

# Virtual Community Ward

Aberdeenshire Health & Social Care  
Partnership

# Background

- **Spring 2016** - VCW model began on a pilot basis, as part of a 3 year programme of implementation across Aberdeenshire.
- **Model** – co-ordination of short term (matter of days) wrap around health and care at home as an alternative to hospital or care home admission.
- **Geographic Scale** – existing health & social care team structure around GP practice population
- **Small core team** – typically GP, community nurse, care management/home care at its core, often supplemented by other disciplines such as AHPs.

# Overview of Model

Health & Social Care Team communicating and working closely together to identify vulnerable people earlier, put in place support at short notice, avoiding crisis and acute interventions where feasible.

# Objectives

- Better experience for all
- Wider cross-system collaboration
- Improved organisation of care
- Good quality anticipatory care
- Reduction in emergency hospital admissions
- Reduction in emergency hospital re-admissions
- Reduction in emergency occupied bed days
- Reduction in unplanned Out of Hours primary care contacts

# Mrs Smith

- Mrs Smith is a 87 year old lady living alone at home with care twice daily for assistance with personal care and medication prompts each morning and evening.
- The home carers noticed a change in Mrs Smith's behaviour, she had become confused and this was raised at the Virtual Community Ward (VCW). It was agreed a carer should return to obtain a sample of urine.
- It was found that Mrs Smith had an infection and the GP prescribed antibiotics.
- It was agreed visits were increased to 3 times daily to ensure the antibiotics were given at prescribed times and to encourage Mrs Smith to drink plenty of fluids.
- The Homecare Responder Service was made aware of a change in Mrs Smith's needs, should they be called out of hours.
- Mrs Smith was able to remain in her own home with additional visits to monitor her health and well being. Mrs Smith remained in the VCW for 5 days until her condition improved. Support was then reviewed and returned to having twice daily visits.
- Questions?

# Mr Reid

- Mr Reid is a 83 year old man who lives alone at home. He is known to the home care team and receives assistance with showering twice a week.
- Mr Reid had a fall at home resulting in a minor injury to his leg.
- On finding Mr Reid on the floor home carers contacted their co-ordinator and he was discussed at the Virtual Community Ward (VCW) .
- It was agreed the Occupational Therapist and District Nurse would visit Mr Reid to assess his injuries and put in place additional support and aids.
- Home care was increased to visits once a day for a period of a week and he was supplied with a commode and equipment to support him at home
- A further visit was carried out by a Physiotherapist to support Mr Reid and build his confidence again.
- Mr Reid was discharged from the VCW whilst District Nurses visited until his injury healed.
- Questions?

# Mr Skinner

- Mr Skinner is a 60 year old gentleman who has an acquired brain injury. Following his wife becoming ill and being admitted to hospital he was discussed at the Virtual Community Ward (VCW).
- Mr Skinner's wife is his main carer and he receives no care and support services beyond regular visits from the GP.
- It was arranged following discussion with the couple and their family that care and further equipment could be provided to enable him to remain at home.
- Care Management and Home care set up regular care allowing for assistance with personal care, medication and meals four times daily.
- Care visits were increased to include support from the Home Care Responder Service to ensure Mr Skinner's family were supported when required overnight.
- Mr Skinner was then discharged from the VCW.
- When Mr Skinner's wife returned home additional carer support was put in place, including regular respite care.
- Questions?

# Criteria

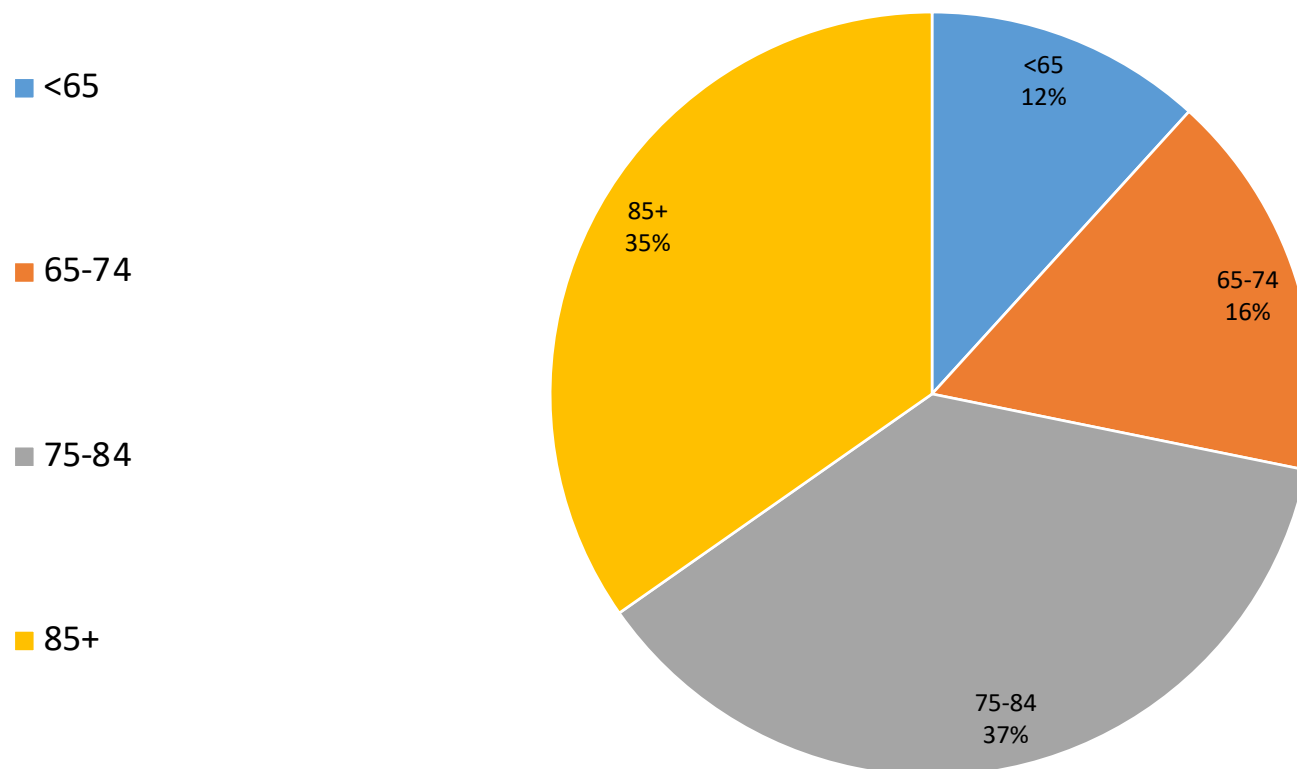
- Those people at risk of a hospital admission, and those discharging from hospital who are at risk of re-admission.
- Predominant focus on older people (70+) but not exclusively, with:
  - Acute illness/unwell
  - Multi/co-morbidity
  - End of Life care
  - Social reasons
  - Complex hospital discharge
  - Confusion/delirium
  - Fall



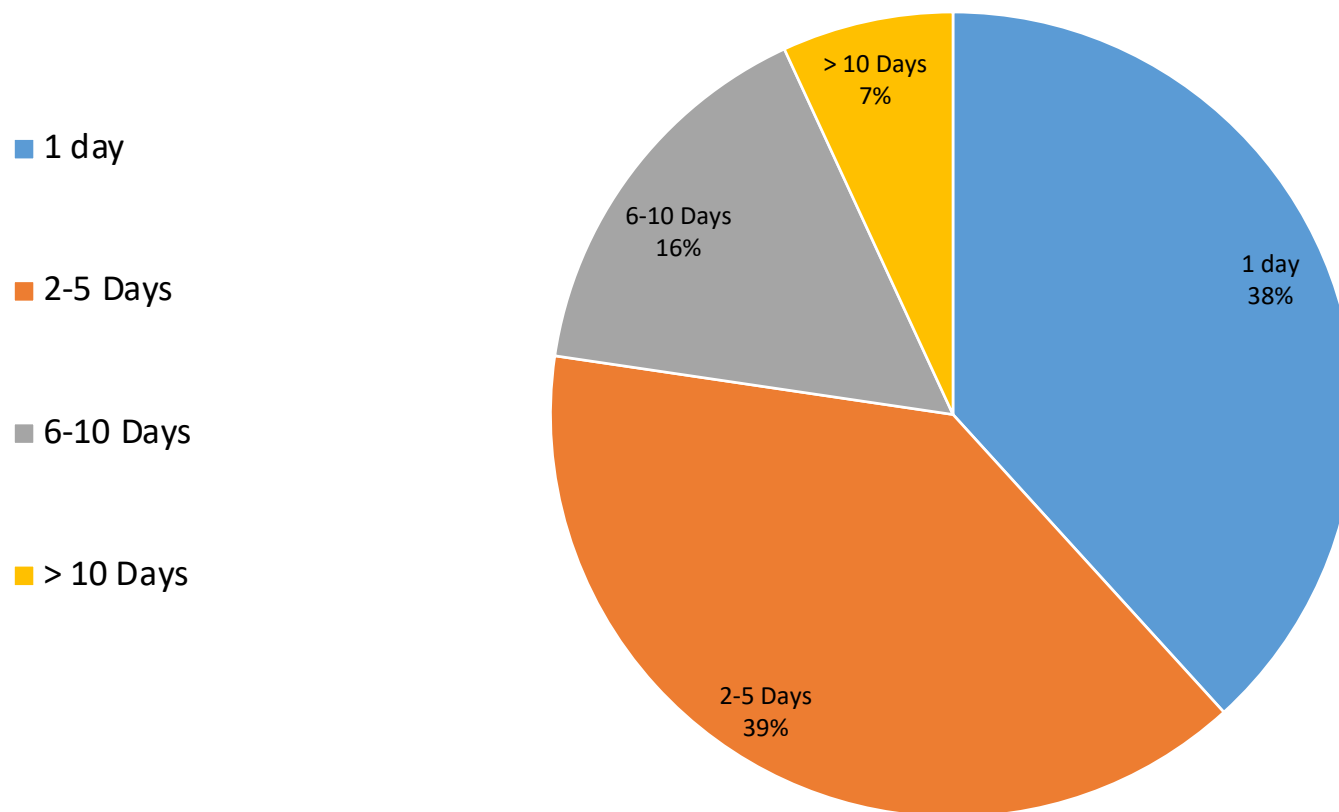
# Feedback from Teams

- Communication
- Upstream
- Access
- Resources
- Integrated and seamless
- Outcomes
- Staff experience

# Age Band

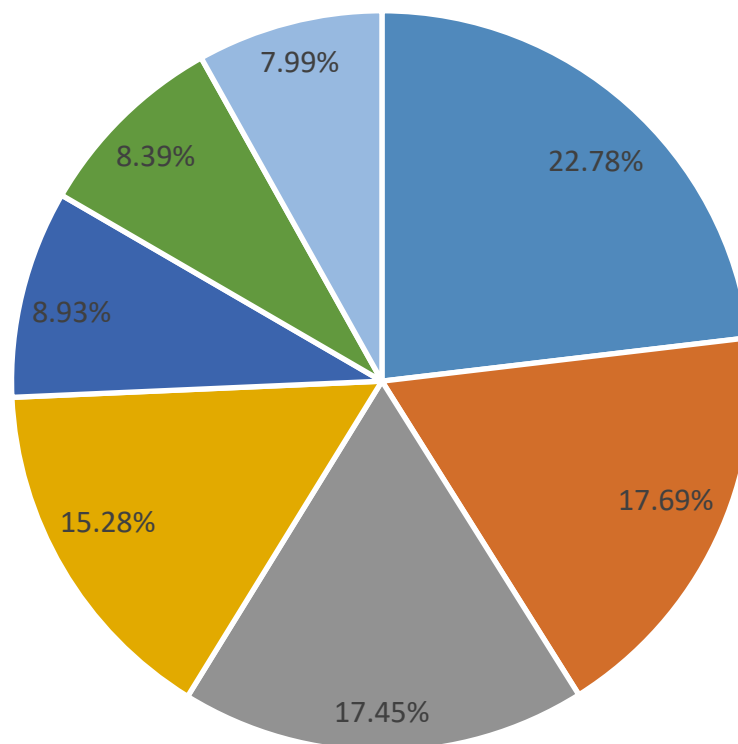


# Length of Admission



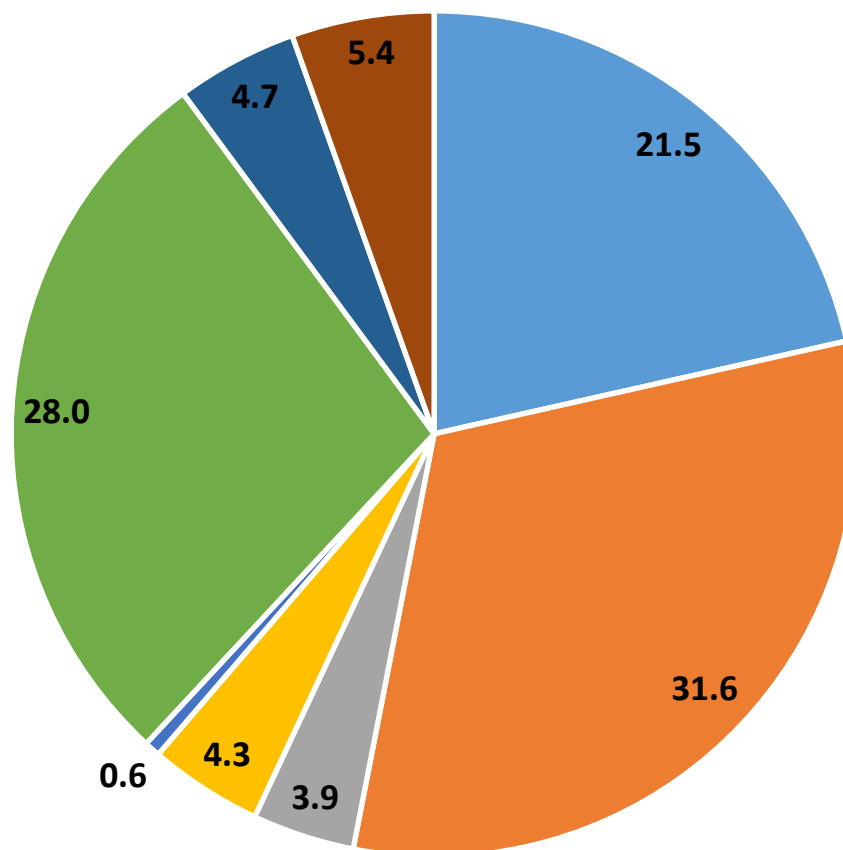
# Reason for Admission

- Multiple Co-morbidities/Unwell
- Other
- Acute Illness
- End of life care
- Complex Discharge from Hospital
- Delirium/Confusion
- Falls

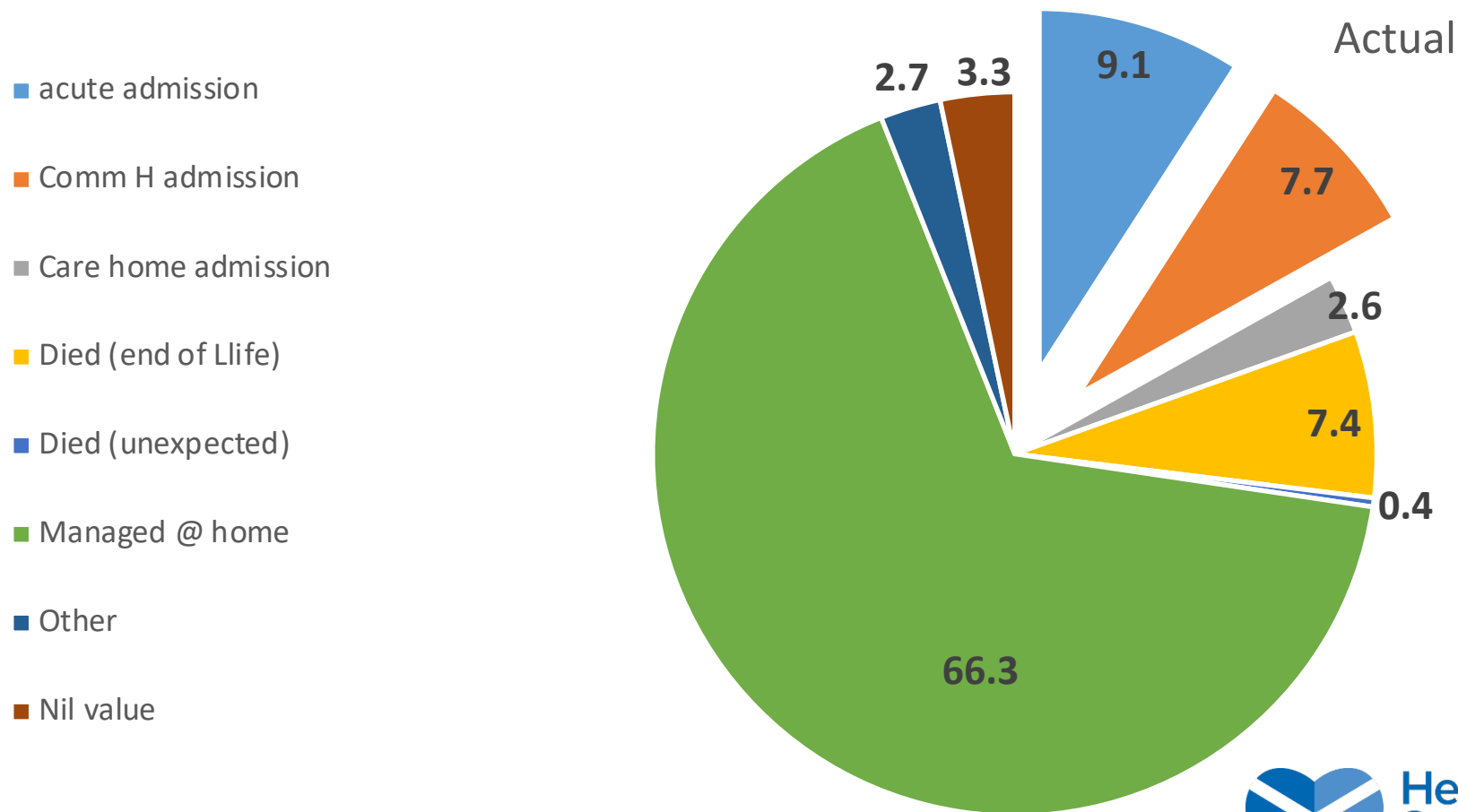


# Presumed Outcome

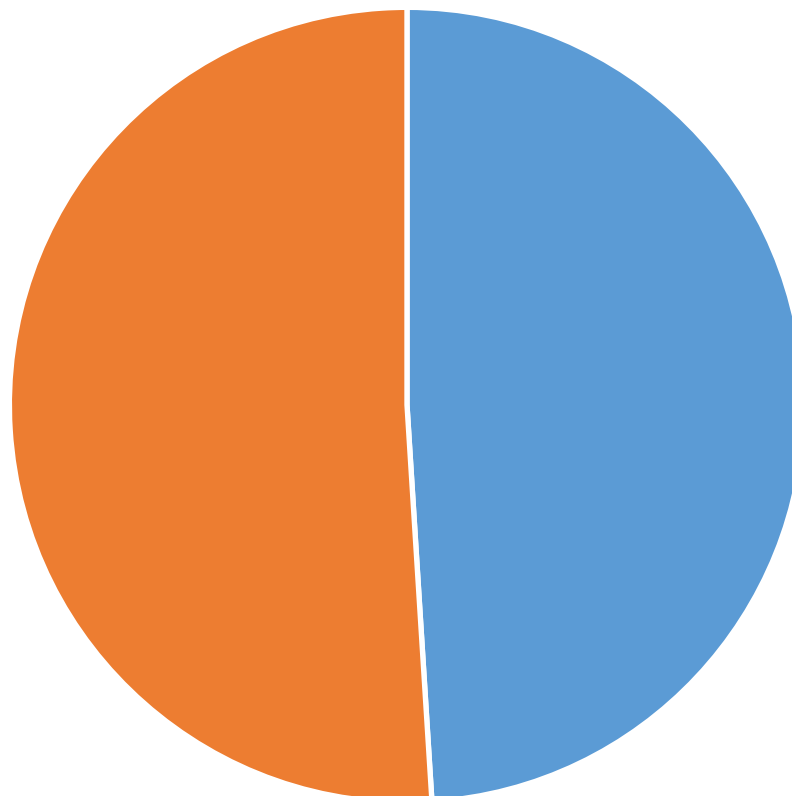
- acute admission
- Comm H admission
- Care home admission
- Died (end of Life)
- Died (unexpected)
- Managed @ home
- Other
- Nil Value



# Actual Outcome



# Altered Outcome



■ Altered ■ Not Altered

# Picture So Far...

Been running now for almost 3 years

- 28 VCWs in operation across Aberdeenshire
- 36 months of monitoring data collected
- 4,685 patients admitted and discharged from a VCW (to 31 March 2019)
- Personal care/home care, nursing care – cited as the most critical interventions required to meet the needs of VCW patients



# Whole System Impact

*1,640 hospital admissions have been avoided since Virtual Community Wards began across Aberdeenshire in Spring 2016*