Whittington Health's Virtual Ward

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Whittington Health

Helping local people live longer, healthier lives

In the financial year 2023-24: **500,000** people in our patch **|** **4,400** staff employed by our Trust **|** **£400 million** income **|** **Over 30** community locations **|** **Over 70 acute** and **70 community** health services **|** Dental services in **10** London boroughs **|** **One** hospital, in the heart of our North London community

103,891 ED attendances

226,714 Community nursing appointments

57,099 School appointments

3,429 Births

69,276 Physio appointments

424,129 Outpatient appointments

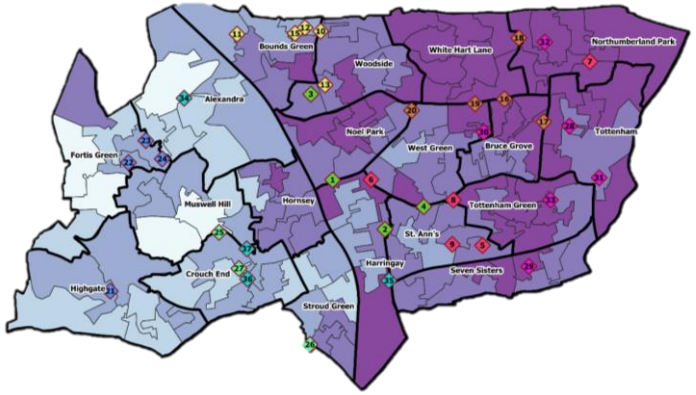
23,458 Day cases

47,483 Dental appointments

Our area

North Central London:

Haringey:

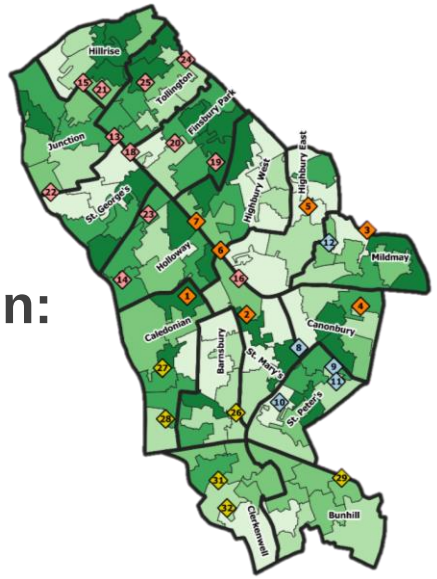


Legend

Index of Multiple Deprivation Quintile (2019)]

- 1 (Most deprived)
- 2
- 3
- 4
- 5 (Least deprived)

Islington:



Legend

PCN as of April 2020

- Central 1
- Central 2
- North
- South

Local deprivation quintile (IMD 2019)

- 1 (Most deprived)
- 2
- 3
- 4
- 5 (Least deprived)

Our virtual ward provide hospital level care at home

virtual wards

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

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

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

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

History of Whittington Virtual Wards

October 2013
- Virtual Wards Launch at Whittington for Islington and Haringey

April 2014
- Virtual Wards Upgrade to Enhanced Virtual Wards by adding GP Support

May 2015
- Virtual Wards join with Rapid Response Haringey to form VWRR

April 2017
- Islington Rapid Response launches alongside Whittington Virtual Ward

January 2018
- Whittington provides UCLH@Home Virtual Wards services.

Nov 2021
- 20 Virtual Ward beds are opened with BEH at NMUH covering Haringey and Enfield

Jan 2022
- Whittington Health becomes Lead Provider for Virtual Wards in NCL

April 2022
- Bed Base is expanded from 8 Virtual Ward Beds to 20 Virtual Wards beds.

Jan 2023
- 8 Remote Monitoring Beds are opened at Whittington Virtual Wards

July 2023
- 8 Bed Borough Based Frailty Virtual Ward Developed for Islington in line with Fuller Report

Our Mission Statement

Whittington Health's Vision:

- Helping local people live longer, healthier lives.

Virtual Wards Mission Statement:

- To provide complex care to patients in their own homes as a safe alternative to hospital care allowing local people to live longer healthier lives.

Existing Pathways

Frailty / General	Heart Failure	IV Diuretic Pathway	Remote Monitoring	Delirium
• This is intended for frail patients, especially but not exclusively the elderly, who have increased vulnerability to adverse health outcomes. The pathway involves comprehensive geriatric assessments, personalized care plans, regular monitoring, and interventions aimed at reducing the risks associated with frailty, like falls, hospitalization, and deterioration of mental and physical health	• This is for patients diagnosed with heart failure. The pathway involves regular monitoring of vital signs, medication management, education about heart failure and self-care, dietary advice, and coordination with multidisciplinary teams including cardiologists, nurses, and pharmacists to manage the condition and prevent hospital readmissions.	• This pathway is primarily designed for heart failure patients who require intravenous diuretics to manage fluid overload. It allows patients to receive IV diuretic treatment at home, reducing the need for hospitalization. This includes regular monitoring of patients' vital signs, symptoms, and response to treatment, along with close coordination with healthcare professionals for medication management	• This pathway caters to patients with manageable acute conditions requiring regular but not constant monitoring. It uses remote technology to track vital signs, symptoms, and medication adherence, detecting gradual health changes to prevent complications. It aims to minimize hospital readmissions while promoting self-management of health at home.	• This is designed for patients who have been diagnosed with delirium or are at risk of developing it. The goal is to prevent, detect early, and manage delirium in the virtual ward setting. It includes a multidisciplinary approach, with regular monitoring, mental status assessments, medication management, and provision for physical, psychological, and cognitive support and 24 Hour Packages of Care.

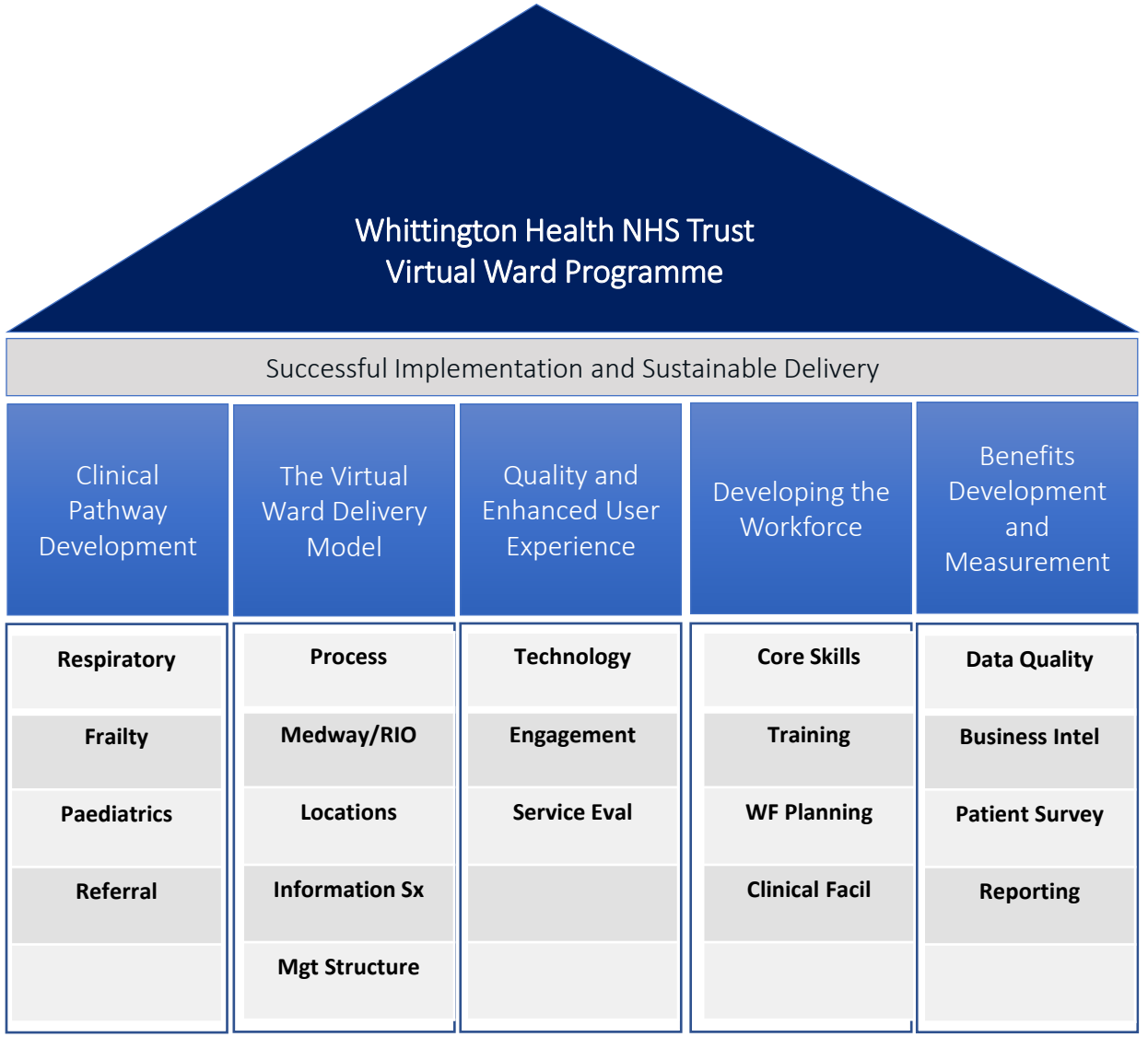
Vision for Virtual Wards

- To be at the forefront of virtual ward care, setting new standards of excellence in patient management and outcomes.
- We aspire to be recognised as a leader in innovative and efficient healthcare delivery, utilising advanced technologies and evidence-based practices.
- Our vision is to create a nurturing and supportive environment that values staff wellbeing, support, and development, recognising their crucial role in delivering exceptional care.
- We prioritise staff engagement at all points, involving them in the design and improvement of the virtual wards to ensure their expertise and insights contribute to creating an optimal care environment.
- We strive for greater integration with adult community services and social care, fostering seamless collaboration and coordination across healthcare and social support sectors.
- By working closely with these partners, we aim to enhance the holistic care experience for our patients, promoting comprehensive well-being and addressing social determinants of health.
- Through our dedication to integration, collaboration, and excellence, we aim to improve health outcomes and enhance the overall quality of life for individuals in our communities.

Future Pathway Considerations

Pre and post-operative surgery:	• Support patients undergoing pre and post-operative surgery, such as bariatric surgery at University College London Hospital (UCLH). This can help to ensure that patients receive the necessary care and support before and after their surgery, reducing the risk of complications and improving outcomes.
Respiratory:	• Support patients with respiratory conditions, such as COPD, community-acquired pneumonia, acute respiratory infection, and bronchiectasis. This can help to monitor patients' symptoms, provide early interventions, and prevent hospitalizations.
Maternity, including hyperemesis:	• Support pregnant women with conditions such as hyperemesis gravidarum. This can help to provide more coordinated care and support for pregnant women, reducing the risk of complications and improving outcomes for both mother and baby.
Patients awaiting diagnostics/reviews:	• Support patients who are awaiting diagnostics or reviews, ensuring that they receive timely and appropriate care while they wait.
Diabetes, IBD – as per NWL expansion plan:	• Support patients with diabetes and inflammatory bowel disease (IBD) as part of the North West London (NWL) expansion plan.

VW Framework / Programme of Work



Case Study

- An 83-year-old gentleman named Mr D, brought in by London Ambulance Service; Mr D who is known to live with advanced dementia, was at home when he felt dizzy, had a fall, landed on the left side, and complains of pain on the left side of the chest.
- Had left rib fracture, patient lives with his elderly wife, Mr D and his wife both do not speak English, has son who lives far away, Mr D was discharged home with a Virtual Ward follow up for pain management and social support.
- VW senior clinician went to see Mr D at home and his son helped to translate, we noticed that Mr D is still complaining of left side chest pain, having been sent home with paracetamol. Mr D was put on a course of on Codeine and laxative.
- Mr D was provided with a twice a day, package of are by the VW team.
- Mr D was reviewed by VW clinician again to ensure that his pain had improved; on this visit clinician noticed Mr D's chest pain/rib pain had indeed improved however he appeared to be in discomfort, Mr D's wife mentioned that he was not eating well and had not opened bowel for past 5 – 7 days. Clinician carried out abdominal examination and D was found to be constipated. His wife reported she never actually gave the laxative he had been provided with previous as she was scared that Mr D may pass stool in bed based on previous experiences.
- Mr D was given glycerine sophistry whilst the codeine was discontinued as his pain was improved. Mr D was followed up by VW clinician and once his bowel patterns were normalised, he was discharged back to the care of his GP.

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