Virtual Wards: developing seamless co-ordinated care

Solveig Sansom
Senior Commissioning Manager for Integration
Key Whole System Principles

- Robust alternatives to hospital admission
- Risk stratification and case management
- Excellent end of life care
- Smooth flow and discharge of patients through the system
- Specialist rehabilitation
Identification

- Predictive Model
- Real time data
- Local intelligence
- Co-ordinator, community matron and nurse practitioner
**Risk Scores in Previous 12 Months**

**Inpatient Variables**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Weight Rank</th>
<th>Present Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 distinct inpatient primary diagnosis (any episode) - last 0 to 730 days</td>
<td>91</td>
<td>No</td>
</tr>
<tr>
<td>4 distinct inpatient primary diagnosis (any episode) - last 0 to 730 days</td>
<td>99</td>
<td>Yes</td>
</tr>
<tr>
<td>1+ Emergency admission - last 0 to 30 days</td>
<td>20</td>
<td>No</td>
</tr>
<tr>
<td>Emergency admission - last 30 to 90 days</td>
<td>40</td>
<td>No</td>
</tr>
<tr>
<td>2+ Emergency admissions - last 30 to 90 days</td>
<td>19</td>
<td>No</td>
</tr>
<tr>
<td>Emergency admission - last 90 to 180 days</td>
<td>13</td>
<td>No</td>
</tr>
<tr>
<td>2 Emergency admissions - last 90 to 100 days</td>
<td>35</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency admission - last 180 to 365 days</td>
<td>69</td>
<td>No</td>
</tr>
<tr>
<td>2 Emergency admissions - last 130 to 365 days</td>
<td>55</td>
<td>No</td>
</tr>
<tr>
<td>3+ Emergency admissions - last 180 to 365 days</td>
<td>31</td>
<td>No</td>
</tr>
<tr>
<td>Emergency admission - last 365 to 730 days</td>
<td>39</td>
<td>No</td>
</tr>
<tr>
<td>2 Emergency admissions - last 365 to 730 days</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>Average number of episodes per Emergency admissions &gt; 3</td>
<td>92</td>
<td>Yes</td>
</tr>
<tr>
<td>Observed/expected ratio for rate of rehospitalisation for hospital of last admission</td>
<td>70</td>
<td>Yes</td>
</tr>
<tr>
<td>2+ Elective admissions - last 0 to 90 days</td>
<td>6</td>
<td>No</td>
</tr>
<tr>
<td>Any day case admission - last 0 to 90 days</td>
<td>81</td>
<td>No</td>
</tr>
<tr>
<td>ACS admission for fall - last 0 to 90 days</td>
<td>98</td>
<td>No</td>
</tr>
<tr>
<td>ACS ER/T admission - last 0 to 90 days</td>
<td>13</td>
<td>No</td>
</tr>
</tbody>
</table>
Monthly Combined Predictive Model

Primary Care and Complex Care Team Joint Meetings

Very High and High-Risk Patients Identified

Regular CPM report and VW Bod-state reviews

Admit to Virtual Ward

Daily interactions within team, Regular VW Ward Rounds and Reviews (cf. Core Group Meetings)

Virtual Ward staff = CCT and Primary Care

Exacerbation Pathways

COPD

Community Specialist Nurse Service
Consultant Outreach
Out-patient Review
Ward Assessment
Acute Admission

Community Specialist Nurse Service
Consultant Outreach
Out-patient Review
Ward Assessment
Acute Admission

Case Manager

PATIENT

Housing
ACS Social Worker
ACS OT
ACS CCW
Community Matron
District Nurses
CCT Co-ordinator (VW Ward Case)
CFT Physio
CFT OT
Mental Health
Voluntary Services
Rep
Charities (3rd sector)

GP
Practice Nurses

1. What is/are the most vulnerable factor(s) in the patients scenario?
2. What would be the tipping point and what event may cause an admission?
3. What can we do to improve or protect those vulnerable factors?
4. What have we put in place to ensure this happens?
Proactive Case Management

- Allocate appropriate case manager
- Identify patient needs - holistic
- Produce care plan
- Provide intensive support
- Patient experiences joined up seamless services
- Once stable, patient discharged
Enhancing function and co-ordination

Primary Care

Virtual Ward

Devon Predictive Model

Community Services

CQUIN LES

Service Specification & Investment
Case Study: David

- Male, aged 89, Charles Bonnet Syndrome, CKD, high risk score
- Socially isolated, small family network, not willing to engage with services
- Referred to VW Nov 2012 – discharged from hospital following fall.
- Community Matron case manager
- Voluntary sector input advice and benefits
- Day care services and befriending
- Social Services twice daily care package
- OT and physio input
- No subsequent admissions
Case Study: Freda

- Female, aged 88, dementia, high risk score
- Daughter providing 24 hour care
- DPT: mental health assessment
- Voluntary sector: befriending, sitting service
- Social Services: care package
- Regular respite care
- Contingency plan set up
Not on Virtual Ward?

- Richard, aged 44, works
- Primary Progressive MS, increasing falls
- Access to Work - Electric wheel chair
- MS society - DLA claim
- Physio – prescription for a walker
- OT (health) – hand holds in the house (Care & Repair)
- OT (social services) – Hand rail to house
- Private contractor – path to house
- DCC – financial assessment for stairlift
“I think this has only worked because my partners kept going at the risk models and we worked very hard relationship building with the community teams and social services to come to our monthly meeting. Since that happened we have made a difference in emergency admissions this last year. Down 20% over the previous year.”

GP, South Devon
Conclusion

• Need to identify right patients – mix of technology & local intelligence
• Need to be proactive in case management
• Need to be holistic
• Need right people in the room, face to face with good relationships