NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

# BSW Virtual Wards

## For PCN / Practice Pharmacy Teams Webinar

10 January 2024

# Introductions

**Swindon:**

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# What are Virtual Wards?

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## virtual ward

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A virtual ward is a safe and efficient **alternative to NHS bedded care**.

Virtual wards support patients who would **otherwise be in hospital** to receive the acute care and treatment they need in their own home.

This includes either **preventing avoidable admissions** into hospital, or **supporting early discharge** out of hospital.

- **The acuity and complexity of the patient's condition differentiates virtual wards from other community and home-based services**
- It provides **urgent access to hospital-level diagnostics** (such as endoscopy, radiology, or cardiology) and may include bedside tests such as **point of care (POC) blood tests**
- It provides **hospital-level interventions** (such as access to intravenous fluids, therapy, and oxygen)
- It requires **daily input from a multidisciplinary team** and sometimes **multiple visits and provisions** for 24 h cover with the ability to respond to urgent visits, often **enabled by technology**
- It requires **consultant practitioner specialist leadership** and **clear lines of clinical responsibility**
- **Defined inclusion and exclusion criteria**, with defined target population and deliver a **time-limited short-term intervention** of 1–14 days.
- **VW patients have equity of access to other specialty advice as though an in-patient**.

# BSW Virtual Wards / NHS@Home

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Provided by four providers

- Swindon – GWH Community Services
- Wiltshire – Wiltshire Health & Care
- BaNES – RUH
- BaNES – HCRG

Aim is for one model of care across BSW

Short duration – up to 14 days

# What happens in a VW?

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**Step down patients**

- Patients discharged from hospital or having been seen in ED / SDEC etc although not ‘medically fit’
- Could be IV pathways eg IV antibiotics, IV furosemide, IV fluids
- Could be enhanced monitoring – remote monitoring
- Bloods / other tests
- Use of NEWS2 for detecting deterioration
- Co-ordination of care and other needs

**Step up patients**

- From primary care
- Patients who would usually go to ED / SDEC / hospital
- Hospital avoidance
- Enhanced monitoring – remote monitoring
- Bloods / other tests
- Use of NEWS2 for detecting deterioration
- Co-ordination of care and other needs


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# Benefits of a VW

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**People using virtual wards and their carers**

- People are cared for in familiar surroundings supported by remote monitoring technology and digital tools
- People are less likely to decompensate while acutely unwell, meaning they do not need as much increase in care provision when they recover
- Opportunity for medicines optimisation and reduced side effects from poly-pharmacy
- Opportunity for people to become more confident in use of digital technology to manage their condition, and reduction of digital inequalities through support given
- A shared decision is taken between people and health professionals about the most appropriate place of care
- Learning from COVID-19 virtual wards shows that people who deteriorate can be escalated sooner with better outcomes, less intense care and more easily supported to self-manage

# Benefits of a VW

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**Staff**

- Improved job satisfaction
- Opportunities to experience different ways of working and develop new skills

**System benefits**

- Improved flow through acute hospitals due to reduced admissions, length of stay and timely discharge
- Improved positive risk taking in managing clinical risk for people staying at home
- Improved collaboration and integration across system as MDT approach taken with potential to develop an end to end pathway
- Reduction in care packages being stopped and needing restarted due to hospital admission, reduction in numbers of people being discharged to care homes due to becoming decompensated as looked after in their own home.

# National pathways

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## Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

**Scoring frailty in people with dementia**

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.



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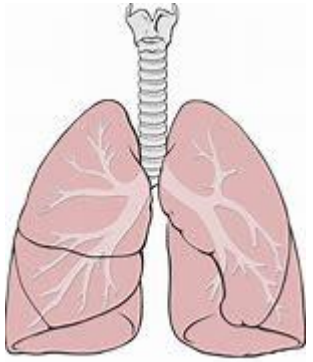
**Frailty**

## Acute Respiratory Infection



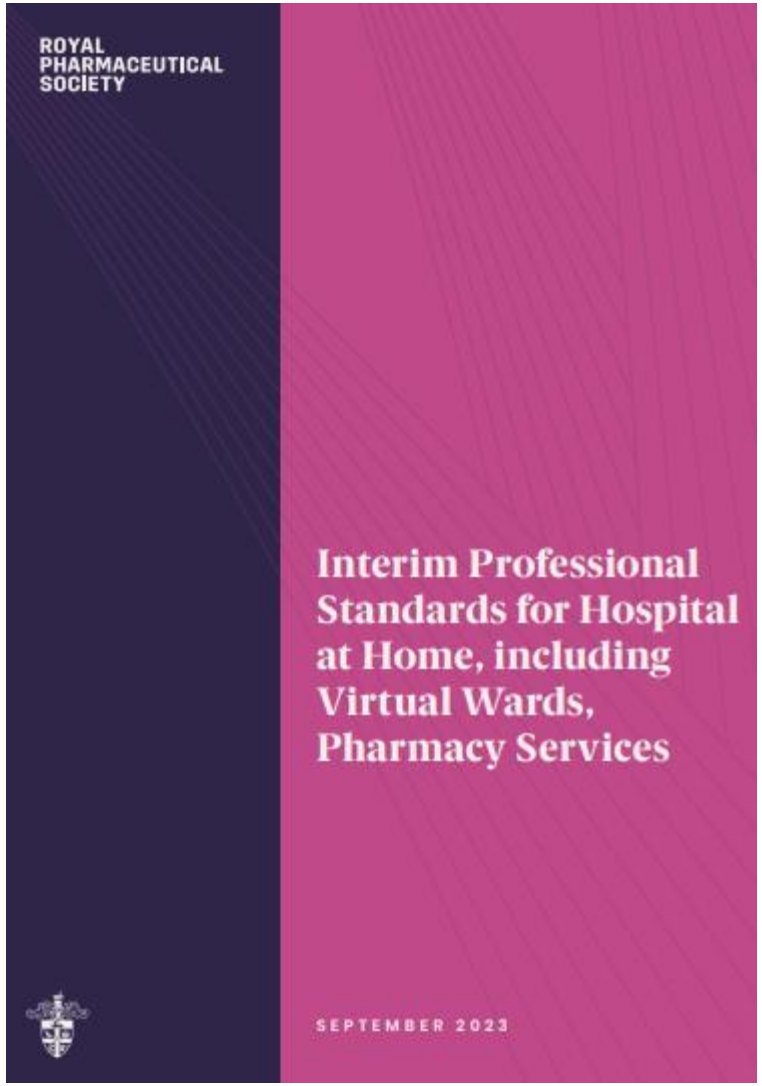
# Where does pharmacy come in?

National Interim Standards produced by the Royal Pharmaceutical Society and NHS England – covers Scotland, Wales and NI as well.

Outlines what pharmacy services should look like within VWs.

8 key standards:

- Putting people first
- Episode of care
- Integrated transfer of care
- Medicines and pharmacy services governance
- Safe and efficient supply of medicines
- Leadership
- Systems of work
- Workforce



# Working together

*How do you know your patient is on the Virtual Ward?*

SystmOne notes (Swindon, Wiltshire, HCRG – not RUH)

*Where do patients get their medicines from on the Virtual Ward?*

This depends on the service

*What about medicines reconciliation / medicines optimisation?*

This should happen during their stay on the Virtual Ward – variation in current service

*What happens on discharge from the Virtual Ward?*

GP practice will have a discharge letter from the Virtual Ward

# Additional resources

NHS England » Virtual wards

Interim Professional Standards for Hospital at Home (rpharms.com)