British Red Cross

Virtual inequality?

Investigating risk, responsibility and opportunity on virtual wards (also known as Hospital at Home) for health inequalities

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Overview

The NHS is currently in the process of assessing virtual wards, also known as Hospital at Home (which is used interchangeably in these slides), with a view to scaling up and standardising their use.

This has been widely welcomed. Hospital at Home has the potential to mitigate some health inequalities by enhancing access to healthcare for those who might experience difficulties in accessing or receiving healthcare in hospital.

However, there has been little published research or guidance to date on the impact of virtual wards on health inequalities. The British Red Cross (BRC) therefore undertook this research project to scope health inequalities in virtual wards in order to identify areas for further investigation. Through consultation with clinicians, people with lived experience of health inequalities, and VCSE organisations that support them, we found a strong consensus that if virtual wards are set up without real focus on addressing barriers to both access and people's quality of care, then they risk widening the inequality gap further for some groups.

To support improvement, this document contains findings and reflections from our consultation. These cover the different experiences and circumstances which may positively or negatively impact people's access to and experience of Hospital at Home, and ideas for how to ensure they can be as equitable and effective as possible.

To avoid exacerbating inequalities, it is crucial for systems and providers of virtual wards to:

1. **Develop a detailed understanding of the barriers that their local populations face in access and in quality of care**

During our consultation we identified many potential barriers and five priority areas of concern about virtual wards and health inequalities. Systems and providers of virtual wards should have awareness of these priority areas alongside other specific issues that may affect their local population's ability to access and benefit from using a virtual ward.

2. **Explore how programme adaptations or the provision of additional support can help to overcome barriers**

Considering the five priority areas of concern that arose during our consultation, we identified six practical steps that we think will support Hospital at Home programmes in identifying and overcoming barriers to offering quality of care for all.

We welcome further input based on practical experience of Hospital at Home and health inequalities.

If you would like to add to our learning, please contact: advocacy@redcross.org.uk

About virtual wards

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Virtual wards provide hospital care at home

- NHS England's virtual ward's programme was launched in April 2022. There are now over 11,000 virtual wards 'beds' across the country, with more than 8,000 people a month treated on a virtual ward rather than in hospital.
- Also known as Hospital at Home, virtual wards offer people short-term hospital care and treatment in their home. The average stay on a virtual ward is less than two weeks.
- People on a virtual ward receive the same level of care as they would in hospital, with daily input from mobile teams of clinical staff and ongoing access to diagnostics and treatment in their own home. Virtual ward teams often make daily home visits. They provide people with equipment (like pulse oximeters, blood pressure machines, and mobile devices) to measure vital signs and enter data into an app, website or wearable devices (like watches and other monitoring devices). This provides continuous monitoring of vital signs that the virtual ward team can access.
- Virtual wards can be used to prevent hospital stays for people who prefer, or will benefit from, staying at home ("step-up"). They can also support early discharge out of hospital ("step-down") for people with acute care needs who continue to receive treatment at home.
- Virtual wards are for people with acute health needs. They are not for long-term condition management nor are they a preventative service to stop someone becoming ill or routine or outpatient appointments delivered remotely.
- Most existing virtual wards focus on providing care and treatment to older people with frailty-related illness, or people with respiratory or heart conditions. Some virtual wards specialise in services for children and young people, presenting an opportunity to support children and their families as part of the wider health care pathway.

National policy seeks to expand this model of care

- NHS England has a national Hospital at Home programme, and their policy is to increase the number of people who can benefit from access to virtual wards as well as a focus on improving quality and standardisation.
- There is also a renewed focus on step-up support to avoid hospital admission.
- The ambition is to spread and scale virtual wards so that they are widely available to more people with a wider range of conditions.
- National guidance sets out the core clinical considerations and recommended approach for developing a virtual ward.
- But local systems and clinical leaders have flexibility to design and develop the virtual ward service in a way that best suits the local area. Different models and approaches for virtual wards have developed as a result.

North Cumbria case study - summary

Context

The North Cumbria Virtual Wards service commenced in January 2023 with support from North East and North Cumbria ICB to provide virtual ward respiratory and frailty pathways. Recognising the need to widen access to the service to address heath inequalities, North Cumbria Integrated Care NHS Foundation Trust partnered with the British Red Cross (BRC) in September 2023. BRC work alongside the virtual ward clinical team, providing holistic support to patients to meet their wider social needs such as household maintenance, meal provision, prescription collection and connecting with valued social activities such as church or library groups.

How it works

Holistic Support Workers are part of the virtual ward multi-disciplinary team, attending daily board rounds to identify those patients in need of wider support. The support workers undertake holistic assessment to identify needs that might impact on health outcomes and experience, including digital and health literacy, daily living needs, and ensuring a safe home environment. Support is provided for 0-4 weeks, enabling more people to benefit from access to a virtual ward safely and with confidence.

Impact and learning

- 174 people received BRC's holistic support between September 2023 and March 2024, with 81% of people aged 65 years or over.
- 41% of patients lived alone. Prior to BRC involvement, patients were only given the choice of a virtual ward if they were living with family.
- Of those supported by BRC, clinical staff reported that the holistic support enabled 88% to transfer onto the virtual ward e.g. via help with digital equipment or support at home
- Satisfaction scores are very high. 100% of patients who provided feedback on the support service stated that they had a very good/good experience. 87% said they felt less anxious, 84% felt less lonely and 71% had better health management due to the support provided. Feedback comments indicate people supported felt comfortable, safe and listened to.
- The service provided has needed to be flexible as the Cumbria virtual ward service has developed e.g. providing support to care home staff to increase confidence in the digital equipment and accept their residents onto the virtual ward.
- Lessons learned include the value of engaging potential third-sector partners at an early stage of planning and being open-minded to the range of potential services that can be offered.

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Investigating inequality

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The aim is to further improve Hospital at Home

- Some virtual wards have been in place for a number of years. There are also many other organisations, including in the voluntary, community and social enterprise (VCSE) sector, that provide support in people's homes or to people with health inequalities whose experience and learnings may have relevance or application in virtual ward settings.
- Insight from existing practice and people with lived experience of virtual wards and/or health inequalities creates opportunity to capture and share learning about how to design and deliver virtual wards in a way that provides quality care that is accessible to all.
- The Health and Wellbeing Alliance (HWA) exists as a partnership between NHS England, the Department of Health and Social Care (DHSC), the UK Health and Security Agency (UKHSA) and 18 VCSE members to reduce health inequalities and improve ease of access to services for all communities.*
- As part of our membership of the HWA, British Red Cross worked in partnership with others to better understand the impact of different circumstances on people's ability to use and benefit from a virtual ward.

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What we did

Undertook a desktop review of existing research and evidence

Conducted a survey of 17 national VCSE organisations in the Health and Wellbeing Alliance with specialist expertise in different health inequalities

Held interviews and visits with clinicians running virtual wards in Homerton in North East London, Cumbria, Blackpool, Cheshire and Merseyside and South West London

Hosted a workshop attended by 18 people with lived experience of health inequalities and representatives from 42 VCSE organisations to explore potential barriers and solutions to accessing quality care on virtual wards

Further semi-structured interviews with VCSE organisation representatives, individuals with lived experience of health inequalities and clinicians

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Virtual wards can improve care for many

Our investigation highlighted the potential benefits of virtual wards for improving access and experience of acute care and support for certain groups of people. We heard about how the groups shown in the table below could benefit from a virtual ward. We hope that by helping virtual wards to think about the ways they can identify and tackle some people's barriers to using and benefitting from virtual wards that this list can grow.

- People who live far away from their nearest hospital, such as those in rural areas and those who face difficulty in meeting the cost of transport to hospital may benefit from no longer needing to travel to receive care.
- People who might find a hospital environment distressing, such as those with mental health issues, dementia or learning disabilities, may benefit from being able to receive care in their home environment.
- Children may benefit from being able to remain in their family environment while receiving care.
- Some people may feel they can better follow their religious practices at home.
- People who are admitted to hospital more frequently, such as older age people, may prefer to receive treatment in their own home.
- People who are concerned about facing discrimination or lack of sensitivity in a clinical setting, such as those who identify as LGBTQ+, may prefer to receive care at home.
- Anyone at increased risk of infection or deconditioning in a hospital setting may benefit from being treated in their home environment.

However, despite these potential benefits we noted that in the official guidance at the time of our research in 2023, the case for further expansion of virtual wards was rarely expressed in terms of benefits for reducing inequality. Rather, it tended to focus on benefits to the health system of reducing emergency department presentations and hospital admissions.* We understand this guidance will be updated soon in 2024.

Virtual wards could exacerbate inequality

In our conversations with VCSE experts, people with lived experience of health inequalities, and clinicians, we found a strong consensus: Despite recognition for the positive opportunity from virtual wards to increase access to and improve experience of hospital care at home, there is also a significant and parallel risk of exacerbating inequality.

During our investigation we heard how virtual wards could exacerbate inequality in two ways, if they fail to address:

- Barriers to access
- Barriers to quality of care

What we heard is not an exhaustive list but provides a useful starting point for systems to look at when developing a detailed understanding of the barriers that their local populations may face in access and experience of virtual wards.

Access barriers

There is currently no national data identifying which people decline the offer of a virtual ward and why (although some insightful local data is available, e.g. Healthwatch).

These are some of the barriers that this project identified as potentially influencing people's decision:

- Fear of virtual care or lack of understanding about what a virtual ward means
- Preference for face-to-face care and the misperception that this is not a feature of care in virtual wards
- Lack of landline, broadband and mobile coverage
- Fear of interaction with healthcare professionals and public officials in the home due to immigration / welfare / other status
- Fear of strangers entering the home
- Lack of transport to home – for professionals and patient – especially in rural areas
- Poor home environment, such as lack of adequate space privacy, warmth, ventilation and facilities and/or presence of mould and damp
- Having no home or living in circumstances that include sofa surfing, street homeless, shared accommodation, temporary accommodation or living under parole conditions
- Additional, complex and/or multiple physical or mental health needs
- Lack of access to additional personal and social care and / or worry about burden on family members and other unpaid carers.

Quality of care can be affected by a range of factors

Once on a virtual ward, we heard about barriers that can impact on people's experience, quality of care and outcomes:

- Ability to prepare good food and maintain necessary level of nutrition for recovery
- Money – to pay for food, heating and additional cost of operating hospital equipment, like nebulisers, especially if on an electricity meter.
- Basic health literacy and confidence using technology for monitoring own health
- English as a second language
- Literacy levels and ability to read and understand instructions
- Cultural aspects, including restrictions on home visiting days for certain religious groups
- Sight / hearing issues and need for British Sign Language and other informal means of communication
- Dyslexia, memory and other cognitive issues
- People living alone, with a small social circle and lack of support
- Lack of support for unpaid carers
- Barriers to using technology including long-term conditions like arthritis.

A barrier spiral can be prevented

Quality of care barriers present a particular challenge to Hospital at Home programmes. Responding with new, additional non-clinical criteria for enrolment – e.g. not accepting individuals living in homes with mould and damp or who are living alone – can be well-intended but also create additional barriers to access.

We heard examples of ‘soft exclusion’ where, for example, individuals experiencing a mental health crisis are less likely to be supported on a virtual ward. This may be due to genuine concern for their safety at home, but the exclusion may be perceived differently by the individual, who might assume discriminatory treatment or that their needs are simply ‘too complicated to bother with’.

It is therefore crucial for Hospital at Home programme designers to:

a) Understand the barriers their local population face in as much detail as possible

b) Explore how programme adaptations and / or provision of additional support can help to overcome access and quality of care barriers.

Identifying and understanding barriers

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Five priorities to look at in relation to inequalities

Participants at our workshop identified five areas to think about in relation to Hospital at Home and health inequality:

1. Communication
2. Safety and safeguarding
3. Digital and technology
4. Living circumstances
5. Carers and social care

These can be a starting point for identifying and understanding the local barriers for effective virtual ward development. Further detail on what we heard is provided on the pages that follow.

Communication about virtual wards needs to be clearer

What we heard

- During our conversations with VCSE organisations and people with lived experience, it became clear that virtual wards are not well understood by those who have not been on one.
    - The term ‘virtual ward’ is misleading, causing some to think this is a 100% online service when it’s not.
    - Often information about virtual wards is not widely available, nor is it in multiple language or accessible formats.
    - There is confusion with other services (like long-term condition care, hospice at home, domiciliary care, and routine appointments that take place by video conferencing) and about how virtual wards interact with people’s wider care and support in place (from primary care, social and personal care providers, mental health services, domiciliary care and the community and voluntary sector).
    - We also heard fear that virtual wards are about cost-cutting and reducing access to hospital-care, rather than about increased choice and improvement in services. People with lived experience also expressed concern that they would not be given a choice between going onto a virtual ward or being admitted to hospital.
    - All these factors point to the need for clear, accessible information for those offered care on a virtual ward to avoid creating a barrier from mistrust or assumptions regarding eligibility and desirability.

Digital technology concerns needs to be addressed

What we heard

- While face-to-face treatment options are offered on virtual wards, participants expressed concerns about the use of technology and the practicalities of remote monitoring, diagnostics and treatment.
    - There were concerns about connectivity, either from not having Wi-Fi or data or because there is no coverage or poor connection, especially in rural areas.
    - Some of the concerns related to the technology itself. We heard questions about what happens if people do not have the necessary devices or are not confident in using the technology. There were also questions about tech failure, with people worried about what happens if they lose connection or if something goes wrong.
- Other questions related to communication within or about the technology. On a practical level many people had questions about how to get communication support – through interpreters and the like – outside of hospital and the choices available for monitoring, diagnostics and treatment. For example, some people had previous experience from other services of digital technology that is not available in languages other than English or which cannot interact with accessibility tools like blind readers.
    - Some people also had concerns over the transmission of personal health data and how patient confidentiality is protected on a virtual ward.

Safety and safeguarding need to be built in

What we heard

- People have different levels of confidence in the virtual ward model based on their different situations and experiences.
  - For some there are concerns about the risk of safety being compromised from having people physically approach and enter the home.
  - For others, concerns about safety are related to their status and lack of trust in public officials being in their home environment.
  - There are also concerns about the loss of the safe-haven of hospital for some – including for domestic abuse victims, carers respite, and people with low income.
- We heard how not being in a hospital environment could reduce safety for some people, including those with mental health issues where reduced opportunity to communicate in person with clinical staff could lead to nuances of the condition being missed, leading to increased risk of harm to the individual and healthcare professionals entering the home.
- However, there was also recognition that the hybrid nature of virtual wards, including home visits, could also help identify issues of concern and provide greater insights into people's holistic needs, as long as staff had adequate training and connections to others involved in safeguarding and mental health.
- Many highlighted the need for special consideration for how a virtual ward can safely support both people with dementia as well as highlighting the need for healthcare professionals to receive additional training on entering people's homes. For example, the need for virtual ward staff to be trained to manage a situation where someone suffering from dementia has wrongly accused them of theft and other situations that could result from mental confusion.
- Other studies have found that some LGBTQ+ people, particularly among older generations, fear strangers coming into their homes may be unaccepting or discriminatory towards their sexual or gender identity. This points to a need for virtual ward services to be proactive in signalling their inclusivity when offering enrolment.

Living circumstances must be assessed and adapted

What we heard

- There are many living circumstances that can make virtual wards more challenging to deliver effectively.
  - This includes people living alone, in overcrowded multiple occupancy homes, in homes affected with mould and damp, in poverty, or unable to personally care for themselves and cook nutritional meals.
  - It also includes homes that do not have the right infrastructure in place, like a bed on the ground floor, an accessible bathroom, or the ability to increase the supply of electricity for medical equipment.
- Insight from people with experience of shared and temporary accommodation – like prisons, hostels and immigration detention centres – highlight many challenges to the delivery of virtual wards in these circumstances.
  - These are related to the short term and often uncertain nature of stays in hostels and immigration detention centres, the lack of privacy and hygiene, with no access to smart phones and internet nor safe places to store medication or devices.
- At the same time, we heard how virtual wards have potential to shine a light on people's wider social, environmental and economic needs as well as improve healthcare for people in detention and hostels in the longer term.

Carers and social care need to be involved

What we heard

- Some participants with lived experience as unpaid carers noted that having the option of supporting someone at home rather than having to travel to hospital would be very welcome. However, there were also issues and concerns raised in relation to the potential expectation on unpaid carers to pick up even more responsibilities on a virtual ward without receiving the support they would need.
- There were many questions about how health, social care and carers interact on a virtual ward and a desire for reassurance that infrastructure is in place to properly support people requiring social and personal care on a virtual ward.
- Concerns were raised that healthcare professionals may make assumptions about the capacity of unpaid carers to support someone on a VW. Specific examples were raised about how having someone receiving treatment at home could be very difficult for carers that have multiple responsibilities, such as children and older relatives.
- As an extension to this, people asked how a virtual ward would work for people in care of social services, and whether such assumptions might affect these individuals too.
- Concerns were also raised regarding the agency of the carer. This related to whether they would have the ability to ‘opt out’ of a care role if the person they care for had chosen to enrol in a virtual ward. There was also concern for situations where the unpaid carer may require access to medical records and to be involved in shared decision making to enable the person receiving care to engage with the virtual ward service, and whether this would be recognised and enabled through the service.
- For many it was hard to ignore the systemic inequalities in access to social care and unpaid care - for example a person with learning disabilities and no family members to advocate for them. Participants highlighted how it is difficult to find and fund social and personal care and there is very little support for unpaid carers. This pointed to the importance of support for holistic care needs on virtual wards.
- On the specific issue of discharge there were questions about whether people just stay on a virtual ward until a care package is in place, like in hospital, or if there is potential for people to fall through the gaps outside of the hospital environment.

Addressing the barriers

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Six steps to improve virtual wards

During our investigation we heard how virtual wards can work for a wide range of people provided the barriers to access and effective use are understood and addressed upfront, and that this is essential to prevent the exacerbation of inequality in their roll out. We also heard a lot of ideas from existing practice and learning about how virtual wards could address some of the barriers identified.

Bringing these together, we identified a potential approach – the six steps – that we offer to clinical leaders and frontline managers to aid thinking in how to overcome barriers to effective access and use of virtual wards.

These steps all offer practical implementation recommendations for the five principles for action on inclusion health as set out in the NHSE national framework on action on inclusion health, helping areas to plan, develop and improve virtual wards to meet the needs of people experiencing health inequalities.

1. **Understand who** virtual wards will benefit in your area
2. **Identify what** elements you need to include in the design of the virtual ward to maximise accessibility and quality of care
3. **Communicate how** the virtual ward works and what support is available to people and unpaid carers
4. **Diversify the skill mix** through provision of training to staff and by partnering with other services and organisations to deliver non-clinical support roles
5. **Offer choice** and include options for personalisation of the virtual ward service on offer
6. **Collect data** on inclusion and outcomes

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1. Understand who

It is never too late to spend time identifying who might have difficulty accessing or benefitting from a virtual ward in the local area.

1. There will be local variation, so it is important to consider your local population and the different barriers some people will face.
    - If there is a not a clear picture of the local population already available then work with relevant local groups, people in different communities and professionals and organisations that already provide care and support in the community, including in the VCSE sector, to build understanding.
2. Consider the five priority areas of concern set out on slide 17 related to inequality found during this investigation as a starting point, supplemented by local coproduction to determine other ways the service can increase accessibility and quality of care on the virtual ward.
3. Identify other organisations you can learn from about how to provide accessible and high-quality care and support in the home. Opportunities to learn from other health and care services provided in home settings include:
    - Hospice at Home to understand the practicalities of arranging beds and other temporary home adaptations
    - Home from hospital services
    - St Mungo's and Marie Curie Palliative Care Service
4. Review how you can partner and learn from existing services to evolve the virtual ward over time to support people in different living circumstances, including those in shared, temporary or no accommodation. For example, Homeless Nurse Schemes like the one in Kent.

2. Identify what

Once you understand your population, identify elements that need to be designed into the service to address the barriers affecting accessibility and quality of care. This will support programmes to avoid exacerbating inequalities and help address them where possible, as set out in ICS' duties in the Health and Care Act 2022 and the NHSE Health Inequalities Framework. This could include the following:

1. Providing holistic needs assessment, including a home environmental assessment, falls risk assessment and safeguarding assessment.
2. Providing an assessment of the unpaid carers needs to ensure they are properly supported. Excellent guidance on this is available from Carers UK.
3. Cultural competency and language support by incorporating staff who are not only linguistically diverse but also culturally competent.
4. Following good practice on digital inclusion, as set out in Good Things Foundation's accessibility guidance, with devices, apps and websites that are accessible and easy-to-use, and available in multiple languages if needed, and:
    - can be used even if there is no wifi or access to data – for example through providing devices that come with mobile data or an alternative method if needed in rural areas
    - have a back-up or alternative in case of technology failure or crisis
    - people and their carers can easily learn to use, potentially through digital champions attached to the virtual ward, staff with time and skill to offer digital support, or through partnership with digital inclusion support services such as Surrey's Tech Angels.
5. Developing connections and partnerships with other services and organisations that enable people to access appropriate personal care, nutrition and wider support to reduce additional burden on families, unpaid carers and other social and personal care providers – such as the NHS Volunteer Responders programme who offer support to virtual ward programmes.
6. Creating small teams of named individuals and/or female only teams to provide reassurance about continuity of appropriate care, particularly where safeguarding is a concern.
7. Developing a data confidentiality agreement that sets out how personal health data transmitted through the virtual ward will be protected.

3. Communicate how

Information on enrolment is needed to clearly explain what the virtual ward service is, what it is not, and how it works. This needs to be provided through communication materials and made clear in conversations in a way that reassures people about concerns, addresses specific issues that may affect access or quality of care for certain groups, explains the wider support available and answers common questions.

1. Consider what you call the service and how you explain it in a way that most people can understand – the term ‘virtual ward’ may foster misconceptions.
2. Make sure that communication materials clearly outline that there is a choice between the virtual ward and a hospital stay and explains the differences, including what the discharge process will be.
3. Clear communication on discharge will be especially important where continuity of care arrangements are made with primary or community care providers – both to the individual and to the other providers concerned.
4. Develop information and communication materials for unpaid carers including details of the support that is available and clarity on their role as key partners in decision making. Existing resources are available from Carers UK including their virtual ward checklist and guide.
5. Provide materials and non-written communication in additional languages including British Sign Language. Consider co-producing these with different groups, using relevant VCSE organisations to support co-production (like this online Barnardo’s resource).
6. Consider partnership with VCSE organisations and/or individuals who have previously been treated on the service to act as ‘ambassadors’, particularly with regards to groups who may be less likely to accept enrolment.
7. Targeted community engagement - actively reaching out to and engaging with black & minority ethnic communities through cultural gatherings and community-specific health discussions - has also shown promise in improving awareness and uptake of the service.

4. Diversify the skill mix

1. Make sure the virtual ward team has the right skills mix to overcome barriers to access and provision of quality care for all, and that staff are equipped with the appropriate training, skills and partnerships. This could include training about:
    - Trauma-informed approaches – like those adopted in Scotland - where people have a choice about the person coming into their home, that whoever's home you are going into knows who you are, when you are coming, what you are coming to do, that you will be wearing a lanyard or badge, will ring the bell, or send a message at an agreed time before arriving so that they know exactly what will happen when you come into their home.
    - Safeguarding and how to spot signs of distress, decline, abuse and what to do about it.
    - How to escalate safeguarding concerns or share information about home environment more widely in the system.

2. As well as upskilling clinical staff, it is important to think widely and creatively about who is delivering the service and the skills needed to tackle the barriers a local area has identified. This could involve partnering with other local services and organisations including in the VCSE sector and council to:
    - Overcome specific local and common barriers through accessible communication for people and their carers
    - Assess and meet holistic support needs

5. Offer choice

When you invite people onto the virtual ward service, offer genuine patient choice and options for personalisation. To aid in this:

1. Reiterate that there is a choice between a virtual ward and a hospital stay and choice regarding the balance between remote and face-to-face communications while on a virtual ward.
2. Create a personalised care plan, ‘what matters to me’ document or hospital passport (if this does not already exist) to record people’s preferences and reasonable adjustments alongside clinical needs.
3. Undertake a holistic needs assessment, alongside the clinical assessment, to identify a person's wider needs while on a virtual ward. Then equip teams with the resources to undertake initial safeguarding and home assessments face-to-face in the home environment. Ensure this assessment looks at a wide range of things to do with facilities, warmth, damp and mould in the home, especially for people with respiratory conditions, as well as how to ensure appropriate nutrition for recovery and support. Add this information to the personalised care plan.
4. Offer different options for technology, including landline, and a choice in the form and format of communications. Starting with face-to-face options for people that are less comfortable with digital technology and blending to more remote forms of communication can be helpful. Include their preferences on the personalised care plan.
5. Discuss people’s preferences for professionals coming into the home, including use of identifiable lanyards prior to entry or more private methods of identification. Ensure that this information has prominence in the personalised care plan.
6. Offer choice to unpaid carers too, by ensuring they are aware of options for opt out before and during the service, receiving access to health records and shared decision making where needed and receiving support.
7. Keep the details of preferences and reasonable adjustments on file, in the personalised care plan, for future use or if staff change.

6. Collect data

1. When the service is up and running, collect data on who is treated on the virtual ward and the outcomes, as well as who refuses, rejected referrals and the reasons for them.
2. The collection of this health inclusion data is important to inform future service development, including whether more targeted communication and engagement work is required.
3. Ideally capture data broken down by demographics, including age, ethnicity, disability and deprivation, to aid better understanding of inclusion and outcomes for different groups of people.
4. Mapping this with wider data on health inequalities such as the demographic profile of people living in the local area served, including the size and geographical distribution of more disadvantaged groups, will support areas to move towards a joined-up approach to tackling health inequalities across relevant support services, including but not limited to health and care services.
5. Consider working with other virtual wards in your locality, system or region to develop a standard approach to collecting this data so that it can be used to identify where more targeted or specific approaches might need to be taken in partnership with others.

Closing remarks and system-wide recommendations

We hope that these slides serve as a thought-provoking and useful resource to support Hospital at Home / virtual ward programmes in meeting the need to address health inequalities, as set out in the NHSE Inclusion Health Framework, Core20PLUS5 and in priorities and operational planning guidance.

However, we recognise that both the implementation of these recommendations and their impact will be affected by contextual factors. To create an enabling environment for Hospital at Home / virtual ward programmes to succeed in delivering on their potential to reduce health inequalities, the British Red Cross recommends the following.

1. **Choice is vital:** NHSE and DHSC should provide sufficient availability of both hospital beds and Hospital at Home beds to support patient choice in where they receive care. Systems should ensure that adequate information on virtual wards are widely available, highlighting the benefits and risks associated with treatment.
2. **Clarity in guidance:** Hospital at Home should be referenced in all relevant DHSC and NHSE guidance on health inequalities. Health inequalities must also be integrated into new guidance for Hospital at Home.
3. **Need for data:** The accessibility and impact of virtual wards on inclusion health groups and others who live with health inequalities is not yet documented. Any new NHSE data requirements for Hospital at Home programmes should address this by requiring data collection on the enrolment, refusals and health outcomes of inclusion health groups. ICSs should also play a role by supporting local data collection and advocating for continuity of metrics across different virtual wards in their area.
4. **Carers count:** The critical role of carers in virtual wards was a clear message from the participants we consulted with. Support for unpaid carers should be regarded as a vital component in the quality standardisation of Hospital at Home while social care leaders need to ensure that professional carers are provided with the training they require to support their clients on virtual wards.

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Age UK
Autistica
Bernardos
British Institute of Learning Disabilities (BILD)
Burnley, Pendle & Rossendale Council for Voluntary Service
Carers UK
Clinks
Communities 1st
Community Action Dacorum
Complex Needs Consortium
Good Things Foundation
Gosport Voluntary Action
Groundswell
Hackney Council for Voluntary Service
Homeless Link
Hospice UK
LD England
LGBT Foundation
LGBT Partnership
Locality
NAS
National Autistic Society
National Development Team for Inclusion (NDTi)
National Voices
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Race Foundation
Roma Support Group
Sense

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