partial					
7.1	Virtual wards should offer in-person visits to a patient's usual place of residence in conjunction with care management and monitoring, which can be technology-enabled.	Yes	All pathways offer blended care with remote monitoroig, telephone & video consultations and f2F reviews				
7.2	Appropriate in-person therapies should be available, such as intravenous therapies (diuretics, fluids, antibiotics as a minimum), subcutaneous fluids, nebulisers and oxygen. The MDT may also provide at home services, such as physiotherapy, occupational therapy, assessment and delivery of equipment to improve independence and reduce risk of harm	Partial	Pathways offer blend of in-person therapies including diuretics, antibiotics, nebulisers and oxygen (weaning). There is access to OT and PT as part of the pathway as part of the wider integrated neighbourhood team as well as within NHS@Home including provision of equipment if required	IV fluids not currently ofered in the community- project devellping this alongside UCR to support management of AKI - for implementation winter 24/25	31/03/2025	Jen Tomkinson	
7.3	There should be access to advice and guidance from other specialists, consultant-level reviews and medicines management and optimisation.	Yes	There is access to A&G				
8	Technology-enabled care, including remote monitoring	Yes					
8.1	All virtual wards should have the capability and capacity to use technology-enabled monitoring, where appropriate, to improve access to information that supports clinical decision-making, and support remote consultation and connections between the patient and their care team. Technology should not be used to deliver virtual care where face-to-face care is required. Services should be able to support patients, carers and care home staff with the use of technology and offer alternatives to prevent digital exclusion	Yes	Remote tech fully embedded in all pathways for vital signs and symptom data to support decision making. Vital signs have direct integration with clinical record. Where patients require support to utilised remote monitoring support is given to train carers including in care homes / rehabilitation teams to support. Work ongoing to support accessibilty to devices				
8.2	Electronic patient record (EPR) configuration should support delivery of virtual wards by enabling access to information across all delivery partners. This should also provide read/write functionality and enable the flow of clinical information from referral, assessment, admission, care delivery (including visibility of remote monitoring data) and discharge or ongoing transfer of care	Yes	All staff in NHS@Home use community EMIS as the clinical record				
8.3	Where EPMA and e-prescribing systems are not integrated with provider EPRs, these should be optimised to reduce the risks of medical error; support process improvement; and enable integration across service partners	Yes	Prescribing where possible is completed in the community using E-prescribing in EMIS. Where it is prescribed in hospital, this is managed through the dedicated pharmacy team through usual				
9	Pharmacy, medicine reconciliation and optimisation	Partial					
9.1	There should be equitable access to pharmacy, with dedicated pharmacy professionals involved in daily board rounds and MDT meetings as required, and in the delivery of comprehensive assessments	Yes	established pharmacy workforce across the pathways.				
9.2	Virtual wards, particularly their step-up functions, should have access to medicine 'grab bags' to ensure timely access to appropriate treatments	Partial	Unclear if applicable to the VW in BNSSG	There is access to PGD and common medications in repsiratory pathway for Abx and steroids only. No scoping completed for other pathways as work in partnership with other community colleagues to support prescribing where required. Work to develop the IV Fluids in community pathway will support a grab box for utilsation by HCPs	31/03/2024	Gayle Wynn	
9.3	Processes for prescribing and deprescribing, dispensing and delivering medicines should be clearly defined and signed off by the organisation's chief pharmacist or equivalent. Where possible, medicines should either be delivered to the patient's usual place of residence or e-prescribing used to dispense medicines to a local pharmacy to limit travel	Yes	System wide pharmacy group supports governance and development of SOPs/ processes for management of medicines across NHS@Home. EMIS supports prescribing electronically to local pharmacy. Where the patient steps down from hospital, NHS@home supports dispensing of required medication through the hospital pharmacy team				
9.4	On discharge from a virtual ward, relevant information about changes to a patient's medicines should be shared with the patient's GP and community pharmacy. This could be shared via a summary care record	Yes	Shared via the TTA/ discharge letter when stepped down from hospital. All patients have a discharge summary at the end of the NHS@Home episode of care where medication changes are clearly described. Any changes made once the patient is in the community during the episode are also communicated with the GP to ensure awareness				
10	Clear discharge processes, including monitoring of length of stay	Yes					
10.1	Virtual wards should agree the estimated discharge date for a patient on admission based on clinical judgement and in discussion with the patient and/or their carer. Patients should be discussed daily to identify whether they still require acute care or should be discharged. Decisions should support the safe and timely discharge of people in line with the Hospital discharge and community support guidance	Yes	This is included as part of the BR process				
10.2	The length of stay can differ for each person, but is expected to be short (especially where a virtual ward admission for diagnostics and rapid treatment replaces an ED attendance) and up to 14 days. Services should monitor length of stay to ensure it is appropriate for both patients' needs and local demand and capacity considerations	Yes	This is monitored per pathway and through BI systems				
10.3	Services should ensure early discharge planning, including early referral to transfer of care hubs for anyone likely to require an additional package of support on discharge. Suitable arrangements should be made for transferring care from the virtual ward to alternative pathways, including those led by primary, community or social care. This includes rehabilitation and reablement services as outlined in the Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge; long-term condition management services (including NHS @home services); and EoL and specialist palliative care services	Yes	Pathways to support patients on transfer out of the virtual ward including into P1 pathways or EOL.				
10.4	There should be appropriate communication with patients and carers to ensure they understand the discharge process and are aware of onward referrals or required further management by other services	Yes	patients are included in any discharge letters (written to the patient and cc'd to the GP) as well as discharge planning				

ICB name: BNSSG
Date of completion of assessment:01/10/2024

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1	Lead and co-ordinate strategic oversight and planning	Partial					
1.1	Have an ICB leadership (that is, an executive lead, clinical leads and UEC operational lead) in place to provide appropriate governance and risk management of the delivery of virtual wards at a system level, as well as ensure that there is oversight of the growth, quality and use of virtual wards alongside wider UEC and system management.	Yes					
1.2	Strategically co-ordinate and deliver virtual ward capacity at a place and system level alongside existing out-of-hospital and physical hospital capacity, ensuring it is used as efficiently and productively as possible.	Yes					
1.3	Have a capacity and demand plan for virtual wards across the ICS, considering both CYP and adults and prioritising key UEC demands as well as suitable discharge arrangements including links with social care and Better Care Fund plans.	Partial		CYP is not yet in scope and plans need developing.			
1.4	Support the flow of operational data, including real-time capacity, to ensure accurate occupancy data is available as part of provider capacity and UEC capacity management across the system.	Partial		SCC data does no yet incorporate occupancy data and therefore real time capacity. Needs further development.			
1.5	Consider virtual wards as part of wider ICB digital strategies, addressing any variability in digital maturity across all service providers, based on the What Good Looks Like framework, and focusing on system-wide approaches to technology procurement to achieve economies of scale.	No		Virtual ward not yet part of a system wide digital strategy.			
1.6	Enable effective access to care information across service partners, including transfer of information from remote monitoring devices and remote diagnostic test results (including imaging), allowing patient information to be recorded remotely and supporting interoperability of EPR systems.	Yes					
2	Lead on alignment of referral pathways and improving system flow	Partial					
2.1	Work together with providers, services and all relevant system partners to improve the flow of referrals to virtual wards. This includes supporting providers to educate and support case finders and referrers, such as NHS 111, 999, primary care, community care, care homes, acute respiratory infection hubs, transfer of care hubs, inpatient settings, the voluntary sector and social care.	Partial		Integrated Cordination Centre being developed to include virtual wards			
2.2	Ensure population and live maintenance of the information in the Directory of Services to support safe and effective referrals into virtual wards, which may require regional input to support consistency.	Yes					
2.3	Consider the operational alignment of virtual wards with UEC and UCR to support the development and expansion of virtual wards that provide an alternative to hospital attendance or admission, particularly when accessed directly from home. Where possible, encourage utilisation of a single point of access (SPoA) or an integrated care co-ordination (ICC) centre to maximise the use of virtual wards along with other services across a system (for example, UCR, respiratory infection hubs, SDEC, acute frailty and falls services).	Yes					
3	Lead on ensuring equitable and sustainable service provision across a system	Partial					
3.1	Develop a consistent offer of virtual wards and pathways across the system, in line with the functions and core components outlined in this framework. This includes implementing consistent ICS-wide admission and discharge criteria. Consider provider collaboratives to deliver virtual wards across community, secondary and primary care.	Yes					
3.2	Embed health inequalities measures to support equitable virtual ward access, experience and outcomes across different population groups with protected characteristics, including age, sex, race or membership of a health inclusion group.	No		Health inequality data not yet embedded, needs further development work.			
3.3	Take account of the funding of virtual wards in ICB planning to ensure their sustainability, with virtual wards built into ICB long-term strategies and expenditure plans.	Yes					
4	Lead on supporting workforce planning and capability with providers and places	Partial					
4.1	Enable providers to share staff flexibly across services as required (for example, through sharing agreements and 'passport' arrangements) to support workforce capacity and productivity. In some instances, planning and investment will be needed to ensure the right specialist care can be provided across the system.	Partial	MOU in place for NHS@Home to support easier movement of staff and support access to systems, buildings etc (wihtout the need for honorary contracts)	Workforce planning to incorporate flexible arrangements across organisations is being developed but still some challenges with workforce capacity and partnerships.			
4.2	Support providers to match workforce capacity to demand, following the principles of safe, sustainable and productive staffing. This should follow National Quality Board guidance on safe staffing with a triangulated approach using evidence based tools, professional judgement, comparison with peers and monitoring alongside clinical outcomes.	Partial					
4.3	Explore how training provision (for example, advanced clinical practice courses and training on remote clinical assessment) and opportunities can be shared across providers to support staff to develop the skills and competencies outlined in the Capabilities framework, to accompany the eLearning on the Learning Hub.	Partial					
4.4	Develop partnerships within local communities, including with the local authority, independent sector, voluntary sector, social care and other local organisations, to support capability building, particularly to ensure a diverse skill mix is available to meet holistic needs. Explore the development of plans to enable training and career routes through virtual wards, to support staff recruitment to and retention in virtual wards in line with the NHS Long Term Workforce Plan.	Partial					

Number of relevant or partially relevant recommendations	#REF!
Number of recommendations met	35
Number of recommendations partially met	13
Percentage of recommendations met	
Percentage of recommendations partially met	

Example of formulas to be included once content finalised