Effect of a “discharge to assess” Geriatrician led Virtual ward promoting integration of services on rates of discharge

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How I became interested in Quality Improvement

• Worked in Sheffield as a junior doctor in Geriatric Medicine
• Heard Tom Downe’s talk at a Regional British Geriatric Society meeting:
  – The “Big Room”
  – Elderly AMU – Frailty Unit
  – Moved from ‘post-take’ to ‘on-take’

Why become involved in the Virtual Ward

• Service development
• Clinicians limited capacity and resource to evaluate impact
• Learning, successes and failures of service development should be shared
• Spread and translation into new areas as appropriate
Bradford

- Urban area with high levels of deprivation
  - 68 GP practices
  - 446,567 people
- Bradford Teaching Hospitals over 900 bed base
- Elderly Admissions Unit (Ward 3) for those over 77 (and those over 65 from 24 hour care facilities) has been in place since 2002
- In 2013 average 469 admissions each month
Community Support Team

- Running out of secondary care a Community Support Team has been managing:
  - an enablement/social pathway
  - a COPD pathway
  - an Outpatient and Home Parenteral Antibiotic Therapy (OHPAT) pathway
- 3 Advanced Nurse Practitioners (ANPs), 4 physiotherapists, 6 sisters, 19 nurses and 18 rehabilitation support workers
- 8 empty posts were filled prior to the establishment of the pilot

Drivers for development of Virtual Ward

- Integration agenda – Lower rates of hospital bed use are observed where health and social services are well integrated (Imison, 2012)
- 40-55% of hospital bed days a patient’s needs could be met in another setting (Poteliakhoff, 2011)
- A hospital stay can result in adverse outcomes for elderly patients
- Re-admission penalty – Ward 3 has a 30 day re-admission rate of between 22-27%
- Research has shown re-admission rates can be reduced by a combination of home visits and calls (Wong, 2014)
NHS Better Care, Better Value Indicators

The Vision

Virtual Ward Hub
The Virtual Ward

• Geriatrician led
• Multidisciplinary
• “discharge to assess” and supported discharge model
• Commenced October 2012
• Typical support of enablement 3 times per day and one nurse visit, with MDT discussions three times each week

Key enablers

• A close working relationship between acute, community and social services
• A shared electronic health care record
• Cross boundary skill sharing using the Calderdale framework has maximised workforce capability by sharing competencies between staff
The Virtual Ward (2013)

- The average number of patients on the Virtual Ward was 41 patients per month (20 patients at any one time)
- 75% were from Ward 3, while the remaining patients were generally from Geriatric Medicine wards
- 10% of all Ward 3 discharges went onto the Virtual Ward
- 98 ♀
  - Mechanical fall with minor soft tissue injury
  - Mobile
  - Home + assess
  - 4pm some delirious aspects
  - 7pm home
  - A little muddled
  - Settled in
  - Overnight visit
  - Next day “answered door dressed with lippy on”

- 88 ♀
  - PMH OA/Breast carcinoma
  - 3rd floor flat
  - Lived alone
  - Mobile with stick
  - Supported/supports family (learning difficulties)
  - Legs gave way
  - # R supracondylar (above elbow back slab)
  - Facial injury (sutures)
  - Transfer with 1-2
  - “keen to go home”
Rate of re-admission

Virtual Ward commenced

Ward 3 Monthly Readmission Rate

Bed occupancy across Geriatric Medicine reduced by 6% (8 beds)
(compared to a reduction of 1.5% across the rest of the hospital)
The dominant driver for bed occupancy of patients over 65 has been found to be rate of admission.

Rate of discharge increased from 53.4% to 58.3% (equivalent to 23 patients/month)

Virtual Ward commenced
Balance Measures (Complexity of patients)

Average Age of patients on admission to Ward 3

Virtual Ward commenced

Balance Measures (Complexity of patients)

Average number of coded diagnosis on admission to Ward 3

Virtual Ward commenced
Balance Measures (Workload)

W3 Monthly Admissions

Virtual Ward commenced

Balance Measures (Workload)

Average Length of Stay for Patients Discharged from Ward 3

Virtual Ward commenced
Balance Measures (Staff morale)

Ward 3 Staff Sickness Rate

Virtual Ward commenced

Balance Measures (Adverse outcomes)

Percentage of Geriatric Medicine Ward 3 patients who died whilst in hospital, or within 30 days of discharge from Ward 3

Virtual Ward commenced
Balance Measures (rest of hospital)

Time has needed to be spent reassuring patients and their families that home is the right place for them to be.
Patient Feedback

• “The virtual ward team were only a phone call away that was good knowing that someone was there when you need help.”
• “The care I received from the team was first class. When you live alone, nights can be frightening, but knowing I could get in touch 24 hours made me feel safe. Thank you all.”

Outcomes

• Greater integration of acute, community and social services (no longer using Section 2)
• A reduction in the rate of admission into Geriatric Medicine beds
• Suggesting that higher risk patients are now discharged and safely supported at home
• Better recruitment and retention of community support team
• Perceived reduction of pressure on acute hospital
The Future

• Continue Bradford integrated care agenda
• Expansion
• Development of locality groups
• Further development of the ‘Hub’
• Co-location with social services; OPMH services
• Increase ‘step up’ numbers
• Embed CGA
• Bed bureau for community beds
References

