Making the most of virtual wards, including Hospital at Home
Practical guidance for clinicians to maximise use of virtual wards for the benefit of patients

New in November 2023: Guidance on virtual wards for patients with heart failure added
Introduction

The Getting It Right First Time (GIRFT) and Virtual Ward programmes at NHS England have produced this guide, which outlines how the NHS can make better use of virtual wards, allowing more patients to get the care they need at home, safely and conveniently, rather than being in hospital.

Virtual wards provide personalised care and choice for patients, by combining face-to-face provision and technology to allow hospital-level care. They can provide an alternative to admission or facilitate earlier discharge from hospital and have been identified as a key ambition in the ‘Delivery plan for recovering urgent and emergency care services’ published by NHS England in January 2023.

Virtual wards are well established for acute respiratory infections and frailty, where they are often known as ‘Hospital at Home’. There has already been significant progress in the roll out of virtual wards and the ambition is to have the capacity to manage acute care for up to 16,000 patients at any one time by 2024. In many places there are major opportunities to make more use of our virtual ward capacity.

Aimed at clinicians and operational teams, this guide draws on the existing guidance and resources and highlights key advice and steps to get the most out of virtual wards, and in doing so, deliver better care for more of our patients.

Vin Diwakar, Medical Director for Transformation, NHS England  
Prof Tim Briggs CBE, Chair of GIRFT and National Director for Clinical Improvement and Elective Recovery, NHS England  
Adrian Hayter, National Clinical Director for Older People and Integrated Person-Centred care, NHS England

Updates to this guidance

August 2023: Guidance on virtual wards for patients with heart failure.  
May 2022: Guidance on frailty and acute respiratory infection.

The scale and scope of virtual wards is growing rapidly, shaped by and based on the assessment of emerging evidence and research. This guide will receive updates in future to include new areas of national guidance.

Acknowledgements

We are grateful to:  
• Asthma + Lung UK  
• The Association of Chartered Physiotherapists in Respiratory Care  
• The Association of Respiratory Nurse Specialists  
• The British Thoracic Society  
• The British Geriatrics Society  
• The Primary Care Respiratory Society  
• Royal College of Physicians  
• National Asthma and COPD Audit Programme

for their input and contributions to this guide.

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What is a virtual ward

Virtual wards, which include Hospital at Home, are a safe and efficient alternative to NHS bedded care. Virtual wards support patients, who would otherwise be in hospital, to receive the acute care and treatment they need in their own home. This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital.

Virtual wards support increased patient choice and personalised care. Feedback from patients on existing virtual wards shows the vast majority would recommend them.

The ambition for virtual wards is to have the capacity to manage acute care for up to 16,000 patients at any one time by 2024.

Virtual wards differ from other community services:
- Led by a named senior clinician or consultant practitioner who could be a physician, nurse, AHP, or GP depending on local arrangements
- Patients sick enough to otherwise be in hospital
- Defined inclusion and exclusion criteria
- Access to hospital-level interventions and diagnostics
- Daily clinical input, with equity of access to specialty input as though an in-patient

Virtual wards are not for:
- Safety netting
- Home IV or infusion services where an admission wouldn’t be needed
- Enhanced primary care programmes
- Chronic disease management
- Discharging patients for assessment

Click to watch a video introducing virtual wards

GIRFT
Produced in partnership by GIRFT and the NHS England Virtual Ward programme

Expanding virtual wards is a key ambition in the Delivery plan for recovering urgent and emergency care services, published in January 2023.
The benefits seen in existing virtual wards including Hospital at Home services

Research and studies are providing strong evidence for the benefits of virtual wards. * The data below is based on observations from single site analyses relating to frailty.

### Patient choice and preferences

- **Over 99%** of patients on existing virtual wards would recommend the service *

### Treatment and care

- In a more comfortable home environment.
- Keeping patients in a place where they would prefer to be cared for in future.
- 23% of patients treated in a virtual ward achieved a more independent social care outcome than they would have in an acute setting.*

### Reducing health inequality

- Development of virtual wards offers opportunities to address healthcare inequalities in target areas including COPD and frailty.

### Patient wellbeing and safety

- **Patients** are eight times less likely to experience functional decline * whilst in a virtual ward compared to equivalent treatment in an acute setting.
- **Patients** are five times less likely to acquire an infection * when treated on a virtual ward compared to an acute setting.

### Improved staff experience and opportunities

- **Frees up physical beds for other patients who require an in-patient admission**
- **Improves integration between hospital and community services**
- **Enabled by technology including remote monitoring**

### Capacity and productivity

- **Two and a half times fewer patients** treated on a virtual ward are readmitted * to frailty beds than the national acute benchmark.
- **5 x** Patients are five times less likely to acquire an infection * when treated on a virtual ward compared to an acute setting.
- **8 x** Patients are eight times less likely to experience functional decline * whilst in a virtual ward compared to equivalent treatment in an acute setting.

* The data below is based on observations from single site analyses relating to frailty.

**Click to download a catalogue of evidence, covering different themes, pathways and countries**

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Produced in partnership by GIRFT and the NHS England Virtual Ward programme
### Principles for virtual wards

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provide acute clinical care delivered by a multidisciplinary team (MDT) if clinically appropriate, led by a named consultant practitioner (including a nurse or AHP consultant) or suitably trained GP with relevant experience and training, with clear lines of clinical responsibility and governance.</td>
</tr>
<tr>
<td>2</td>
<td>Have clearly defined criteria to admit and reside, supported by daily clinical review, by an MDT if clinically appropriate, to provide a safe and robust service.</td>
</tr>
<tr>
<td>3</td>
<td>Ensure that patients are given clear information on who to contact if their symptoms worsen, including out of hours. There should be clear pathways to support early recognition of deterioration and appropriate escalation processes in place to maintain patient safety. Training on escalation processes should also be provided to carers, staff, the MDT, etc as necessary.</td>
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<tr>
<td>4</td>
<td>Provide patients (and/or their carers) with adequate information to allow informed consent and understanding of their care, and to support the use of equipment or digital technology such as mobile phones, apps, web-based tools or wearables, as appropriate.</td>
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<tr>
<td>5</td>
<td>Have access to specialty advice and guidance / diagnostics equivalent to acute hospital access as appropriate to enable timely clinical decision-making.</td>
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<tr>
<td>6</td>
<td>Deliver time-limited interventions and monitoring based on clinical need for a secondary care bed.</td>
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<td>7</td>
<td>Be fully aligned or integrated with other service development programmes, including urgent crisis response (UCR), same day emergency care (SDEC) and unscheduled care across their systems.</td>
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<tr>
<td>8</td>
<td>Be developed for a range of conditions / symptoms / settings and should track specific metrics that measure appropriate outcomes to demonstrate patient safety and sustainability.</td>
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<tr>
<td>9</td>
<td>Consider the risk of excluding patients from virtual wards through the exclusive use of digital tools, and offer alternatives should patients lack the ability to fully use the technology.</td>
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### Technology enablement

A virtual ward enabled by technology consists of (as a minimum):

- The ability for patients to measure and input agreed health data (for example vital signs) into an app or website (this may also be done automatically, for example with wearable/Bluetooth technology).
- These data feed into a digital platform / dashboard which is reviewed remotely by a clinical team.
- The clinical team are alerted when a patient moves outside of agreed parameters so they can take appropriate and timely action.

### Pathways

Systems must ensure they have clear, formalised pathways supporting early recognition of deteriorating symptoms and out-of-hours (OOH) support to manage deterioration, enabling capacity in existing OOH services, including community night nursing team services or GP OOH services where appropriate. There must always be appropriate escalation processes and services in place to maintain patient safety. This should include providing comprehensive patient information (translations and easy read where appropriate), supported with videos, written and digital resources and links.

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**Indemnity**

It is important that all clinicians understand what their NHS duties are and operate within the scope of their practice and their employed role. NHS Resolution has confirmed that provision of NHS care within a virtual ward commissioned to be provided by an NHS organisation will be covered by one of its clinical negligence schemes.
Providing acute level care at home through virtual wards

**What happens with virtual wards**

Virtual wards should provide:
- Equitable access to hospital-level diagnostics such as endoscopy, radiology, or cardiology, and which may include bedside tests such as point of care (POC) blood tests.
- Hospital-level interventions such as access to intravenous fluids, therapy, and oxygen.

**Description:** Assessment is made at home using point of care testing to support clinical decision making with patient/carer

**Benefit:** Direct referrals to a virtual ward provides an alternative to hospital admission

**Virtual wards require:**
- Daily input from a multidisciplinary team and sometimes multiple visits
- Staffing for minimum of 12hrs a day (8am-8pm, 7 days) with locally arranged provisions for Out of hours cover enabling flexibility of service provision as determined by local need

**What would happen without virtual wards**

**Description:** Decision is made to admit the patient to a virtual ward and patient remains at home

**Benefit:** Acute level care provided in the community offers the same, if not better, outcomes for our patients

**Description:** Decision is made to admit the patient and they are transferred to a ward

**Benefit:** Technology supports appropriate monitoring of patients allowing effective care delivery and prioritisation

**Description:** Patient is ‘discharged’ from the VW and continues to recover as care is transferred to primary care or community health services

**Benefit:** Patient has remained at home, received the appropriate care and remained as mobile as possible and feels confident for care to be transferred to a lower intensity team where needed

**Stage 1:** Referral points

**Stage 2:** Clinical assessment

**Stage 3:** Admission to system

**Stage 1:** Treatment, assessments and monitoring

**Stage 1:** Discharge and transferring care

Produced in partnership by GIRFT and the NHS England Virtual Ward programme
Frailty virtual wards, including Hospital at Home

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

These virtual wards have a good track record of providing a patient-centred model in line with personalised care principles and the concept of a virtual ward for frailty is well established.

What do successful frailty virtual wards offer?

- **Integrated with core teams** like pharmacy and night care, to avoid unnecessary admissions and understand the cause of referrals
- **Effective use of enabling technology** such as point of care testing and remote monitoring
- **Led by a named senior clinician or consultant practitioner** who could be a physician, nurse, AHP, or GP depending on local arrangements.
- **Staffed for 12 hours a day, 7 days a week**, with locally arranged provision for out-of-hours cover and line-of-sight from a senior clinical decision maker
- **Closely linked** with social care, rehab and recovery services, ensuring support for social care needs and identifying carers’ needs
- **Upskilled and flexible** workforce, deployed depending on need. This can include:
  - consultant geriatricians (hospital or community based), consultant practitioners, advanced clinical practitioners, pharmacists, nurses, AHPs, GPs with special interest, health and care support staff, social care workers, operational support, third sector.
- **Effective use of enabling technology** such as point of care testing and remote monitoring
- **Led by a named senior clinician or consultant practitioner** who could be a physician, nurse, AHP, or GP depending on local arrangements.
- **Staffed for 12 hours a day, 7 days a week**, with locally arranged provision for out-of-hours cover and line-of-sight from a senior clinical decision maker
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Useful links:
- Full guidance on frailty virtual wards and Hospital at Home
- Frailty ward resources and discussion forum on FutureNHS

Hospital at Home is widely available and better for many patients. How often do you ask your patients where they would like to be treated?

The most important criteria is an informed patient choice: someone who when given a choice, wishes to have their care provided at home

**Inclusion criteria**
- Aged 65 or over, has been assessed to be living with frailty and is in a crisis that requires acute level care.
- An informed and capacitous decision of the patient or carer/family member where appropriate, who wants to have their treatment at home.
- Where a person is living with dementia, this should not exclude admission to the Hospital at Home service.
- Expected required treatment time is short-term intervention of 1 to 14 days.

**Exclusion criteria**
- Severe injury, for example non-ambulatory fractures requiring urgent orthopaedic opinion.
- Is experiencing a mental health crisis and requires referral/assessment by a specialist mental health team that cannot be supported in the community.
- Needs acute/complex diagnostics and/or clinical intervention that can only be offered in hospital. This can become a shared risk with the patient if they do not wish to be admitted.
- For safeguarding reasons, it is not safe for a person to remain in their home or usual place of residence.
Frailty virtual wards, including Hospital at Home (2) - Pathway stages

Admission to the virtual ward

- Patient identified as ‘sick enough to require hospital level care’ and offered choice of admission into hospital or to a virtual ward.
- Referral sources can be ‘step up’ including primary care, community teams or ambulance teams or ‘step down’ including ED, same day emergency care, frailty services or wards within the hospital.

Initial assessment

- Assessments can be in person, remote or a combination.
- A full clinical history and examination should be undertaken. This should be combined with a full comprehensive geriatric assessment if Clinical Frailty Score (CFS) of 5 or above. This can be undertaken at a later date if more appropriate, for example if the patient is too unwell.
- Ideally point of care testing (POCT) should be undertaken to allow urgent decision making. If not available, the relevant investigations should be undertaken elsewhere.
- Assessments should include:
  - Calculation of National Early Warning Score (NEWS2)
  - Clinical Frailty Score (CFS) frailty screening, those scoring CFS 5 or above should have a Comprehensive Geriatric Assessment
  - 4AT rapid test for delirium.
- The existing care plan or treatment escalation plan will be reviewed and updated if needed. If no plan is in place, a new plan will be agreed and documented. If agreed and not already in place, RESPECT or DNAR (Do not attempt resuscitation) documentation can be completed.

Treatments and other interventions

- Appropriate treatments initiated, e.g. medication changes, IV and SC treatments.
- Equipment needs assessed and appropriate equipment provided, for example, mobility aids or pressure relieving equipment.
- Increased support needs at home discussed with patient and carers, including: new or increased personal care, carers support, overnight needs (referral for night sitters if required.)
- Patients at risk of deterioration and dying identified. Preferred place of death documented, shared with the relevant providers, and appropriate treatments put in place, e.g, just in case medications.
- Medicines optimisation assessment carried out.
- Remote monitoring considered and arranged if appropriate.
- Advice offered to patient and carers on what to do in situation of deterioration or new concerns. Documented treatment plan for patient, carers and other professionals.

Ongoing monitoring and discharge

- In person or remote senior review of patient undertaken on first or second day of admission.
- Regular in person or remote review, commonly daily. Remote monitoring reviewed, if in use.
- Ongoing treatments continued and adjusted if required.
- Investigations (e.g. radiology) and transport arranged as required.
- Discharge plan agreed with patients and carers, with onward referrals if required, such as rehabilitation, hospice support and community nursing.
- Where a Comprehensive Geriatric Assessment has been started, this must be clearly communicated to the services taking over a person’s care to enable continuity and completion of the assessment.
- Clear communication with patient’s GP, sending written discharge notification and communicating in person if required.
Acute Respiratory Infection

Acute respiratory infection (ARI) virtual wards support personalised care for adults by providing an alternative pathway to hospital admission or a safe early discharge (typically day 1 - 3 of admission pathway). Patients treated in an ARI virtual ward would otherwise be staying in a hospital bed.

They are particularly beneficial for patients living with chronic lung disease, such as COPD and bronchiectasis, who may have had frequent and repeat hospital admissions. COPD is the second most common cause of admission to hospital in the UK.

ARI virtual wards have existed for over 20 years in the form of early supported discharge and admissions prevention. These have been associated with significant falls in COPD hospital admissions. Virtual wards are now being enhanced and extended with technology such as remote monitoring.

There is variation in local access to specialists with adequate time in their job plans for virtual ward activity, due to nationwide shortages in suitably trained respiratory professionals.

The most important criteria is an informed patient choice: someone who when given a choice, wishes to have their care provided at home.

Clinical judgement remains paramount for all assessments, particularly for patients at higher risk of serious illness, with a learning disability or living with serious mental illness.

### Inclusion criteria

Inclusion and exclusion criteria will vary between local systems and virtual wards, depending on what is available and how long services have been established. The general criteria in the national guidance are available online. These criteria are under review.

### Exclusion criteria

Typical exclusion criteria include:

- severe or life-threatening presentations of pneumonia, asthma or COPD – but remembering that patients may receive end of life care at home if that is their preferred place
- unstable or worsening clinical trajectory, e.g. saturations <93% unless confirmed baseline and/or NEWS2 ≥5
- suspected sepsis
- chest pain that is concerning for a serious cause requiring immediate hospital transfer, e.g. acute coronary syndrome
- pregnant women with saturations of ≤94%

### Useful links:

- Full guidance on acute respiratory infection (ARI) virtual wards
- Resources and discussion forum on FutureNHS
- NICE guideline [NG115] on COPD, including Hospital at Home
- GIRFT National Report on respiratory medicine

### What do successful ARI virtual wards offer?

- **Led by a named senior clinician or consultant practitioner** who could be a physician, nurse, AHP, or GP depending on local arrangements.
- **Staffed for 12 hours a day, 7 days a week**, with locally arranged provision for out-of-hours cover.
- **Oversight of infection prevention and control** by local infection specialty teams, including antimicrobial stewardship and diagnostic pathway.
- **Equal access to integrated input** from pharmacists, therapists and other specialties.
- **Care under a specialist in respiratory medicine**, which may not always be the case in the acute trust.

Produced in partnership by GIRFT and the NHS England Virtual Ward programme
Acute Respiratory Infection (2) – cohorts and optimisation

**Frailty and ARI**
- There is potentially considerable overlap between ARI and frailty.
- People with frailty should not be excluded, but local guidance and team working is needed to establish individuals’ primary issue and which virtual ward would be most appropriate to meet their needs.

**End of life care**
- ARI virtual wards can contribute to end of life care at home if that is the preferred place.
- These patients should still meet the criteria for virtual wards, including a maximum 14 day period of virtual ward care, presentation with an acute respiratory infection and who would otherwise be in a hospital bed.

**Follow-up post ARI virtual ward care**
- Every contact should count and each ARI VW episode should include confirmation of diagnosis, facilitate further investigations post-VW if indicated and appropriate follow-up (preferably in other community services where appropriate.)
- Patient education should encourage self-management, which can reduce future hospital admission.

**Reducing health inequalities**
- Despite COPD being more common in deprived communities COPD services are often less well utilised in these areas, resulting in healthcare and health inequalities.
- ARI VW Leads should promote equity of access to VW services, taking account of known inequalities and likely prevalence to monitor their ARI VW population to ensure it is representative of the local community.

**COPD optimisation**
After admission to virtual ward with COPD or asthma exacerbation, optimal management includes:
- Confirmation of diagnosis and facilitation of investigations post-VW if indicated
- Advice about smoking cessation, support, prescription and referral
- Review and optimisation of vaccination (influenza, Pneumococcal and Covid)
- Ensuring inhaler technique is optimal
- Optimising pharmacological therapy
- Referral for pulmonary rehabilitation
- Education about breathing techniques and chest clearance
- Self-management education and use of rescue pack
- Advice where to source further written information
- Referral to local self-help groups

See a suggested template for patient information and safety netting for ARI virtual wards

Click to watch a video on a virtual wards service for respiratory infections >
Virtual ward care for people with heart failure (HF) can support personalised care for suitable adults with a confirmed diagnosis of heart failure through an alternative pathway to hospital admission and / or a safe early discharge pathway to receive treatment and monitoring in their usual place of residence.

ICBs should consider virtual wards on a whole system basis or in partnership with other ICBs, working with Cardiac Clinical Networks to understand population needs.

The most important criteria is an informed patient choice: someone who when given a choice, wishes to have their care provided at home.

Local criteria should be developed by HF specialists, with input from the HF MDT and reflecting the need of the local population. These should consider a patient’s preference for where their care should take place.

Clinical judgement remains paramount for all assessments, particularly for patients at higher risk of serious illness, with a learning disability or living with serious mental illness.

Useful links:
- NHSE Guidance note: virtual ward care for people with heart failure
- Supporting information for virtual wards including hospital at home
- NICE clinical guideline (CG187) on acute heart failure
- NICE guideline (NG106) on chronic heart failure
- Resources and discussion forum on FutureNHS

Typical inclusion criteria
- ≥ 18 years, needing acute level care
- can be safely & effectively managed in community
- Current HF diagnosis confirmed by a HF specialist
- high risk of deterioration or admission to hospital or could step down from HF admission for early supported discharge
- would otherwise remain in a secondary care bed
- discussed with and/or reviewed by a HF specialist at the time of onboarding.
- referred by the HF MDT
- can benefit from daily remote monitoring, regular clinical re-assessment and are suitable for remote treatment by a HF specialist team, including home visits where required.
- have made an informed decision and consented to be on a virtual ward based on their needs and preferences, and carer support where appropriate at the patient’s best interest.
- are expected to be in the service in the short term (usually managed within 14 days).

Typical exclusion criteria
- Clinical presentations, co-morbidities or psychosocial problems which can only be investigated, treated, or care coordination that can only be achieved with a hospital admission. The definition of each of these exclusion criteria should be developed with HF specialists and be robustly considered by each ICB co-ordinating their own virtual ward programme.
- Acute pulmonary oedema should not be a reason for heart failure virtual ward admission unless supporting patients as part of an end-of-life care at home pathway.
- For safeguarding reasons, where it is not safe for a person to remain in their home or usual place of residence.

Admissions decided by a senior clinical decision-maker, with same level of clinical assessment and decision making as if being admitted to a hospital bed.

Clearly defined criteria for triaging, admission, discharge and follow-up, including personalised and shared decision making.

Daily virtual review with HF team / MDT. Robust provision for out-of-hours care. Prompt access to advanced HF therapies and advance care planning when indicated.

Care under a named HF specialist with clear lines of responsibility. Access to specialist HF input from MDT including practitioners across care settings, expertise in specialist prescribing, medical, nursing, AHP and palliative care.

Hybrid approach to care with face-to-face reviews and physical exams when required. Timely access to blood tests and point of care testing. Remote prescribing enabled to ensure optimisation of HF prognostic therapies.
Heart failure (2) - Pathway stages

1. Identifying people with heart failure
Presentation / referral points:
- ED or acute medical ward as part of admission avoidance
- On or following discharge home from hospital as part of early supported discharge
- People with HF at home with deterioration who would normally require admission to hospital
- MDT or information sharing across teams
- People with HF with severe frailty or in the last year of life who wish to be managed in their home environment

Not all those people identified will be suitable for virtual ward care, so subsequent clinical assessment is required.

2. Clinical assessment and suitability
- Clinical holistic assessment and investigations should be carried out before entry to virtual ward
- This may be in hospital, where a person is already admitted, or in their usual place of residence
- Include consideration of medicine optimisation and appropriate care planning for frailty and/or palliative care
- Include person’s wishes, their safety, consideration of family or carer’s ability to provide support and any capacity, consent or safeguarding concerns

3. Onboarding
Onboarding should ideally be a face-to-face appointment with support from HF specialists, including:
- An understanding of benefits and risks of virtual ward care in comparison to those of care in a hospital ward
- Patient agreed goals covering condition, lifestyle and signs of deterioration
- Assess and provide equipment to keep the patient safe at home and support/maintain their independence
- Initiate discussion to review existing personalised care plans, treatment escalation plans, and emergency care and treatment plans if the person is willing and able to do so. This should include a holistic review and management plan for those with multi-morbidities.

4. Assessments, monitoring and management
- Daily review of every person on the virtual ward and communication between the virtual ward team and the person’s specialist HF team.
- Patient and carers kept well informed and offered practical & emotional support as needed.
- All staff involved in patient’s care can recognise early signs of deterioration and escalation processes are in place.
- Essential clinical parameters are monitored daily, based on individual and clinical needs, e.g. daily symptom questionnaire.

5. Discharge and transferring care
When it is considered safe to discharge patient:
- Follow-up with a HF specialist within 2 weeks of discharge as per NICE Quality standard [QS103]: Acute heart failure.
- Robust discharge process to appropriate primary, community or secondary care providers including onward referral (e.g. Managing Heart Failure @home, cardiac rehabilitation). This should be in line with the national discharge policy for all NHS providers
- Care planning with clear pathways between services needs to be agreed to ensure high quality end of life care delivery.
Resources available to support virtual wards

A range of resources are available from the Virtual Ward FutureNHS workspace, including many examples shared by trusts already running virtual wards. The workspace also includes a discussion forum.

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<tr>
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- Introducing or expanding Hospital at Home virtual wards for people living with frailty
- Introducing and expanding acute respiratory infection virtual wards
- Maximising the roll-out of virtual wards, including Hospital at Home
- Virtual ward care for people with heart failure

Published guidance on virtual wards

- Introducing or expanding Hospital at Home virtual wards for people living with frailty
- Introducing and expanding acute respiratory infection virtual wards
- Maximising the roll-out of virtual wards, including Hospital at Home
- Virtual ward care for people with heart failure

Evidence catalogue

- A spreadsheet cataloguing evidence on virtual wards, covering different pathways, themes and countries.

Pharmacy

Guidance on pharmacy services and medicine use within virtual wards

FutureNHS resources

- Including examples from existing virtual wards of Ceftriaxon prescribing and administration, stock order sheet, medicines management operational guidance, Checklist for doctor's bag and SPS virtual wards conference

Diagnostics

FutureNHS resources

- Including national guidance, journal articles and reports evidencing impact, NICE diagnostic guidance and NICE Medtech innovation briefings

Training and workforce

E-Learning for Healthcare

E-learning for Healthcare has a training programme for clinicians on ‘Virtual wards enabled by technology’.

Example job description

- A generic job description which includes support the skills needed for the role within a virtual ward.

Click here to access the Virtual Wards FutureNHS workspace

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