healthwatch Staffordshire

Avoiding Hospital Admissions

(all you need to know)

January 2025

Contents

Introduction

The NHS Long Term Plan

The NHS long term plan often referred to as the 10-Year Plan was published in January 2019. It outlines the vision for the future of the National Health Service in England over a decade, focusing on improving health outcomes, integrating care, and addressing key challenges in the healthcare system, (England 2023).

Vision

- To improve healthcare outcomes, patient experience, and system efficiency.
- Deliver care that is more personalised, digitally enabled, and prevention focused.

The Plan set out the aims of the NHS over this period. It said that …'to succeed, we must keep all that's good about our health service and its place in our national life. But we must tackle head-on the pressures our staff face, while making our extra funding go as far as possible. And as we do so, we must accelerate the redesign of patient care to future-proof the NHS for the decade ahead.' The plan sets out five major, practical, changes to the NHS service model to bring this about over the next 5 years,

We will boost 'out-of-hospital' care and finally dissolve the historic divide between primary and community health services.

The NHS will redesign and reduce pressure on emergency hospital services.

People will get more control over their own health, and more personalised care when they need it.

Digitally-enabled primary and outpatient care will go mainstream across the NHS.

Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.

Quote from "NHS Long Term Plan » Chapter 1: A new service model for the 21st century"

In July 2024 Staffordshire Healthwatch published a Deep Dive report on patient experiences of using the 999 Ambulance Service. This was the first of 3 Deep Dive projects as part of our workplan for 2023/24. The Deep Dive report highlighted some of the significant pressures in terms of ambulance response times and handover times once reaching Emergency Departments at hospitals. The study also highlighted several admission avoidance initiatives aimed at reducing conveyance and admission to hospital by treating patients in their own home where possible. This Deep Dive therefore aims to look in some detail at admission avoidance services that focus on reducing unnecessary admissions to hospital and relieving some of the pressures on the ambulance and secondary services. Whilst looking at admission avoidance services overall, Healthwatch are looking in greater detail at the concept and development in practice of 'virtual wards. The initial intelligence gathered through feedback from the public suggests that there is limited understanding of what a 'virtual ward' is and what this means in

practice for them as a potential patient. The aim of this deep dive therefore is to educate and inform the public about admission avoidance in a way that enables them to feel involved in their care at treatment and understand the impetus behind and benefits Admission Avoidance.

Staffordshire Admission Avoidance Programme:

In Staffordshire, a targeted admission avoidance programme has been implemented to support elderly patients at risk of hospitalisation. The programme includes the use of multi-disciplinary teams (MDTs) that offer coordinated care across health and social services, aiming to manage conditions in the community. The scheme has been shown to reduce hospital admissions, promote better health, and improve patient satisfaction. The programme is delivered through;

The Staffordshire Integrated Care System:

"We need to reduce unnecessary hospital admissions for our frail elderly population through effective proactive interventions as well as providing rapid support at home when they become sub-acutely unwell. This requires the provision of effective out-of-hospital services including virtual wards, remote care systems and other community teams. Our focus should be on keeping people within their own homes – reducing the often-negative impact of hospital admission. People almost universally prefer to avoid hospitals where possible – and we need to be able to offer them that choice. Care and treatment in the usual place of residence is preferable – if safe to do so with an appropriate care model in place. We know that admitting elderly people via busy emergency departments can shorten their lives and is often a poor experience. Avoiding unnecessary admissions will play an important part in improving our capacity to discharge people effectively. " ***Quote from the Staffordshire and Stoke on Trent Integrated Care Board Operational Plan 2023 to 2024.***

Integrated Care Coordination for Urgent Care

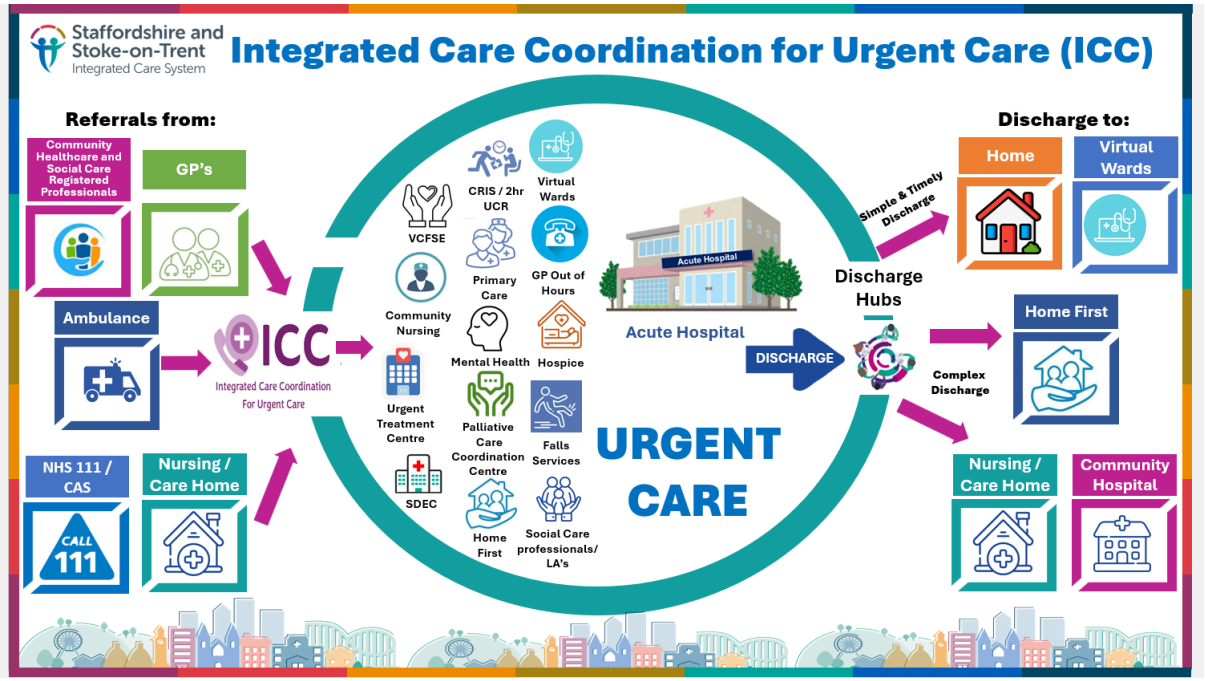
Admission avoidance in Staffordshire and Stoke on Trent is provided through several pathways. It is a broad-based approach which is delivered through a process known as Integrated Care Coordination for Urgent Care (ICC).

Integrated Care Coordination (ICC) for Urgent Care in Staffordshire and Stoke-on-Trent 'Right care, right place, right time.' Most often, when safe and appropriate the best place for a person to receive urgent care is in the community and, where possible, in their own home. The ICC for Urgent Care is a triage function that supports health and care professionals to coordinate and navigate urgent care to support people to remain in their usual place of

residence. This may be in the community, via an outpatient clinic, community nursing, community rapid intervention service, first contact and front door social care, specialist community teams or virtual wards, avoiding unnecessary hospital admissions and helping to protect vital resources like ambulances and emergency department services for those who need them most.

A preventable admission is one where there is scope for earlier, or different action to prevent and individuals' health or social circumstances deteriorating to the extent where hospital or long-term bed-based residential or nursing care is required.

The diagram below highlights the different pathways for admission avoidance,



the goals of which are to:

- Develop a true integrated care coordination service for urgent care to streamline access to non-emergency department pathways and reduce the barriers to access the 'right care, right place, first time' through a single number.

- Get patients the right service in the right place, at the right time, and redirect to services who know them best; not only to manage the current crisis but to develop contingency for the next crisis or escalation.

- Make it easier for health and social care professionals to have an earlier clinical conversation to reduce avoidable ambulance dispatch and handover delays.

- Collect data on service gaps to inform offers of alternative provision.

There are currently 18 pathways in total with each playing a different but important and integral role in reducing pressures on hospitals and emergency services. Evidence suggests that personalised care approaches through community health services can help reduce pressures hospitals and emergency services by supporting patients at home and in the community. This leads to

better outcomes for both patients and the NHS. Below is a summary of some of the main pathways that provide wrap around services which contribute to admission avoidance. Referrals to the team are made by professionals such as GP's, West Midlands Ambulance Service, Emergency Departments, NHS 111 and other health care professionals.

Acute Care at Home Services (ACAH)

Community Rapid Intervention Service (CRIS)

The Community Rapid Intervention Service (CRIS) is an integrated service provided by both University Hospital of North Midlands (UHNM) and Midlands Partnership NHS Foundation Trust (MPFT) for patients at risk of needing an admission to hospital.

The service is provided across Staffordshire and Stoke-on-Trent and offers a helpline for GPs, care homes and West Midlands Ambulance Service to refer patients for care within their own home.

We have Clinical Coordinators on duty who receive the referrals from our key stakeholders, once the referrals are received, they are passed to the Advanced Clinical Practitioners who would then see the patients in their own home within two hours of referral. The service operates from 8am -10pm, 7 days a week. The majority of patients are elderly and frail and include patients with infection, respiratory conditions and heart failure.

The service is used as a diversion for patients taken to A&E. An A&E consultant reported, A&E is a very busy department and not really the right place for many of our patients to be, particularly those who are old and frail. CRIS provides a responsive, flexible, accessible service providing care in the home and a better patient experience while reducing the pressure on A&E and demand on our hospital beds."

Same Day Emergency Care (SDEC)

A brand-new, purpose-built Same Day Emergency Care Unit (SDEC) has welcomed its first patients at University Hospitals of North Midlands NHS Trust (UHNM).

The Acute Medical Rapid Assessment Unit (AMRAU) aims to investigate, treat, and discharge patients on the same day, freeing up space at Royal Stoke's emergency department and other acute medical wards.

The Unit provides an additional 16 beds and 10 trolley spaces for patients referred from A&E, as well as those sent by GPs.

This new Unit provides important additional beds for patients with medical conditions at UHNM, improving our ability to see, assess and treat patients more quickly, safely, and efficiently. It increases the number of patients we will be able to treat and discharge on the same day, reducing the demand on our wards and ensuring our patients receive the best possible experience."

Patients on AMRAU are treated in four bed bays and two trolley bays where patients can be transferred into. The Unit also offers eight, en-suite side rooms.

Home First

In Staffordshire, the national approach to Discharge to Assess (D2A) is referred to as 'Home First' This service aims to help patients return home and receive care where previously they would have stayed in hospital. Whilst some people may not need any help when they get home but for those who do, the home first team will make sure that the right support is in place. The ethos of the service is that it is best for people's health and well-being to be treated away from hospital, ideally in their home, when medically safe to do so.

Palliative Care

Care and treatment in the usual place of residence is often preferable to patients – if safe to do so with an appropriate care model in place. Evidence suggests that admitting elderly people to hospital via busy emergency departments can shorten their lives and is often a poor experience.

There are still people who are at the end of their life being escalated into hospital who have clearly indicated they want their care at home, and an enhanced community offer will help ensure their wishes are met.

Avoiding unnecessary admissions will play an important part in improving the system's capacity to discharge people effectively.

The Palliative Care Coordination Centre aims to support rapid discharges from hospital and source safe and timely care for those individuals who have a deterioration in health and entering the terminal stage of life. The service also supports people to remain at home rather than being admitted to hospital.

Aims of the Pathway

- To provide high quality care at end of life at home or in a home.
- To reduce bureaucracy.
- To promote the principle of going home first.
- To collaborate with partners to improve service delivery, particularly providers.

To improve services for patients and families, the aim of the NHS & MPFT is to implement proactive and timely interventions to prevent hospital admissions, reduce delays in hospital discharge, and decrease the number of patients dying in the hospital while waiting for care.

From January to April 2024, the service received 216 referrals per month at the Palliative Care Coordination Centre. The average time from acceptance to placement has decreased from 4-11 days (prior to implementing the pathway) to an average of 1 day. For care homes, the average time from acceptance to placement has decreased from an average of 6.89 days in July 2023 to 2 days. Since January 2024, an estimated 1172 hospital bed days have been saved either through admission avoidance or early discharge.

Falls Services

Falls are a significant factor in hospital admissions particularly in people who are frail and elderly. Falls prevention is a key pathway to helping reduce hospital admissions and there are a number of initiatives across Staffordshire working to

reduce the number of falls. The specialist falls service is commissioned differently in different parts of Staffordshire and Stoke on Trent (though all delivered by MPFT)

There are three falls' teams covering Staffordshire: South, East, and North Staffordshire. A description of each of the teams and its remit can be found on: https://www.mpft.nhs.uk/services/falls-prevention-service

In addition

Staffordshire Fire and Rescue Service

have recently been celebrated for their achievements in responding to falls with a dedicated national award. They started a joint initiative with the NHS, West Midlands Ambulance Service and the Stoke-on-Trent Integrated Care Board to respond more effectively to reports of falls across the region.

The team has received bespoke training to use specialist equipment to help the individual who has fallen before looking to address any hazards or obstacles that may have contributed to the incident.

Members of the team are each trained in first responder emergency care (FREC) to help anyone in need of support and operate a service during the day, seven days a week.

Since its inception up to the end of September 2024, the team has been called out to help 1,900 times to assist patients who have fallen and unable to get back on their feet.

The initiative was designed to reduce the demand on the ambulance service and local hospitals by assigning fire service personnel to attend incidents where people had fallen and needed help.

It has meant that ambulance crews have been freed up to attend incidents involving serious injury and admission times at hospitals have been eased.

As part of the response, the team also carry out a safe and well visit with the person affected and make sure they have access to the necessary support.

Community Nursing, Long Term Conditions and Therapy Services

These community-based services are provided by the Midlands Partnership University Foundation NHS Trust (MPFT).

The information below provides details about some of the services that are provided in the community with the aim of maximising the health of our local communities and supporting people to access assessment, treatment and rehabilitation close to home, and where appropriate, without the need for hospitalisation.

Community services are provided in a variety of community-based settings, mostly these will be clinics or community buildings to ensure care is as close to home as possible. Services are provided in a person's own home, or place of residence if they are registered as housebound, this is when a person is unable to leave their home to attend appointments.

As well as providing direct patient care, the teams also have a teaching role, working with patients to enable them to care for themselves or with family members teaching them how to give care to their relatives. Supporting people to regain or retain their independence where possible.

Community teams work closely with each other and with colleagues in GP practices, social care, hospices, hospitals and other community services to ensure a holistic approach is provided. Many of the services are delivered by teams that are aligned to the Primary Care Networks (PCNs) in Staffordshire and Stoke-on-Trent, these are groups of GPs who work together to provide services across several practices which enables them to deliver services that could not be delivered by single practices alone, often responding to specific needs of their local communities.

These teams play a vital role in keeping avoidable hospital admissions, and readmissions, to a minimum and ensuring that patients can return to their usual place of residence as soon as possible.

Community teams include:

District Nursing

District Nursing (DN) teams provide care to adults at home, when someone is permanently or temporarily unable to access services from their GP or other clinic-based settings. The DN service also provides wound care clinics at multiple locations where specially trained nurses and support workers carry out assessment and treatment of people with complex or chronic wounds (usually leg ulcers).

DNs play a key role in admission avoidance by providing nursing interventions, that may have previously been carried out in hospital, in patients' homes. Examples of this are administering intravenous medications and providing end of life care at home.

The DN teams in Staffordshire and Stoke-on-Trent carry out an average of 70,000 patient contacts each month. The DN teams provide assessment and care co-ordination, providing a wide range of nursing procedures in patients homes including administration of non-oral medications if the patient or family member cannot administer these themselves; post-surgical wound care; pressure ulcer management; leg ulcer management; catheter and bowel care; palliative and end of life care.

A large proportion of DN visits are for nursing interventions that can be planned in advance like leg ulcer management and catheter care, however there an increasing number of visits that cannot be planned. More terminally ill people are being supported to, rightly, die at home. Often support to these patients, and their families cannot be planned and needs a quick response, multiple times a day or through the night. This response is particularly important when someone is in pain or distressed, so the DN day will often change multiple times to ensure they can react where they are needed most.

DN teams include a range of roles, a senior nurse allocates visits daily ensuring a practitioner with the right skills and experience visits each patient. If you, or a family member or friend are receiving visits from the DN team, you won't always see a District Nurse, there are a number of different roles in the

team, the District Nurse or Senior Staff Nurse will carry out visits and also delegate the visits to appropriately competent members of the team that may include staff nurses, nurse associates or health care support workers depending on your needs. It is the District Nurse, who is an experienced community nurse who has completed the District Nurse degree in addition to their registered nurse training, who take responsibility for the caseload of patients.

The services provided by the District Nursing Team include:

- Assist patients to be independent and improve health
- Complex care
- Co-ordinate care and work with other agencies
- Long term conditions
- Palliative and end of life care
- Skilled nursing assessments
- Supported discharge
- Wound care/tissue viability

Long Term Conditions and Specialist Teams

There are several specialist nursing teams who provide community services, most appointments are provided in clinics however home visits are carried out if the patient is registered as housebound. The teams consist of highly specialised nurses and therapists who will have completed additional training in addition to their registered professional degree.

Specialist teams will deal with patients with complex needs and will work closely with GP and hospital teams to deliver joined up care. Examples of services provided in the community include:

- Diabetes
- Heart Failure
- Respiratory Disease
- Continence
- Tissue Viability (Wound Care)
- Pulmonary Rehabilitation
- Cancer support

Community Therapy

A wide range of therapy services are provided in the community in clinics and in patients usual place of residence. Services include Podiatry, Dietetics, Occupational Therapists, Physiotherapists, Pain Management, Physical and Neuro Psychology, Rehab and Speech and Language Therapy.

The teams aim to provide expert assessment and treatment to people in the community with the aim of supporting people to recover and rehabilitate at home, avoiding the need for hospitalization, or supporting people to be discharged home as soon as possible.

The community therapy teams are made up of a wide range of roles, with appointments planned with the most appropriate professional, this may be with

a therapy support worker, a registered therapist, or an advanced or consultant therapist.

Virtual Wards

The concept of Virtual Wards emerged as a response to growing challenges in healthcare systems worldwide, particularly the need to reduce hospital overcrowding, improve patient outcomes, and deliver cost-effective care. Several key factors contributed to their development:

1. Hospital Overcrowding and Bed Shortages

- Increasing demand for hospital beds due to aging populations and chronic diseases strained healthcare systems.
- Virtual wards offered a solution by enabling patients to receive hospital-level care at home, freeing up beds for more critical cases.

2. Advances in Remote Monitoring Technology

- Innovations in digital health tools, wearable devices, and telemedicine allowed healthcare providers to monitor patients' vital signs and conditions in real time.
- Companies like ''Spirit Health'' and ''Dignio'' pioneered technologies that facilitated the integration of virtual wards.

3. NHS "Home First" Strategy

- The NHS introduced the "home first" policy, emphasising care in community settings to enhance recovery and patient satisfaction.
- Virtual wards align with this strategy by prioritising home-based care and reducing unnecessary hospital stays.

4. Focus on Cost-Effective Healthcare

- Prolonged hospital stays are expensive and resource intensive. Virtual wards provide a more affordable alternative without compromising care quality.

5. NHS Long-Term Plan

- The NHS Long-Term Plan (2019) highlighted the importance of delivering care closer to patients' homes and leveraging digital technologies to improve healthcare accessibility and efficiency.

6. COVID-19 Pandemic

- The pandemic accelerated the adoption of virtual care models, including virtual wards, to reduce the risk of infections and maintain healthcare delivery during lockdowns.

What is a Virtual Ward?

According to Staffordshire and Stoke-on-Trent Integrated Care System's leaflet "General Acute and Frailty Ward Referral Guide".

"A virtual ward provides clinical assessment, treatment, monitoring and review to people in their own home who become unwell and would normally be admitted to hospital, or to those under the care of one of the following: Royal Stoke University Hospital, County Hospital at Stafford, New Cross Hospital at Wolverhampton or Burton Hospital."

A virtual ward is sometimes known as "Hospital at Home". When used to avoid hospital admission it is known as **'Step Up'**. When a person's hospital care continues at home it is called **'Step Down'** this can happen for patients who are not medically fit, but are stable, and can be monitored at home.

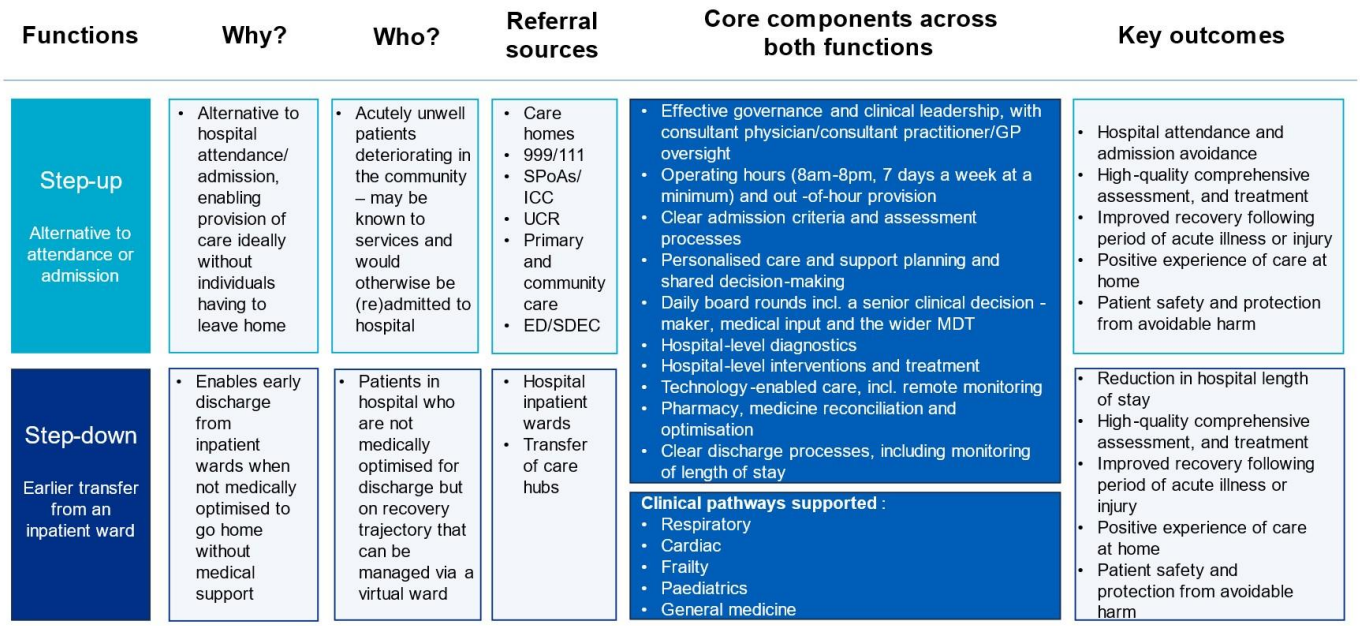
Referrals to Step-Up can be made via the CRIS team by:

- Care Homes
- 999 or NHS 111
- Single Points of Access
- Integrated Care Centre
- Urgent Community Response teams
- Primary and community care
- Emergency Department (A&E)
- Same Day Emergency Care (SDEC)

Referrals to Step-Down can be made by

- Hospital in-patient wards
- Transfer of care hubs

The following figure from NHS England Virtual Wards Operational Framework gives more detailed information.



Functions	Why?	Who?	Referral sources	Core components across both functions	Key outcomes
Step-up Alternative to attendance or admission	• Alternative to hospital attendance/ admission, enabling provision of care ideally without individuals having to leave home	• Acutely unwell patients deteriorating in the community – may be known to services and would otherwise be (re)admitted to hospital	• Care homes • 999/111 • SPoAs/ ICC • UCR • Primary and community care • ED/SDEC	• Effective governance and clinical leadership, with consultant physician/consultant practitioner/GP oversight • Operating hours (8am-8pm, 7 days a week at a minimum) and out -of-hour provision • Clear admission criteria and assessment processes • Personalised care and support planning and shared decision-making • Daily board rounds incl. a senior clinical decision - maker, medical input and the wider MDT • Hospital-level diagnostics • Hospital-level interventions and treatment • Technology -enabled care, incl. remote monitoring • Pharmacy, medicine reconciliation and optimisation • Clear discharge processes, including monitoring of length of stay	• Hospital attendance and admission avoidance • High-quality comprehensive assessment, and treatment • Improved recovery following period of acute illness or injury • Positive experience of care at home • Patient safety and protection from avoidable harm
Step-down Earlier transfer from an inpatient ward	• Enables early discharge from inpatient wards when not medically optimised to go home without medical support	• Patients in hospital who are not medically optimised for discharge but on recovery trajectory that can be managed via a virtual ward	• Hospital inpatient wards • Transfer of care hubs	**Clinical pathways supported :** • Respiratory • Cardiac • Frailty • Paediatrics • General medicine	• Reduction in hospital length of stay • High-quality comprehensive assessment, and treatment • Improved recovery following period of acute illness or injury • Positive experience of care at home • Patient safety and protection from avoidable harm

This source also states:

> There is growing evidence that when all core components of these services are delivered at scale for appropriate patients, they provide a better patient experience and can improve outcomes compared to inpatient care and narrow the gap between demand and capacity for hospital beds by preventing attendances and admissions, shifting acute care into the community or reducing length of stay through early discharge. The virtual ward model has broad clinical support, including endorsement from professional bodies.

In the NHS England Delivery Plan for Recovering Urgent and Emergency Care, Progress Update and Next Steps, published in May 2024, it said that virtual wards have:

	Created almost 12,000 virtual ward 'beds' allowing patients to receive hospital-level care at home, with 73% of this capacity used in March 2024 – the equivalent of 20 hospitals' worth of beds.

This equated to 240,000 patients. (Pages 2 and 4).

Staffordshire currently has a number of virtual wards, which are for **'General Acute & Frailty'**. People can be admitted to the ward for conditions such as respiratory, urinary tract infections (UTI's), cellulitis, and deconditioning – dementia. This video has been created to better explain what a virtual ward is.

When admitted to the ward, the care that people receive depends on how unwell they are. 'Acute' means the person is more unwell than if they are 'sub-acute'.

If someone is acutely unwell, or frail, they will have in person visits from the Virtual Ward staff. They may also have some remote monitoring depending how unwell they are (and how familiar they are with using technology).

In all cases, if the need arises, people can be transferred into hospital. Patients who are under the virtual ward care are regularly reviewed and discharged depending on presenting conditions.

According to NHS England Virtual Wards Operational Framework, a virtual ward is not for:

- deterioration prevention
- for patients who can be discharged from hospital, but whose symptoms may change
- intermediate care

Once referred to the virtual ward, a member of the Team will visit them at home and complete a clinical assessment, and digital assessment. They will discuss their treatment plan, understand if there are other professionals already involved with their care, and provide reassurance on what will happen next.(Staffordshire Virtual Ward leaflet)

Patients are reviewed daily by the clinical team led by a consultant and the 'ward round' may involve a home visit or take place through video technology. Many virtual wards use technology, enabling clinical staff to easily check in and monitor the person's recovery._The Team works alongside existing care providers if the person already receives homecare or other support in the home, to ensure continuity.

The Role of Carers

There may be concern that if someone has carers, paid or unpaid, that placing a patient on a virtual ward may place additional responsibilities on those carers. NHS England's Virtual Wards Operation Framework addresses this in Appendix 2 which states that;

"Unpaid carers should be recognised as equal partners in care who can provide vital information about the person with care and support needs. To support carers and mitigate any potential risk associated with virtual wards that unpaid carers will be asked to pick up more caring responsibilities, virtual wards must be designed in such a way that enables professionals to:

- *identify unpaid carers*
- *signpost carers to carers' assessments and further support, such as advocacy and respite care*
- *involve carers as equal and expert partners in care*
- *be aware of carer rights…*

- *have informed discussions with carers about the choices available for care and their right to choose the level of care they provide, including no care if they are unable or unwilling to provide any care*
- *ensure that carers have access to information about what to do if: they are no longer able to provide care on a virtual ward or their needs or those of the person receiving care increase*

The impact on paid carers should also be recognised, including the potential for increasing social care needs for people living in care homes and those with a domiciliary care package. Should any tasks arising from virtual ward care be delegated to non-NHS staff including social care staff, local services should ensure sufficient funding arrangements are in place".

The Carers UK website also provides a good explanation and a virtual wards checklist.

Virtual Wards in Different Regions

Each part of the country has an Integrated Care System (ICS) that manages NHS services. Virtual wards are available in every integrated care system, although what they provide can vary.

For example, Derbyshire virtual ward has been completely digital but is attached to the out of hours service at weekends. In February they are starting a pilot with an acute response car which can provide face to face visits in the week for patients on a Virtual Ward. They also have other trials planned around falls and getting extra equipment in the community to increase the acuity of patients they can cover.

Healthwatch Staffordshire also looked at virtual wards in Leicester as a comparison. Virtual wards in Leicester, Leicestershire, and Rutland represent a significant advancement in delivering healthcare services. They allow patients to receive hospital-level care at home through remote monitoring and digital technologies (Leicestershire Partnership NHS Trust, 2023).

This initiative is a collaboration between key stakeholders, including the Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB), University Hospitals of Leicester NHS Trust, and technology partners like Spirit Health. Virtual wards are designed to treat conditions such as chronic obstructive pulmonary disease (COPD), heart failure, diabetes, and community-acquired pneumonia (Leicestershire Partnership NHS Trust, 2023).

Although Staffordshire's virtual ward, is General Acute & Frailty, Healthwatch have learnt that they are looking to develop other wards, such as haematology, surgical, and palliative care.

Patient Experience of Virtual Wards.

We wanted to know what patients thought of Virtual Wards, so spoke with people in Staffordshire about their experiences. Here's what they told Healthwatch.

At an engagement event Healthwatch asked 90 people over the age of 55 if they had heard of the term "virtual wards". Thirteen people reported that they had. Once explained, the general consensus was that virtual wards are a great concept, but that the public didn't know about them, their function or how to access them.

People also told us that other forms of support need to be considered when people are on a virtual ward, such as meal delivery, care needs, isolation assistance, and medication management.

Feedback for patients in Care Homes

Healthwatch also obtained feedback from staff at care homes who had had residents on a virtual ward.

a) One care home was not aware of virtual wards, until one resident was stepped down to a virtual ward from hospital. The resident/patient was not given the choice of staying in hospital or being discharged to a virtual ward.

   On asking what could have been improved, the Unit Manager responded:

> 'Reliability. The nurses said they were coming to see the resident, but they did not turn up for some of the days'.

b) A care home in Lichfield reported that their residents were informed about virtual wards and their role, and all expressed a preference to be treated in the home where possible. A resident was then treated on a virtual ward, and staff worked with the care home staff to keep her in the home. Staff stated they were delighted with the support and pleased that their resident could remain at the home.

> 'We had the "virtual ward" complete the care for our resident and were really pleased with the outcome. The service organised an emergency CT scan as they wanted to rule out certain aspects of potential life-threatening risks. We got the results sooner than expected and all turned out to be negative which was a relief for everyone. I also sent them a feedback complimentary email thanking them for their exemplary care.'

   The home went on to say that the virtual ward was good because it meant that the resident did not need to go to hospital and wait in Ambulances, waiting rooms or corridors and could be treated in their own (care) home with respect and dignity and compassion.

   Staff said "nothing could have been done to improve this service as we were just so glad that professionals came to the resident and treated them the same as if there were in hospital but in the comfort of their own home". There was also less risk of infection due to not mixing with other ill patients for hours.

This service is valuable to us because we feel it's much more personal and they are treated with empathy and given time to explain how they felt, like human beings instead of a number on a conveyor belt.

c) In another case, the Lichfield home called 999 in connection with a resident who was showing FAST signs of a stroke and were put through to CRIS (Crisis Rapid Intervention Service) who came out within two hours and completed an assessment based on all the observations.

They were told that in no circumstances did the resident want to be admitted to hospital although the CRIS advised it. The resident had a high temperature and a possible infection. It was agreed that she would stay in the home and have a Virtual Ward Team visit. This was arranged by the CRIS team on the basis that the resident had capacity and had a bad experience of a previous hospital admission and did not want to repeat it. It was also suggested that the Virtual Ward Team helped the resident complete a RESPECT form so her future wishes would be clear.

Feedback for patients in their own Homes

We also spoke with Staffordshire residents who were admitted to a virtual ward in their own home.

a) A family member told us that the patient was stepped down to the virtual ward from hospital, and that the virtual ward was explained to them while they were in hospital. They were not given a choice of staying in hospital or going to the virtual ward. Healthwatch were told that the person's family found the virtual ward reassuring, and that nursing staff visited every day to take blood pressure and temperature readings. The family felt they could ask staff anything without feeling that they were interrupting or distracting from other patients. When asked what could have been improved, they said, 'Knowing a bit more about virtual ward in advance.'

b) We spoke with a relative who was contacted after an elderly family member was taken to A&E. Staff wanted to transfer the patient to a virtual ward, but the family member refused this as the person lived alone and had no support. They also felt the person's symptoms were not being considered. The relative didn't feel they were given a free choice, and the person was admitted to hospital. Upon leaving hospital neither the patient nor relatives were clear if they were being stepped down onto a virtual ward or discharged to community care.

The relative suggested that part of the problem is communication. The patient couldn't understand and the family member who was told about virtual wards imagined that they would be meeting Doctors and staff via

Teams or Zoom. They believed it was not explained properly at all and as a carer they were not listened to.

> 'It's like the moment you go into hospital they are trying to get you out, and the virtual ward gives them the opportunity to do that.'

The same person had had a very different experience with relatives admitted to a virtual ward elsewhere in England. This family member was in their thirties and was admitted to hospital with pneumonia. They were offered the chance to go on a virtual ward and it was perfect for them.

c) Another Staffordshire resident Healthwatch spoke with had a similar situation, with their elderly relative being taken to hospital. This time they were admitted to a virtual ward. They received visits from nurses every day for a week. No computer equipment was given to the patient, instead nurses visited to complete the monitoring. The usual visits by paid for carers continued.

Healthwatch were told the nurses who visited made clear who was visiting, how they could be contacted, and what to do outside 8am-8pm. During the 'stay' a family member received a phone call from the virtual ward to say they had done the patient's bloods and they were ok, everything was fine, she will now be discharged so there will be no more visits. Family member appreciated that this was explained so clearly.

> 'Mum is in the best place, her own home – she hated being in hospital.'

The experience of a virtual ward was as the family member expected it to be, and the care and treatment received was as good as being in hospital, and the family had confidence in the virtual ward team to diagnose and treat their mum to the same level as if she would have been in a physical hospital.

When Healthwatch asked what could have been done better we were told that' 'It would be better if something could be written down for family members, e.g. written information with instructions.'

> Mum was capable of personal care and only had carers going in to help with other things. When she was admitted to hospital for long periods of time in the past, following discharge she would need help with personal care. When she was on the virtual ward, this didn't happen, and she continued to do her own personal care, whilst on the virtual ward.

d) Another resident was admitted to the virtual ward after a short stay in hospital. This patient was told they were being sent home on a virtual ward, and didn't know what this was. It was explained that they would send carers with him to monitor his recovery. However, the patient's partner was not told what a virtual ward was. Once at home, two nurses arrived with a pack that included a Blood Pressure monitor, computer, thermometer, and device to measure oxygen levels. This is when the patient's partner was told what a virtual ward was. The partner completed the monitoring each day, recorded the results on the computer, and sent them off each morning (after 8am) to the virtual ward team. If there was an issue with the results the virtual ward would call them.

Someone from virtual ward visited each day, but the patient was unsure why as they did not carry out any medical activities. It was felt by the carer that they could have been better utilised elsewhere.

Another concern was that the virtual ward staff did not appear interested in how some of the results they were getting from the daily monitoring, impacted on the person's long-term condition.

No-one asked them if they could manage or if they needed anyone to visit; the couple were capable of just sending the readings over the computer. Neither did anyone explain why they needed readings for a further 10 days following them leaving hospital. They also felt that if staff had told both the patient and their partner about the virtual ward in hospital, they would have been able to say if it was suitable for them.

The patient didn't feel confident that the virtual ward could treat and diagnose them as well as they could if they were in hospital,

> 'When a person is in hospital, there is a backup of Drs that can be called on quickly. When on a Virtual ward, the person must go back to the office, and then it may be the next day before the patient sees the right person.'

From a carer's point of view, the patient's partner was never asked if they were ok, managing, or had anything they were concerned about.

e) Another patient who gave us feedback told us that she was In Leighton hospital for two weeks with a chest infection and was stepped down to a virtual ward. Nurses came from Haywood every day to take temperature, blood pressure etc. Was on the ward for 1 week and then discharged. Thought it was very good; can't think of anything they could have done better.

> 'Better than the nurses in the hospital' - 'Rather have them coming to me than being in hospital' - 'can't fault them'.

This study has focused specifically on some but not all of the of the pathways involved in admission avoidance in Staffordshire. Expansion of virtual ward pathways are being planned and developed to cover a wider range of conditions such as respiratory and neurological and to include pathways for children and young people. These will be developed at a local level to meet population needs and demand for hospital services across Staffordshire.

Thinking Beyond Admission

Thinking beyond admission avoidance refers to taking a proactive, holistic approach in healthcare that not only focuses on preventing unnecessary hospital admissions but also emphasises long-term, sustainable health outcomes for patients. Some key points to consider in this approach:

1. **Holistic Care Planning**

   Treating the whole person, not just the immediate medical condition, by considering physical, mental, and social factors that influence health outcomes. This can include creating personalised care plans that address chronic conditions, lifestyle factors, and social support needs.

2. **Preventative Care and Early Intervention:**

   Implementing strategies that detect and manage health issues before they become severe enough to require hospitalisation. This includes routine health screenings, vaccinations, and education on managing chronic conditions.

3. **Community-Based Care:**

   Shifting focus from hospital-based care to community health services that provide support in the home or local clinics. This involves integrated care with social services and local health initiatives that support people in managing their health conditions in familiar environments.

4. **Patient Empowerment:**

   Encouraging self-management by educating patients on their conditions and providing them with the tools and confidence to take control of their health, reducing the likelihood of a crisis requiring admission.

5. **Collaborative Healthcare Teams:**

   Involving a multidisciplinary team—such as nurses, social workers, physiotherapists, and mental health professionals—to ensure comprehensive support is available, preventing health issues from escalating.

6. **Technology and Innovation:**

   Utilising telemedicine, remote monitoring devices, and digital health platforms to keep track of patients' health without requiring frequent hospital visits. This allows healthcare providers to detect early warning signs and intervene promptly.

7. Social Determinants of Health:

Addressing non-medical factors such as housing, employment, education, and access to nutritious food, which are critical to maintaining long-term health and reducing the need for hospital admissions.

By integrating these strategies, healthcare providers can move beyond just avoiding admissions and work towards improving the overall quality of life for patients, promoting wellness, and ensuring that care is accessible and tailored to individual needs.

Health Promotion Schemes

Health promotion schemes are organised efforts, often led by public health agencies, community organisations, or healthcare providers, to improve health and well-being in populations by encouraging healthier lifestyles, preventing

illness, and addressing factors that impact health. They focus on proactive rather than reactive care, aiming to reduce the burden of disease and improve quality of life.

a) Key Components of Health Promotion Schemes:

1. Education and Awareness: Providing information on healthy behaviours, such as nutrition, physical activity, and avoiding harmful habits like smoking and excessive alcohol consumption. Examples include public campaigns on mental health awareness or healthy eating.
2. Behavioural Support Programs: These involve programs that help people make positive changes, such as smoking cessation clinics, weight management classes, or support for physical activity. They often include tools, counselling, and resources to encourage sustainable change.
3. Community-Based Activities: Health promotion often takes place in communities to make activities more accessible. Examples include free exercise classes, walking groups, or wellness workshops offered in local centres.
4. Preventative Health Services: Offering screenings, vaccinations, and routine health checks to detect and manage risks early. For example, screenings for diabetes or hypertension can help manage these conditions before they worsen.
5. Addressing Social Determinants of Health: Many schemes also target non-medical factors affecting health, like housing, education, and access to nutritious food. Programs might include social prescribing, which links individuals to community resources to improve well-being.

b) Examples of Health Promotion Schemes:

Health promotion schemes that intervene early to prevent individuals from requiring medical treatment focus on educating and empowering people to make healthier choices:

1. Smoking Cessation Programs: These programs, such as the NHS Smoke-free service in the UK, provide free support to help individuals quit smoking. They offer resources like counselling, nicotine replacement therapy (NRT), and

digital tools like apps and text messaging services. Studies show that these interventions significantly reduce smoking rates and the risk of smoking-related diseases like lung cancer and heart disease.

2. National Diabetes Prevention Program (NDPP): This U.S.-based initiative focuses on preventing type 2 diabetes by targeting individuals at high risk. It offers structured lifestyle change programs aimed at improving diet, increasing physical activity, and maintaining a healthy weight. The NDPP has been shown to reduce the risk of developing diabetes by up to 58%.

3. Change4Life Campaign: In the UK, this program targets childhood obesity through public education on healthy eating and physical activity. It encourages families to adopt healthier lifestyles through tools like meal planners and activity trackers. Early intervention helps prevent obesity-related illnesses like diabetes and cardiovascular disease

Staffordshire Specific VCFSE Support Services

Within Staffordshire there are a whole range of services provided through the voluntary, community, faith and private sector organisations who provide complementary support to the admission avoidance programme. Below we detail the range of services that are offered to support admission avoidance and hospital discharge which Staffordshire residents can tap into as an additional support mechanism.

NHS & Care Volunteer Responders

- Check in and chat
- Pick up and deliver
- Community response

Contact information: https://nhscarevolunteerresponders.org/

Independence at Home

- Short term care for up to six weeks, providing practical support to help regain independence and essential skills

Contact information: independence@staffordshire.gov.uk
Telephone 03303 115 137

Shared Lives PSS from hospital to home

- Trained carers to welcome individuals home after a hospital stay, settling them in and providing practical support such as washing, cooking, medication and accessing the community.

Contact information: sharedlivesmidlands@pss.org.uk
Telephone: 01543 448380.

Home Instead

- Personal care
- Companionship
- Live in care
- Overnight care
- Complex care
- Overnight care

Contact information: https://www.homeinstead.co.uk/stafford/
https://www.homeinstead.co.uk/tamworth-lichfield/

Support Services through MPFT

Health Inclusion

- Help to people who may be excluded due to homelessness, in temporary accommodation,
- Have complex needs
- Are vulnerable
- At risk of exclusion
- Have substance misuse issues

Contact information: healthinclusionservice@mpft.nhs.uk

Mental Health and Emergency Care - working with VCSE partners

- Crisis café (Safe Haven)
- Safe hands - Out of hours home sitting service
- Crisis assessment centre

Contact information:
https://www.mpft.nhs.uk/service-users-and-carers/emergency-help
https://www.mpft.nhs.uk/services/mental-health-community-services

MPFT Memory and Dementia Pathway Community Service South Staffordshire

- First assessment within 2 weeks of referral
- Access to diagnosis and treatment to help families continue to care for family member.
- Access to Cognitive Stimulation Therapy
- Aids and equipment to support the patient at home.

Contact information: https://www.mpft.nhs.uk/services/dementia-assessment-and-support-service-dass
https://www.mpft.nhs.uk/services/mental-health-community-services

Staying Well Service

- Preventative support to people aged 55 and over across South Staffordshire
- Help maintain well being
- Assessment of general health, medication, social support, Functional performance, mood and cognition.

Contact information : https://www.mpft.nhs.uk/services/staying-well-service

West Midlands Ambulance Services

West Midland's Ambulance service have a fleet of Mental Health Response Vehicles to better assist emergency calls regarding mental health concerns.

Conclusions and Recommendations

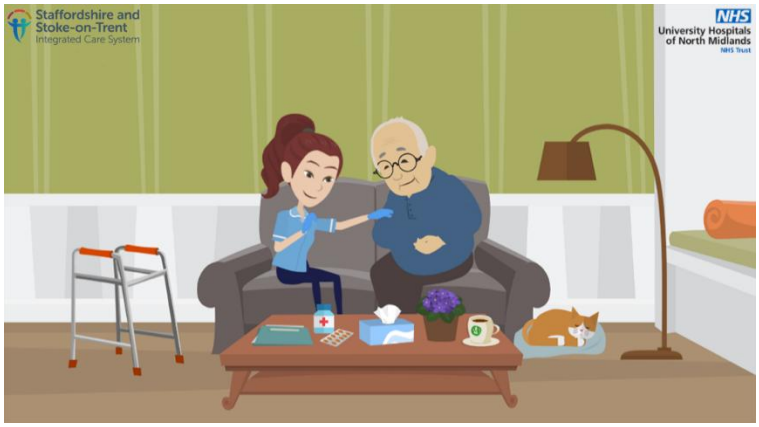
During our study, Healthwatch Staffordshire heard that people being referred to a virtual ward from the hospital depends upon good communication between community or hospital staff, talking to patients about virtual wards and involving them in the decision making and informing them of what the service would be

and how it would be delivered so that the patient and their family could be fully aware of and signed up to the process. Again, for patients in hospital, it was found that hospital ward staff were not as aware of exactly how a virtual ward operated in the patient's own home, so patients were often in the dark about what to expect and having any choice in the decision.

In some parts of the county, a nurse from the virtual ward team visits Royal Stoke hospital to see which patients are eligible, and this is an initiative that may well be of value to patients in Queens Hospital Burton and County Hospital Stafford in terms of engaging patients and family members in the process. Communication between providers and the public would potentially lead to greater confidence in the service and more patients and family members accepting of the service.

Public Awareness

Although Healthwatch has been told that virtual ward staff are trying to increase public awareness of the service, from our research this does not seem to be having an impact. We would suggest increasing public awareness by more publicity, for example, screens in GPs surgeries explaining what virtual wards are and promoting the Home Care is Best Care Campaign.



Additional Support

If virtual wards are to be the preferred place of treatment, the other forms of support individuals living alone might require when they are unwell, such as meal delivery, care needs, isolation assistance, and medication management, need to be considered. This could include working with the VCSE sector.

Renaming the service

National Guidance (NHS England – Virtual wards operational framework) states that the service can be referred to as 'Virtual Ward' or 'Hospital at Home'. We recommend that the latter term is used as it better describes the service being provided. This is also the term that is preferred by the UK Hospital at Home Society, the British Geriatrics Society and the Royal College of Physicians (https://www.hospitalathome.org.uk/Name_Statement)

Communication

Many of the people we spoke with mentioned poor communication often between services, e.g., hospital and community, statutory and non-statutory as being a barrier on occasions, including staff providing services on the front line.

The comment *"it could always be better"* was used several times. There are a whole range of wrap around type services aimed at supporting admission avoidance and improved communication between these services would benefit both the service and patients significantly.

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We are also grateful to our volunteers Pearl Obiorah and Lynn Ashburner for their contributions to this Deep Dive.

End of Report

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