Report produced by Devon Communities Together

Virtual Wards VCSE Pilot:

March-July 2023

Final report: summary and evaluation of data

The Virtual Wards Pilot is delivered by a consortium of VCSE organisations:

Contents

The following report is a summary of the project and an analysis of evaluation of the data collected throughout the pilot, from 1st March to 14th July 2023.

1. Overview of the pilot proposal

The pilot launched at the start of March 2023 to support patients who have left the Royal Devon University Hospital (RDUH, formerly the RD&E) under the Virtual Wards Scheme. The scheme exists in every hospital in the country, with the aim of sending patients home for monitoring and avoiding long hospital stays. Devon Communities Together (DCT) along with Wellmoor identified an opportunity for the VCSE sector to offer non-clinical support to these patients in their homes and prevent readmittance to the hospital ward.

The Acute Hospital at Home (AHAH) team at the hospital refers the patient to the hub at DCT where, following a triage call, DCT refers them on to the appropriate VCSE partner. Wellmoor is responsible for leading on the digital support: training the partners to help with the devices that the hospital sends patients home with for monitoring, such as Apple watches, Kardia monitors and blood pressure machines. A network of 8 additional delivery partners across the Eastern LCP area is available to visit patients to provide 'wraparound', non-clinical support, such as household tasks, shopping, collecting prescriptions, companionship and dog walking.

This cross sectoral pilot Virtual Wards model was the first in the UK to incorporate parallel referral pathways for hospital at home patients with clinical teams & local VCSE organisations providing digital & wrap around support. Early findings from

the pilot were provided in evidence to the House of Lords Select Committee on the Integration of Primary and Community Care in March 2023. Patients are very supportive of the Virtual Wards project and all report that they prefer being at home rather than in hospital. This is an excellent example of collaboration between VCS and Statutory, working together in a clinical and non-clinical way, which can deliver on the ambition of working in partnership to provide more community-based wraparound care and health prevention work outside clinical and hospital settings.

The aim of the pilot was to reach 40 referrals over 3 months. The project began in March 2023 and the final number of referrals received is 46; at the end of May it was 31. The pilot was extended until Friday 14th July to try and collect as much data as possible. The Acute Hospital at Home team (AHAH) was proactively promoting the scheme to all their Virtual Wards patients and this helped to increase the number of referrals in the latter part of the project.

1.1 Co-design of the proposal

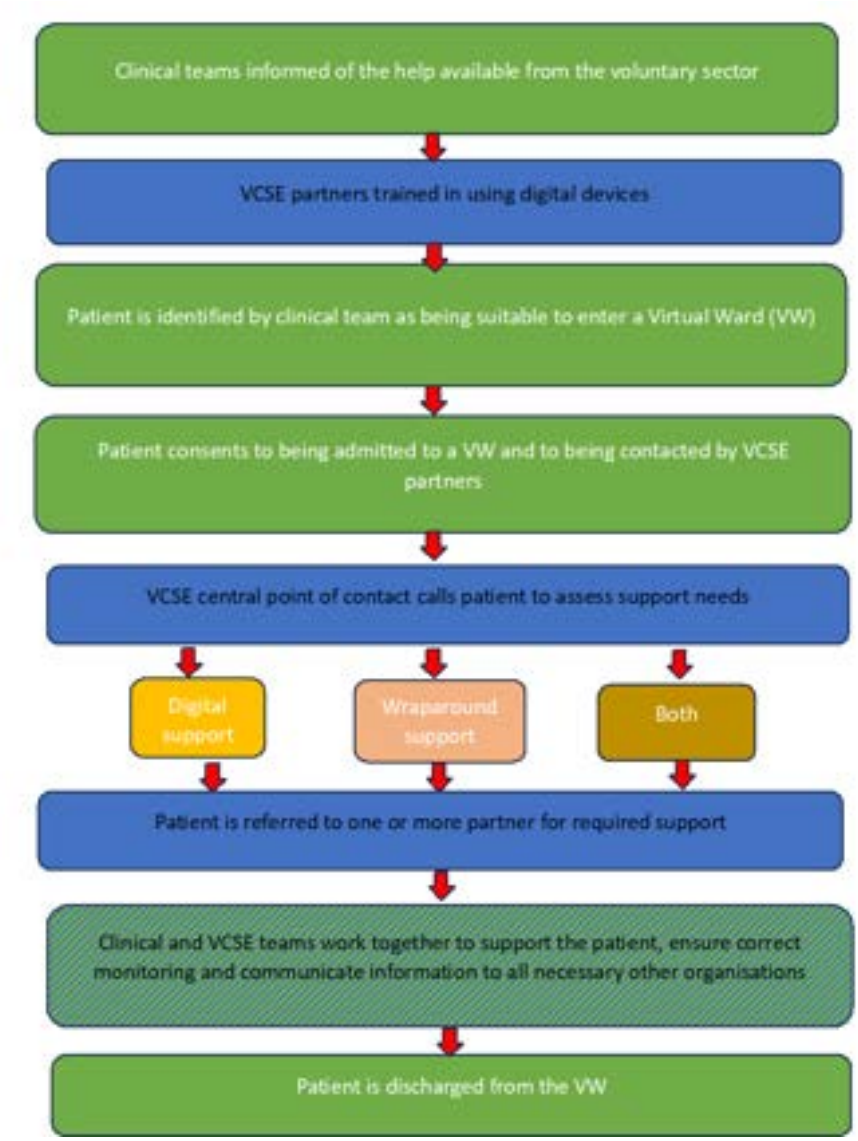
The VCSE Virtual Wards pilot was initially discussed in depth at a meeting convened by the ICB in August 2022. A set of recommendations to address Health Inequalities was put forward, including the need to build relationships between clinicians and community groups and to ensure automatic referral to a single point of access in the community to a non-clinical community navigator/co-ordinator to support people with their non-clinical needs. The existing working relationship between Wellmoor and Devon Communities Together and two projects these organisations has collaborated on in 2021 and 2022, became the basis on which the proposal was founded. The first programme, “Rural Digital Health Inequalities” was a joint cross-sector initiative addressing digital inequality in clinical pathways, funded by NHS X and delivered by Devon Communities Together and Wellmoor. The second programme was a Contain Outbreak Management Fund (COMF) Digital Inclusion Partnership, which provided place based digital befriending and upskilling support. Both programmes provided comprehensive insight into the problems and challenges faced by some citizens about digital access - particularly those living in areas of deprivation and/or in very remote rural locations.

With a track record of delivery of place-based digital inclusion and building upon the partnerships established and proven experience of running successful digital projects across rural Devon, DCT led a VCSE co-design process to create a

proposed model of VCSE delivery of both digital support and wraparound care for virtual wards patients. The result was a joint proposal to NHS Devon on behalf of a collaboration between several VCSE organisations, all of whom are members of the Devon, Plymouth & Torbay VCSE Assembly, delivering services within the Eastern LCP geographic area.

1.2 Collaborative working

Over and above the digital befriender service which is the "golden thread" at the heart of this proposed pilot, the VCSE partners were able to link VW patients to other services in their local community, with full referral & assessment details so that the patient only had to tell their story once.



VCSE Pilot delivery model flow chart

Once the project was underway, DCT and Wellmoor liaised weekly in order to respond rapidly to referrals and any amendments to systems and processes. The AHAH team met with DCT, Wellmoor and the ICS biweekly to share updates on progress. A steering group comprising delivery partners and key organisations supporting the pilot met three times during the pilot.

2. Key learnings

- **The involvement of VCSE partners has helped to alleviate the workload of RDUH staff.**
- **The Devon VCSE sector has both the capacity and the capability to deliver the support requested.**
- **The value of support to unpaid carers is much greater than anticipated.**
- **The collection/return of equipment was a key need identified but should be part of a wider support package to warrant this being a VCSE/Virtual Wards activity.**
- **The opportunity to see the patient in their home and observe any needs relating to their environment is vital.**
- **Due to the demographic of patients, there was often confusion about visits, the role of the VCSE and the distinction between this programme, clinical support and other discharge support programmes; partners need to be aware of this.**
- **Patients and delivery partners are overwhelmingly supportive of the Virtual Wards Programme.**
- **There is value in setting up a system for the hospital to monitor readmittance, frequency of calls regarding digital support and the number of patients not previously able to go on a Virtual Ward due to lack of digital and wraparound care support.**

2.1 VCSE Staff and digital training

3 DCT staff and 3 Wellmoor staff received initial in-person training at the hospital at the end of February. Wellmoor then created a training session for other VCSE partners, with the aim that they may be able to provide both wraparound and digital support if needed. This training included a slideshow covering basic information on the devices, instructions for using these, safeguarding information and contact details for advice or questions. The slides used during these sessions were shared with all attendees after the session, as well as demonstrational videos used during training offered to all and sent to those who requested them.

The dates of training sessions were as follows:

- 8th March (1.5 hours delivered over Zoom)
- 21st March (1 hour via Zoom)
- 24th March (1 hour, intended to be an in person visit to a VCSE partner, but rescheduled to Zoom after unforeseeable transport problems)

- 4th May (1 hour delivered via Zoom)
- 16th May (2.25 hours delivered in person at the DCT offices)

Across these sessions delivered by Wellmoor, a total of 13 people were given training in digital devices (with one person attending both an online session and in person also). Across these 13 people who attended training sessions, digital training was provided to employees and volunteers of a total of 9 VCSE organisations: The Red Cross, Westbank, Devon Carers, Age UK, Seachange, Ottery Help Scheme, Community Links Southwest, West Devon CVS and TRIP.

Feedback on the training:

On 18th May 2023, a feedback form for the training was sent out to all those who had attended sessions. So far, **a total of 5 feedback forms have been filled out and received,** resulting in feedback from 4 different organisations, which covers 3 separate training sessions, including both the in- person and online training. Feedback has been overwhelmingly positive, and all those who gave feedback said that after having attended a training session, they would feel confident in helping virtual wards patients with their devices. Feedback also showed that whilst online training was very well received, **those who attended in person training felt that for them, the option to see the devices in real life and a more hands on approach was beneficial**, and therefore it was good to have both styles of training options available.

Those who gave feedback gave very little suggestions for how to improve on future training. However, the suggestion that most frequently appeared was that **it would be good to be able to try out the devices on somebody within the training session to gain full practical experience and the opportunity to test the devices** – this is something which we had tried to organise, but due to requiring account creation and activation codes from the hospital for the different apps needed, this had proved difficult to set up. Additionally, it was suggested that the training should include sections to further explore Wellmoor's actual experiences delivering digital assistance, what this entailed and any problems which were overcome.

Other queries encountered from the feedback included more general questions about what is expected of VCSE partners in terms of numbers of visits, if visits would be independent or with Wellmoor, the spread of referrals between organisations, and if the project was being well received by the NHS. In all cases, **queries received through the feedback forms were responded to and appropriate information provided to the person who had sent the feedback form.**

However, as previously stated, **all feedback was generally positive, with all responders stating that on a scale of 1 – 5 (with 1 being the lowest), the training scored a 4 or 5**

in terms of how helpful it was, meaning that the training was very well received overall and was deemed as useful by all.

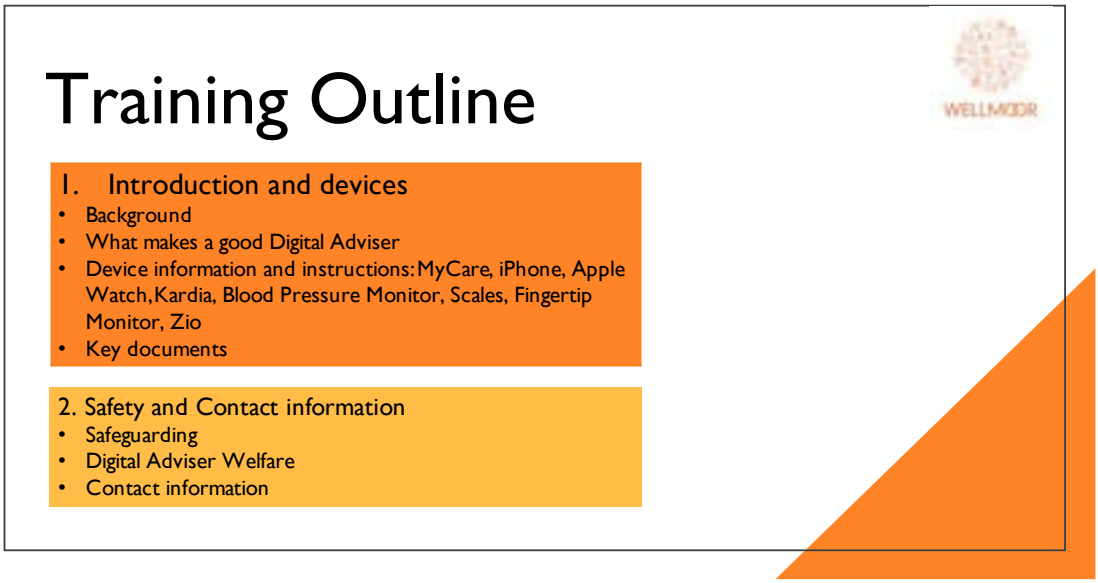


Figure 1 Digital training for VCSE staff

2.2 System for collection and monitoring of data

The AHAH team asked each patient for permission to share their data and the response was recorded on the referral form. DCT used a CRM system to store this and subsequent data about the patients and their journey. The data was only accessible to the small number of staff working on the project. Patients were otherwise referred to by their unique reference number. The CRM system allowed for data to be exported rapidly to Excel format, in order to be analysed. As the pilot evolved, frequent changes needed to be made to this database, with the addition of fields, adaptation of drown-down menus and so on. In the future, all documents sent between partners could be further secured by being password protected.

3. Overview of referrals

The number of referrals had reached 46 as of 14th July 2023. 14 of these were for digital support only, 10 were for digital support and equipment transport, 5 were for equipment transport only (but in most cases a welfare check on the patient was also made), 1 was referred for both digital and wraparound support, 1 was for digital support, wraparound care and equipment transport, 3 were for wraparound and equipment transport and 7 were for wraparound care only. Following the decision at the end of May to offer VCSE support to all Virtual Ward patients, 5 referrals were received which, following a detailed triage conversation, were

considered to be not in need of support (in one case the patient had managed to get the device working before the arranged visit).

Type of support	No. of referrals
Digital only	14
Equipment transport	5
Wraparound care	7
Digital and equipment transport	10
Digital and wraparound	1
Digital, equipment transport and wraparound	1
Wrap around and equipment transport	3
No support required	5
Total referrals	46

Table 1 Total number of referrals per type of support

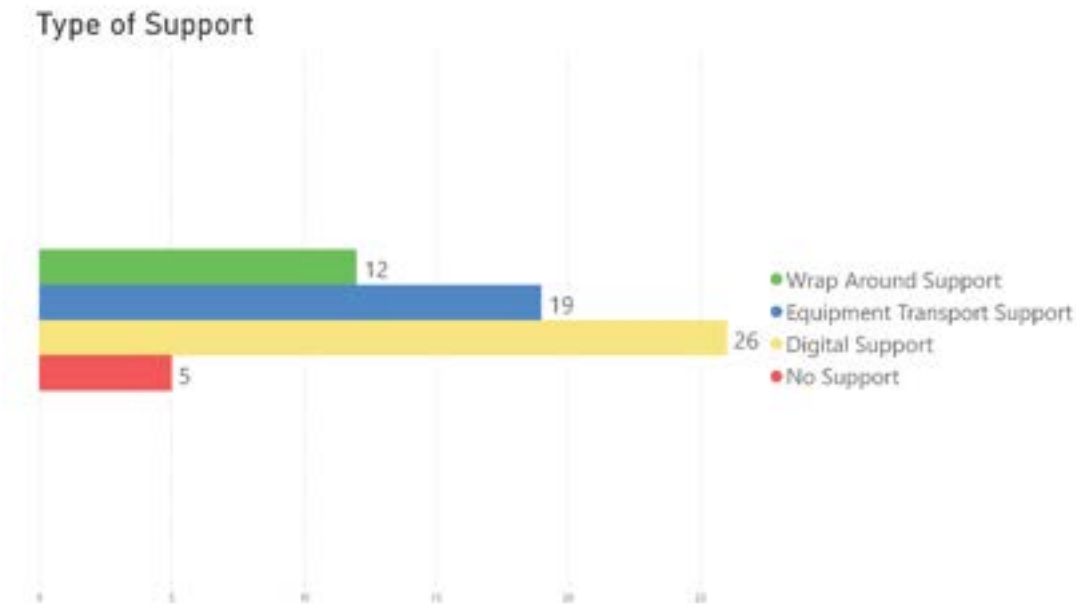


Figure 3 Type of support

The above graph shows that the highest number of referrals was for digital support; this type of referral was most common at the start of the project and then again in the latter stages when all patients were offered VCSE support. Equipment transport was a need identified early on but apart from the initial couple of visits, partners also checked on the welfare of the patient and their supporters, as well as reiterating the offer of wraparound support.

3.1 Referrals

Ref. number	Partner	Support required	Time spent with patient (minutes)	Distance travelled	Turnaround time
VW001	Wellmoor	Digital; Equipment Transport	75	60	1 day
VW002	TRIP	Equipment Transport	15	32	3 days
VW003	Wellmoor	Digital	50	43	0 days
VW004	Wellmoor	Digital; Equipment Transport	80	93	0 days
VW005	Wellmoor	Digital	80	3	0 days
VW006	Wellmoor	Digital; Equipment Transport	40	38	0 days
VW007	Wellmoor	Digital	35	44	0 days
VW008	DCT	Equipment Transport	10	98	5 days
VW009	Wellmoor	Digital	40	44	0 days
VW010	DCT	Equipment Transport	10	65	2 days
VW011	Wellmoor	Digital; Equipment Transport	20	66	0 days
VW012	Wellmoor	Digital; Equipment Transport	120	90	1 day
VW013	Age UK	Wraparound; Equipment Transport	60	32	0 days
VW014	Seachange	Equipment Transport	15	34	0 days

VW015	Seachange	Wraparound	40	5	0 days
VW016	Ottery Help Scheme	Wraparound	360	0	1 day
VW017	TRIP	Wraparound; Equipment Transport	30		0 days
VW018	TRIP	Equipment Transport	30	36	1 day
VW019	Wellmoor	Digital	100	71	1 day
VW020	Wellmoor	Digital	50	29	1 day
VW021	TRIP	Wraparound	210	160	0 days
VW022	TRIP/Wellmoor	Digital	60	89	0 days
VW023	Wellmoor	Digital; Equipment Transport	90	64	0 days
VW024	Wellmoor	Wraparound		90	4 days
VW025	Wellmoor/Age UK	Digital; Wraparound	95	53	9 days
VW026	TRIP/Age UK	Wraparound	30	0	0 days
VW027	No support required				
VW028	Seachange	Digital; Equipment Transport	0	31	0 days
VW029	Wellmoor	Digital; Equipment Transport	115	44	0 days
VW030	Wellmoor	Digital	30	23	1 day
VW031	TRIP	Wraparound	45	31	0 days
VW032	DCT/Age UK	Wraparound	47	0	1 day
VW033	Wellmoor	Digital	40	20	1 day

VW034	Wellmoor	Digital	25	31	2 days
VW035	No support required				
VW036	Age UK	Digital; Wraparound	30	0	0 days
VW037	Wellmoor	Digital; Wraparound; Equipment Transport	100	46	0 days
VW038	TRIP	Digital; Equipment Transport	85	59	3 days
VW039	Wellmoor	Digital	5	0	0 days
VW040	Wellmoor		30	49	1 day
VW041	Wellmoor		75	14	0 days
VW042	No support required				
VW043	No support required				
VW044	Wellmoor	Digital	50	42	3 days
VW045	No support required				
VW046	Wellmoor	Digital; Equipment Transport	20	84	0 days
Average			**41 mins**	**52 miles**	**1 day**

Figure 2 Overview of referrals

3.2 Location of referrals

22 referrals were for patients in East Devon, 8 for Exeter, 8 for Mid Devon, 6 Teignbridge, 2 West Devon and 1 on the Devon/Somerset border. Initially, most referrals were for East Devon but numbers increased for other areas as the project progressed.

Figure 4 Location of referrals

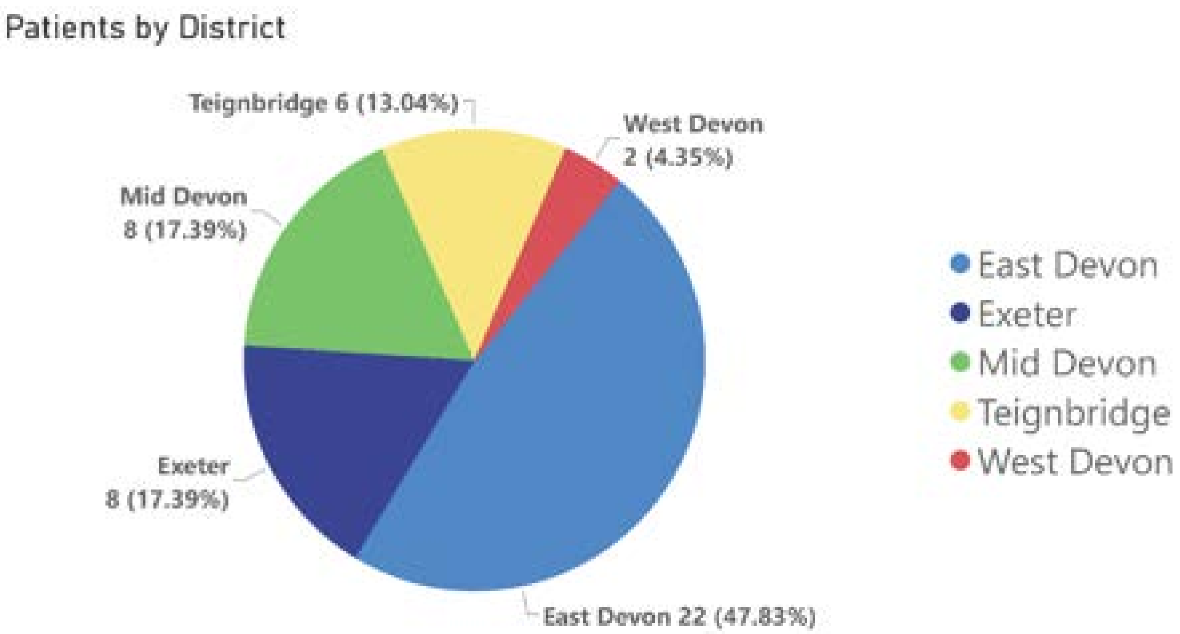


Figure 5 Number of patients per district

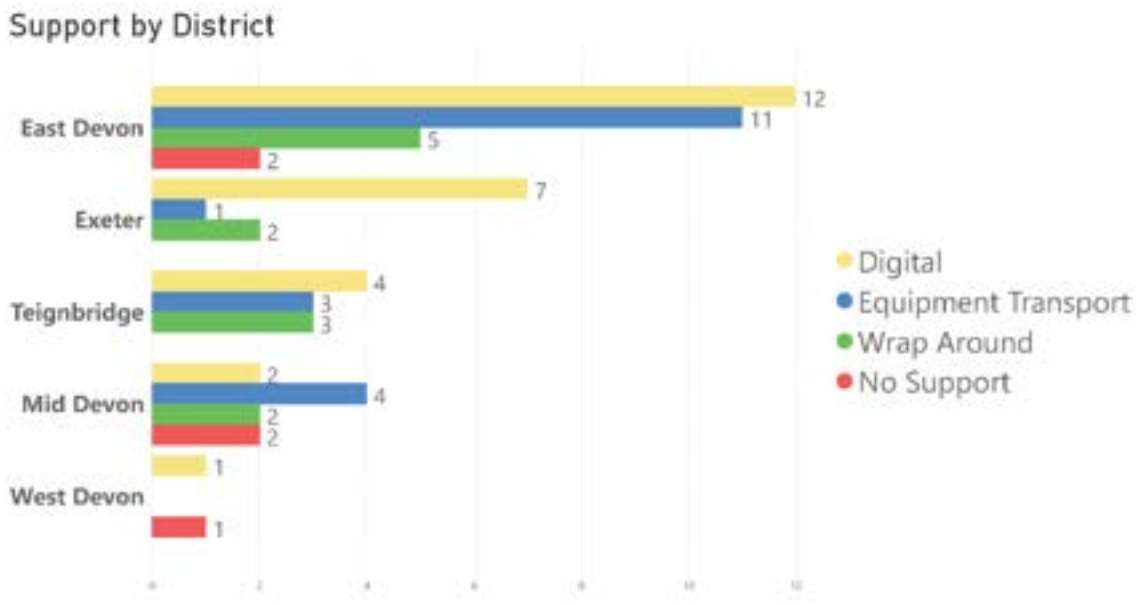


Figure 6 Type of support per district

Unsurprisingly, given the number of patients in East Devon, their relative age compared to patients in other districts (with places such as Sidmouth and Exmouth known for their above-average number of retired people) and the reduced public transport system, numbers requiring equipment transport were high compared to other districts.

3.3 Average response time

The time from the referral to DCT to the date of the first visit was on average one day. There was one referral when there was 9 days between the date the support was due to start and the first visit. This gap was due to the patient changing their mind about wanting support and then being referred to us again a few days later. This is detailed in the patient's timeline of actions on CRM. In some cases, it was not possible to arrange a convenient time with the patient. With referrals which took more than 1 day to action, this was because the referrals were received over the weekend, so support visits had to be scheduled on/for a Monday.

3.4 Time spent on visits

Most patients were visited only once; the average time the delivery partner spent with a patient was just over one hour, with a total of 40 hours. This gave them the time to deliver the support requested, check on the patient's welfare and that of their carers and signpost them to any other organisations for assistance, as necessary.

9 patients received 2 visits and 3 patients received 3. In these latter cases, the patient was being transported to hospital appointments or respite was being provided to an unpaid carer.

In 2 cases, the delivery partner spent extra time outside of the visits researching appropriate organisations to provide additional support to the patient.

3.5 Mileage for visits

The average of 52 miles per visit takes into account the fact that mileage was higher when devices needed to be picked up from/taken back to the RDUH, or prescriptions picked up from there and taken to the patient. This applies to all but one visit where the mileage was more than 50. One patient was taken 3 times to the hospital for an appointment.

3.6 Value to the RDUH

The Theory of Change evaluation framework created at the start of the pilot set out how we wished to capture the value to the AHAH team, and wider hospital, as a result of VCSE support of Virtual Wards patients. One of the key targets was to save clinical staff time; they often had to provide support on the phone or in-person to patients.

The hospital gave us the figure of £519.19 as the average cost to the NHS of a patient spending time in a hospital bed. By adding up the time (periods of 24 hours) that patients spent on the Virtual Ward rather than in hospital, it was possible to calculate the approximate financial savings to the hospital during the period that the VCSE pilot was operational.

- 25 hours of time saved by VCSE providing digital support to patients, calculated by adding the time spent directly on digital support during each visit to a patient
- 196 nights spent on virtual ward during the period of the VCSE pilot (£519.19 is the average cost of a bed per day so this equates to £101,761). *N.B. this is based on the VCSE figures but we are aware that some patients were discharged earlier than expected and some had their stay extended.*

3.7 Patient profiles

The majority of patients referred were aged 70 or over, of White British background and heterosexual. 50% identified as female, only slightly more than male. About the same number said they were Christian as said they had no religion. This is pretty much in line with the general demographic of Devon, where, according to the 2021 census[1], 94.2% of the population of East Devon, where most referrals come from, identifies as White British, 90.55% identify as heterosexual, there are slightly more women than men and 50.1% connect or identify with Christianity.

[1] Ethnic group - Census Maps, ONS

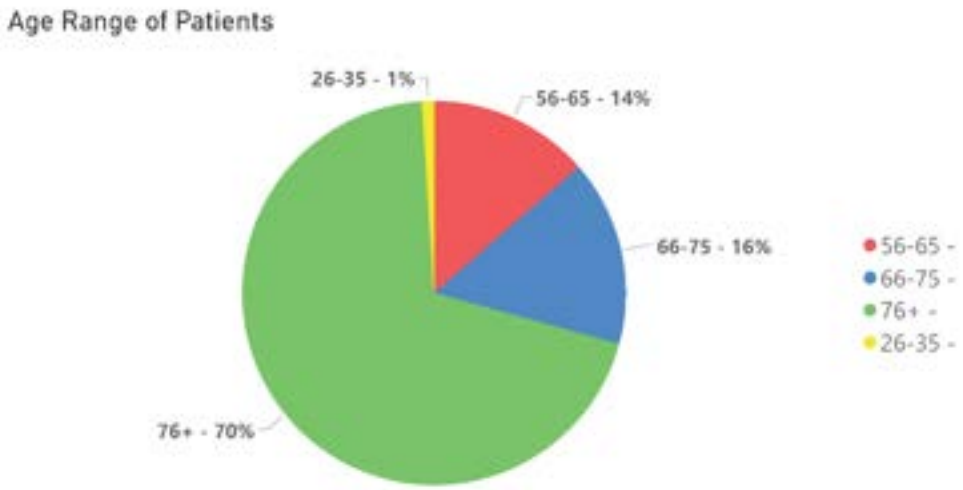


Figure 7 Patient age

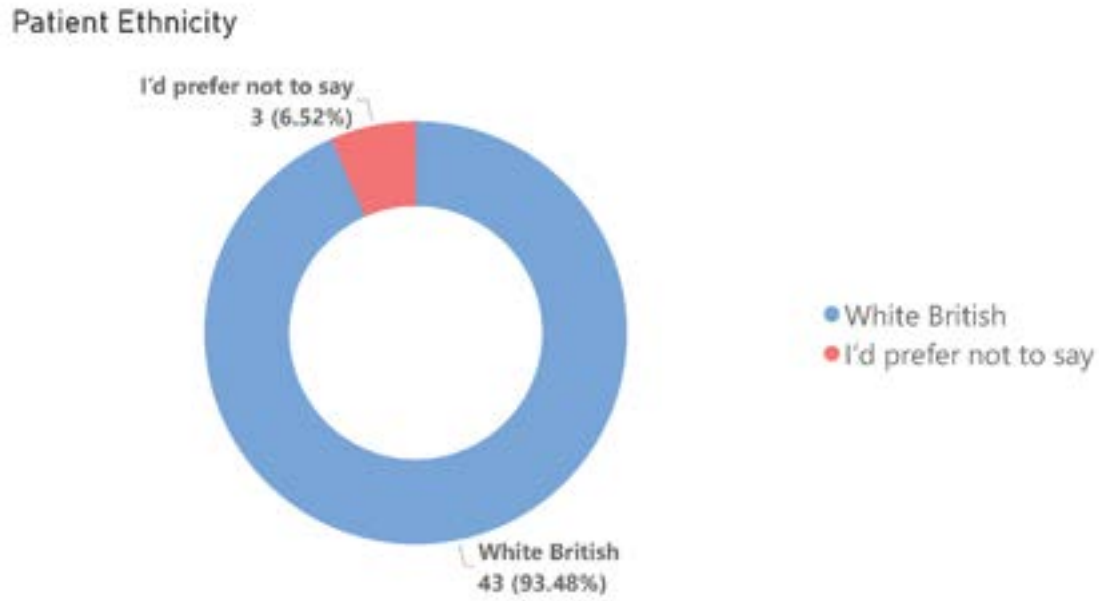


Figure 8 Patient ethnicity

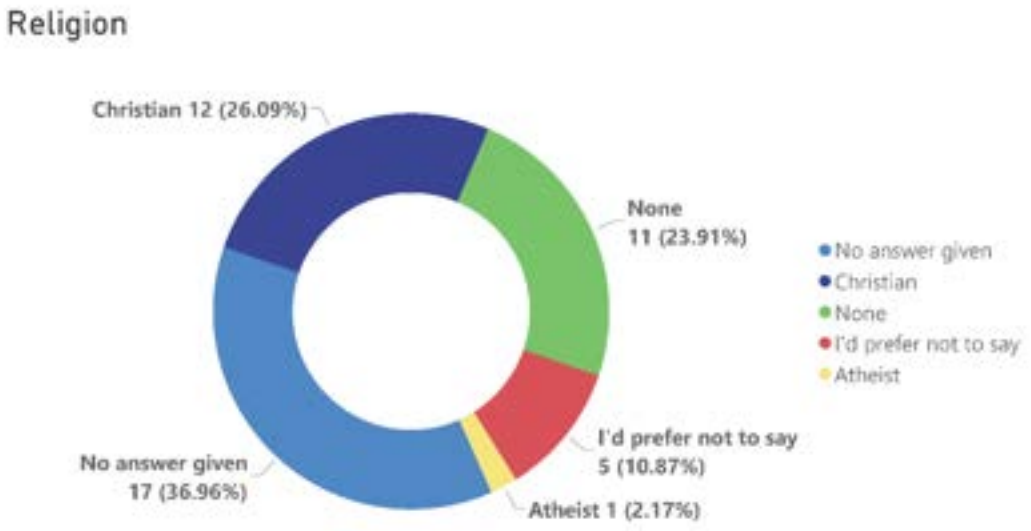


Figure 9 Patient religion

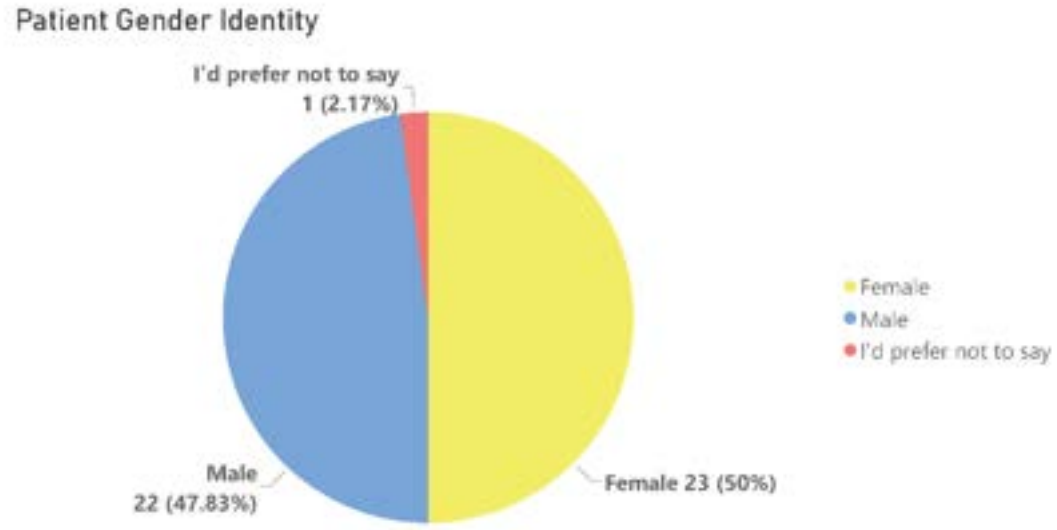


Figure 10 Patient gender identity

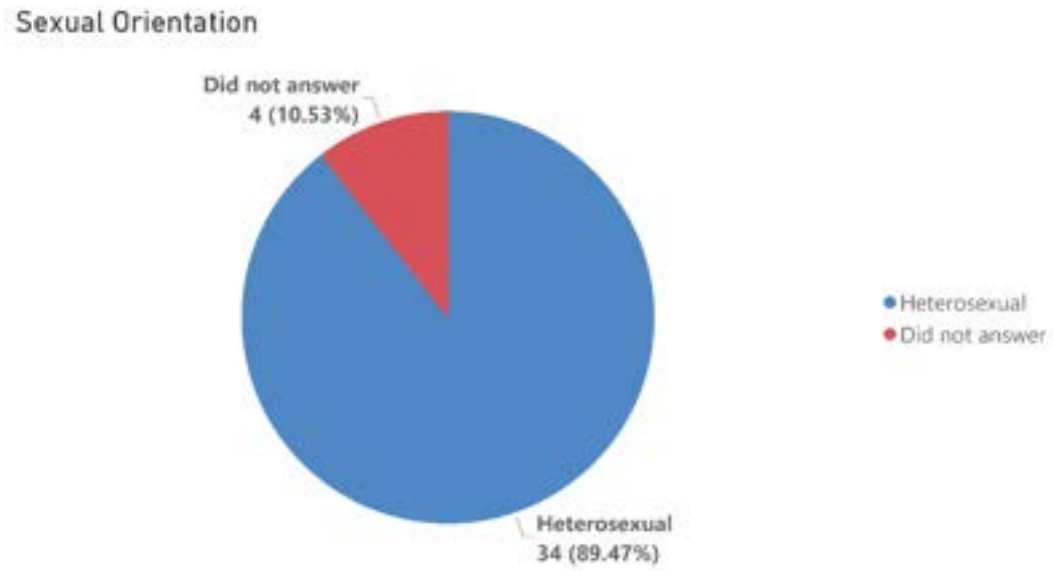


Figure 11 Patient sexual orientation

3.8 Disability

Very few patient disabilities were noted on the referral form, the highest number being 4 with a hearing disability and only one patient having more than one disability. However, following a visit, it was ascertained that 8 patients had some form of disability which limited their day-to-day activities. Delivery partners were knowledgeable and experienced enough to signpost patients to support to make daily life easier, for example, providing advice on which type of stairlift to get and arranging for mobility equipment to be mended.

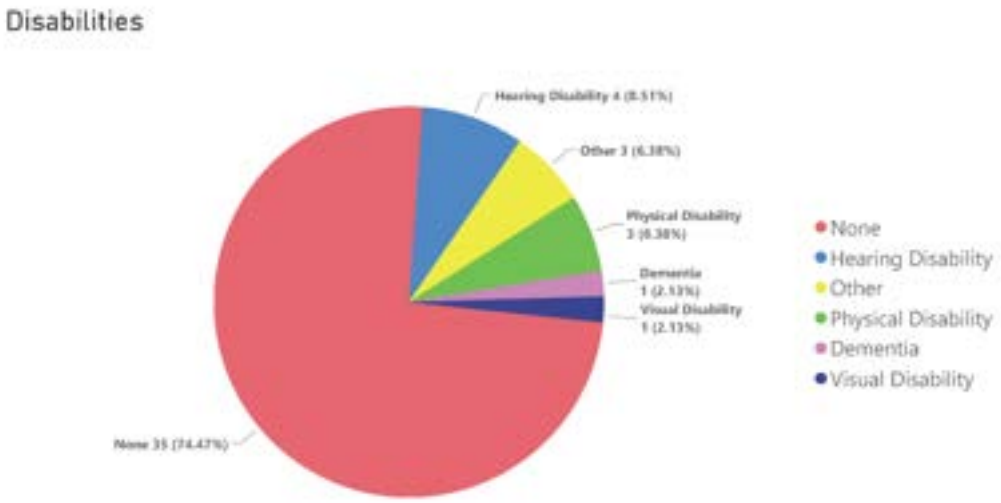


Figure 12 Disabilities

3.9 Digital confidence and upskilling

15 patients stated explicitly that they were more confident using the equipment issued by the hospital, out of 26 patients given digital support. The others already had a good level of confidence, had someone at home they could rely on to help them or were happy to admit that they would need support if they had to use the equipment again. Over a longer period, it would be interesting to note if any of these patients were re-referred to the Virtual Ward and what their capacity to remember how to use the equipment was, although it is likely to be low with this demographic. The figures show that older patients, in particular, felt more confident after having the devices explained by VCSE staff.

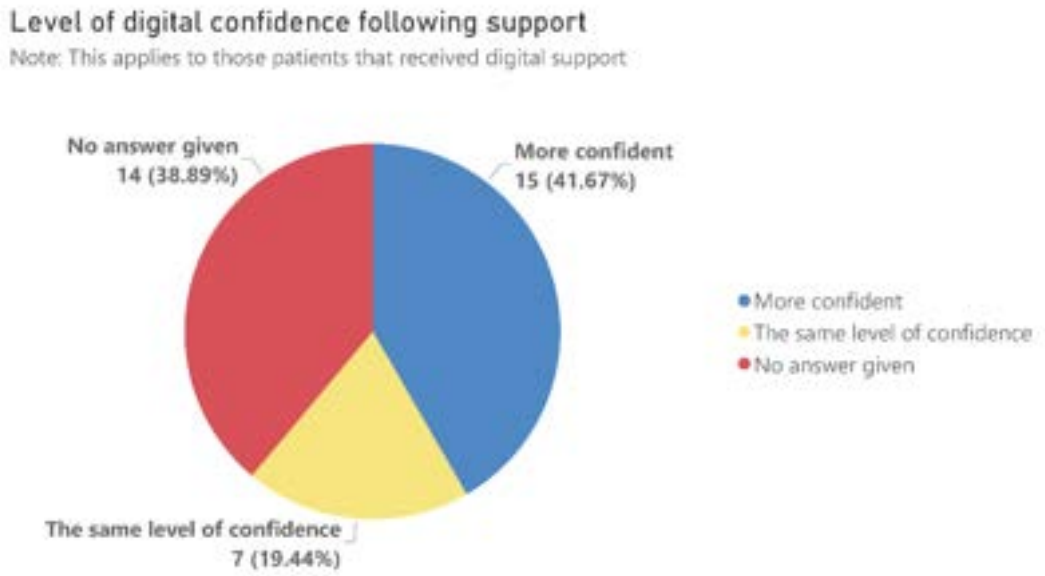


Figure 13 Digital confidence

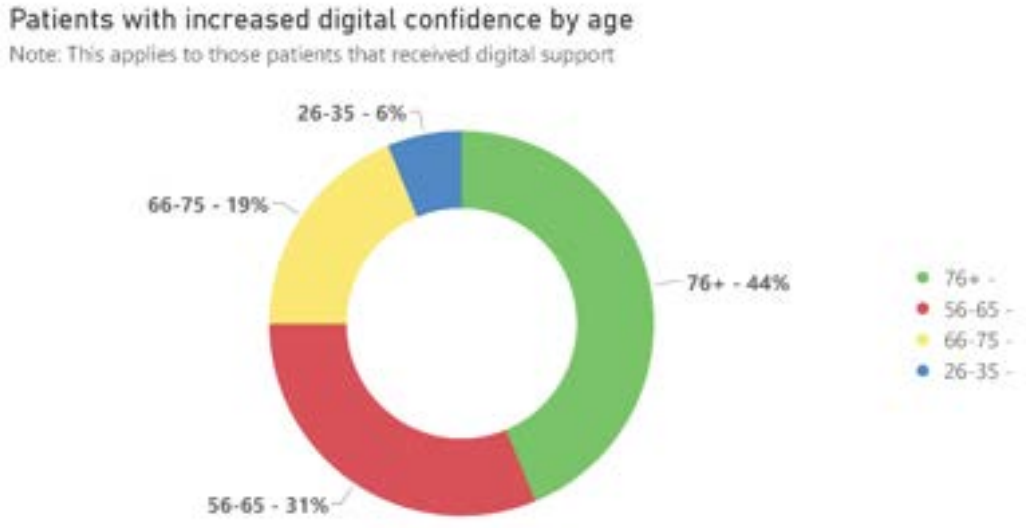


Figure 14 Digital confidence per age group

The majority of patients found scales, fingertip monitors and blood pressure monitors the easiest to use; most support was required for using Apple watches and iPhones.

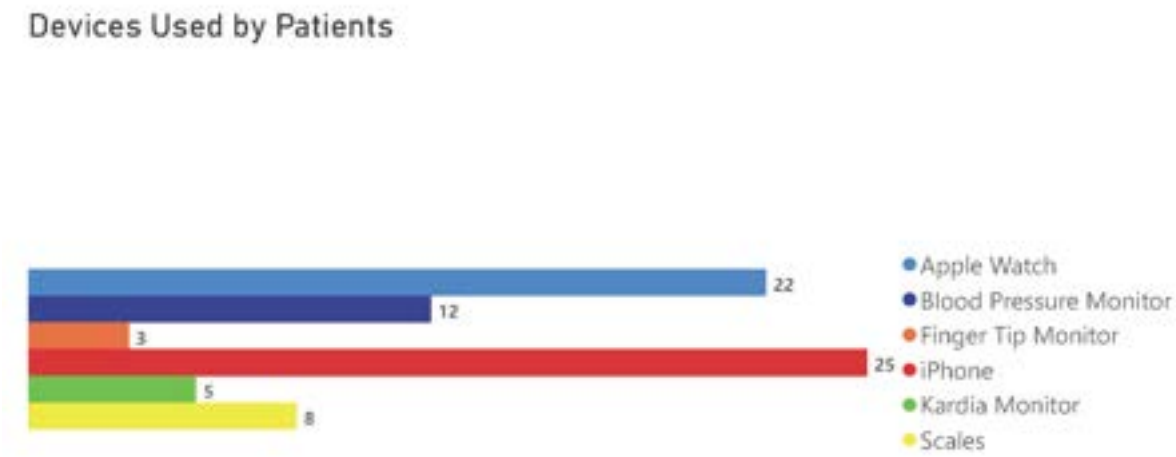


Figure 15 Devices

3.10 Patient wellbeing

From the end of May, DCT began to assess patients' wellbeing both at the start of their VCSE-supported Virtual Wards experience and after. The same questions were asked during the triage call and during the customer survey call:

- Overall, how satisfied are you with your life? On a scale of 1-4, with 1 being often/always and 4 being hardly ever
- How often do you feel lonely? Often/always; Some of the time; Occasionally; Hardly ever; Never

Of the 17 patients who were asked these questions, scores in relation to wellbeing were understandably low; these were difficult questions to put to people who had just been in hospital with many pointing out that of course they weren't feeling brilliant. One patient who answered 4 explained that this was due to the physical distress he was feeling; he was otherwise upbeat during the customer survey about being at home with his wife, saying ""Very pleased with all the help. It gave us a great deal of reassurance. Every department has been amazing." The other patient who gave this score was overwhelmed by her diagnosis and was very young. She was fairly tech savvy so was reassured to know that she was using the device correctly. All were made aware that the VCSE offer of support included companionship and that other organisations were available to help them if they wished.

Table 2 Wellbeing

Satisfaction with life	
1 (often/always)	3
2	5
3	5
4 (hardly ever)	2
Loneliness	
Often/always	1
Some of the time	1
Occasionally	1
Hardly ever	5
Never	9

All patients had a support network at home, with a partner living with them or friends/family often visiting, although of course this does not guard against feeling lonely. One patient who said she was occasionally lonely was used to her daughter coming round but the latter was currently ill so not visiting. Only one said that they were often or always lonely but didn't give a reason for this; this patient was offered support but was adamant none was needed and declined all support. The patients who scored well on both questions tended to still be working and had a partner at home. All patients were made aware of the VCSE support on offer which included companionship. Often chatting on the phone during triage and customer survey calls seemed to cheer the patient up somewhat. However, some said they were lonely despite having family at home but in most cases their physical symptoms meant they were not getting out and about as much as they might have normally so this is understandable. In several cases, the patient was too confused to answer questions about their wellbeing so either no answer was given or a carer answered to the best of their ability on the patient's behalf. A future programme would also ask the same questions of unpaid carers to measure the impact of VCSE support on their own wellbeing.

3.11 Supporters

One area of the support provided that grew in importance was the identification of and support for unpaid carers. Very often, the person caring for a patient did not recognise themselves as a carer – they felt it was their duty or responsibility to do everything for the patient and in several cases it was clear that they needed support themselves. In most of these instances, it took more than one discussion

with the carer before they agreed that they also had support needs. Initially, the RDUH did not refer patients for wraparound support if they had someone living with them; it became clear that very often, the carer also needed support, and this was not obvious until the first visit had been made.

The number of carers started to be monitored in June: out of 11 referrals, 6 patients had unpaid carers providing significant amounts of support (a minimum of one visit a day if the carer did not live with the patient). In two cases 2 people overall provided live in and personal care to the patient. Although delivery partners knew to signpost people identified as such to Devon Carers, it was decided to obtain leaflets for this and other care organisations, to be handed out during visits.

In two cases, the patient was also the carer for their partner and was concerned that they were unable to be as proactive whilst they themselves were ill; this was not picked up at the point of referral in either case.

4. Theory of Change

The Theory of Change evaluation framework was created at the beginning of the pilot and shared with delivery partners for feedback and comments; it set out these statements and mission:

Statements

- The success of the Virtual Wards programme at the RDUH relies on the patient being able to stay happily in their own home rather than on the hospital ward.
- The VCSE sector in the area is ideal placed to offer digital and wraparound support to these to enable them to stay at home.

Mission

To support the RDUH to deliver a successful Virtual Wards programme.

Objectives

- Community partners are able to successfully provide patients with digital and wraparound support as part of the RDUH's Acute Hospital at Home scheme.
- Patients feel supported to monitor their health at home in an environment they are more comfortable in.
- Health professionals are able to concentrate their resources on in-patients with acute needs.

Table 3 Virtual Wards VCSE pilot Theory of Change

Inputs	Activities	Outputs	Outcomes	Impact
Staff time Travel expenses Digital training Steering group meetings Bi-weekly management updates	Referral process Triage calls Support visits Patient support record Data processing Customer survey calls Partner survey Evaluation	Number of individuals trained in using digital devices. Number of staff feeling more confident about using devices. Number of organisations carrying out visits to provide digital support	Pilot provided a valuable opportunity to link up local voluntary and community groups, primary healthcare services, hospital discharge support workers and social prescribers to provide a strengths-based element to the model. VCSE organisations have increased their capacity to deliver services, increased their organisation's profile and resources and trained their staff in using digital devices. The pilot area has increased the use of technology in healthcare and helped prepare patients for future initiatives.	**1. Community partners were able to successfully provide patients with digital and wraparound support as part of the RDUH's Acute Hospital at Home scheme.**

			The success of the pilot has encouraged a roll out to more areas in Devon and, eventually, nationwide.	
		% of patients preferring virtual wards to a hospital stay. % of patients finding the process clear and helpful. .% of patients with increased confidence in using digital devices	The number of readmissions has decreased as the patients are supported to recover well and safely at home. Patients have been more confident in using the devices and submitting readings to the hospital.	**2. Patients have felt supported to monitor their health at home in an environment they are more comfortable in.**
		Number of appointments freed up for return of devices. Reduction in the number of readmissions from VW patients. Money saved by not having a patient on the ward.	AHAH staff have been able to spend more time with other patients in need. The RDUH has been better able to deploy financial resources elsewhere in the hospital.	**3. Health professionals have been able to concentrate their resources on in-patients with acute needs.**

5. Quantitative and qualitative evaluation

DCT used a CRM system specially designed to track the patients' journey through the programme. At the point of referral, the patients gave consent to their data being shared with partners for the purposes of the pilot. The data was obtained from:

1. **The initial referral form from the hospital**
    - contact details
    - age
    - time spent on Virtual Ward
    - gender
    - ethnicity
    - additional support needs
    - type of support required
2. **The triage call made by DCT**
    - details of support
    - confidence using digital equipment
    - general wellbeing
    - Virtual Ward expectations
    - sexual orientation
    - religion
3. **The support record filled in after each visit**
    - time spent on visit
    - mileage
    - follow up
    - disability and any limitations
    - apps downloaded
4. **The customer survey call made to the patient**
    - preference for being in hospital or at home
    - overall satisfaction with experience
    - feedback on the delivery partner
    - general wellbeing
    - digital confidence
5. **The partner survey (to be carried out at the end of the project)**
    - processes
    - communication
    - impact on organisation
6. **The hospital staff survey (to be carried out at the end of the project)**
    - time able to be spent with other patients
    - other benefits to their work

6. Predicted versus Actual Outcomes

The table below shows the outcomes that the pilot hoped to achieve, set out as part of the Theory of Change evaluation framework. The final column highlights any changes to these predicted outcomes, including additional outcomes.

6.1 Objective 1: Community partners will be able to successfully provide patients with digital and wraparound support as part of the RDUH's Acute Hospital at Home scheme.

Table 4 Objective 1

Predicted Outcome	How was quantity measured?	How was quality measured?	Actual/additional outcomes
Pilot provided a valuable opportunity to link up local voluntary and community groups, primary healthcare services, hospital discharge support workers and social prescribers to provide a strengths-based element to the model.	**Number of referrals received.**	**Feedback from patient and delivery partner customer surveys.**	
The following organisations participated in the project as delivery partners: *Wellmoor, Seachange Devon, TRIP CTA, Ottery Help Scheme, Age UK, Devon Carers, Community Links Okehampton.*	*46 referrals had been received by 14th July 2023.*	***% of patients giving positive comments about service and support received***	

These organisations have been supportive of the project, have helped to guide processes and are interested in being involved in the future: *British Red Cross, Living Options, Westbank, West Devon CVS.*		*Out of the patients who commented on the service and support provided, 100% of these comments were positive.* ***In addition, a directory of services was created for delivery partners to have information to hand on other organisations to signpost patients to.***	
VCSE organisations have increased their capacity to deliver services, increased their organisation's profile and resources and trained their staff in using digital devices.	**Number of individuals trained in using and troubleshooting digital devices.**	**Record of training attended and feedback on the training. Feedback from patients via the customer survey.**	
**further data to be collected from delivery partners at the end of the pilot*	*A total of 6 staff members from DCT and Wellmoor initially attended training in using the digital devices at the AHAH. In the 3 months of the project, 13 participants from*	*The feedback received showed that those trained rated the training as 4 out of 5 overall.* *100% of patients who gave feedback on the delivery partners were satisfied with the support received:* *"Saskia was so helpful and set it all up for me. Would have not been able to do it without her."*	

	delivery partner organisations have been trained to use the devices by Wellmoor.	*"I don't think you could've done anything more!"* *"Would score you a ten if I could!"* *"Very pleased with the whole shebang!"*	
The pilot area has increased the use of technology in healthcare and helped prepare patients for future initiatives.	**Number of patients who download the MyCare/Joy/other app as a result of Virtual Wards support.**	**Feedback from patients showed increased confidence in using technology and a belief in the ability to be able to use the devices with decreasing support.**	
	20 patients downloaded and/or activated at least one health monitoring app with VCSE support. This supports the RDUH's drive to increase the use	Not all of the patients felt more confident about using the equipment, despite the support. 2 of the patients who commented said they would continue to require support if readmitted to the Virtual Ward. This depended on whether family members were competent IT users and available to support. However, as no patients were readmitted, it was not possible to	*Feedback from AHAH staff:* *"I received good feedback, it gave people more confidence with the technology".*

	of the MyCare app.	see whether they actually did continue to need support. "*But once I knew how to use the equipment and it was very easy.*" "*Support was excellent. Felt confident using the equipment afterwards.*" *"Feel more confident."* *"Definitely more confident using the MyCare App for communication with the hospital, checking own medication records etc."*	
The success of the pilot has encouraged a roll out to more areas in Devon and, eventually, nationwide.	**Number of staff confident to provide digital support and going out on visits.**	**Feedback from patients showed that patients find the digital support offered to be clear and helpful.**	

**To be ascertained following the submission of the final report.*	*2 organisations now feel confident to deliver digital support by themselves. Wellmoor offered to go on an initial joint visit with any partner as required. However, if these skills were not used then it was easy to feel less confident as time wore on; refresher training or the opportunity to use skills immediately, maybe shadowing another partner, should be considered.*	*"Explained everything."* *"Saskia was very good at explaining and very nice."* *"Very helpful - couldn't do it myself!"*	

6.2 Objective 2: Patients feel supported to monitor their health at home in an environment they are more comfortable in.

Table 5 Objective 2

Predicted Outcome	How was quantity measured?	How was quality measured?	Actual/additional outcomes
The number of readmissions decreased as the patients are supported to recover well and safely at home.	**% of patients not readmitted compared to previous figures.**	**Feedback from patient customer surveys showed that patients preferred being at home to staying in hospital and that they were happy with the support the project provides for them to remain in their homes.**	
		Unsurprisingly, the majority of patients preferred to be at home, with none expressing a preference for being in hospital. "Made a huge difference being at home and being able to get on with things." "Great to be at home, was not necessary to stay in the hospital."	The hospital does not currently collect figures showing reasons for readmission; it is thought that reasons for readmission are largely clinical and would

		"He preferred being at home because he could relax more there and it was quieter. They both felt reassured by being part of the VW project and felt safe and secure knowing they had people to call on if needed." "because of the stresses and overwhelming nature of being in hospital couldn't take on the information regarding the devices when first discussed". From AHAH staff: ..... "Very helpful service that made patients feel supported and looked after." "Being able to set patients up in their own home when they are less overwhelmed benefits the patients and therefore us."	therefore not be affected by VCSE support. However, in future, it might be possible to keep data on any patients who are readmitted to hospital because, for example, they are unable to monitor their health independently or do not have the necessary support to remain comfortably in their own homes.
Patients were more confident in using the devices and submitting readings to the hospital.	**RDUH reported fewer enquiries**	**Carers were upskilled in their use of digital devices to monitor health, and better placed to support their patients.**	

	about devices.		
		“No problems now. All the information is getting to the hospital.” “Knows what to do next time (wife).” “Showed patient and her husband how to log into my care, how to unlock the phone and how to charge the apple watch.” “Showed patient’s husband where they could view this to check new readings were being sent if they wished”. “Showed patient and family how to use My Care app to access appointments, medications etc, which they were happy with.”	The RDUH reported fewer enquiries about devices and the number of patients attending the hospital for problems with devices decreased as they were dealt with at home by VCSE. The number of enquiries prior to the VCSE pilot was not measured so in future, a baseline would be useful.

			Wellmoor will remain up to date with changes in devices and apps used by the hospital, ready for any continuation of the project.

6.3 Objective 3: Health professionals are able to concentrate their resources on in-patients with acute needs.

Table 6 Objective 3

Predicted Outcome	How was quantity measured?	How was quality measured?	Actual/additional outcomes
AHAH staff are able to spend more time with other patients in need.	**Amount of time freed up for AHAH by patients having devices set up for them.**	**AHAH staff report having more time with other patients.**	
	25 hours.	"It reduced us having to try and talk people through fixing things over the phone and reduced bringing people back in to problem solve. Sometimes when the watches go wrong we would spend ages trying to talk the patient through it over the phone then trying again with their family, then we'd end up bringing them back to hospital for us to look at it if we got nowhere over the phone. Being able to ask VCSE to visit saved this." "Being able to trouble shoot issues in the patients home means they don't have to come back to the	NB: The team reports that they often have to get devices collected by taxi, courier or at times have had to collect them themselves.

		hospital again and we can use our time in hospital for other patients."	
The RDUH is better able to deploy financial resources elsewhere in the hospital.	**Number of hospital beds freed up by a supported virtual wards project.**	**AHAH staff report benefits to their work**	
	The average cost to the NHS of a bed for 24 hours is £519.19. 2The total number of days spent on the virtual ward, supported by the VCSE partners, is 196; the monetary value to the NHS of patients not	"It also allowed us to give more complicated devices to people who wouldn't have otherwise been able to manage them." "I think this pilot has been very successful and I would like to see it continue. The VCSE team are now very knowledgeable about AHAH and our devices, it would be a shame if this was lost." "It was helpful to know that we could rely on VCSE to help set up our patients with monitoring equipment that we would often struggle to get set up here in the hospital. The support of VCSE really helped reduce the stress of this part of our role. The	AHAH managers report that since all patients were referred for VCSE support, this has lightened the load on the nurses as they haven't had to make the decisions about whether support was needed or not. "Yes, it reduced the inequality in care in terms of technology as patient who are not tech savvy and who would otherwise have had to have something very basic.

[2] Figures provided by AHAH team

	being on a hospital ward during the period of the pilot is therefore £101,761.	VCSE team were really adaptable, responsive, intelligent and reliable." "VCSE helped us to continue delivering a high standard of care to people once they left the hospital. I know our patients felt well supported by the service and as staff we felt that we could rely on VCSE to provide a quality to anybody and at short notice."	This would not have given us as much information as more complicated devices and therefore we would not have been able to give care of as good a standard as someone who was given something better. Now, more people who are not confident with technology will accept it with the reassurance that someone could pop in and make sure it's working as intended. The tech support is the thing I think is valuable."

6.4 Summary of patient feedback

6.4.1 Positive comments (NB: all narrative comments are included below)

"Excellent. A few hiccups. Felt strange but it works! Felt was taking up a bed that someone else could be in. Wonderful service. Couldn't fault it. Made a huge difference being at home and being able to get on with things. Bored in hospital."
"Okay. Hospital was really busy."
"Positive VW experience and happy to be at home at the time vs in hospital."
"Great to be at home, was not necessary to stay in the hospital."
"Was very glad to be at home."
"Would much rather be at home than waiting for hours in the hospital."
"The support from your staff was very helpful."
"It was reassuring to have the number of the hospital whilst being at home and know that I can ring whenever I need to."
"Good system indeed – should be continued. Great service to have someone drop off the device and help with the faulty Kardia."
"Everyone marvellous."
"It's always nice to be back home."
"Nice to have her things around her."
"He preferred being at home because he could relax more there and it was quieter. They both felt reassured by being part of the VW project and felt safe and secure knowing they had people to call on if needed."
"Better than being in hospital."

"Grateful to be able to recover at home with family around."
"Very positive."
"Happy to be at home. Hospital was very noisy and had to get up at 6am."
"Prefer to be at home, happier, doesn't like hospital."
"Having someone collect the equipment at the end was also helpful. Feels looked after and cared for."
"Didn't need to be in hospital."
"Very happy to go home and happy with the support he received."
"Preferred being at home. You are more relaxed at home. There are other people worse off than me that need the beds in hospital."
"Preferred being at home. Nothing like your own bed. Lack of sleep in hospital."
"Happier – easier at home."
"A lot nicer than being in hospital, it is not so clinical. Obviously, feeling at home and I am with my wife and family so it is a lot better experience all around, really."
"Found the whole process very clear and helpful."
"Very helpful and clear. Was given lots of information and process was explained clearly."
"Excellent, very clear."
"Explained clearly. Saskia was very jolly and friendly."
"The process was clear, and help was quickly available when John's heart monitor fell off in the night. Having someone visit three times in that week when John was being discharged worked extremely well."

"Best blood pressure machine ever used – very easy and clear, just the right size."
"Excellent little machine."
"Explained everything. Lovely girl."
"It was very helpful to have someone visit and collect the equipment – saved us a trip to Exeter."
"Satisfied, has lots of support and was really happy with the care provided. I know where to go for more support."
"Everyone has been so kind and helpful."
"Thank you for calling and being so polite."
"Would use the service again if needed."
"I will continue to access support."
"Very satisfied for that week while John was being discharged."
"Very helpful to have someone collect the equipment and ask about if any other support is needed."
"Was happy that I advised her to speak with her GP."
"Big thumbs up to the project. She (patient) was better being at home."
"It was very helpful to have the scales delivered and someone to talk through the process."
"Saskia was very good at explaining and very nice."
"Support was excellent. Felt confident using the equipment afterwards."
"So kind to get the device out to me."

"Went very smoothly."
"Really useful to be able to have someone see her once she was back at home and more settled"
"I don't do all this stuff, my daughter does the internet, but it's brilliant when you think about it!"

6.4.2 Comments to follow up

"Patient was very worried about messing up and the viability of her being able to carry out her VW stay due to how complicated the technology seemed to her."
"Lots of contact from lots of different people overwhelming."
"The free service OHS can provide going forward is only for companionship and sitting with the patient (any other support costs money)."
"It could have been made clearer that we were eligible for this one week only while John was being discharged."
"Didn't suggest using the iPhone to note readings – wife has been jotting these down in a notebook but thinks they could also be added on the phone."

6.5 Summary of delivery partner feedback

Discussions with delivery partners have been scheduled for the middle of July.

Questions:

- **How helpful was the initial information provided by DCT?**
  "All the links and shared information was very helpful and gave insight into who was involved and the reason for the project to support the AHAH service."

  "Good information."

  "Good, but like most things the understanding of the project became clearer once we were actively involved."

  "Helpful and clear."

- **How did you find the communication between project partners?**
  "Communication was exceptional when discussing referrals."

  "Good – but there did seem a lot of forms and comms between delivery partners/clients SPOA – however I understand this works for some people but can be a bit overwhelming for some patients."

  "We had one joint visit with Wellmoor which went well, with good communication."

  "Good but would have been useful to have a better understanding of what services each partner could offer and where they were based."

- **How well equipped did you feel to support the patients with the medical equipment?**
  "I have a background in HCA so I feel well equipped to use and explain the medical equipment."

  "We would have been ok and learnt as we go along."

  "Haven't really had to do anything with medical equipment apart from collecting or returning."

  "Very well equipped and supported by DCT, thank you!"

- **Do you feel confident, and have the right information, to go out and provide support to patients with their digital devices?**

  "*The training given was really useful and increased my confidence should I need to use or explain the devices to patients.*"

  "As an organisation we offered to help in the East Devon area with digital support – however we received no referrals for this even though we had volunteers and staff trained and so this was a bit disappointing. I presume all digital support went to Wellmoor but initially if that was the plan then perhaps we should not have been offered the opportunity/and therefore not asked volunteers to turn out for volunteer training in this area."

  "Was reassuring knowing there was always someone at the end of the phone to support but had difficulties getting digital support on a Monday when there was only one member of staff working/on call in which they had signal issues at home address."

  "Yes."

- **What parts of the project do you think worked well?**
  "The support given to patients, was provided quickly and on an individual basis."

  "SPOA." (single point of advice/access)

  "I found that Patients often had little knowledge about VWards, and once I explained how it worked, they appeared to feel more reassured and at ease and more supported."

  "Worked well that DCT received referrals in and did the initial triage call, then passed on to us to do the visit."

- **Do you have any suggestions to make this process work better for you?**
  "It would be good to know about possible referral numbers as soon as possible so we can assess staff's availability and allocate accordingly. Reduce contact with patients (maybe not in all cases), reduce forms, perhaps an invoicing strategy at the end of each month, let organisations contact the patient directly so they can arrange where/when."

  "Maybe a little more detail on the referral i.e., a detailed list of equipment to be collected and perhaps a procedure in place to record when equipment has

been collected or returned. Patients to be given a better understanding of VWards before they leave hospital."

- **Did you feel adequately supported by the training provided?**
  "Yes, very."

  "Yes."

  "We have been provided one to one training and also given the training pack to print out to refer to when needed, which is great, however without supporting patients regularly the information/knowledge can soon become a little hazy."

  "Yes, very useful to go to hospital in person for the training."

- **What impact did the project have on your organisation?**
  "Staff quickly responded to referrals as they came in, staff always acted in the best interests of the patients but this puts extra pressure on staff who are already busy with other projects. As we didn't know how many referrals we were going to get, staff had to do this on an ad hoc basis at very short notice, so had to juggle things about to make the referrals work for the pilot."

  "Limited."

  "The project seemed to fit into our everyday fairly well as we cover East Devon."

  "Built skills within our team and gave us valuable experience about the emerging Virtual Wards programme."

- **Did the funding that your organisation received cover your costs?**
  "Yes, the payments have just about covered the staffing and travel costs. I think because of the answer to question 8, if this was going to be a longer-term project then having regular contracts, even for short periods, or for so many hours, would be a better way forward, so staff can be allocated weekly hours to cover support needed. I appreciate referrals have been very ad hoc and this is impossible to predict. But maybe everyone under the AHAH service could have an assessment by the providers whether that be over the telephone or at home."

  "Yes, however sometimes it seemed we were paid more for less and vice versa."

"Yes."

- **If the project is extended, would you like to be involved?**
  "Yes, very much so."

  "Yes."

  "Yes, absolutely."

  "Yes!"

- **Any other comments**
  "This is a great project for patients and I hope it is able to continue."

  "None."

  "We've enjoyed being part of this project."

  "Thank you for all the support from DCT – both in organising the project initially and providing ongoing support in setting up the patient visits."

6.6 Summary of hospital staff feedback

An in-depth discussion about the pilot with hospital staff involved was held at the end of July. AHAH managers report that since all patients were referred for VCSE support, from the end of May, this has lightened the load on the nurses as they haven't had to make the decisions about whether support was needed or not. From this point onwards, only 4 were determined to not be in need of support.

AHAH staff were also concerned that with the VCSE support available, in-patients were not being offered the same opportunities as those on virtual wards.

Questions:

- **What feedback from patients on the VCSE support did you receive?**
- **What were the benefits to AHAH staff of VCSE support?**
- **Did you feel the participation of the VCSE sector in the pilot has been positive and if yes, why?**

Table 7 AHAH staff comments

What feedback from patients on the VCSE support did you receive?
"I received good feedback, it gave people more confidence with the technology."
"Very helpful service that made patients feel supported and looked after."
"Patients reported they found the help valuable and the support made them feel more confident with the equipment they had been given."
What were the benefits to AHAH staff of VCSE support?
"It reduced us having to try and talk people through fixing things over the phone and reduced bringing people back in to problem solve. Sometimes when the watches go wrong we would spend ages trying to talk the patient through it over the phone then trying again with their family, then we'd end up bringing them back to hospital for us to look at it if we got nowhere over the phone. Being able to ask VCSE to visit saved this. It also allowed us to give more complicated devices to people who wouldn't have otherwise been able to manage them."
"It was helpful to know that we could rely on VCSE to help set up our patients with monitoring equipment that we would often struggle to get set up here in the hospital. The support of VCSE really helped reduce the stress of this part of our role. The VCSE team were really adaptable, responsive, intelligent and reliable."
"Being able to set patients up in their own home when they are less overwhelmed benefits the patients and therefore us." *"Being able to trouble shoot issues in the patients home means they don't have to come back to the hospital again and we can use our time in hospital for other patients."*
Did you feel the participation of the VCSE sector in the pilot has been positive and if yes, why?
"Yes, it reduced the inequality in care in terms of technology as patient who are not tech savvy and who would otherwise have had to have something very basic. This would not have given us as much information as more complicated devices and therefore we would not have been able to give care of as good a standard as someone who was given something better. Now, more people who are not confident with technology will accept it with the reassurance that someone could pop in and make sure it's working as intended. The tech support is the thing I think is valuable."
"Absolutely yes. As well as the points I have already mentioned, VCSE helped us to continue delivering a high standard of care to people once they left the hospital. I know our patients felt well supported by the service and as staff we felt that we could rely on VCSE to provide a quality to anybody and at short notice."

"I think this pilot has been very successful and I would like to see it continue."

"The VCSE team are now very knowledgeable about AHAH and our devices, it would be a shame if this was lost."

7. Unexpected outcomes

- Dedicated delivery partners in the Mid Devon district had not been identified during the course of the pilot; however, Wellmoor has the staff capacity to travel more widely around the county and another existing partner has decided to expand the area they operate in, in response to demand, and is able to cover addresses up to one hour's drive from Exeter.
- Early on in the project, the need was identified to have equipment returned by patients who couldn't easily get to the hospital. This service has evolved into an equipment pick up (or sometimes delivery) that encompasses a welfare check and identification of any additional support needs.
- The expectation was that there would be a strong number of referrals for support with digital devices. It has become apparent that some of these patients actually require wraparound support as well, and that this could only be identified by visiting the patient at home. The pilot has, in the second half of the project, been encouraging joint visits from our digital support experts and also wraparound support delivery partners.
- The number of unpaid carers providing support at home for Virtual Wards patients has become increasingly visible. Devon Carers are supportive of the project and keen to offer support to any carers identified.

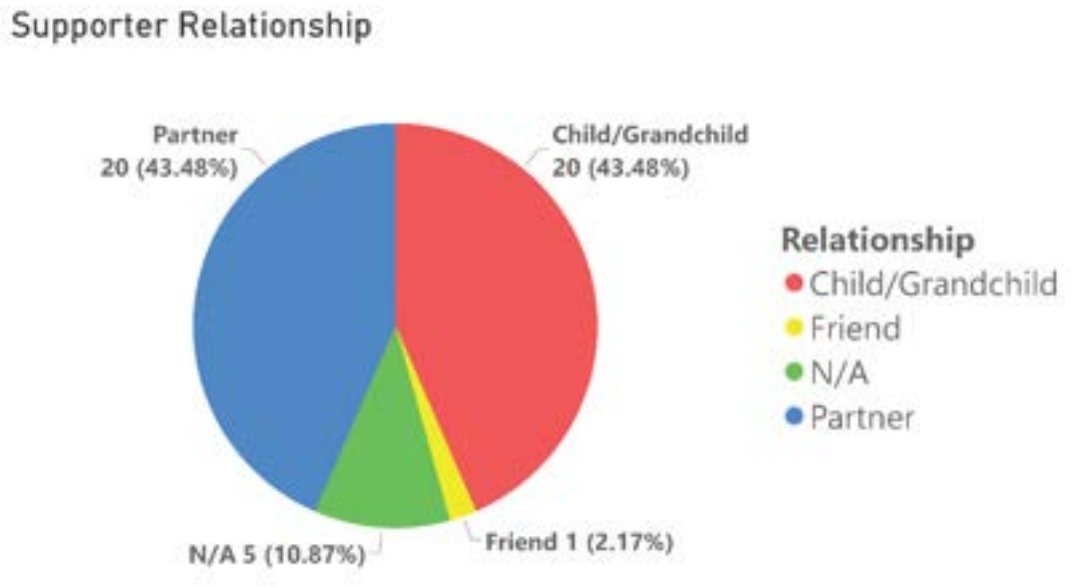


Figure 16 Home support

8. Areas for development

8.1 VCSE partners and geographical coverage

Ideally, there would be at least one delivery partner in every district served by the RDUH. Some organisations had been identified and were keen to be involved but were unable to commit due to the lack of certainty around when referrals might come in and the impact this may have on their allocation of staff time. This has meant that some delivery partners have been out to visits in areas that they are not familiar with and have felt less well-equipped to support the patient, particularly in signposting to other local organisations for support.

Wellmoor, having taken on the majority of the referrals, feel the number of partners offering digital support needs to be kept small and that fewer partners but with a wide geographical remit would be easier to manage. Although they were aware of how the random nature of referrals might adversely affect other partners, Wellmoor was generally happy with their contract, cost-effectiveness and commitment, being lucky to have a member of staff who could organise visits easily around her other work. From their point of view, it was important to offer a seamless service.

8.2 Delivery partner availability

As partners mentioned in their feedback, it was tricky not knowing when referrals might come in. As the graph below shows, the majority of referrals came from the hospital for support to start on a Tuesday or a Friday. In the future, staff in delivery organisations could arrange staff availability so as to fit the pattern shown. However, the numbers aren't significant enough to warrant, for example, no staff working on a Monday or Wednesday. A future model could employ delivery partners in areas of high numbers of referrals on a contract basis, to give them more security, accepting that it will still be impossible to predict when referrals might come in.

Staff also felt it was more useful for DCT to check delivery partner availability before the triage call, to minimise the time patients spent on the phone with different organisations. Other partners felt they would prefer to liaise directly with the patient; this is certainly simpler but adds to the complexity for patients.

Although joint visits to cover the digital and wraparound care aspects of the service were a good way of reaching those who might not immediately have identified these support needs for themselves, coordination of this sometimes meant a delay in referral turnaround; it was felt by most partners that it was better for the digital support to start as soon as possible after referral and the wraparound partner would visit at a later time/date.

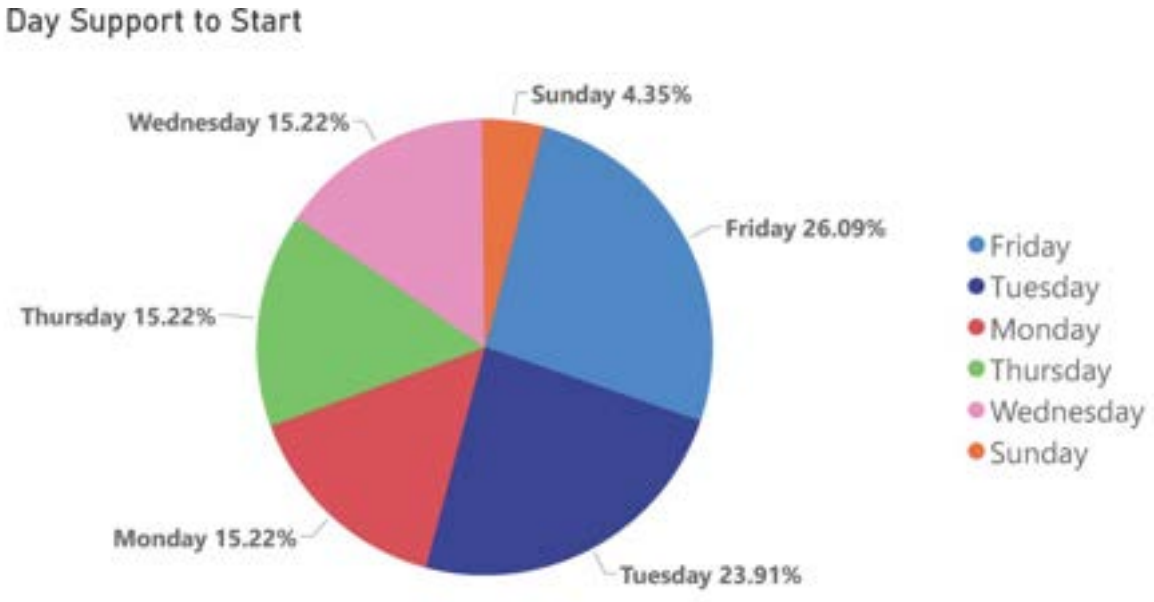


Figure 17 Day support to start

8.3 The Virtual Wards VCSE pilot and other discharge support services

There are a number of different schemes at the RDUH and it is not always clear to all involved what these are, where they operate and how the VCSE pilot fits in. This has at times led to confusion amongst hospital staff and some patients as to what the pilot is offering. Flyers explaining what the VCSE support was were given to all AHAH staff, laminated and pocket sized. Different options were explored for informing hospital staff about the pilot but the logistics proved difficult. In future, posters displayed in other wards as well as the AHAH might help staff understand what the programme is and encourage other wards to consider participating, if appropriate.

8.4 Support for carers

One of the trickiest areas was collecting data on unpaid carers as many did not recognise themselves as such, felt it was their duty to care for their loved one and were adamant they themselves did not need any support. A question that could be asked in the future is how many are already registered with an organisation such as Devon Carers, or how many are able to access respite care when needed. A measure of success could be how many then go on to register with such an organisation as the result of VCSE signposting.

In addition to the directory of services put together as part of the pilot, and leaflets for, for example, Devon Carers, being made available to delivery partners to take out on visits, there is mileage in considering whether a bespoke package of support for unpaid carers could be created, including advice on discussing the subject with members of the patient's support network. Carers

might also benefit from learning how to use the digital devices as part of a tailored training session, away from the patient's home and without the pressure of needing to provide immediate readings to the hospital. This could be carried out after the patient has been discharged from the virtual ward, for example, in anticipation of future visits. A patient with a supported carer is likely to have an increased chance of success on the virtual ward and the impact of the loved one's illness on the carer would be lessened, contributing to their own wellbeing.

8.5 Phone support

45 minutes of support was given over the phone. In some cases, it was not possible to visit the patient straight away and their needs were met during the phone call. In other cases, the phone support has been an additional support need following a first in-person visit. A video call was set up with another patient and her daughter.

A future model could include phone support as part of the services offered. If a patient or their carer is able to follow instructions for digital devices over the phone, this could mean less travel time and mileage. A video call would also allow the VCSE organisation to have a glimpse into the person's living environment, which can be helpful when assessing wraparound support needs.

8.6 Equipment transport

Although the pilot showed that collecting and returning equipment was vitally important for the hospital and had a place in the wider context of wraparound care and digital support, it would be useful to carry out a more thorough analysis of time and cost savings to the hospital – how much they spend on taxis and couriers for example. Another figure to explore would be the number of times devices do not get returned at all, and how this compares to other hospitals. Wellmoor felt strongly that any delivery partner taking devices to patients should be confident in setting these up and troubleshooting any issues.

8.7 VCSE services available

As the pilot progressed, a greater variety of support needs were identified and different types of support delivered. As the breadth of services became clear, this was communicated to the hospital. Consequently, at the start of the pilot, it was not always apparent to AHAH staff what they could refer patients for and this may have accounted for the lower numbers of referrals. The AHAH team ended up with a clearer idea of what services were on offer and could communicate these more effectively to the patients. A directory of services was also created, giving the contact details of local organisations who can provide additional support. This was shared with delivery partners, who were encouraged to access it during visits.

In order to ensure equality of access, these services could also be offered to in-patients, as part of a package that could include support for specific conditions and advice on prevention and monitoring of these conditions. VCSE staff did raise the question of support groups available and whether patients were given information

about these whilst at the hospital (this information is currently not provided as standard and clinical staff were concerned that if mentioned by the VCSE, this would go against their aims of ensuring all patients, whether on the hospital ward or the virtual one, received the same quality of care).

8.8 Training and support for VCSE staff

Digital training was offered to all VCSE partner organisations but it wasn't always possible for them to attend in person. Ideally, all staff should have the opportunity to try out the equipment themselves, hands on. Some of those trained did not then get to use their new skills, either for a while or at all. A way of ensuring that staff can put their skills into practice as soon as possible, maybe shadowing other VCSE staff or with support from Wellmoor, could help provide reassurance. Some were understandably disappointed that they didn't use their skills at all. During a longer programme, Wellmoor would keep up to date with changes in technology and offer refresher training as required. They would benefit from having a stock of equipment which could be given out to partners to familiarise themselves with and as spares for patients.

Key documents were shared with partners via DCT's SharePoint; not everybody felt confident using this so some basic training at the start would have been helpful. There were also issues with needing to request access multiple times which meant that some partners did not have access to the most up to date documents as the process was not easy for them.

Although it was made clear that VCSE staff working with patients were not expected to have any clinical training, some staff feel it would be beneficial to have some basic knowledge that would help them recognise, for example, when a reading they were assisting the patient in taking was abnormally high and therefore medical intervention was required. Guidelines from the hospital about 'normal' BP and HR ranges would be useful. However, VCSE staff felt that they were able to call the hospital for advice if necessary.

It would also be helpful for all staff to have some sort of training and support to help with difficult situations: many patients are ill and/or distressed and it can be difficult dealing with this both in person and over the phone. Some patients are at the end of their lives and one of the patients worked with sadly died; support needs to be in place for anyone affected by this.

8.9 Feedback from patients

It was recognised early on that many patients assumed that the VCSE partners were from the hospital. Photo ID was made to identify VCSE staff but the confusion still persisted, particularly during telephone calls. As a result, patients were not always clear when giving feedback and comments often seemed to concern the clinical support provided by the RDUH as well as the non-clinical VCSE support. It was therefore difficult at times to state that comments given by patients clearly

related to the VCSE support delivered. Patients benefitted from being reminded what the VCSE support entailed, and how it was separate from Virtual Wards, at several stages of their journey.

Due to the patient demographic, it was not always straightforward to collect data, particularly when they had just been sent home from hospital and, as mentioned previously, may not have been clear at all about why someone is arranging to come out to deliver digital and/or wraparound support. As a result, a question about their satisfaction with support did not always lead to a direct answer or one that referred to the VCSE input only. It is helpful when family members are able to be present on visits.

There was some duplication of processes which can lead to the patient becoming confused or annoyed, for example, one patient received a call from the hospital, a call from URC and two calls from us (triage and appointment arrangement) in a short space of time.

Some patients felt increased pressure having to monitor their health at home and may have been better off staying on hospital, despite reassurance from all concerned. One patient expressed in her feedback that she was very worried about messing up and the viability of her being able to carry out her VW stay due to how complicated the technology seemed to her. It needs to be considered that technology can be extremely daunting, particularly for older patients, and that if they do not have anyone at home with the IT skills and confidence to oversee the monitoring, and if they are not amenable to regular visits or phone support, it may not be possible for them to submit the readings themselves.

Patients need to be given a chance to express preference about how they give feedback and it needs to be clear as to why these questions are needed. Outside of the pilot, this process could be more easily implemented and less onerous for the patient.

8.10 Identifying benefits to the NHS

AHAH staff were very clear that the pilot was beneficial to them and to their patients, particularly the digital support element, which is more easily quantifiable. In addition, staff reported that they were able to give more complicated monitoring devices to some patients, knowing they would have the support to use them. Any future project would benefit from more understanding about the impact of this on patient health and the numbers given such devices.

In terms of evaluating the benefits of the pilot to the RDUH, a clear method of calculating the numbers of patients readmitted to the hospital would have helped show the impact of the pilot. Another set of data that could have

helped show impact is the number of patients on the Virtual Ward who called the hospital for support with digital devices, prior to the pilot; this could then help calculate whether the number of calls has decreased and if yes, by how much. Monitoring data over a longer period would also allow for comparison of digital

confidence and ability to remember how to use devices if a patient is readmitted to the Virtual Ward.

Hospital staff may also benefit from learning ways to troubleshoot the various devices. As new devices come to the market and are used, an organisation such as Wellmoor could become expert in these and lead training for hospital as well as VCSE staff.

Staff in the AHAH team are keen to note down what their thoughts as to how the rest of the summer runs without the VCSE support and feel it will be clearer for them then to appreciate the value of the support that was provided during the pilot.

8.11 Expanding the pilot

An extension of the scheme could include:

- Offering services in other geographical areas
- Offering support to younger patients
- Building expertise in supporting particular clinical areas such as those on long-term antibiotics or with issues related to frailty.
- Measuring and focussing on the wellbeing of unpaid carers

9. SWOT analysis

Strengths	Weaknesses
• Knowledge of VCSE sector in all parts of Devon • Partners now have a much more detailed knowledge of hospital processes • Able to respond quickly • Detailed evaluation • Positive feedback • Flexibility of partners in going out on visits and adapting to changes in processes • Delivery partners were able to build a rapport with patients • Reduced inequality of access to monitoring health digitally	• Sporadic nature of referrals • Patients not understanding distinct non-clinical support on offer • Duplication from different departments and agencies • Patients overwhelmed by calls and questions at times • Lack of robust system for recording and communicating when patients have been discharged from the VW
Opportunities	**Threats**
• Drive to increase number of VW beds by March 2024. • Support for unpaid carers • Phone/video support • VW patients and in-patients could be made more aware of VCSE support outside of the hospital • Wellmoor has become the expert in digital devices and liaison with hospital re equipment – they could take on more of giving out devices and setting up apps • Joint leaflet given at the hospital could explain the Virtual Wards scheme and the VCSE support • Strengthened partnership between clinical staff and VCSE organisations could lead to innovation in other areas. • Linking with the Eastern LCP unpaid carers group • There is potential for VCSE partners to support clinical staff by being present on wards • A supported accommodation site is keen for its residents to learn about VW prior to hospital visits and therefore be able to request to go on the scheme.	• Lack of ongoing funding • Variety of different discharge services operating in any one hospital • The number of questions asked of patients can be off-putting for many of them and discourage them from talking. • External factors such as hospital staff strikes. • Barriers – what are patients' anxieties and fears? • Lack of connectivity at the hospital means that devices often can't be properly set up before the patient is discharged

Appendices

1. ICS questionnaire
2. Evaluation questions
3. Graphs showing every response from patients (pdf)

1. ICS questionnaire – data required from each patient

Our ref: VCSE

Patient Experience Survey for Virtual Wards

The voluntary, community and social enterprise sector (VCSE) provides services for local communities. Examples include charity organisations such as Age UK and The British Red Cross along with local community groups such as Westbank, TRIP and Seachange.

You recently received care from the VCSE while you were on the Royal Devon University Hospital Virtual Ward.

Your local NHS would like feedback on the barriers you faced in accessing the virtual ward and your experience of the care you received from the VCSE to help us continue to develop and improve the service in the future.

A bit about you

Please answer the following questions to help us to know more about the people who use this service. You do not have to answer these if you do not want to.

We might want to include questions in this section to find out:

- *If the patient lives alone or with a family member*
- *If the patient has access to a computer/uses a computer or mobile phone or other (to assess digital ability)*

1. What is your age range?

☐ Under 18

☐ 18-25

☐ 26-35

☐ 36-45

☐ 46-55

☐ 56-65

☐ 66-75

☐ 76+

☐ Prefer not to say

We'd like to ask you some more sensitive questions. You might not have come across some of these before. If you are not happy to answer, please feel free to say so at any point.

2. How do you describe your background?

☐ Indian

☐ Pakistani

☐ Bangladeshi

☐ Chinese

☐ Other Asian background

☐ Black or Black British

☐ Caribbean

☐ African

☐ Other Black background

☐ White British (Welsh/English/Scottish/Northern Irish)

☐ Irish

☐ Gypsy or Irish Traveller

☐ White and Black Caribbean

☐ White and Black African

☐ White and Asian

☐ Any other white background

☐ Other (please let us know)_____

☐ I'd prefer not to say

3. How do you describe your sex?

☐ Female

☐ Intersex

☐ Male

☐ Non-binary

☐ Transgender female

☐ Transgender male

☐ Other (please let us know)_____

☐ I'd prefer not to say

4. How do you describe your sexual orientation?

☐ Heterosexual / straight

☐ Lesbian

☐ Gay

☐ Bi-sexual

☐ Other (Please let us know)_____

☐ I'd prefer not to say

5. What is your religion?

☐ No religion

☐ Atheist

☐ Buddhist

☐ Christian (including Church of England, Catholic, Protestant and other Christian denominations)

☐ Hindu

☐ Jewish

☐ Muslim

☐ Sikh

☐ Other (please let us know): _____

☐ I would prefer not to say

6. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months (include any problems related to old age)

☐ Yes, limited a little

☐ Yes, limited a lot

☐ No

☐ I would prefer not to say

7. If you answered 'yes' to question 2, please indicate your disability

☐ Vision (e.g., due to blindness partial sight)

☐ Hearing (e.g., due to deafness or partial hearing)

☐ Mobility, such as difficulty walking short distances, climbing stairs, lifting, and carrying objects

☐ Learning, concentrating, or remembering

☐ Mental Health

☐ Stamina or breathing difficulty

☐ Social or behavioural issues (e.g., due to neuro diverse conditions such as Autism, Attention Deficit Disorder or Asperger's Syndrome)

☐ I would prefer not to say

A bit about your experience

1. What equipment were you given to use on the virtual ward?

2. What help were you given to understand how to use this equipment?

3. How often was this help provided?

☐ Once

☐ On more than one occasion

☐ Every day

☐ When I requested it

4. How would you rate the help that you were provided with to use this equipment?

☐ Very poor

☐ Poor

☐ Good

☐ Very good

5. Were you provided with information about the support available in the community to help you to live more independently?

☐ Yes

☐ I don't know

☐ No

If yes, what community support have you received?

6. How has this community support helped you?

7. How would you rate the following: (please tick)

	Very poor	**Poor**	**Good**	**Excellent**
Your overall experience of help provided by the VCSE while on the virtual ward				
Being treated with care and respect				
Access to VCSE staff when you needed to				
Advice given by the VCSE to help manage your symptoms				
Further community support after your discharge from the virtual ward				

8. Please add any other comments you have / or any reasons you would like to give for your ratings above in the box below

Thank you for taking the time to complete this questionnaire.

Please return it to .....

2. Evaluation questions

1. Patient name
2. Postcode
3. District
4. Time spent on VW
5. Age
6. Gender
7. Background/ethnicity
8. Additional Support Needs
9. Type of support
10. Equipment
11. GDPR consent

Referral form (hospital)

- ✓ Please describe the type of support you would like to receive whilst on the Virtual Ward (looking after pets, shopping, cooking, how spending time, companionship, laundry, prescriptions, support for carer etc)
- ✓ On a scale from 1 to 4, how confident do you feel using the digital equipment you have been provided with?
- ✓ Overall, how satisfied are you with your life? On a scale of 1-4, with 1 being often/always and 4 being hardly ever
- ✓ How often do you feel lonely? Often/always; Some of the time; Occasionally; Hardly ever; Never

What do you expect from being a patient on a Virtual Ward?

Sexual orientation

Religion

Delivery partner

Triage form (DCT); call after checking availability with partner

a) Time spent on visit
b) Mileage
c) Activities
d) Follow up
e) Disability. If yes, does it limit what you can do?)
f) With '1' being Highly Unequipped and '4' being
g) Highly Equipped, how well equipped were you
h) to support the patient today?
i) Have they downloaded the MyCare/Joy/
j) other app (as a result of Virtual Wards support).

Support record (delivery partner); complete after each visit

- What was your experience of being on a Virtual Ward? Did you prefer being at home to being on a hospital ward? If yes, why?

- Overall, how satisfied are you with your life? On a scale of 1-4, with 1 being often/always and 4 being hardly ever

- How often do you feel lonely? Often/always; Some of the time; Occasionally; Hardly ever; Never

- How helpful and clear was the overall process? e.g. initial triaging phone call, visiting times) 1-4

- Did the person who came out to you treat you with care and respect? 1-4

How confident do you feel about using the digital equipment now? 1-4 OR

How satisfied were you with the 1-4 additional support?

Customer survey (DCT on the phone, same person as on triage call). Call 2 days after discharge from VW.

- How helpful was the initial information provided by DCT?
- How did you find the communication between project partners?
- How well equipped did you feel to support the patients with the medical equipment?
- Do you feel confident, and have the right information, to go out and provide support to patients with their digital devices?
- What parts of the project do you think worked well?
- Do you have any suggestions to make this process work better for you?
- Did you feel adequately supported by the training provided?
- What impact did the project have on your organisation?
- Did the funding that your organisation received cover your costs?
- If the project is extended, would you like to be involved?
- Any other comments

Partner survey/ discussion post-pilot (send link to Microsoft Form, partners discuss and then hold online with key rep from each partner – to be recorded)

Number of partners digitally trained

Confident to offer digital support

Carried out digital support

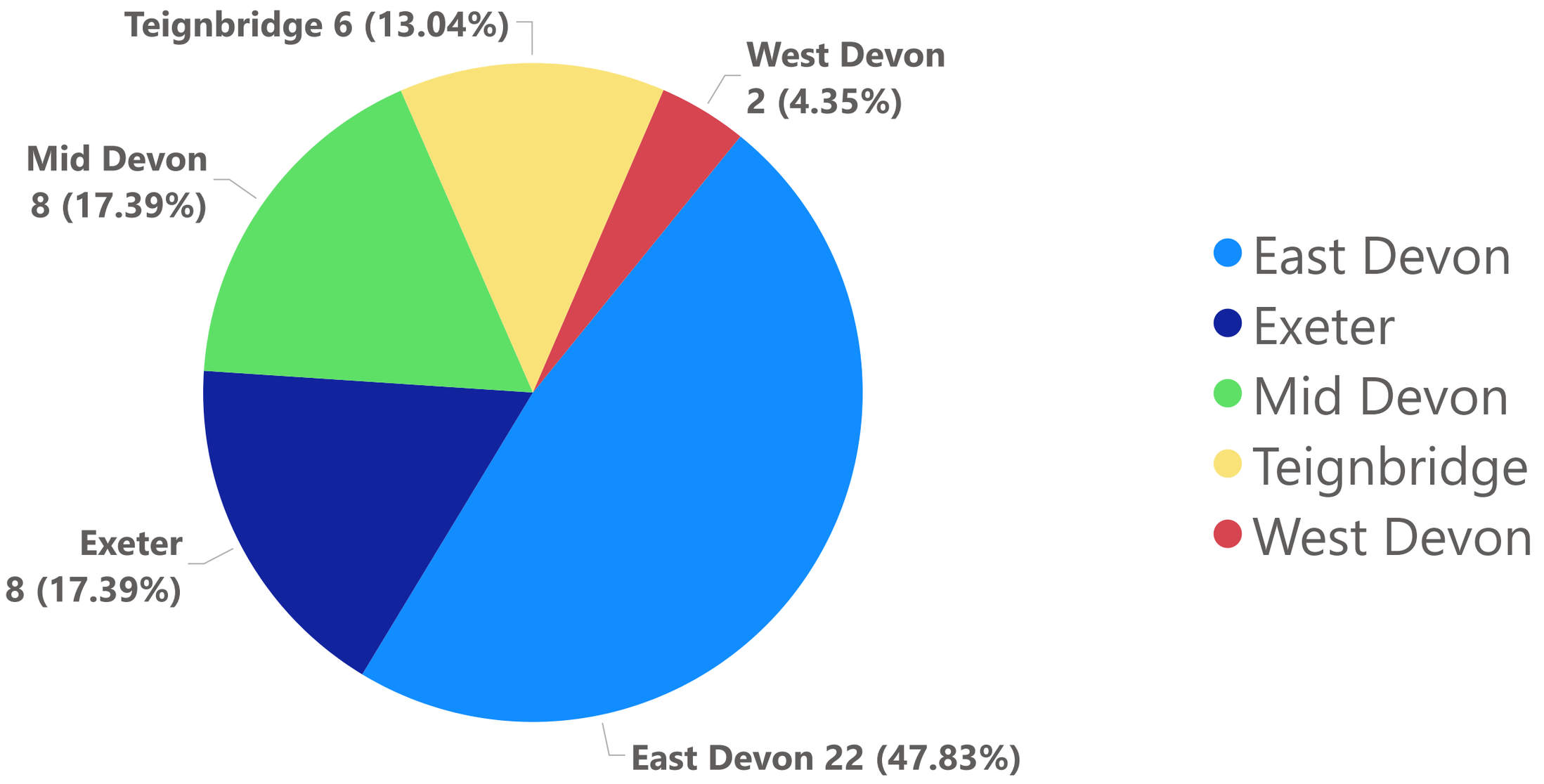
Wellmoor – info after each training session

1. Number of appointment slots freed up for AHAH by not seeing patients for the return of devices.
1. Number of hospital beds freed up by a supported virtual wards project.
2. AHAH feedback from patients
3. AHAH staff benefits
4. Did you feel the participation of the VCSE sector in the pilot has been positive and if yes, why?

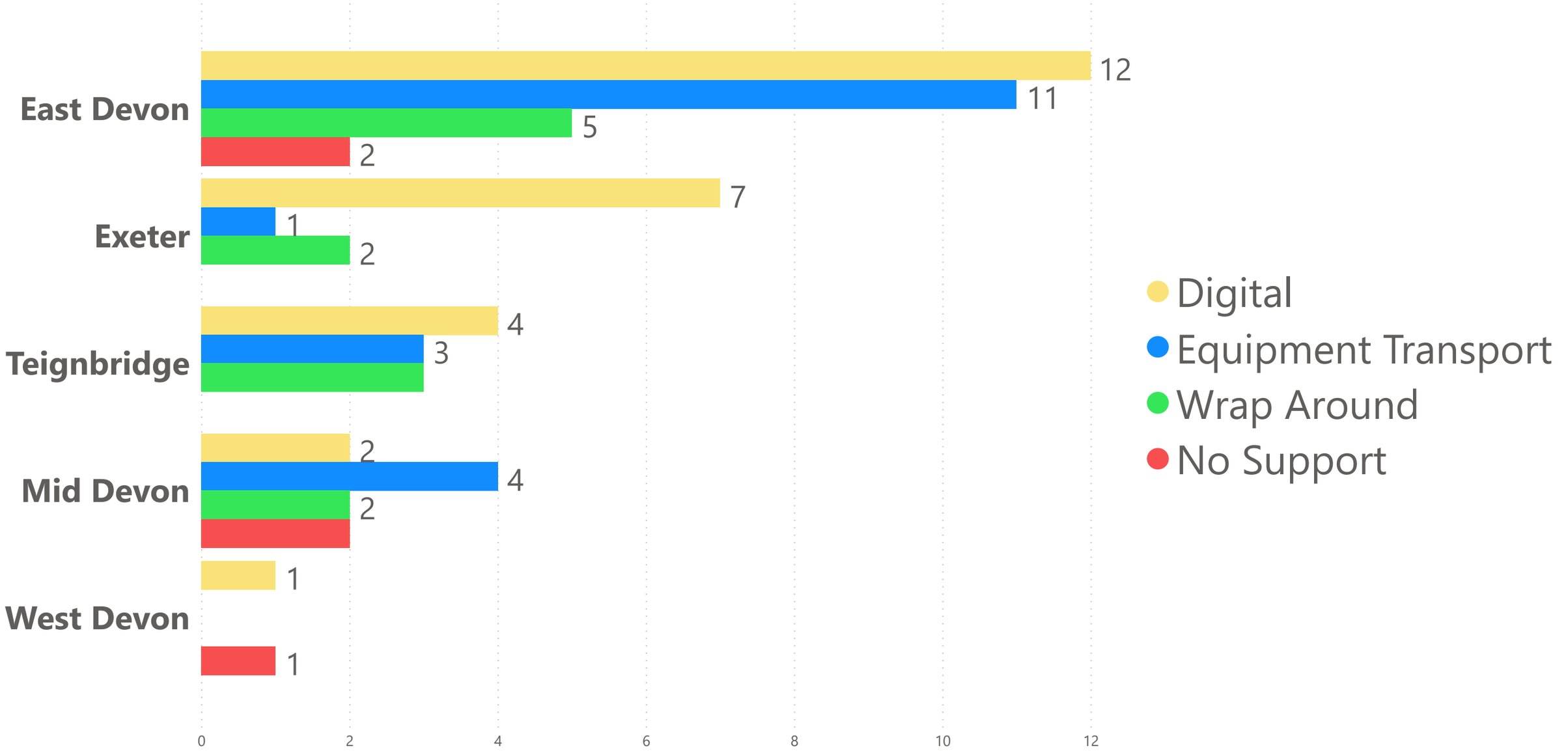
Hospital survey post-pilot

3.Graphs showing every response from patients (pdf)

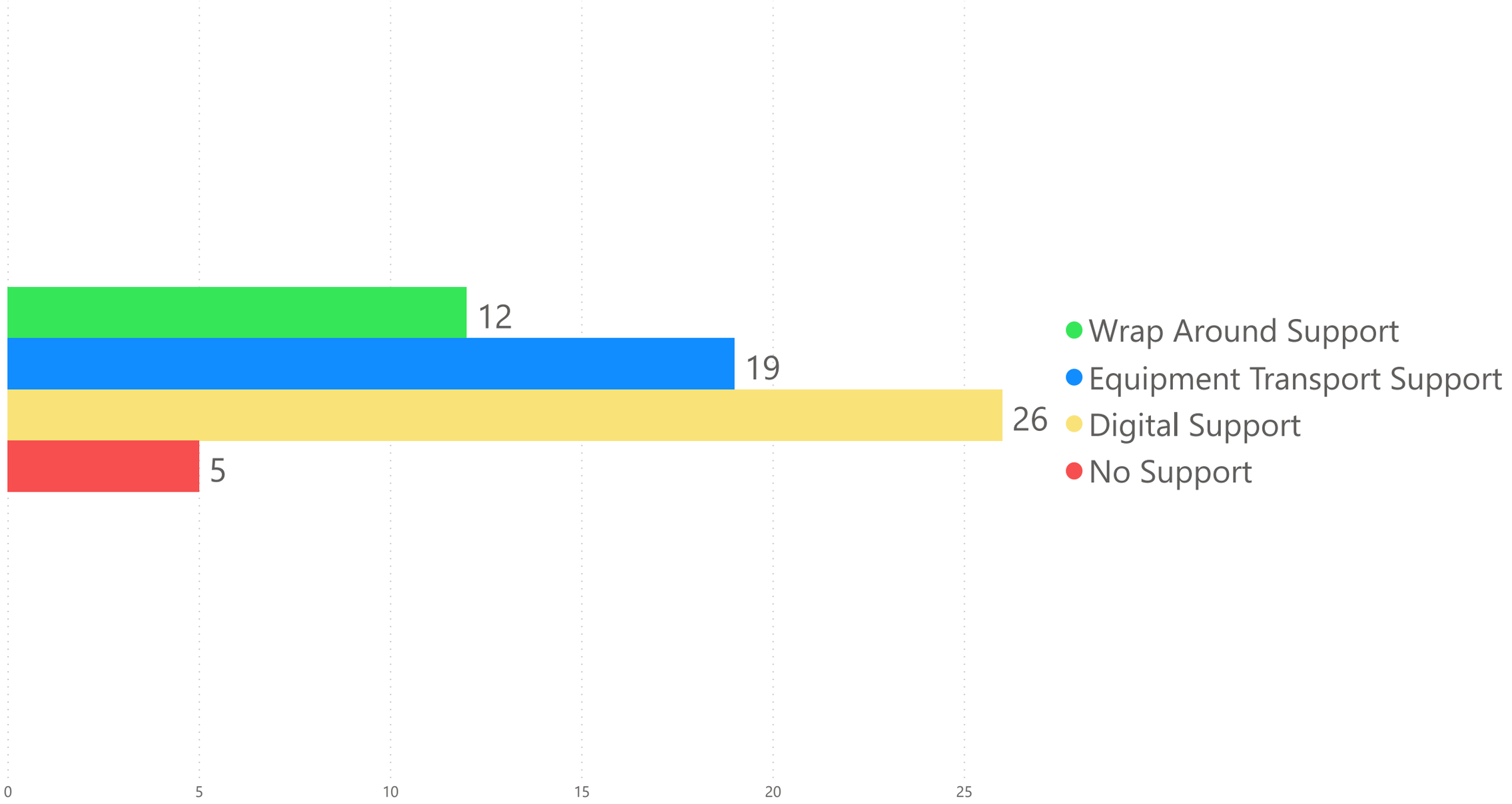
Patients by District



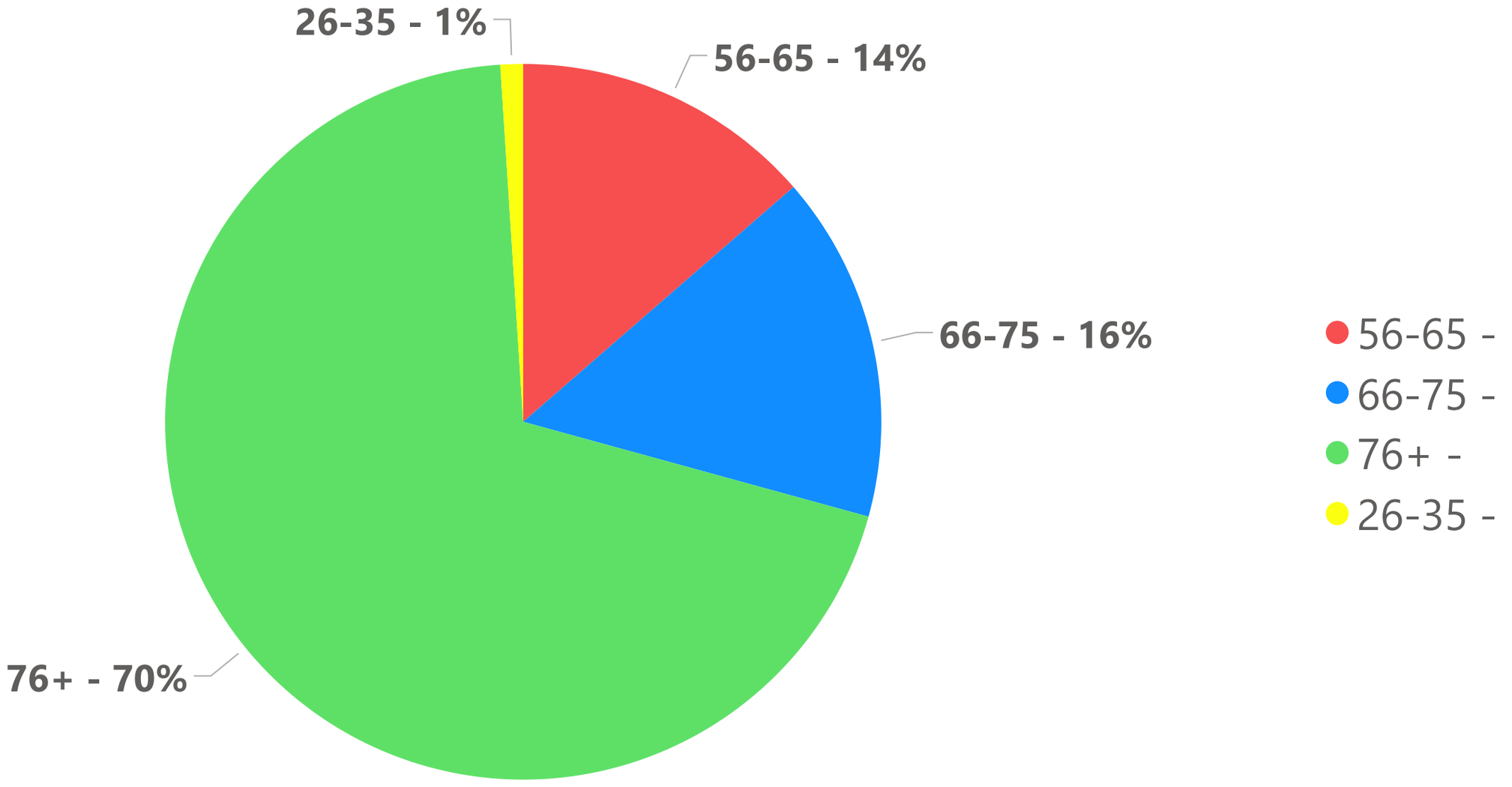
Support by District



Type of Support

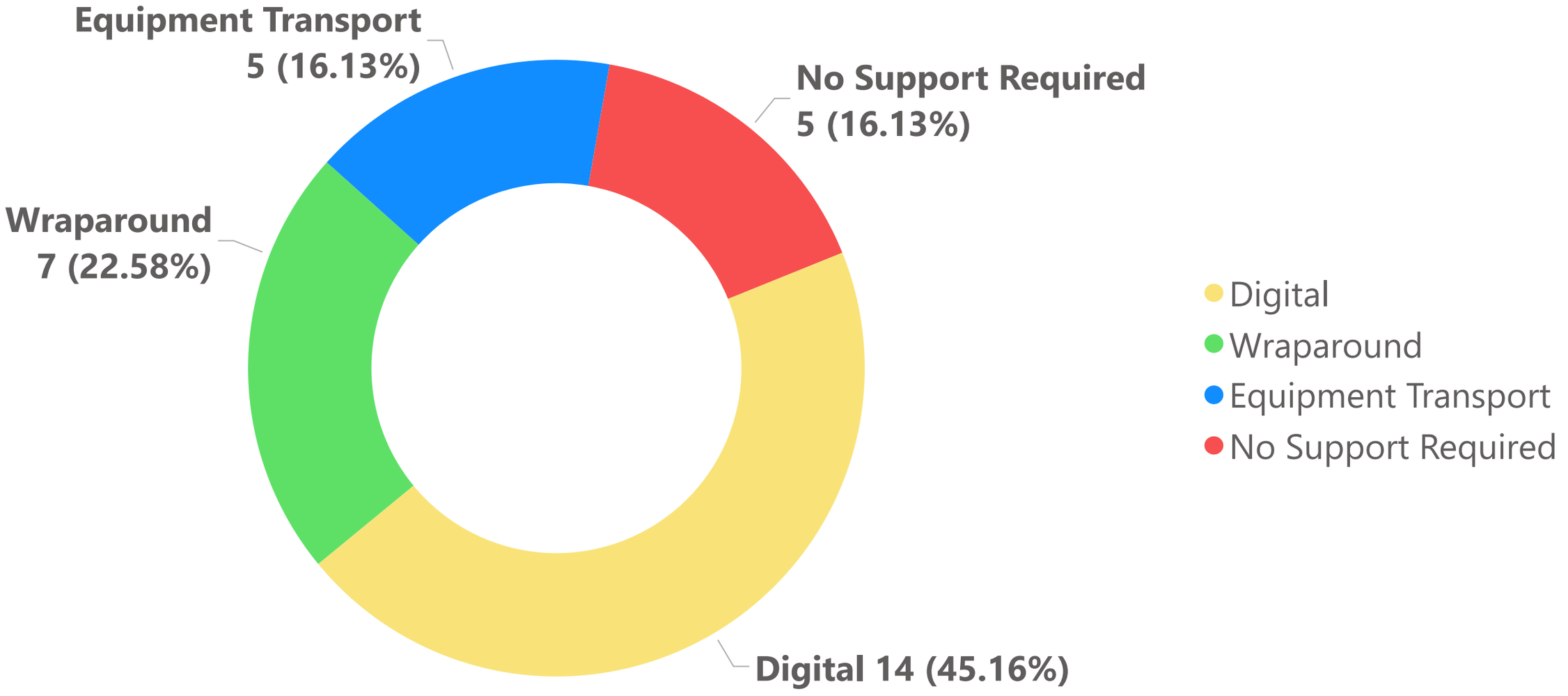


Age Range of Patients

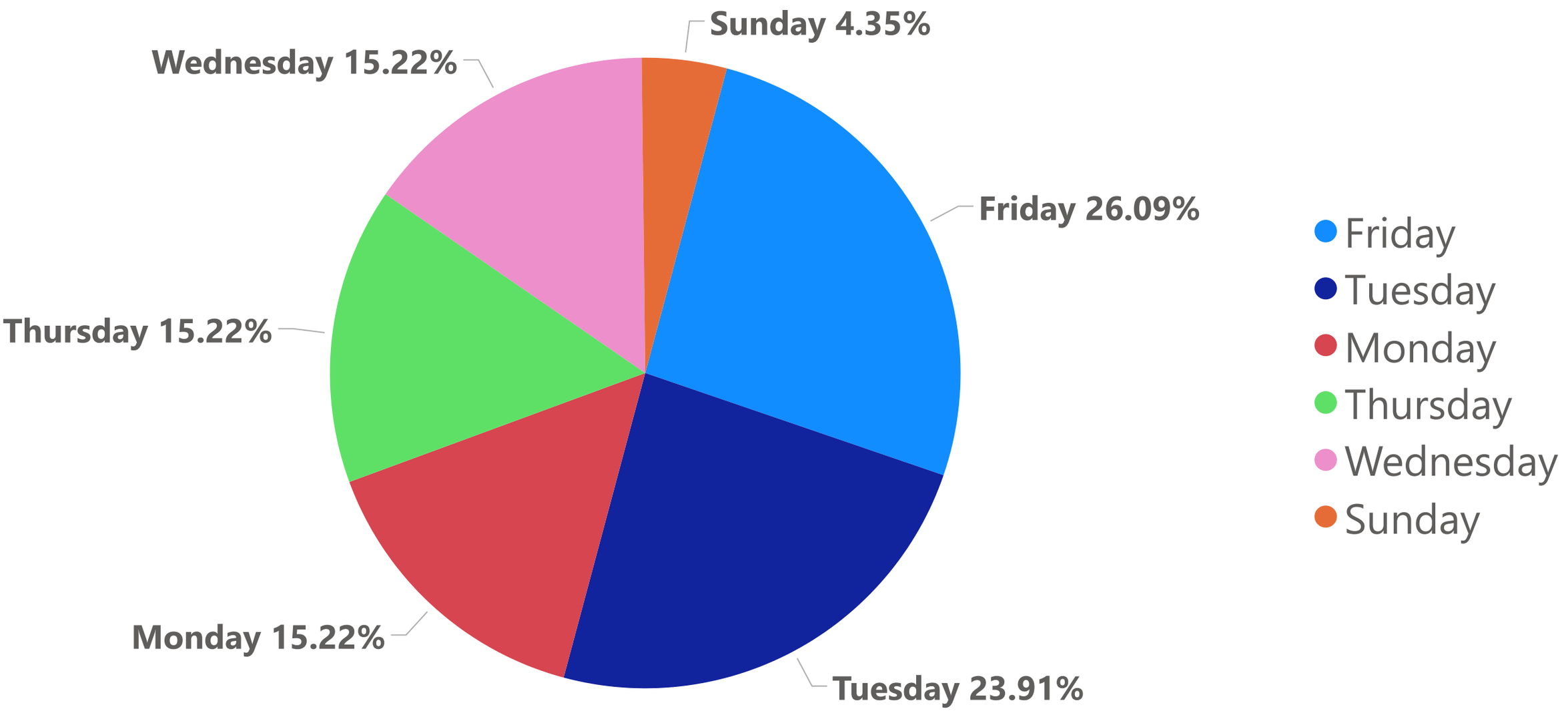


Exclusive Support

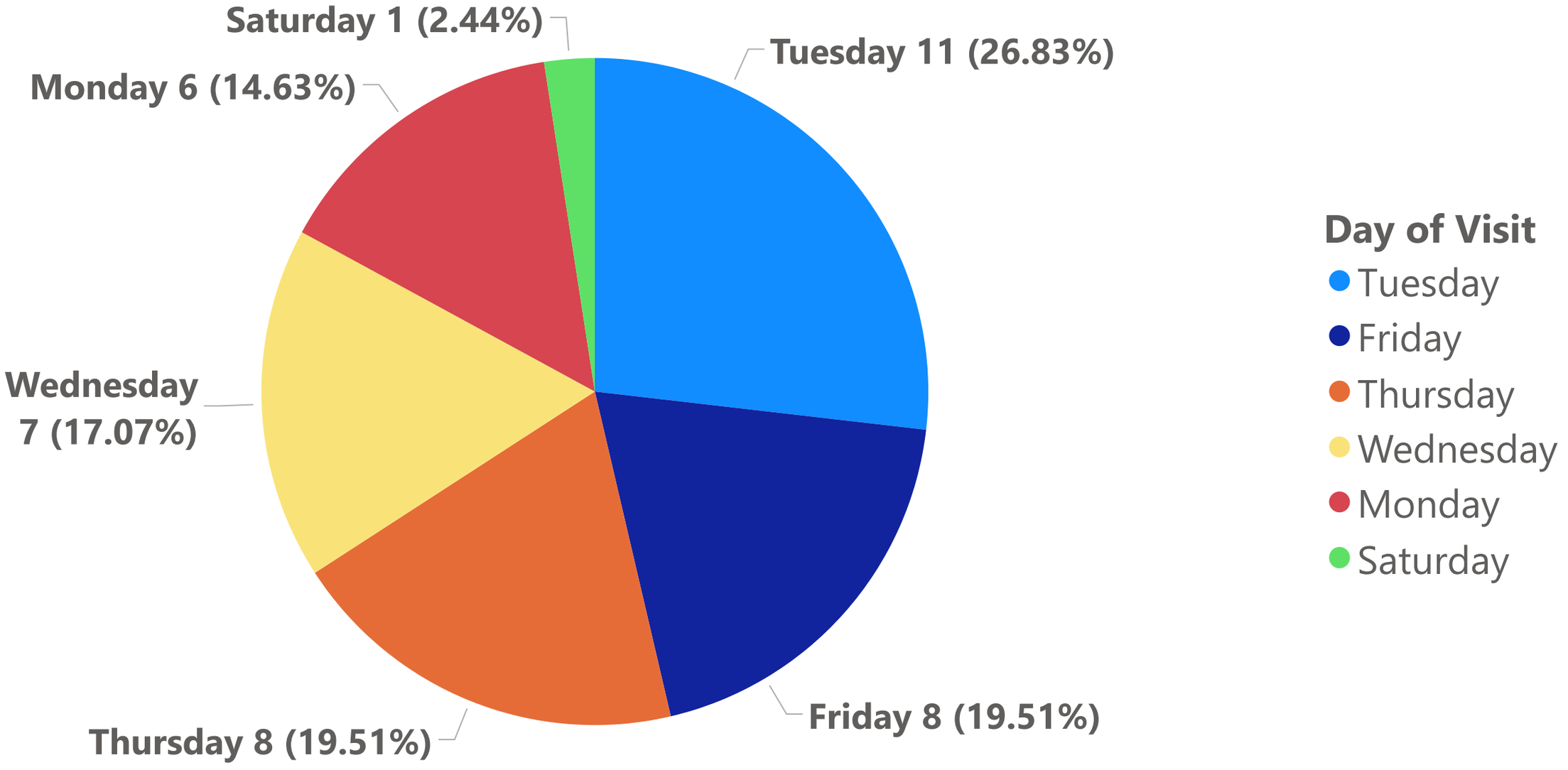
Note: This refers to patients that received only one type of support.



Day Support to Start

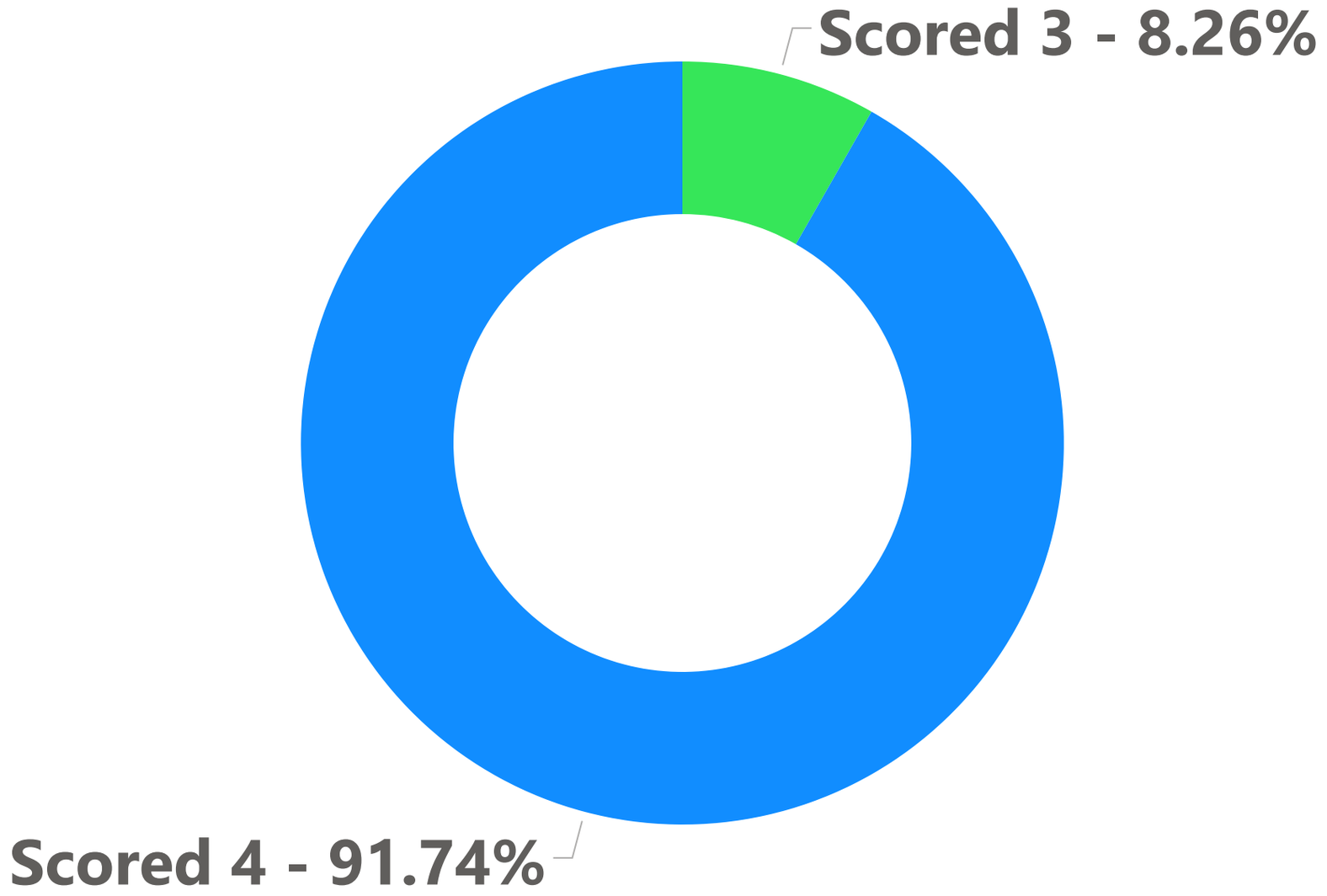


Support by Day

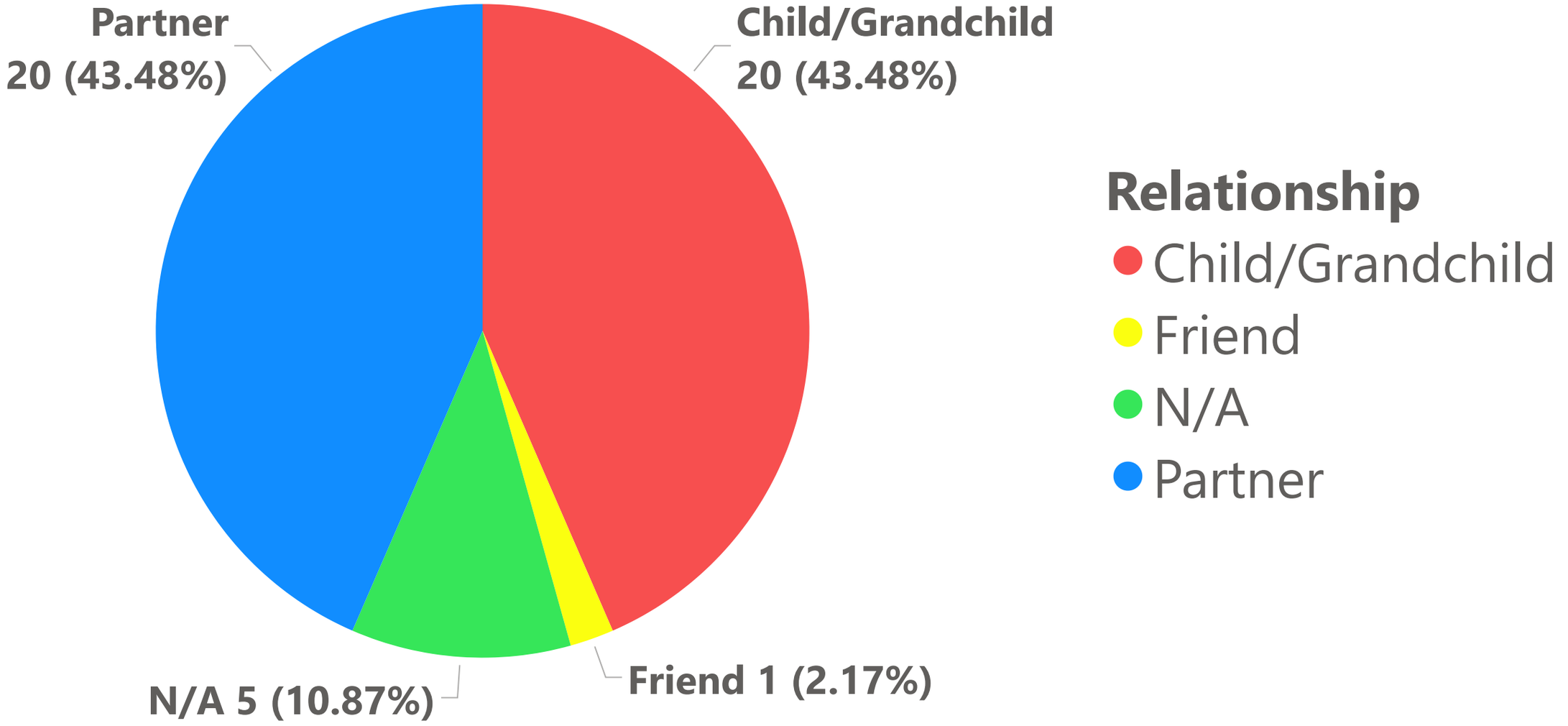


Satisfaction With Support

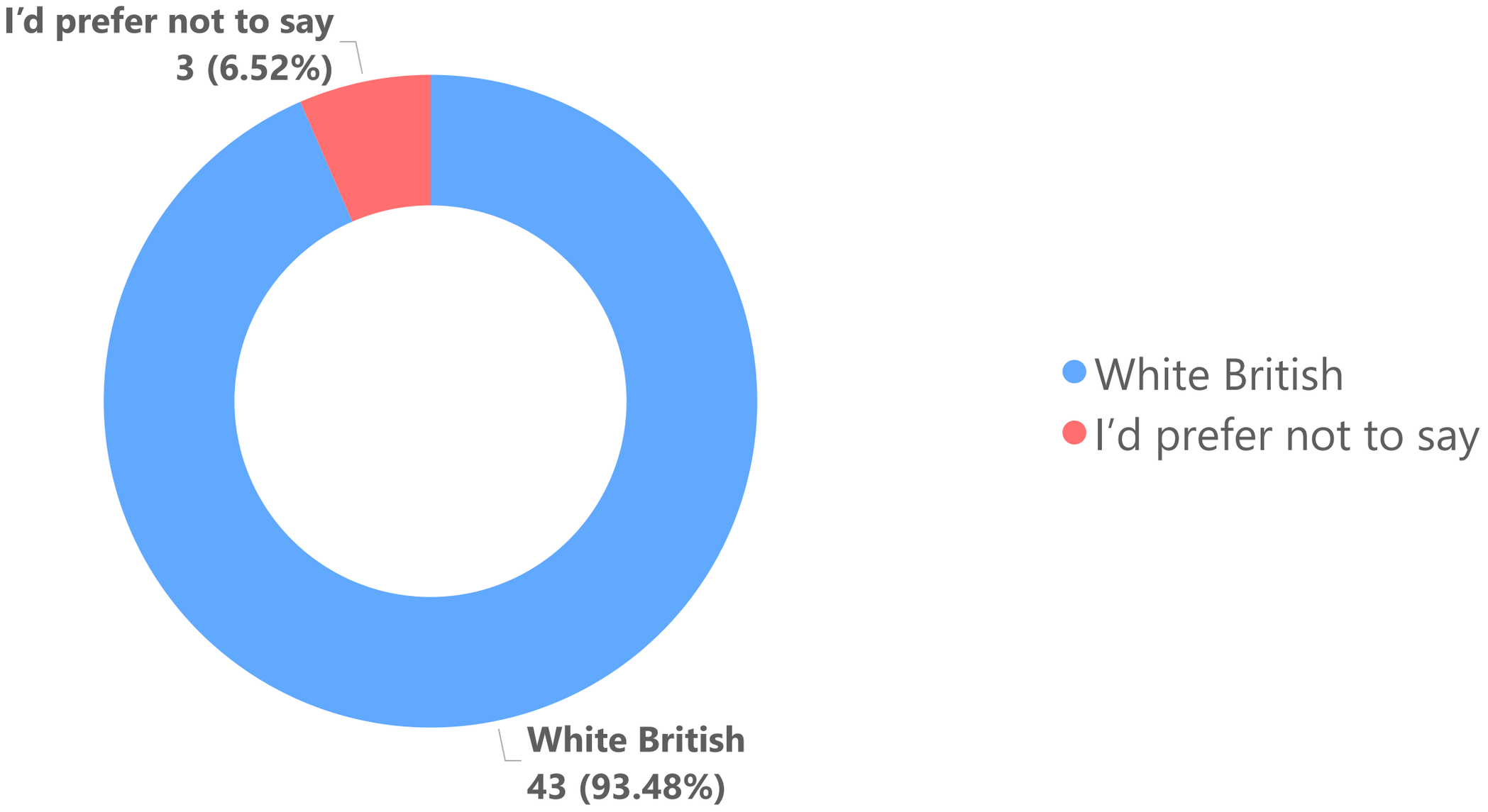
1 = Highly Dissatisfied. 4 = Highly Satisfied



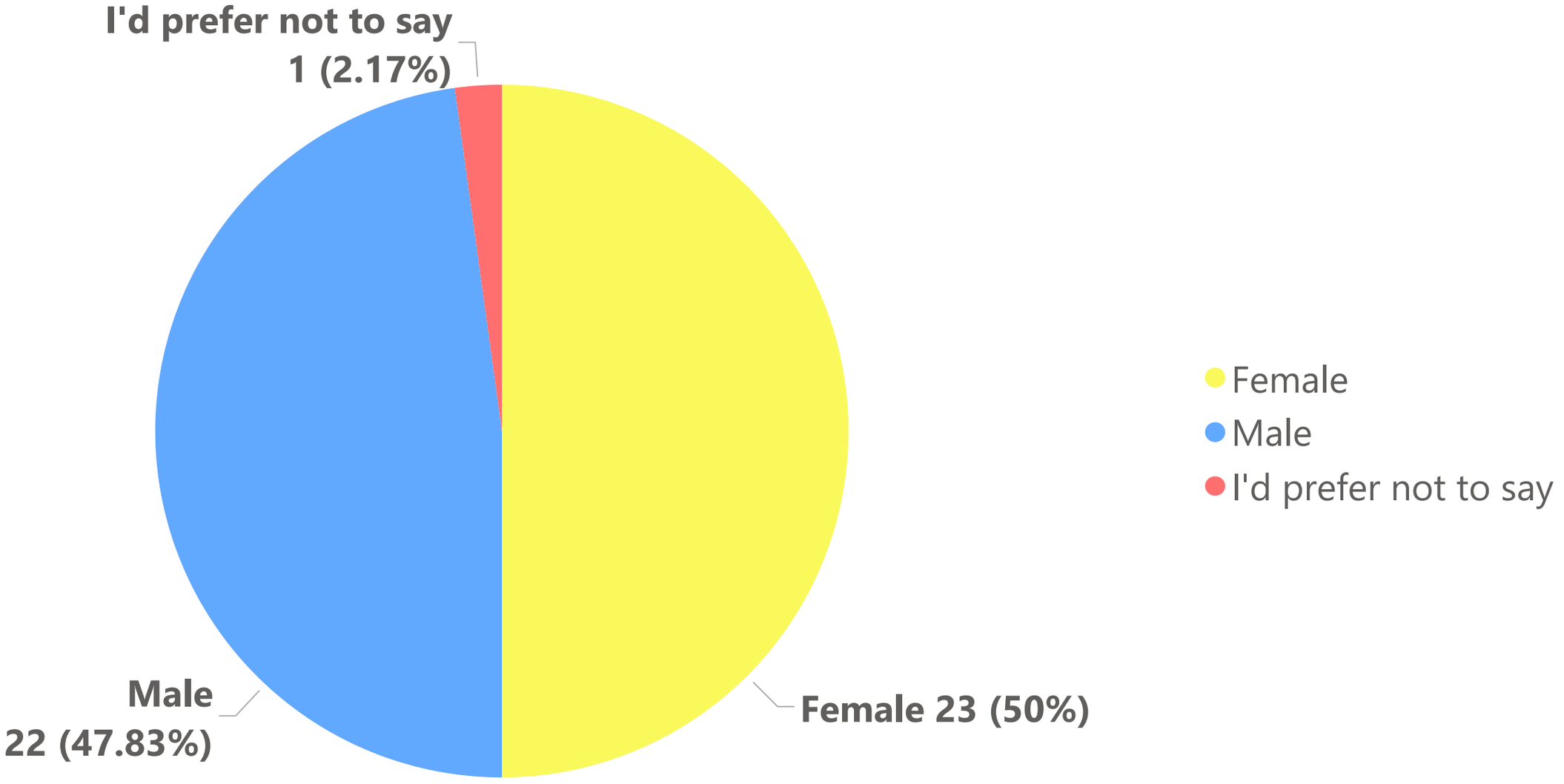
Supporter Relationship



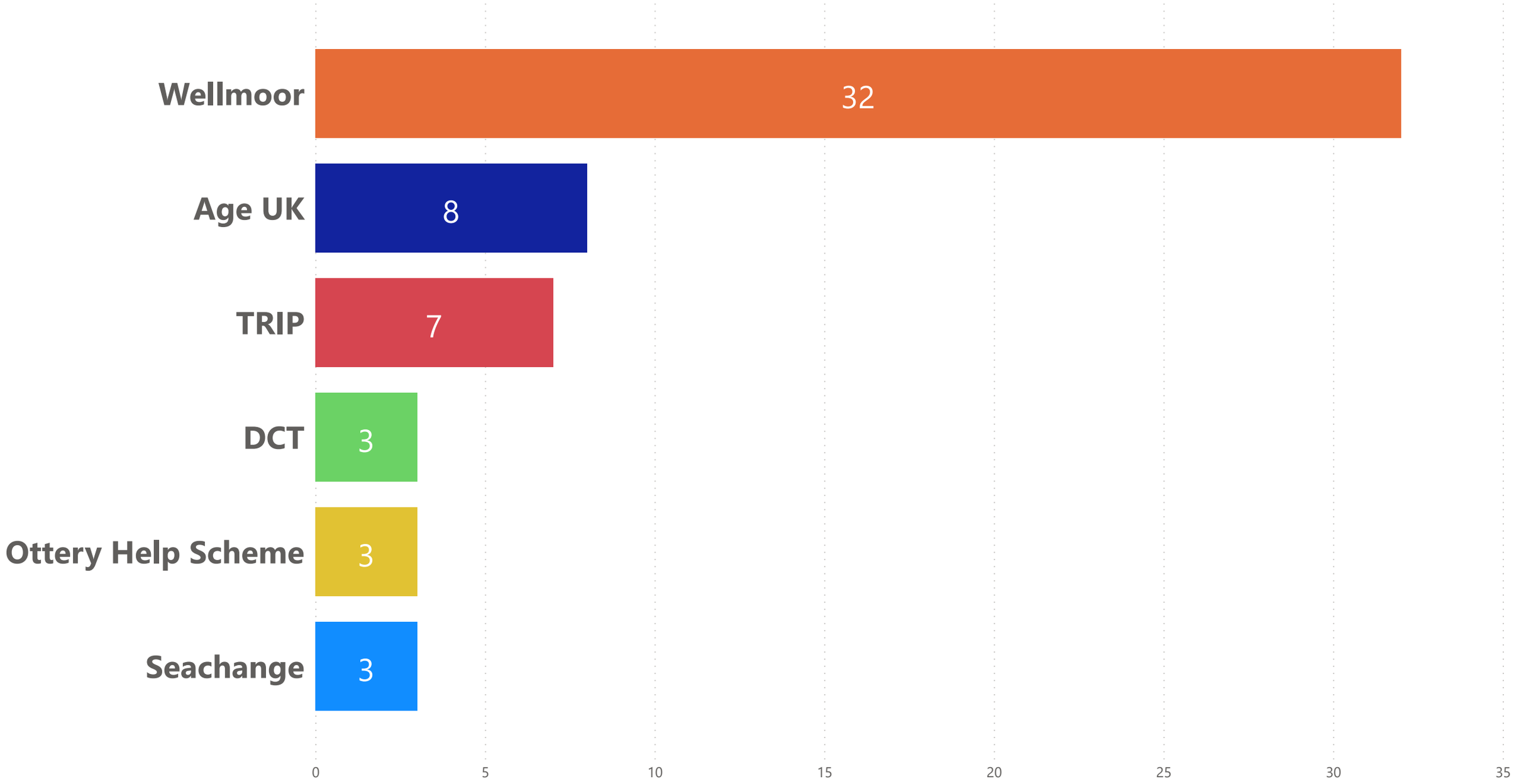
Patient Ethnicity



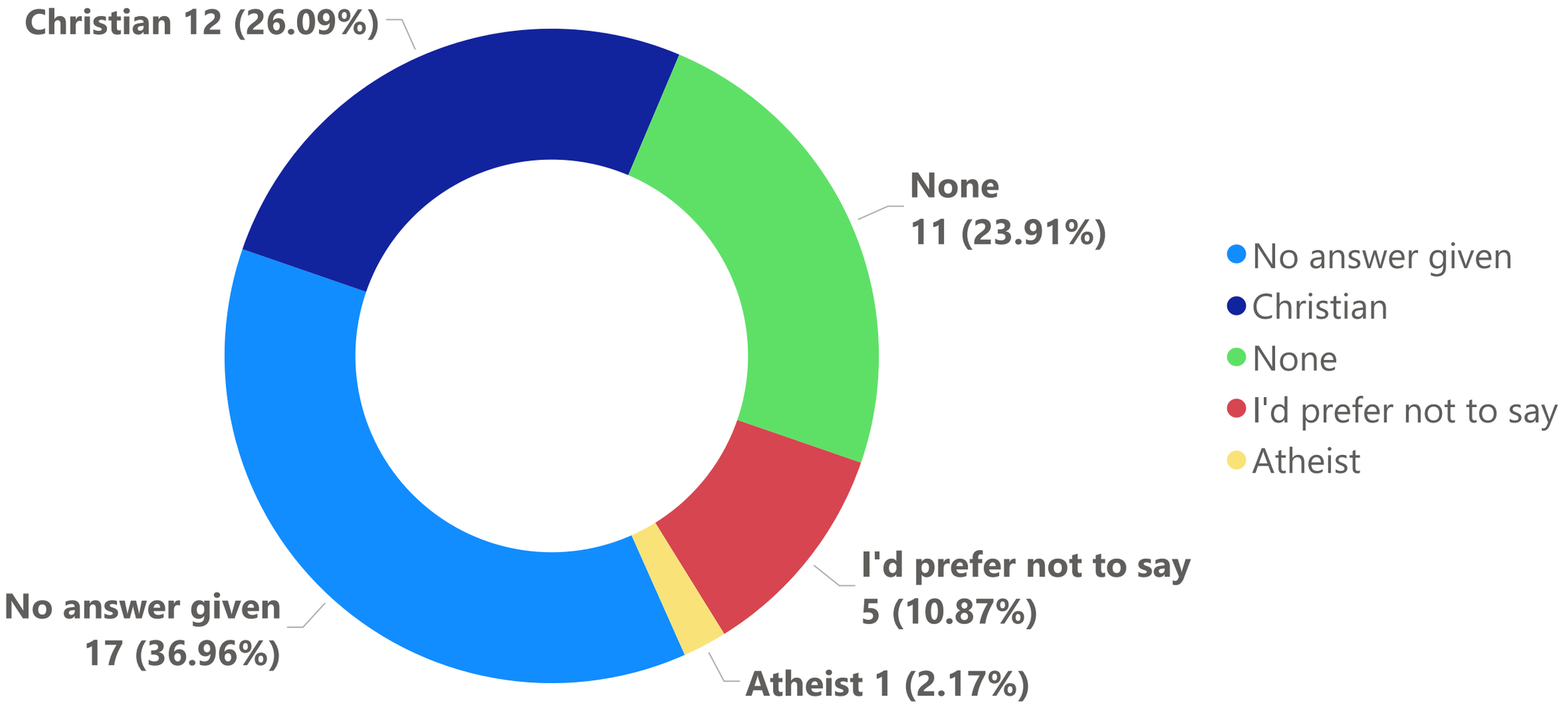
Patient Gender Identity



Support Providers

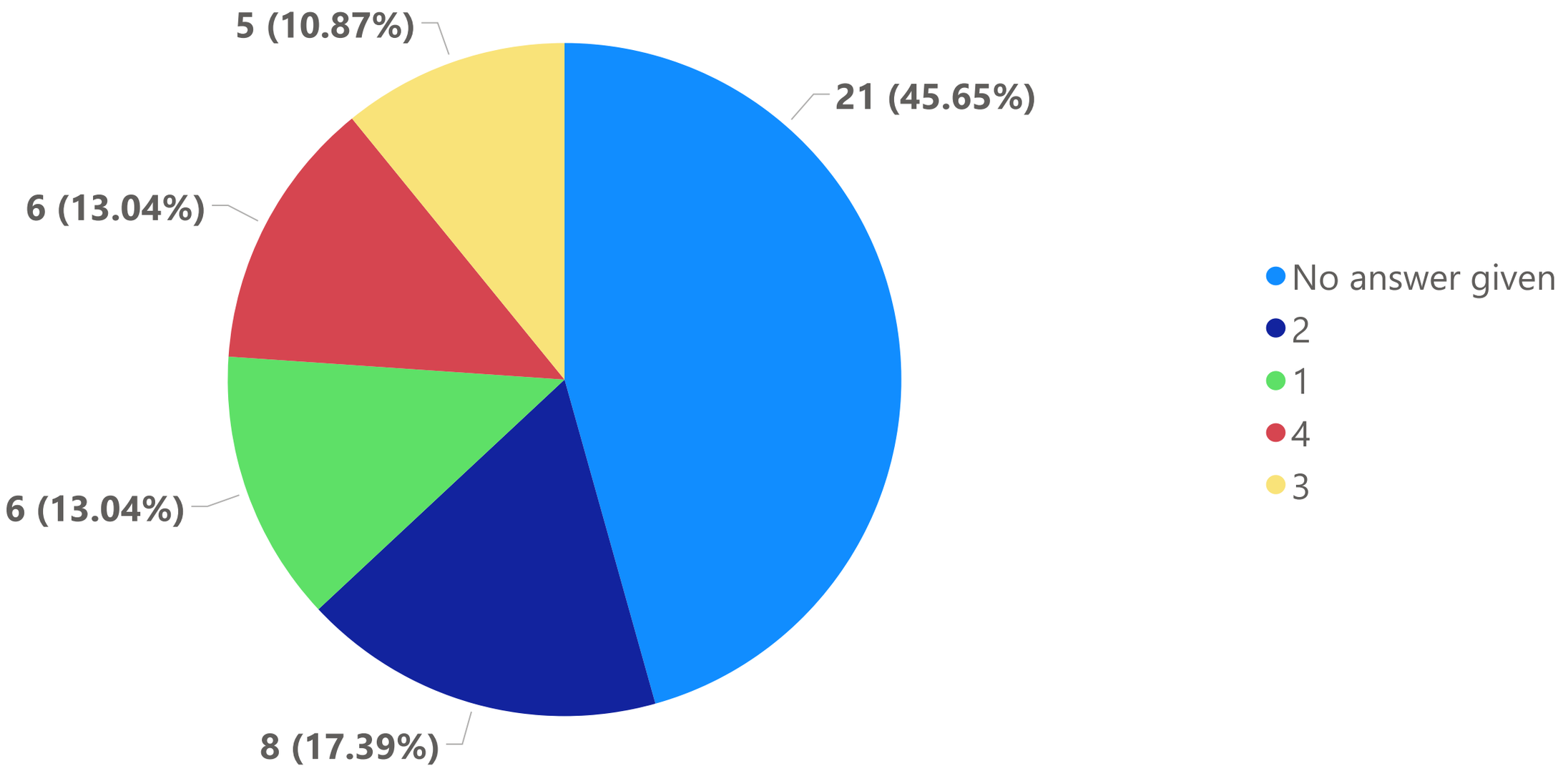


Religion


Christian 12 (26.09%)
None
11 (23.91%)
I'd prefer not to say
5 (10.87%)
Atheist 1 (2.17%)
No answer given
17 (36.96%)
No answer given
Christian
None
I'd prefer not to say
Atheist

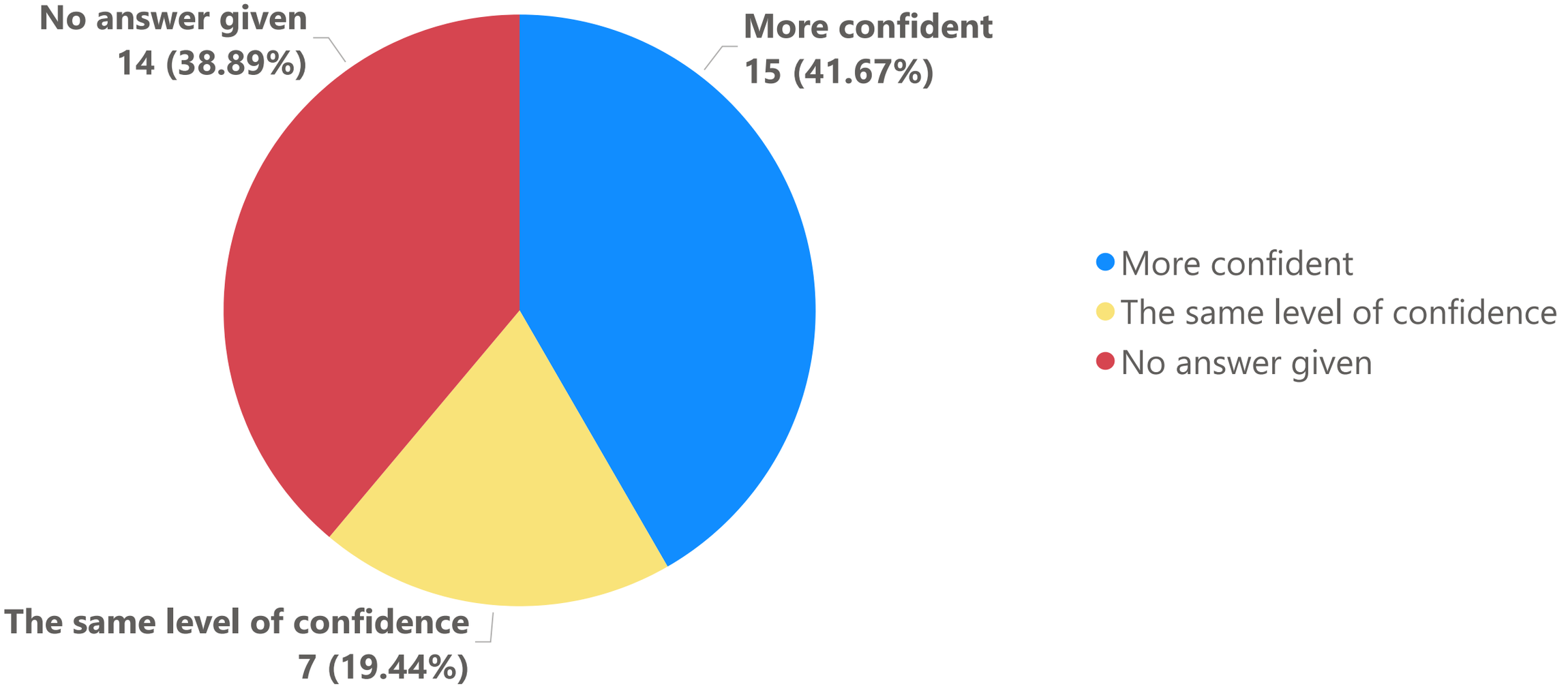
Sexual Orientation

Level of confidence with equipment provided



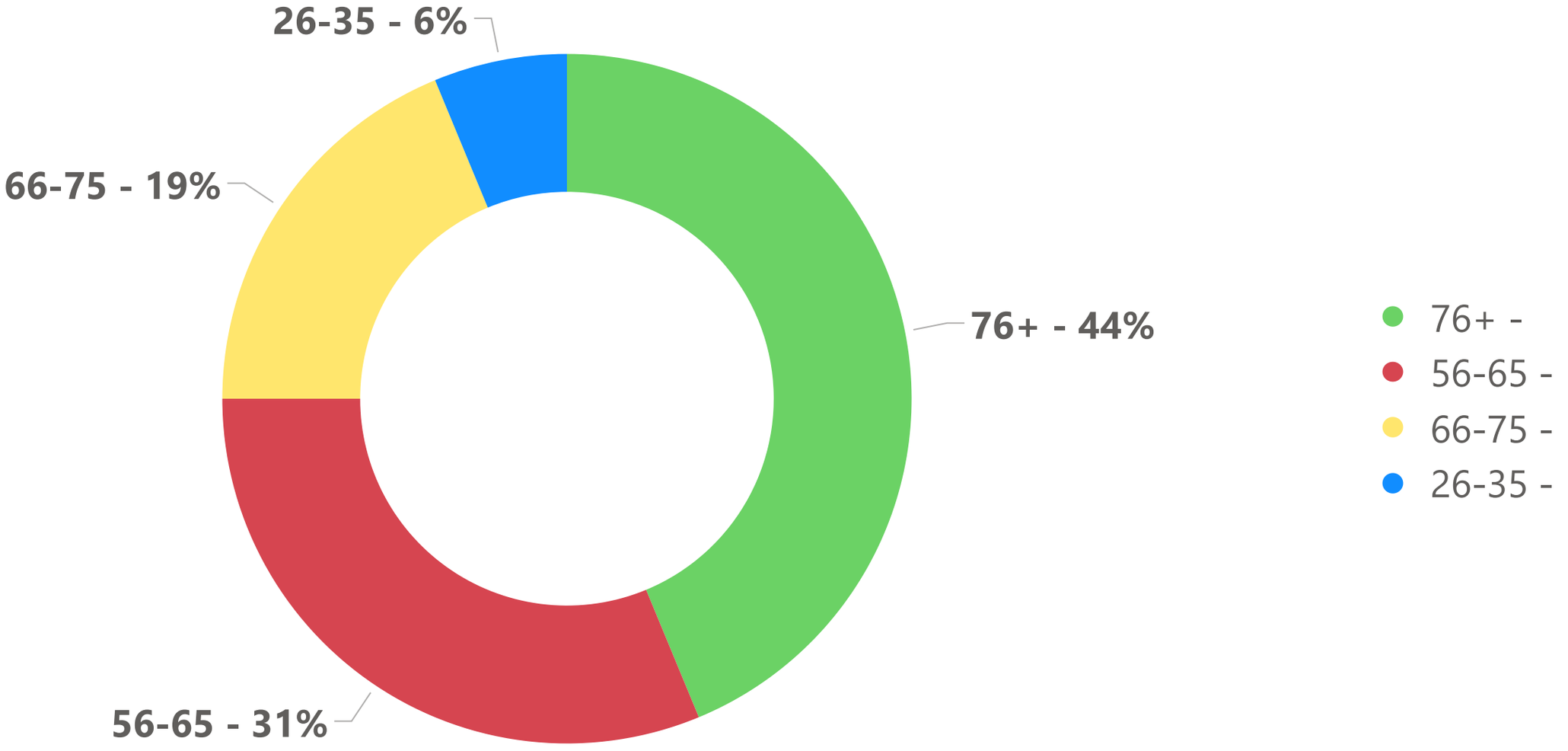
Level of digital confidence following support

Note: This applies to those patients that received digital support

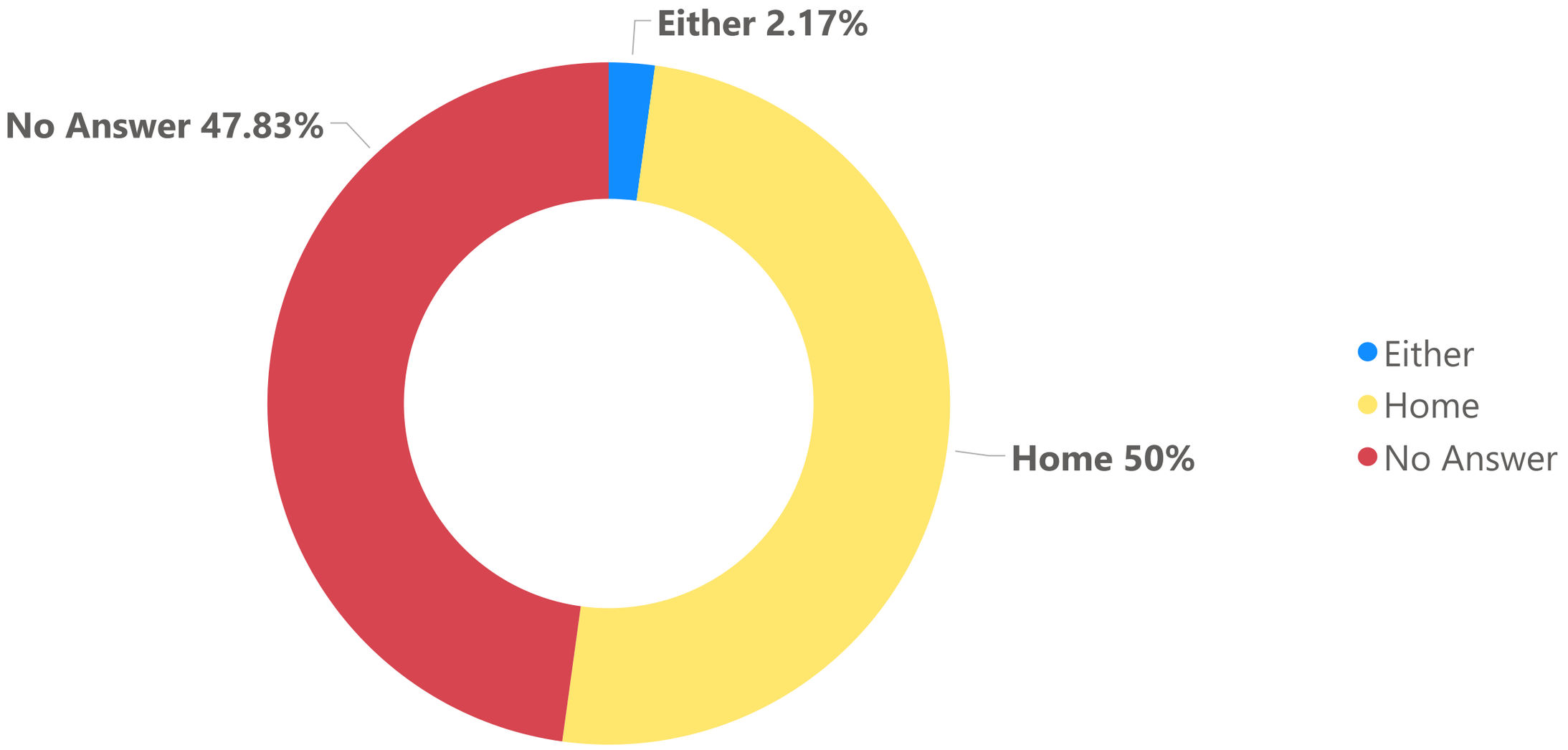


Patients with increased digital confidence by age

Note: This applies to those patients that received digital support

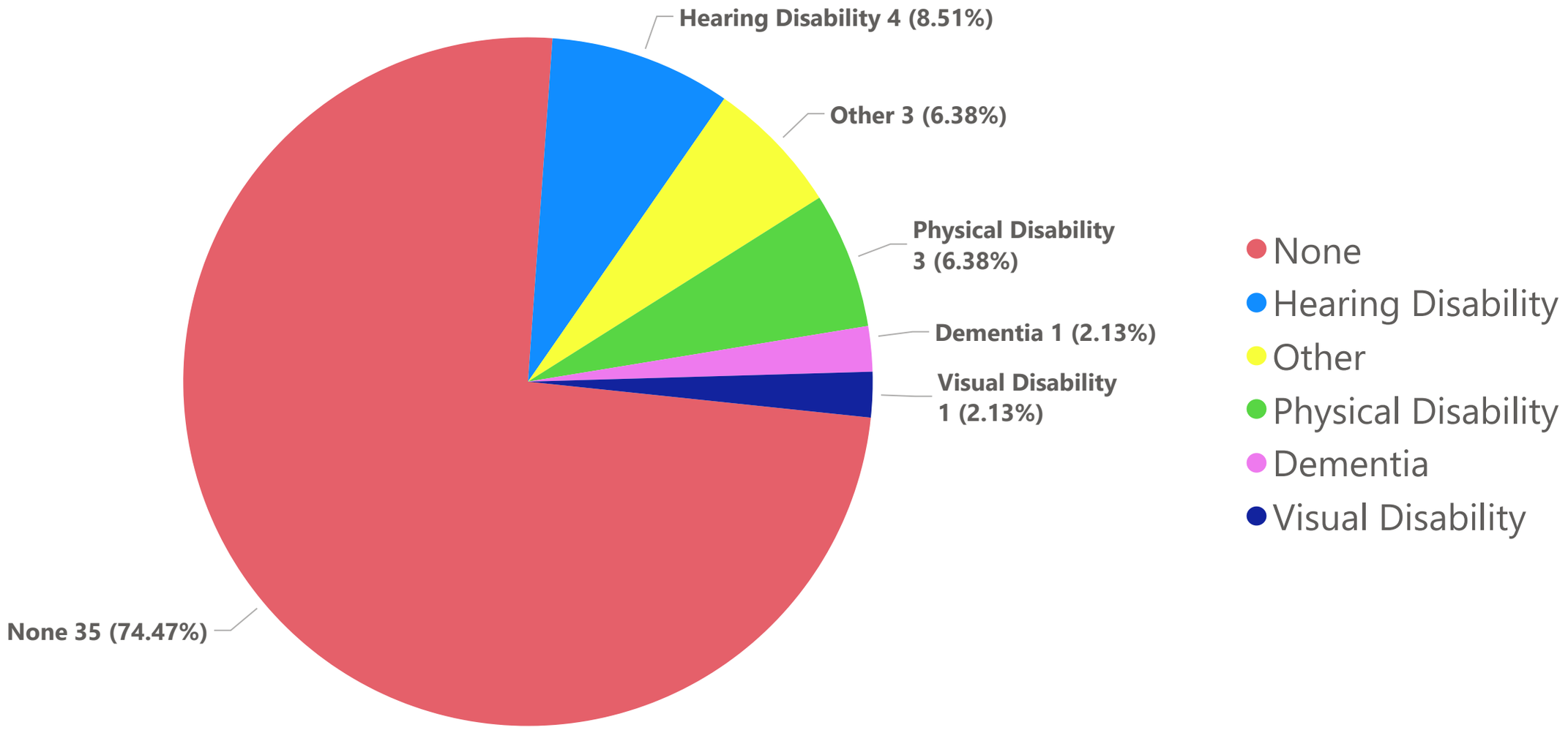


Preference for being at home or in hospital

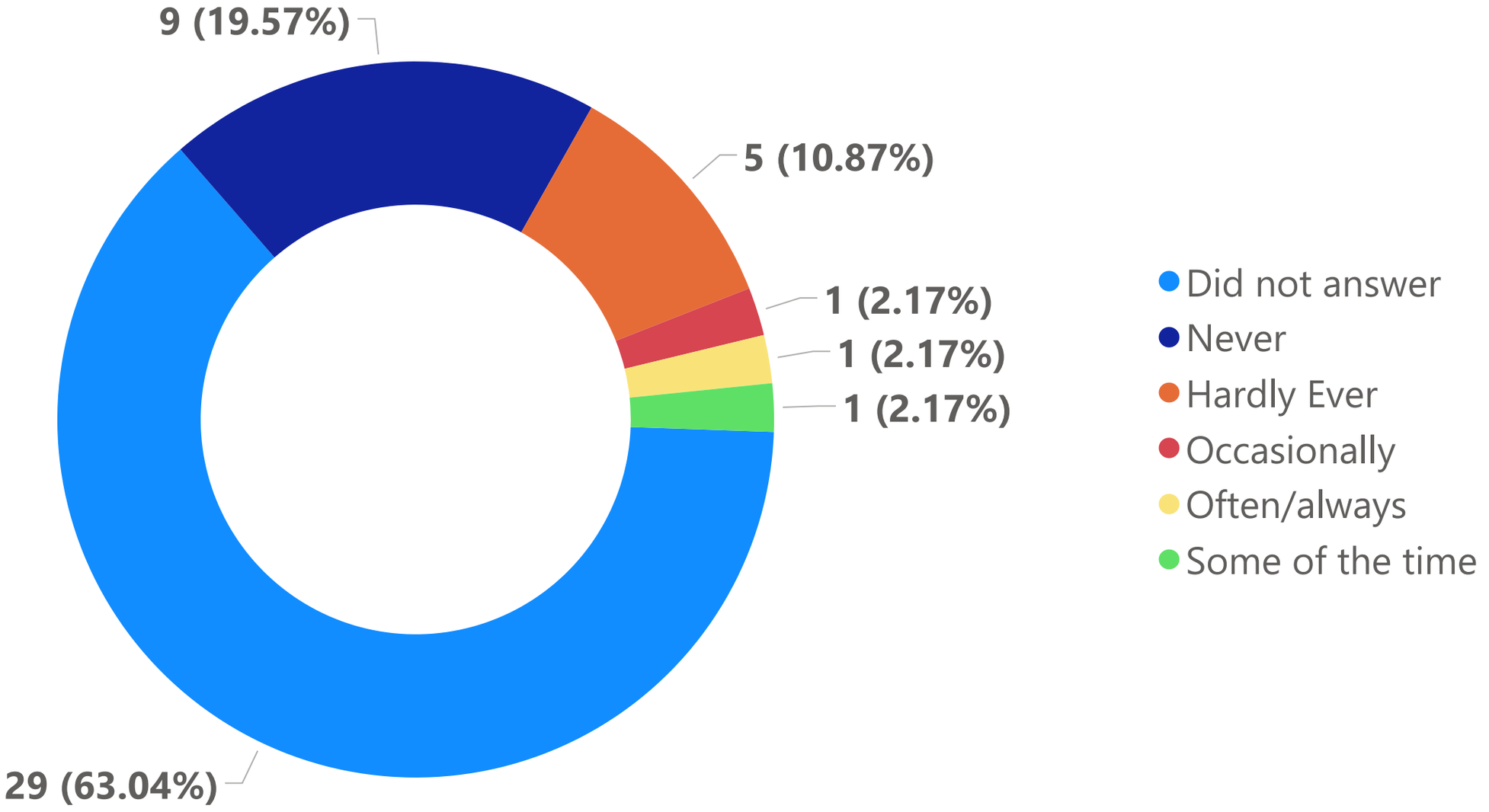


Devices Used by Patients

Disabilities

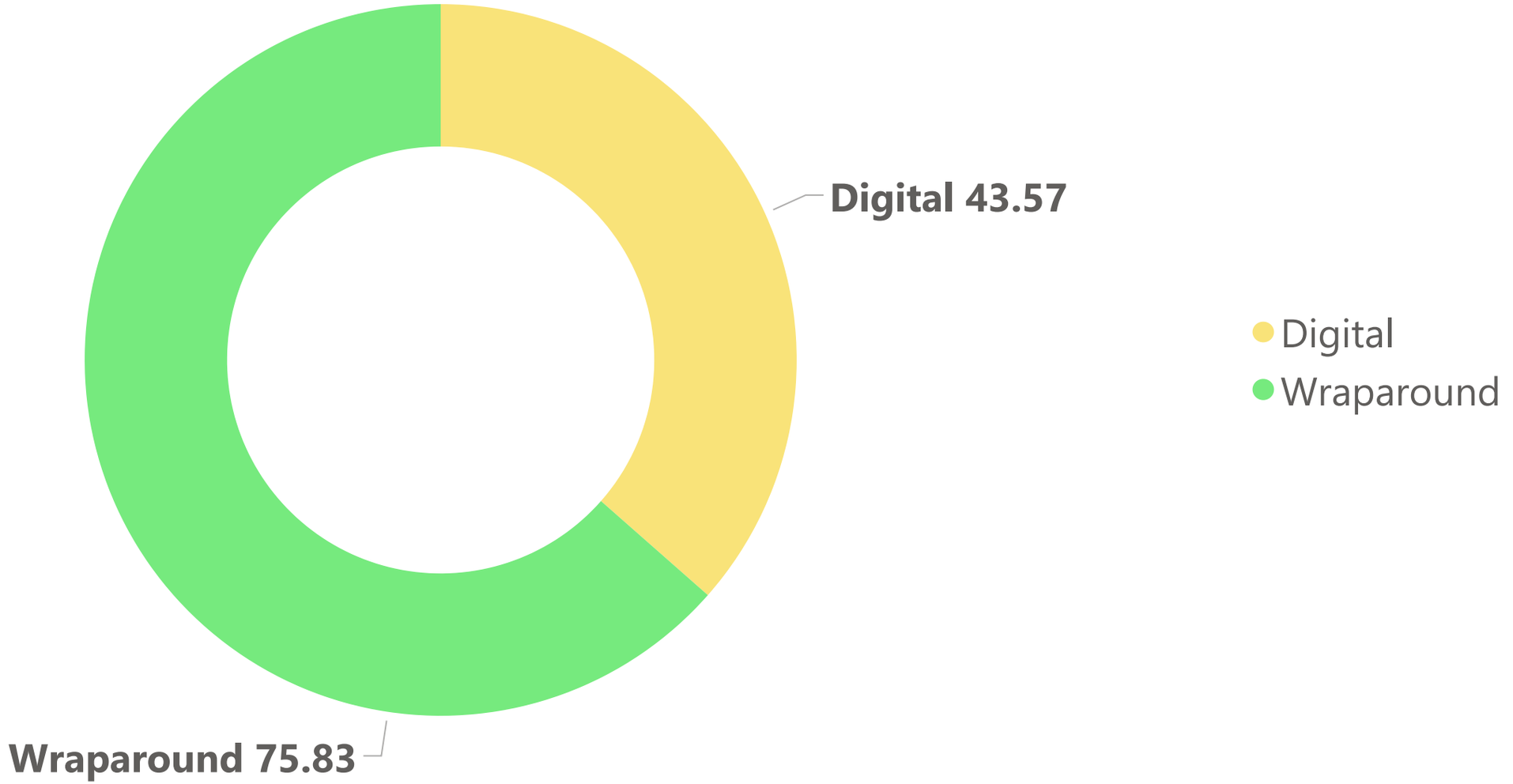


Frequency of Loneliness

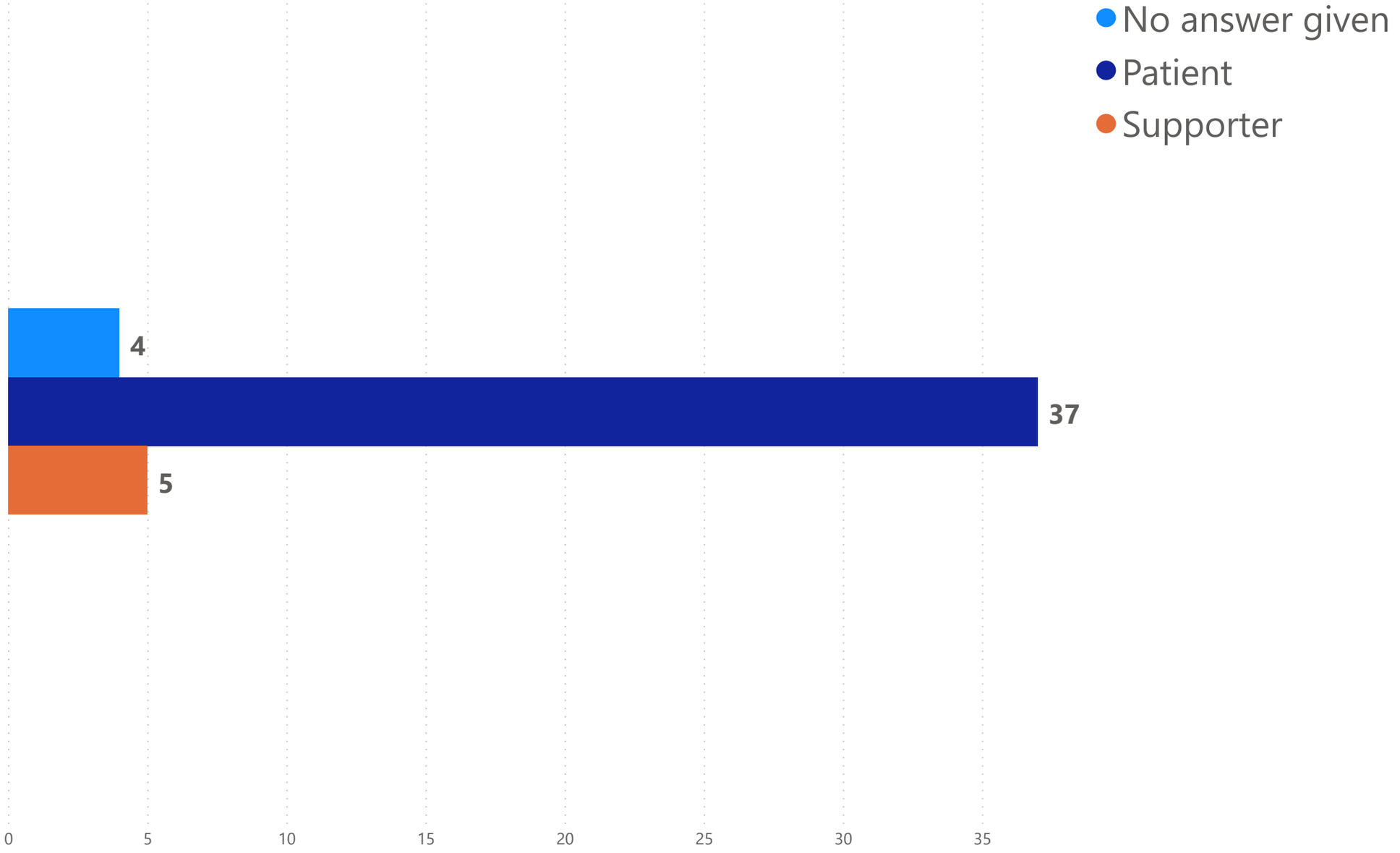


Average minutes spent with patient

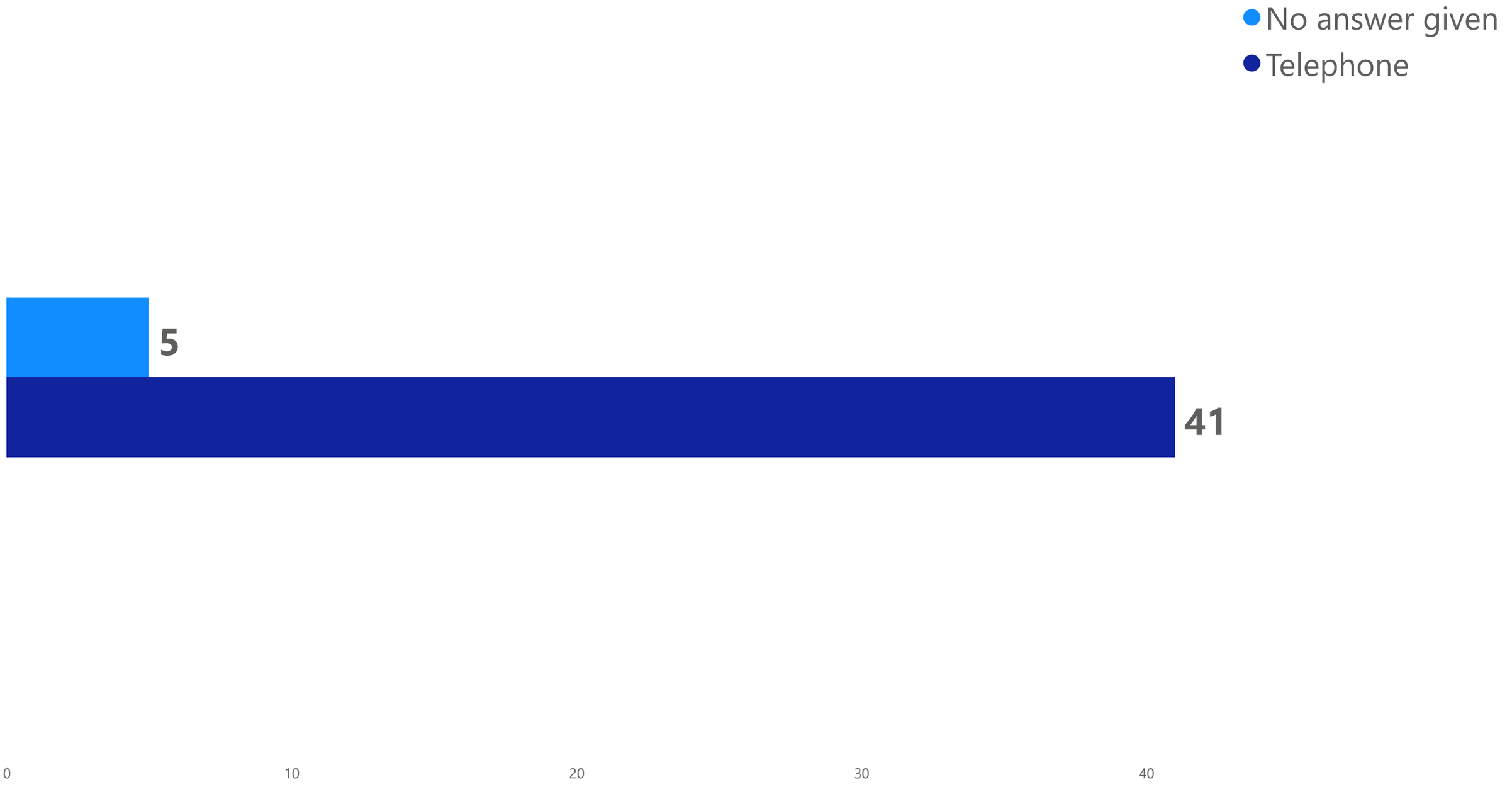
Note: This refers to patients that received only wraparound or digital support



Preferred person to contact



Preferred method of contact



Using app