Community Wellness Team (VAWAS)

Service Aims:

To assign each service user a Care Coordinator to carry out an initial assessment and create a personalised care plan:

This includes individual care requirements, medications review, risk assessment of the home environment and specific needs or concerns raised by the individual in the event of their admission to hospital.

Care plans will be discussed with both the patient and any health care professionals or informal carers involved in their care.

To identify eligible service users through liaison with practices and practice registers.

To supply service users and/or their carers with contact details for their named Care Coordinator, should they need to discuss routine or urgent care.

To review care plans as appropriate to the service user's medical condition or as a minimum every 6 months.

To coordinate different providers and services to provide an holistic approach to care.

To provide regular home visits, where appropriate.

To attend acute visits when medical attention is required.

To deliver rapid response care packages for up to 48 hours.

To use their close knowledge of service users to support their GP and other healthcare professionals involved in their care.

To maintain transparency of information with member practices regarding Community Wellness Team visits and interventions.