Shropshire Community Health NHS
NHS Trust

STW Virtual Wards and Integrated Discharge Team

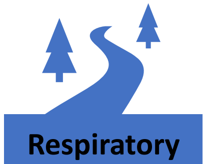
April 2024

Introduction to the Virtual Ward

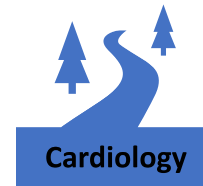
Shropshire NHS - Virtual Ward - Master on Vimeo

Current Pathways

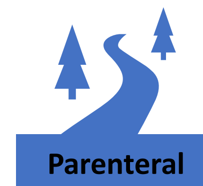
- Managing deterioration of health in Community (step-up)
- Step-down Management of Frailer Adult with changes in health status
- Care Home Virtual Ward
- Early Supported Discharge



- Management of exacerbation of Bronchiectasis – Step-up & Step down
- Management of upper and lower respiratory tract infections – oxygen step-down included
- Management of COPD, asthma, bronchiectasis and ILD



- Managing acute-on-chronic heart failure (step-down & step-up) with ability to deliver IV Furosemide



- UTI with ESBL
- Cellulitis
- Re-hydration using subcutaneous fluids

Improving Lives in Our Communities
Commitment to Quality · Respect & Dignity · Working Together · Compassionate Care · Everyone Counts

Patients suitable for Virtual Ward

- Patients who are housebound or ambulatory
- Any Care Home resident
- Patients who already have a pre-existing package of care.
- Frequent attenders (x2+ in last 6 months).
- Patient on palliative care/ End of Life register. Or seems more appropriate to palliate given clinical presentation.
- Patients who can have IV Antibiotics in the community as per DAART/ community IV pathways.
- Patients who do not need ventilatory support acutely. I.e. Anyone who does not meet the right to reside criteria.
- Anyone who has/or needs an advance care plan to say they should be for community-based care only.
- Patients who can have their antibiotics IV at home or need step down to oral.
- Patients who may find admission distressing (e.g. Advanced Dementia, Learning Disability).
- Patients already under community teams/Virtual Ward caseload.

Performance of Service

Total referrals to VW is 4,156

Average Length of Stay is 14 days

8% of patients readmitted within 30 days

Pathway Utilisation

Referrals by Team and Referral Reason

No. Referrals

350
300
250
200
150
100
50
0

Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24

Received Date

Referral Reason Description

- Bronchiectasis [J47] VW
- Cancer - All Sources [C15-C26]
- Cellulitis [L03] (VW)
- COVID-19 (Virtual Ward)
- Frailty (Virtual Ward)
- Heart Failure [I50.9] (VW)
- Urine Infection [N39.0] (VW)
- Acute Respiratory Infection Pathway (J06)
- Heart Failure Pathway (I50)

Contact Medium

No. of Contacts

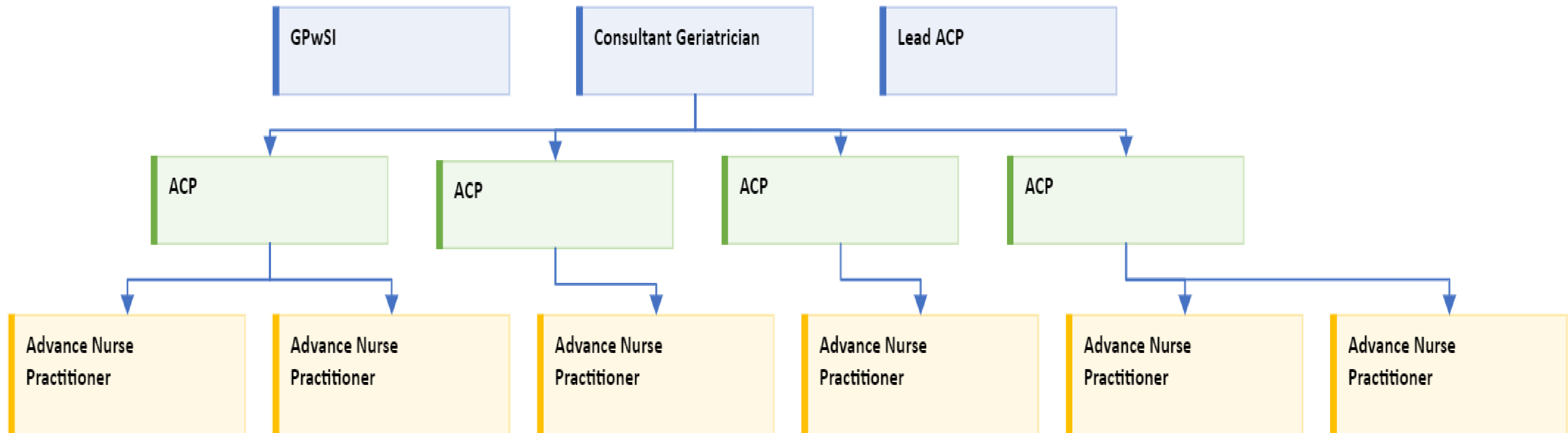
3,000
2,500
2,000
1,500
1,000
500
0

Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24

Contact Date Display

Contact Type Description
- Email - Client
- Face to Face communication
- Group with Client
- Other Client linked activity
- Telemedicine web camera
- Telephone

Workforce – Locality model



Clinical Scenario

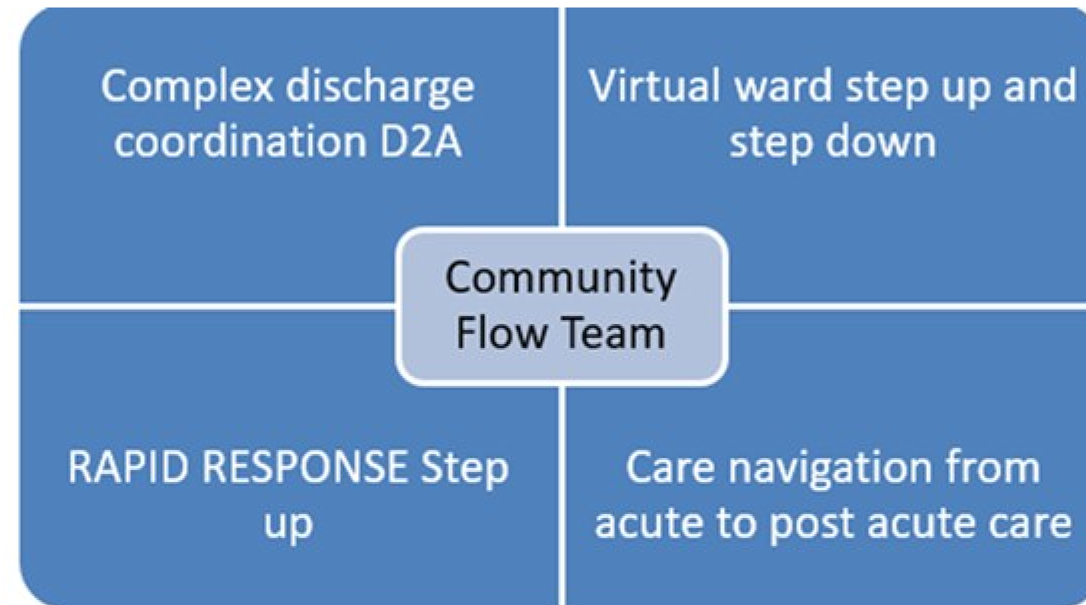
Improving Lives in Our Communities
Commitment to Quality | Respect & Dignity | Working Together | Compassionate Care | Everyone Counts

Introduction to the Integrated Discharge Team

April 2024

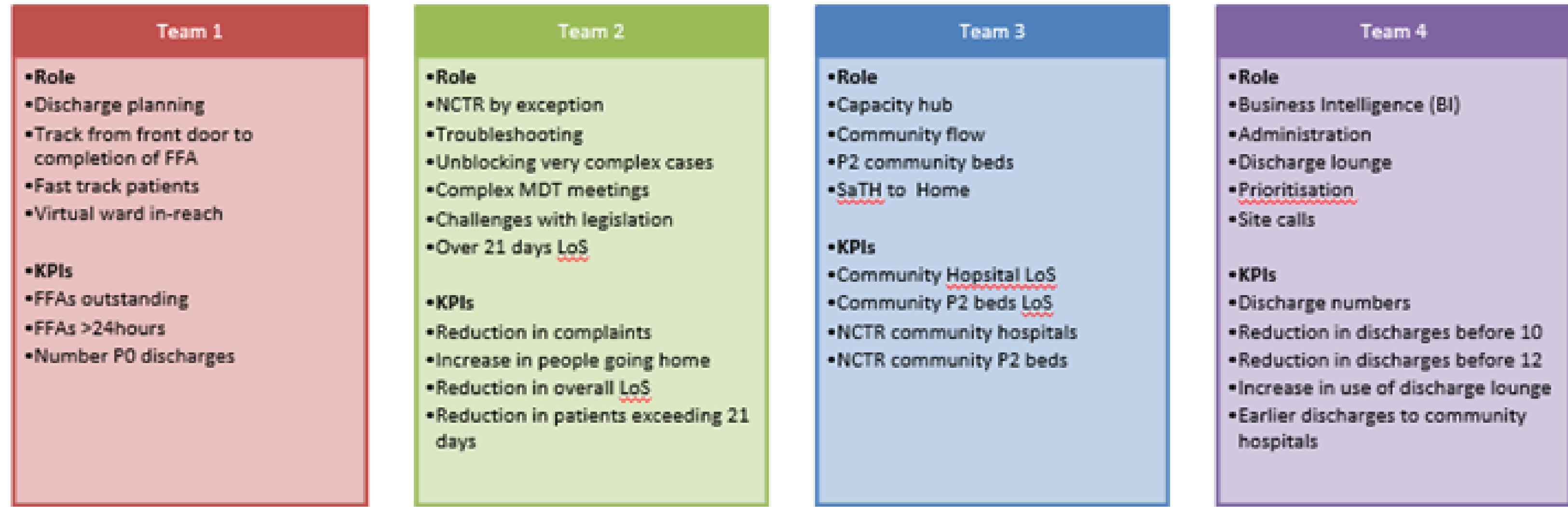
Integrated Discharge Team

- SCHT Strategic priority of building community care capacity, supporting people to stay well and out of hospital.
- Key objective to enhance the IDT improvements across STW, further reducing the length of stay (LoS) for patients with 'No Criteria to Reside’,
- Partnership working across Health and Social Care Teams
- Ambition to promote and commit to adopting a home first philosophy
- Discharge people from hospital at the right time, to the right place and with the right care



The Integrated Discharge Team

- Mutual endeavor and single narrative across the system to support people home as a default option, ensuring continuity of care co-ordination from admission through to discharge
- Co-located Team including Shropshire, Telford and Wrekin, Powys Health and Social Care Staff



Key Achievements

- Positive working relationships between partner organisations has created shared learning and understanding
- Recruitment to plan for IDT staffing inline with the business case, 19 staff employed to date with 3 vacant posts in progress of recruitment
- Reduction in the number of patients meeting No Criteria to Reside
- Reduction in average days complex NCTR from baseline 4.6 days to a range of 2.5 to 3.4 days- achieving a reduction in LoS by 2 days in acute hospital. 24/25 target set at 2.5 days via demand and capacity planning
- MDT approach taken to Transfer of Care Documents involving therapy and IDT have taken over completion of the ToC documentation enabling therapists to focus on direct clinical care.
- Development of Policies across organisation to develop improved prcesses including Housing / Homelessness and Choice policy
- Move to Business as usual with service improvement plans and KPI / metrics