Virtual Wards Evaluation: Patients' and Unpaid Carers' Experiences

Final report

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This report

Between September 2023 and March 2025, the Strategy Unit conducted a qualitative study exploring the experiences of patients, unpaid carers, and families using virtual wards (also known as hospital at home) – commissioned by NHS England (NHSE). The findings will inform NHSE's evaluation of virtual wards, supporting the development of the programme and providing actionable insights for regions, systems, and providers to support a consistent, high-quality service.

This report synthesises key findings from the interviews. It is structured by findings from across the patient pathway; a section exploring the distinct perspectives of carers; and the benefits and challenges identified by patient and carer participants. It concludes with recommendations designed to inform improvements to the delivery of virtual wards

Supporting documents

A set of documents support this report.

- **Patient and carer stories:** a selection of detailed personal narratives and key learning from the stories.
- **Topic guides and information sheets:** tools that were used to structure and facilitate interviews.

Note on language:

This report uses the term virtual ward as this was the language used to explain services to participants during the research. However, it should be noted that virtual wards are also called hospital at home and that there is no difference between these services. NHSE's definition of a virtual ward is aligned to the World Hospital at Home Congress and the NHS is increasingly moving towards using the term hospital at home.

Throughout this report, the term 'carers' refers to unpaid carers, such as family members or others providing care to patients during their time on the virtual ward.

Acknowledgements

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- The evaluation advisory group who provided invaluable advice and guidance to the evaluation team throughout the project. The group included representatives from NHS England, evaluation specialists, virtual ward clinicians, regional and national leads, and third-sector organisations representing patients' and carers' voices. Their diverse expertise and perspectives were instrumental in shaping the evaluation approach and ensuring its relevance to stakeholders.
- The virtual ward national programme team at NHSE and NHSE regional leads who supported identification and engagement with virtual wards.

- Virtual ward teams
    - West Hertfordshire – Virtual Hospital
    - Shropshire, Telford & Wrekin – Virtual Ward
    - East Kent – Frailty Home Treatment Service
    - East Sussex – Virtual Ward
    - Mid Hampshire – Southern Health NHS Foundation Trust - Urgent Community Response and Hospital at Home

    - South West London – Remote Monitoring Hub / Hospital at Home (Croydon, Sutton, Kingston & Richmond)
    - East Lancashire – Intensive Home Support Service
    - North Cumbria – Virtual Ward/Hospital at Home

- A special thanks to all the patients and carers who shared their experiences.

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Executive summary

Background and context

A virtual ward is an acute clinical service with staff, equipment, technologies, medication and skills usually provided in hospitals delivered to selected people in their usual place of residence, including care homes. They are available for a range of acute conditions, including but not limited to respiratory problems, heart failure or exacerbations of a frailty-related condition. Whilst this report focuses on virtual wards for adults there are also paediatric virtual wards, which support children with acute conditions including acute respiratory illness, gastroenteritis and neonatal jaundice.

The national virtual ward programme began in 2022 and since then virtual wards have been rolled out at scale across the country. They are in place in every ICB, with over 12,700 beds available nationally. The expansion of virtual wards aims to increase bed capacity, alleviate pressures on inpatient hospital services and improve patient outcomes and experience through the provision of hospital-quality care at home.

Project aims

The Strategy Unit was commissioned by NHSE to evaluate the experiences of patients, unpaid carers and families using adult virtual wards, aiming to:

- Understand the patient and carer experience of virtual wards to inform the programme's development
- Identify benefits, challenges, and areas for improvement to support providers, systems, and regions
- Generate actionable recommendations for enhancing the service offer and supporting patients and carers.

Structure of this report

Findings are presented as:

- The patient pathway: insights into experiences from referral to discharge
- Carers' experiences: exploration of their roles, challenges, and support needs
- Benefits and challenges: identification of what worked well and what the challenges were
- Recommendations: suggestions for NHSE and service providers to strengthen virtual ward implementation and delivery.

Learning for future evaluation is also discussed. Supporting materials include detailed patient and carer stories, the scoping report, and interview topic guides.

Methodology

The evaluation explored the experiences of patients, unpaid carers and families using virtual wards. The methodology included scoping, recruitment, in-depth interviews, analysis and reporting.

Scoping phase

The scoping phase (September 2023 – January 2024) established a foundational understanding of virtual wards delivery and shaped the evaluation's key lines of enquiry (KLoEs). Activities included:

- A rapid literature review of guidance documents and early evaluations
- Stakeholder interviews with 24 national and regional leads, clinical, and operational experts.

Key findings informed the study's focus on frailty, acute respiratory infection (ARI), heart failure, and general medicine wards. The scoping phase also highlighted gaps in evidence regarding carers' experiences and the impact of health inequalities.

Research phase

To ensure diversity, virtual wards were selected based on factors such as the virtual ward model, maturity of provision, and geographic and demographic variation. From 32 potential wards identified, 25 were approached, with eight wards ultimately recruiting participants. Recruitment challenges included: delays due to information governance (IG) and local trusts' approvals; winter pressures; and variable capacity among staff in virtual ward teams.

A total of 139 potential participants were identified, with 80 completing interviews (56 patients and 24 carers). Participants were recruited from diverse wards, including frailty, ARI, heart failure, and general medicine pathways. Interviews were semi-structured, lasting 20–45 minutes, and aimed to capture in-depth perspectives.

The evaluation team employed thematic coding using NVivo software to systematically analyse interview transcripts. Emerging patterns and themes were identified collaboratively during reflection sessions. Coding was informed by the key lines of enquiry.

Findings were synthesised into key thematic areas: patient pathway; carers' experiences; benefits and challenges; and patient and carer stories.

Recruitment challenges limited the diversity of the sample, with gaps in representation from specific regions and demographics. Additionally, reliance on virtual ward teams for recruitment may have excluded some eligible participants. Despite these limitations, the findings provide a robust understanding of virtual ward experiences and highlight areas for improvement in service design and delivery.

Key findings

Patient pathway

Referral: Most patients were unfamiliar with virtual wards prior to their referral. However, those with prior knowledge – either through relatives or past experiences – were generally more open to accepting the option. For many patients, virtual wards were seen as an empowering alternative to hospital stays, especially for those with previous negative experiences in hospital settings.

Admission: Experiences of the admission process varied widely. Some participants received clear information beforehand, which helped them make informed decisions about admission, while others only fully understood the service after joining the virtual ward. Many participants highlighted the need for written information to improve understanding. Home assessments and carer involvement were inconsistent, and some carers described feeling their needs were overlooked.

Treatment: Participants valued the flexibility and personalised nature of care provided by virtual wards. They appreciated the time and attention from staff compared to their perception of hospital care, which was often described as rushed. Accessible contact numbers offered a vital channel for communication and escalation. On the other hand, unscheduled visits and changes to routines occasionally caused disruption.

Monitoring: Most participants experienced a mix of face-to-face visits and technology-enabled monitoring. Remote monitoring devices were generally seen as empowering and reassuring, though occasional technical issues and a lack of training materials caused anxiety. Regular check-ins and efficient responses to alerts created a sense of safety and confidence, and some participants noted that monitoring helped them identify or manage other health conditions.

Discharge: Most patients trusted the timing of their discharge, which they viewed as a reflection of clinical readiness. However, some felt unprepared or vulnerable during the transition. Clear communication and involvement in discharge decisions reassured both patients and carers. Long-term support after discharge varied, with some participants experiencing gaps in continuity of care and a few requiring readmission.

Carers' experiences

Balancing caregiving and other responsibilities: Carers often balanced caregiving responsibilities with other household and professional obligations. For some, the flexibility of virtual wards allowed them to maintain continuity in their lives, reducing the logistical and emotional strain of hospital visits. However, for others, caregiving added significant pressure to their existing commitments.

Relief and support with caregiving: Carers reported that the convenience of virtual ward monitoring and professional healthcare support at home reduced their mental and emotional strain. For many, the improvement in their loved one's health and the ability to avoid frequent hospital visits were significant benefits.

Overlooked needs: Despite the advantages many carers felt their needs were overlooked during the admission process, with assumptions made about their caregiving capacity and reported a lack of involvement in decisions.

What's working well for patients and carers

Enhanced comfort and familiarity of home: Patients valued receiving care in the comfort of their homes, which helped them maintain routines and avoid the stress of hospital environments.

Emotional comfort and trust in staff: Participants expressed high levels of trust in virtual ward staff, citing their professionalism and compassionate care.

Accessible and convenient care delivery: Virtual wards simplified care delivery by allowing patients to remain close to their families and in some instances keep a more convenient routine.

Reassurance through monitoring: Participants found monitoring through technology and face-to-face care empowering and reassuring, particularly having options tailored to their needs and capabilities.

What patients and carers found challenging

Communication and coordination gaps: Inconsistent scheduling and insufficient communication created stress for patients and carers.

Barriers to effective technology use: Initial challenges with technology, including lack of training, which disrupted some participants' experiences.

Learning for future evaluation

The evaluation provides unique insights into the experiences of patients and carers across diverse virtual wards, addressing a significant gap in existing evidence.

However, delays in information governance approvals and local trust processes impacted recruitment timelines. Virtual ward teams with prior research experience facilitated smoother recruitment efforts.

Additionally, some participants struggled to recall details of their virtual ward experience, particularly during the admission process. Joint interviews with carers often improved recall and added valuable perspectives.

Carers' experiences, previously underrepresented in virtual ward evaluations, were an essential component of this study. However, limited representation of diverse populations highlights the need for targeted recruitment strategies in future evaluations.

Recommendations

The evaluation identified actionable recommendations to enhance the design, delivery, and impact of virtual wards based on patient and carer feedback and the evaluation team's analysis. Recommendations are directed to providers and virtual ward teams and NHSE and the national virtual ward programme.

Providers and virtual ward teams

Holistic assessments of patients', their home environment, and their support needs

Providers should continue to ensure that holistic assessments are undertaken of patient circumstances, as well as the home environment, before admission.

Continuous assessment of carer needs and preferences

Virtual ward teams should involve carers in their initial assessments, regularly check in with them, and support a carer's right to reconsider providing care during the patient's admission. As part of this they should consider working with local organisations supporting carers, or using, and signposting carers where relevant, to tools from organisations such as those produced by Carers UK[1] .

Accessible and culturally tailored information

Provide both patient and carer-facing hard copy information in Plain English, Easy Read and/or other languages about virtual wards before admission to support active decision-making and on discharge. Information should be culturally appropriate and tailored to meet the diverse needs of local communities. Audio information should also be considered for some patient populations.

[1] https://www.carersuk.org/media/w35oyfax/carers-uk-virtual-wards-toolkit-re-unpaid-carers-november-2024-final.pdf%20%20

Clear communication of visit schedules

Where possible, virtual ward teams should clearly communicate the schedule of visits or provide sufficient notice in advance, notifying patient and carers of any changes to allow for better planning.

Streamlining care delivery

Ensure continuity of care by assigning the same team members for patient visits whenever possible. Where multiple different health and care teams are supporting the patient, coordinate care to try to minimise the overall number of visits.

Consistent messaging from all staff

Ensure that patients and carers receive consistent and unified messages from all staff members involved in providing virtual ward care.

Limiting stress of remote monitoring for patients and carers

Providers should provide additional training, written and verbal information to support patients and carers and ensure the remote monitoring is as easy as possible to use (such as wearable devices which require limited manual input).

Briefing carers on monitoring technology

Virtual ward teams should ensure that carers are fully briefed on the use of monitoring technology, even if the patient appears confident. This will enable carers to provide effective support when staff are not present.

Alternative options to remote monitoring

Providers should assess patient and carer's ability to use remote monitoring technology, as well as their preferences for how they receive care, discussing this before admission, and providing alternatives such as increased face-to-face visits if necessary.

Involving patients in care decisions

Ensure patients feel involved and understand any decisions taken on their care (including who has made them), offering opportunities to talk these through. Involve carers where appropriate or patient has given permission.

NHSE and the national virtual ward programme

Increase public awareness of virtual wards

Develop public-facing communications strategies to raise awareness of virtual wards, supporting proactive decision-making during admissions and potentially self-referrals where that is an option.

Understand gaps in care for lower acuity patients

Beyond the GIRFT[2] programme and other provider-focused work, consider conducting a broader consultation with virtual wards to identify and to understand why some patients with lower acuity are

[2] Getting It Right First Time (GIRFT) is NHSE's national programme to improve treatment and care through clinically-led reviews health services in England, including virtual wards.

admitted and what gaps in care these wards address. This could help inform national planning.

Support working carers

Collaborate with organisations supporting carers and employers to explore policy options for aiding working carers supporting people admitted to virtual wards.

Facilitate learning and knowledge sharing

NHSE should continue to provide structured opportunities for virtual ward teams to share examples of good practice, emphasising the importance of aspects such as:

- Holistic and environmental assessments of patient and carer circumstances
- Clear communication throughout the virtual ward journey
- Shared decision-making with patients and carers
- Personalised care

1. Introduction

This section provides the background and context for the virtual wards programme and the aims of this project.

1.1. Background and context

A virtual ward is an acute clinical service with staff, equipment, technologies, medication and skills usually provided in hospitals delivered to selected people in their usual place of residence, including care homes. They provide safe and efficient alternatives to NHS bedded care and are available for a range of acute conditions, including but not limited to respiratory problems, heart failure or exacerbations of a frailty-related condition. Virtual wards are a time-limited intervention, with most patients remaining on the ward for up to 14 days.

The national virtual ward programme began in 2022 and since then virtual wards have been rolled-out at scale across the country. They are in place in every ICB, with over 12,700 beds available nationally. The expansion of virtual wards aims to increase bed capacity, alleviate pressures on inpatient hospital services and improve patient outcomes and experience through the provision of hospital-quality care at home.

NHSE's vision for virtual wards is outlined in several key policy documents, including the *virtual wards operational framework*[3], *Neighbourhood Health Guidelines 2025/26* [4]and the *2025/26 Priorities and Operational Planning Guidance*.[5]

According to the operational framework[3], there are two core functions of virtual wards:

1. Provide 'step-up' care where an acutely unwell patient is offered a choice between being treated at home or in hospital. Patients are typically referred directly from their usual place of residence and can be admitted from sources such as a single point of access (SPoA), same-day emergency care (SDEC) or emergency department (ED).
2. Provide 'step-down' care where virtual wards facilitate an earlier discharge or transfer from an inpatient ward, enabling individuals who are not medically optimised for discharge to continue to receive acute hospital-level treatment, oversight, and diagnostics at home.

Virtual wards rely on multidisciplinary teams (MDTs), technology-enabled monitoring, and a blend of remote and in-person care to meet patient needs. Enablers of successful implementation are described as being coordinated efforts across Integrated Care Systems (ICSs), provider collaboratives, and support from families and carers.

[3] https://www.england.nhs.uk/long-read/virtual-wards-operational-framework/

[4] https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/

[5] https://www.england.nhs.uk/long-read/virtual-wards-operational-framework/

1.2. Core components of virtual wards

The national operational framework outlines ten core components that virtual wards are expected to adhere to:

- **Effective governance and leadership:** with clear lines of clinical responsibility, consultant physician/ consultant practitioner/GP oversight for all patients
- **Operating hours:** virtual wards should be staffed between 8 am and 8 pm, seven days a week, with locally arranged provision for out-of-hours and access to speciality advice
- **Admission criteria:** a senior clinical decision-maker should assess patients for admission. This may include Comprehensive Geriatric Assessment (CGA)[6], National Early Warning Score 2 (NEWS2)[7], Clinical Frailty Scale (CFS)[8], 4AT delirium detection tool[9] and holistic needs assessments
- **Personalised care**: patients and carers are given the information they need for informed consent. Personalised interventions and advance care planning should take place
- **Daily board rounds:** daily board rounds must be overseen by a senior clinical decision-maker, include medical input, and be supported by a dedicated MDT
- **Diagnostics:** patients should have access to the same tests and urgent diagnostics as they would in hospital (e.g. blood tests, CT scans, X-ray, MRI)
- **Interventions:** virtual wards should offer in-person visits in conjunction with care management/ monitoring. Hospital-level interventions are provided
- **Technology-enabled care:** virtual wards should have the capability and capacity to use technology-enabled remote monitoring, where appropriate. Electronic Patient Record (EPR) configuration should be in place
- **Pharmacy and optimisation:** virtual wards should have equitable access to pharmacy, and there should be dedicated pharmacy professionals involved in daily board rounds and MDT meetings when required
- **Discharge:** virtual wards should deliver time-limited interventions. Estimated discharge dates should be agreed on admission and patients discussed daily.

These core components should also be underpinned by a focus on maintaining patient safety, improving outcomes, and enhancing patient and carer experiences.

1.3. Project aims

NHSE commissioned The Strategy Unit to conduct a qualitative evaluation exploring the experiences of patients, unpaid carers, and families using virtual wards for adults. This evaluation aimed to:

[6] https://cdrc.nhs.uk/resources/systmone-resource-centre/specialties/geriatrics-overview/comprehensive-geriatric-assessment/
[7] https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearlywarningscore/
[8] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2022/02/rockwood-frailty-scale .pdf
[9] https://www.the4at.com/

- Understand the patient and carer experience of virtual wards to inform the programme's development
- Identify benefits, challenges, and areas for improvement to support providers, systems, and regions
- Generate actionable recommendations for enhancing the service offer and supporting patients and carers.

1.4. Structure of this report

This report presents findings from qualitative interviews, structured around:

- **The patient pathway**: insights into experiences from referral to discharge
- **Carers' experiences:** exploration of their roles, challenges, and support needs
- **Benefits and challenges:** identification of what worked well and what the challenges were
- **Recommendations:** suggestions for NHSE and service providers to strengthen virtual ward implementation and delivery.

Supporting documents include patient and carer stories, and topic guides.

2. Methodology

This section outlines the methodology used to evaluate the experiences of patients, unpaid carers and families using virtual wards. The approach included: a scoping phase; sample selection and site engagement; semi-structured qualitative interviews; and analysis, culminating in key insights and recommendations.

2.1. Scoping phase

The scoping phase (September 2023 – January 2024) aimed to develop a foundational understanding of virtual ward delivery and inform the design of key lines of enquiry (KLoE) for the qualitative interviews. Activities included:

- Setting up an advisory group to inform key decisions about the design, engagement and dissemination of the evaluation and identify solutions to challenges
- Conducting a rapid literature review of guidance documents and some early evaluation reports
- Completing 24 stakeholder interviews with national and regional virtual ward leads, as well as clinical and operational leads directly delivering virtual wards
- Identifying initial themes and refining research questions to develop KLoE. These informed the design of the topic guides for the interviews.

Key findings from the scoping phase were presented to the advisory group and informed the approach to the interviews:

- Although the national guidance includes paediatric wards it became clear that they have distinct differences from the variety of adult wards in their clinical focus and the delivery of the care. As such it was decided that paediatric wards would not be included within this evaluation. Additionally, general medicine wards were beginning to emerge as a model of

provision. It was agreed with the NHSE programme that the focus of the interviews would be on adult participants from frailty, acute respiratory, heart failure or general medicine virtual wards

- Although some stakeholders mentioned local evaluations of virtual wards, many participants identified a gap in the evidence about carers' experiences
- Many participants also highlighted that there was a gap in knowledge on the impact of health inequalities on virtual ward provision.

The full findings from the scoping phase are detailed in the *Scoping Phase Report*.

2.2. Sample selection and site engagement

Following the scoping phase, sample criteria was produced to select a diverse mix of virtual wards based on virtual ward model, maturity of provision, and geographic and demographic variation.

The sample aimed to include virtual wards in the following criteria:

- The four core types of clinical specialty for virtual wards: acute respiratory infection, frailty, heart failure, and general medical wards
- Varying maturity of wards, including recently developed virtual wards and those which have been operating for several years
- Different bed capacities
- Regional representation.

Regional leads helped identify 32 potential virtual wards. Using the sampling criteria, 25 virtual wards were approached and invited to participate as research sites for the evaluation. If they agreed to be involved, sites were required to invite patients and carers to participate in the evaluation.

There were several challenges engaging sites. Initially engagement was delayed due to a lengthy approval process for the NHSE Data Protection Impact Assessment (DPIA) for the patient and carer research phase of the work. There were also local challenges. Some sites required their own local trust information governance (IG) approvals. There were also delays linked to the capacity of staff during the NHS winter pressures period. Some sites were already participating in local evaluations, so had limited capacity to engage.

Eight virtual ward teams were able to engage with the evaluation and recruit patient and carer participants (see Table 1). Virtual ward teams provided patients and carers with a Participant Information Sheet and asked for consent to pass their contact details to the Strategy Unit team. Patients who participated in an interview were also asked if they had a carer who would be willing to take part.

Table 1: Virtual wards that recruited participants

Virtual ward	Clinical speciality	Brief description
East of England		
West Hertfordshire Virtual Hospital	Heart Failure Respiratory	• Established in 2021

		• Delivered from Virtual Ward Hub (the operational base that manages these virtual wards) • Diverse urban and rural population • Technology-enabled monitoring and face-to-face visits where required.
Midlands		
Shropshire, Telford & Wrekin Virtual ward	Frailty	• Established in 2023 • Mainly frail elderly, white, patient population • Mostly face-to-face monitoring, with some remote monitoring.
South East		
East Kent Frailty home treatment service	Frailty	• Long established since 2020 • Mixed population with high levels of social deprivation • Mixture of face-to face and remote monitoring.
East Sussex Virtual ward	General	• Established in 2022 • Mixed rural and urban and mostly older white population • Technology enabled monitoring, with in-person visits as required.
Mid Hampshire Southern Health NHS Foundation Trust - Urgent Community Response and Hospital at Home service	Frailty	• Established hospital at home during pandemic • Team is part of urgent response service
		• Urban and very rural populations, mixed affluence, mainly elderly population • Monitoring is predominantly delivered through face-to-face visits.
London		
South West London Remote Monitoring Hub / Hospital at Home team (Croydon, Sutton, Kingston & Richmond)	Respiratory Heart Failure Frailty	• Established in 2022 • Hub covers multiple virtual wards and providers across different boroughs in SW London • Diverse, urban population • Mainly technology enabled remote monitoring, with individual virtual ward teams conducting face to face visits where required.
North West		
East Lancashire Intensive home support service team	General	• Developed from long established intensive home support service since 2015 • Main referrals from GP • Some diverse population, but mostly older white population • Mainly frailty and respiratory patients • Mostly face-to-face monitoring, with some remote monitoring.
North East		
North Cumbria Virtual ward/Hospital at Home service	Frailty Respiratory	• Established in 2023

		• Central hub with team working across three sites, one community hospital and two acute hospital sites • Team works with British Red Cross to support patients at home • Mainly white Caucasian, rural population • Mostly face-to-face visits for monitoring with some technology-enabled remote monitoring.

2.3. Interviews

A total of 139 potential participants were identified. 80 participants took part in 71 in-depth semi-structured interviews (Table 2 organises these by site). Interviews were approximately 20-45 minutes. Participants were:

- **56 Patients:** recently discharged from virtual wards
- **24 Carers:** unpaid carers, family members, and others who supported patients during their virtual ward admission.

Each participant received a £20 high-street voucher in recognition of their time.

Table 2: Participants recruited by each virtual ward

Virtual Ward	Patients	Carers	Total
West Herts - Virtual Hospital	6	2	8
Shropshire, Telford & Wrekin Virtual Ward	11	3	14
East Kent - Frailty Home Treatment Service	2	5	7
East Sussex - Virtual Ward	17	6	23
Mid Hampshire- Southern Health NHS Foundation Trust - Urgent Community Response and Hospital at Home	1	2	3
South West London - Remote Monitoring Hub / Hospital at Home (Croydon, Sutton, Kingston & Richmond)	13	3	16
East Lancashire - Intensive Home Support Service	3	1	4
North Cumbria - Virtual Ward/Hospital at Home	3	2	5
	47	**15**	**80**

There were 62 individual interviews and nine were joint patient and carer interviews (see Table 3 for the breakdown of types). The majority of participants were female (see Table 4).

Table 3: Interview participants by role

Interviews	Individual	Joint
Patients	**47**	**9**
Carers	**15**	

Table 4: Interview participants by gender

Participant	Male	Female
Patients	**23**	**33**
Carers	**8**	**16**

The majority of patient admissions were 14 days or less. Most were between five and 14 days. Among patients with longer lengths of stay, many patients had previous hospital admissions, and some had experience of similar lengths during inpatient hospital admissions (see Table 5).

Table 5: Length of stay[10]

Length of stay	Numbers of patients
1-4 days	**8**
5-9 days	**21**
10-14 days	**20**
15+ days	**15**
Didn't specify	**3**

[10] Some patients described multiple admissions and have been included in all relevant categories in this table. Where patients and carers both discussed the same patient experience, the patient has been counted only once, unless describing multiple admissions.

The largest proportion of participants were admitted to the virtual ward through a step-down referral from an inpatient hospital ward. Of the step-up referrals most of these were from other healthcare professionals including GPs and Paramedics, referrals from A&E or same day emergency care (SDEC) and some were self-referrals.[11]

Table 6: Interview participants by referral route[12]

Referral route		Numbers of patients
Step-down	**From hospital inpatient ward**	**37**
Step-up	**From A&E or SDEC**	**10**
	Paramedic	**5**
	GP	**5**
	Other healthcare professional	**14**
	Self-referral	**7**

The majority of participants received care through frailty and acute respiratory virtual wards. This was expected due to early NHSE guidance focusing on these clinical areas. Heart failure virtual wards were newer and general medicine virtual wards were often delivered by

[11] Self-referrals in this context refers to patients who asked to be referred to a virtual ward during an inpatient stay, and patients who had previously been treated via a virtual ward who, on presentation of new symptoms, asked to be referred for an additional admission.

[12] Where people described experiences of multiple admissions to virtual wards, these have been counted separately in this table.

one team delivering care to multiple clinical pathways. Table 7 presents the clinical speciality of the virtual ward and Table 8 shows that the clinical condition associated with most admissions of participants was acute respiratory infections.

Table 7: The clinical speciality of the wards' participants came from.

Participant Group	Virtual Ward Speciality				
	Frailty	Acute Respiratory Infection	Heart Failure	General*	Total
Patients	17	14	5	20	56
Carers	9	5	3	7	24
Total	26	19	8	27	80

**'General' includes sites where virtual wards have patients for frailty, acute respiratory infection , heart failure, and other acute conditions.*

Table 8: Participants by the admission related clinical condition of the patient.

Participant Group	Clinical condition of patient				
	Frailty	Acute Respiratory Infection	Heart Failure	General	Total
Patients	17	25	5	9	56
Carers	9	8	4	3	24
Total	26	33	9	12	80

2.4. Analysis

The analysis process was methodical and collaborative, ensuring that key insights were drawn from the data collected during the interviews. The evaluation team conducted reflection sessions following the interviews, allowing them to discuss emerging themes and identify patterns in the data.

With informed consent, interviews were recorded and transcribed verbatim. A coding frame was developed, structured by the KIoEs and the themes from the reflection sessions. It was applied to a sample of the interview transcripts, reviewed and amended, and then applied to the full dataset using NVivo software. The Strategy Unit approach to coding qualitative data has been quality assured by NHSE evaluation leads and identified as best practice.

Emerging findings were presented to the advisory group, who further informed the analysis.

2.5. Reporting

The findings from the analysis were organised into key thematic areas that form the structure of this report:

- **Patient pathways:** this section traces the journey of patients (through their and their carers' perspectives) through virtual wards, from referral to discharge in line with the NHSE guidance. It highlights the processes, decisions, and experiences that shaped their perceptions of the care

- **Carers' experiences:** this section explores the critical role played by carers, detailing their experiences, the impact of the admission on them and the support they provided and received
- **Benefits and challenges:** this section examines the positive aspects of virtual wards described by participants as well as the barriers they faced
- **Patient and carer stories:** anonymised personal narratives illustrate in greater detail the lived experiences of patients in virtual wards and their carers. They were selected as examples because of the range of themes the participants discussed and the detail in which their experience was described
- **Recommendations:** drawing from both the insights gathered as suggestions from participants and from the evaluation team's analysis of the dataset, this section presents actionable suggestions to inform improvements to the design and delivery of virtual wards. These have been further discussed and developed with the advisory group for the project.

2.6. Limitations of the evaluation

Limitations of the evaluation include:

- **Engaging participants:** this posed some challenges during the evaluation. The sample was limited to virtual wards that were willing and able to participate, which constrained the ability to target specific demographics, including participants from more diverse demographic backgrounds. As a result, findings related to addressing health inequalities are limited
- **Recruitment:** this relied on virtual ward teams approaching eligible patients and carers. As most teams had limited staff available for recruitment, not all eligible individuals were invited to participate. Of the 139 potential contacts identified, 80 interviews were completed. Reasons for non-participation included patient illness and individuals declining to take part
- **Sampling:** the study aimed to involve wards from a wide range of locations A notable gap in the final sample is the absence of representation from the South-West region,

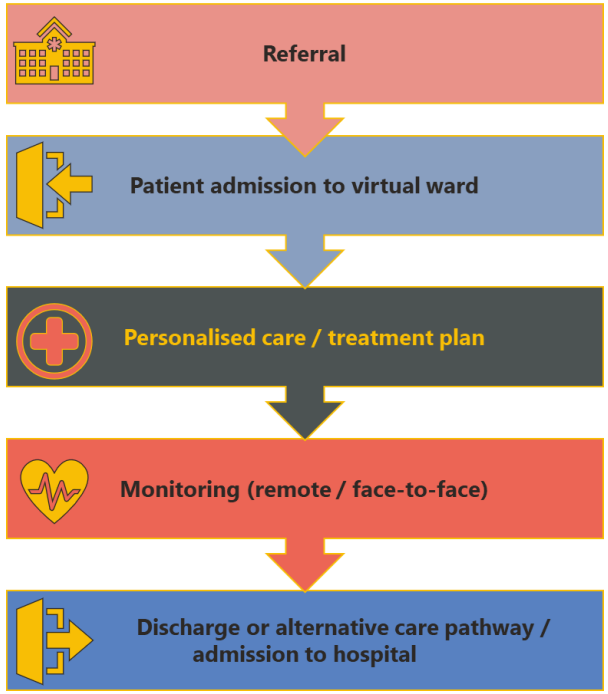
Despite these limitations, the insights gathered provide a valuable understanding of the virtual ward experience and highlight areas for improvement in service design and delivery.

3. Patient pathway

NHSE national guidance for virtual wards highlights key elements of the patient journey, covering referral, admission, treatment, monitoring, and discharge (see Figure 1).

This evaluation explored patient and carers' experiences across each stage and their perspectives of what worked well and where improvements could be made. This section discusses the findings by theme, for each stage of the patient pathway.

Figure 1: Patient pathway



3.1. Key findings

Referral: although most people had not previously heard of virtual wards, patients with prior knowledge of them – through relatives or past experiences – were generally more open to the option when it was offered because they had received good reviews. For many patients, virtual wards offered an empowering alternative to hospital stays, especially for those with previous negative experiences in hospital settings.

Admission: some participants received clear and timely information before making the decision to be admitted to the virtual ward, while others only understood the service after admission. Many participants highlighted the need for written information to improve understanding. Home assessments and carer involvement were inconsistent, and some carers described feeling their needs were overlooked.

Treatment: participants valued the flexibility and personalised care provided by virtual wards. They appreciated the time and attention from staff compared to their perception of hospital care, which was often described as rushed. Accessible contact numbers offered a vital channel for communication and escalation. On the other hand, unscheduled visits from health professionals and changes to routines occasionally caused disruption.

Monitoring: most participants experienced a mix of face-to-face visits and technology-enabled monitoring. Remote monitoring devices were generally seen as empowering and reassuring, though occasional technical issues and a lack of training materials caused anxiety. Regular check-ins and efficient responses to alerts created a sense of safety and

confidence, and some participants noted that monitoring helped them identify or manage other health conditions.

Discharge: most patients trusted the timing of their discharge, but some felt unprepared or vulnerable. Clear communication and involvement in decisions reassured participants, but some carers described feeling excluded from the process. Long-term support after discharge varied significantly, with some participants reporting gaps in continuity of care and a few requiring readmission.

3.2 Referral

3.2.1 Diverse referral pathways

Participants were referred for virtual ward admission through various routes, including hospital inpatient wards, paramedics, GPs, or proactive self-referral.

Although most people had not previously heard of virtual wards, patients with prior knowledge of virtual wards – through relatives or past experiences – were generally more open to the option when it was offered to them because they had received good reviews.

Each route reflected different circumstances, with some participants encountering the concept of virtual wards for the first time during a healthcare interaction.

> *"I didn't know much about the virtual ward before, but when the paramedics explained it to us, it sounded like a good alternative to hospital." (Patient)*

For many, virtual wards offered an empowering alternative to hospital stays, particularly for those with negative past experiences in hospital settings or heightened anxiety about hospital admission.

> *"My mum refused to go into the hospital, but the paramedics offered this as the next best thing, and it was such a relief." (Carer)*

Most participants were happy to be referred to a virtual ward, whether they were referred via a step-up route or a step-down route. The limited awareness and understanding of the service at the point of referral highlights opportunities for more proactive education and communication.

3.3.Admission

3.3.1 Mixed awareness and information on virtual wards

Participants' awareness of what being a patient on a virtual ward involved prior to admission varied widely. Many described having little understanding beyond the basic concept explained at referral, which led to confusion about what to expect.

> *"I didn't know about the service until the paramedics explained it to me. It felt like I was learning as I went along." (Patient)*
>
> *"When they said, 'virtual ward,' I thought it was just a phone call. Then a nurse turned up with technology, and I was a bit surprised." (Patient)*

Some participants highlighted how staff provided clear, step-by-step explanations, which eased concerns and built trust in the care they would receive.

> *"The nurse explained everything thoroughly, even showing me how to use the equipment, which made me feel much more confident." (Patient)*

However, others reported gaps in the information provided, expressing a desire for clearer communication and written materials to complement verbal explanations.

> *"It would have been helpful to get a leaflet or something; verbal explanations were good, but there was a lot to take in at once." (Carer)*

Participants suggested that providing consistent, clear, and accessible written materials prior to admission would help address confusion and ensure patients and carers feel more prepared joining a virtual ward.

3.3.2 Assessing the home environment and suitability for virtual wards

The process described for assessing home environments and support systems varied significantly among participants. Some experienced thorough evaluations: others felt that assessments were minimal, indirect, or not clearly communicated.

> *"They asked about stairs and space, but it wasn't a detailed conversation. I felt like they mostly observed when they visited." (Patient)*

Carer involvement during these assessments also varied. Although some felt included, others expressed frustration at being overlooked or at the assumption that they would be able to provide support without consultation.

> *"They didn't ask my partner if he was comfortable supporting me. It felt like it was assumed he'd manage." (Patient)*

A few carers described how patient preferences were prioritised during the admission process, sometimes at the expense of fully considering carers' needs.

> *"They asked my mum if she wanted to be on the virtual ward, but no one asked me how I felt about it." (Carer)*

Participants directly and indirectly highlighted the need for carers to be more involved in decision making processes at admission.

3.4 Treatment

3.4.1 Flexible and coordinated care delivery

Patients described receiving care in a variety of ways, including daily calls, video consultations, and face-to-face visits. Care plans were tailored to individual needs, with the frequency of visits adjusted based on clinical changes.

> *"They came every day to set up my IV and check my vitals." (Patient)*

Patients requiring complex care, such as IV administration, support with medication, and more complex observations, benefitted from blended care.

While flexibility was valued, unscheduled or poorly communicated visits disrupted routines and caused inconvenience.

> *"Sometimes they turned up at 6:00 PM, which wasn't ideal when I had plans to go out." (Carer)*

Participants suggested that while flexibility in care delivery is important, clearer communication about visit schedules and advance notice of changes would help patients and carers better plan their routines.

3.4.2 Personalised care

Many participants praised the individual, personalised approach of the virtual ward team. Some participants mentioned how face-to-face visits, and the use of tech-enabled monitoring was discussed to plan what would work best for them.

> *"Nobody rushed me; they took their time, explained everything, and answered my questions." (Patient)*

Participants valued the time and attention they received in comparison with their views about hospital care, which they described as comparatively rushed or not as attentive.

> *"I felt safer on the virtual ward than I ever would have in the hospital." (Patient)*

This level of care fostered a strong sense of safety and trust for many. However, there were a few examples where participants were worried about the seriousness of the health condition and treatment at home.

> *"I was worried about having the oxygen [tank] in the house… if it was safe." (Carer)*

Participants indicated that maintaining open communication about care decisions and addressing any concerns about treatment at home, such as safety measures for equipment, would further enhance the sense of trust and reassurance provided by the virtual ward model.

3.4.3 Communication and staff expertise

The professionalism and expertise of virtual ward staff were a key part of participants' descriptions of their positive experiences, particularly during face-to-face visits.

> *"They were always kind, thorough, and made me feel cared for." (Patient)*

Accessible phone numbers provided a safety net, ensuring help was always available in the case of any problems or concerns.

> *"I had their number on my fridge magnet, which was a great reassurance." (Patient)*

However, limited communication with doctors about important changes, like medication adjustments, frustrated a small number of patients. Similarly, a few individuals felt that virtual wards lacked the level of doctor interaction available in hospitals. This was potentially due to their perceptions of the roles and responsibilities of different medical staff rather than a reflection on the competency of the staff they interacted with.

> *"It would have been nice if the doctor had explained the changes instead of hearing it second-hand from the nurse." (Patient)*

This small group of participants suggested that offering opportunities for direct communication with other healthcare professionals making

treatment decisions for them, where this was not the clinician interacting with them in their home, would help their understanding and confidence.

3.4.4 Palliative care and advance care planning

A small number of participants with terminal conditions praised the support provided to them by virtual ward staff with their palliative care needs, including advance care planning. They particularly valued being able to avoid going into hospital as a result of any deterioration in their condition.

> *"What it means now is if [I] ring [the virtual ward team] instead of the hospital or an ambulance, they'll sort out it all, [I'll] never have to go into hospital again." (Patient)*

While not yet at the end-of-life stage, they appreciated virtual ward staff for highlighting the rationale and purpose of planning and ensuring their preferences are respected, as well as guiding them through official documentation (such as Do Not Resuscitate (DNR) or Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms).

> *"[A virtual ward nurse] gave us some good advice… she thought that I should be filling out a ReSPECT form [which would detail] what I would want to happen, given the various conditions that I could find myself in the next year or so. So, she said I should be filling that in." (Patient)*

One patient and their carer positively contrasted the time taken by virtual ward staff to explain the relevant processes, with the (lack of) explanations they were provided by hospital staff. This made them far less worried about it.

> *"[She] felt like if anything happened [the hospital staff] were just not going to resuscitate her. And then it wasn't until [the virtual ward staff member] said, 'that's not what [the DNR form] is, it's there for when it reaches that stage…' [and] explained everything properly… [we're] less anxious about everything now." (Carer)*

3.5 Monitoring

3.5.1 Technology-enabled monitoring

Most participants had a mix of face-to-face visits and technology-enabled monitoring. Technology-enabled remote monitoring had mixed responses from patients and carers. Many participants stated that their device was easy to use after initial orientation.

> *"The app is very simple. Inputting the information on the Tablet was absolutely fine." (Patient)*

Many participants discussed how remote devices like oxygen monitors, blood pressure monitors and Tablets provided a sense of safety and empowerment after initial orientation.

> *"If I didn't do it right, the phone would ring straight away to explain how to fix it." (Patient)*

Some reported technical challenges, such as Wi-Fi disruptions, confusion during set-up processes and false alerts, which occasionally caused anxiety.

> "*I found the instructions confusing at first, but they were very patient.*" *(Carer)*

Participants suggested that written guides and more training would improve their confidence in using the technology.

3.5.2 Frequent phone calls and face-to-face visits as required

Many participants reported receiving regular phone calls from the virtual ward team, often multiple times during the day or throughout the week. For some this was the main mode of monitoring and for others it was in addition to technology-enabled monitoring or face-to-face visits. These calls were used to check on the patient's condition, discuss symptoms and adjust treatment plans.

> "*Every morning, I had a phone call... they rang me up to tell me how it was going.*" *(Patient)*

Many participants found the phone calls reassuring, as they provided a direct line to medical advice. The clarity and empathy of the callers were frequently praised.

> "*It was comforting to know they were just a phone call away.*" *(patient)*

A few participants reported receiving video calls. Although most appreciated the visual connection, some participants preferred phone calls or in-person visits, as they found them more personal and easier to manage.

> *"Video calls felt impersonal, and mum struggled with the technology" (Carer)*

Home visits were highly valued, especially for patients with complex needs. Home visits were used for physical assessments, for example to check blood pressure and vital signs, or to deliver care, for example wound care.

> "*They came every day, checked his stats, and adjusted his meds—it was a lifeline.*" *(Carer)*

Face-to-face interactions allowed for thorough evaluations and immediate adjustments to care plans.

> "*The nurse noticed my swelling right away and called the doctor—it made all the difference.*" *(Patient)*

However, some respondents noted a lack of consistency with visit times or unfamiliar staff, which caused minor disruptions.

3.5.3 Responsive monitoring and escalation

Many participants highlighted efficient responses to remote monitoring alerts, such as immediate follow-ups for flagged vital signs on technological devices, as providing reassurance for both patients and carers.

> "*When my blood pressure was low, they called straight away to guide me on what to do.*" *(Patient)*"

Regular check-ins and clear escalation processes ensured a sense of security. Several participants described the benefits of virtual ward staff attending in-person for identifying and supporting patients when they deteriorated while at home, sometimes requiring admission to hospital.

"The nurse came out on a Saturday morning, saw that my breathing was quite bad and phoned an ambulance straight away and I was blue-lighted back into hospital… I got quite scared, and the nurse came out to me, and she actually put me at a bit more ease, if you know what I mean." (Patient)

However, some carers expressed feeling overwhelmed by their role in managing remote monitoring tasks, especially when balancing other caregiving responsibilities.

"Sometimes they wanted additional readings or, blood pressure readings… at first, it was overwhelming… one day, we probably had four people here and maybe four or six phone calls. It was really overwhelming." (Carer)

Participants suggested additional training and support for carers involved in monitoring tasks could ensure they feel supported.

A few participants gave examples of how monitoring helped them identify or better manage other underlying health conditions.

"As it happens, I've got sleep apnoea. I would not have known that without the hub, without all this equipment." (Patient)

3.6 Discharge

3.6.1 Varied readiness for discharge

Most patients trusted the timing of their discharge from the virtual ward, based on the medical assessments.

"At first they came every day, then they saw me recover and they knew that I was recovering, it was every other day. Then, it was the case of, right, 'You're up where you need to be. If you need us, give us a call. They were checking my observations, and they could see themselves that I was recovering, and I could feel that I was recovering as well ." (Patient)

However, some felt unprepared, particularly those with unresolved health issues.

"I didn't even know I'd been discharged; they just stopped coming. It would've been nice to be told." (Patient)

Discharge often created mixed emotions, with participants describing feeling relief, gratitude, and apprehension (or a mix of all three).

For some, discharge signified independence and progress. For others, it created a sense of vulnerability, particularly for those managing long-term conditions.

"I felt vulnerable managing without them at first, but over time I adjusted." (Patient)

Participants suggested that a clearer, more structured discharge process, including guidance on managing health independently and reassurance about available support, could help address concerns.

3.6.2 Communication and shared decision-making

There were variations in the discharge process described by patients and carers. Some discussed how they were given clear explanations and involved in decisions, which provided reassurance.

"They explained what to expect and let me know the day before. I appreciated being kept in the loop." (Patient)

Others reported having limited or no input, describing feeling excluded, with little notice or clarity about next steps.

> *"I didn't feel like I had a say, and I was left to follow up on the physio referral myself after he was discharged." (Patient)*

Carers highlighted the need for better communication with them to support the ongoing care which they provided or would need to provide.

> *"I was told [name] was being discharged on the phone, but no one had spoken to us beforehand. It felt sudden." (Carer)*

Clearer and more inclusive communication, ensuring patients and carers are well-informed and involved in planning the transition from virtual ward care, could improve satisfaction and readiness for discharge.

3.6.3 Continuity of care and support post-discharge

The long-term support provided after discharge from the virtual ward varied, with some patients receiving clear follow-up care plans and contact details for any future concerns.

> *"They keep the doctor [GP] informed of everything they do, and then they sent me a letter as well – [explaining] that I could keep in touch with them." (Patient)*

Others reported gaps in continuity of care, particularly when transitioning to other services. Issues they identified included a lack of clarity about next steps or feeling unsupported in managing their condition independently.

> *"The nurse was great, but once she discharged me, it felt like the system dropped me. I had to chase the next appointments myself." (Patient)*

There were several cases of readmissions to the virtual ward after discharge. Patients valued being able to access the service again if required. .

> *"I ended up needing antibiotics again and went back on the (virtual) ward for a week. It's reassuring that they're there when I need them." (Patient)*
>
> *"I would normally then have to go back to ambulatory care, have IV antibiotics and things, but this time, the virtual hospital took me over back, when my chest wasn't well, I phoned the community respiratory nurses. They came out, saw me, and said, 'Yes, we think we need to onboard you to the virtual hospital so we can make a plan and keep an eye on you'." (Patient)*

While some saw the readmissions as being necessary, a few participants expressed frustration at the lack of ongoing monitoring, which they believed could have prevented escalation.

A couple of patients also described continuing self-monitoring after they were discharged to manage their long-term health condition.

Providing clear, and accessible post-discharge care plans, alongside mechanisms for follow-up, could address gaps and reduce the likelihood of readmissions.

4. Carers' experience

4.1. Balancing caregiving and other responsibilities

Carers supporting patients on virtual wards were often navigating complex family and household responsibilities, balancing caregiving with their own commitments. These responsibilities were shaped by the patient's condition, family structure and the household dynamic.

Many carers already lived with the patient or moved in temporarily to provide round-the-clock support during their admission on the virtual ward. For some, caregiving was a new responsibility that they came to undertake when the patient was admitted on to the virtual ward. For many, caring responsibilities were layered onto existing obligations, and participants reported juggling medications, mobility support and appointments alongside existing commitments, such as work or childcare.

> *"So, I work full time, and I have 2 teenage daughters. I have a twenty-one year old and a sixteen year old. And a husband that is very busy in a full time employed job and works all over the country. So, not only do I care for Mum, but I also work full time as well." (Carer)*

Despite these challenges, virtual wards allowed many carers to maintain a sense of continuity in their lives and meet their loved one's needs without the logistical and emotional strain of hospital visits.

> *"When [patient] was in hospital, I wasn't really doing the school pick ups because I was at the hospital…during virtual hospital it was fine, I could do it." (Carer)*

> *"We just did all the requirements… so it didn't add to our workload at all. It would have added a lot to our workload if we had to go to hospital every day to visit [patient]." (Carer)*

Virtual wards enabled continuity for patients who were also caregivers themselves, allowing them to maintain their caregiving responsibilities and some normality in their routines.

> *"For me, it actually works quite well because I have nine children, three of them are severely disabled. So, going into hospital for long periods at a time is not good." (Patient)*

Some carers suggested that the virtual ward reduced the pressure on their time and provided tools to better balance caregiving with other responsibilities.

> *"Whenever I needed staff or I needed a prescription or I needed equipment, they would literally just send the courier out and it would be there the same day." (Carer)*

4.2. Relief and support with caregiving

Many carers reported that the convenience of monitoring and professional support at home had lightened their mental and emotional load... They were relieved that their loved ones didn't have to go into hospital, which was often described as distressing, and were confident in the care they were receiving at home, which was seen as the best place for recovery.

> *"Knowing they're at home and improving every day takes a big weight off your shoulders." (Carer)*

Carers expressed relief from the stress of frequent hospital visits, long waits and the logistical challenges of hospital care. They felt able to focus on supporting their loved ones without the added pressures of hospital environments.

> *"The benefit was absolutely not putting anyone through the trauma of going to hospital, to A&E, and probably spending hours over there before she was seen, because I would have had to have gone over there with her and sat with her for who knows how long." (Carer)*

Support from healthcare professionals and access to monitoring technology provided reassurance, enabling carers to feel less isolated in their roles. Many described the value of professional assistance in managing medical tasks they were not equipped to manage independently.

> *"There's only so much I can do as a full-time carer. I am not medically trained. I know how to change her catheters and administer her meds. If I didn't have the support of these (virtual ward) teams, my mum, would've been in hospital three, four, five times a year. I can't imagine life without them." (Carer)*

4.3. Overlooked needs

Many carers felt their needs were overlooked during assessments at admission, with assumptions made about their capacity to provide care, adding to their emotional and physical strain.

> *"I didn't expect to care for my wife twenty-four-seven while working full-time. It's been very tough." (Carer)*

Some carers reported feeling the weight of their responsibilities, leading to emotional and physical fatigue, especially those providing round-the-clock care or managing complex needs.

> *" I've been off work now for nearly a month , the doctor quite kindly said, 'I'm going to sign you off work so you can look after your wife 24/7.' But I'm constantly getting little messages. What am I supposed to do. Because I've used my annual leave, they've gave me days gratis off and now I've been signed off by the doctor, so I can look after her. I'm just wondering if there's anybody in the care system that could pop in while I'm at work." (Carer)*

Some thought that their own needs had not been considered and highlighted the importance of being able to access wider social support.

> *"I'm always checking in and out. I'm always doing something. I mean, I do the shopping, I do the cleaning to a degree. I have rheumatoid arthritis myself so it's not easy, and I can't always walk because sometimes my legs are bad." (Carer)*

There were also a few young carers mentioned by patients. They were mostly their children or relatives who provided support with a range of activities including help using monitoring technology and household tasks.

> *"My teenage daughter helped me by collecting medications and managing things at home, even while going to school." (Patient)*

5. Benefits and challenges

5.1. What worked well

5.1.1. Enhanced comfort and familiarity at home

Participants frequently highlighted the benefits of receiving care within their own homes as providing a sense of comfort, privacy, and mental wellbeing.

Care at home allowed patients to maintain their routines and avoid the stress of hospital environments such as noise, lack of sleep and discomfort. Familiar surroundings were reported to be particularly beneficial for patients' psychological health and recovery.

> *"It would have been absolutely chaotic for her to go into hospital. The fact [is] that we were receiving what would have done in hospital, but in the comfort of her own home by people she knows and loves, compared to strangers in a hospital ward." (Carer)*

5.1.2. Emotional comfort and trust in virtual ward staff

Participants expressed a strong sense of trust in virtual ward staff, often attributing their positive experiences to the professionalism and compassion of the team. The care and reassurance provided by the staff was a key factor in patient and carer satisfaction.

> *"I felt like they genuinely cared about my wellbeing throughout the process." (Patient)*

> *"They keep people out of hospital, they keep people in their homes, which is what they want, and they make people comfortable." (Carer)*

Many participants compared the virtual ward service favourably to the perceived alternative of "no care," although this gratitude often reflected low expectations of broader healthcare systems under pressure.

> *"The NHS, as it is, is struggling, isn't it? And then to provide a service like they have done with [the virtual ward], it's a miracle they can do it. We are in a better place for having them, we are one of the few lucky ones." (Carer)*

5.1.3. Accessible and convenient care delivery

One key benefit patients identified of being on the virtual ward was that it enabled them to continue maintaining and supporting their own households.

> *"It makes me able to stay at home. I don't have to go to hospital, I don't have to leave the kids because once you're in hospital you'll be in there for weeks." (Patient)*

Participants also frequently highlighted the ease of accessing care at home, describing how it alleviated common stressors like hospital commutes and the busyness of hospital environments.

> *"The fact that someone comes to you, and it's all done at home is incredibly convenient." (Patient)*

5.1.4. Reassurance through technology-enabled monitoring

For many patients, once they had become familiar with it, technology-enabled monitoring fostered a sense of safety and independence. The knowledge that they were being constantly monitored through the virtual ward model reassured patients that they were being cared for.

> *"They could monitor whatever it was that he needed you know. I would be very reassured by that." (Carer)*

5.2. What were the challenges?

5.2.1. Communication and coordination gaps

Some participants reported inconsistencies in communication and scheduling, especially when multiple healthcare professionals were involved in the patient's care. Unclear visit schedules or insufficient updates created stress for patients and carers alike.

> *"Sometimes it was overwhelming, with calls and visits making it hard to manage." (Patient)*

Carers reported varying levels of support from healthcare providers. Some were positive about the guidance they received and their engagement with the virtual ward team. Others felt excluded from critical discussions about patient care or overwhelmed by resources provided by the virtual ward team to ease their burden.

> *"I had a pack arrive, but I haven't done anything about it because I just haven't had the time. There are not enough hours in my day. Carer's needs assessment, what are they and how do I get one. It's just got all of these things here, and I have read some of it and thought, 'Oh, for goodness sake, I can't be bothered.' I've just got to get on." (Carer)*

In some instances, the lack of communication or access routes to staff left them feeling unsupported.

> *"The nurses just did their medical side of everything. They didn't ask me, 'Are you managing alright?'" (Carer)*

5.2.2. Barriers to effective technology use

Initial use of monitoring technology was challenging for some participants, particularly when recording observations or using unfamiliar devices. Technical issues and a lack of training occasionally disrupted care delivery.

> *"It takes a while to familiarise yourself, especially if you need to record your own observations." (Patient)*

6. Learning for future evaluation

This section reflects on the key lessons learned during the evaluation process, highlighting both the challenges encountered and the insights gained to inform future research with virtual ward patients and carers.

6.1. Approvals and recruitment of participants

The processes of obtaining Information Governance (IG) approvals with NHSE and engaging with local trusts (including but not limited to IG) and virtual ward teams took much longer than expected, delaying participant recruitment and interviews.

The main challenges for the NHSE Data Protection Impact Assessment (DPIA) approval were the use of an external transcription service, and NVivo software with data hosted outside of the UK. Both providers required additional, more rigorous governance checks than had been encountered before with both providers having to submit additional certifications and assurances.

The main challenge when engaging local trusts was their varied approval processes for evaluation. Each site required a locally tailored approach ranging from simple clinical lead agreement, to review and approvals from IG teams in addition to those already in place with NHSE. Over time, the evaluation team supplemented the initial information pack for trusts and virtual ward teams with the additional IG and other information other trusts had requested, creating a comprehensive set of resources for all eventualities. This helped to speed up the process.

Virtual ward teams with prior experience in research and evaluation had greater confidence in recruiting participants. Their familiarity with evaluation processes often led to smoother approval and recruitment efforts, emphasising the value of building research / evaluation capabilities within virtual ward teams. Some teams were able to proceed with recruitment with the information packs setting out the detail of the research and the required approach, once key stakeholders had been engaged; others needed more in-depth briefings for wider groups of staff.

Not all patients who consented to their contact details being shared with the evaluation team went on to complete interviews. Some were too unwell to participate, and others had been readmitted to hospital or virtual wards by the time of follow-up. Where initial contact attempts were unsuccessful, re-engaging with participants after a few weeks often improved response rates.

Despite the recruitment challenges, this evaluation is the first study to examine patient and carer experiences across a diverse range of virtual wards. Although some local evaluations have been conducted, this study offers a broader view, capturing insights from different types of virtual wards, including carers' perspectives, and providing a more comprehensive understanding of experience across England.

6.2. Challenges with patient recall

Across the research interviews, there were difficulties with patient recall, particularly regarding the admission process. Some were confused, and many accounts were fragmented or not shared in chronological order.

Patients were not always aware of implicit processes, such as assessments or clinical observations conducted during routine conversations. These subtle but important interactions were sometimes overlooked in patients' narratives.

Joint interviews with patients and their carers addressed recall challenges. Carers often provided complementary details, filling gaps in patients' accounts and clarifying timelines.

6.3. Diversity in perspectives

There were instances of contrasting perspectives between patients and their carers, highlighting the need to consider multiple viewpoints when analysing experiences. Carers often had distinct insights into the realities of virtual ward patient care, which added depth and nuance to the evaluation findings. Although joint interviews helped address recall challenges, the downside was that sometimes they created barriers in patients and carers sharing more open feedback in relation to their own individual perspectives, perhaps due to the potential impact on their relationship.

As with many evaluations involving patients and carers, there is potential for participation bias. Since involvement was voluntary, it is possible that those with particularly positive or negative experiences were more inclined to take part, which may have influenced the overall findings.

It is important to note that there is a lack of representation from diverse populations among participants in the evaluation. This limitation stemmed from the recruitment approach, which relied on virtual ward teams to recruit participants in a short timescale. Although they were encouraged to recruit a diverse range of patients, there was not the time or resource to target particular groups. Future evaluations should prioritise underrepresented groups to ensure findings reflect the full range of experiences within virtual wards, particularly those most at risk of experiencing health inequalities.

This evaluation does not capture the perspectives of individuals who are unable or choose not to access virtual wards. During the scoping phase, the project team and advisory group determined that focusing on the experiences of those who used the service would be the primary objective, leaving this group outside the scope of the study. As a result, there remains a need to further explore the experiences and motivations of those who choose not to engage with virtual ward services or who are not referred to these services.

7. Conclusions and recommendations

This section provides recommendations from the evaluation. The first section presents recommendations from the patients and carers who participated in the research. They are included without comment to reflect their views. The second section presents the conclusions from the evaluation team's analysis of the data, along with linked recommendations that incorporate, but extend beyond, those from the participants. These were tested and refined with the evaluation advisory group.

7.1. Recommendations suggested by patients and carers

Most patients and carers expressed high levels of satisfaction with their virtual ward experience. They described the care as effective, supportive, and empowering. Whatever their experience, some offered suggestions for improvements, primarily directed at virtual ward providers and teams. These recommendations focused on carer involvement, technology use, enhancing communication, and patient experience.

- **Involve carers** or those supporting the patient in decision-making about admissions, avoiding assumptions about their caregiving role or the patient's competence and decision-making ability
- **Brief carers on monitoring** technology, even if the patient demonstrates they understand, because the patient may require support once staff leave
- **Take (more) time to explain to patients** how to use monitoring technology and any decisions about treatment and medications, ensuring they understand, have the opportunity to ask questions and can make informed choices about their care
- **Provide written versions of important information** about the virtual ward, from before admission through to discharge, on topics such as (but not limited to): what to expect from the first visit; daily routines (either face-to-face or remote monitoring); how to use remote monitoring equipment; and discharge processes
- **Build public awareness** of virtual wards to widen patient and carer choice and support informed decision-making
- Where possible, **ensure that the same members of staff visit the patient each time** e.g. for. blood tests and observations. This is particularly important when the patient may already be receiving visits from multiple healthcare professionals as part of routine care for long-term conditions.
- **Provide opportunities for more direct contact with senior clinical decision-makers** for example regarding medication changes or other relevant treatment decisions if requested by patients and/or carers.

7.2. Recommendations from analysis

The recommendations below have been developed from the analysis of all patient and carer interviews, integrating suggestions from patients and carers. Although some are already features of the national guidance, they are included here because participants' accounts indicate these areas might require renewed emphasis or consideration.

These recommendations are aimed at providers and virtual ward teams and NHSE and the national virtual ward programme

Providers and virtual ward teams

Holistic assessments of patients, their home environment, and their support needs

Finding: holistic assessments of patients' circumstances, including their home environment and support network, do not appear to have been conducted consistently.

Recommendation: providers should continue to ensure that holistic assessments are undertaken of patient circumstances, as well as the home environment, before admission.

Continuous assessment of carer needs and preferences

Finding: some carers felt overlooked or uninvolved in decisions about a patient's admission to a virtual ward, with assumptions made about their ability to manage caregiving responsibilities. Carers were not always provided with the support they needed throughout the patient's time on the virtual ward. Furthermore, there was no mention of assessments of the support needs of young carers where they were involved in providing care.

Recommendation: virtual ward teams should involve carers in their initial assessments, regularly check in with them, and support a carer's right to reconsider providing care during the patient's admission. As part of this they should consider working with local organisations supporting carers such as British Red Cross[13], or using, and signposting carers where relevant, to tools from organisations such as those produced by Carers UK[14].

Accessible and culturally tailored information

Finding: many participants were confused about the virtual ward before and during admission and requested written materials to complement verbal explanations.

Recommendation: provide both patient and carer-facing hard copy information in Plain English, Easy Read, and/or other languages about virtual wards before admission to support active decision-making and on discharge. Information should be culturally appropriate and tailored to meet the diverse needs of local communities. Audio information should also be considered for some patient populations.

Clear communication of visit schedules

Finding: disruptions caused by unscheduled or poorly communicated visits by virtual ward staff were sometimes a source of frustration for patients and/or carers.

Recommendation: where possible, virtual ward teams should clearly communicate the schedule of visits or provide sufficient notice in advance, notifying patient and carers of any changes to allow for better planning.

Streamlining care delivery

[13] https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/vcse-health-and-wellbeing-alliance

[14] https://www.carersuk.org/reports/virtual-wards-toolkit-getting-it-right-for-unpaid-carers/

Finding: some patients and carers described feeling overwhelmed by the number of staff visiting or the number of interactions with different members of staff as part of their virtual ward experience.

Recommendation: ensure continuity of care by assigning the same team members for patient visits whenever possible. Where multiple different health and care teams are supporting the patient, coordinate care to try to minimise the overall number of visits.

Consistent messaging from all staff

Finding: inconsistent communication, especially around discharge caused confusion and stress for some participants.

Recommendation: ensure that patients and carers receive consistent and unified messages from all staff members involved in providing virtual ward care.

Limiting stress of remote monitoring for patients and carers

Finding: some participants described challenges with using technology, including initial confusion and technical issues, which caused stress and disrupted care.

Recommendation: providers should offer additional training, written and verbal information to support patients and carers and ensure the remote monitoring is as easy as possible to use (such as wearable devices which require limited manual input).

Briefing carers on monitoring technology

Finding: carers often support patients with managing their monitoring devices. Some carers were not present when patients were briefed on how to use the devices and in some instances, patients were not well enough to recall full instructions.

Recommendation: virtual ward teams should ensure that carers are fully briefed on the use of monitoring technology, even if the patient appears confident. This will enable carers to provide effective support when staff are not present.

Alternative options to remote monitoring

Finding: some patients and carers did not want to use remote monitoring offered or felt unable to do so.

Recommendation: providers should assess patients' and carers' ability to use remote monitoring technology, as well as their preferences for how care is delivered, discussing this before admission and providing alternatives such as increased face-to-face visits if necessary.

Involving patients in care decisions

Finding: a small number of participants were frustrated about clinical decisions (such as medication changes) not being discussed with them beforehand and (their perception) that decisions were being taken by clinicians outside of their immediate visiting care team (such as a wider MDT).

Recommendation: ensure patients feel involved and understand any decisions taken on their care (including who has made them), offering opportunities to talk these through. Involve carers where appropriate or patient has given permission.

NHSE and the national virtual ward programme

Increase public awareness of virtual wards

Finding: although a small number of participants were aware of virtual wards because of personal or family experiences, most had very limited understanding of them prior to admission.

Recommendation: develop public-facing communications strategies to raise awareness of virtual wards, supporting proactive decision-making during the admission process and potentially self-referrals where that is an option.

Understand gaps in care for lower acuity patients

Finding: There was a wide range of patients supported across the virtual wards, with some patients appearing to be lower acuity.

Recommendation: beyond the GIRFT[15] programme and other provider-focused work, consider conducting a broader consultation with virtual wards to identify why some patients with lower acuity are admitted and what gaps in care these services are addressing. This could help inform national planning.

Support working carers

Finding: there can be an emotional and logistical strain on carers balancing employment with caregiving (both in their homes or at a distance), highlighting the need for systemic support.

Recommendation: collaborate with organisations supporting carers and employers to explore policy options for aiding working carers supporting people admitted to virtual wards.

Facilitate learning and knowledge sharing

Finding: patients and carers provided examples of experiences which indicate that virtual wards are following operational guidance to varying levels of success.

Recommendation: NHSE should provide structured opportunities for virtual ward teams to share examples of good practice, emphasising the importance of aspects such as:

- Holistic and environmental assessments of patient and carer circumstances
- Clear communication throughout the virtual ward journey
- Shared decision-making with patients and carers.
- Personalised care

[15] Getting It Right First Time (GIFT) is NHSE's national programme to improve treatment and care through clinically-led reviews of health services in England, including virtual wards.

8. Patient and Carer stories

This section presents examples of patient and carer stories that provide a more detailed illustration of individual experiences for the key themes in the findings. The stories use pseudonyms and have had some personal details amended to protect the identity of the participants.

Aisha and Fatima's story

Aisha has complex health needs including epilepsy, lung failure and learning disabilities. She requires continuous care and monitoring. She is currently living with her sister Fatima, who is her primary carer. She has limited communication abilities and relies heavily on her sister and her sister's family (husband and son) for support. **Fatima** has been living in the UK for over 40 years and is well-versed in navigating the healthcare system. She balances her job alongside her deep involvement in Aisha's care, including managing her medical needs, communicating with healthcare professionals, and supporting her wellbeing. Her husband (who is retired) and son also support Aisha.

What happened?

- Aisha was referred to the hospital due to severe lung failure and low oxygen levels. Her GP recognised the urgency and immediately sent her to the hospital for intensive care.
- Towards the end of her stay in hospital, Aisha's clinical team discussed her returning home for care with a supply of oxygen as a virtual ward patient. Fatima agreed and Aisha was discharged from the hospital.
- The first visit from the virtual ward team was not scheduled. At the visit, Fatima initially declined the monitoring equipment because she struggles with technology and her husband was not around to support her during the demonstration. With notice, she would have made sure that he was.
- During a follow-up phone call, which Fatima found stressful, the nurse indicated that Aisha could not remain at home if Fatima did not accept the equipment. A return visit was rescheduled for a time when Fatima's husband would be present. This was more successful, and the monitoring equipment was set-up.
- Fatima, her husband, and son were then able to support Aisha with monitoring and communicating with the virtual ward team.
- Aisha was monitored at home for a fortnight with a tablet for video calls, a wearable device to track her oxygen levels, blood pressure, and heart rate, and regular remote check-ins from the respiratory team .
- Aisha was discharged from the virtual ward when the team were happy with her breathing and oxygen levels. Fatima was relieved to have the oxygen tank removed from the house, as she had had some safety concerns, and for the reduced night-time monitoring.

What worked well?

- **Communication:** the respiratory team maintained regular contact, providing updates on Aisha's condition. Fatima appreciated their responsiveness.
- **Home setting:** Aisha had a more comfortable place to recover, and it was easier for Fatima and family.
- **Support from respiratory team:** Fatima praised the team's professionalism and quality of care.
- **Family involvement:** Fatima's husband's and son's support eased some of her stress.

"As soon as [Aisha's] oxygen went down, they called me and said to me, '[Fatima], please put [Aisha] on the oxygen because her oxygen level is

down.' Their monitoring was fantastic. They called me in the middle of the night, they called me when I was at work, then I called home, whatever, who is there, either my son or my husband, I told them. So, the service was perfect. I'm quite happy."

What challenges did Aisha and Fatima face?

- **Choice/concerns regarding equipment set-up:** At the first, unscheduled, home visit and follow-up phone call, Fatima felt pressured to accept the remote monitoring equipment, particularly when a nurse said they would otherwise remove the oxygen, and Aisha would have to return to hospital. This caused significant stress.
- **Language and communication barriers:** Aisha's limited English and learning disability made communication difficult. Fatima is the only person who can effectively communicate with Aisha, (as her family, and health and care services, do not speak Fatima and Aisha's native language) which added to her stress, especially when she was at work and needed to communicate between Aisha and other family members or health care professionals.
- **Technical issues:** there were occasional connectivity problems with the monitoring equipment, requiring multiple attempts to get accurate readings.
- **Oxygen safety concerns:** Fatima was nervous having oxygen equipment in her home due to potential safety risks, such as fire hazards. However, she accepted it as a necessity for her sister's health.

"They called to say, 'we will take the oxygen if you don't accept [the remote monitoring equipment].' And I said, 'Please bring anything you want to bring. Please come any time you want to come. Because if you take the oxygen my sister, she will end up in the hospital or worse.'"

What is the learning from this story?

- **Communication prior to admission:** describing how the virtual ward will work, including remote monitoring processes and carer roles and responsibilities, more clearly before patients are sent home will ensure a smooth admission, where patients and carers can be more prepared.
- **Alternatives to remote monitoring:** where patients and carers are not confident and comfortable using remote monitoring technology, virtual ward staff should offer alternatives such as increasing the number of in-person visits.
- **Culturally competent care:** health care professionals communicating directly with the patient in a language they understand and speak takes the burden off caregivers having to translate often complex messages.
- **Support for carers:** additional support for carers can be necessary, particularly with managing the technical aspects of remote monitoring and dealing with the emotional stress of caring for a loved one with complex needs.
- **Family dynamics:** even when there are other family members available to support, caregiving responsibilities often fall primarily on one person and services should explore how they can support

these individuals and address any needs that may arise from providing care on the virtual ward.

- **Healthcare system navigation:** even for people with extensive experience navigating the healthcare system, staff should be mindful that new services and ways of working can be challenging at first.

Caroline and her mother's story

Caroline's mother Beryl is in her 80s with complex health needs, including recurrent infections, diabetes, and mobility issues and is at risk of hospitalisation. **Caroline** has been living with and caring for her mum full-time (as well as working from home) for three years, in a remote village. She previously moved back home with her partner from another region, after her mum had a couple of long stays in hospital and could no longer live independently. She supports her mum with personal care, meals, catheter care and medication.

What happened?

- Beryl was referred to the virtual ward for the first time in 2022 after a sepsis infection returned following a four week stay in hospital. Caroline phoned the GP who sent out the urgent response team who support the virtual ward.
- The virtual ward service was introduced to Caroline when her mother developed another infection. The service was recommended by her GP, and since then, Caroline has relied on the virtual ward team to manage her mother's recurrent infections at home rather than hospital.
- Caroline's mother has been on the virtual ward multiple times, typically for four to ten days, depending on the severity of the infection. The team continues to monitor her until her blood tests show improvement, at which point she is discharged from the service.
- The virtual ward team provides daily home visits, including blood tests, urine tests, catheter changes, and monitoring of her mother's condition. They also liaise with the hospital and GP to ensure she receives the right antibiotics and treatment.

What worked well?

- **Daily home visits:** the virtual ward team provided consistent, daily home visits, which Caroline describes as "*phenomenal*." They monitored her mother's condition, took blood and urine samples, and ensured she was on the right treatment plan.
- **Personalised care:** the team came to know Caroline's mother well, having cared for her for three years across multiple admissions. They recognised her unique symptoms and provided tailored care, even when her observations appeared normal despite her being unwell.
- **Support for Caroline:** the team provided significant support for Caroline, advising her on medication administration, catheter management and other care tasks. They also liaised directly with the hospital and GP, reducing the burden on Caroline.
- **Avoiding hospitalisation**: Caroline believes the virtual ward has kept her mother out of hospital multiple times, which she described as being important given her mother's frailty and the risks associated with hospital stays.

"I can absolutely, positively without doubt say that without the support of the team and the nurses who have come out… my mum would be in hospital most of those times. They are absolutely so good. At the end of the day, it takes the pressure off the hospitals having a team like this."

What challenges did Caroline face caring for her mother?

- **Limited local healthcare resources**: living in a remote village means that access to immediate healthcare resources was limited. The virtual ward team has been essential in bridging this gap, but Caroline has faced challenges with other services, such as delayed flu and COVID vaccinations.
- **Carer burden**: while the virtual ward team provides significant support, Caroline still bears the primary responsibility for her mother's care. This includes managing her catheter, administering medications, and coordinating with an increasing number of healthcare professionals.

What is the learning from this story?

- **Importance of personalised care:** the virtual ward team's deep understanding of the patient's condition highlights the value of personalised, long-term care relationships. This has been crucial in managing recurrent issues and avoiding unnecessary hospitalisations.
- **Support for carers:** there is a need for ongoing support for carers, particularly those managing complex health conditions at home. The virtual ward team has been instrumental in providing this support and helping carers develop capabilities to support patients at home, but additional resources could further ease the burden on carers.
- **Remote and rural healthcare access:** the virtual ward *"has been a lifeline"* for those who live in remote areas with limited access to healthcare services. This highlights the importance of expanding virtual ward services to other rural communities.
- **Integration with other services:** even with effective and 'exceptional' care from virtual wards there can be challenges with other parts of the healthcare system, such as delays in vaccinations. Better integration between services could improve the overall care experience for patients and carers.

June and Mark's story

June is a 69-year-old woman living in a small industrial town with her husband, **Mark**, who is her primary carer. June has terminal cancer, lung cancer and COPD, which significantly impacts her mobility and overall health. She relies on Mark for daily support, including personal care and managing her health needs. After a difficult hospital experience, June was introduced to the virtual ward, which has since become a critical part of her care. The team provides home-based care, allowing June to avoid hospital stays and remain in the comfort of her home.

What happened?

- June was initially hospitalised for her conditions, where she had a negative experience. She felt rushed and poorly informed about her treatment options, including discussions about a do not attempt cardiopulmonary resuscitation order (DNACPR) order, which caused significant distress.
- After her hospital stay, June was introduced to the virtual ward by a district nurse. The service was presented as an alternative to hospitalisation, allowing June to receive care at home.
- The virtual ward team provided comprehensive support, including regular home visits, medication management, and coordination with other healthcare services like Occupational Therapy. They also helped June and Mark understand her condition and treatment options.
- June has used the virtual ward service multiple times, most recently for a urinary tract infection, during which the team visited her daily for a week to monitor her condition and provide treatment.
- Although June is no longer actively using the service, she knows she can contact the virtual ward at any time if her condition worsens, providing her with a sense of security and continuity of care whilst she manages her terminal condition.

What worked well?

- **Personalised and compassionate care:** the virtual ward team took the time to explain June's condition and treatment options in a way that was easy to understand. They addressed her concerns about the DNACPR order and provided reassurance, which helped reduce her anxiety.
- **Home-based care:** June and Mark both emphasised how much more comfortable and relaxed they felt receiving care at home compared to the hospital. The virtual ward team allowed June to avoid the stress and discomfort of hospital stays.
- **Support for carers:** Mark, as June's primary carer, described feeling included in the care process. The team took the time to ensure he understood June's condition and treatment plan, which helped him feel more confident in his caregiving role.
- **Continuity of care:** the virtual ward team provided consistent support, even after June was no longer actively using the service. Knowing she could contact them at any time gave June and Mark peace of mind.

"I can't praise them enough. They have so much patience, unbelievable. I mean, they're as busy as anybody else, but they do take the time." (June)

What challenges did June and Mark face?

- **Negative hospital experience:** June's initial hospital stay was described as traumatic, with poor communication and a lack of empathy from staff. This experience left her feeling anxious and distrustful of hospital care.
- **Complex health needs:** managing terminal cancer, lung cancer, and COPD is challenging, including for Mark, who bears the primary responsibility for June's care. The virtual ward has been essential in providing support when June has become acutely unwell.
- **Limited understanding of treatment options:** June and Mark initially struggled to understand terms like 'fast track' and 'DNACPR', which were poorly explained by hospital staff. This caused unnecessary distress until the virtual ward team clarified these terms.

What is the learning from this story?

- **Importance of clear communication:** it is crucial that healthcare providers communicate clearly and compassionately, especially when discussing sensitive topics like end-of-life care. The virtual ward team's approach to explaining treatment options and addressing concerns are a key factor in a patient's positive experience.
- **Value of home-based care:** the virtual ward model can be configured to provide care for patients with complex health needs and end of life care. It reduces the stress of hospital stays and allows patients to remain in a familiar and comfortable environment.
- **Support for carers:** it is important to include carers in the care process. Providing clear information and emotional support to carers can help them feel more confident.
- **Continuity and accessibility of care**: ongoing availability of virtual ward support, even after active care has ended, provides patients and carers with a sense of security.

Rachel's story

Rachel is a 60-year-old woman and works as a part-time cleaner. Although she has no previous medical conditions, she was hospitalised in November with severe respiratory problems, including pneumonia and undiagnosed COPD. She was introduced to the virtual ward team during her hospital stay, where she heard it being discussed with another patient. She was then admitted on to the virtual ward and supported to recover at home with continuous monitoring. Rachel's husband, who is confident with technology, helped set up the monitoring equipment and supported her throughout the process.

What happened?

- Rachel was admitted to hospital with severe respiratory issues, including low oxygen levels and hallucinations. She was initially diagnosed with pneumonia and later found to have undiagnosed COPD.
- During her hospital stay, Rachel was introduced to the virtual ward team by a nurse who was discussing it with another patient. The team explained the service and offered her the option to recover at home with continuous monitoring.
- Rachel was discharged from the hospital early and sent home with monitoring equipment, including an armband, an iPad, and a blood pressure monitor. Her husband helped set up the equipment, and Rachel began her recovery at home.
- The virtual ward team tracked Rachel's oxygen levels, heart rate and blood pressure. The monitoring revealed that Rachel had sleep apnoea, which was previously undiagnosed.
- Rachel's discharge from the remote monitoring service was described as abrupt and poorly communicated, leaving her feeling unsettled and without clear follow-up care instructions.

What worked well?

- **Continuous monitoring:** Rachel felt safer at home than in the hospital because the remote monitoring team tracked her condition 24/7. The team alerted her when her oxygen levels dropped or her heart rate spiked, which helped her manage her condition more effectively.
- **Personalised care:** Rachel appreciated the personalised attention from the team, particularly from a nurse, who checked in on her regularly and provided emotional support.
- **Discovery of sleep apnoea**: the remote monitoring revealed that Rachel had sleep apnoea, a condition of which she was unaware. This was an important discovery by the service, allowing her to seek further treatment.
- **Support from husband**: Rachel's husband played a crucial role in setting up the monitoring equipment and supporting her throughout the process, which made the transition to home care smoother.

"I felt really safe, I'll be honest with you… from that monitoring, I learned a lot about myself… I wouldn't have known without the hub, without all this equipment."

What challenges did Rachel face?

- **Abrupt discharge:** Rachel's discharge from the virtual ward was sudden and poorly communicated. She received a call telling her to remove the monitoring equipment without any prior warning or follow-up care instructions, which left her feeling unsettled.
- **Inconsistent communication:** while Rachel described most of the team providing excellent care, she found that some staff members were dismissive and did not listen to her concerns. This inconsistency in communication was frustrating for her.
- **Lack of follow-up care:** after her discharge, Rachel did not receive any follow-up care or information about her condition. She was left unsure about whether her pneumonia had fully resolved and what steps she should take next.
- **Limited information:** Rachel felt that she lacked sufficient information about her condition and how to manage it. She would have appreciated a booklet or guide explaining what to expect and how to care for herself after discharge.

What is the learning from this story?

- **Reassurance of continuous monitoring:** for conditions where symptoms can change quickly, continuous monitoring can empower patients/carers and provide reassurance that changes can be noticed by the healthcare team.
- **Importance of clear communication:** it is critical that all communication is clear and consistent, particularly around discharge. Where possible, patients should be given information at the start of their admission to the virtual ward about how long they are likely to require care for. The discharge process should be fully explained, and patients should be provided with detailed follow-up care instructions.
- **Patient education:** providing patients with clear, written information about their condition and how to manage it at home would help them feel more confident and supported during and after their recovery.
- **Consistency in care:** ensuring all team members provide the same level of care and attention is crucial.

Sharon's story

Sharon is a 50-year-old Jamaican woman living in temporary accommodation (a hotel) with her teenage daughter. She has multiple health conditions, including asthma, diabetes, high cholesterol, and a history of respiratory issues. Sharon has been placed in the hotel by the local authority for over eight months; despite being told it would be a temporary stay of 56 days. The living conditions are poor, with no working lift, cockroaches, and limited access to hot water, which has exacerbated her health issues. Sharon was admitted to the hospital with severe respiratory problems and was discharged on the same day to continue her care at home with remote monitoring through the virtual ward service.

What happened?

- Sharon was admitted to the hospital after experiencing severe chest pain, vomiting and difficulty breathing. She called 111 and later 999, and an ambulance took her to the hospital, where she was diagnosed with a chest infection and Norovirus.
- Due to a lack of available beds, hospital staff advised Sharon could be discharged the same day and sent back to her temporary accommodation and admitted on to the virtual ward with remote monitoring equipment. Sharon described having to walk up five flights of stairs because of the lift being broken.

"The doctor came and said they haven't got a bed, so they're going to send me back to the hotel, because it is in front of the hospital… just five minutes' walk from the emergency service. So, they said I should take my time to walk over…it was very cold. It took me probably about two hours to get to my room, because I had to take one step each on the stairs."

- The virtual ward team set up the equipment in her hotel room and provided her with an iPad for video calls and text communication.
- Sharon was monitored for a week and a half, during which the team tracked her oxygen levels, heart rate and blood pressure. She also received daily video calls from the team to check on her condition and adjust her medication.
- Sharon's daughter helped her with daily tasks, including taking her blood pressure and collecting medication from the pharmacy. Sharon's living conditions made her recovery more challenging as it was cold.
- Sharon was discharged from the virtual ward after completing her medication, but she continues to experience some respiratory issues and at the time of the interview had an upcoming appointment with an asthma clinic as part of follow-up care.

What worked well?

- **Continuous monitoring:** Sharon felt that the remote monitoring provided her with the same level of care as being in the hospital. The team tracked her vital signs and adjusted her treatment as needed, which helped her manage her condition effectively.
- **Daily communication:** the virtual ward team maintained regular contact with Sharon through video calls and texts, ensuring she felt supported throughout her recovery. This daily communication helped her feel less isolated and more connected to her care team.

- **Support from daughter:** Sharon's teenage daughter played a crucial role in her recovery, helping her with tasks like taking blood pressure readings and collecting medication. As her daughter was under legal age to collect the prescribed medicine, Sharon had to call the pharmacy at the hospital and agree for them to give the medicines to her daughter.

"They were on the phone, (whilst she was on the road), the pharmacist with my daughter, and I was on the phone as well. I couldn't speak long, because when I speak, my chest hurts. She collected my inhalers, and whatever I needed at the pharmacy. They were telling me one time, if I needed my medication could be delivered, but because I'm diabetic, I've got high cholesterol and asthma, I needed to get my prescription now."

- **Avoiding hospital stay:** Sharon appreciated being able to recover at home rather than staying in the hospital, especially because of her perception of what it was like in the pandemic. The remote monitoring allowed her to avoid the risks associated with hospital stays while still receiving high-quality care.

What challenges did Sharon face?

- **Poor living conditions:** Sharon's temporary accommodation in the hotel was not conducive to recovery. The broken lift forced her to climb multiple flights of stairs, which worsened her asthma. The presence of cockroaches and lack of hot water added to her stress and discomfort.
- **Limited follow-up care:** After her discharge from the virtual ward, Sharon did not receive any follow-up care or information about managing her condition. She felt that more guidance, such as a booklet or instructions on self-care, would have been helpful.
- **Constipation from medication:** Sharon experienced severe constipation as a side effect of her medication, which added to her discomfort during recovery. She felt that the team could have provided more support in managing this.
- **Abrupt discharge:** Sharon's discharge from the virtual ward was sudden and she felt that more communication about the process would have been beneficial. She was left unsure about what to do next and how to manage her ongoing symptoms but expressed gratitude for the service she got when there were no hospital beds.

What is the learning from this story?

- **Importance of suitable living conditions:** poor living conditions can have a detrimental impact on health and on recovery. Patients in temporary or inadequate housing may struggle to manage their health, even with remote monitoring. Conducting a housing/environment assessment and addressing any issues identified should be a priority for healthcare providers. Providers should also consider how they can work with other organisations, for example the VCSE sector, to provide further support to patients around housing and accommodation if required.
- **Need for additional support during admission and follow-up care:** providing links to supporting organisations who can support with prescriptions and other routine activities is important . Patients should receive guidance on managing their condition, including potential side effects of medication and when to seek further help.

- **Support for young carers**: young carers can often play a vital role in providing care whilst also going to school and managing household responsibilities. Healthcare providers should consider the particular needs of young carers and provide additional assistance when necessary.
- **Clear communication during discharge:** the abrupt nature of discharges can leave patients feeling unsupported. Clear communication about the discharge process and what to expect afterward would improve experience.

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