NHS
Shropshire
Community Health
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Shropshire, Telford and Wrekin Virtual Wards

Information Leaflet for Professionals

Version 2: 2024-03-28

What is Virtual Ward?

Virtual Wards (also known as hospital at home or NHS@home) allow patients to get hospital-like level care at home safely and in familiar surroundings, helping speed up their recovery while freeing up hospital beds for patients that need them the most.

Those cared for on Virtual Wards are looked after by a multidisciplinary team led by a Consultant. Patients are managed by a combination of house visits, video calls, telephone calls and remote monitoring solutions. The clinical team formulate an acute/ subacute management plan to try to limit the patient's time in hospital or to prevent admission to hospital.

The patient should remain on the Virtual Ward (VW) for no more than 14 days as this is a key period post hospital discharge, as well as during an acute illness.

The service operates across Shropshire, Telford and Wrekin between the hours of 0800-2000hrs, 7 days a week.

What is the evidence for Virtual Ward?

Being in hospital results in a lot of iatrogenic harm, which often is underestimated, such as: deconditioning, sarcopenia, psychological distress, delirium, potential hospital acquired infections, manifold increase in falls risk.

Multiple studies show (recently: https://evidence.nihr.ac.uk/alert/hospital-at-home-good-option-older-people) our Frailer patients (particularly those with a clinical frailty score 5 and above) benefit the most from Virtual Ward/ Hospital at Home. Showing it is, at worst, non-inferior to hospital admission, with several indicators which confer favourable outcomes over hospital admission.

What can Virtual Ward do for patients?

Virtual Ward can offer an enhanced service in the community including subcutaneous fluids, Intravenous (IV) antibiotics, remote monitoring, and other parenteral therapies to keep the patient at home, thereby avoiding hospital admission or utilised to provide early supported discharge from secondary care.

Current pathways include IV therapy for Pseudomonas related Bronchiectasis exacerbation, Cellulitis and Extended Spectrum Beta Lactamase producing (ESBL) urinary tract infections, as well as subcutaneous fluids, a Heart Failure pathway which includes IV diuretics, and an Acute Respiratory Infection with oxygen weaning. The team is working on more pathways and when these are agreed and ratified further information will be shared.

What will Virtual Ward not be able to do for patients?

Unfortunately, we cannot perform routine house visits for patients, keep the patient on the caseload long-term, take over the responsibilities of the practice or district nurses. Regrettably, we cannot prevent all admissions to hospital. Virtual Ward is also not a 24-hr inpatient service.

Who is suitable for Virtual Ward?

As mentioned, our frailer patients would benefit the most, but many other patients who are not in this cohort will also benefit.

Potentially suitable patients (not exhaustive):

- Care Home residents.
- Patients who are housebound.
- Patients who have a package of care.
- Frequent hospital attenders (two or more admissions last 6 months).
- Any patient who is deemed to be suitable for an advance care plan to say they should be for community-based care only or the patient does not wish to go to hospital.
- Patients who meet the criteria for community IV pathways.
- Those who would benefit from assisted hydration (e.g. subcutaneous fluids).
- Patients who need oral antibiotics but close monitoring.
- Patients who need urgent blood monitoring to be stepped down from hospital or in the community (for example monitoring of inflammatory markers or electrolytes).
- Anyone patient who does not meet the hospital right to reside criteria.
- Patients on palliative care/ End of Life register, but not in terminal phase. Or patients who are more appropriate to palliate given clinical history and presentation.
- Patients who can be weaned off nebulised therapy in the community or require nebulised therapy in the community.
- Certain patients who may find admission distressing (e.g., Advanced Dementia, Learning Disability).
- Patients already under community teams or recently seen by Virtual Ward.
- Patients with acute exacerbations of chronic disease.

How does this work with Rapid Response (now Urgent Community Response)?

Rapid Response can be seen as the emergency department/ acute medical unit of the community teams, where a 2-hour response is needed. If the anticipated duration of the patient's recovery is less than 72hrs, then the patient may remain under the rapid response team. If the anticipated recovery time is more than this, or the needs are deemed more complex, then the patient can be transferred across to the Virtual Ward.

Currently, the Primary Care Team retain medical responsibility for the rapid response patients, however, should the team feel the patient's presentation would be better managed by the Virtual Ward team then they can inform the rapid response service and the patient can be transferred to the Virtual Ward.

How do I refer to Virtual Ward?

You can call the Virtual Ward referral line on 07974 080 415 to discuss the case and email relevant information to the Virtual Ward email shropcom.vw@nhs.net. It is usually better to discuss the case over the phone first.

What is expected from the Referrer?

Clear SBAR (situation, background, assessment, and recommendations for the Virtual Ward) referral, forwarding important relevant information, such as discharge summary if from the hospital, or EMIS summary from the primary care team with recent consultation(s).

Who holds Medical Responsibility for the Virtual Ward service patients?

During the Virtual Ward admission, medical responsibility is held by the Virtual Ward Consultant, GP with Special Interest, or suitably qualified Consultant ACP.

How do we know if someone is on the Virtual Ward?

An onboarding letter should be sent to the patient and the Primary Care Practice with information about the reason for admission.

The patient will also be given an information pack which will include the appropriate lines of escalation.

What is expected of the Primary Care Team?

During the stay on Virtual Ward, the Virtual Ward will endeavour to ensure the acute / subacute patient needs are met from a medical, nursing and therapy point of view. However, there may be pre-existing Practice appointments, which the patient should keep (i.e. joint injections) or special requests that maybe made of the practice, for example, assistance with compliance aids.

What about repeat medications?

Repeat Medications would remain the domain of the Primary Care team as the patient will be on the virtual ward for only a short period of time, and therefore the practice would be uniquely best placed to renew the prescriptions. If the patient is running low on medications, they will contact the Virtual Ward team, who will liaise with the GP practice, thereby preventing medication errors, waste and encouraging patient autonomy. If there are any medication queries the virtual ward team would be happy to confirm the current medication with the Practice.

Please note any new medication will be prescribed by the Virtual Ward team and at least 7 days' supply will be given on discharge, should it need to be continued. Also, any changes to existing medication will be clearly communicated to the patient and/or their carers.

How will I know if any of the medications are altered?

The Practice will get an updated medication list on discharge, much like a hospital discharge letter. During the stay we will not inform the GP practice of changes, like a hospital stay, although feel free to call the VW line if you require any updates or have any queries.

The discharge medication will undergo a clinical review on discharge from the Virtual Ward.

What happens if a patient dies whilst under the Virtual Ward service?

We will endeavour to inform the Practice in good time if the team feels that the patient is deteriorating to the point that they are in the last few days/ weeks of life and will discharge the patient back to the care of the GP with appropriate medication and support services in place. However, if there is a sudden death and no one from the practice can complete the medical certificate of cause of death (MCCD) the Virtual Ward Doctors will complete the paperwork. Please discuss with the team.

What happens on discharge from Virtual Ward?

A discharge summary will be sent to the patient and the Primary Care team. The patient's usual community pharmacy will be informed of significant medication changes, where appropriate.

Who can I speak to if there is an issue with a Virtual Ward patient or if I need further information?

For any professional enquiries relating to the service or to discuss patients who are currently supported by Virtual Wards please email shropcom.vw@nhs.net leaving your preferred contact details, and a brief summary of your query, and we will get the most appropriate person to call you back as soon as possible.

For anything that is time sensitive please call 07811 946 946.

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Virtual Wards & UCR

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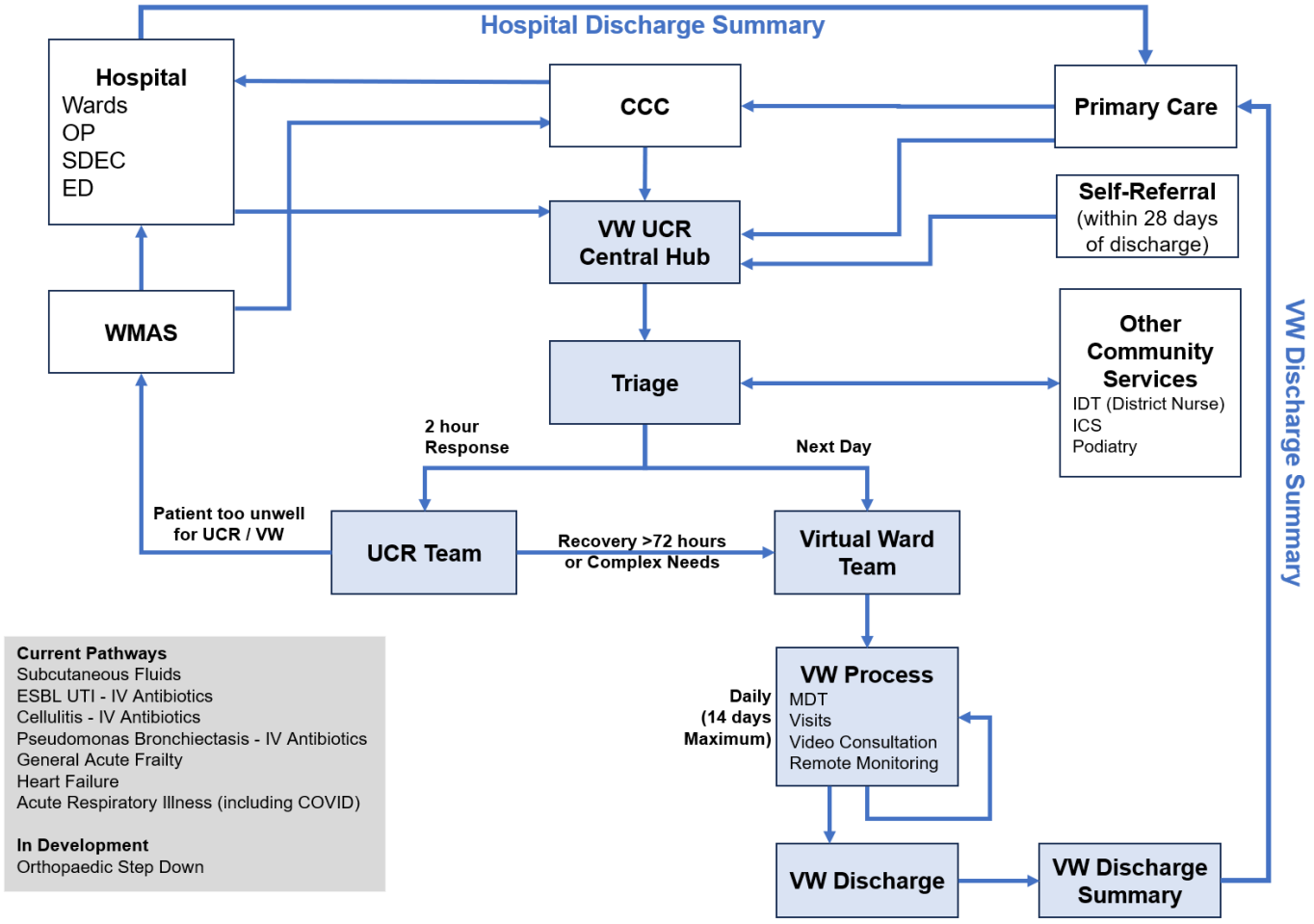

Call us to refer

07974 080 415

Send any requested documents

shropcom.vw@nhs.net