Transforming the role of the Community Matron through the implementation of the Virtual Ward

**Project overview:**

An opportunity was identified to refocus the role of the Community Matrons in NHS Swindon in order to:

- Provide more intensive multi-disciplinary care management of specifically identified high intensity users
- Improve the quality and consistency of care for these patients
- Reduce readmission to hospital where appropriate
- Develop the virtual ward concept using the community matrons as the orchestrator of care.

The very high intensive user project was launched to pilot an integrated model of care across primary care and the Community Matrons. The project was led by the Practice Based Commissioning GP across one of the three localities.

The project was launched in January 2010 and the implementation was phased over three months with plans to roll out across all three integrated teams within nine months.

**What we did:**

Patients identified for the first phase of the project were those who were admitted six times or more to the Great Western Hospital between April 2008 and June 2009, excluding children and certain clinical conditions.

The patient was admitted from the Single Point of Access to one of the three hundred virtual beds across Swindon. Each bed is case managed by a Community Matron working in conjunction with the patient’s GP.

The Community Matron has access to a resource pool of skilled professionals and support that can be drawn upon to create the most appropriate virtual team for each patient. The resource pool is continually developing and has changed throughout the pilot to now include mental health.

**Why we did it:**

The way in which community and primary care services were being provided in Swindon was changing and so the role of the Community Matron needed to change to remain integral to supporting the very high intensive users of secondary care services.

The Community Matrons were invited to pilot a new way of working to take into account these changes and developed the virtual ward model for the area.

**Patient story:**

**Mr Y: GP Identified Patient**

Mr Y was referred to the Community Matrons by his GP after spending three weeks in an acute hospital for the management of his ischaemic heart disease. He is also diabetic and had developed renal failure. He was listed for the insertion of an internal defibrillator. He had returned home from hospital feeling unwell, he and his family were finding it difficult to manage and wanted him to return to hospital.

The Community Matron visited Mr Y and found him confused, unsteady and at high risk of falling. His blood sugars were so high that they didn’t register a score on the glucometer. He was on insulin three times a day and a large amount of other medication, although it was unclear whether he was taking them as prescribed.

Following work between the Community Matron, the Crisis Team, the out-of-hours nurse and Single Point of Access, Mr Y was shown how to monitor his condition, manage his medicine and eat a healthy diet.

After two weeks Mr Y’s condition had improved, he was in a better mood, was no longer confused and started to go out to the local shops.

The Matron rechecked Mr Y’s bloods and liaised with the GP who was delighted that all results had improved, even Mr Y’s renal function. Matron input will continue until he is confident in the management of his long term conditions and understands his clinical management, patient and escalation plan.

**Organisational benefit:**

(both financial and operational/ productivity)

The table below shows the comparison of High Intensity User and Community Matron Core Caseload activity February 2009 – January 2010

The data shows a dramatic reduction in the number of contacts per patient since the start of the pilot.