From innovation to inclusion

Examining Accessibility of Virtual Wards in Lancashire

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healthwatch Lancashire

Contents

Acronyms

BTH – Blackpool Teaching Hospitals NHS Foundation Trust
CYP – Children and young people
ELHT – East Lancashire Hospitals NHS Trust
ICB – Integrated Care Board
UHMBT – University of Morecambe Bay NHS Foundation Trust
MWLTH – Mersey and West Lancashire Teaching Hospitals
NHSE – NHS England
NWAS – North West Ambulance Service
LSCICB – Lancashire and South Cumbria Integrated Care Board
LTH – Lancashire Teaching Hospitals NHS Foundation Trust
UCR – Urgent Community Response
VCSE – Voluntary, Community and Social Enterprise

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1. Executive summary

Virtual wards (also known as 'Hospital at Home') have expanded rapidly since becoming a priority for NHS England (NHSE) in 2022. These services allow patients with acute conditions to receive hospital-level care in their own homes - including care homes - who would otherwise be in hospital as an inpatient. NHSE hopes that virtual wards will help lower healthcare costs, ease pressure on hospitals by preventing unnecessary inpatient referrals, and improve patient outcomes by delivering high-quality, personalised care in a familiar setting.

However, as with any new and expanding healthcare service, there is a risk that virtual wards could introduce unforeseen health inequalities and barriers to access. Therefore, between September and December 2024 Healthwatch Lancashire conducted a study to examine accessibility in virtual wards in Lancashire. The study involved engaging with NHS trusts delivering virtual ward services in the region, the Lancashire and South Cumbria Integrated Care Board (LSCICB), and members of the public. Our aim was to identify barriers to inclusive care, evaluate efforts to address them, and assess public perceptions and understanding of virtual wards.

Key findings

There is generally good awareness of barriers to virtual wards among sector leads

Positively, we found that healthcare professionals working in virtual wards in Lancashire are aware of accessibility challenges, and have in most cases implemented important measures to tackle them. However, significant work remains to be done to ensure equitable access.

Overlooked referrals are common

Overlooked referrals are an accessibility barrier. This issue stems primarily from a lack of awareness, understanding, and, in some cases, confidence in virtual wards among healthcare professionals in primary and secondary care settings.

Public awareness is poor, limiting engagement with the service

Public awareness of virtual wards is low, reducing the likelihood of patients, carers, and families advocating for referral into virtual wards.

People do not like the term 'virtual wards'

The term 'virtual ward' causes confusion. There is a clear preference for the alternative term 'Hospital at Home'.

Pathways into virtual wards remain too narrow and exclusive

Most virtual wards in Lancashire, as nationally, operate with condition-specific pathways, limiting access to individuals who do not meet the criteria for those specific conditions.

Lack of standardisation

Virtual wards across Lancashire vary considerably in terms of their size, structure and operational pathways. While some variation is appropriate, these differences can create inconsistencies in accessibility.

Informal exclusions

Some people, though not excluded from virtual wards, can face additional obstacles to accessing them. This includes people experiencing homelessness, and those with communication challenges such as individuals requiring interpreters.

Underrepresentation of ethnic minorities

There is a significant underrepresentation of ethnic minority groups in virtual wards in Lancashire, particularly among people from Asian and Asian British communities.

Capacity and funding

Funding challenges prevent some of the expansion of virtual wards, not least because expansion requires the employment of additional staff including healthcare professionals with appropriate specialisms. This is a major issue against the backdrop of NHS cost-saving measures and staffing cuts.

2. Introduction

The wider context

In recent years several local and regional studies have drawn attention to both actual and potential health inequalities in virtual wards in England, mainly concerning barriers to inclusive access.

These studies have highlighted the underrepresentation of ethnic minority groups in virtual wards and, in some cases, people from CORE-20 (high deprivation) populations.[1]

Furthermore, it has been observed that people are vulnerable to being overlooked for referral to virtual wards due to combination of factors including socio-economic circumstances, digital literacy, language barriers, housing conditions, and their level of familial and social support.[2]

There is also a need to address structural accessibility barriers within the virtual wards service. For example, many providers currently offer limited, condition specific pathways, which restrict eligibility. Similarly, there is a significant lack of virtual ward services for children and young people.

Local and regional variation

Any regional assessment of virtual wards must take into account the considerable variations which exist between these services from one NHS trust to another. No two virtual wards are exactly alike. While all virtual wards are required to include pathways for Acute Respiratory Infection (ARI) and frailty, trusts have the flexibility to introduce additional pathways based on their capabilities and the specific needs of the local population. Consequently, barriers to access and inclusivity issues identified in one area may not be applicable, or as applicable, in another, or may manifest in different ways.

Aims and methods

Healthwatch Lancashire undertook to examine the accessibility of virtual wards in Lancashire. We want to know what barriers exist, what has been done to alleviate them, and how access might be improved.

To conduct this research, we employed a mixed-methods approach, integrating qualitative and quantitative data. Our methodology included meetings with healthcare professionals and other NHS stakeholders, public focus groups, and data analysis.

Stakeholder and clinical meetings	We engaged with key healthcare professionals at NHS trusts delivering virtual ward services in Lancashire, and service leads at LSCICB, to gain insights into how virtual wards function. The purpose was to identify barriers to accessing virtual wards, and strategies implemented to reduce them.
Focus groups	To ensure that patient and public perspectives were captured, we conducted six focus groups with people from different socio-economic backgrounds across Lancashire. We asked: • Whether participants had previously heard of virtual wards. • What they thought of the term 'virtual wards'. • Whether they would be confident receiving care on a virtual ward. We also spoke to individuals who had experienced virtual ward care.
Data analysis	To supplement our qualitative evidence, we analysed both publicly available and unpublished data related to virtual wards in Lancashire. This analysis allowed us to develop a better understanding of the operational dimensions of virtual wards across the LSCICB footprint, and patient demographics.

3. What are virtual wards?

In 2022, NHSE committed to transforming out-of-hospital services to address growing pressures on healthcare systems, including long waiting lists and high demand for hospital beds. A vital component of this strategy has been the rapid expansion of virtual wards (also known as Hospital at Home) across the country.[3]

Virtual wards provide at-home care to patients with acute (i.e. severe and sudden) conditions, who would usually require urgent inpatient hospital treatment. They are distinguished from more traditional community care services, which mainly support people with chronic, non-urgent conditions.

NHSE defines virtual ward care as:

'a safe and efficient alternative to bedded hospital care.'[4]

Virtual wards use technology to monitor patients remotely, with the intention of providing hospital-level care in the place they call home (including care homes). Patients are provided with medical equipment, such as pulse oximeters, blood pressure monitors, and temperature sensors, the readings from which they transmit to virtual ward healthcare professionals via secure digital platforms or by phone. Clinicians review this data to monitor vital signs, and consult with patients daily via telephone or remote video call to discuss their progress. Where necessary, clinicians arrange face-to-face visits at the patient's home.

Referrals to a virtual ward can happen in two ways: step-up, where admission serves as an alternative to hospital admission, and step-down, where patients are transitioned to a virtual ward after an inpatient stay in hospital. As virtual wards are designed to support patients with acute healthcare needs, their stay is typically short. NHSE recommends a maximum stay of 14 days on a virtual ward. However, national data indicates that the average length of stay is generally much shorter; in Lancashire, it is around 4-5 days.

Since 2022, the expansion of virtual wards has been considerable. The number of virtual ward 'beds' in England has increased from approximately 4,500 in mid-2022 to around 12,700 by December 2024.[5] It is important to note that the number of virtual ward 'beds' does not refer to physical beds. Rather, it indicates the number of people who can be cared for in virtual wards. In reality, some virtual wards are able to admit more patients than the number of beds suggests.[6]

Initially, NHSE directed local Integrated Care Boards (ICBs) to focus on developing frailty and Acute Respiratory Infection (ARI) virtual wards as the standard pathways. However, many individual NHS trusts have gone beyond this basic requirement, expanding these services to address local needs and specialisms by creating pathways for conditions such as end-of-life care and heart failure. Additionally, generic pathway models are emerging to provide virtual ward care to a broader range of patients with acute conditions.

Research indicates that virtual wards offer significant benefits for both the NHS and patient outcomes.[7] Studies have shown that this model of care is not only cost-effective when implemented at scale, but also plays a vital role in alleviating pressure on hospital resources by freeing up inpatient beds for those with the most critical needs.[8] For patients, evidence suggests that most people prefer receiving treatment in the comfort and familiarity of their own homes, surrounded by family, friends and pets, and that patients often experience faster recovery times when they are treated in a home-based setting.[9] There is also less risk of hospital-acquired infections at home.[10]

Internal surveys conducted by NHS trusts and independent studies find high levels of patient satisfaction, which further underlines the appeal of virtual wards.[11] Despite some patient concerns about aspects of remote care, patients overwhelmingly report feeling safe and secure.

Virtual wards have tremendous potential to transform how acute healthcare is provided by the NHS, reducing demands on hospitals beds, saving money, and improving patient outcomes. If scaled appropriately, they should play an

integral part in meeting the health demands of an aging population. Over two-thirds of people admitted to hospital in England are over 65 years old, and the proportion of elderly people receiving care on virtual wards is even higher. The number of elderly people being admitted to hospital is going to increase significantly over the next decade, and virtual wards offer a promising solution to this challenge.

4. Virtual wards in Lancashire

The five NHS trusts in the area covered by LSCICB currently delivering virtual ward services provide 373 virtual ward beds to a GP-registered population of 1,852,079.[12] This equates to 20.1 beds per 100,000 people, a figure which aligns with the national average.

In the two years since December 2022, a total of 30,719 patients have been admitted to virtual wards across the five trusts. The total number of bed days in this period amounts to 116,017, averaging at 4.45 bed days per patient. Ninety-one percent of patients have been discharged without requiring further hospital care, indicating the general success of this model of care in Lancashire.

At present, bed capacity across the five trusts is broadly divided into the following pathways:

- Respiratory – 16%
- Frailty – 19%
- Acute medicine – 9%
- Generic – 47%
- Other – 9%

Behind this overall picture, however, lies significant variation in the maturity, size, structure, and operational pathways of virtual ward services across the five trusts.

A notable example is the high proportion of 'generic' virtual ward beds (47%) in Lancashire, which is largely due to the model implemented at ELHT. The generic virtual ward at ELHT accommodates patients with any acute condition, although most have conditions associated with respiratory, frailty and heart failure. The service is by some margin the largest in Lancashire; 43 percent of virtual ward beds in Lancashire are provided by ELHT.

The ‘Other’ category includes the paediatric and palliative virtual wards at Blackpool Teaching Hospitals (BTH), which are currently the only virtual ward services in Lancashire offering these specialised care pathways. It also includes the ‘Speciality’ virtual ward at Lancashire Teaching Hospitals (LTH), which represents an effort to broaden the scope of virtual ward care beyond the core respiratory and frailty pathways. This pathway currently cares mainly for people with cardiac, renal, and gastroenterological conditions. A fuller breakdown of virtual ward services in Lancashire is shown in the table on the following two pages.

Against this backdrop, NHSE has recently proposed moving towards more standardised models of care in the virtual ward service nationally, while also recognising that **‘some local variation will remain appropriate.’**[13]

LSCICB is seeking to encourage more standardisation within the region, with a longer-term ambition of establishing generic care pathways in all virtual ward services. We understand from our conversations with virtual ward leads at trust level that additional pathways should be introduced in most virtual wards in the coming year, but much depends on resource allocation and workforce capacity.

Utilisation of virtual ward beds in Lancashire has usually been, in most cases, below the NHSE target of 80 percent. Occupancy rates tend to increase in the winter, but even during these months most virtual wards in Lancashire have not regularly achieved that target according to single-day counts (as indicated in the table on the following page). It should be noted that there is a large turnover of patients in some virtual wards, particularly those dealing with frailty, so the single day utilisation figures do not necessarily capture a true reflection of usage. However, there is clearly potential to increase utilisation of virtual wards across the region.

Virtual wards in Lancashire, December 2024				
Trust	**Pathway**	**Bed capacity**	**Beds occupied**	**% occupied**
Blackpool Teaching Hospitals	**Respiratory**	21	17	81
	End of Life	10	4	40
	Frailty	20	6	30
	IV Therapy	10	3	30
	Paediatric	10	3	30
	Total	71	33	47
East Lancashire Teaching Hospitals	**Generic Hospital at Home**	150	157	105
	Generic Virtual Ward	10	0	0
	Total	160	157	98

Lancashire Teaching Hospitals	**Acute Medicine**	20	18	90
	Frailty	25	7	28
	Respiratory	20	9	45
	Speciality	15	5	33
	Total	80	39	49
Mersey and West Lancashire	**General**	15	4	27
	Total	15	4	27
University Hospitals Morecambe Bay	**Acute Medicine – IV**	5	0	0
	Frailty	25	18	72
	Respiratory	17	10	59
	Total	47	28	60
Lancashire and South Cumbria Total		373	261	70

Survey data collected by NHS trusts in Lancashire indicates overwhelmingly high patient satisfaction with virtual ward care. One of our focus group participants told us about their recent positive experience on a virtual ward at LTH:

"I recently had a heart problem whilst on a walk. I was rushed to A+E, but after a short while my heart returned to a normal pattern. I received really good care in the hospital.

After a couple of hours, I was offered the opportunity to go on a virtual ward. I had never heard of the service before, but the nurses talked to me about what it was, and they gave me a pamphlet explaining how the service worked.

I needed to take blood pressure checks and monitor my pulse each morning, and at 12pm every day the nurse called to take my readings. It was very straightforward. They then reported my readings to a consultant, who they met with straight after the phone call. I was on the virtual ward for just three days.

I was quite surprised when they said I was being discharged after three days. I would have liked to remain on the virtual ward for a little longer, but the care I received was good and I trusted that they knew what they were doing.

The consultant sent a report to the cardiologist, and I was monitored after that by my GP. Throughout, I received really good care. The whole process was very open and transparent, and there was excellent continuity of care. I would have no hesitation using the service again. I much preferred being at home to in a hospital."

5. Barriers and Inequalities

The rapid expansion of any healthcare service carries the risk of unintentionally introducing health inequalities, and potentially creating barriers to access for certain individuals or groups. Additionally, it requires overcoming challenges associated with changing established practices. Both of these considerations, as we shall explore, are relevant to the implementation of virtual wards.

Over the last couple of years, a number of reports have highlighted the emergence of health inequalities and accessibility barriers in virtual wards in England. Research on the South East, for example, has suggested that black and minority ethnic people are often underrepresented on virtual wards, although the absence of complete data prevents firm conclusions as to the extent of the underrepresentation or its cause.[14]

Further, people experiencing high social deprivation (CORE-20) appear, in some cases, to face particular barriers to access, although the evidence here is more mixed.[15] More generally, reports have suggested that clinicians often make judgements about a person's suitability for virtual ward care based on their own impressionistic assumptions, rather than though consultation with patients and carers, leading to missed opportunities to refer into virtual wards.[16]

Additional challenges coalesce around issues relating to understanding of virtual wards. For example, it appears that although most clinical staff in hospitals acknowledge the benefits of virtual wards, risk-aversion prevents some from referring patients into them.[17] Moreover, there is a need to foster 'buy-in' among primary and community care services and other health providers who play a key role in referring patients into the system.[18]

In our discussions with LSCICB and virtual ward leads across the NHS trusts we engaged with, we were encouraged by their awareness of these challenges and the steps they have taken to address them. Many challenges remain, but many are unavoidable outcomes associated with the rapid

implementation of a new service. With time, effort and, above all, appropriate funding, most of the problems we identify in this report should be resolved.

Thus, our following discussion explores existing barriers to virtual wards but also showcases efforts to improve inclusion and widen access.

We have identified the following barriers to access, which we will discuss in turn:

- Overlooked referrals
- Limited pathways and informal exclusions
- Resources and Capacity

5.1 Overlooked referrals

Our research indicates that overlooked referrals represent the most significant barrier to accessing virtual wards, and contribute to the failure of some virtual wards to meet utilisation targets. By extension, overlooked referrals undermine admission avoidance, a core principle of the virtual ward service.

By our definition, overlooked referrals occur when patients who are suitable for virtual ward care are not offered this pathway. This typically occurs in two ways:

- **Overlooked step-up opportunities:** Patients who could be cared for on a virtual ward are instead admitted to inpatient hospital care.

- **Overlooked step-down opportunities:** Hospital inpatients who are suitable for discharge to a virtual ward are not referred.

Most of the healthcare professionals we spoke to acknowledged that overlooked referrals are a common problem. We were told that they are caused by a combination of factors, including a lack of awareness, understanding, and, in some cases, confidence in virtual wards among healthcare professionals across hospital, primary, and community care settings. As one virtual ward lead in Lancashire told us,

> **'One of our biggest challenges has been raising awareness about what we do among health professionals.'**

It is clear that as a relatively new model of care, virtual wards have not yet been fully embedded into routine clinical decision-making processes. While the extent of this challenge varies between NHS trusts, our investigation found it to be a widespread issue across Lancashire.

We were informed that during the busy winter period in 2024, some healthcare professionals seemed to forget about virtual wards altogether, and resorted to familiar and established practices. This resulted in many unnecessary referrals to hospital and missed step-down opportunities, which considerably increased pressure on hospital beds at a time when services were already stretched. **'It is'**, one virtual ward clinician stated,

'a continuous battle to remind staff of virtual wards.'

It is evident, more generally, that many healthcare and community care professionals, often unconsciously, continue to rely on traditional ways of working. This issue presents itself in several ways:

- Many healthcare professionals, particularly in primary and community care settings, are not sufficiently informed about virtual wards and therefore do not routinely consider them as a referral option.
- Some healthcare professionals mistakenly assume their patient is unsuitable for virtual ward care.
- While evidence indicates that support for virtual wards among healthcare professionals is generally high, some remain cautious. This includes clinicians in hospitals, who might prefer to keep patients under their direct supervision rather than step-down to virtual wards.

We were informed that a contributing factor is that healthcare professionals tend not to consult with patients, family members or carers when deciding whether a person is suitable to be referred to a virtual ward. While people can refuse admission to a virtual ward, the decision to offer such care lies initially with consultants.

As one virtual ward lead explained,

'Patients [in hospital] are not usually consulted about whether they could be transferred to a virtual ward. Some clinicians think they know what is best for their patients.'

Reflecting this, another told us that **'It's about changing the culture. It will take time.'**

One group of people who could benefit from a more embedded virtual ward service are those with capacity to make decisions who refuse to be admitted to hospital, or who self-discharge against medical advice. In such cases, ongoing care often falls to community care services. We heard that such patients are often open to being cared for on a virtual ward, but many fall through the gaps, in part because the virtual ward is not always considered, but also if their acute condition is not one of the dedicated care pathways.

Public awareness

In addition to raising professional awareness is the importance of increasing public awareness. Our investigation indicates that many people in Lancashire have never heard of virtual wards and do not understand the type of care they provide. This causes a significant gap in the capacity for patients, family members and carers to engage in the virtual ward service, contributing to overlooked referrals.

Interestingly, some of the virtual ward leads we spoke to in Lancashire do not consider this to be a critical issue. They told us that as referrals are primarily handled by healthcare professionals, their priority is to enhance engagement and buy-in among hospital, primary and community care workers. Yet, while we acknowledge that professional awareness and buy-in is a pressing issue, enhancing public awareness is vital for the following reasons:

- If patients and carers know about virtual wards, they can be involved in informed discussions with health professionals about step-up or step-down referral, reducing the likelihood of overlooked referrals.

- Where appropriate, better awareness could allow patients to self-refer into virtual wards.
- Many people do not realise they have been overlooked for virtual ward care because they are unaware that it is an option. Greater awareness would allow them to challenge decisions.
- Greater awareness would also position family and carers to advocate on the behalf of patients for admission to virtual wards.

"My mum was recently in hospital with a head injury following a fall. After a week or so she wanted to go home, but she was kept in. If I had known about the virtual ward I would have asked if she could be referred into it. It sounds like it would have been perfect for mum.

I have since found out there are red flags for referral to virtual wards, and having a severe head injury is one of them. This might be why the virtual ward was not offered, but I would have liked the opportunity to ask.

I saw that on the screens of nurse's laptops were notices reminding them of virtual wards (at Preston Hospital). The noticed asked, "is your patient suitable for a Virtual Ward?". So, it's being brought to their attention."

As this case illustrates, virtual wards are not suitable for everyone. Exclusion criteria prevent the admission of people with acute mental health conditions or other serious health issues that pose an immediate risk. However, limited public awareness risks leaving people feeling excluded or overlooked, without understanding why they were not offered the service.

The lack of public awareness and understanding surrounding virtual wards is exacerbated by the absence of clear, accessible, and consistent public-facing information online. Many NHS trusts in our region do not have a dedicated virtual ward webpage, making it difficult for patients and carers to find essential details.[19] There are some examples of good practice. Lancashire Teaching Hospitals provide a downloadable booklet, offering contact information and other details.[20] Blackpool Teaching Hospitals has a dedicated webpage for virtual wards aimed at patients and professionals.[21]

Elsewhere, ELHT and UHBMT occasionally share virtual ward success stories on their websites.[22] However, they do not provide general information about how the service works. Mersey and West Lancashire Teaching Hospitals (MWLTH) does not appear to feature any virtual ward information on its website.

In some trusts, the absence of a dedicated virtual ward webpage reflects how the service is integrated with others. For example, at ELTH it forms part of the Integrated Home Support Service (IHSS). Although the ELTH website provides accessible information about the IHSS, members of the public seeking details specifically about the virtual ward might not realise this.

The LSCICB website provides useful general information on virtual wards, which includes a patient experience video and an FAQ section.[23] However, it is unlikely that most patients or carers would instinctively know to search there, rather than on their local trust's website.

Overall, the information around virtual wards in Lancashire is inconsistent. A more standardised approach, ensuring that every NHS trust provides a clear, user-friendly virtual ward webpage with key details, would aid public awareness and engagement.

Public perceptions of virtual wards

An associated and recurring theme which frequently emerged in our discussions with the public was the widespread dislike of the term 'virtual ward'. Almost universally, people expressed a preference for the alternative name

'Hospital at Home'. One of our focus group participants said the term 'virtual ward' was confusing, adding that **'it sounds like something out of science fiction.'** The preference for 'Hospital at Home' expressed by our research participants supports the findings of other studies.[24]

The term 'virtual ward' dates back more than a decade, but it gained widespread currency during the Covid-19 pandemic when reducing hospital admissions became an urgent priority.[25] The word 'virtual' denotes heavy reliance on digital technology and remote monitoring. Yet, as virtual wards have evolved post-Covid, they have gradually become less dependent on digital technology. This is, in part, to prevent digital exclusion, but also reflects the complexity of patient needs and their abiliuty to use the technology. Patients on virtual wards no longer necessarily need to use digital technology at all, and its use is never mandatory. The term 'virtual', therefore, can be misleading. The term 'ward' too, is misleading, as patients are not cared for in a ward setting in any meaningful sense.

Currently, guidance provided by the NHS states that the official term is 'virtual wards' but adds the caveat that local services can decide if they want to call them 'Hospital at Home' instead.[26]

We believe that public understanding of this model of acute remote care would be enhanced by adopting 'Hospital at Home' (or similar emphasising the 'home' aspect of the service) as the singular term. However, given that many trusts have actively promoted 'virtual wards' for some time through physical and digital campaigns, an immediate change risks undermining progress. A practical short-term solution might be to promote the service as 'Hospital at Home (previously known as virtual wards)' until the new terminology is embedded.

It is important to note that despite these issues, public support for virtual wards appears to be high. Participants in our focus groups were overwhelmingly favourable of this model of care when we explained how it worked. People who had used virtual wards, or knew of someone who had, were overwhelmingly positive.

The benefits highlighted by focus group participants included:

- Many expressed a strong preference for receiving care in the comfort of their own home, as long as they felt reassured about their safety outside the hospital and had a clear understanding of their responsibilities within a virtual ward.
- Participants were positive about the independence that care at home would provide, including the ability to spend more time with family and friends without restrictions.
- Avoiding long-distance travel was seen as a major advantage, particularly for those living in remote or rural areas and those who rely on others to drive them to hospital.
- Many participants noted the reduced risk of hospital-related infections as a benefit of home-based care.
- Participants highlighted the potential benefits of virtual wards for family members, friends and carers, including less demanding travel, unrestricted visiting opportunities, and increased involvement in patient care. However, some unpaid carers voiced concerns about added caregiving responsibilities on virtual wards.

A small number of individuals we spoke to were sceptical about virtual wards, perceiving them as merely a cost-cutting measure introduced by the NHS to shift the care of acute patients onto family and carers. This further highlights the importance of promoting this model of care to foster public confidence and trust.

What are trusts doing to tackle overlooked referrals?

Many of the problems identified are inevitable outcomes of the relative newness of the virtual ward service. Over time, with sustained promotion, the service's integration into existing practices will improve. Virtual ward leads in Lancashire are aware of these challenges, and are actively working to tackle them in the following ways:

- Collaborating with hospital clinicians, GPs, community care providers, North West Ambulance Service (NWAS), and Voluntary, Community and Social Enterprise (VCSE) organisations to raise awareness of the service and increase referrals.
- Public awareness initiatives at trust level have sought to increase knowledge and understanding of virtual wards.
- The introduction of a shared referral contact number through the 2-hour Urgent Community Response (UCR) service has streamlined referrals.
- When virtual ward services expanded in 2022–23, there were initial concerns about digital exclusion. However, virtual ward care is no longer entirely reliant on digital technology, and we are confident that this is not a significant barrier to access in Lancashire. NHSE's latest virtual ward guidance requires that patients are **'offered alternatives to prevent digital exclusion'**, and this appears to have been successfully implemented.[27] This does not mean that remote technology is never a challenge. For instance, we heard that patients in remote areas with poor signal may struggle with virtual ward care. In such cases, face-to-face visits can be arranged as an alternative. Certainly, virtual ward leads recognise the risks of digital exclusion and have taken steps to minimise them.

5.2 Limited pathways and informal exclusions

The limited number of pathways into virtual wards is a significant structural barrier to inclusion. Reducing this barrier by broadening the range of pathways into the service will enhance accessibility and maximise the impact of virtual wards on the NHS.

At present, the primary beneficiaries of virtual ward care are elderly patients. Individuals aged 65 and over account for the vast majority of admissions. This is understandable and necessary, given that this demographic represents the largest proportion of acute NHS patients in hospitals. Yet, there is substantial scope to extend virtual ward services to other patient groups, including children and young people.

Immediate opportunities for expansion

The virtual ward leads we spoke to recognised the importance of increasing pathways to virtual wards, although we were also told that issues relating to funding and capacity are an impediment.

Currently, only ELHT and MWLTH offer generic pathways to virtual wards in Lancashire, but, crucially, they are exclusively for adults. Only BTH's virtual ward includes pathways for children and young people. A major obstacle is that referrals into virtual wards are primarily handled by 2-hour UCR teams, which deal solely with adult patients.

Our research suggests that children and young people should be prime candidates for virtual ward care. Hospitals can be daunting environments for CYP, and older teenagers (16-17 years old) are sometimes admitted to adult hospital wards which is far from ideal. Being at home allows CYP to remain in a familiar environment, spend more time with their families, and feel more comfortable and relaxed during their recovery.

NHSE's operational guidance states that virtual wards:

"allow patients of all ages to safely and conveniently receive acute care at their usual place of residence, including care homes."

However, in practice, this is not the case in most of Lancashire's virtual wards. Addressing this gap is crucial to ensuring equitable access to virtual ward care across all age groups, and enhancing the care experience of CYP. The Royal College of Paediatrics and Child Health supports paediatric virtual wards, noting that they could be particularly valuable for **'children with ongoing health needs or high care demand who may otherwise be in and out of hospital.'**[29]

Another patient group that would greatly benefit from virtual ward expansion is those receiving palliative and end-of-life care. For many people in this category, remaining at home or in a non-clinical care setting is a clear

preference, reducing unnecessary hospital admissions. Many of our focus group participants spoke highly of the potential benefits of virtual ward care for palliative patients, reinforcing findings which suggest that prolonged hospital stays could be avoided with virtual ward support. Successful examples, such as the collaboration between BTH and Trinity Hospice in Blackpool, demonstrate the potential of virtual ward palliative care.[30]

Two healthcare professionals we spoke to also suggested that virtual wards could provide care for individuals within the criminal justice system, including in prisons. Currently, prisoners admitted to hospital require supervision by prison staff, creating logistical and financial challenges. While expanding virtual ward care into a prison setting would undoubtedly pose difficulties, the potential benefits, including cost savings and improved patient outcomes, justify further exploration.

Informal Inclusion Barriers

Beyond expanding pathways into virtual wards, it is equally important to tackle barriers faced by certain groups who, while not formally excluded, often encounter obstacles to accessing virtual ward care.

We have already explained that there are many missed opportunities to refer into virtual wards. Some people, including those from the CORE-20 population, appear to be particularly vulnerable. They include:

- **People of no fixed address:** Our research found that homeless individuals are likely to be overlooked for virtual ward care, despite the feasibility of providing remote care within temporary accommodation settings such as shelters or hostels. While some virtual ward services in Lancashire have accommodated homeless patients in isolated cases, collaboration between virtual wards and homeless organisations currently remains underdeveloped.
- **Non-English speakers:** While being unable to speak English does not exclude access to virtual wards, language barriers can prevent non-English speakers from accessing the service if interpreters are not available at short notice.

- **People who live in an unsuitable care environment:** We found that patients may be excluded from virtual ward care if their homes are deemed unsuitable as a care environment. It is, of course, necessary for health professionals to assess accommodation prior to referring a patient into the virtual ward service. Moreover, adjustments to a patient's houses often takes place to accommodate patients. Yet, capacity issues can prevent such adjustments taking place.

- **People living in remote areas:** Referrals into virtual wards occur primarily following an assessment from 2-hr UCR teams. Response rates are good in Lancashire, standing at roughly 90 percent, but we heard that for people living in remote rural areas the chances of not being seen within the two-hour window can be higher. There are also potential barriers for people living in remote areas with poor signal.

Underrepresentation and ethnicity

Since the routine collection of virtual wards data began in 2022, a persistent underrepresentation of ethnic minority groups has become evident in Lancashire. Between December 2022 and November 2024, at least 90 percent of virtual ward patients have been white. In contrast, the proportion of virtual ward patients recorded as 'Black and Black British' stands at less than 1 percent, as does the proportion of those identified under 'Chinese or other ethnic groups.' Asian or Asian British patients account for just 3 percent of virtual ward users. A limitation of the dataset is that demographic information is unavailable for 7 percent of patients.

Lancashire, including Blackburn with Darwen, has a diverse population, with approximately 85 percent registered as white, 11 percent as Asian, around 1 percent as Black, and 2.3 as mixed.[31] However, given that virtual wards predominantly serve older adults, comparisons with the demographic composition of the general population should be avoided. Among those aged 65 and over, the proportion of white residents in Lancashire is significantly higher than 85 percent; in many areas it exceeds 90 percent. Despite this, the

the data clearly indicates a notable underrepresentation of some ethnic minority groups, particularly the Asian population who represent a much smaller proportion of virtual ward patients than would be expected even when adjusting for age.

While general population statistics suggest that Black people in the region might not be as drastically underrepresented as Asian people, the raw data paints a different picture, with their participation in virtual wards being almost negligible. At no point since records began in 2022 has the number of Black and Black British people admitted to virtual wards in Lancashire reached double figures in a single two-week period.

The reasons for this disparity remain unclear. This trend is not unique to Lancashire, as similar patterns have been observed in other regional studies. Several factors could be contributing to this issue, including lack of awareness, differing cultural perceptions and uses of healthcare services, and language barriers such as those identified earlier.

Recognising the importance of addressing this imbalance, LSCICB is currently engaged in research to better understand the causes of minority ethnic underrepresentation. Additionally, they are collaborating with ELHT to actively promote Hospital at Home services within Asian communities in Blackburn, Burnley and surrounding towns.

What has been done to tackle these barriers?

Throughout our investigation, we observed a strong commitment from virtual ward leaders to expand services. However, significant challenges remain. Key initiatives we identified include:

- Blackpool Teaching Hospitals has taken a proactive approach to widening inclusion by introducing palliative and paediatric virtual wards, ensuring that both end-of-life patients and children can access the service.

- ELHT and MWLTH have introduced generic virtual wards to provide flexible, generalist care, while LTH has developed a specialist virtual ward tailored to a wider range of acute patient needs.
- Healthcare teams in virtual wards have been working closely with VCSE organisations to ensure patients' homes are suitable for remote care, and that the patient is safe, secure, and has everything they need.
- Recognising the underrepresentation of ethnic minority groups in virtual ward services, research initiatives are underway in East Lancashire to better understand barriers to access.

5.3 Resources and Capacity

A major barrier to achieving the vision of an expanded and more inclusive virtual ward service is the limited capacity of healthcare professionals to deliver it due to funding constraints. The challenge of expanding the service is particularly acute in the context of current staff shortages and cost-cutting measures being imposed across the NHS.

Nearly all the healthcare professionals we consulted emphasised that financial limitations significantly hinder service expansion, both in terms of available beds and care pathways. The introduction of additional virtual ward pathways, for instance, necessitates the employment of more senior clinical specialists, while the creation of generalist models requires additional general clinical staff who can manage patients with multiple co-morbidities.

Given the current constraints, expanding virtual ward services is a considerable challenge. The shortage of staff, in particular, presents a substantial barrier to scaling up these services and ensuring they are accessible to a wider patient population.

In our conversations with healthcare professionals, we learned they are exploring innovative strategies to maintain and, where possible, expand service delivery. Many are collaborating closely with VCSE organisations to support professional staff. These partnerships help provide medical equipment, care

packages, and other essentials directly to patients' homes. Additionally, targeted recruitment events - where same-day job offers are extended - have proven effective in quickly hiring qualified medical personnel.

However, the outcomes of these efforts remain inconsistent. One virtual ward professional shared that the timely delivery of equipment and other resources at patients' homes can sometimes feel like a 'postcode lottery', with much still depending on the availability of family support. This issue is especially challenging for patients who live alone and lack family or friends to assist them. To address these disparities, we encourage broader collaboration with charities and other community resources, such as NHS volunteers.

All virtual ward services are working on ways to enhance services, but the highly integrated Hospital at Home service at ELHT, which operates within the trust's Integrated Home Support Service, is a good example of how an expansive and complex virtual ward can function efficiently and effectively on a large scale. As the largest such service in Lancashire, the ELHT Hospital at Home provides medical and social care to thousands of patients each month. The service expanded considerably in 2022-3, building upon an established community care infrastructure which brought together health professionals, social care teams, and charitable organisations (including Age UK) within a single operational unit at Burnley General Teaching Hospital. We visited the ward in January 2025, and were impressed by the integrated network of interdisciplinary services operating collaboratively under the same roof.

6. Conclusion

This study aimed to identify barriers to accessing virtual wards, examine the steps service leads have taken to address them, and highlight further actions needed to improve accessibility.

Positively, we found that virtual ward leads at LSCICB and NHS trusts are aware of accessibility concerns and have made efforts to reduce them. However, as our findings illustrate, key challenges remain.

Many of these challenges are unavoidable outcomes associated with expanding a new service area. Issues such as limited referral pathways, varying levels of professional buy-in, lack of public awareness, and the general absence of standardisation, should be overcome with time and sustained commitment. Appropriate and recurrent funding, however, is vital for the continued expansion and improvement of these services, so that virtual wards become an established part of healthcare delivery.

There is, nonetheless, an immediate need to implement measures to achieve more inclusive access to virtual wards, preventing the problems associated with overlooked referral opportunities, and to address the current underrepresentation of ethnic minority groups.

We hope that this report is useful to those responsible for ensuring equitable access to virtual wards, and that by considering our recommendation we can contribute to improving the service.

7. Recommendations

The following recommendations aim to address the key challenges identified in this report. Given the significant variation between virtual wards in Lancashire, some recommendations may be more relevant to certain trusts than others. However, they are designed to reflect common challenges experienced across the region.

Address overlooked referrals:

- Expand and sustain efforts to educate healthcare professionals across hospitals, primary care, and community settings about virtual wards.
- Introduce mandatory virtual wards training for all new healthcare professionals, and refresher training.
- Extend general and targeted outreach initiatives to enhance public awareness and understanding of virtual wards.
- Virtual ward staff should regularly join consultants on ward rounds to identify appropriate patients for virtual wards.
- Healthcare professionals should routinely consult with patients, their families, and carers when considering whether a patient is suitable for virtual ward care.

Rebrand 'Virtual Wards' as 'Hospital at Home'

- LSC ICB should consider the adoption of 'Hospital at Home' as the standard service name, phasing out 'virtual wards'.

Improve public-facing information on virtual wards

- Each NHS trust should have a dedicated, easily navigable virtual ward webpage, including essential details and FAQs addressing common concerns.

Establish 'generic' virtual wards as a priority:

- Generic virtual wards should be genuinely inclusive, incorporating dedicated pathways for children and young people (CYP) who are currently excluded from most virtual wards in Lancashire.

Extend collaboration with VCSE organisations to aid capacity and enhance inclusion:

- Virtual ward services should prioritise collaborating with homeless shelters, hostels, and other relevant organisations to ensure vulnerable populations with complex needs can access the service.
- Extend collaboration with voluntary organisations to help address capacity challenges, particularly in the areas of equipment delivery, care packages, and other forms of non-clinical home-based support.

Understand and address underrepresentation of people from ethnic minority groups:

- Implement more robust and consistent data collection practices to ensure comprehensive ethnicity data is captured.
- Actively engage with ethnic minority communities across the region to understand any specific barriers they face in accessing virtual wards.

Introduce co-ordinated inclusion initiatives across LSCICB footprint:

- Designate a dedicated Virtual Ward Inclusion Lead within each trust to monitor and identify access barriers, overseen by a Regional Virtual Ward Inclusion Lead based in LSCICB.
- Facilitate collaboration and knowledge sharing through quarterly meetings between inclusion leads to discuss best practices and address common challenges.

8) LSCICB's Response to our report

Thank you to Healthwatch Lancashire for developing this report and to the members of the public and clinical staff who have contributed. We are grateful for your insight and shared experience. Virtual wards (also known as Hospital @ Home) are an area of focus for Lancashire and South Cumbria ICB, including improving access to these services, which will help to support more people in their own homes out of hospital. We are pleased to receive this report and note its findings. We will collaborate with our partners to work towards implementing the recommendations.

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