**Case Study Template**

**Virtual Community Wards**

| How does this link with the criteria of Best Value? |
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| The Virtual Community Ward model began in Aberdeenshire in 2016 where local health and social teams were invited to work together within the boundaries of GP Practices population as a means to ensure that resources for the communities were working well and to prevent unnecessary hospital admissions and to enable people to remain safe in their own home or local community. This links with the BV themes of Effective Resources and Partnership Working |

| How does this link to our priorities? |
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| Links with the strategic priority of 'Support delivery of the Health and Social Care strategic plan'. |

| What research was undertaken to ensure best practice? |
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| There have been staff surveys carried out since the implementation of the VCW which have been positive in terms of building relationships, gaining awareness of roles and better utilisation of resource with less duplication. We currently have a team in the process of evaluating the experience of those who have been on the VCW to enable us to use this research to plan future developments and review the experiences of patients and their families. |

| What was the background to the case story? |
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| This was set up as although historically we have worked in local core teams, this involved more regular daily huddle type contacts across the teams to really identify the most vulnerable people within our communities and how we could respond to them in a more timely manner to meet their outcomes within their own home or community when this was safe to do so. |

| What activity was undertaken? |
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| We initially started this using a smaller practice within Aberdeenshire however the success of this led to other practices being involved and signing up to a service level agreement contract to be part of this model in the longer term. |

| How did this contribute to improved outcomes? |
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| This has resulted in better outcomes for both staff in terms of more effective communication, better use of resources, quicker access to interventions, more holistic and person centred care, a reduction in hospital admissions and over the three years approx. 1,640 hospital admissions avoided and people have remained at home or in their local community care settings. |

| How did this assist in delivering value for money? |
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| Through earlier intervention, better use of resource and ensuring the key staff member is engaging with the patient or their carer, less duplication of services and time if this is led by one key member of staff. |

| What did we learn? |
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| That the key to this success has been based on the trust and building relationships between the staff to ensure they have greater understanding of each other's roles and are able as a team to make a decision about the best outcome for the people within our communities who are at risk of hospital admission or readmission. |

**To be placed at: 5.2 Where We Are Now- Aberdeen Health and Social Care Partnership**