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

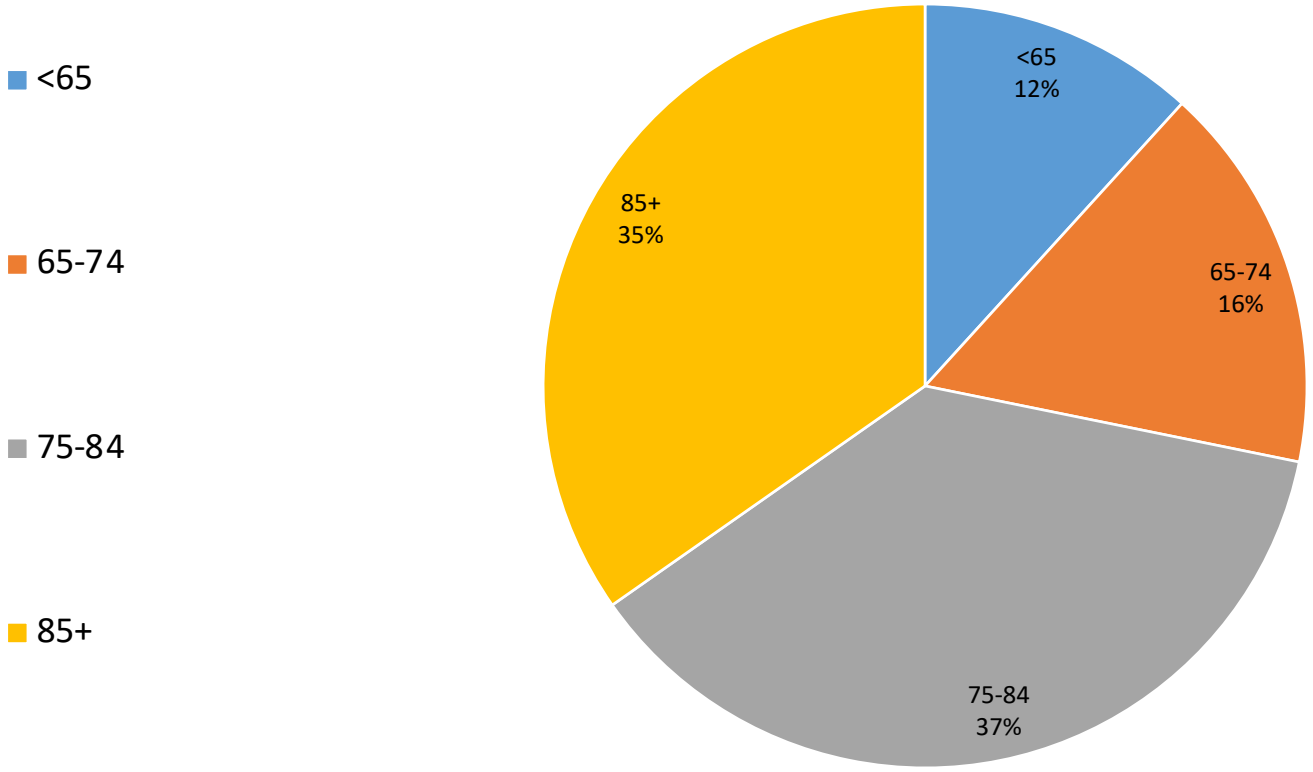
  Confusion/delirium

  Fall

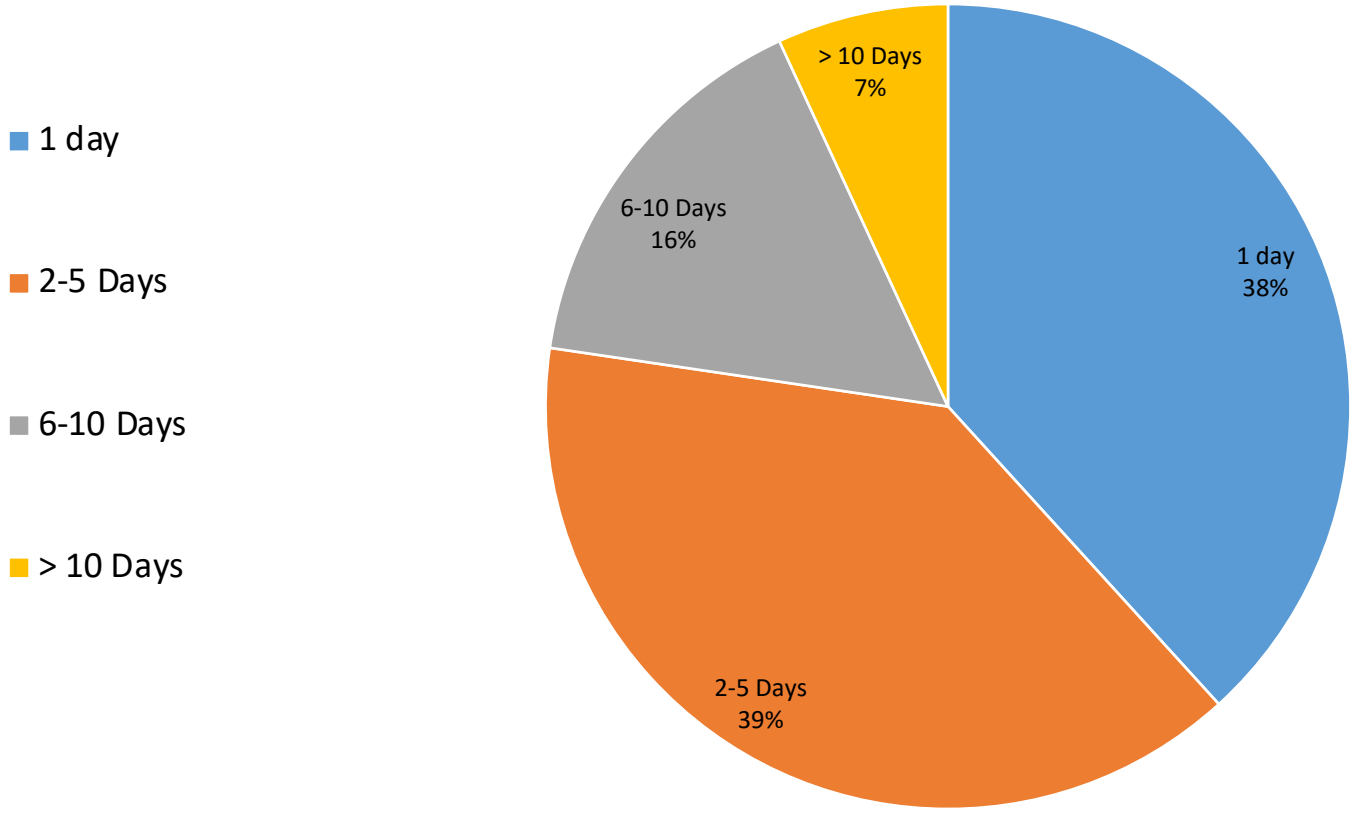
Feedback from Teams

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

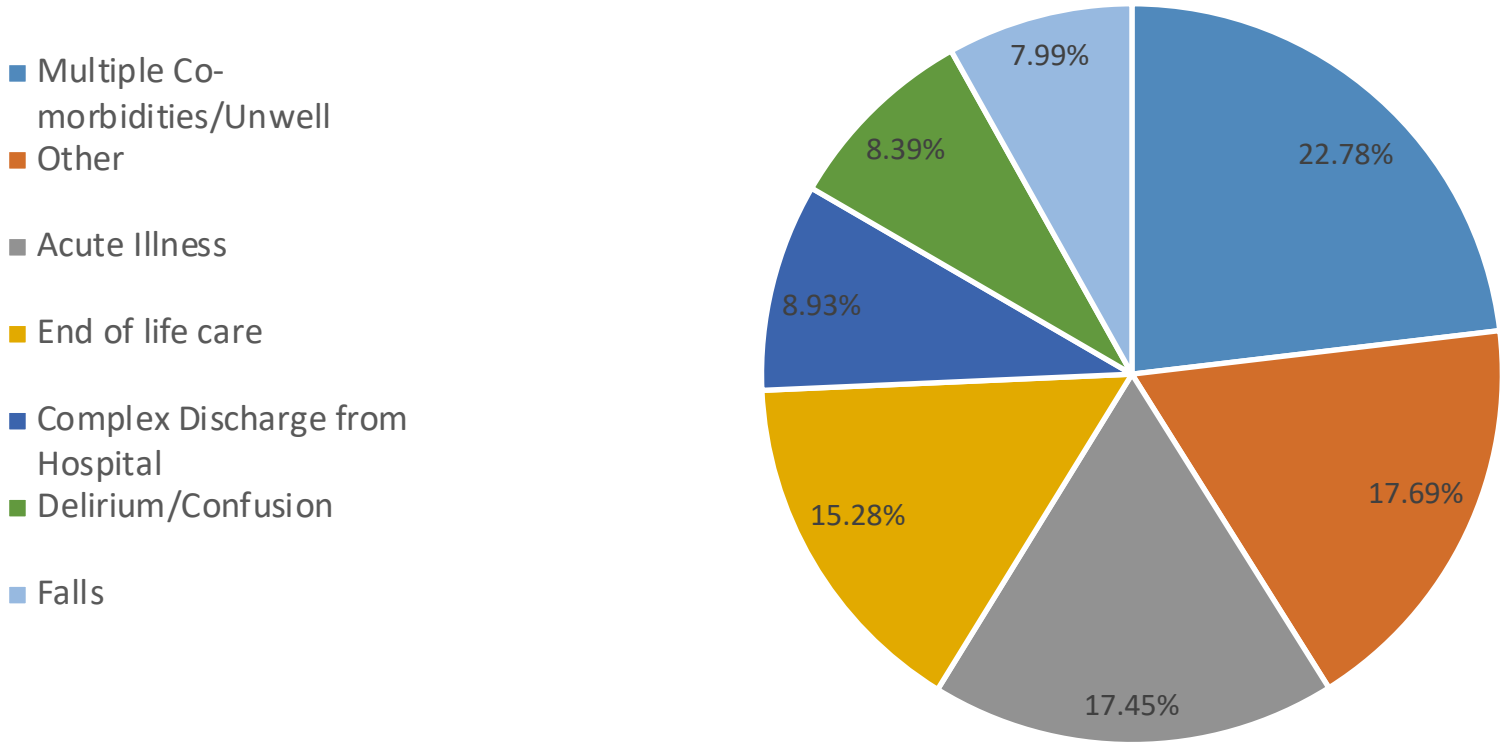
Age Band



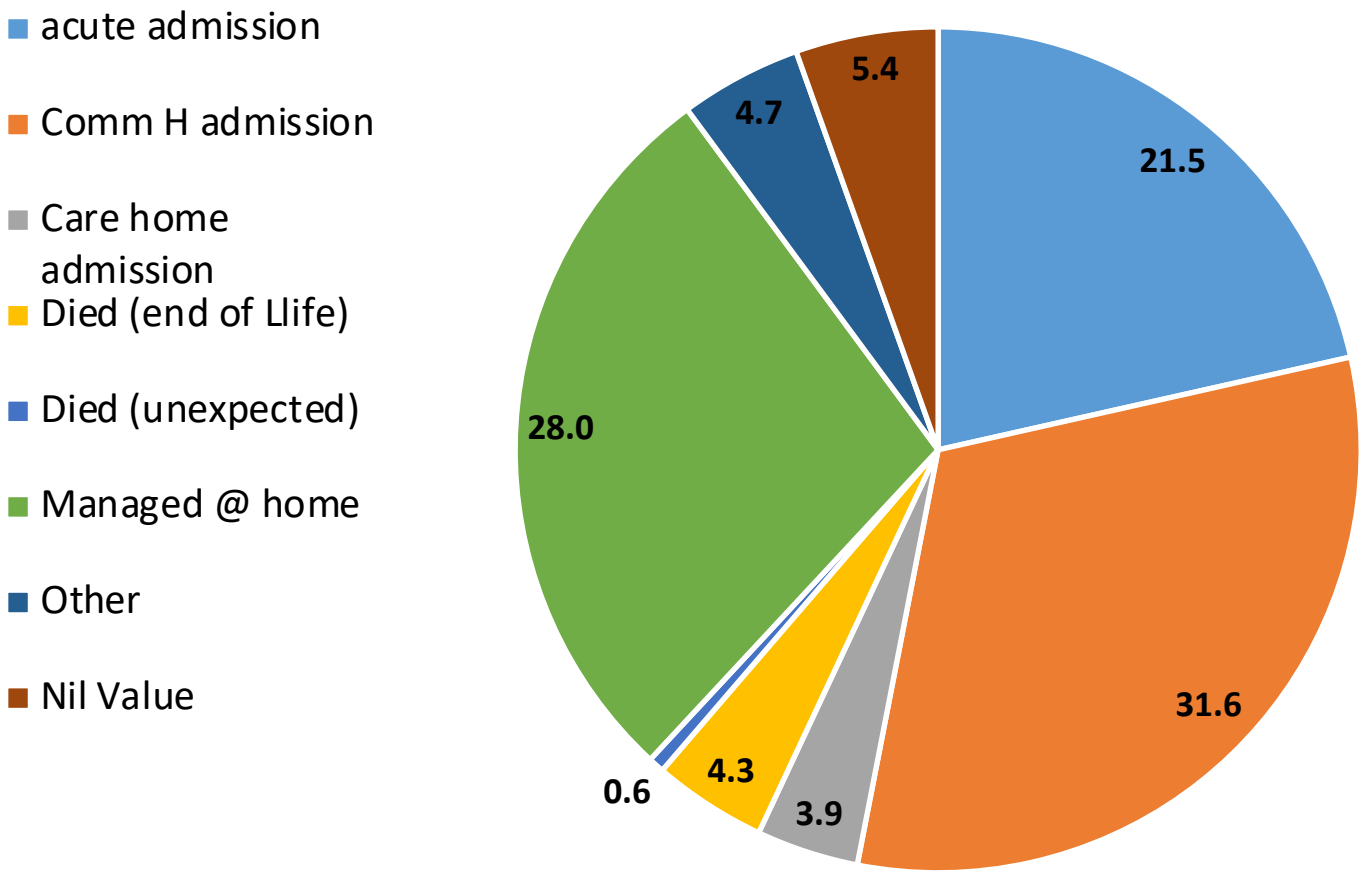
Length of Admission



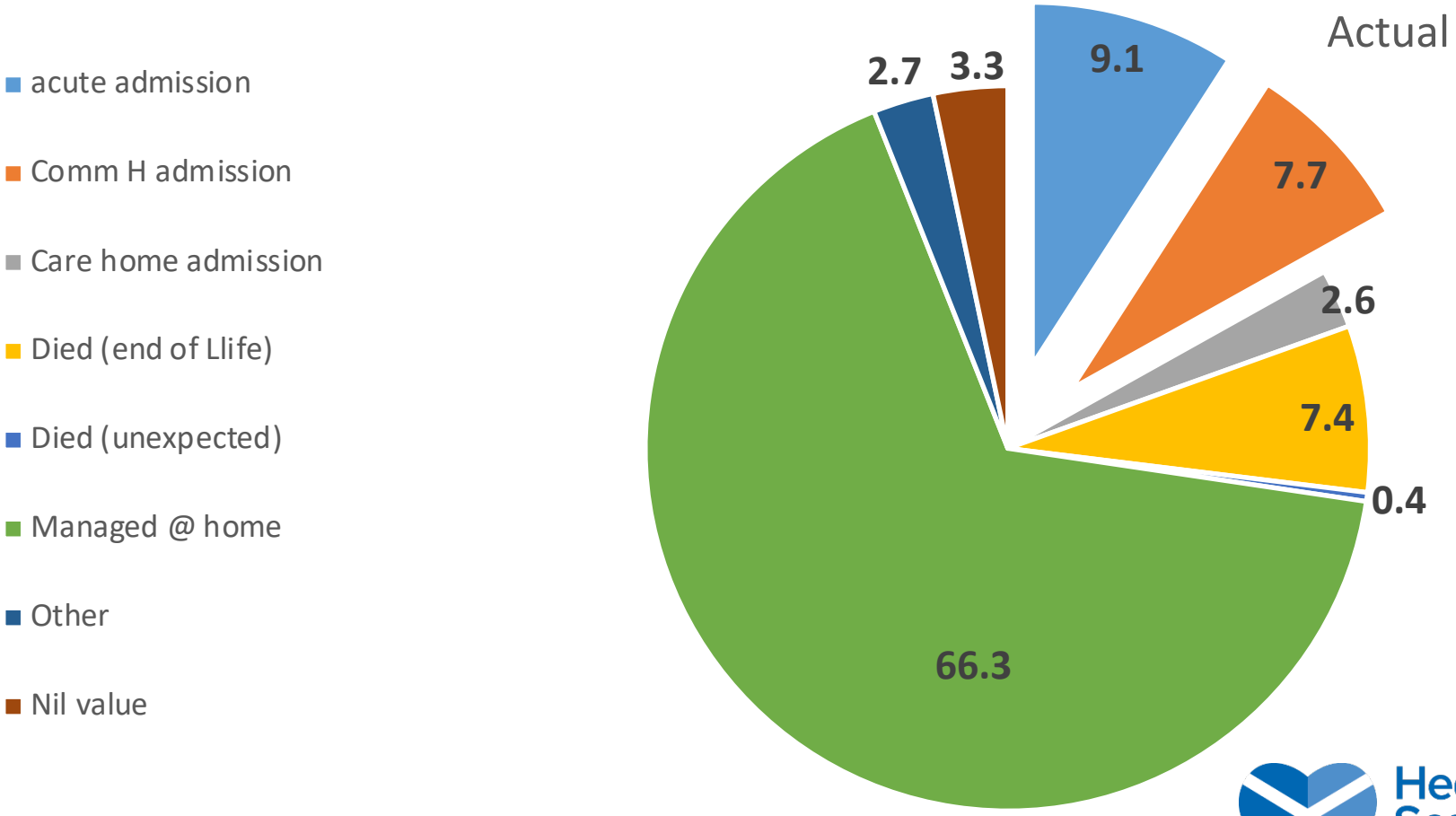
Reason for Admission



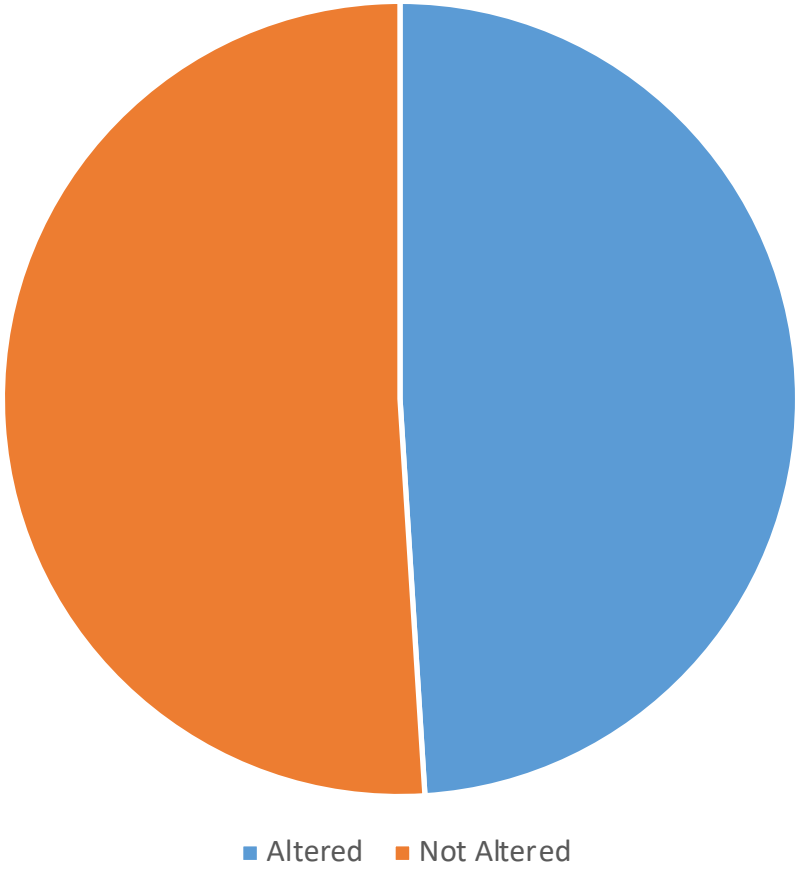
Presumed Outcome



Actual Outcome



Altered Outcome



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