Surrey Virtual Ward Report – September 2012

NHS Surrey and Surrey County Council (SCC) have led the planned approach for spend against the Department of Health (DH) investment for Partnership Grant in 2011/12 and 2012/13. Based on local need, it was agreed that the priority for this funding was to develop a whole system, integrated re-ablement and recovery service centred on promoting, recovering and maintaining levels of independence and self care wherever possible.

A number of projects were set out in the plan which included pump priming the set up of virtual wards in each Clinical Commissioning Group (CCG) area.

Virtual Wards

The virtual wards aim to reduce the number of patients who are admitted unnecessarily to hospital whilst improving the experience and quality of care that patients receive

Virtual wards are intensive case management services led by community matrons who identify proactively the most complex patients most at risk of an admission to hospital and provide a high level of care and support, tailored to their specific needs, in their own home or place of residence – i.e. care home.

Virtual Ward Team

The day-to-day clinical work of the ward is led by a community matron who works with the patient's GP as a link to community and social care services. The team includes an identified social worker and mental health nurse as well as, when required, primary care pharmacists, specialist nurses (e.g. heart failure, Parkinsons, palliative care), therapists and other specialist community teams.

A key member of staff is the ward clerk who is the first point of contact with the patient and is able to collect and disseminate information between patients, their carers, GP practice staff, virtual ward staff and hospital staff.

Medical input comes from telephone and face to face contact between the community matron and the patient's GP for routine matters, and the duty on-call doctor for more urgent contact at each constituent GP practice.

The virtual wards have close working relationships with organisations such as hospices/palliative care staff, ambulance services, out of hours GP service and voluntary sector agencies.

A typical virtual ward pathway would include:

Identification and 'referral' process

- Identifying suitable patients proactively using a recognised risk profiling tool. In Surrey most CCGs have signed up to use the Surrey adapted Combined Predictive Model (CPM). This is a tool developed by the Kings Fund which has been developed into a Surrey model by Docobo.

The CPM predicts the risk of someone being admitted to hospital in the next year. The risk is informed by many factors including unplanned use of services, age, number of long term conditions, number of medications etc.

The data is the main way that community matrons will identify suitable patients for case management with the GP practices. In addition, patient referrals for assessment for the virtual ward where beneficial will also be accepted.

- Practices can actively get involved with identifying suitable patients or agree that the community matron can suggest patients based on the review of the patients' risk scores.

Assessment
- Contacting the patients to consent to assessment
- Health and social care integrated assessment and carers assessment (if required)

Case management
- Integrated case management – this is for a time-limited period to establish services and support for people which, once in place, can enable the patient to stay at home (some patients will require longer than others to achieve outcomes).

  The patient's personalised care plan will be developed, agreed and regularly reviewed and updated by the multi-disciplinary team (MDT) and the patient and carer. This will be shared with the GP practice.

  The matrons will be able to admit into a community bed if necessary and will oversee the delivery of the personalised care plan reporting regularly at their weekly MDT meetings.

Step down and discharge
- Discharge/step down – patient will either be:
  - Discharged back to the GP for supported self care,
  - Maintained by community and/or social care services, or
  - Kept on an 'observation' ward for ongoing multi-disciplinary review as required.

Who would benefit from admission to the virtual wards?
People who have:
1. Two or more hospital attendances or admissions in six months (this includes an A&E attendance but excludes planned surgical and outpatient appointments)
2. Two or more GP home visits in three months
3. Two or more GP surgery consultations in three months
4. A current, recent or severe exacerbation of a long-term condition
5. Two or more active chronic conditions

6. Polypharmacy (four or more long term medications)
7. History of poor concordance with prescribed medication
8. History of poor attendance at health promotion opportunities
9. Recurrent falls
10. Recurrent urinary tract infections
11. Individual may live in any care environment
12. Patient and GP give consent for admission

People in care homes
If the CPM data identifies patients who live in a care home – nursing or residential – the Community matron will contact the home to arrange a visit to carry out an assessment.

What happens when the patient is ready for discharge from the virtual ward?
Virtual ward patients are expected to stay on the 'ward' for a set period. Some patients will not require this length of stay whilst others will require longer. The length of stay will be assessed on an individual basis. Depending on the patient need services will be put in place which will support the patient long term after discharge. After discharge the patient will be given information and an ongoing management plan.
They will be provided with information about contacting the service if their condition changes or worsens. If required readmission to the virtual ward can be arranged.

How will we know if the virtual wards are making a difference to patients?
Information will be collected about the patient on admission, during case management and at a set time after case management to monitor the impact of the virtual wards. In addition they will also be getting patient feedback about how supported they feel to manage their LTC(s) and how confident they feel in managing their condition(s).

Developing Local Models
Each CCG has been able to develop its own local model of delivery, working with community, mental health and social care services to agree how this would be set up and implemented but each had to demonstrate that key requirements were met to include:

- Proactive case finding using a predictive tool and local intelligence
- Integrated assessment and case management
- Personalised care planning
- Supported self management including provision of information, structured education and use of Telecare and Telehealth where appropriate
- Link with the mental health partnership project for providing 24/7 mental health support for older people with dementia or mental health conditions (optional)

Implementation
A phased planned approach to implementation has been established in all CCG areas. Community services have led on this: developing local pathways, establishing MDTs and providing regular updates to their local transformation boards.

Quality, Innovation, Productivity and Prevention (QIPP) Programme
Virtual wards are included in the NHS Surrey transformational QIPP programme which aims to ensure quality is maximised and processes are efficient, evidence based and cost effective.

The NHS Surrey QIPP Target is for Virtual wards to be fully operational in all CCG areas by end of October 2012 in order to achieve the required reduction in unplanned care activity.

Future Plans

- To work with primary care to ensure the CPM tool can be used to support a more proactive care approach for all people with long term conditions to enable targeting of appropriate interventions
- Phase 2 of the CPM project is expected by the end of September which will include more conditions, improved ease of use and in addition the inclusion of end of life indicators which will help clinicians identify when the patient has reached the end of life phase and needs to access appropriate services and support including advance care planning and specialist palliative care.