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Welcome to The National NHS Virtual Wards Summit!

7th November 2024
15 Hatfields Conference Centre,
London SE1 8DJ

Chair Opening Address

Dr Gurnak Singh Dosanjh
GP - LLR ICB

Keynote Presentation

Tracy Stocker
Director of Operations for Flow and Integration - Medway NHS Foundation Trust

Unlocking Virtual Hospitals

Tracy Stocker

Director of Operations, Flow and Integration

Medway NHS Foundation Trust

SRO Virtual Ward Programme Medway and Swale HCP

NHS Medway NHS Foundation Trust

Patient FIRST

Medway NHS Foundation Trust

- Acute Trust serving a population of more than 427,000 people across Medway and Swale in Kent.
- Some wards in the 10 per cent most deprived areas in the country.
- High DNA rates, late presentation of disease and greater acuity / chronic complexity with increased co-morbidities.
- Servicing vulnerable patients across seven prisons and young offender institutions in Kent and Medway.
- Higher health needs at an earlier age than the general population.
- Ethnic minority groups report poorer health poorer experiences when using health services.
- SEDIT data 100 beds short
- 2 community CIC / Private and 2 LAs

What do virtual wards look like in England?

Medway NHS Foundation Trust

".. little clarity on what is needed to ensure effective and safe virtual wards… various models are so new, research has not yet addressed how virtual wards can use technology safely and effectively".

"Frailty, acute respiratory infection and heart failure … estimated at 65% of virtual wards in England [April 2023]"

The Health Foundation

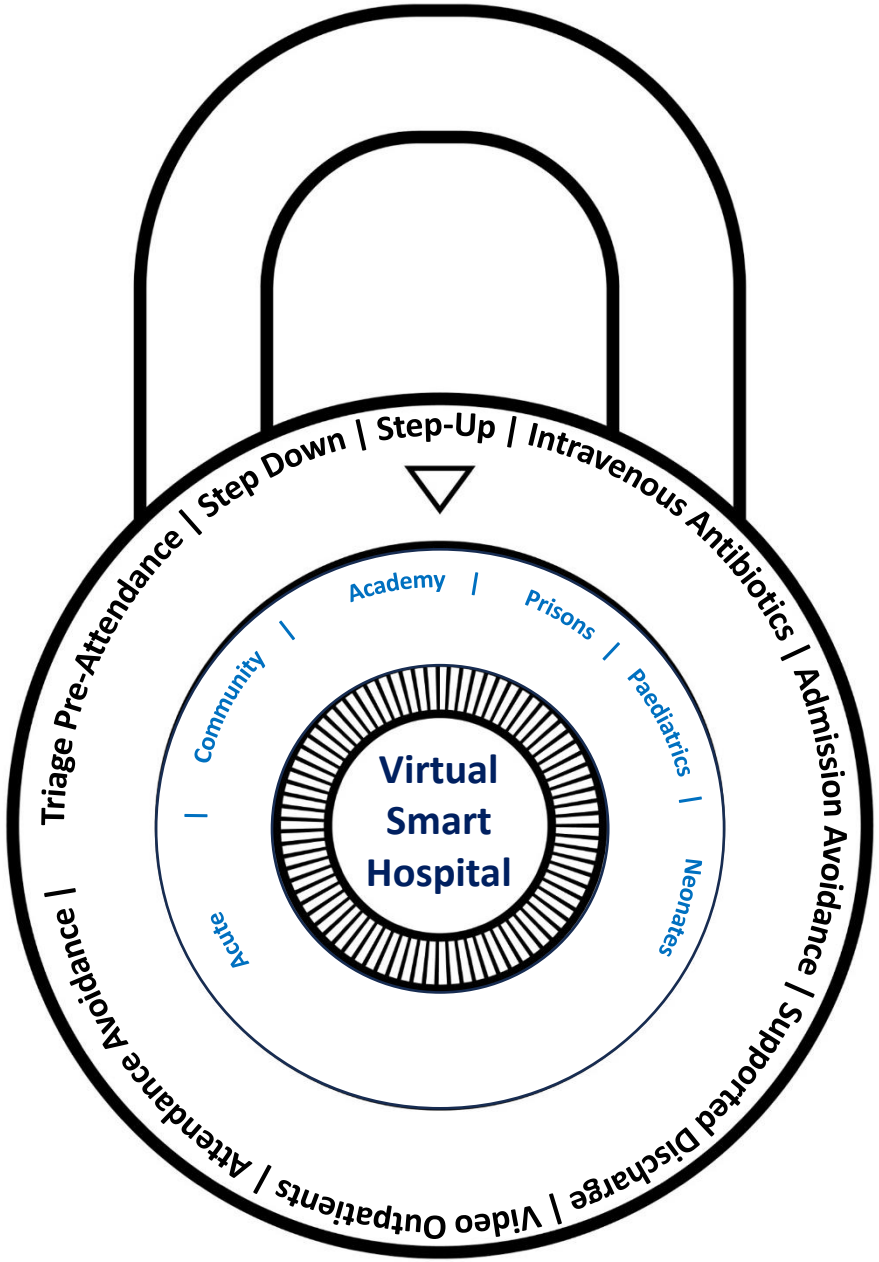
“The SMART (Surgical Medical Acute Recovery Team) VW is an innovative service that seeks to accommodate general medical and surgical patients into a step-down model of care in order to facilitate flow in the acute provider site.”

“The service has well-established step-down pathways which generate over 90% of their referrals”

“The virtual ward is already exceeding capacity, so it is essential that the ward is discharging patients appropriately in order to free up capacity for those who need it most” (LOS)

SMART Virtual Ward Review: 19/12/2023

“Acute episode of care”



Truly acute VW

With the new additions of prisons and the academy as the latest concepts

Alternative pathway thinking:

- Bottom up – Patient First

Each single Virtual Hospital pathway needs to accommodate patients with different care requirements E.g. respiratory patient from an acute respiratory ward, an emergency department or going into the academy (self-managing)

- Top down - system thinking

Pathway governance must accommodate multiple types of patient moving through multiple organisations

Acute

80 beds with occupancy above 100

Admission Avoidance from:

- ED
- SDEC
- FSDEC
- AAU
- SAU
- Outpatients
- Community VW
- Hot Clinic

Step Down from an Acute Bed into the AVW:

- Frailty
- Spec. Med.
- Acute Med.
- Surgery
- Theatre recovery
- Elective
- Obs and Gynae
- Oncology

Early Supported Discharge:

- Orthopaedics

HCRG

Community VW
20 beds

step up from GP and community services

- Frailty
- Heart Failure
- Respiratory
- other

Step down from Acute wards and from Acute VW

MCH

Community VW
25 beds

step up from GP and community services via Urgent Response

- Frailty
- Heart Failure
- Respiratory

Step down from Acute wards and from Acute VW

Prisons

Pre-Attendance Triage

- Triage for suitable clinical pathways in the prison overseen by AVW physician

Admission Avoidance from:

- ED
- SDEC
- FSDEC
- SAU
- AAU

Step Down from an Acute Bed into the Prison VW:

- Frailty
- Spec. Med.
- Acute Med.
- Surgery
- Theatre recovery
- Elective
- Oncology

IV pathway

Virtual Out-Patients for appropriate services

Paediatrics

Neonatal Pilot

- Enabling clinically well babies to go home with family with Team Noah support. Family provided with feeding equipment and scales

Paediatric respiratory VW in scope

Academy

Using technology and CNS expertise to set up clinical parameter to be monitored alongside education, advice and tips to manage condition at home, prevent exacerbation and ED attendance. Supported by the VW team using technology and apps.

- Heart Failure
- Respiratory

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8 Steps to unlock Virtual Hospitals

NHS Medway NHS Foundation Trust

1. Clinical Governance Model

Wider stakeholders inside the oversight of this scaling service. Maintain effective clinical responsibility for referred patients alongside existing clinical pathways - Mapping to one reference document for pathways. System level governance model - participation, reports, procedures and policies

2. Correct remote monitoring devices

How the right technical solution will allow your virtual hospital service to increase in capacity and have capability to manage a broader set of care over the next few years.

3. Staffing

The right staffing template and skill mix to deliver a virtual hospital

Extending into Care Homes, Prisons and operating as 24 Hrs a day service

4. System Integration

Scaling requires bringing the ICS' Virtual Hospital together to act in a coordinated fashion. The right patient information from each electronic patient system shared in real time as remote monitoring remains with patient

5. Evolution

Virtual care is evolving rapidly. This work will provide a live virtual hospital shared platform allowing for service adaptations, new innovations and evidence

6. Data Management and ROI Mapping metrics, outcomes, KPIs. A reporting overlay providing an integrated view. Covering patient, staff, clinical and system/financial data & feedback. Identifying current and desired data. Improve clinical safety, minimise duplication, increase flow and capture and report on evidence of effectiveness

7. Faster Data Flows Minimal Viable Product

Medway has been selected as Federated Data Platform Incubator Site.

This will require a single data specification from RPM, through EPRs, SCR to FDP and ROI.

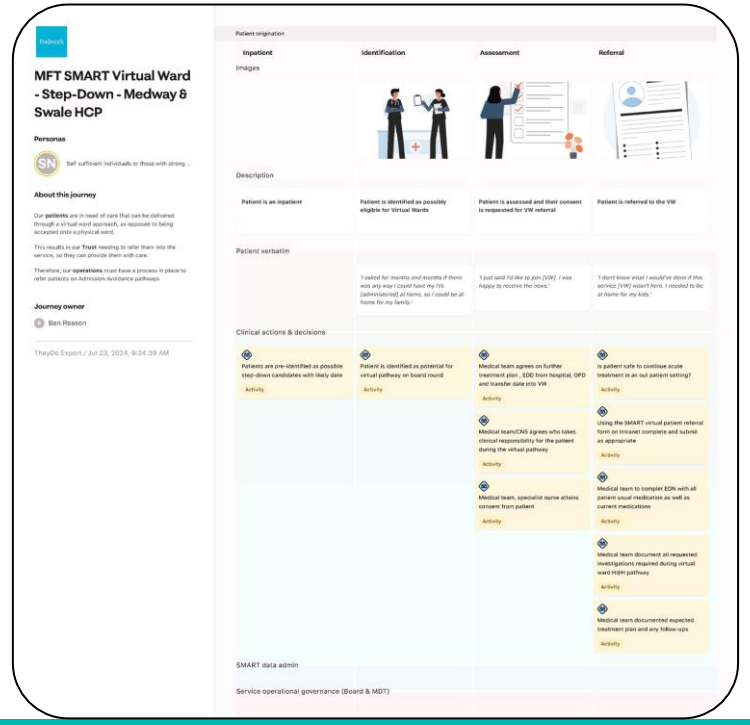
8. Funding

Intention is to develop a detailed Business Case to support scaling for ICS and Trust

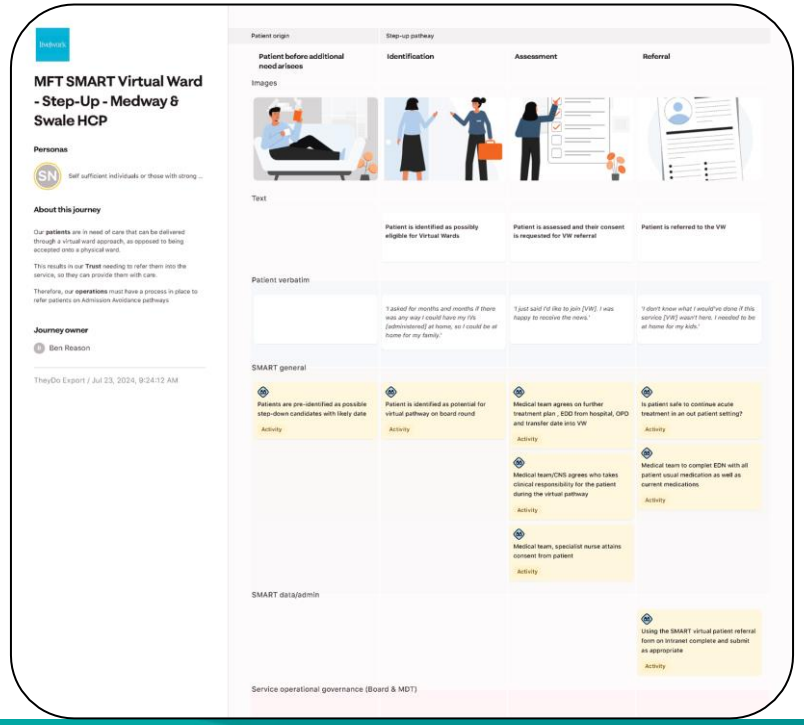
Pathways

We have mapped the pathways for the SMART ward
This give us the framework to add Community VWs
To build new pathways such as for frailty
To create new Virtual Wards for Prisons

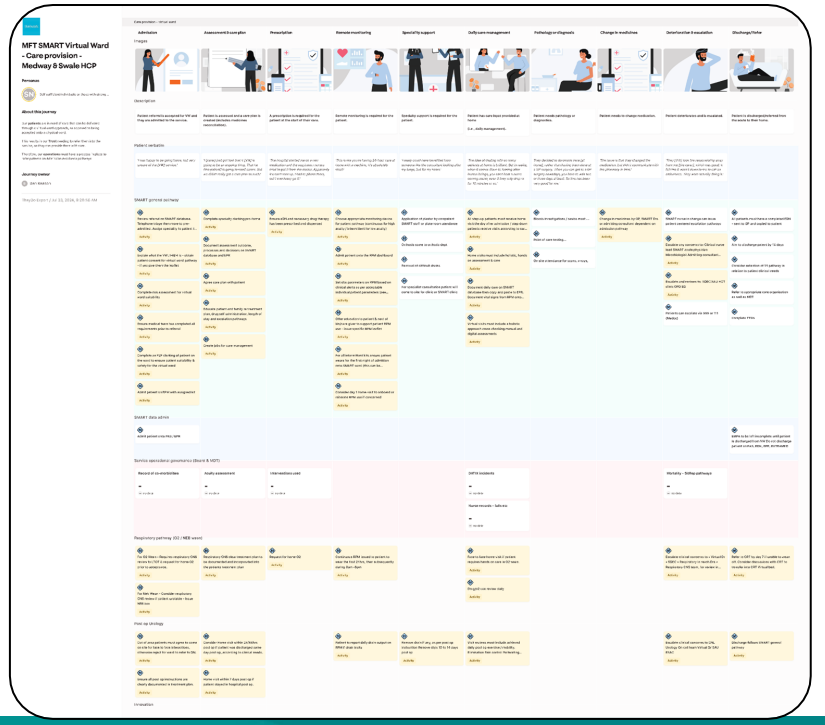
Step-up (Admission Avoidance)



Step-down (Early Supported Discharge)



Care on SMART ward



Pathways overview

The pathways are structures to provide a common and comprehensive frame ‘map of maps’. All specific clinical pathways can be created from a common baseline structure.

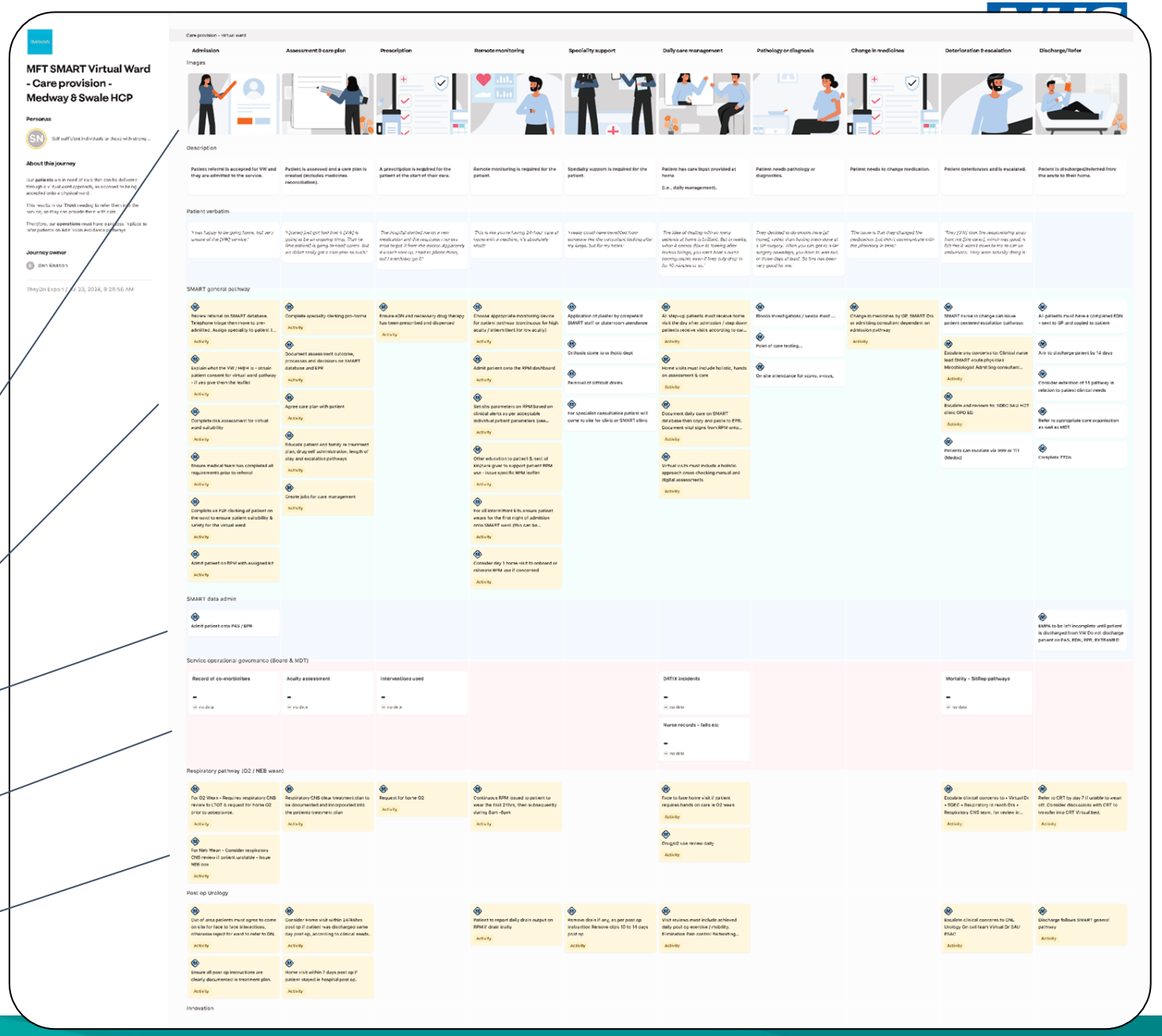
Patient experience structures around comprehensive view of activities from admission to escalation

General process & activities for SMART

Administrative actions – EPR

Metrics

Pathway specific process and activities e.g. Respiratory o2 Wean



Pathways dashboard

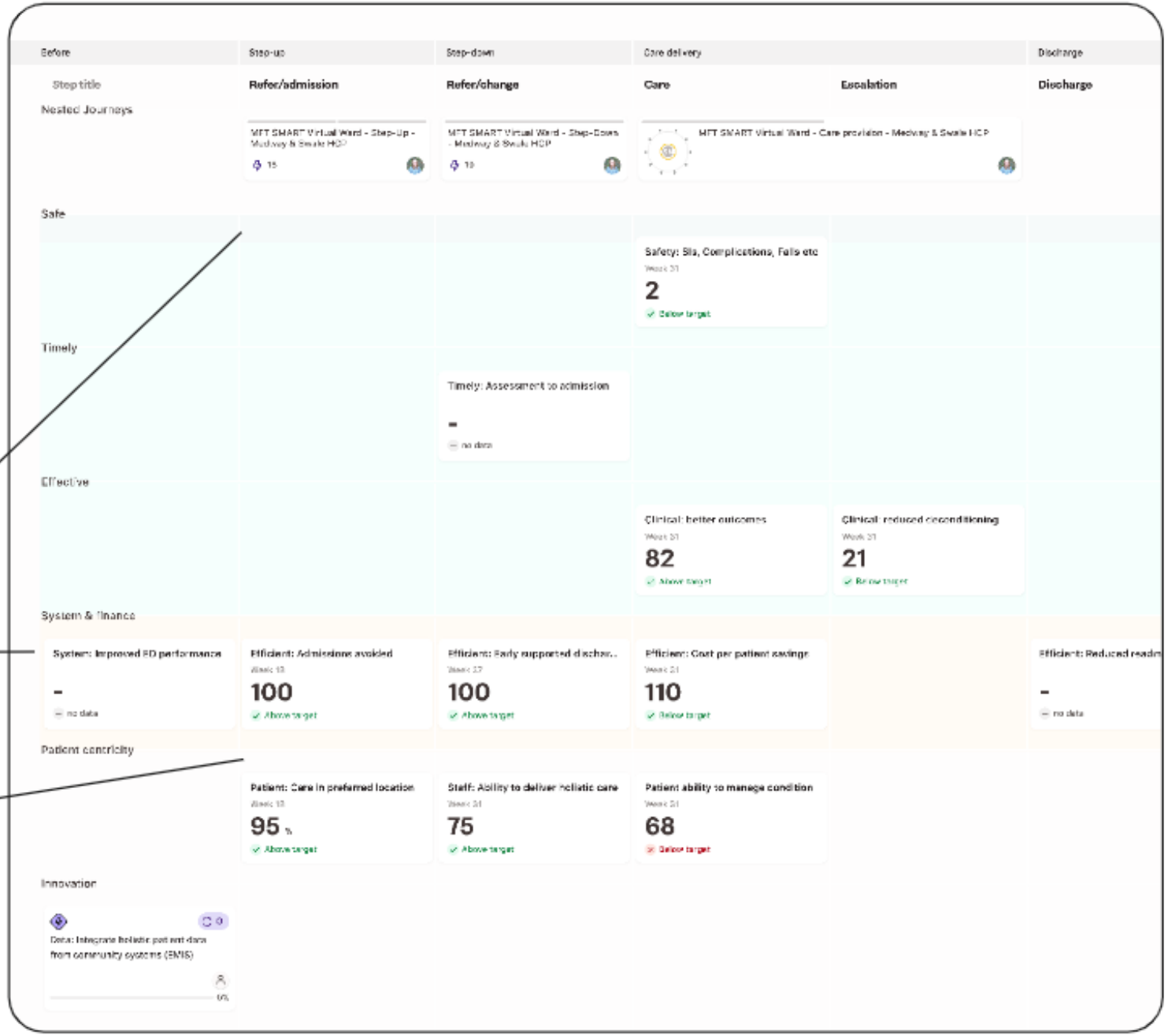
Our ambition is to align outcomes and metrics to the pathways at all levels levels:

1. Executive governance
2. Op board etc
2. Ward operations

Aligned to the pathways - step-up, step, down and key aspects of care on the ward

Using CQC framing - Safe, Effective, Caring, Responsive, Well Led + Efficient,

Specific metrics tracked over time



Towards more sensible collaboration: a map of maps

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The Patient Journey Framework is a dynamic, evolving document.

It is never really finished as you keep on improving and expanding your services. You can update it with new pathways, SOPs, or even services (e.g. prison VW, patient academy).

The framework is broken down into different "levels" which represent different layers of "zoom."

As with every model, this is an **imperfect representation of reality**, but it will help us:

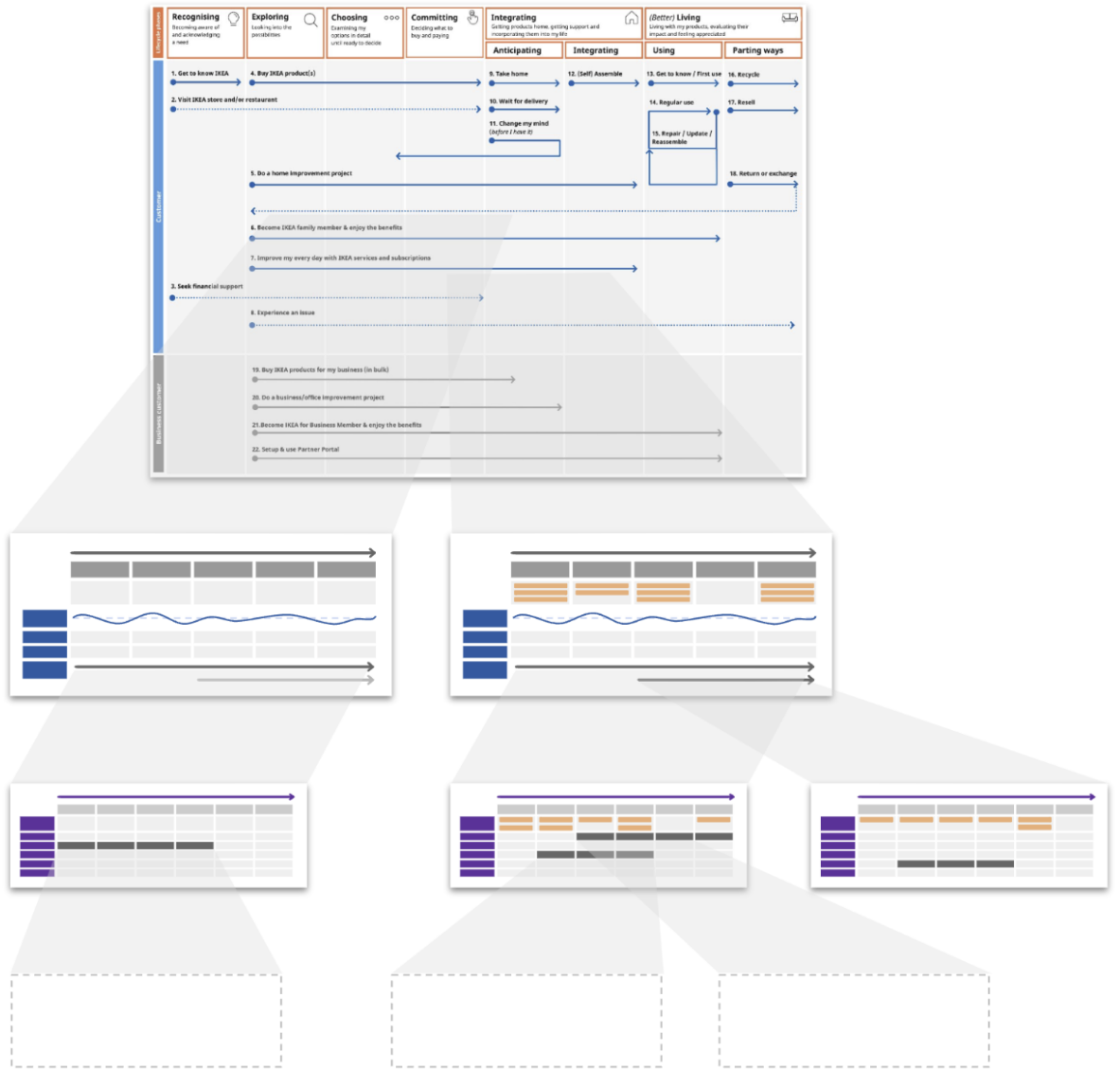
- establish a shared view of our patient and staff experiences;
- enables stakeholders at different levels to understand the scope of our services and their part in it;
- orient and inform your decisions around governance, metrics, reporting, and so on.

The framework is (and should be) **co-created by all teams involved.**

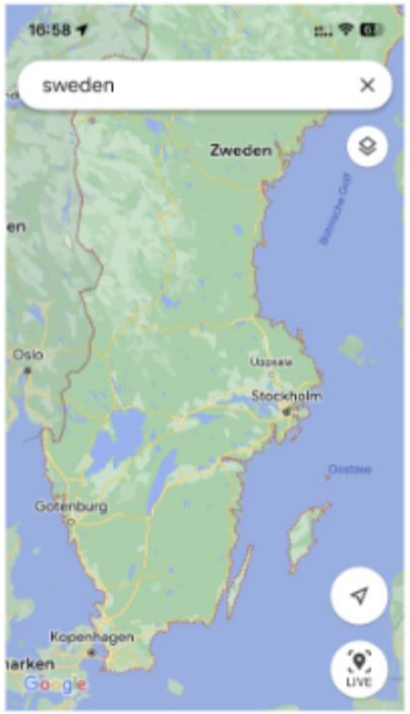
The framework will only be as useful as the contributions made to it (at the outset and over time, as additional details are added).

A nested system

The Patient Journey Framework is a nested system, in which different levels of patient experience abstraction - and detail - are connected. It begins at "level 0" -- the map of maps that connect all parts of our organisation together. From there, you can navigate to and from different parts of the service ecosystem.

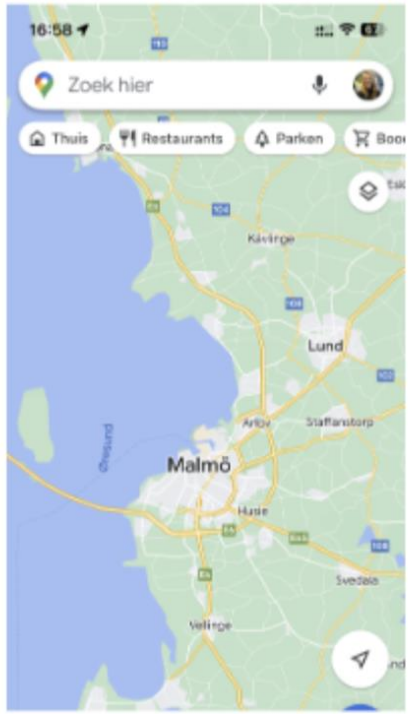


This nested system allows you to "zoom in and out," allows you to "zoom in and out," like Google Maps to navigate the layers of your services.



Level 0:

Sweden

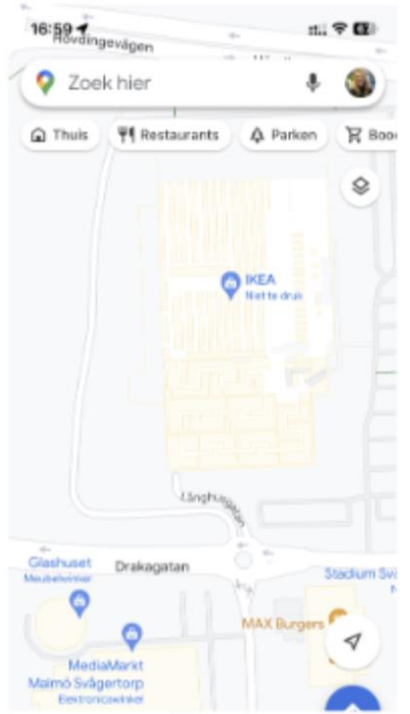


Level 1:

Malmo

Level 2:

Kulladal



Level 3:

Drakagatan

Our Patient Journey Framework for Medway

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L0

The virtual hospital, centred around the patient journey.

This view represents the "service ecosystem" -- all of the services within the virtual hospital, framed around the patient's perspective on the spectrum of wellness to illness. In our framework, this will be called "level 0 (L0)."

L1

Each service within the virtual hospital, still centred around the patient journey.

Each service will have a holistic view, linked from L0, which summarises the key details of the service and centres the journey of a patient on the services. These will be called "level 1s (L1s)"

Example L1s: "SMART Ward," "Community VWs."

L2

Integrated care journeys that span across services.

Linked from the service level (L1), you can click into integrated care journeys. These will be called "level 2s (L2s)," and will display the specific actions taken by each organisation or team.

Example L2: "Step down from SMART to Community VW."

L3

Clinical pathways, governance SOPs, and policies, centred on staff experiences.

These are the specific tasks and resources that support each step in an integrated care journey. They will provide guidance on things like clinical responsibility, out of hours protocols, and more.

Example L3: "Referral from ED / SDEC step up pathway."

Virtual Hospital requirements for RPM (3 yrs)

For Neonates, Paediatrics and Adults

- Temperature (tympanic, axillary & skin)
- Weight
- Heart rate
- Respiration rate
- Blood pressure
- Glucose level
- Motion detection
- Oxygen saturation
- Cardio respiratory function
- ECG rhythm
- Electromyography (EMG)
- Easy of use (patient and staff)
- Communications (alerts, messaging, tasks etc)
- EPR, SCR and NHS App standards-based integration
- Integration with Social Care / Nursing homes
- AI raw data capability

Detailed full procurement spec available on NHS Futures /request

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Prison Virtual and Supported Healthcare

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NHS Oxleas NHS Foundation Trust

HM Prison & Probation Service

NHS England

Prisons within the MFT Catchment

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Establishment	Category	Capacity
Swaleside	Male Category B Trainer	1112
Elmley	Male Category B Local	1252
Cookham Wood	Rochester overflow	
Rochester	Male Category C Trainer	742
Stanford Hill	Male Category D Open	464

Data for HMP Elmley 01/04/2023 to 31/03/2024

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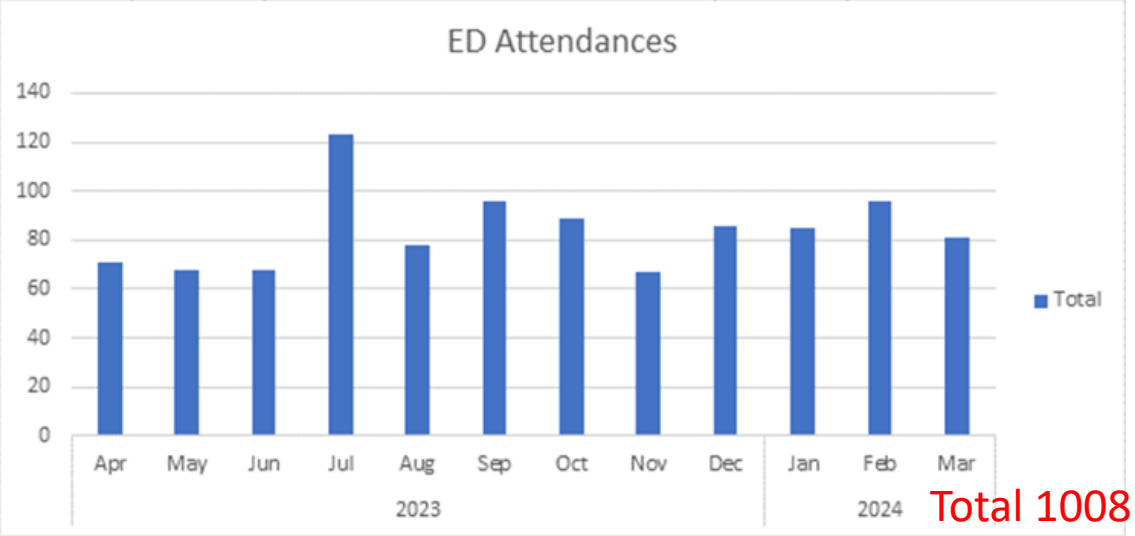
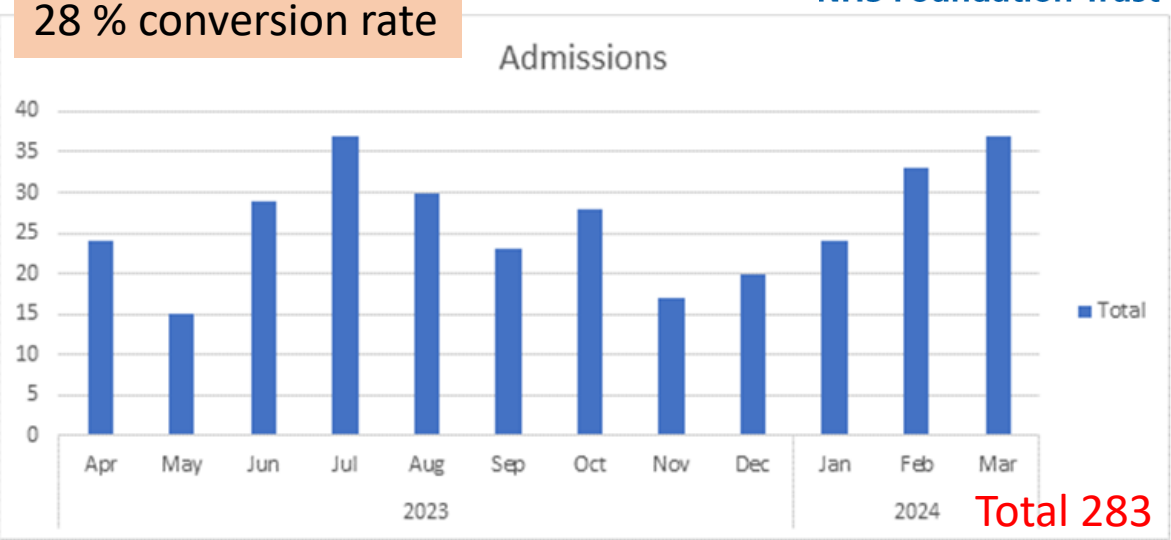


Total 1008

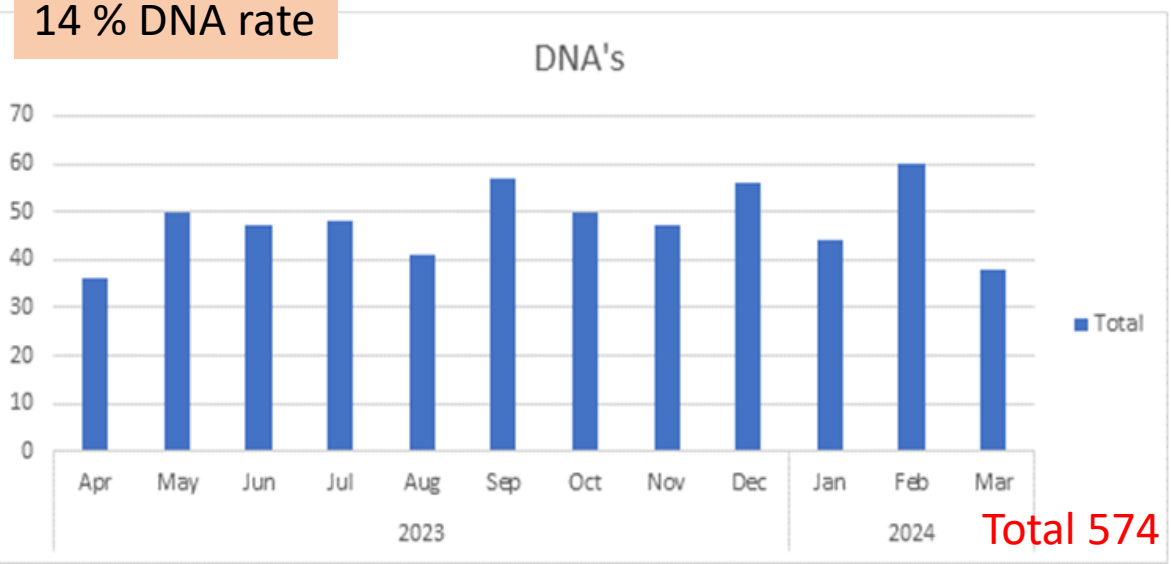
28 % conversion rate



Total 283

Total 4184

14 % DNA rate



Total 574

son Virtual and Supported Healthcare Programme

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Project

Clear project plan agreed across all organisations. Clear milestones, deliverables with required and measurable outcomes. RAID logs, TAFG's, Steering Group and programme governance

Governance

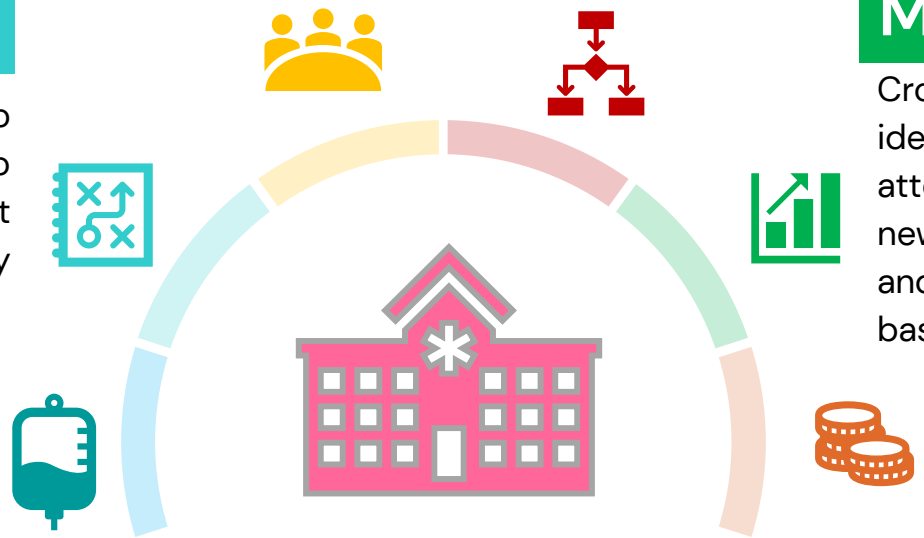
Developing a governance framework which spans the four organisations involved in the healthcare of prisoners; clinical governance, medicines management, risks and safety, feedback, PSURF, IG and legal / legislative requirement. Ensuring clinical accountability across all of the pathways as well as sharing learning and service development.

Planning

Collaborative partnership working to ensure the programme is designed to meet the health needs of the patient and is efficient in delivery with security considerations met

Metrics

Cross-referencing data from all organisations to identify the types of conditions the prisoners attend ED with. This enabels us to design the new pathways with the gratest economy of scale and in-turn deliver the grater efficiencies. Also baseline to measure impact / sucess



Clinical

Co-designed Clinical Pathways which are safe, and high quality; delivered in the appropriate setting using technology and joint skillsets. In-line with security and healthcare requirements

Efficiency

Delivering this programme will result in efficiencies across the four organisations, including productivity efficiencies, reduced ED attendances, ESD, AtED. A reduction in DNA's for outpatients and the potential for cash out savings if demand is moved from the acute. Escort and bed watching costs are with the NHS not HMPPS.

Truly Collaborative and Sharing

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Academy – Supported Self Managed Care for Respiratory and CVD Patients

RESPIRATORY & CVD ACADEMY OVERVIEW

Making Every Breath Count

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Respiratory & CVD Occupancy

c.133 beds pcm

Peak occ. Nov/Dec: c.200 beds pcm

+80% demand increase Aug - Jan

Faster Detection & Treatment

Alert triggers early review

- Aim to intervene to prevent further deterioration
- Support patient rehabilitation
- Avoid escalating care needs

Demand

9,287 admits p.a.

Winter Peak: 24% of all inpatients

ALOS = 5.24 days

Observable patterns

Repeat Hospitalisation: 1,242 patients re-admitted 90 days of d/c

Monitoring & Observations:

- Varying rates of breathing
- Increased effort breathing
- Deviation from personal norms

Inpatient and Virtual Intervention

When core CRR deviates from nocturnal or diurnal norms

In person or virtual care provided to prevent care escalation

Inpatient ALOS reduction = 1 day

<= 90 Day readmission reduction = 50%

CVD & RESPIRATORY ACADEMY: A Digital Nervous System

HIGH IMPACT REAL-TIME MONITORING AND CLINICAL INTERVENTION

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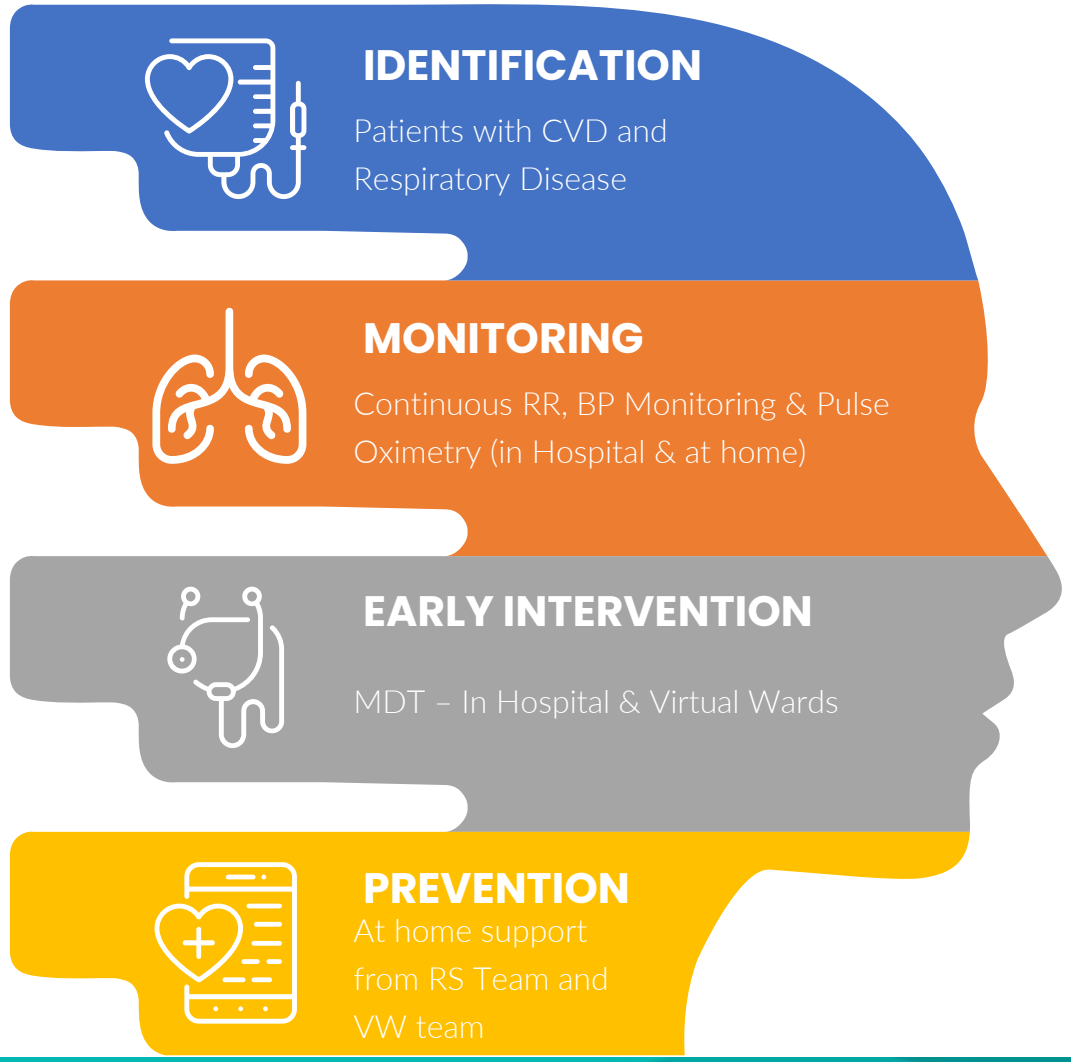


IDENTIFICATION

Patients display a pattern of exacerbations and illness

Culminating in repeat Hospital attendance / admission

RR is most important predictor of prognosis / clinical condition

MONITORING

Suite of tools: RespiraSense (RR monitoring), Blood Pressure & Pulse Oximetry at home & in Hospital

EARLY INTERVENTION

Virtual team to respond to Virtual Ward patient alerts

Hospital team respond to inpatient alerts as they occur

PREVENTION

RS Provides dedicated patient onboarding team 7 days per week to support Virtual Wards team & provide patient education

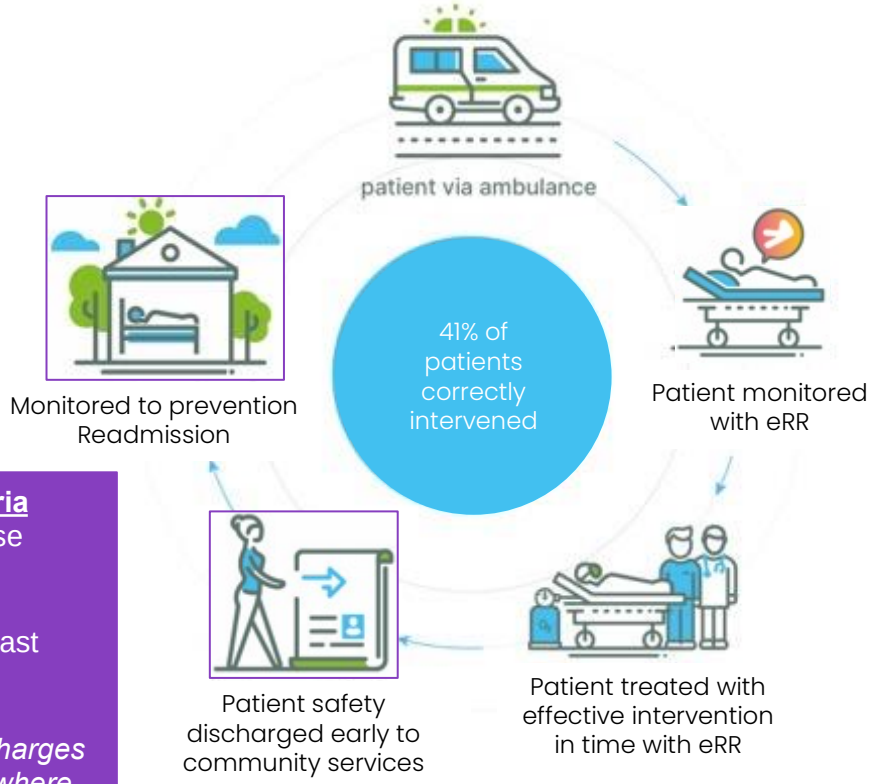
Section 3: Transforming the Clinical Pathway for COPD Patients

Today's pathway

- Delayed Intervention
- Prolonged Length of Stay
- Increase Cost of Care

cRR powered Pathway

- Right care Right Time
- Safe early discharge
- Integrated case with virtual wards



VCW Admission Criteria

- Severe COPD disease (Gold D)
- >4day LoS Acute
- >1 admission within last year

**UK shows 23% of discharges readmit within 30 days where LoS >4days in acute within 30 days; 43% within 90 days*

Faster Data Flows

Automated near real-time NHS reporting

Supporting NHS priorities and local innovation

The NHS FDP will provide trusts and ICBs (on behalf of ICSs) with a set of core capabilities and nationally developed products to support five key NHS priorities along with NHS England's objective to improve services:

1. **Elective recovery** – to get patients treated as quickly as possible, reducing the backlog of people waiting for appointments or treatments, including maximising capacity, supporting patient readiness and using innovation to streamline care
2. **Care coordination** (joining up care) – to ensure that health and care organisations all have access to the information they need to support the patient, enabling care to be coordinated across NHS services
3. **Vaccination and immunisation** – to ensure that there is fair and equal access, and uptake of

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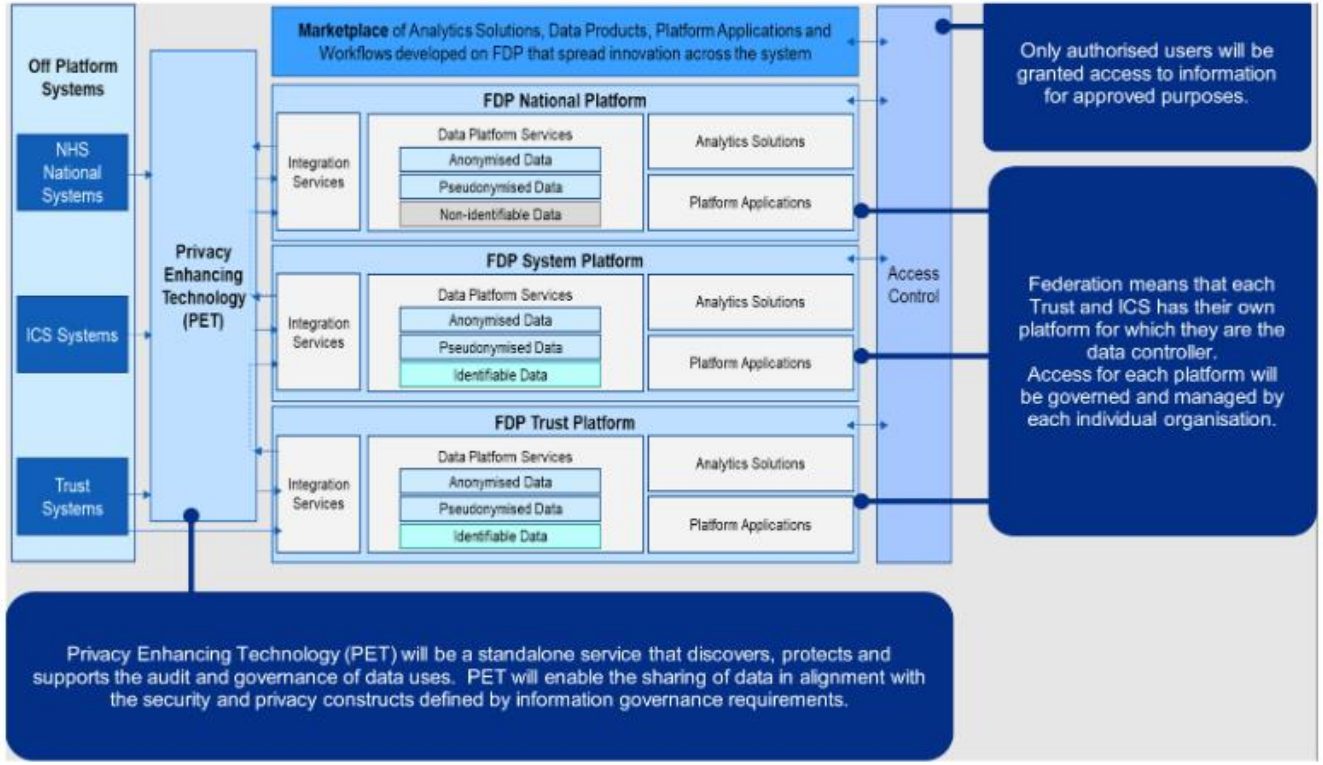
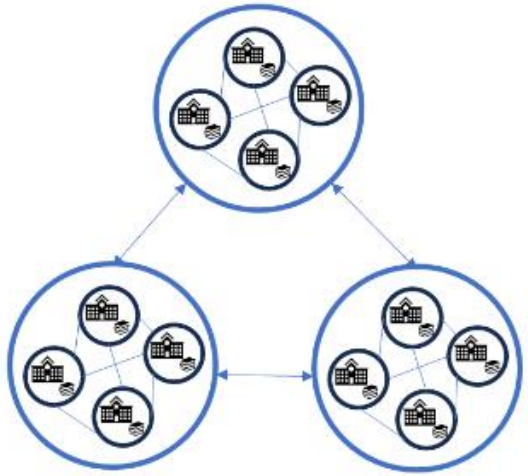


MFT are the national incubator site for developing the FDP minimum patient level dataset for VW



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Thank You

Patient
FIRST

Panel Discussion

Francesca Markland
Senior Programme Manager, Remote Monitoring & Virtual Wards - NHSE London Region Digital Transformation Team

Adam Fitzgerald
Head of Nursing, Integrated Local Services - Guy's and St Thomas' NHS Foundation Trust

Dr Reggie Sangha
Content Guru
Medical Director

Greg Edwards
Chief Medical Officer
Doccla

Clare Evans
Care Co-ordination and Hospital@Home Programme Manager - Bath, Swindon & Wiltshire ICB

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Case Study

CONTENT GURU
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Case Study

Dr Reggie Sangha
Content Guru
Medical Director

Refreshments & Networking

Chair Opening Address

Dr Gurnak Singh Dosanjh

GP - LLR ICB

Case Study

access
freedom to do more

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SCAN ME

Case Study

Laura Thompson
Director of Marketing
Access Group

Deborah Snook
Integrated Care Consultant
Access Group

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Case Study

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SCAN ME

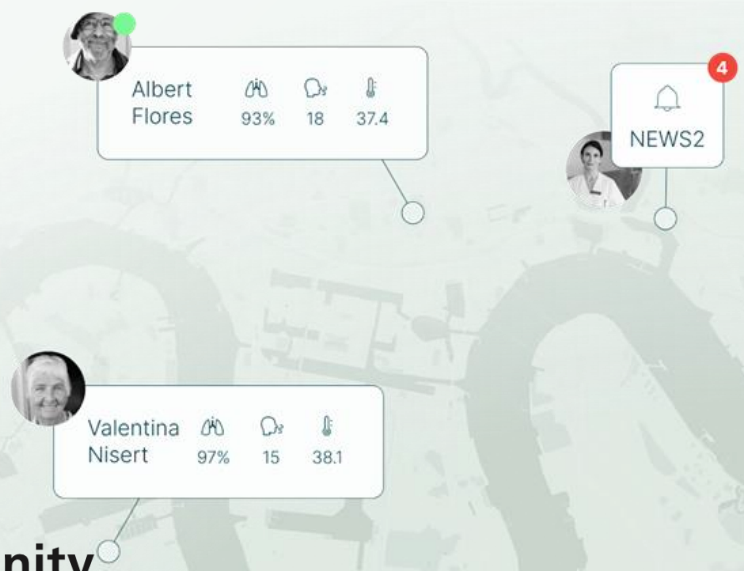
Case Study

Dr Maha Balakrishnan
GP and Hospital at Home
Clinical Lead

Managing Heart Failure @Home

doccla

Sarah Brierley
Director of Strategy and Partnerships, HCT
Tara Donnelly
Founder Digital Care and Advisor Doccla



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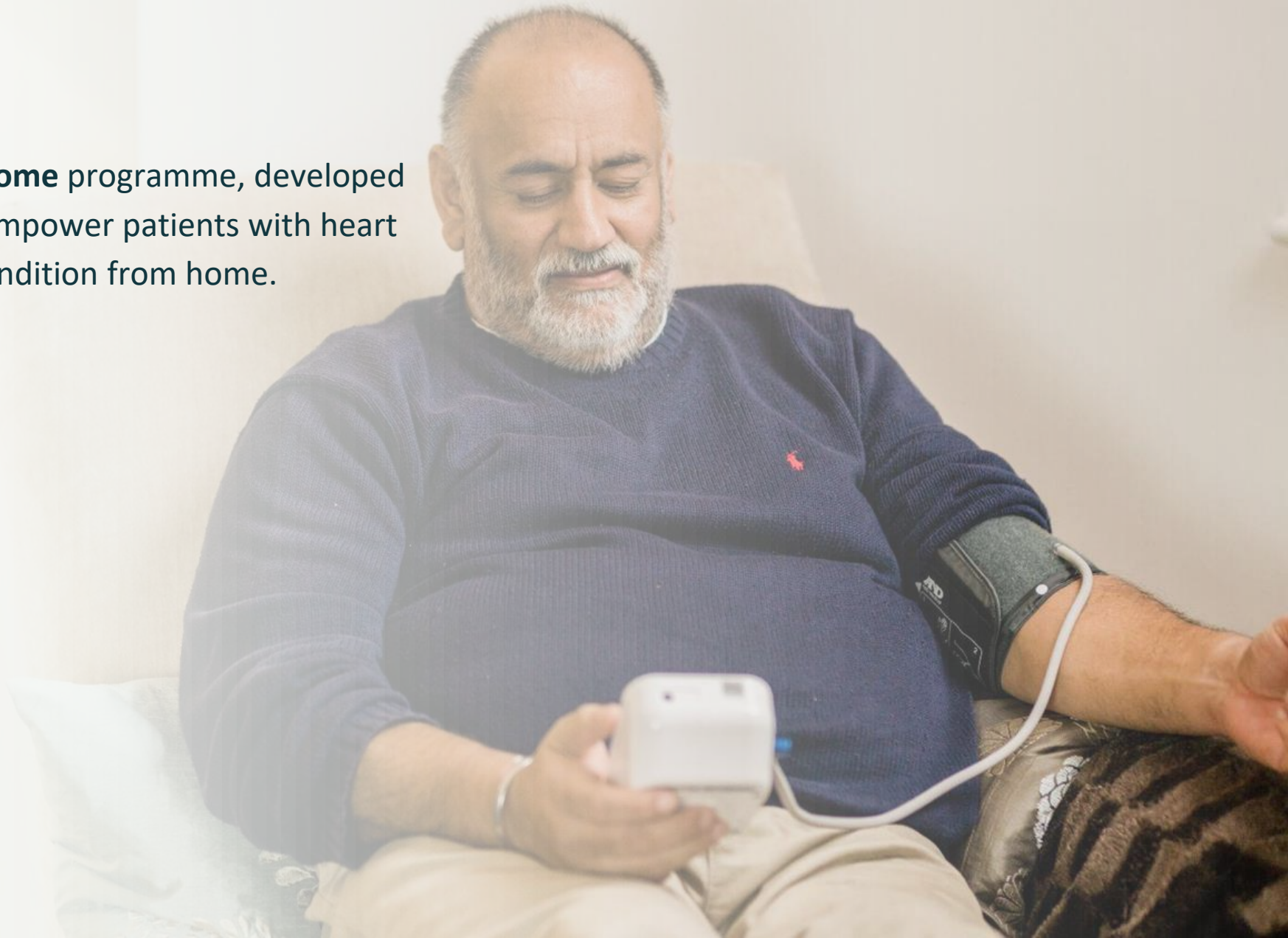
Introduction

The **Managing Heart Failure @Home** programme, developed by NHS England, is designed to empower patients with heart failure to better manage their condition from home.

It focuses on three key areas:

- **Personalised Care**
- **Remote Monitoring**
- **Integration of Care**



Background

The programme was developed in response to:

Increasing Prevalence

730,000
people living with heart failure in the UK

Late diagnosis

80%
of heart failure diagnoses are made during emergency admissions

System Pressure

5%
of all NHS emergency hospital admissions in the UK

Other Strategic initiatives aligned to:

Proactive Patient Care

Enabling early detection and timely intervention.

Digital Care Transformation

Digitising patient monitoring for better insights and efficiency.

Home-Based Healthcare

Bringing high-quality care directly to patients at home.

Working together: **Managing Heart Failure @ Home**

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Working Together - Setting Goals

East and North Hertfordshire Health and Care Partnership (ENH HCP) was selected as one of ten early adopter and accelerator sites to implement MHF@H into their heart failure service and received funding to support project setup and upskilling of staff for 6 months.

Patient Outcomes and Quality of Life:

- Improve clinical outcomes of people with Heart Failure
- Improve quality of life for people with Heart Failure

Health Equity and System Efficiency:

- Reduce health inequalities in relation to diagnostics
- Improve use of system resources

Enhance Service Productivity

- Optimise resource use by minimising the need for in-person patient assessments.
- Empower remote monitoring to streamline patient health checks.

Working Together - Local Context

A health needs analysis of East and North Hertfordshire:

4,176
registered heart failure patients

1,698
emergency admissions/year

0.7%
QOF prevalence

Working Together - Local Context

Further analysis also concluded:

- QOF prevalence (0.7%) significantly lower than estimated (1.36%), suggesting that fewer patients are being formally diagnosed or recorded
- Higher prevalence in socioeconomically deprived regions.

- Lack of integrated services for residents in these areas
- Higher readmissions & non-elective spending for heart failure compared to other regions

- Concerns about underserved groups like Black and Asian communities, individuals with Severe Mental Illness (SMI), and Learning Disabilities

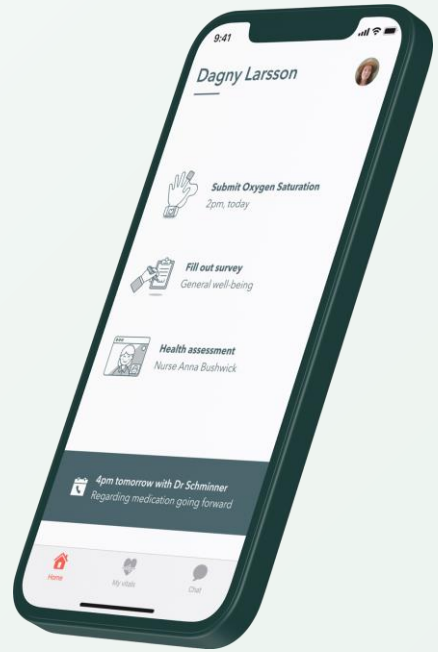
Project Overview

Working Together

Building the foundations for success

- End-to-end Remote Patient monitoring: Devices, Logistics, Patient Support and Clinician Dashboard
- Comprehensive patient selection criteria
- Subjective patient questionnaire
- Escalation Protocols

- **Clinical pathway with measurements:**
  - Blood pressure
  - Heart rate
  - O2 saturation
  - Temperature
  - Weight
  - Electrical activity of the heart



Collecting Data

Data was collected at three time points along the patient journey and shared with NHSE to be evaluated alongside data from the 9 other sites.

Patient-Centered Continuing Professional Education Questionnaire (P3 CPEQ)

Designed to assess the patient's experience of the heart failure care services:

- Patient involvement
- Involvement of friends/family/caregivers
- Personalised care plan
- Coordination across services
- Receiving enough support to help the patient manage their own condition
- Patient education resources
- Confidence to manage condition
- Improvements

EuroQol 5 Dimensions 5 Levels (EQ-5D-5L)

General Quality of Life:

- Mobility
- Self-care
- Usual activities
- Pain/discomfort
- Anxiety/depression

Kansas City Cardiomyopathy Questionnaire (KCCQ)

Condition-specific Quality of Life:

- Symptoms
- Functional limitations
- Emotional well-being

Collecting Data

Data was collected at three time points along the patient journey and shared with NHSE to be evaluated alongside data from the 9 other sites.

Use of healthcare services

Frequency of visits 6 months pre baseline, every month from then till 6 months post baseline:

- GP
- Community/District Nurse
- NHS 111

Demographics

- Age
- Gender
- Ethnicity
- Postcode & LSOA
- Type of heart failure
- Time since diagnosis
- NYHA score
- LvEF score
- Comorbidities
- Status (active, discharged, deceased)

The Results

Improvements in Quality of Life **(6 month assessment)**

EQ-5D-5L Index Score

- There was a statistically significant improvement, with an average increase of **7.6%** for each variable.
- The improvement indicates that patients felt better overall after participating in the programme, specifically around **Pain/Discomfort** and **Self-Care**.

Patient Empowerment and Satisfaction **(6 month assessment)**

Higher Self-Rated Health

- Significant improvement from **65 to 72 out of 100**.
- Reflects enhanced overall health perception and lifestyle changes.

Improved Clinical Outcomes **(6 month assessment)**

Reduction in A&E Attendance

- **32% decrease in A&E** visits for heart failure-related issues after joining the remote monitoring programme.
- This reduction highlights effective early intervention, keeping patients healthier at home and reducing pressure on emergency services.

Improved Clinical Outcomes **(6 month assessment)**

Reduction in Readmissions

- **100% reduction** in 30-day readmissions for heart failure
- Reflects improved management and symptom control, preventing recurring hospital visits and contributing to better long-term outcomes.

Cost Savings and System Efficiency **(6 month assessment)**

Estimated Savings

- Achieved **£6,822** in avoided costs across 51 patients over three months due to reduced readmissions.
- This translates to substantial savings by reducing the frequency of costly readmissions, easing financial strain on healthcare services.

Cost Savings and System Efficiency **(6 month assessment)**

Projected Long-Term Savings

- Potential savings of **£558,601** over six months if applied to all heart failure patients in ENHT.
- Demonstrates the programme’s scalability and its capacity to deliver extensive cost savings across a larger population.

Patient Empowerment and Satisfaction **(6 month assessment)**

Positive Patient Feedback

- **86%** of patients rated the service as good or very good.
- High satisfaction with support quality **(4.6/5)** and equipment reliability **(4.5/5)**, indicating that patients felt well-supported and confident in the technology, which contributed to their successful engagement with remote monitoring.

Conclusion

This is just the beginning—building on our success, we're set to expand and redefine long term condition care across the NHS. Model applies equally well to other major progressive long term conditions such as COPD and if we took the most at risk of hospital admission, in every ICS, and gave them this support, our NHS would look completely different.

Recognised Success and New Funding

Awarded the HTN Award for Most Promising Pilot, the programme has secured additional funding for a six-month extension, setting the foundation for a fully Integrated Heart Failure Programme.

From Reactive to Proactive, Digital-First Care

Moving from reactive to proactive care, we're leveraging digital solutions to detect issues early and empower patients in managing their health independently.

Expanding Home-Based Care

Bringing care closer to home by reducing hospital dependency, minimising associated costs, and enhancing patient engagement and comfort through remote monitoring.

Q&A

Fireside Interview

Francesca Markland
Senior Programme Manager, Remote Monitoring & Virtual Wards - NHSE London Region Digital Transformation Team

CONVENZIS

Case Study

Ortus-iHealth

Slido

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Case Study

Dr. Debashish Das
Consultant Cardiologist Barts NHS Trust - CEO & Founder Ortus-iHealth

Lunch & Networking

Chair Afternoon Address

Dr Gurnak Singh Dosanjh
GP - LLR ICB

Case Study

NHS CARE
Volunteer Responders

Case Study

Ben Long
Programme Manager, NHS and Care Volunteer Responders - Royal Voluntary Service

NHS CARE
Volunteer Responders

Adding capacity to Virtual Ward Teams

Service provided by:

ROYAL VOLUNTARY SERVICE

GoodSAM Instant.Help

Introduction to the programme

NHS CARE Volunteer Responders

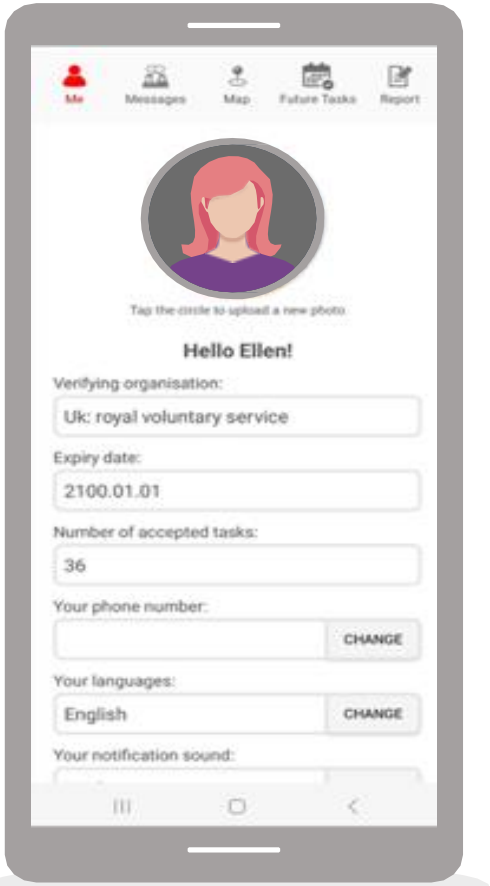
NHS and Care Volunteer Responders (NHSCVR) is a large-scale, **NHS-approved** volunteering programme supporting the NHS and healthcare teams across England.

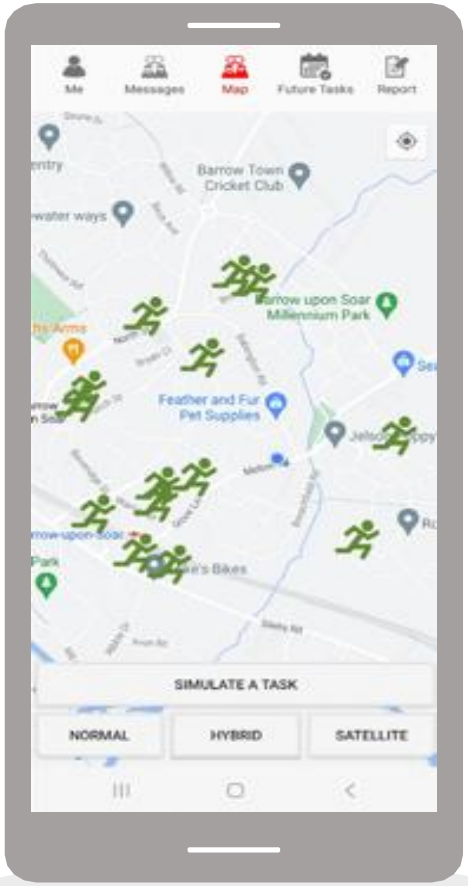
- Digitally delivered enabling fast, real-time volunteer deployment
- Adds capacity to healthcare teams & services to improve delivery
- Compliments existing volunteering programmes
- An inclusive programme with a diverse pool of volunteers
- Evolving programme developed using insights from local systems

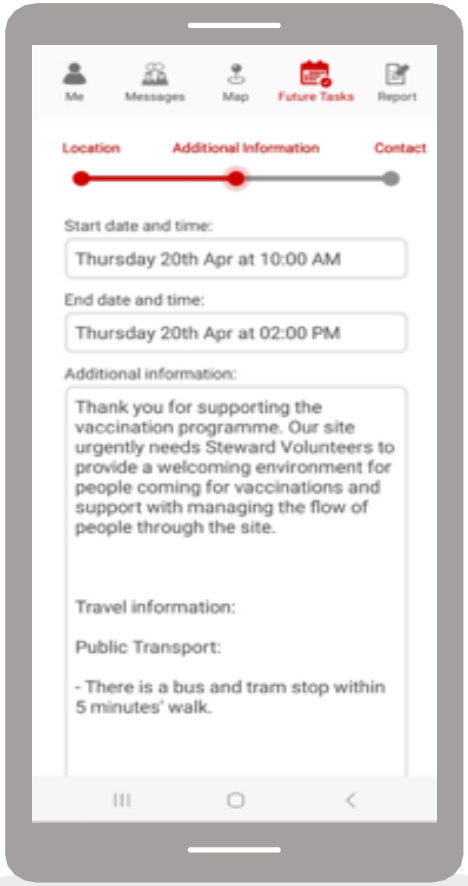
Service provided by: Royal Voluntary Service, GoodSAM Instant.Help

The GoodSAM app

NHS CARE
Volunteer Responders







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NHS CARE
Volunteer Responders

Over 43,000 volunteers

available to support

Service provided by:

ROYAL VOLUNTARY SERVICE

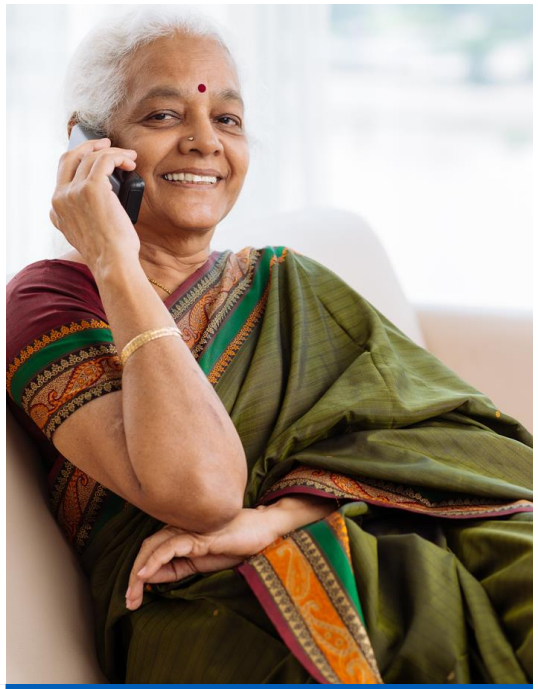
GoodSAM Instant.Help

Suite of volunteer support

NHS CARE
Volunteer Responders

Pick Up and Deliver

Community Response



Check In and Chat

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Driving support services

Pick Up and Deliver volunteers

- Drop off medication/TTOs and equipment to patients' homes following discharge.
- Collect and return equipment to the NHS to recycle and reduce waste/cost.

Benefits of using the service

NHS CARE
Volunteer Responders

- **Quick and reliable delivery of medications and medical equipment** including same-day urgent requests
- **Helps speed up patient discharge -** 8 % improvement in ‘discharge by 17:00’ with Patients, on average, discharged 3 hours earlier in the day
- **Potential cost savings** According to NHSE data ‘If just two out of every five walking aids were returned, the average hospital could **save up to £46k per year**
- **36% of service users attend A & E less often** due to VR support

https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/
https://www.england.nhs.uk/ahp/greener-ahp-hub/specific-areas-for-consideration/walking-aid-reuse/

Service provided by: Royal Voluntary Service, GoodSAM Instant.Help

Testimonial – Barnsley Hospital

We have found the Pick Up and Deliver service to be incredibly helpful and necessary. We have already recommended it to other colleagues and department heads in the hospital.

The service is available seven days a week and is highly responsive, which is fantastic. There is no lengthy referral form required, which makes it easy to use.

Jaqueline Howarth, Operational Manager of Right Care Barnsley

Package of support for your patients

NHS CARE
Volunteer Responders

- **Telephone Support**

Calls to people in need of a friendly voice and a listening ear.

- **Community Response**

Assistance with essential shopping and prescription delivery.

- **Community Response – Connect**

Supporting individuals in enjoying social activities within the community.

- ✓ **Social and emotional support** for people who may otherwise feel isolated
- ✓ **Easing the burden on healthcare providers** by helping patients maintain a sense of connection and well-being
- ✓ **Reduced unnecessary GP visits** by addressing non-clinical needs

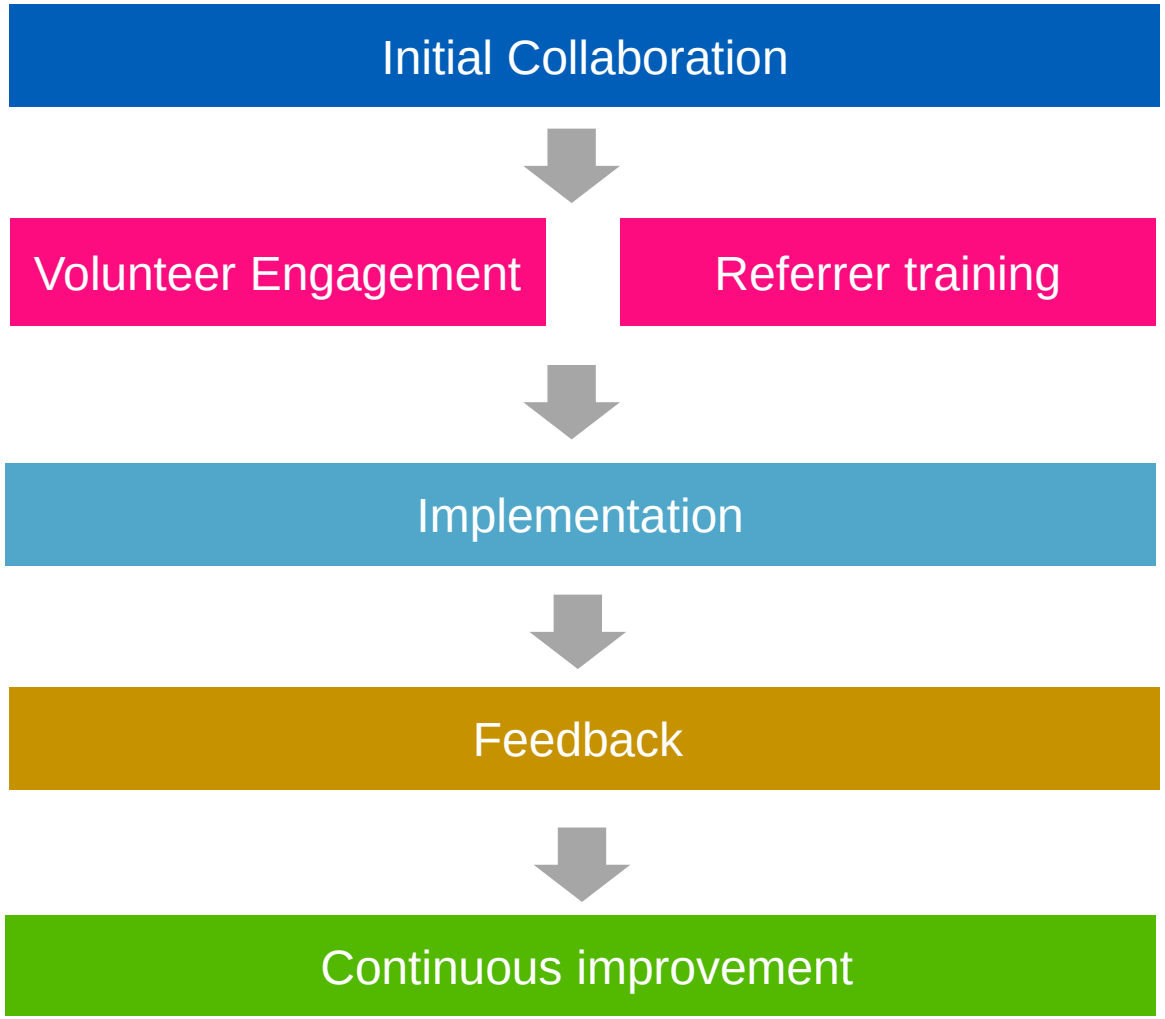
Service provided by: ROYAL VOLUNTARY SERVICE GoodSAM Instant.Help

Hospitals and Pick Up and Deliver

- Pick Up and Deliver being utilised by early adopters
- Hospital teams in Rotherham, Barnsley, Crewe, Wolverhampton, Mansfield, Gloucester and St Georges, West Suffolk, Leicester (amongst others) currently using the service
- Sites launching soon include West Sussex, Chesterfield, Lincolnshire
- Conversations ongoing with more than 10 trusts

Collaborative approach

NHS CARE
Volunteer Responders



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ROYAL VOLUNTARY SERVICE

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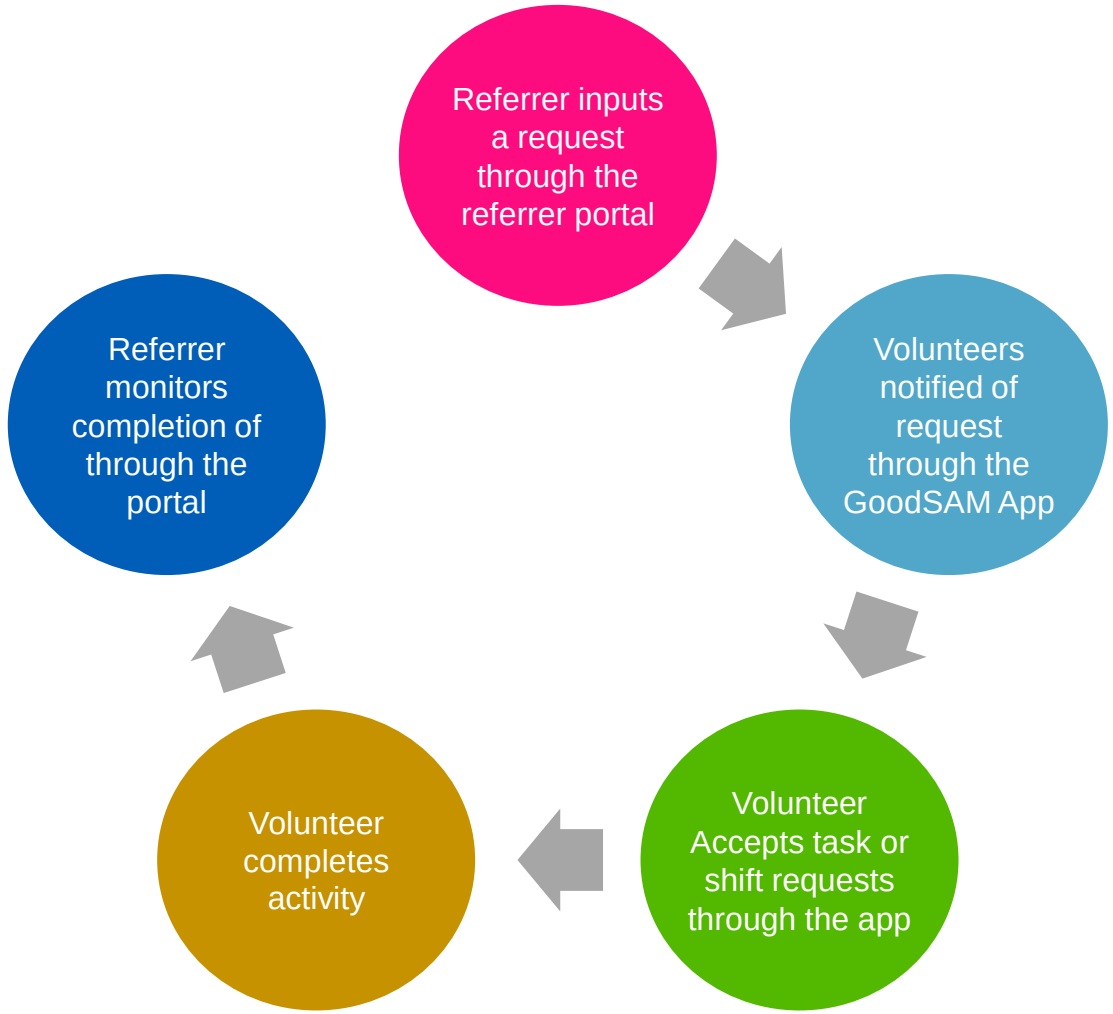
Streamlined processes

NHS CARE
Volunteer Responders

- Straightforward and hassle-free
- Specifically produced asset pack *(NHS approval Letter, SOP & DPIA documents)*
- Training hub on the website



76% *referrers agree that the* ***referral process is easy.***

Service provided by: Royal Voluntary Service, GoodSAM Instant.Help

Volunteer checks

NHS CARE
Volunteer Responders

Fully approved NHS volunteer service. Appropriate background checks are carried out for **all volunteers**

		Check In and Chat	Companionship Calls	Community Response	Driving Support	Driving Support Plus	Site Support
Green	• ID Check • Driver status completed • Enhanced DBS with Adult Barred			✓		✓	
Blue	• ID Check • Driver status completed • Enhanced DBS		✓				
Red	• ID Check • Driver status completed • Self-declaration of unspent convictions for Stewards only	✓			✓		✓

This approach is in line with Home Office guidance around eligibility for DBS checks.

Service provided by: ROYAL VOLUNTARY SERVICE GoodSAM Instant.Help

Volunteer support

- ✓ Volunteers recruited and supported centrally
- ✓ Appropriate background checks are carried out for **all volunteers** in-line with home office guidance
- ✓ Expenses paid for by the programme
- ✓ Problem Solving and Safeguarding Teams available 7 days a week

Impact on clients

42%

People receiving Telephone Support **visit their GP less often** thanks to Volunteer Responders

36%

Attend A&E less often due to the assistance from Volunteer Responders

89%

of VR clients find this **service important**, with **63%** calling it **very important**.

72%

of VR clients are **highly satisfied** with the service, underscoring its **significant impact**.

62%

Report **higher satisfaction with the NHS** compared to just 49% in the general population (ONS, May 2024).

57%

are only receiving NHSCVR support

After having a stroke, I felt so vulnerable and disabled. Your service and the wonderful volunteers gave me back a bit of independence. 'Little steps forward' is what I have been told, I can do this with your NHSCVR volunteer support.

(Male, 45-54)

NHS CARE Volunteer Responders

Service provided by: Royal Voluntary Service, GoodSAM Instant.Help

Key Takeaways

NHS CARE Volunteer Responders

- NHS-approved and free
- Easy to use with real-time support and training
- A growing, national pool of volunteers available immediately
- A trusted volunteer programme - being used by all 42 ICSs in some capacity

*Almost **2 out of 3** front line staff said that NHSCVR had a **positive impact on their workload.***

Service provided by: Royal Voluntary Service, GoodSAM Instant.Help

Next Steps

NHS CARE
Volunteer Responders

Talk to us at our table in the exhibition area

Contact your RRM

Visit the website

Search online for

‘Volunteer Responders’

Service provided by:

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NHS CARE
Volunteer Responders

Questions?

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Panel Discussion

Dr Raees Lunat
Chief Medical Information Officer, GP Registrar and ex Senior Advisor to the Chief Workforce Officer of the NHS - West Hertfordshire Trust

Adam Fitzgerald
Head of Nursing, Integrated Local Services - Guy's and St Thomas' NHS Foundation Trust

Dr. Matea Deliu
Associate Medical Director, One Health Lewisham
Clinical Lead Primary Care Digital Delivery, NHS South East London ICB

Jen Tomkinson
Associate Director NHS@home
Sirona care & health

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SCAN ME

Case Study

myPatientSpace

Case Study

Dr Ian McCabe
Research Fellow and
Project Manager, Hive Lab,
University of Galway

Ciara Gormley
Customer Success
Manager - myPatientSpace

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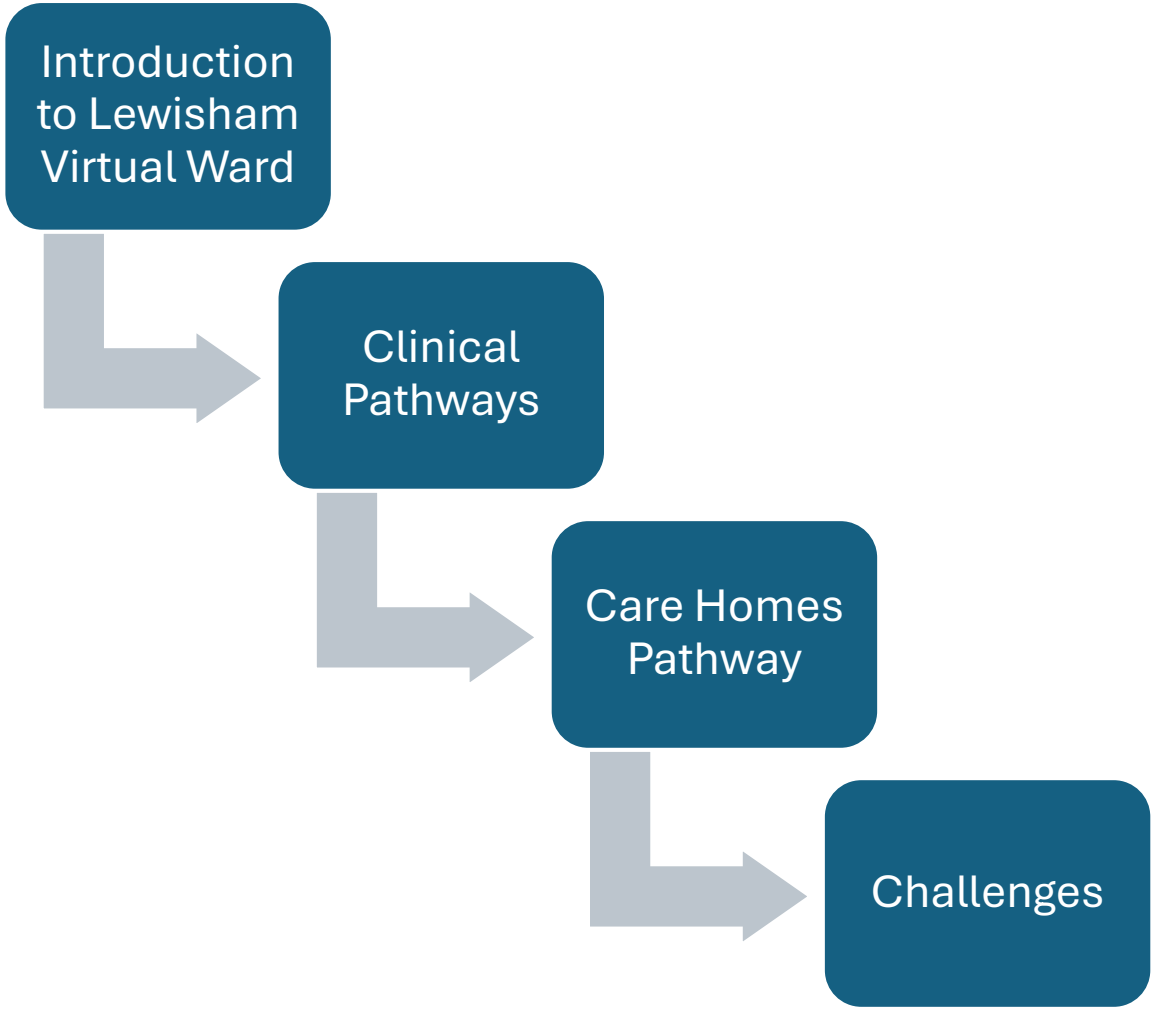
Keynote Presentation

Dr. Matea Deliu
Associate Medical Director, One Health Lewisham - Clinical Lead Primary Care Digital Delivery, NHS South East London ICB

Pioneering a digitally first Virtual Ward (NHS@Home) in South East London

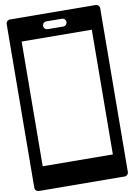
Dr. Matea Deliu, MBBS/MD PhD, MRCGP, GPwSI Health Informatics/ Digital Health,
Clinical Lead Primary Care Digital Delivery *NHS South East London ICB*
Associate Medical Director *One Health Lewisham*
Digital Health Leadership *NHS Digital* | *Imperial College London*

Agenda


Introduction to Lewisham Virtual Ward
Clinical Pathways
Care Homes Pathway
Challenges

doccla

ONE HEALTH LEWISHAM
The Integrated Community Provider



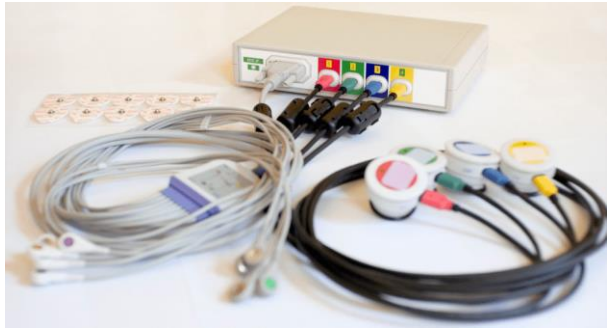
The Lewisham Virtual Ward/NHS@Home service is a fully managed service that enables patients to receive the care they need within their own home, or place of residence, avoiding hospital attendance. Step up and step down pathways.

The service has an objective to support primary and secondary care capacity pressures. Supported by technology, the NHS@Home service provides a safe and convenient alternative to in-hospital care.

- Consultant and GP led, 50 bed capacity service
- Multi disciplinary team of clinicians supporting daily monitoring
- 7 day a week monitoring from 08.00 – 18.00
- Phlebotomy, in home Xray and mobile ECG services available
- Face to Face visits available, where required.
- Exclusive or shared clinical responsibility (pathway dependent)

South East London
Integrated Care System

Pathways live



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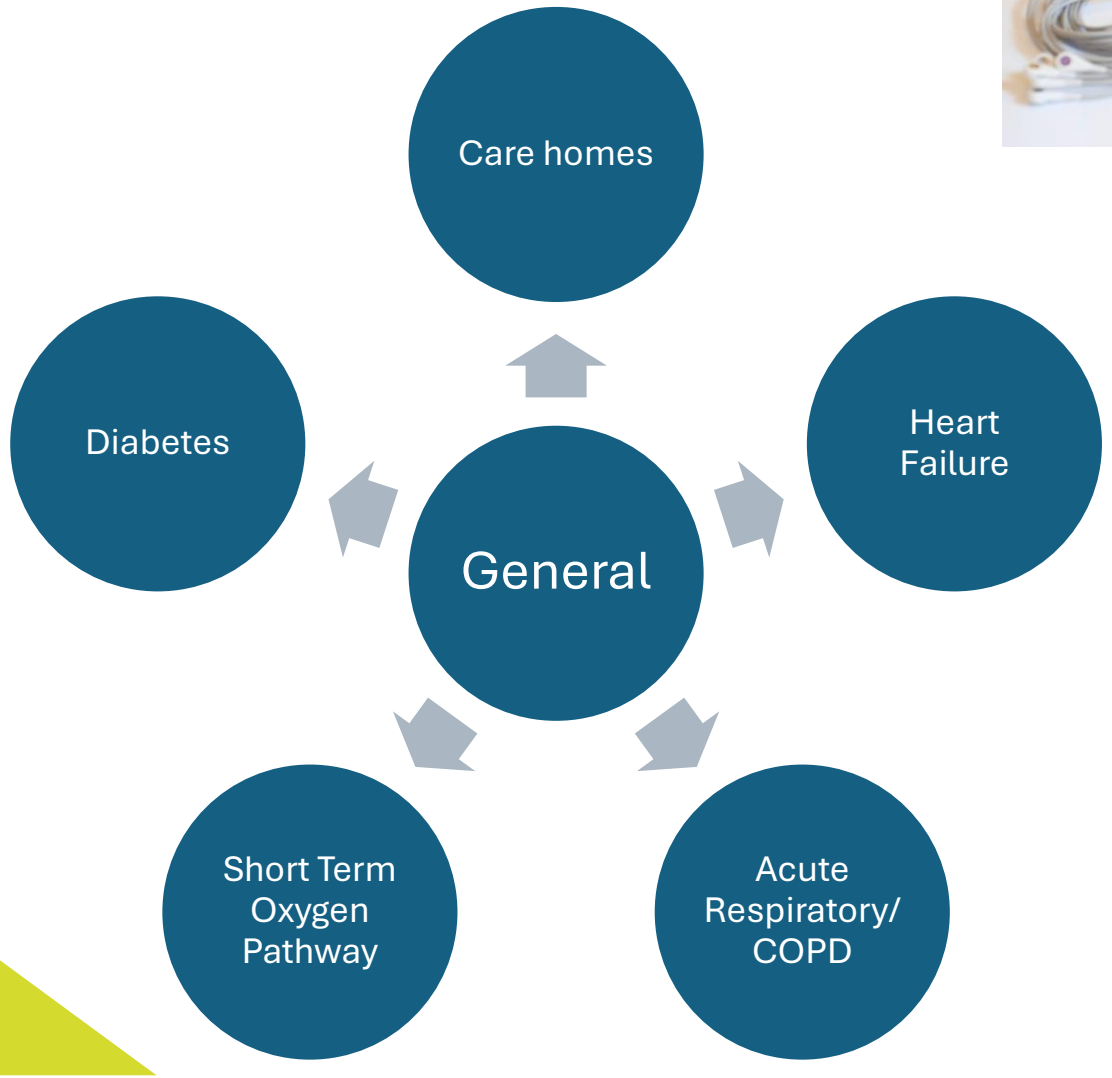
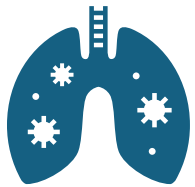
The Integrated Community Provider



Potential pathways



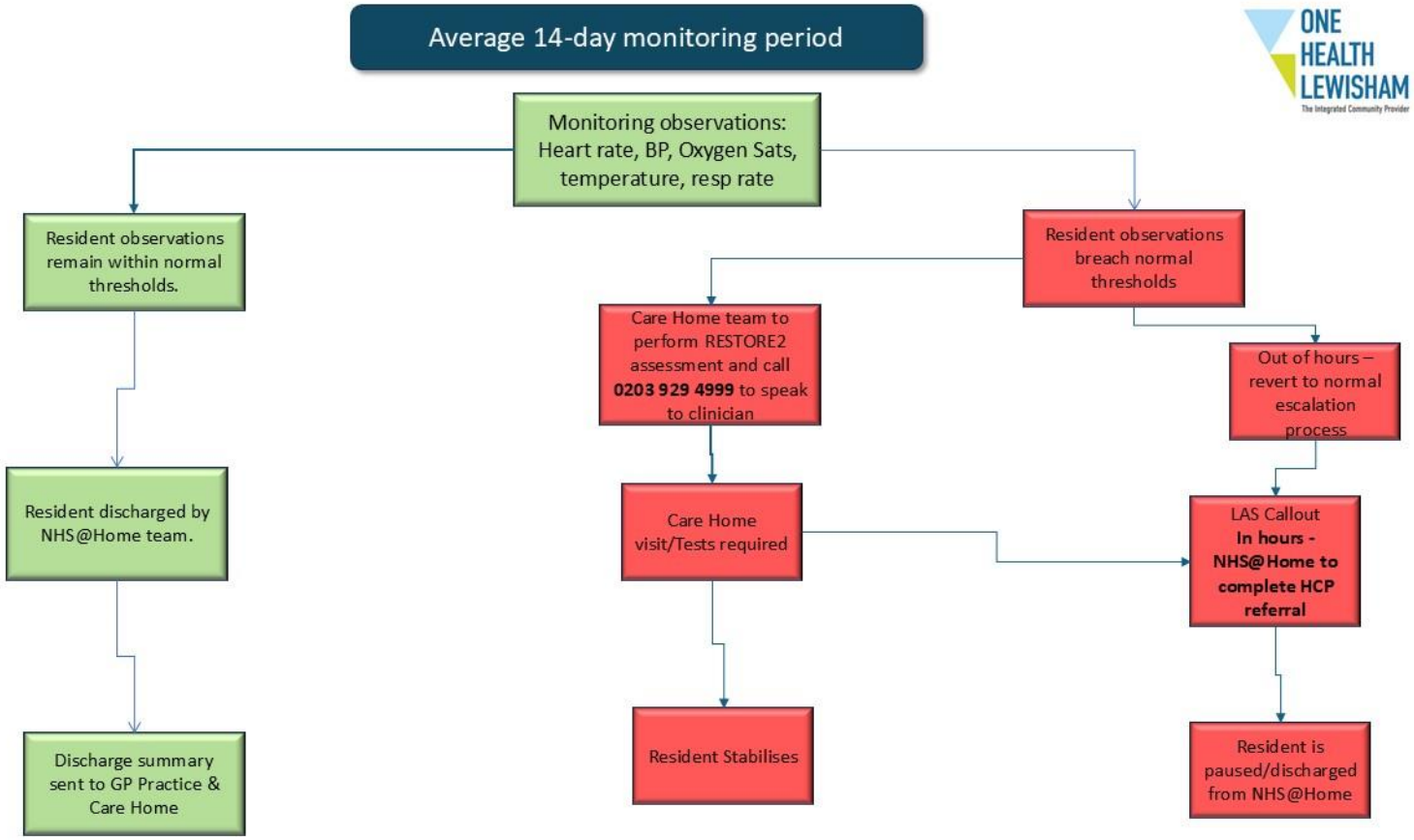
Peak flow monitoring

Acute asthma

South East London
Integrated Care System

Care Homes Pathway

Residents were identified in cohorts of 15 by the Care Home's lead Nurse and referred into the service for a period of 14 days.



Clinical Approach

Holistic Review

Every patient onboarded onto the pathway has a holistic review. A clinician undertakes a detailed review for each patient to include the following information:

- Past medical history
- Repeat medications
- Most recent blood test results
- Summary of vital signs monitoring
- Cognitive status
- Mobility
- Advanced care planning
- Frailty score

Clinical Approach

- The information captured is recorded on a proforma to ensure no information is missed and each patient receives a comprehensive review
- The reviewing clinician draws up a suggested management plan.
- Every week the patients are discussed and proformas reviewed at the weekly ward round. Ward rounds are led by a Consultant Geriatrician with input from matrons and GPs.
- Patients are usually monitored for maximum14 days in order to detect and manage acute health issues
- On discharge a summary is sent to the patient's GP which includes recommended actions to ensure continuity of care

Benefits

1. Comfort and Familiarity: Receiving care in a familiar environment can reduce stress and anxiety, promoting better mental well-being.

2. Personalised care: Home care can be tailored to the individual's needs and routines

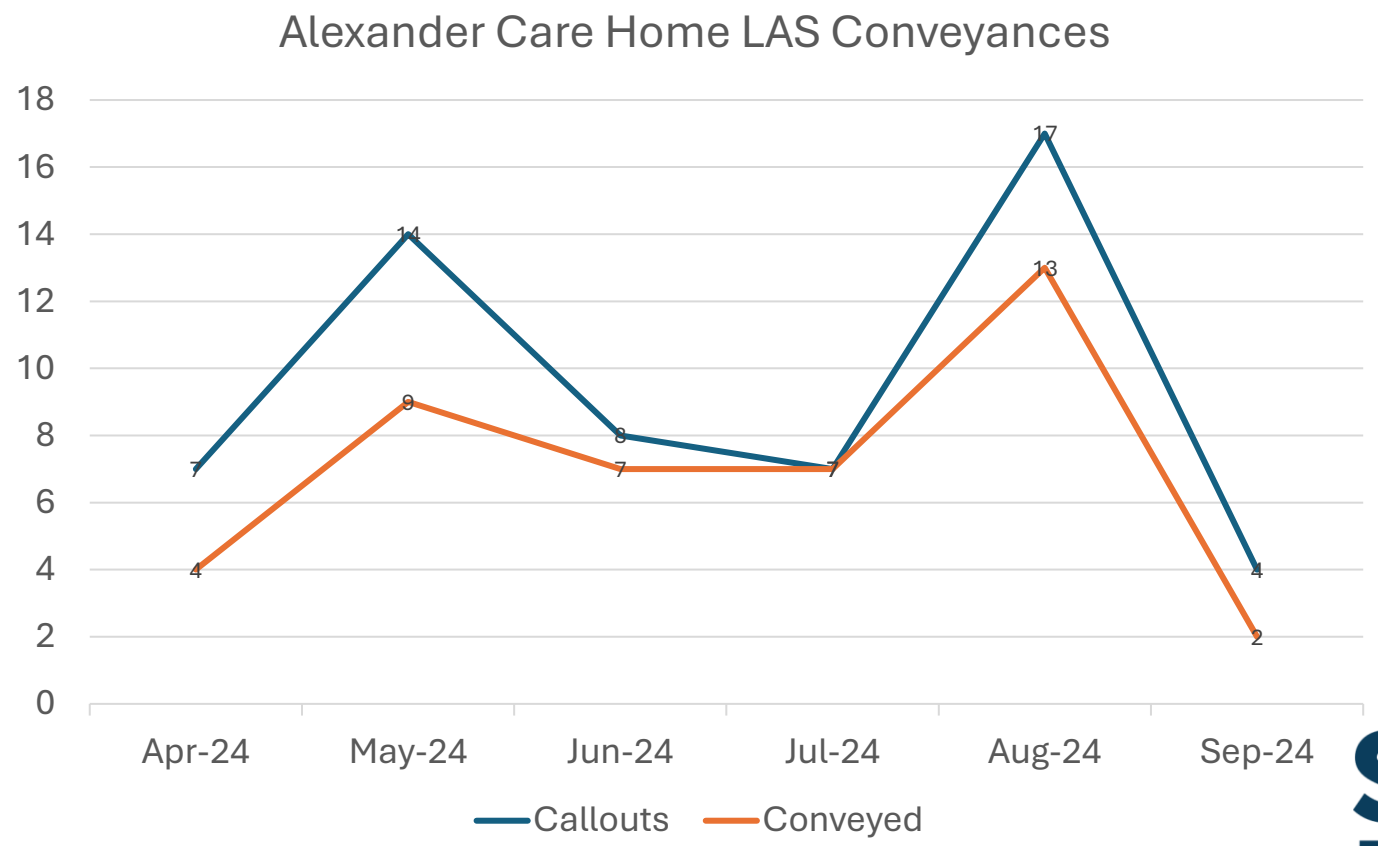
3. Reduced risk of infection: by staying at home the individual reduces chance of exposure to health-care associated infections.

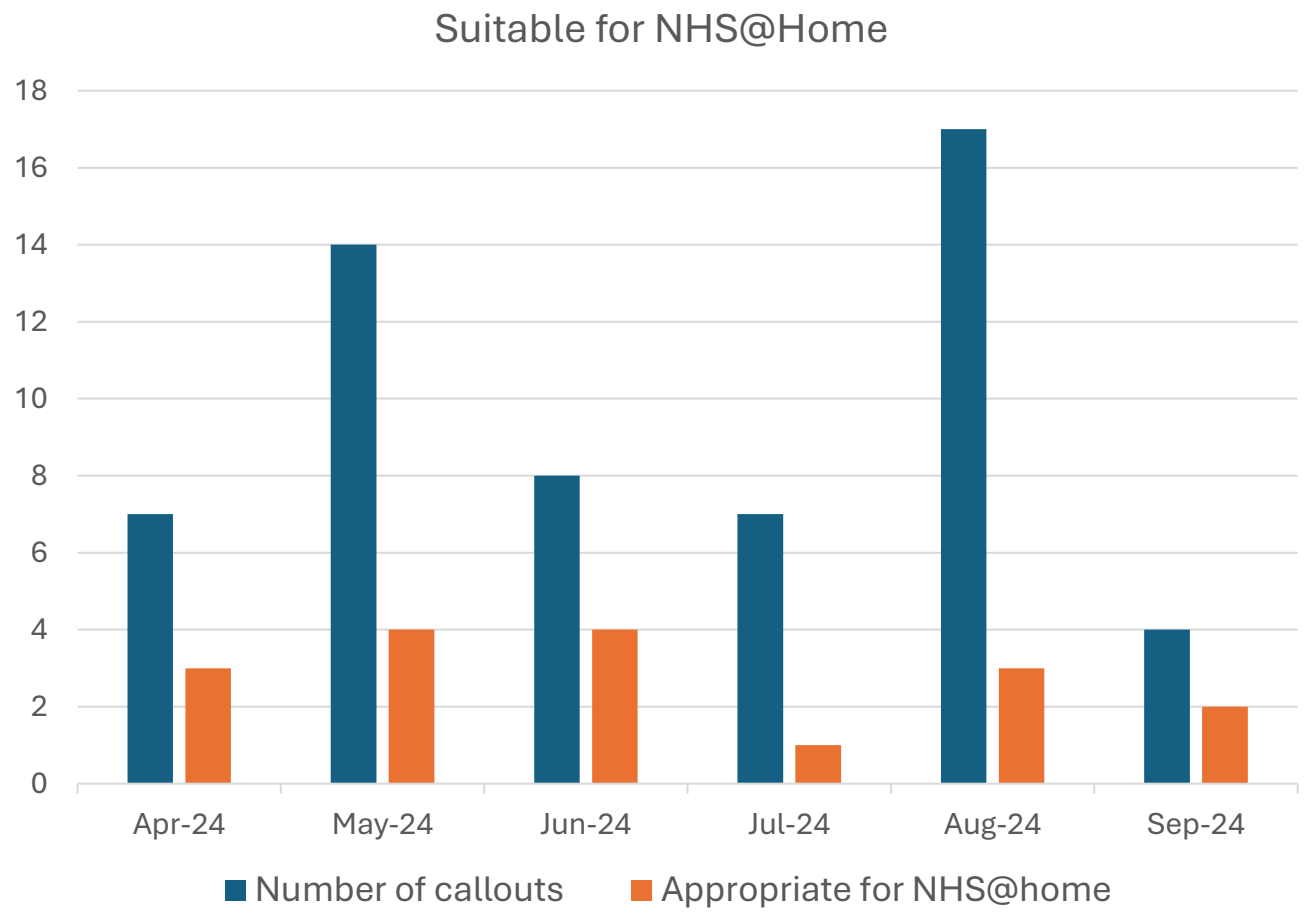
4. Better outcomes: home based care leads to lower readmission rates and improved recovery

5. Family involvement: being at home allows for greater involvement from family members which can enhance support and recovery.

6. Offloading pressure from primary care: limited resources available within GP surgeries to have the time to perform holistic reviews

Outcomes


Alexander Care Home LAS Conveyances
18
16
14
12
10
8
6
4
2
0
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
7
14
8
7
17
4
4
9
7
7
13
2
Callouts
Conveyed


Suitable for NHS@Home
18
16
14
12
10
8
6
4
2
0
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Number of callouts
Appropriate for NHS@home

Targeted achievements

- Training of care home staff
  - Improved digital literacy of care homes
  - Accountability
- Earlier referral and escalation onto the acute NHS@home service
  - Prevents LAS callouts for conditions that can be managed within the home
- Proactive preventative care improves overall health of care home residents to reduce unnecessary hospital admissions

Next Steps

- Work collaboratively with One Care Lewisham to review future areas of potential impact
- Continue to onboard new Care Homes to the dedicated NHS@Home pathway – Westwood House went live on 29th October 2024
- Continue to analyze data that that is coming from LAS to understand the true measurable impact of the collaboration.
- Community Falls pathway integration
- Integration with Proactive Ageing Well Service Lewisham

Challenges of Virtual Wards

ONE HEALTH LEWISHAM
The Integrated Community Provider

Technological barriers (incl. data privacy and security)
Staff engagement and skill mix
Clinical responsibility of care
Patient engagement and access
Financial constraints
Lack of true evidence based evaluations and benchmarking
Social care provision

South East London
Integrated Care System

Strategies for overcoming challenges

ONE HEALTH LEWISHAM
The Integrated Community Provider

Investment in technology and data security

Strong leadership and advocacy for both patients and staff and in policy making

Public engagement

Improving digital literacy through education and training

Core minimum standards across all virtual wards

Continuous data collection and evaluation of impact

Integration of ambulance/111, primary care and secondary care services

South East London
Integrated Care System

What do our patients think?

ONE HEALTH LEWISHAM
The Integrated Community Provider

‘I’m writing this email to all the staff that’s been involved with my care, what a wonderful service that I haven’t had to leave home. You act so efficiently when it comes to calling back, and you’re so reassuring and friendly on the phone. Any issues are always addressed. Keep up the good work.’

‘The team of professionals and my nurse Edith made me feel safe and taken care of. I was lead through all the processes by Edith in a nice warm atmosphere and received help with any I had and support with paperwork too. I’m very grateful for all support received and positivity. The equipment was also easy to use and the system. Once more time Edith, thank you for taking care of me, you are the best.’

‘Three weeks ago my husband was ill and was put on the virtual ward and must say without it and the amazing staff that run it my husband would have ended up in hospital. They saw that my husband oxygen level had dropped and changed his medication without hesitation. I am very grateful for all that they have done for him and hope that this system continues for everybody in need.’

‘My sincere thanks to the whole team for being excellent. The service made me feel safe and took away any vulnerability. I would recommend to any other patients who would need support when coming out of hospital’

South East London
Integrated Care System

Thank you!

Questions?

Matea.deliu2@nhs.net

Keynote Presentation

Mr Mike Waters
Operational Lead Virtual Ward
Norfolk & Norwich University Hospital

NNUH

Virtual Ward

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Working Towards a Regional Virtual Hospital.

Mike Waters

Virtual Ward Operational Nursing Lead,
Norfolk and Norwich University Hospitals (NNUH)

michael.waters@nnuh.nhs.uk

NNUH Digital Health

12/11/2024

NNUH Virtual Ward

The journey so far:

Norfolk and Norwich University Hospitals NHS Foundation Trust

- 13th January 2021 asked by NHSE/I to set up a virtual ward for Covid inpatients
- 9th February 2021 admitted our first patients
- Established a clinical team to mirror a normal ward
- Initially engaged shielding staff
- Created a governance process to fit into the corporate process, sitting within digital health.
- Our initial focus was COVID, but we knew we wanted to use the VW to support recovery
- ICS wide integration with Community/Acutes

"Our primary goal is to provide a safe and effective monitoring and follow-up service for all patients in the virtual ward, and to facilitate early discharge, admission avoidance, and physical bed occupancy reduction where possible"

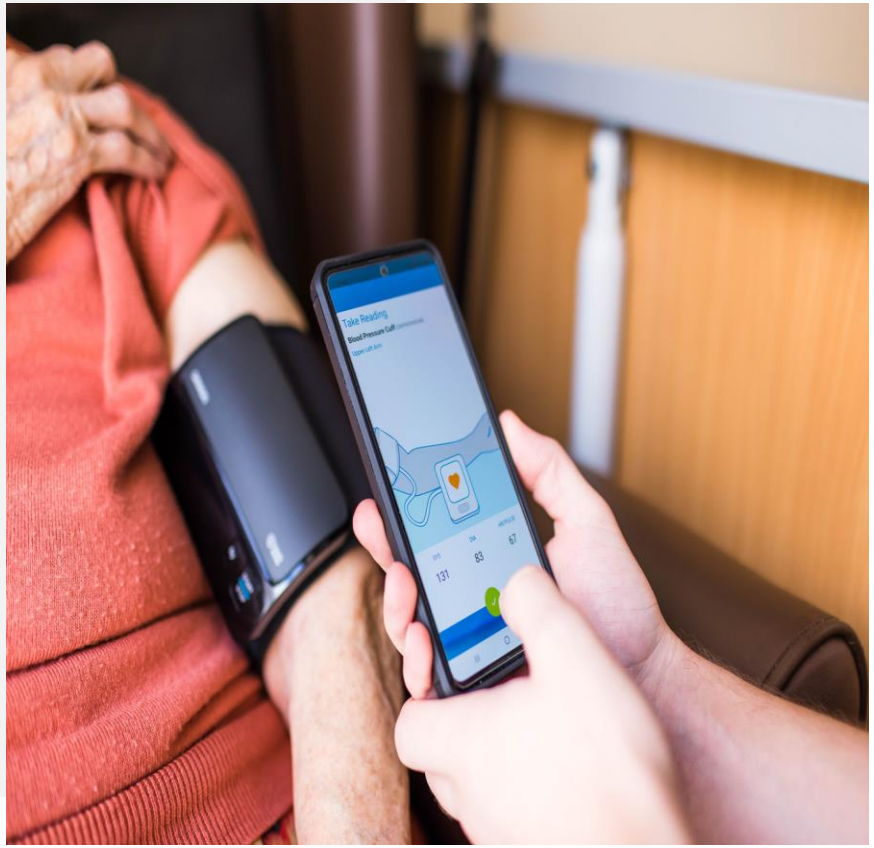
NNUH Digital Health

NNUH Virtual Ward

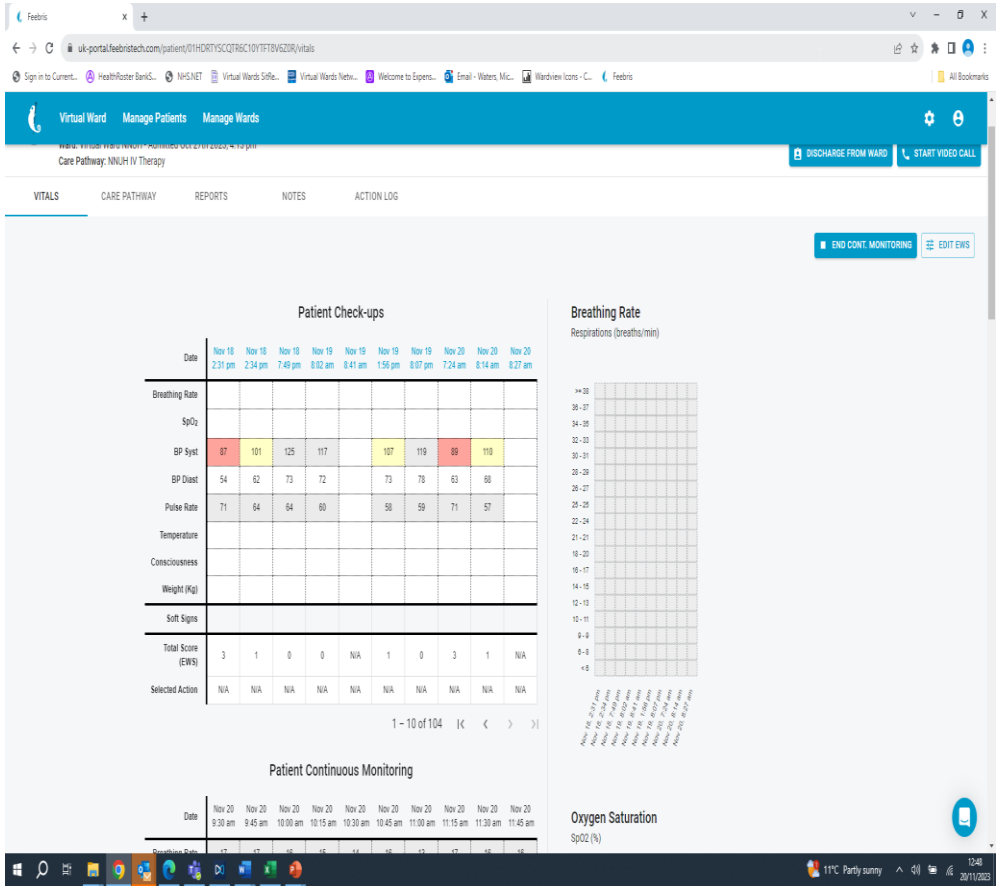
The Kit: Patient

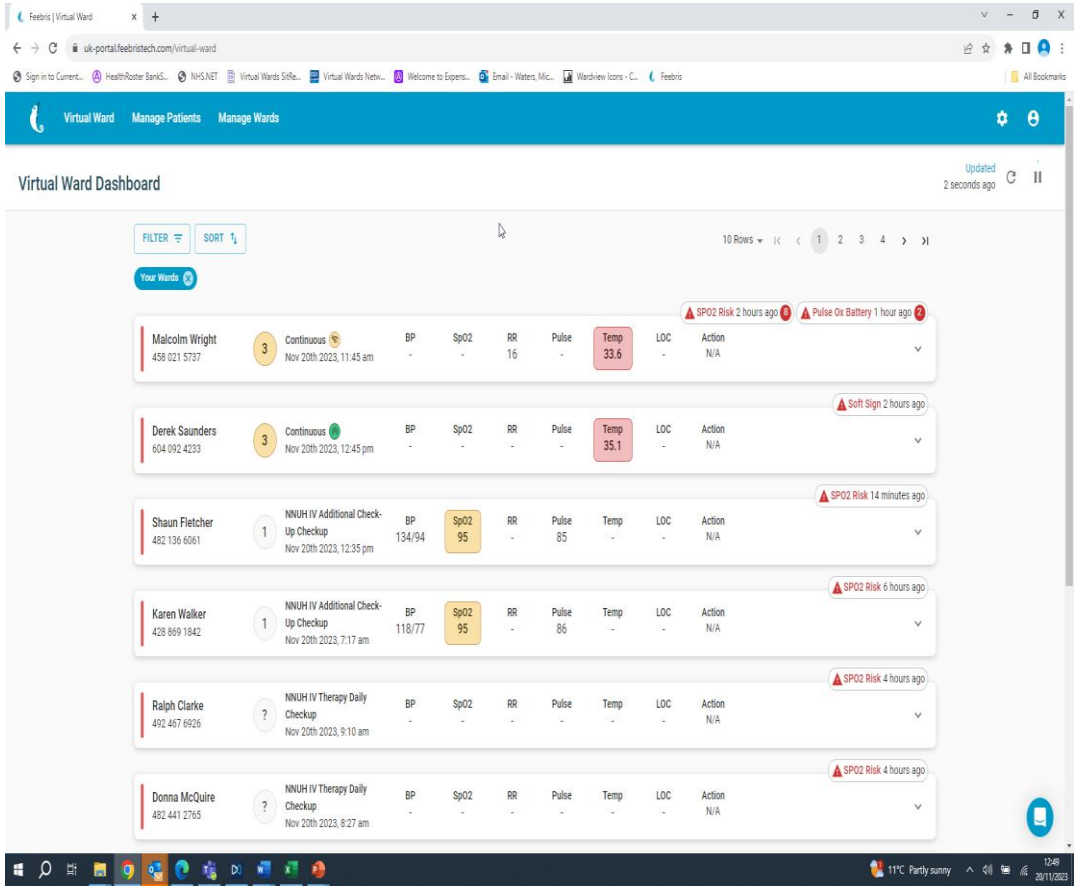
NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

- Continuous, passive monitoring of vital signs
  - Respiration rate
  - Oxygen Saturations
  - Movement
  - Pulse Rate
  - Body Temperature
- Additional monitoring available as required
  - Blood pressure
  - Scales
- Clinical dashboard with intelligent alerts (app/Desktop)
- Phone/Tablet to enable video calls



The Kit: Staff





NNUH Virtual Ward

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

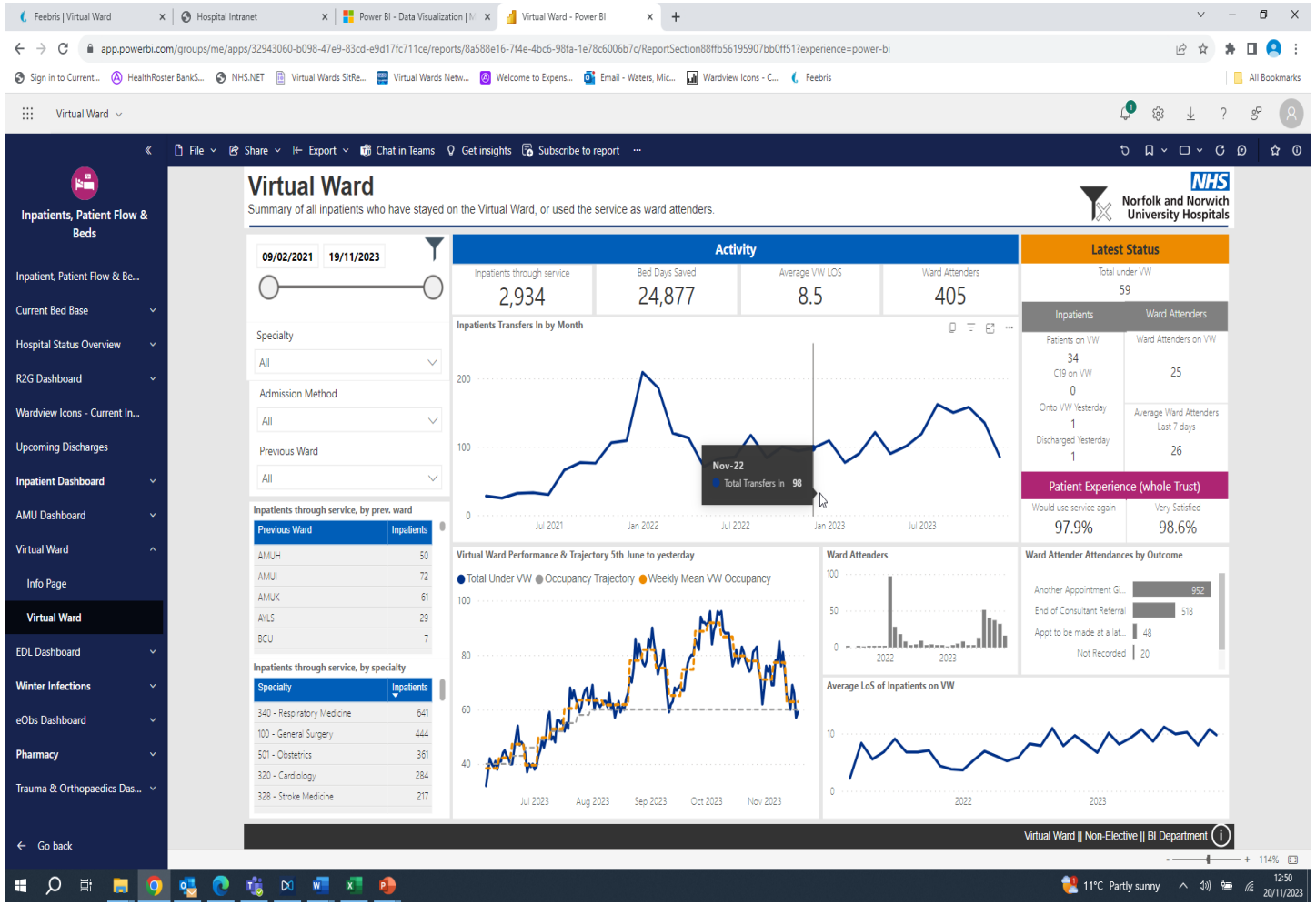
Current Pathways

Live Pathways

- Covid
- Palliative Care
- Respiratory
- Stroke
- Awaiting Diagnostics (CT, MRI, Pet, ECHO, Ultrasounds, Biopsy's)
- Awaiting Treatment. (Surgery, Lines etc)
- Awaiting Cardiology (Valves at Papworth)
- Stroke
- Gastro (IV Steroids)
- Pregnant patients Covid +ve
- Hot Gall-Bladder
- Diabetes
- Oncology
- Bespoke
- Heart Failure
- DPU
- IVAB's
- TIA's

The successes:

Virtual Ward Dashboard



- Patient Experience
- Staff Satisfaction

Services Offered

- 24/7 full monitoring of observations
- Pharmacy and Medicines Support
- Physiotherapy
- Daily Medical Review
- Links with AMDU and NNUH@Home

NNUH Digital Health

Community Virtual Ward: Step-Up

NHS
Norfolk Community Health and Care
NHS Trust

east coast
community healthcare

CLINICAL SUPPORT AND OVERVIEW FOR VIRTUAL WARD STEP-UP PATIENTS

The ACP is the Senior Responsible Clinician following admission to VW.

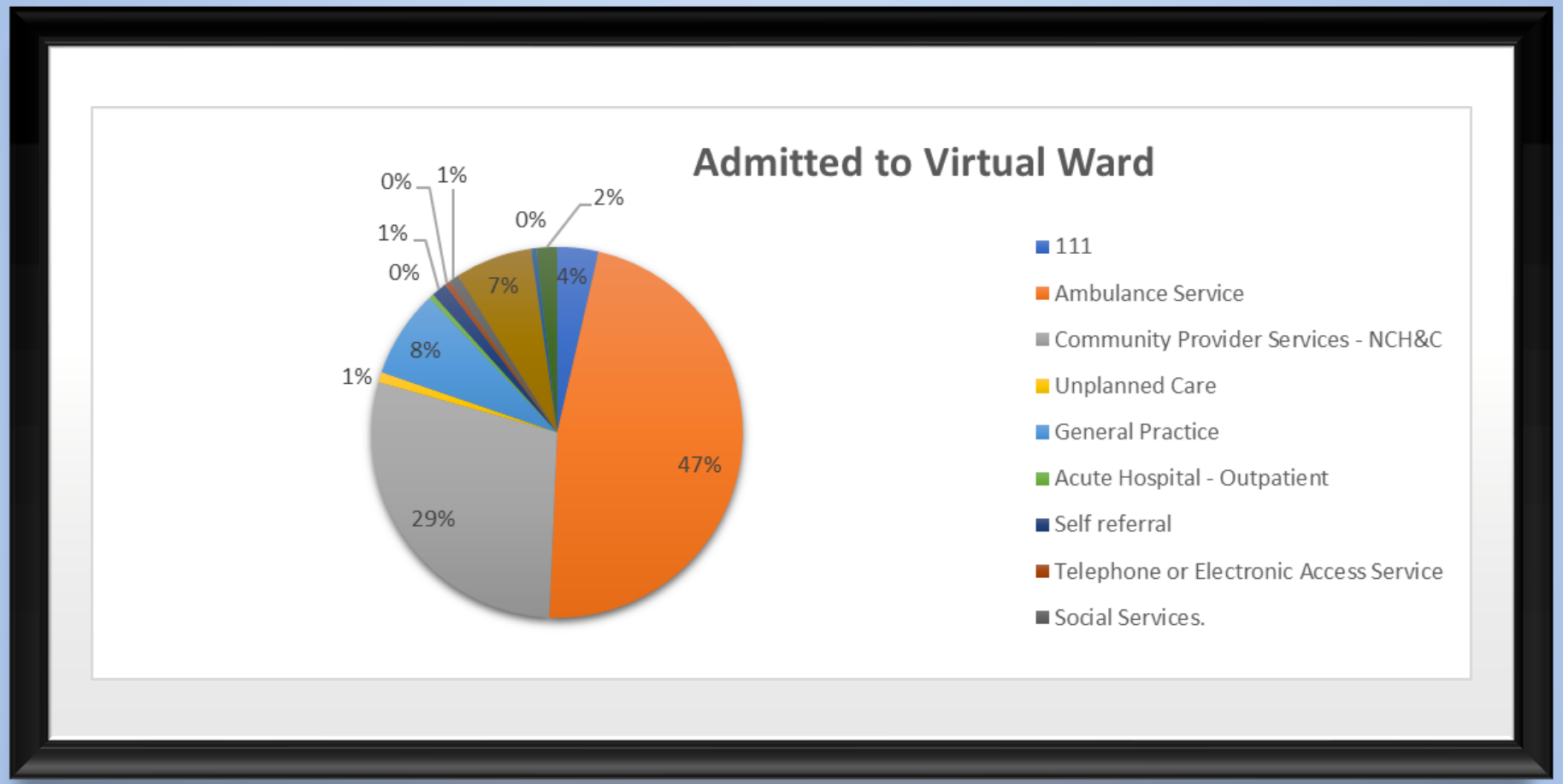
Daily case review per Place, and weekly MDT with wider medical team.

Clinical support obtained from patient's GP, specialist teams and acute Consultant teams via on-call system and SDEC pathways.

Patients will have a diverse acuity with an expected Length of Stay up to 14 days.

Fully integrated into Place teams. Careful integration with other support services during VW episode (e.g. NEAT, IV Therapy, Homeward, East Coast Community Access, ahead of development of planned/unplanned care).

Broader ACP Team (inpatients) and ACP Lead will provide clinical support


Admitted to Virtual Ward
0%
1%
2%
0%
1%
0%
7%
4%
8%
1%
47%
29%
111
Ambulance Service
Community Provider Services - NCH&C
Unplanned Care
General Practice
Acute Hospital - Outpatient
Self referral
Telephone or Electronic Access Service
Social Services.

east coast community healthcare

NHS Norfolk Community Health and Care NHS Trust

The Community Virtual Ward

Guidance for Nursing and Residential Care Home Staff

Referral Line: 03000 247 222 (Option 2)

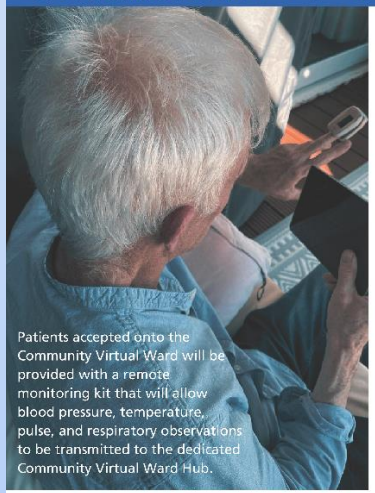
LOOKING AFTER YOU LOCALLY

east coast community healthcare

NHS Norfolk Community Health and Care NHS Trust

Is your patient suitable for

COMMUNITY VIRTUAL WARD



Patients accepted onto the Community Virtual Ward will be provided with a remote monitoring kit that will allow blood pressure, temperature, pulse, and respiratory observations to be transmitted to the dedicated Community Virtual Ward Hub.

Patient care is managed by an Advanced Clinical Practitioner (ACP), who works with other professionals such as doctors, nurses, and therapists to care for patients in person or remotely.

Patients are monitored 8am to 8pm, 7 days a week, including bank holidays, for up to 14 days.

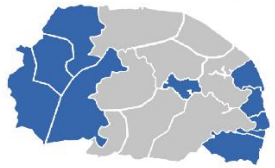
Community Virtual Ward performs tests such as blood tests or heart tracings and administers treatments such as oral and intravenous antibiotics.

Is your patient suitable?

If you have assessed a patient aged 18 or over who you feel would be able to receive care at home with the addition of ACP management and oversight, they may be suitable for Community Virtual Ward care to prevent avoidable hospital admission.

They may be suffering from conditions such as a worsening respiratory condition or exacerbation, worsening heart failure (previously diagnosed), or be frail with a worsening acute or chronic condition.

Community Virtual Ward coverage



Currently available for patients in Norwich, East, and West (North and South border patients considered.)

Please contact us to discuss referral by:

Phone: 03000 247 222 (select OPTION 2)

Your referral will be managed by our dedicated team and triaged by a clinician.

Referrals made by 5.30pm can usually be seen same day with clinician agreement.

LOOKING AFTER YOU LOCALLY

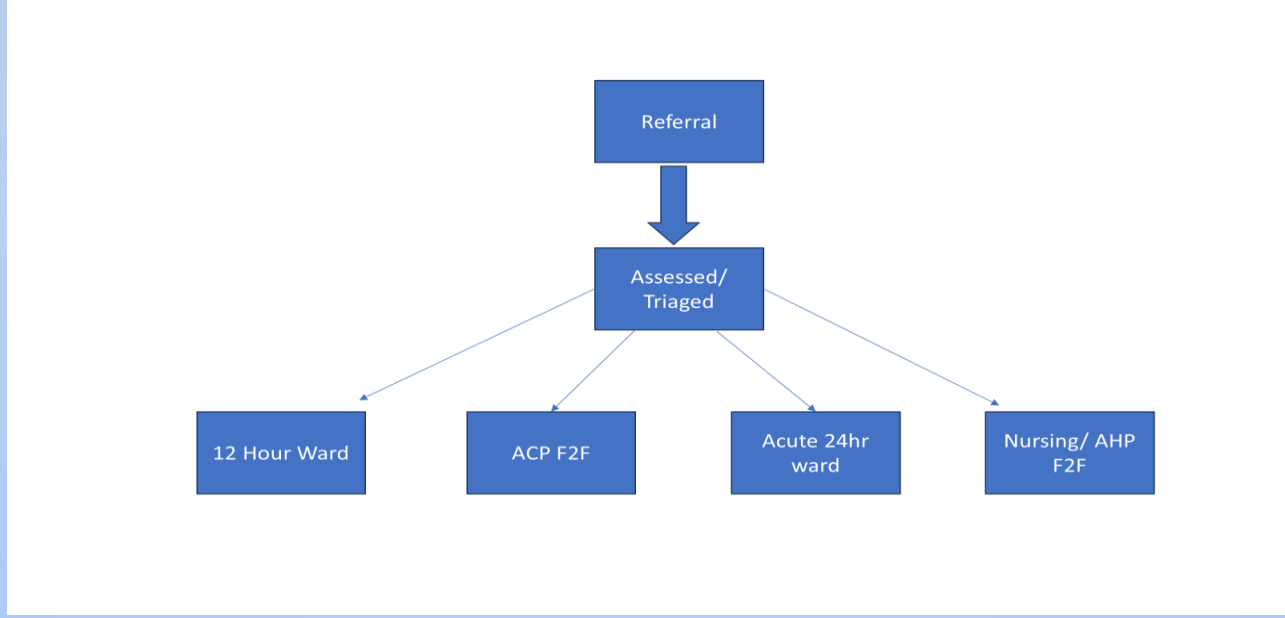
CHALLENGES

- Five Different Trusts with Differing Models of Care And Staffing models
- Data Sharing.
- Governance
- Different Referral Routes
- Large Rural Community.
- Staff Contracts

POSITIVES

- Ensure good relationship with Remote Provider
- Be Flexible
- Patient focussed
- Put the patient first

THE PLAN


Referral
Assessed/ Triaged
12 Hour Ward
ACP F2F
Acute 24hr ward
Nursing/ AHP F2F

NNUH
Virtual Ward

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Any Questions?

Michael.waters@nnuh.uk
Virtualward@nnuh.nhs.uk
Via Switchboard 24/7
ICE Referral (Search Virtual)
Tel: 07935014649

NNUH Digital Health

Drinks and Networking

CONVENZIS

Scan here for the next NHS Virtual Wards Conference...

27th February 2025
15Hatfields Conference Centre,
London SE1 8DJ