

Community Virtual Ward

‘Hospital at Home’ for patients in Norfolk and Waveney

Information for healthcare professionals



What is the Community Virtual Ward?

The Community Virtual Ward provides patients with care that traditionally takes place in a hospital, in the comfort of their own home.

Patient care is managed by an Advanced Clinical Practitioner (ACP), who works with other professionals such as doctors, nurses, and therapists to deliver care in person or remotely.

Patients are monitored by the Community Virtual Ward Hub from 8am to 8pm, 7 days a week including bank holidays. Community Virtual Ward performs tests such as blood tests or heart tracings and administers treatments such as antibiotics.

The service launched in Norwich in September 2023. It is rolling out across all areas of Norfolk and Waveney.

Who is appropriate for Community Virtual Ward?

The service is appropriate for patients over 18 with conditions including respiratory disease, frailty, and heart failure.

Respiratory Pathway	Frailty Pathway	Heart Failure Pathway
Patients with a worsening respiratory condition or exacerbation who you feel would be able to receive care at home rather than hospital with the addition of ACP management and oversight, remote monitoring (including SpO2) and ongoing support for up to 14 days.	Patients aged 18 and over who are frail with a worsening acute or chronic condition who you feel would be able to receive care at home rather than hospital with the addition of ACP management and oversight (including residential and nursing home residents), remote monitoring and ongoing support for up to 14 days.	Patients aged 18 and over with worsening heart failure (fully diagnosed previously) who you feel would be able to receive care at home rather than hospital with the addition of ACP management and oversight (including IV Furosemide), remote monitoring, and ongoing support for up to 14 days.

How to refer

If you are a registered clinician and have assessed a patient who you feel may benefit from Community Virtual Ward care to prevent avoidable hospital admission, please refer by:

Phone

03000 247 222 (existing NEAT contact line) and select OPTION 2. Your referral will be managed by our dedicated team and triaged by a clinician.

e-Referral

Coming soon

Patients accepted onto the Community Virtual Ward will be provided with a remote monitoring kit that will allow blood pressure, temperature, pulse, and respiratory observations to be transmitted to the dedicated Community Virtual Ward Hub.

What happens when treatment ends?

The patient will be assessed by our team for clinical suitability before being discharged. Onward referrals to specialist services will be made if required.

A discharge summary will be sent to the patient and their GP explaining what care has been received while under the care of Community Virtual Ward. The discharge summary will clearly document any changes to the patient's medication.

The Community Virtual Ward team will make arrangements to collect any monitoring equipment provided to patients.

If you would like this publication in large print, Braille, alternative format or in a different language, please contact us on 0800 088 4449 and we will do our best to help.



Contact us

Phone

01603 272575 (not for referrals)

Email

communityvirtualward@nchc.nhs.uk

Website

<https://www.norfolkcommunityhealthandcare.nhs.uk/community-virtual-ward>



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