WELCOME TO

The NHS Virtual Wards Conference 2023

Check Out Our Agenda Here...

Thursday 2nd March 2023 - 10:50am – 15:00pm – Hatfields Conference Centre, London

Conference hosted by Convenzis Group Limited

CONVENZIS

For Each Delegate Attending Our In-Person Event Today, we will be planting 1 tree with our Key Sustainability Partner

PLAY IT GREEN

Slido

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Event Day Overview

Morning Sessions: 9am – 10:40am

Morning Break: 10:40am – 11:40am

Midday Sessions: 11:45am – 13:20pm

Networking Session: 13:20pm – 14:10pm

Afternoon Sessions: 14:10pm – 15:00pm

Drinks Reception: 15:00pm -

Slido is being used to collect feedback, run polls and gather questions across the day, the next slide will have joining instructions..

The event is CDP accredited and your points will be sent within around 6 weeks of the event date.

The NHS Virtual Wards Conference South 2023

Event Chair – Opening Address

James Davis

Founder, CEO

Inicio Health

The NHS Virtual Wards Conference South 2023

Q&A PANEL

Stephanie Sommerville

Director, Community Health Services Transformation & Virtual Wards - NHS England

Dr Gurnak Singh Dosanjh

GP & ICB Clinical Lead for Home First Leicester, Leicestershire and Rutland ICB

Laura Harper

Directorate Manager Adult Community & Primary Care Services (Operational Lead for Virtual Wards) - The Royal Wolverhampton NHS Trust

Emily Jarvis

Senior Sister The Royal Wolverhampton NHS Trust

Grant Oliver

Remote Monitoring Programme Manager - Northampton General Hospital NHS Trust

Denisse Gatmayton

Diabetes Specialist Nurse - Virtual Lead Northwick Park Hospital - London North West University Healthcare NHS Trust

The NHS Virtual Wards Conference South 2023

UP NEXT

access
freedom to do more

The NHS Virtual Wards Conference South 2023

SPEAKING NOW

Alan Payne

Group Product and Engineering Doctor
Access HSC

I will be discussing…

"Virtual Wards Supporting Integrated Care"

access Health, Support and Care

Virtual Wards Proposition

NHS Virtual Wards Conference

2nd March 2023

access
freedom to do more

The Challenge:

There is no specific defined guidance on **how to deliver** a Virtual Ward

As a result, the current funding model is creating a multitude of tactical initiatives all under the banner of a Virtual Ward

- If this continues it could create **duplication, complexity and confusion**
- Resulting in **lack of adoption** and **inefficiency**
- Leading to **throw-away investments** and **wasted time**

Strategic Response

A structured approach which delivers near-term priorities and provides a robust, scalable and frictionless experience to support the evolving needs of the health and care ecosystem, delivering better outcomes for all

Access Group Overview

7,300+ people

80,000+ Customers

SaaS technology focus

High employee engagement & customer NPS scores

Over £75M p.a. in **R&D**

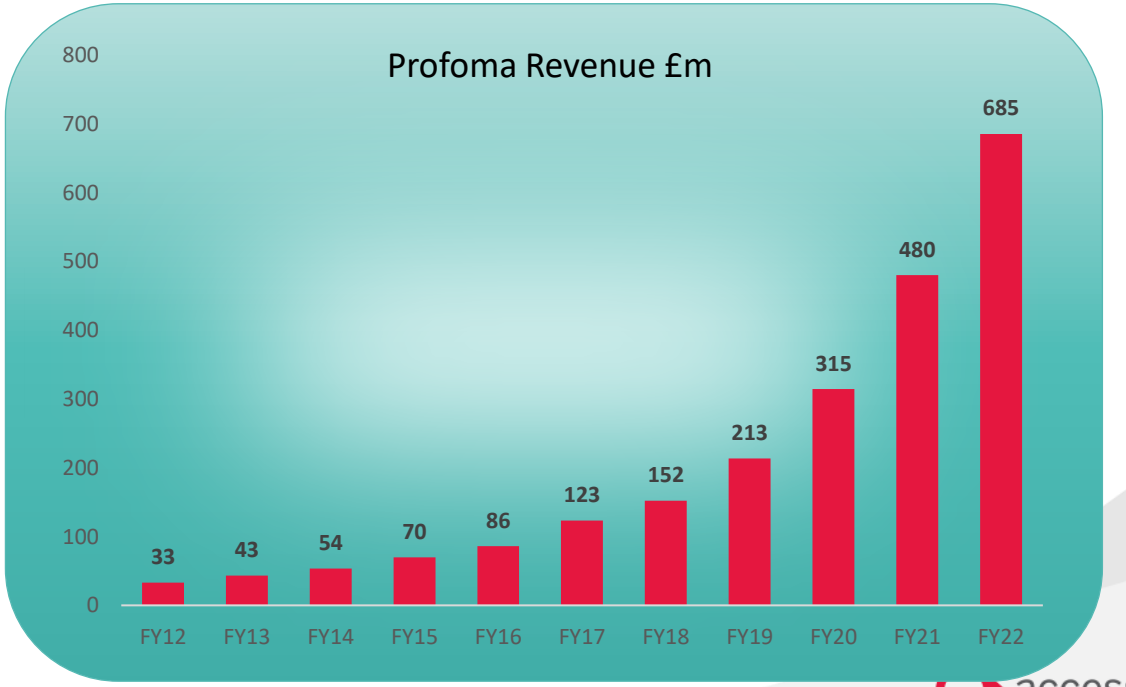
Multiple software capabilities as blended solutions

Giving organisations the freedom to do more

One of the largest **International software companies with a UK HQ**

15 years of **uninterrupted profitable growth**

£9.36bn **Market Cap** – driving continuous investment in digital transformation services



Access in the Health and Care sector: We are unique in offering digital transformation solutions across the Care Continuum – and are already serving Virtual Wards

access Health, Support and Care

Care Providers

353,000+
care workers rostered with Access HSC Software per year

190m+ hours of home care managed per year

25% of Social Care Hours in the UK managed

200m+
hours of residential care managed per annum

Local Authorities

180+
Local Authorities using Access care solutions

15,000+
Workers use Elemental's social prescribing platform

10,500+
registered care branches and community services

NHS Trusts

45+
NHS Trusts and Organisations using healthcare solutions

687,000+
visits carried out using our Social Prescribing solution

70%
of our NHS customers rated 'Good' or 'Outstanding' in CQC

Virtual Wards

14 NHS
trusts using Access 'Rio' Software to deliver virtual services

11,629
virtual stays enabled using Access technology (in 2022)

access Health, Support and Care

Defining ‘VIRTUAL WARDS’

Definition

A Virtual Ward is a safe and efficient alternative to NHS hospital care that is enabled by technology.

Virtual Wards support patients who would otherwise be in hospital to receive the same acute care, monitoring and treatment, but remote from the hospital ward.

The purpose of a Virtual Ward is to deliver hospital standard care in remote locations

- Improve patient outcomes
- Create greater ward capacity
- Enable effective use of limited resources
- Reducing the cost to treat an individual

Achieved through the use of technology to create ‘hospital wards at home’

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The Access View:

Frictionless quality care, anywhere

Virtual Wards is all about an integrated digitised extension of what happens in a hospital ward.

We believe the fundamental premise of a Virtual Ward strategy is to enable high quality seamless care irrespective of location and should: -

- Maintain clinician best practice irrespective of patient location
- Utilise existing physical ward systems and processes
- Extend systems and processes in a remote context, supported by digital : -
    - Communications channels
    - Monitoring, and recording
    - Patient/carer educational materials
    - Commissioning of remote 'equipment packs'
- Integrate remotely captured data into your existing EPR ensuring one patient view
- Deliver both consistency and flexibility in equal measure

Delivering a Blend of Consistency and flexibility

Systems need to **commission, operate, manage** and **provision** services effectively.

Virtual Wards need to operate consistently with the processes and procedures of physical wards – yet be - **Flexible by design** to:

- Handle different care pathways
- Work with current technology in the physical ward
- Allow care providers to adopt tactical components that build towards a scalable strategic delivery model

Deliver the platform and tools that enable physical capabilities in a virtual environment at scale

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The Access View...

“Foundation principles”
to deliver a frictionless Virtual Ward solution

1. Common core components to enable a consistent user experience
2. Flexibility to adapt to various clinical pathways
3. Re-use of existing capabilities to enable clinician adoption and efficiency
4. Integration of health and social care systems
5. Common standards, integrations and data model

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We believe that four elements are required for the successful delivery of Clinically led Virtual Care

1 Provisioning Tool

Patient Needs

Provisioning Platform

Accredited Suppliers
+
Virtual Ward Bed

2 Virtual Care Co-ordination (VCC)

Single intuitive presentation layer
(What you see, and how you see it)

- Communications & Remote Monitoring (How you interact with patients & stakeholders)
- Rostering / Planning / Bed Mgt / Pathway mgt (How you manage the patient & processes)
- Health / Care Record Integration (How you record)
- Reporting & Analytics (How you report, assess & predict)
- Standards, Audit, Security & Interoperability (How you safely share & receive)

Api

3 Pathway-Specific Apps

Virtual & physical tools to enable (self or assisted) measurement & assessment of specific health indicators

- 1: Frailty
- 2: Acute Respiratory Infection
- 3: Diabetes
- 4: etc

Api

4 Interoperability

- Clinical & Regulatory reporting
- Other Clinical systems

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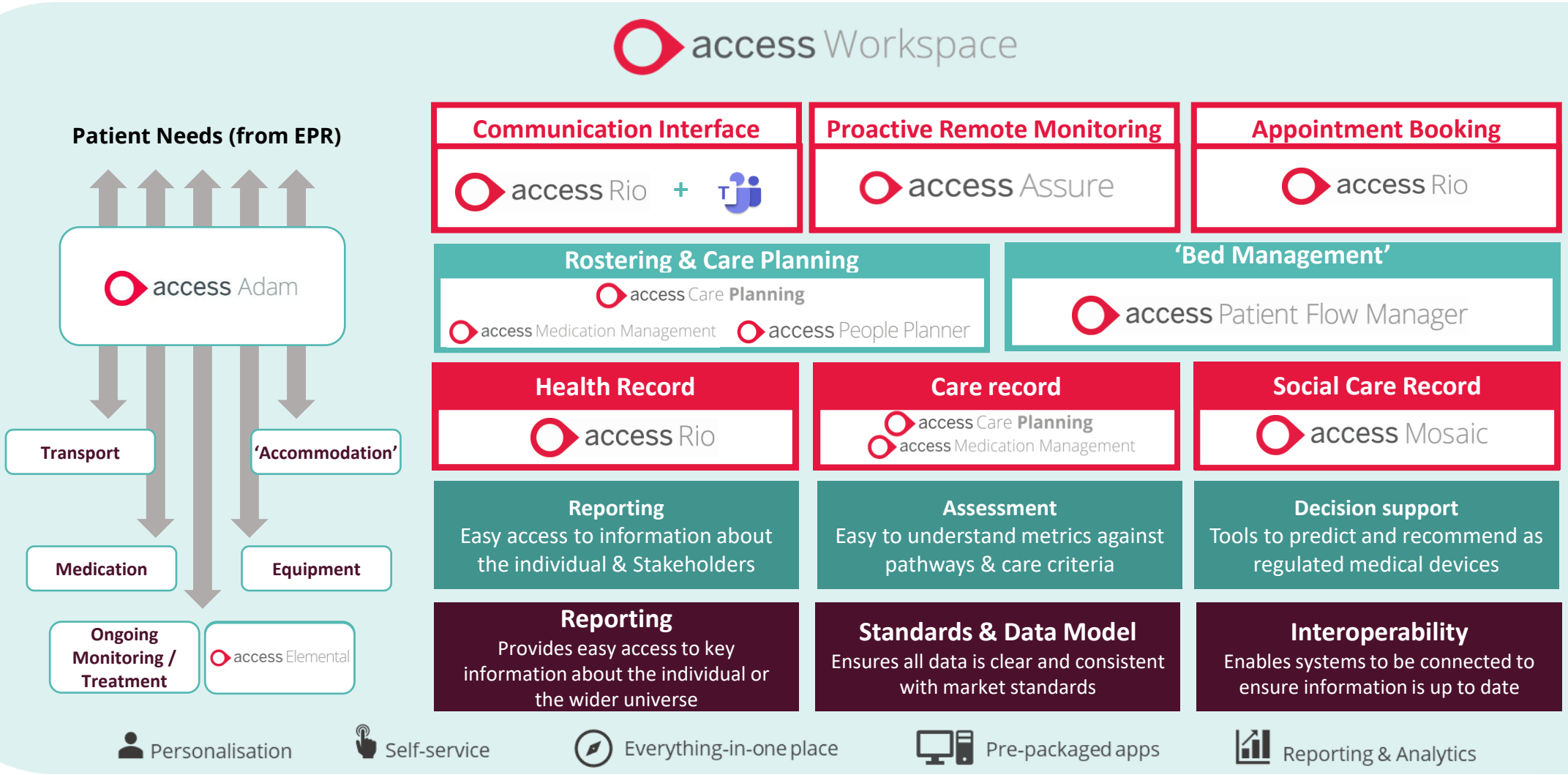
The Access Virtual Care Solution makes frictionless virtual care a reality: efficient, reliable, intuitive, and flexible



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‘One Ward’ enabled with Access

The huge opportunity of Virtual Wards is matched by the challenge to make it a reality.

The combination of multiple departments, differing approaches to care, existing technology systems and patient pathways demands that you seek a partner with experience and capability.

- **Expertise** – We remove the complexity, with frictionless, scalable implementation
- **Experience** – Our advice and solutions are trusted. We have a track record in care
- **Partnership** – We’ll help you develop a business case and define your roadmap
- **Practicality** – Flexibility that meets your technology stack, different pathways and targets

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freedom to do more

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Director, Community Health Service Transformation & Virtual Wards - NHS England

The NHS Virtual Wards Conference South 2023

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MORNING BREAK

The NHS Virtual Wards Conference South 2023

Event Chair – Chair Morning Reflection

James Davis

Founder, CEO

Inicio Health

The NHS Virtual Wards Conference South 2023

UP NEXT

Ortus-iHealth

The NHS Virtual Wards Conference South 2023

SPEAKING NOW

Dr. Debashish Das

CEO
Ortus Solutions Limited

I will be discussing…

"Virtual Wards
& Remote Monitoring
Managing Risks on Waiting
Lists and Enabling Early
Discharge"

Virtual Wards & Remote Monitoring

Managing Risks on Waiting Lists and Enabling Early Discharge

Convenzis NHS Virtual Ward Conference South

2nd March 2023

Presented by:

Dr Debashish Das

CEO Ortus Solutions Limited

Dr Arun Kirupananthavel

Registrar St. Barts Heart Centre

Case Study Overview

- Introductions
- Pan-London Overview
- Atlas Case Study
- Heart Failure @ Home
- Learnings and Insights
- Summary
- Questions and Answers

The Pan-London Overview

From Acquisition to Live

Procurement: November 2021-March 2022

Deployment: April 2022 - March 2022

Pathways: Perioperative Surgical Pathways

Technology: Clinician, Patient Portal and Apps

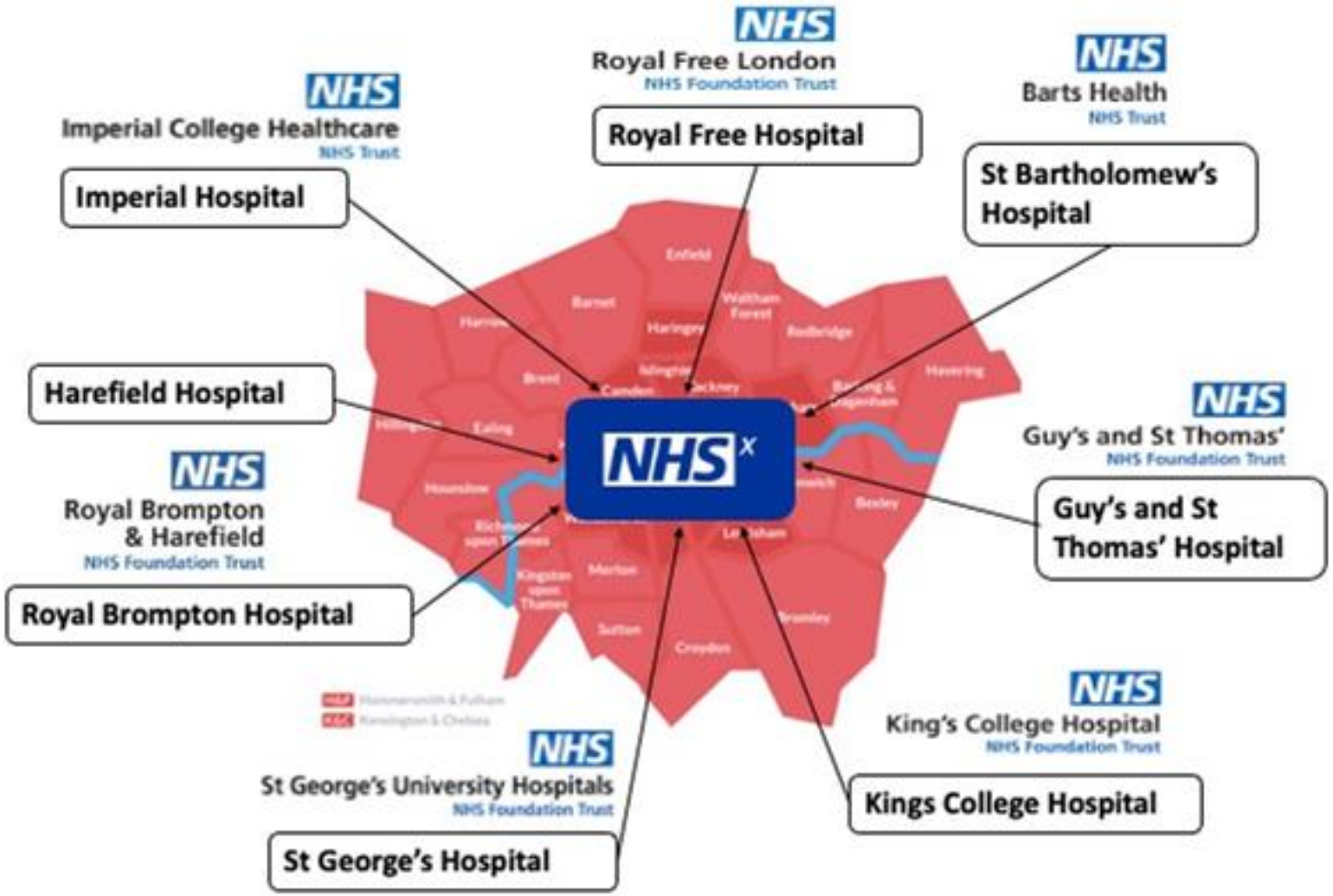
Transformation:

Standardisation of local and regional Pathways, SOPs, Libraries, Consent, Reporting and workforce practices

Observations Support:
BP, HR, Oximeter, Respiratory, Temp, Weight, Blood Sugar

Integration:

OneLondon, Cerner, EMIS & SystemOne



Ortus-iHealth

Barts Health NHS Trust | Guy's and St Thomas' NHS Foundation Trust | Royal Brompton and Harefield hospitals | Imperial College Healthcare NHS Trust | King's College Hospital NHS Foundation Trust | St George's University Hospitals NHS Foundation Trust | Royal Free London NHS Foundation Trust

Virtual Ward & Remote Patient Monitoring

- **Virtual Wards**
  - Flexible and scalable
  - Configurable dashboards
- **Keeping Patients Safe**
  - Patient prioritisation
  - Risk mitigation
- **Automated Care Plans**
  - Pre-assessment questionnaires
  - eConsent
  - PROMs collection
- **Facilitating Early Discharge**
  - Remote patient monitoring
  - Integrated telehealth
  - Patient education and content
  - Cardiac Rehab
- **Up-titration of Medication**

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St George's University Hospitals NHS Foundation Trust

Royal Free London NHS Foundation Trust

Pan-London Deployment – Onboarding and Activation

Deployment Site	Go-Live Date	Total Patients Onboarded	Total Patients activated	Total Patients Activated %	Total Questionnaires completed	Total Patients Escalated and Treatments Brought Forward
St Bartholomew's Hospital	16-Sep-22	543	475	77%	2009	64
Harefield Hospital	07-Sep-22	629	535	78%	2241	48
Royal Brompton Hospital	22-Sep-22	378	304	79%	1737	66
St Thomas' Hospital	07-Oct-22	167	126	64%	303	3
King's College Hospital	23-Nov-22	138	111	77%	261	0
Imperial College Hospital	28-Dec-22	72	67	84%	150	3
Royal Free Hospital	01-Feb-23	4	4	100%	3	n/a
St George's Hospital	Mar-23	TBC	TBC	TBC	TBC	TBC
Totals		1927	1622	80%	6704	184

Phase I

Phase 2

Phase 3

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Royal Brompton and Harefield hospitals

Imperial College Healthcare NHS Trust

King's College Hospital NHS Foundation Trust

St George's University Hospitals NHS Foundation Trust

Royal Free London NHS Foundation Trust

ATLAS: Case Study Overview

336 Bed Days Saved-£135K in 4 Months

£400,000 Projected Savings in A Year

ATLAS Pathway

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Barts Health NHS Trust

Guy's and St Thomas' NHS Foundation Trust

Royal Brompton and Harefield hospitals

Imperial College Healthcare NHS Trust

King's College Hospital NHS Foundation Trust

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Royal Free London NHS Foundation Trust

The Atlas Pathway Criteria

Presentation

- Medical management and outpatient angiography for low-risk NSTEMI patients
- In patients presenting with non-st-elevation acute coronary syndromes (NSTEACS)
- Digital virtual ward monitored

Guidelines

- Current guidelines recommend routine invasive coronary angiography for high-risk patients.
- However, in lower-risk patients the benefit-to-risk ratio of early invasive procedures is less clear and has been re-adjusted.
- Opportunity to risk assess NSTEMIs
  - providing early/expedited procedures in the high and very high risk
  - Early discharge with OP angiography in the low risk

Inclusion Criteria

- Grace score (<140)
- Pain-free>48 hours
- Minimal or no ST segment change
- Moderate biomarker rise
- Haemodynamically stable with no ventricular arrhythmias
- No evidence of new heart failure
- Discharged on optimal medical therapy
- Angiogram date set (within 1 week)

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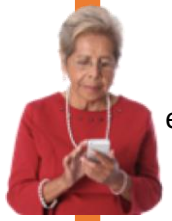
ATLAS: Patient Pathway

Patient has NSTEMI
And awaiting
angiogram



Patient meets
early discharge
Criteria

Patient on Virtual Ward
Until Angiogram

PATIENT MONITORED ON VIRTUAL WARD

Fills out daily
Cardiac Symptoms
Checker

Daily Reviews by ANP

Alerts are Actioned And Escalated

Angiogram

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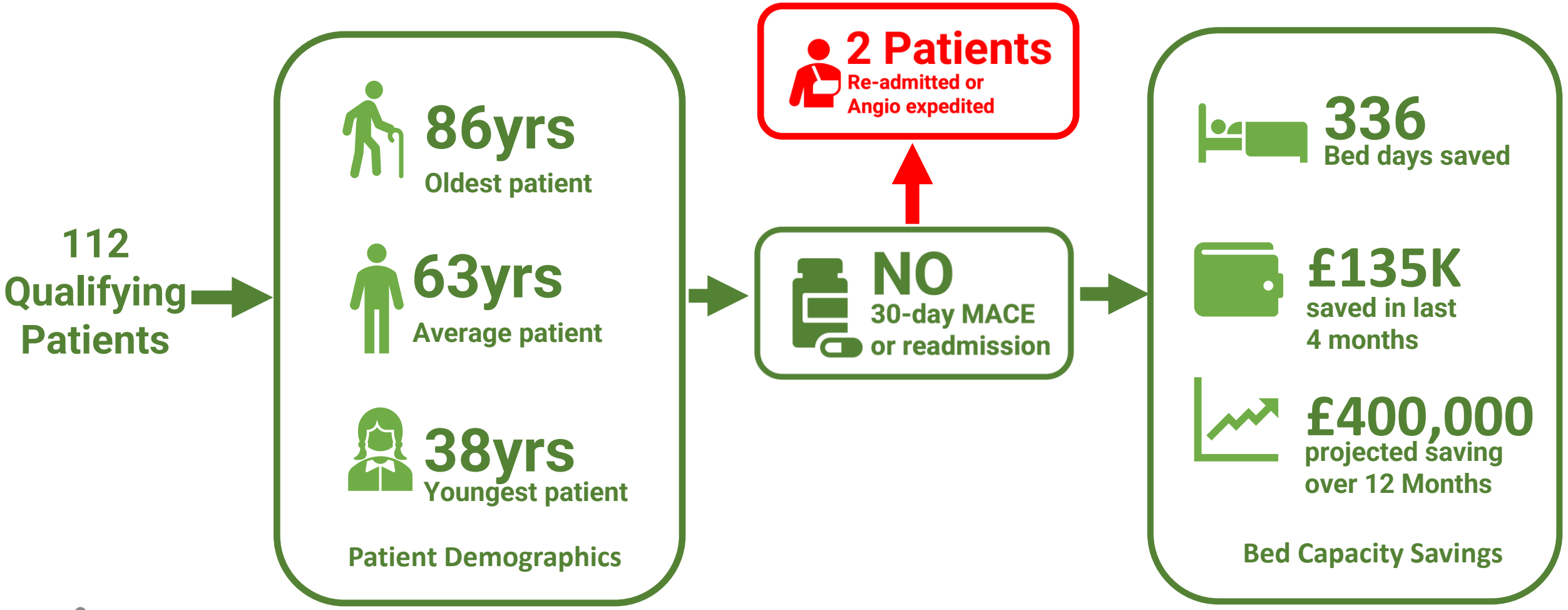
ATLAS: Key Outcomes



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Heart Failure @ Home

Acute Heat Failure admission

Patient is assessed and becomes in-patient

Patient offloaded (IV Diuretics) Medicine optimisation begins.

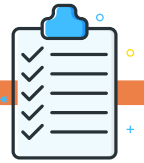
Patient moved to oral Diuretics.

- **Early discharge**
  - Up titration at home
- **Chronic disease/medication management**
- **Remote monitoring** for patient-inputted vitals, symptoms, observations
- **Reviews** according to NICE guidelines
- **Asynchronous messaging** /appointments

Patient discharged to Virtual Ward and sent home with BP Cuff and scales

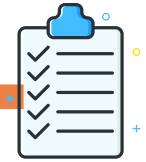
2 Weeks

1 Month



4 Months

12 Months



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NHS Royal Free London NHS Foundation Trust

Learnings and Insights

Implementation

- Repeated IG/DP processes
- Key SOPs across network
- Introduction of new workforce models and resourcing
- Early identification of Task and Finish Groups

Onboarding

- Key patient information pre-onboarding (prehab and rehab)
- Clear avenues for support (technical vs. clinical)
- SOPs for patient follow-up for non-engaging patients
- Continuous and automated collection of patient and staff feedback

Impact

- Early identification of deteriorating patients
- Scalability of project across specialties, models of care
- Reduction in unplanned admissions and bed days
- Enhanced patient to care provider connection and communication
- Removal of cross-site variation with SOPs

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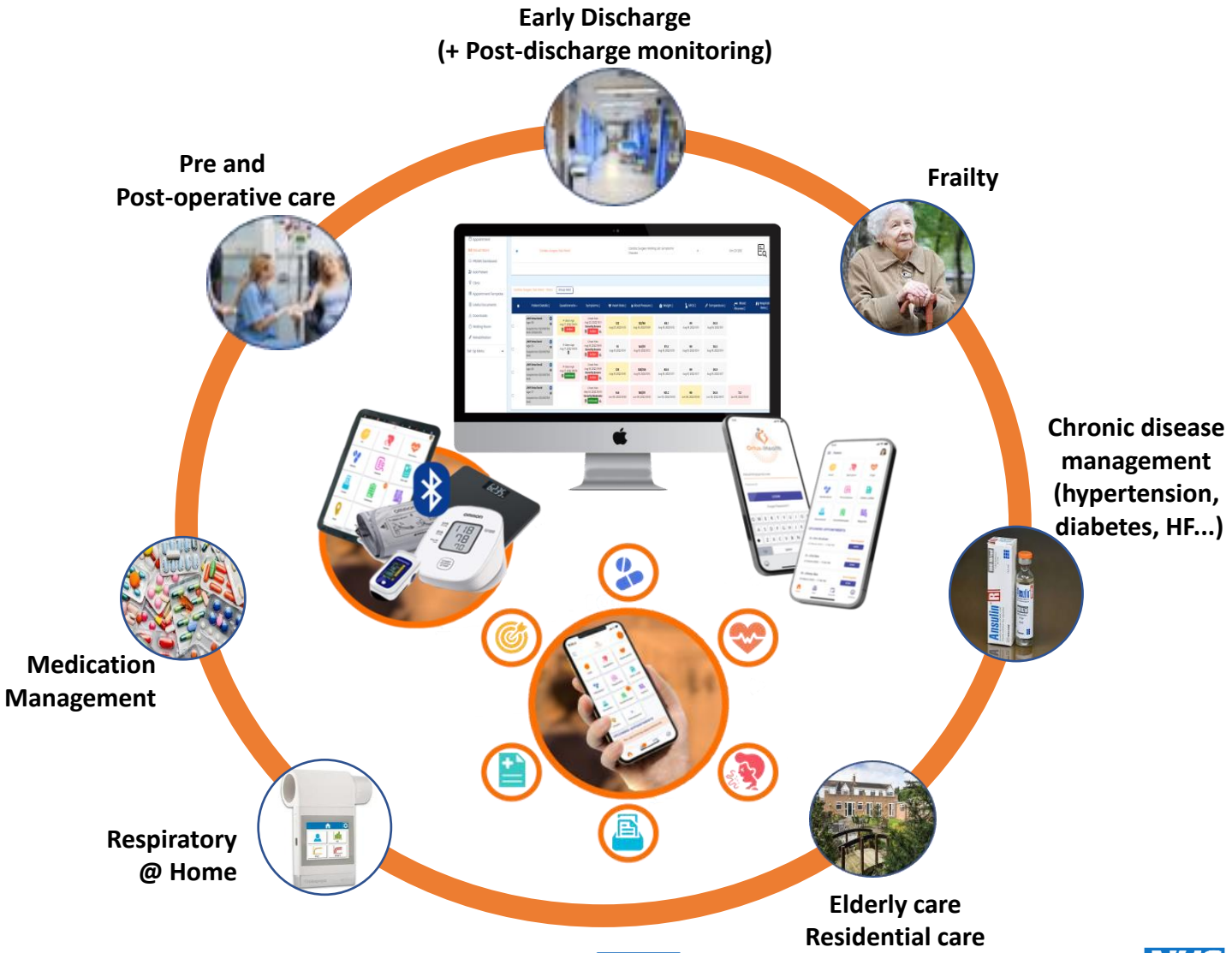
Summary

- Supporting hospitals at Home and care at home agendas
- Establishing local and regional pathway standardisation and SOPs enabling workforce flexibility and scalability
- Achieving high levels of engagement with both patients and clinical teams
- Enhancing patient care and focusing on deteriorating and high-acuity patients
- Identifying patients at risk, hidden in the list
- Increasing the availability of beds through admission avoidance and early discharge



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Questions

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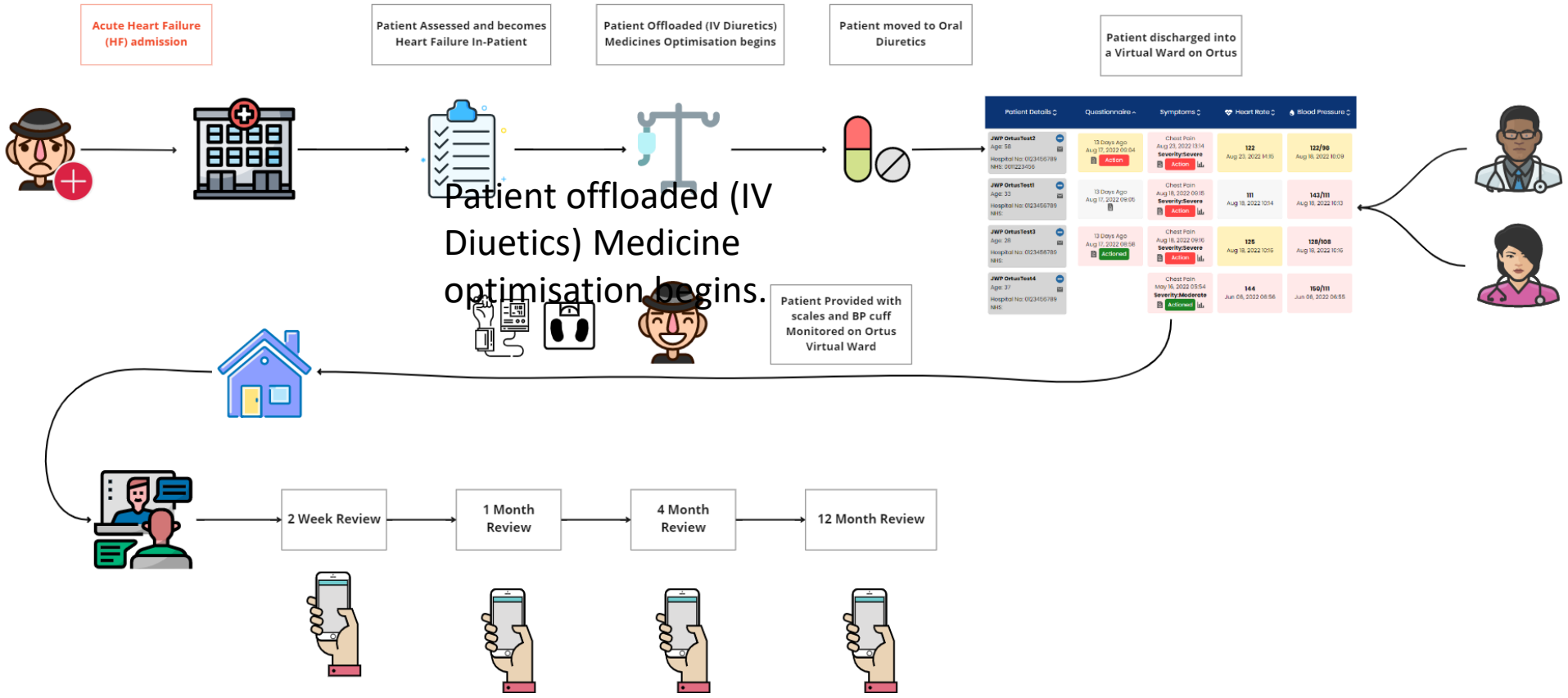
Heart Failure @ Home

- Early discharge
  - Uptitration at home
- Chronic disease/medication management
- Remote monitoring for patient inputted vitals, symptoms, observations
  - Reviews according to NICE guidelines
- Asynchronous messaging/appoint ments
- Live in 1 London site, with 2 more this month



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Key Outcomes

86yrs
Oldest patient

4 days
Average Time For Angio Post Discharge

336
Bed days saved

TOTAL PATIENTS: 112

63yrs
Average patient

2 Patients
Re-admitted or Angio expedited

£135K
saved in last 4 months

38yrs
Youngest patient

NO
30-day MACE or readmission

£400,000
projected saving in a year

Ortus-iHealth

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SPEAKING NOW

Karen Pudge

Senior Programme Manager Blended Learning
Health Education England

I will be discussing…

"Innovation in Healthcare Education: Developing the Future Workforce through Blended Learning"

Health Education England

Innovation in Health Education and Training: Blended Learning

Karen Pudge
Senior Programme Manager & Registered Nurse
Florence Nightingale Leadership Scholar

Context – policy & mandate

LTP (2019) - 4.16

Establish a new online nursing degree for the NHS, linked to guaranteed placements at NHS trusts and primary care, with the aim of widening participation

HEE Mandate 2019-2020 – 2.8

Promote alternative routes into the nursing profession by:

"developing a blended learning nursing degree programme that maximises the opportunities to provide a fully interactive and innovative programme through a digital approach"

People Plan (2020) – p38

HEE will also pursue this blended learning model for entry to other professions

HEE Mandate 2022/23

'continue to develop its proposals for reform of professional education, in partnership with DHSC and NHSE. HEE should also explore the use of blended learning approaches to promote full utilisation of innovative and immersive technologies and support flexibility and widening access in education provision'

Blended Learning Programme

The blended learning programme is promoting innovation in health professionals' education and training for **all.**

By enabling delivery of quality, cost-effective education and outcomes for the NHS and the people it serves through:

- **Commissioning** of courses with improved flexibility and rapid adoption of effective technologies
- **Evidence Reviews**- building on insights from data, cutting-edge research and expert discussions to inform the way that education and training is developed and delivered.
- **Strategic system leadership-** influencing innovation in health education provision

What is blended learning?

Definition: *“a method of teaching that integrates technology and digital media with traditional instructor-led classroom activities, giving students more flexibility to customise their learning experiences”* (Panopto, 2019)

Not Distance learning, mandatory 10-30% taught theory delivered face-to-face (in-person)

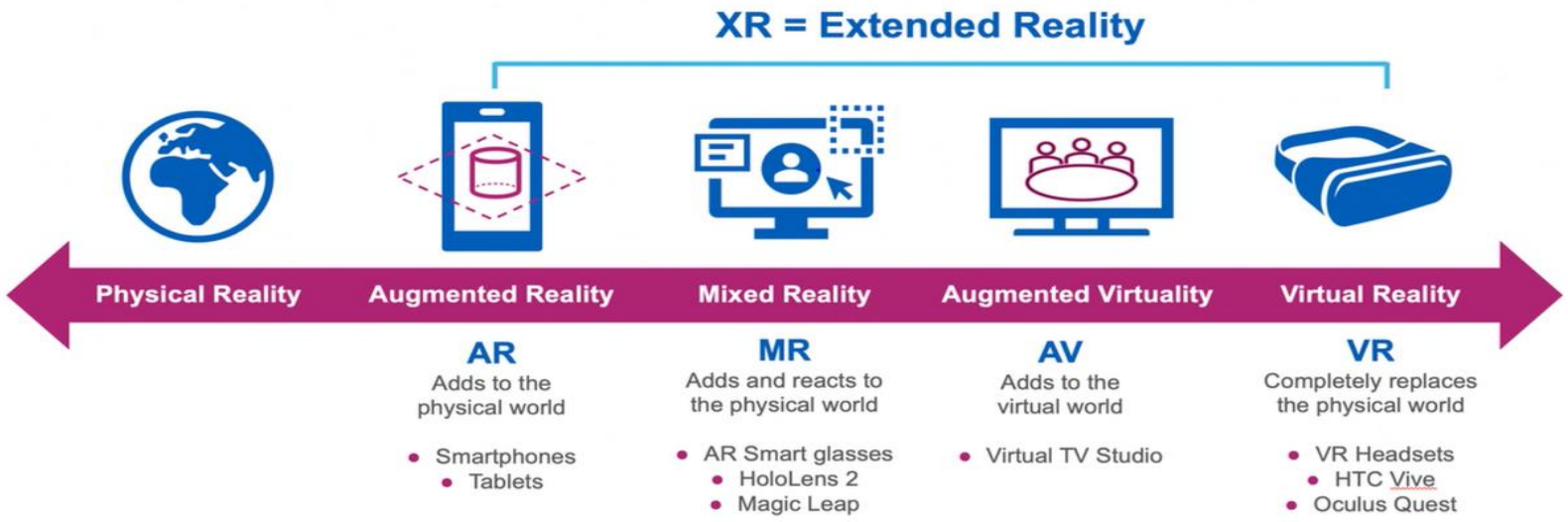
Blended Learning Degree – what's different?

- Full exploitation of **digital technologies** for theory and practice development - simulation, immersive technology, gamification etc.
- Fully **interactive and integrated** programme
- Provision that supports **online communities of practice** leading to development of engaged, self-directed learners with strong digital capabilities
- **Same education, different delivery**

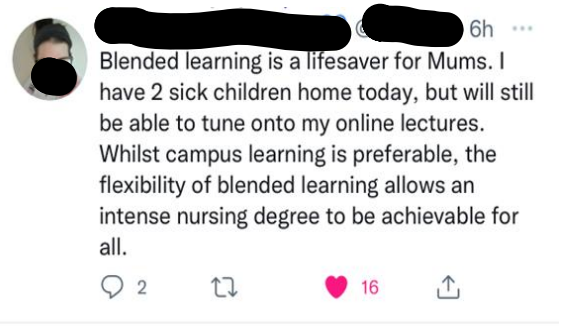
Development of graduates who are flexible, adaptable, resilient, curious, collaborative learners and registered professionals

Simulation and Immersive Technology

NHS
Health Education England



Why this, why now?



- Workforce shortages
- Undergraduate/pre-registration training
- Access & flexibility
- Increase diversity – widening participation
- Digitally ready workforce
- Covid-19

> "The evidence shows that blended learning has benefits that include better student experience and satisfaction, skills development and confidence."
>
> **Patrick Mitchell, Director of Innovation, Digital and Transformation**
>
> Health Education England

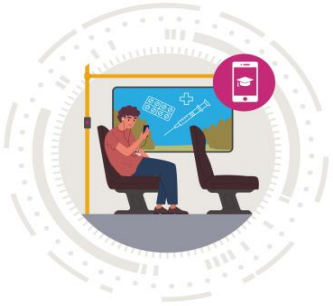
https://youtu.be/oOhqBDbGa30

Commissioned programmes

Programme	Achievements
Adult Nursing	Changes to historic entry criteria Evidence of widening access and participation First cohort completed
Midwifery	UG & PG Shortened programme- respond to capacity and clinical need Development of Digital Literacy Opportunities for global health learning Pathway for Maternity Support Workers
Medical Degree	Focusing on graduate entry programme Apprenticeship route in the future
Anaesthesia Associates	National provision Innovation in training
Nursing (Adult / Mental Health) First Destination in Primary, community and social care	First cohorts to begin in 2023

Commissioned programmes

Programme	Achievements
Critical Care Nursing – Steps 1, 2 & 3	Consistency in cost-savings Wider access to flexible training Supporting a big national ambition
Global Health	Diverse student population
Patient Safety Level 3	Starting 2023



First Destination employment in Community, Social & Primary Care

Blended Learning Adult Nursing Degree

Background

- Nursing workforce shortage
- Applications to Nursing degree decreasing
- Biggest drop from mature students
- 50,000 Nurses – where do we need the workforce?
- NHS Long Term Plan puts community at the heart of its ambition
- Patients receiving care closer to home
- Skills required for nursing in community, primary & social care are different to Acute settings
- Still a commonly held myth that NQN need significant acute experience first
- Need to consider new approaches to education & training

Purpose

Commission HEIs to:

- Pre-registration Nursing Degree for first destination employment in Community, Primary & Social Care service
- Create an innovative, accessible programme to attract a diverse student population
- Provide flexibility in training with increased use of appropriate digital and other learning technologies
- Create a significantly different offer in nurse education that will support the growth of a qualitatively different, expert and professional workforce suited to the demands of 21st century care
- Facilitate the growth of digitally capable learners
- All commissioned bended learning programme will be part of an independent evaluation
- Funding for HEIs for infrastructure & development costs

Other Activities

- **Medical Roundtables- Australia and New Zealand**
  - Digital and AI literacy
  - Levers for change
  - Digital Health in remote and rural areas

- **Midwifery Roundtable- Australia, New Zealand and Indonesia**
  - Use of simulation and innovative technology in midwifery education

- **International collaboration site**
  - Troubleshooting
  - Evidence sharing
  - Study tours

- **Ministerial Roundtables-**
  - Innovation
  - Regulatory flexibility
  - System Capacity

What's on our Horizon?

- **Commissioning**
  - Return to Practice Nursing and Midwifery
  - GP training
  - Dental hygienist and dental therapist
  - ACCEND
  - More in the pipeline!

- **Evidence review**
  - State of the Nation report

Strategic System Leadership

- Organising a study tour for a group from Australia on workforce and innovative training solutions – March 2023

Other Achievements

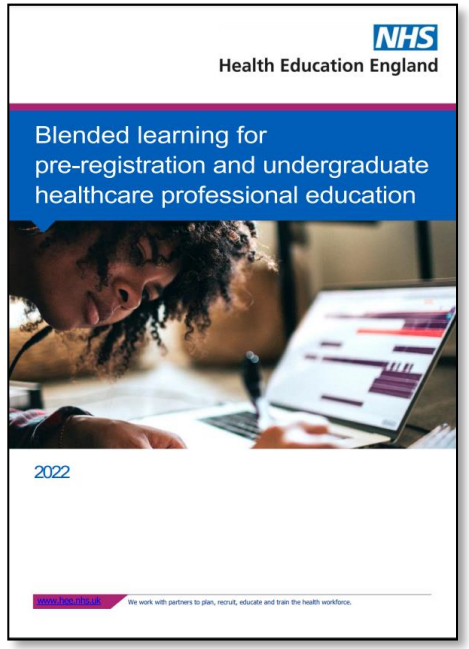
- Blended learning being included in “in attendance” courses to attract student support funding
- Changes to Travel and Dual Accommodation Expenses rules for Blended Learning student
- Potential research collaboration with international partners- midwifery
- Self run University Communities of Practice

What more can we do?

- Promotion of blended learning to Trusts, placement providers and prospective students
- Work with HEIs to develop further placement opportunities for students, including virtual wards and ePlacement opportunities
- Stronger engagement with individual professional bodies to reflect already established partnership with all regulators and membership councils
- Develop a complementary delivery strategy for innovative and flexible education and training alongside HEE framework 15 and workforce strategy
- Influencing regulators and professional bodies to consistently introduce no restrictions in their respective standards for the use of technology
- Generate evidence – independent evaluation, publications
- Future pipelines

Further information

Blended Learning Guidance Report



HEE Blended Learning Website:

https://www.hee.nhs.uk/our-work/blended-learning

"The report sets out the potential role of blended learning for those students in England currently unable to access healthcare pre-registration qualifications easily. ... It also highlights the potential of blended learning programmes to allow (healthcare) students to access learning opportunities flexibly to further their career aspirations, alongside their work, family and personal commitments."

Edward Aggar MP, Minister of State for Health

Department of Health and Social Care

Thank you

Email: blended.learning@hee.nhs.uk

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Thursday 2nd March 2023 - 10:50am – 15:00pm – Hatfields Conference Centre, London

Conference hosted by Convenzis Group Limited

The NHS Virtual Wards Conference South 2023

UP NEXT

The NHS Virtual Wards Conference South 2023

SPEAKING NOW

Myles Murray

Founder
PMD Solutions

I will be discussing...

"Partnership-based approach for Virtual Wards in severe COPD cohorts"

PMD SOLUTIONS

Revolutionising Respiratory Outcomes

Partnership-based approach for Virtual Wards in severe COPD cohorts

realising

The removal of the technology burden and optimising early identification of deterioration

Presented by:
Myles Murray
(CEO of PMD and Fellow of the NHS Innovation Accelerator)
March 2nd 2023, The NHS Virtual Ward Conference South.

Our Shared Purpose

PMD Solutions are #MakingEveryBreathCount

by

Transforming how respiratory rate is monitored

to

Ensure the right care is given to the right patient at the right time with RespiraSense

The Challenge Question:
To design a solution to improve respiratory care in the community

Letterkenny University Hospital 2022:

"How can we empower people with advanced COPD to become a partner in the management of their health care and and ensure they receive the right care at the right time as close to home as possible?"

The Challenge - The status Quo

"Wellness in COPD" tool table/grid

KEY: Very poor; Not good enough, if this criterion is important; Good enough; Recommended; Highly recommended

Tool/ Criteria	Validity/ Reliability	Responsive	Primary Care Population	Practical/ Easy to Administer	Tested in Practice	Other Languages
AQ20	☹	😐	😐	☹	😐	🙁
BPQ-S	☹	😐	😐	😐	🙁	🙁
CARS	😐	🙁	🙁	😐	🙁	🙁
CAT	☹	😐	☹	😐	😐	😐
CCQ	☹	☹	☹	☹	☹	☹
CRQ	☹	😐	☹	😐	☹	😐
MRC-D	😐	😐	☹	☹	☹	😐
RIQ-MON10	😐	😐	😐	😐	🙁	🙁
SGRQ	☹	☹	😐	😐	😐	☹

Impact:

- Deterioration identified through Symptoms
- Patient felt intimidated by technology
- No improvement in Quality of Life

There is no ‘one answer' in delivering better outcomes

But Digitally Transforming pathways can enable improved outcomes and empower patients.

The Lost Vital Sign – Respiratory Rate

The next advance – Continuous Respiratory Rate (cRR)

"Wellness in COPD" tool table/grid

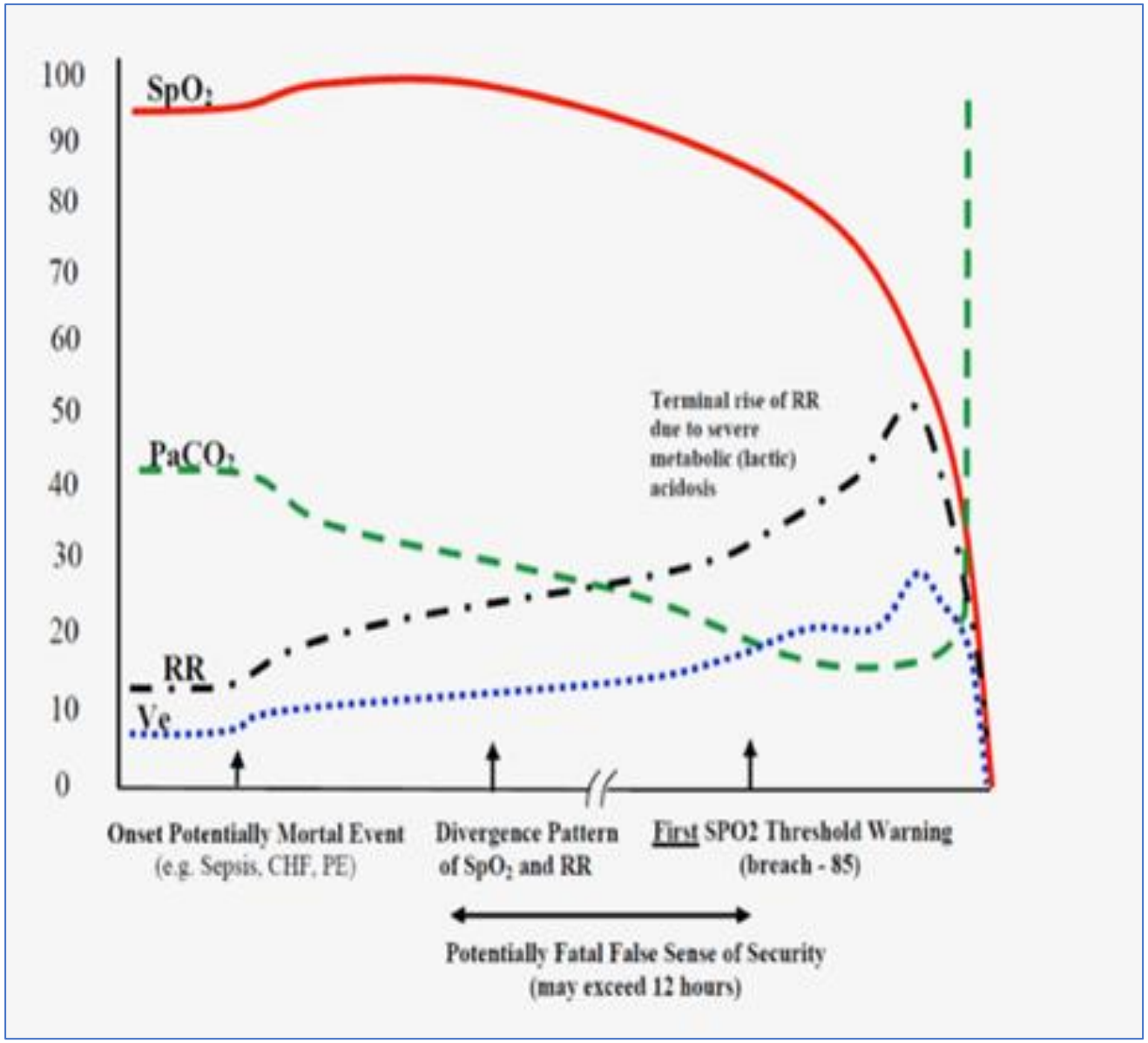
KEY: Very poor | Not good enough, if this criterion is important | Good enough | Recommended | Highly recommended

Tool/ Criteria	Validity/ Reliability	Responsive	Primary Care Population	Practical/ Easy to Administer	Tested in Practice	Other Languages
AQ20	☻	😐	😐	☻	😐	☹
BPQ-S	☻	😐	😐	😐	☹	☹
CARS	😐	☹	☹	😐	☹	☹
CAT	☻	😐	☻	😐	😐	😐
CCQ	☻	☻	☻	☻	☻	☻
CRQ	☻	😐	☻	😐	☻	😐
MRC-D	😐	😐	☻	☻	☻	😐
RIQ-MON10	😐	😐	😐	😐	☹	☹
SGRQ	☻	☻	😐	😐	😐	☻

Impact:

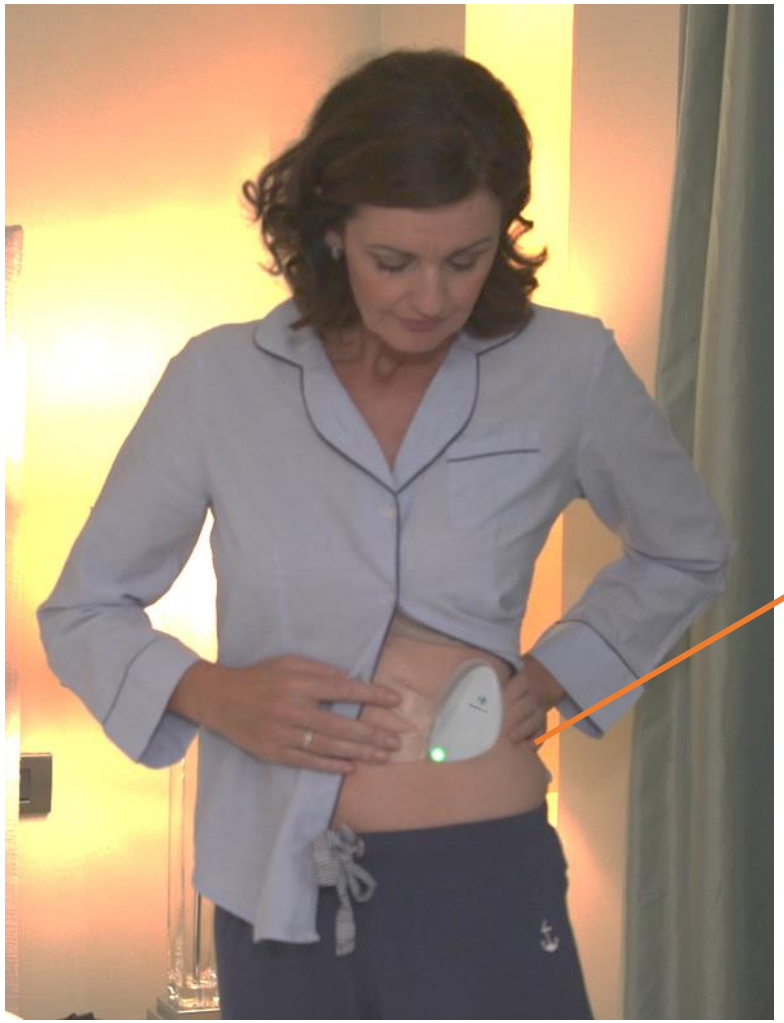
- Deterioration preceded Symptoms
- Patient felt intimidated by technology
- No improvement in Quality of Life

Over Reliance on SpO_2 is risky in patients supported with O_2



- Curry 2018 - Changes in respiratory rate indicate potential Respiratory Alkalosis or Metabolic Acidosis
- SpO_2 can be a lagging indicator of same with delayed interventions happening if accurate measurement of elevated RR is not achieved
- Trends as appose to spot checks for RR give greater sensitivity in correlating abnormal RR with underlined deterioration
- A simple Arterial Blood Gas (ABG) analysis can confirm this in day to day clinical practice.
- Confirmation of Alkalosis or acidosis can give healthcare providers the direction for the appropriate course of treatment.

RespiraSense – Continuous and motion tolerant eRR monitoring

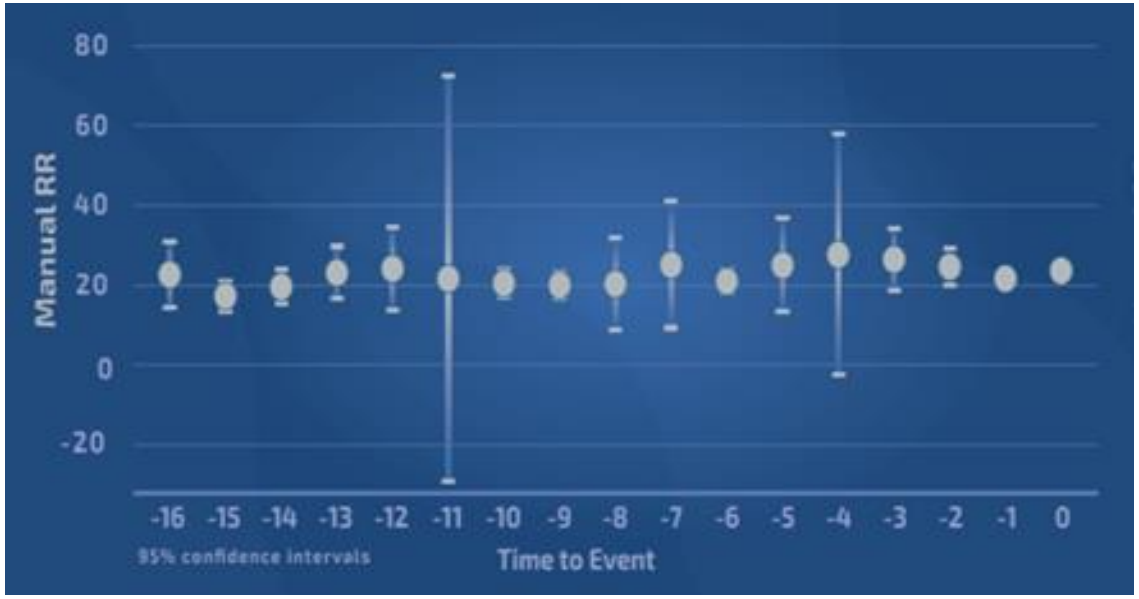


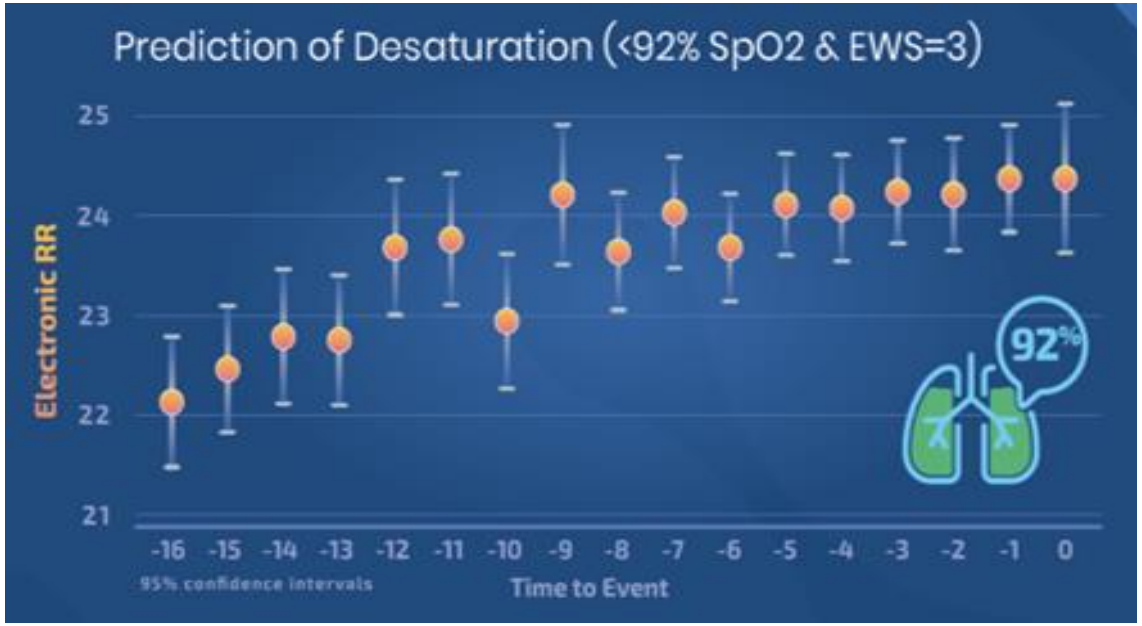
Single Patient Single Use
RespiraSense Sensor

Reusable/Rechargeable Lobe
(measures, processes,
communicates)

Optional: Bluetooth SpO2/PR
monitor - Nonin

cRR prediction of Hypoxia





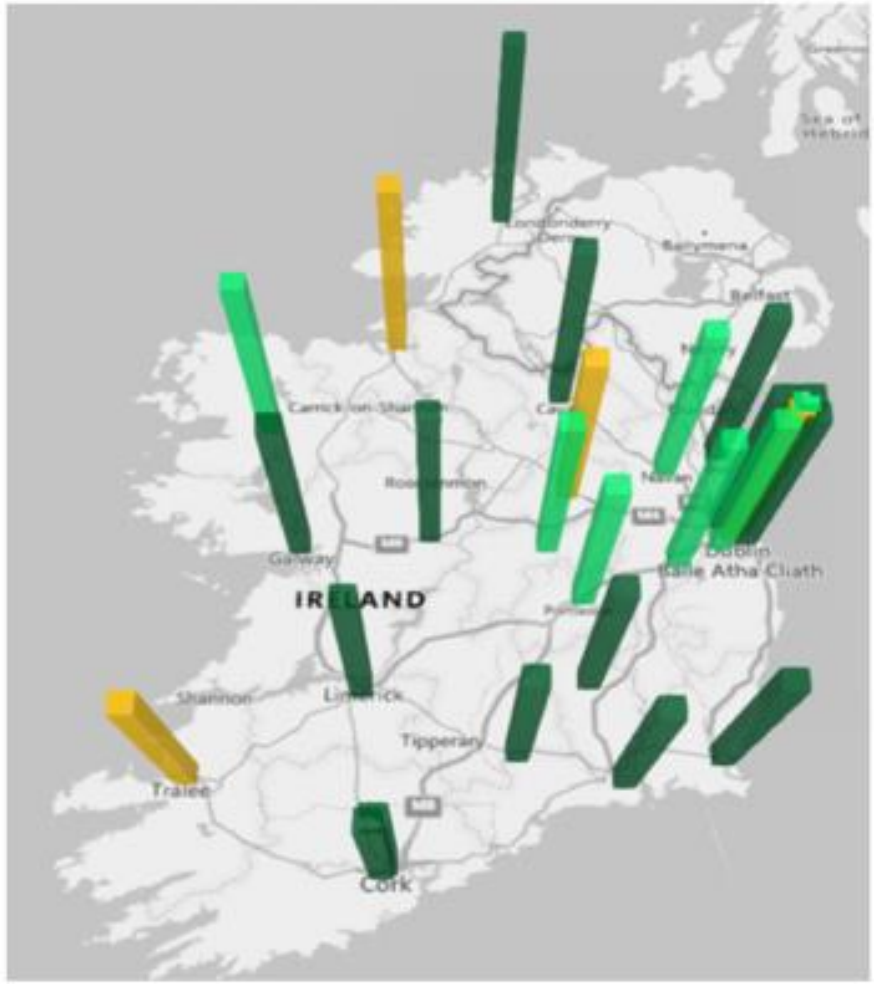
McCartan2020 demonstrated that eRR >24 breaths per minute gave 12hrs early warning of impending hypoxia event with over 90% sensitivity.

Manual RR measurements gave no significant predictive power for pending hypoxia

Electronic monitoring of patients Respiratory Rate can help allocate the Right Resources to the Right Patient at the Right Time.

cRR also predicted pyrexic events of temp>38ºC

Acute monitoring of Respiratory Compromised Patients using cRR



cRR is in 23 Acute Hospitals and 47 Respiratory Wards across Ireland

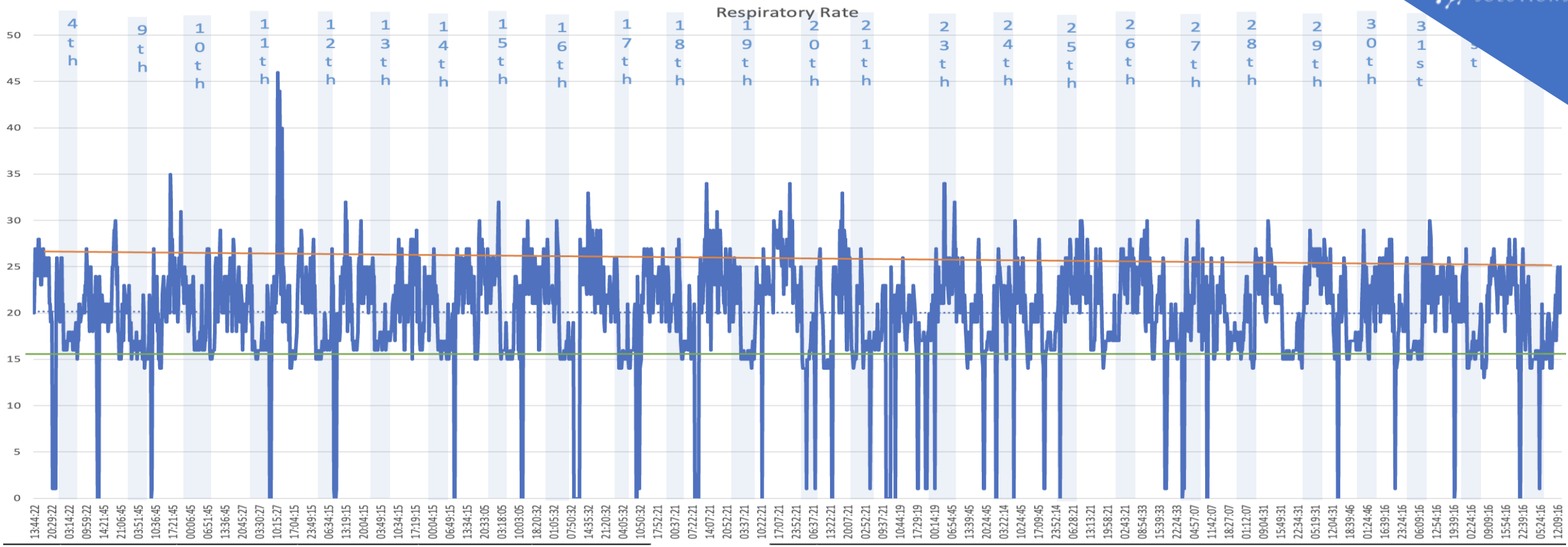
NHSx funded roll-out in Nottingham University Hospital across 3 Wards

40,000+ Patients monitored every year

Intended for patients on 4lt Supplementary O^2, NIV, or HFOT

NHSX NICE National Institute for Health and Care Excellence Nottingham University Hospital NHS Trust HSE Digital Transformation

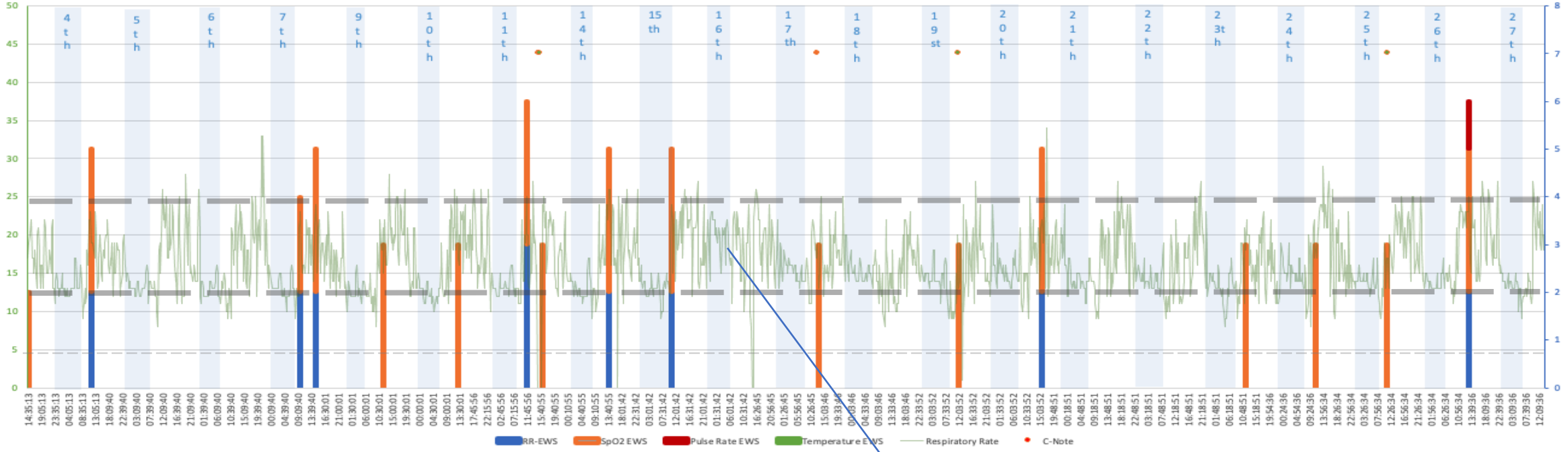
What is a Continuous RR Profile – Patient #1



- Repeating patterns of variation
- Reduction in RR during sleep
- Range of RR is consistent
- Lower and Upper RR averages are consistent

Step 1 – Identify the personalise baseline of 'Normal' for the patient

Example 1: Disturbed cRR profile and Higher Nocturnal mean cRR than Daytime cRR



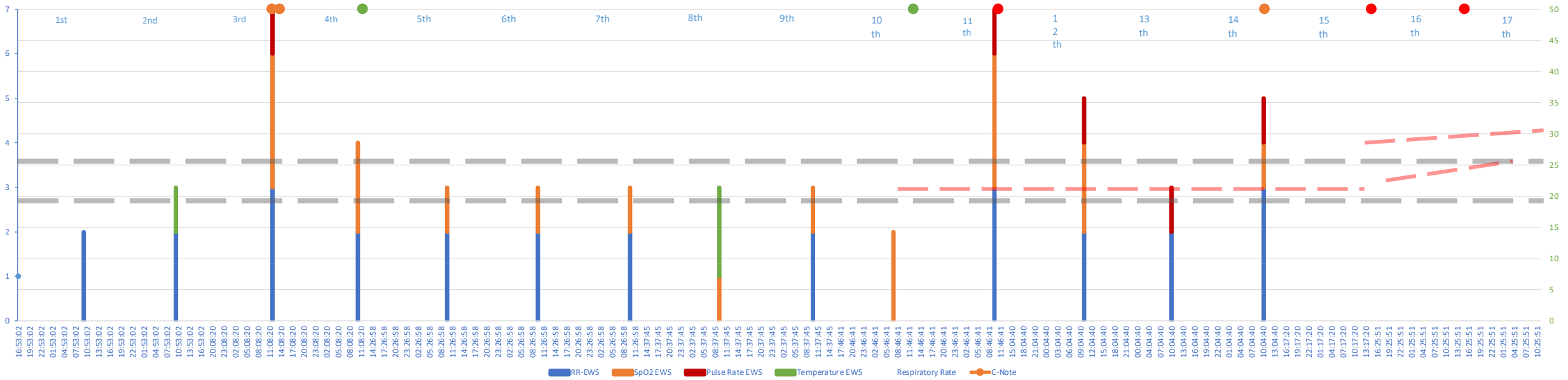
Grey Dashed lines show that from history what the normal stable RR profile is.

Red Dashed lines show how the range changed as events worsened.

COVID+ Confirmed:
No obvious increase in RR Profile….
But very disturbed night sleep –
Ref: Observation 5 on next slide

Step 2 – Identify deviations in range, trend, or averages from the norm

Example 2: Variation in Lower RR range and trending increase in RR range: coupled with disturbed nocturnal cRR

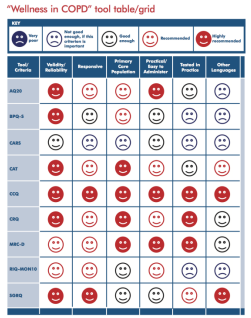


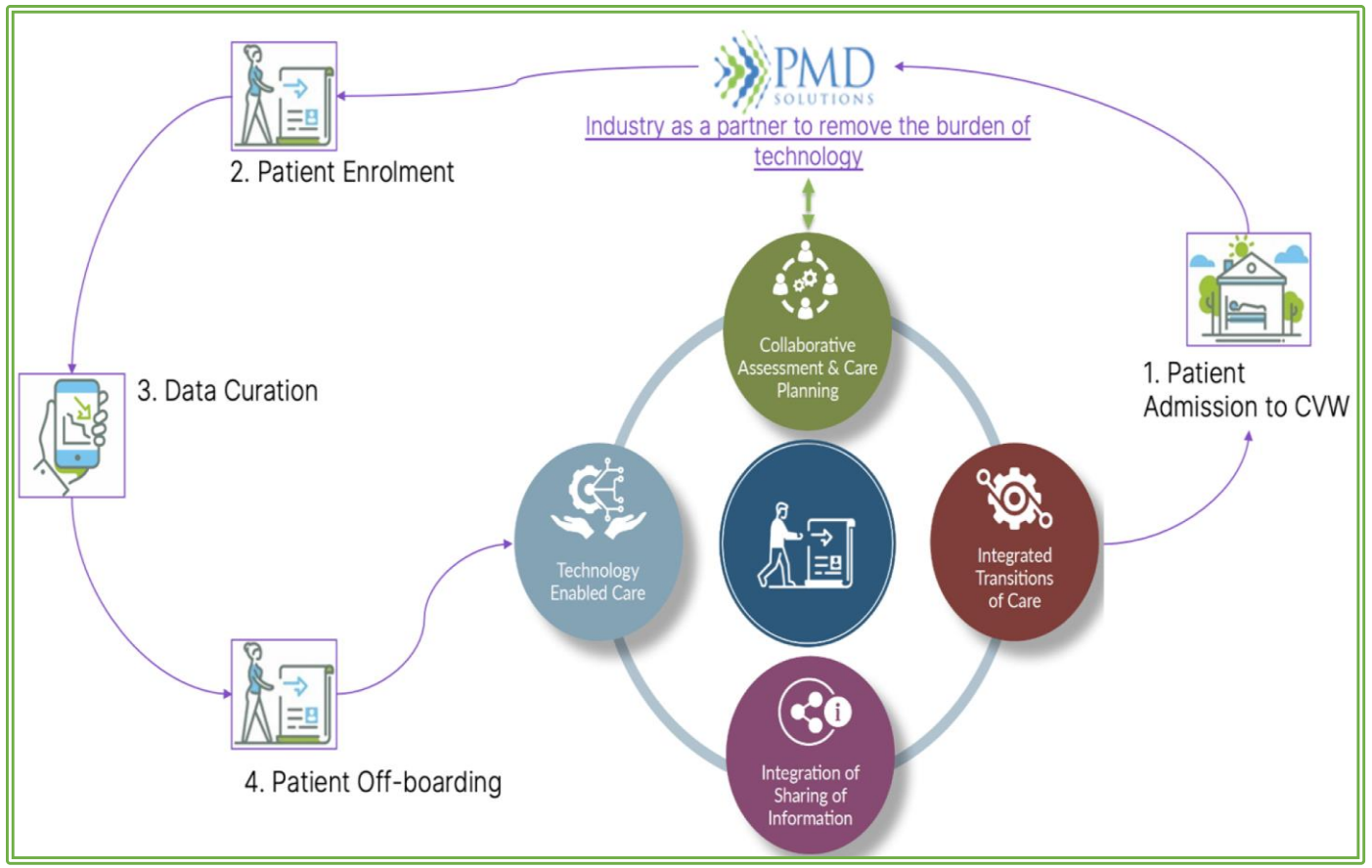
Grey Dashed lines show that from history what the normal stable RR profile is.

Red Dashed lines show how the range changed as events worsened.

The right focus – Patient centric approach

The right approach – Partnership-based Model of Care





Impact:

- Deterioration preceded Symptoms
- Patient felt intimidated by technology
- No improvement in Quality of Life

The right approach – Partnership-based Model of Care 12-week pilot

Doherty2022 et al.

International Journal of Nursing and Health Care Research
OPEN ACCESS
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Research Article

Community Virtual Ward (CVW+cRR) Proof-of-Concept Examining the Feasibility and Functionality of Partnership-Based Alternate Care Pathway for COPD Patients- Empowering Patients to Become Partners in their Disease Management

Antoinette Doherty[1*], Vera Keatings[2], Gintare Valentelyte[3], Myles Murray[4], Des O'Toole[5]

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[3]RCSI University of Medicine and Health Sciences, Dublin, Ireland
[4]PMD Solutions, Cork, Ireland
[5]HSE Digital Transformation and Innovation, Dr Steeven's Hospital, Dublin, Ireland

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Citation: Doherty A, Keatings V, Valentelyte G, Murray M, O'Toole D, et al. (2022) Community Virtual Ward (CVW+cRR) Proof-of-Concept Examining the Feasibility and Functionality of Partnership-Based Alternate Care Pathway for COPD Patients- Empowering Patients to Become Partners in their Disease Management. Int J Nurs Health Care Res 5: 1364. DOI: 10.29011/2688-9501.101364

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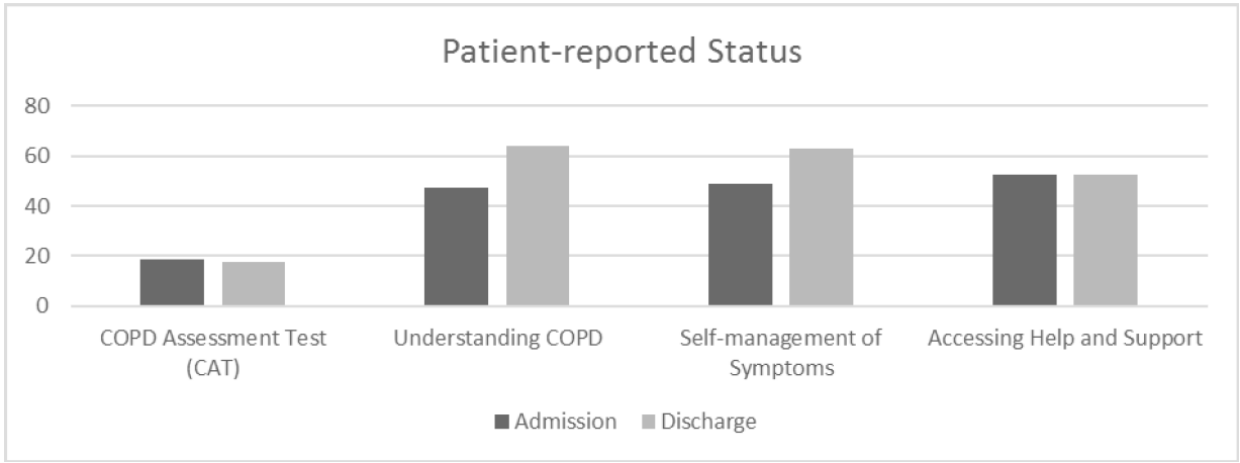
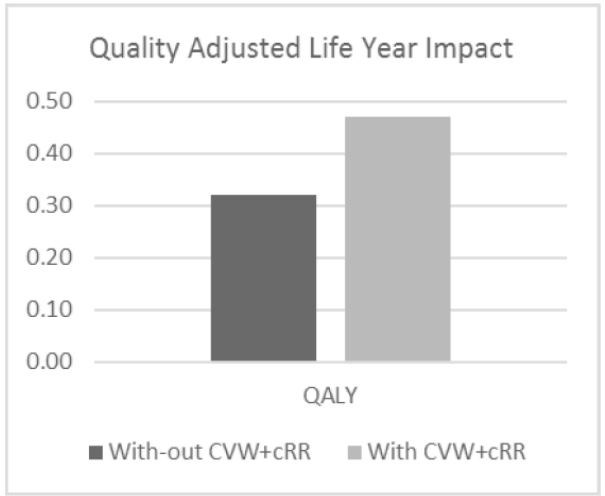
Abstract

Background: Individuals with exacerbating Chronic Obstructive Pulmonary Disease (COPD) display a pattern of exacerbations and illness culminating in repeated hospital admission. In an effort to empower people living with COPD to self-manage their illness and to avoid hospital admission a Community Virtual Ward + continuous Respiratory Rate (CVW+cRR) with a bespoke platform that incorporated respiratory rate (RR) trends was designed and implemented in Co Donegal. The proof of concept took place from May to August 2022 with 15 eligible individuals living with COPD. **Pathway:** Patients with moderate-severe COPD (Gold Scale D) were admitted to the CVW+cRR for remote monitoring, with optimisation of existing care plans and provision of rescue prescriptions for the patient's use. The objective and subjective patient data was reviewed daily by a Registered Advanced Nurse Practitioner (RANP). **Results:** Data from 10 patients was eligible for inclusion. Hospital avoidance was achieved in 100% of the eighteen (18) identified exacerbations in patients admitted to the CVW+cRR with cRR. The average cost per patient reduced from average €19,384.00 to €3,376.44, with a 96.7% probability of being both cost saving and cost effective at a €45,000 willingness to pay threshold. Several patient-reported measures also indicated improvement between admission and discharge, including Self-Management (increase of 29.1%), Understanding of COPD (increase of 35.3%), and Quality Adjusted Life Years (QALY) (increase by 0.15 of a QALY). **Conclusion:** The COPD CVW+cRR offered individuals an alternate care pathway and facilitated early intervention and management of infective exacerbation. The CVW+cRR provided the option to remain at home while receiving care, resulting in avoided hospital admissions with the use of both personalised objective trigger thresholds and patient feedback as to their wellbeing.

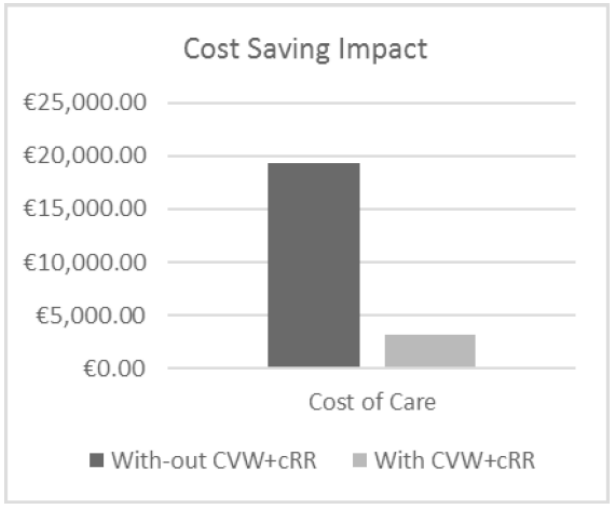
Patient Empowerment



QoL Improvement

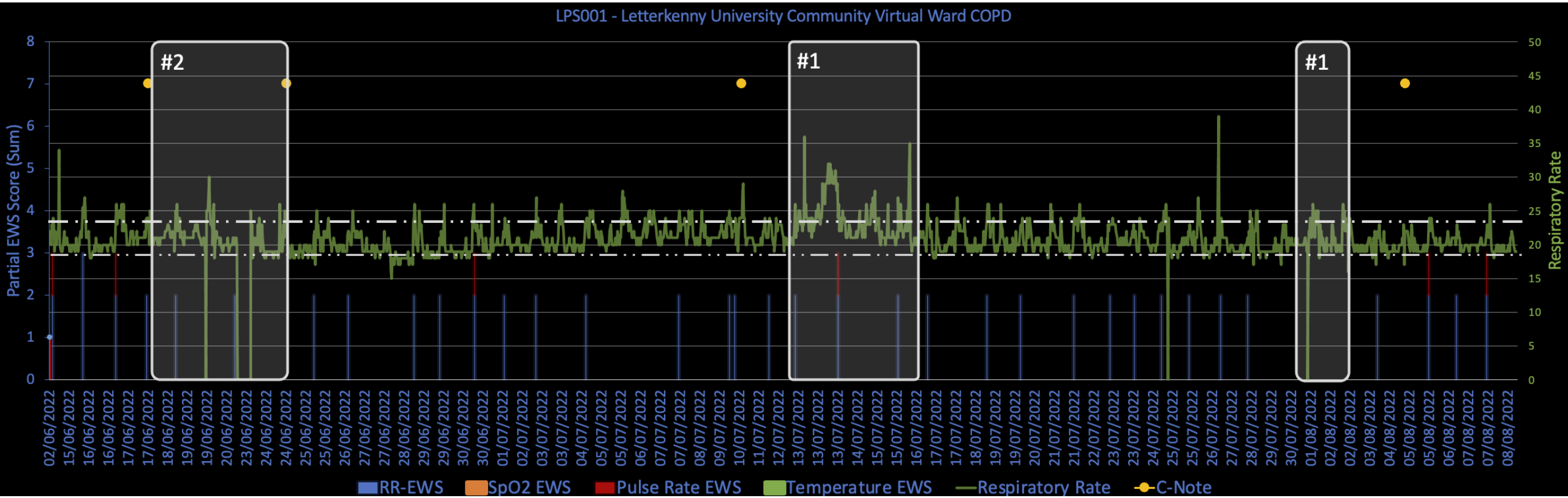


Cost Saving Improvement



Case Study – Patient LPS001

Example 2: Variation in Lower RR range and trending increase in RR range: coupled with disturbed nocturnal cRR



Notes:

- 4 exacerbations supported in the community
- Average Daily SpO2 = 96% +/-1%
- Average daily/nightly cRR = 21 bpm +/- 3

Events:

#1 Increased nocturnal cRR 12-hour pre intervention.
#2 Elevated RR range +10bpm but prior intervention supported recovery

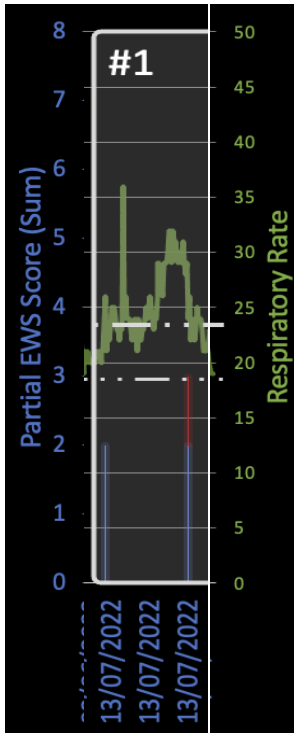
Case Study – Patient LPS001

#1 Patient is flagged with abnormal cRR

#2 cRR trendline is review for last 24 hours

#3 Clinical decision to Phone, Visit, or admit can be made

Example 2: Variation in Lower RR range and trending increase in RR range: coupled with disturbed nocturnal cRR

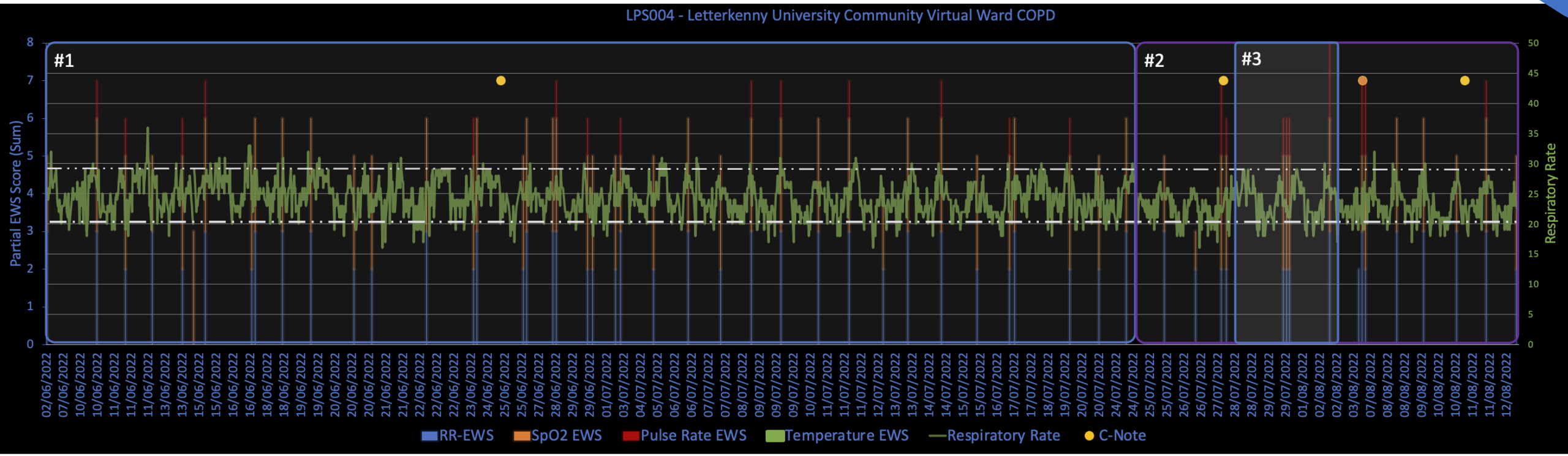


Events:

#1 Increased nocturnal cRR 12-hour pre intervention.

Case Study – Patient LPS004

Example 2: Variance in comparing daytime cRR to night-time cRR

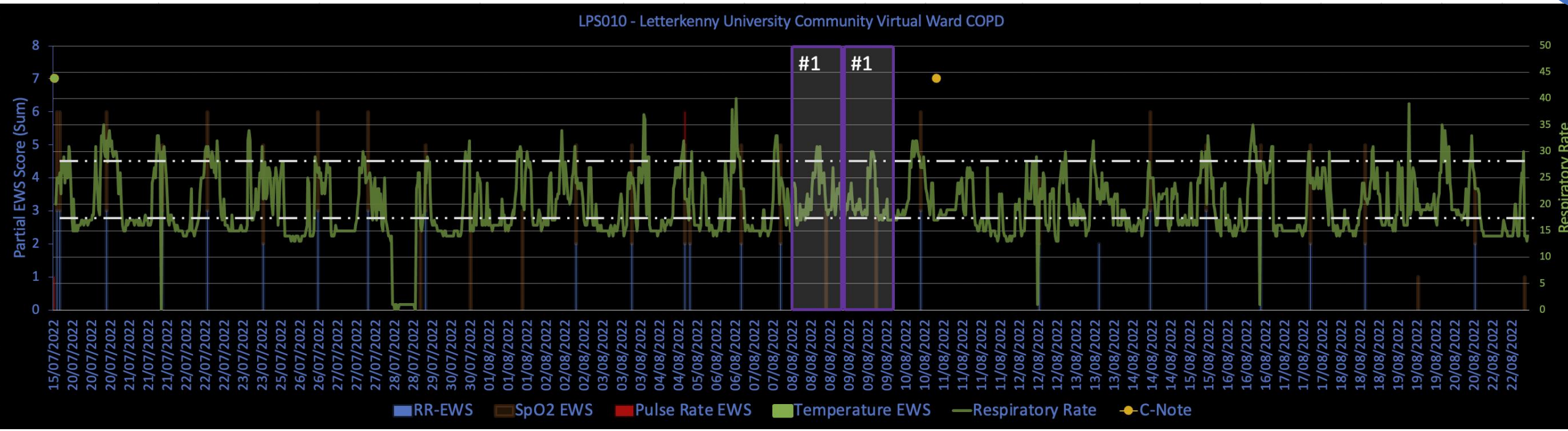


Notes:
- 4 exacerbations supported in the community
- Average Daily SpO2 = 88% +/-5%
- Average daily/nightly cRR = 25 bpm +/- 3
- Consistently High 5+ iNEWS scores

Events:
#1 Increased nocturnal cRR 12-hour pre intervention.
#2 Elevated and disturbed nocturnal cRR coupled with spikes in pulse rate at morning check-in's

Case Study – Patient LPS010

Example 2: Variation in Lower RR range coupled with disturbed nocturnal cRR



Notes:
- 2 exacerbations supported in the community
- Average Daily SpO2 = 87% +/-9%
- Average daily/nightly cRR = 18 bpm +/- 6
- Consistently High 4-6 iNEWS scores

Events:
#1 Increased lower cRR range with disturbed night-time cRR 48 and 24 hrs pre intervention

RespiraSense – Technology that looks after the Patient…

- Using 5G So no interim pairing with an ‘App’ is required for data sharing
- Healthcare professionals will always have objective data at all times: not just when the patient engages with the App
- The App will help educate and share qualitative information with the healthcare professional to help inform clinical decision making
- 14 day+ battery life ensures the technology looks after the patient…. And not the patient looking after the technology

A hypothesis of how automated alarms from cRR can help improve workflow efficiencies and patient outcomes

Observation #1 – Due to the nature of respiratory disease, abnormal SpO2 readings are normalised and clinical deterioration is discreetly and instantaneously represented if measuring this value alone i.e. significantly abnormal SpO2 happen when an intervention is immediately required.

Observation #2 – Assessing changes in EWS based on RR with SpO2 together gives a better transition image of decline both pre and post event i.e. a model to better triage a group of patients in advance of pending events and evaluation of recovery.

Observation #3 – Normal ranges of RR and SpO2 are personalised based on the stage of the patient's disease. Knowing this enables the personalised assessment of changes with respect to a patient's own 'Norm'.

Observation #4 – Changes in the Upper and Lower RR range indicate decline or recovery

Observation #5 – If the mean RR during the night is not lower than daytime RR OR the RR trend increases during the night, it is a sign of instability.

Recap

Design Thinking and Partnership-based

Is a framework that can be used to solve problems. Its structured approach provides a methodology for developing solutions that meets the needs of those we are designing for. Inherent to the function and purpose of overall design thinking is to create a better tomorrow

Challenge Question

How can we empower people with advanced COPD to become a a partner in the management of their health care and and ensure they the “right care ant the right time” as close to home as possible?

Outcome

Continuous monitoring of respiratory rate in patients at home completes the assessment of the patients condition and enables earlier appropriate intervention in the community setting.

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The NHS Virtual Wards Conference South 2023

SPEAKING NOW

Laura Harper

Directorate Manager Adult Community & Primary Care Services (Operational Lead for Virtual Wards)
The Royal Wolverhampton NHS Trust

Emily Jarvis

Senior Sister
The Royal Wolverhampton NHS Trust

We will discuss…

"Virtual Ward and Hospital @ Home"

The Royal Wolverhampton NHS Trust

Virtual Ward & Hospital @ Home

Laura Harper
Directorate Manager Adult Community & Primary Care Services (Operational Lead – Virtual Wards)

Emily Jarvis
Senior Sister in Charge – Adult Virtual Wards & Hospital @ Home Team

Safe & Effective | Kind & Caring | Exceeding Expectation

Virtual Ward Hospital at Home

Paediatric Virtual Ward

Model

The Royal Wolverhampton NHS Trust

Virtual Ward Hospital at Home

Paediatric Virtual Ward

Service Model

- Nurse led service seven days a week from 08:00 – 22:00
- Consultant oversight /medical governance – weekly MDTs
- 25 - 30 patients: 1 RN
- Prescribing Pharmacist and Pharmacy ATO role in acute to expedite discharges
- Monitoring frequency according to clinical need
- Condition specific pathways
- Knowing patients' 'normal'

Onboarding Process

- Referral or proactive onboarding (depending on pathway)
- F2F to supply kit / education
- Virtual monitoring and F2F if required

Clinicians and Nursing

Digital Platforms

System Working

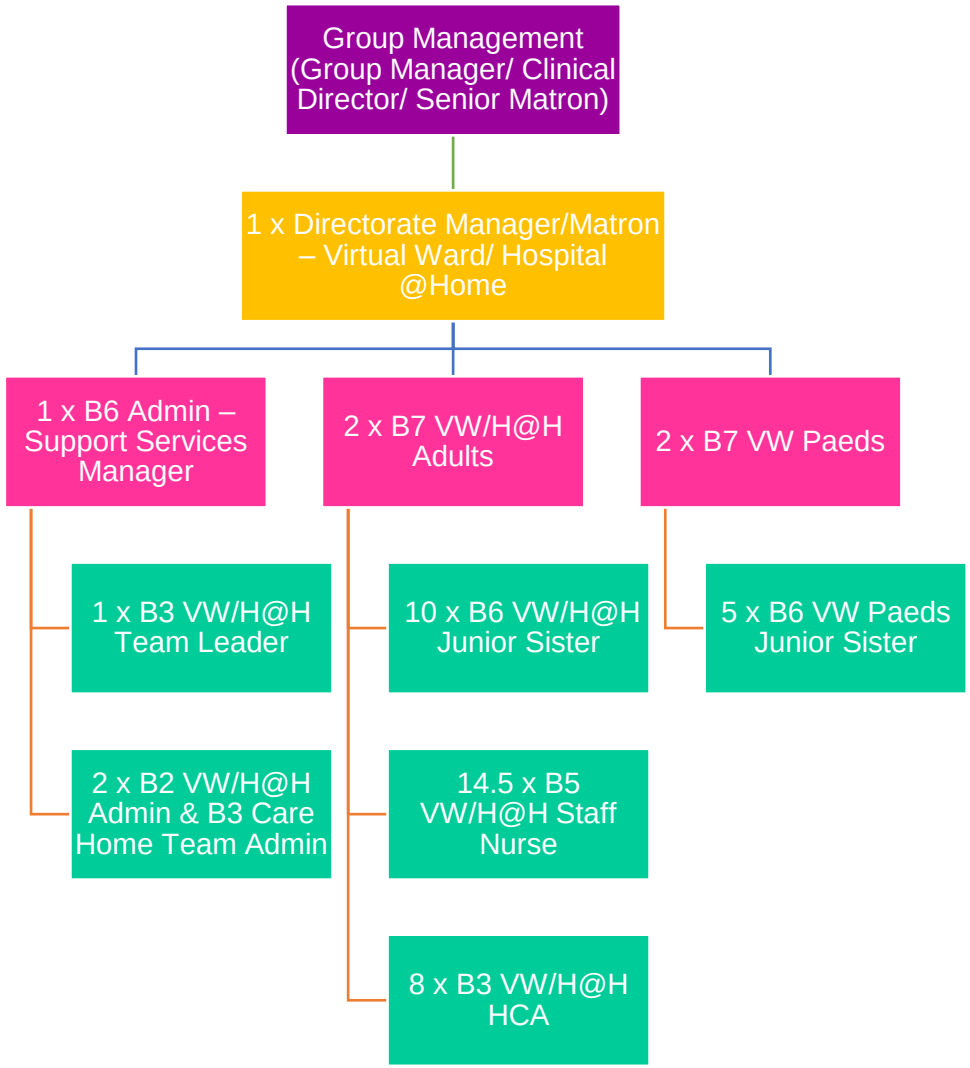
Collaborative Working

MDT/ Consultant Led

Escalation Pathways 24/7

Workforce

The Royal Wolverhampton NHS Trust



Requirements

- Integrated H@H/ VW model
- Integrated adult/ paeds team – economies of scale
- Staff possess the appropriate skillset and competence
- Hybrid clinical/ remote roles
- Cohesive working across sectors
- Offer dual roles for staff to sit across teams in acute and community

Pathways

Virtual Ward Hospital at Home

Paediatric Virtual Ward

Virtual Ward Pathways	WHO	WHEN	HOW
COVID / COPD	Higher acuity / complexity patients	Emergency hospital patients and early intervention	Virtual Delivery of Care Remote Monitoring Hospital @ Home Integrated Services Collaborative / Supervised Treatment MDT Approach
Asthma	Higher acuity / complexity patients	Proactive monitoring to prevent or reduce episodes of illness	
Supportive / Palliative Care	Gold Standards Framework – Green Patients	Monitoring for hospital avoidance, early discharge & detect deterioration	
Paediatrics	Home leave patients, on IV Antibiotics, or medically fit awaiting scan/diagnostics	Supervised remote monitoring and/or treatments	
Remote Monitoring in Care Homes	All patients in Care Homes across Wolverhampton	Early detection of deterioration, support and virtual ward rounds	
O2 Weaning	Higher acuity / complexity patients and/or with comorbidities	To safely monitor O2 management and levelling off O2	
Diagnostics / Awaiting Discharge to Scan	Patients fit for discharge awaiting diagnostics/scan	Monitor patients at home while they await a scan to avoid occupying a bed	
ARI / Pneumonia	CURB65 Score 2 or lower	Managing low / mild symptoms out of hospital	
Frailty	Frailty SDEC, Step Down Beds, ED Reattendances	Proactive CGA, management of care to prevent or reduce episodes of illness	

OUTCOME

- Early Supported Discharge
- Safe Admission Avoidance
- Patient Centric Care at Home
- Improved Patient Experience / Journey
- Ensuring Patients Receive the Right Care at the Right Time by the Right Service
- Early Detection of Deterioration

NHS ampton NHS Trust

Data so far…

The Royal Wolverhampton NHS Trust

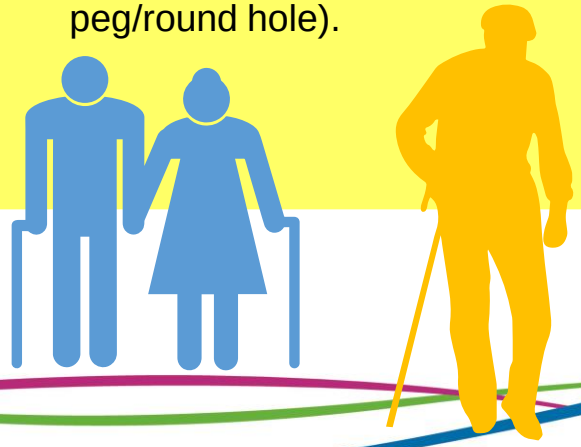
- Total number of referrals received to in the last 12 month is 2582.
- 27% of the total number of patients have had to be escalated back to acute whilst on caseload.
- 73% of the total number of patients had not been re-admitted to hospital whilst on the caseload therefore enabling hospital avoidance.
- Virtual Ward team have enabled early facilitated discharge in the following referring specialties – top seven:
  - Paediatrics (41%)
  - A&E (23%)
  - Respiratory Medicine (11%)
  - General Medicine (8%)
  - Diabetic Medicine (4%)
  - Renal (3%)
  - Older Adults (3%)
- Referrals have significantly increased month on month, as from Jan 21 was around 50 in month, to December 22 with a 174 in month
- Currently around 75% utilisation against SDF funding

Virtual Ward Hospital at Home

Paediatric Virtual Ward

Barriers

- × Some cohorts of patients have been found to be digitally unaware or not trust the app / platform – communication & language.
- × Digital exclusion for patients due to personal circumstances.
- × Restrictions down to the technology on certain providers, there is the need for a proxy (family / carer) to submit readings into the app – the proxy may not always be available.
- × Clinical engagement – being able to engage the acute clinical teams to enable seamless pathways.
- × Data reporting – the ask on data reporting and conforming to an acute way of reporting (square peg/round hole).



The Royal Wolverhampton NHS Trust

Mitigations

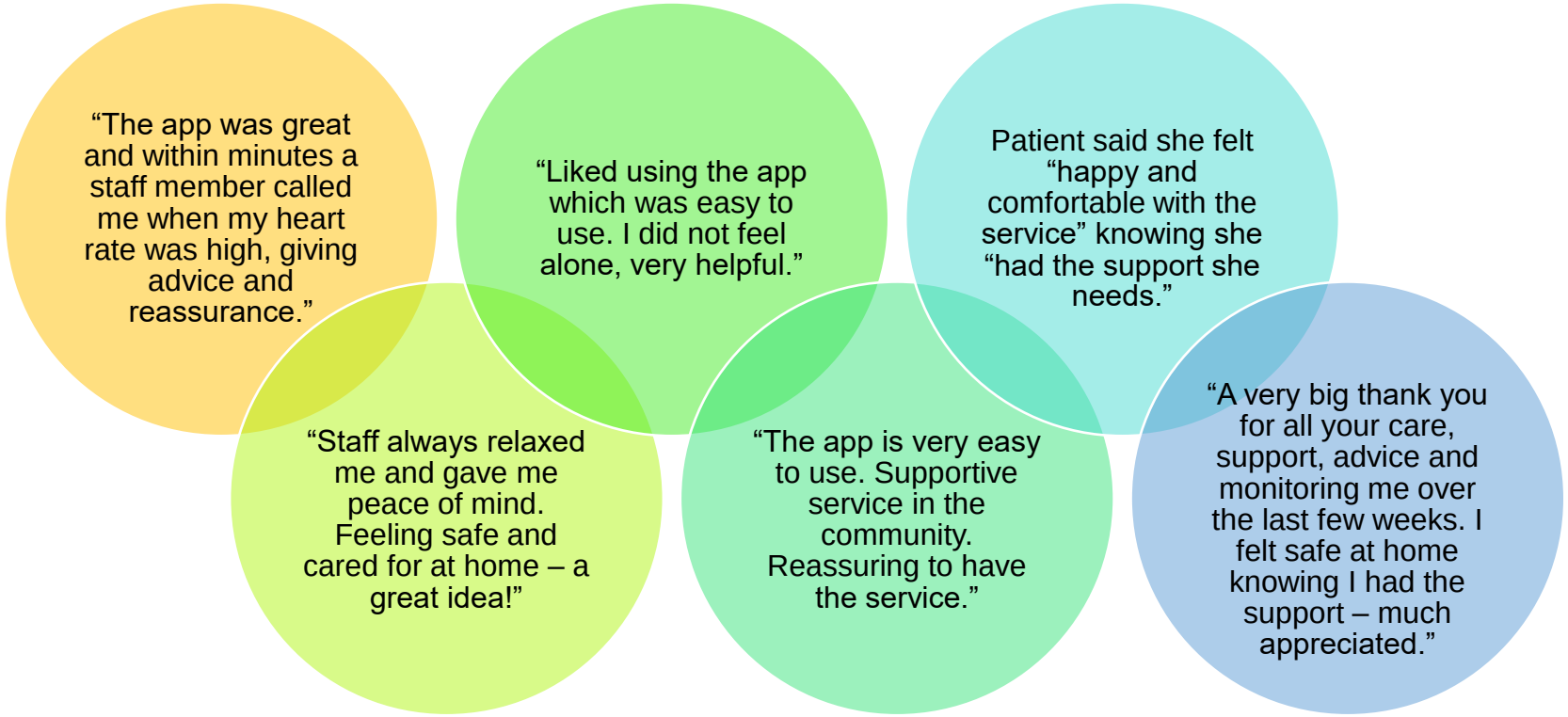
- ✓ Working on a communication plan for internal and external comms, using familiar language with patients.
- ✓ Having access to additional equipment via voluntary organisation to help minimize exclusion/ use of volunteers.
- ✓ Scoping options of third-party providers and costs associated.
- ✓ Pitching to the right audience, working with departments who want to work with us to start.
- ✓ Working with informatics to ensure reporting fits the need of the service and liaising with commissioners.

Virtual Ward Hospital at Home

Paediatric Virtual Ward

Patient feedback

The Royal Wolverhampton NHS Trust



Remote monitoring success

The Royal Wolverhampton NHS Trust

Successes

- Remote monitoring has proven to reach more people proactively whilst **supporting continuity of care** in an alternative way.
- If observations are submitted regularly, the data provides an **individualised snapshot of the patient's health** over a course of time, any peaks or abnormalities triggers / alerts staff to make contact with the patient. This has enabled for **early detection of deterioration**.
- Patients have felt reassured to have **direct access to the same team** / contact via remote monitoring as opposed to going through a secretary or Switchboard.
- Remote monitoring has **improved the patient journey** as travel time, waiting time and clinic time is reduced dramatically.
- Feedback has shown patients feel empowered by **taking control** of their healthcare monitoring.

Some of the team…

NHS
The Royal Wolverhampton
NHS Trust

Virtual Ward
Hospital at Home

Paediatric
Virtual Ward

Slido

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Thursday 2nd March 2023 - 10:50am – 15:00pm – Hatfields Conference Centre, London

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The NHS Virtual Wards Conference South 2023

Q&A PANEL

Karen Pudge

Senior Programme Manager Blended Learning
Health Education England

Dr Debashish Das

CEO
Ortus Solutions Limited

Laura Harper

Directorate Manager Adult Community & Primary Care Services (Operational Lead for Virtual Wards) - The Royal Wolverhampton NHS Trust

Emily Jarvis

Senior Sister
The Royal Wolverhampton NHS Trust

Myles Murray

Founder
PMD Solutions

The NHS Virtual Wards Conference South 2023

CONVENZIS

NETWORKING

The NHS Virtual Wards Conference South 2023

Event Chair – Chair Afternoon Address

James Davis

Founder, CEO

Inicio Health

The NHS Virtual Wards Conference South 2023

SPEAKING NOW

Dr Baribefe Olufemi

Doctor
East Suffolk North Essex Foundation Trust (ESNEFT) - Ipswich Hospital

Hannah Chapman

Ward Manager & Lead Nurse for Virtual Wards
East Suffolk North Essex Foundation Trust (ESNEFT) - Ipswich Hospital

We will discuss…

"Virtual Wards for General Surgery"

ESNEFT - Virtual Wards for General Surgery

Dr Baribefe O. Vite, Virtual ward doctor

Hannah Chapman, Lead nurse and Ward manager for Virtual Wards

NHS
East Suffolk and North Essex
NHS Foundation Trust

Introduction

- **Drivers for use of virtual ward:**
  - Emergency demand up
  - Ambulance delays – 8 hours plus, sometimes over 12 hours
  - Bed waits 18/20 hours

- **Opportunities that virtual ward provides:**
  - Manage lower risk patients with 24/7 monitoring in the usual place of residence
  - Improve emergency flow for patients
  - Improve patient experience
  - Patients are treated as inpatients – daily review to update plans
  - Access to monitoring team for advice and support
  - Return back to hospital bed if necessary

Aim

Provide acute clinical care at home for a short duration (up to 14 days) as an alternative to care in hospital

Goals:

- Proactively identify signs of health deterioration
- Enhance patient experience and patient choice
- Enable early discharge
- Avoid admissions
- ESNEFT has partnered with:
  - Huma, a 'hospital at home' technology provider,
  - Bionical, a provider of virtual nursing teams,
  to deliver virtual wards across the Trust.

1 Doctor agrees patient can go on Virtual Ward

2 Patient given equipment to monitor vital signs if required

3 Patient monitoring app downloaded onto their mobile

4 Patient goes home and starts inputting their vital signs

5 Patient's vital signs monitored at a central location 24/7

1. Doctor agrees patient can go onto virtual ward

Eligible if:
- Assessed by senior clinician as appropriate for virtual ward care
- Able to consent to remote monitoring
- Have access to a smartphone (can be via a family member or carer)
- Able to understand follow up requirements and ability to escalate concerns as agreed

Which patients are suitable?
- Acute patients awaiting diagnostics
- Early supportive discharge
- Post op – elective

- Huma app is downloaded onto the patient's phone

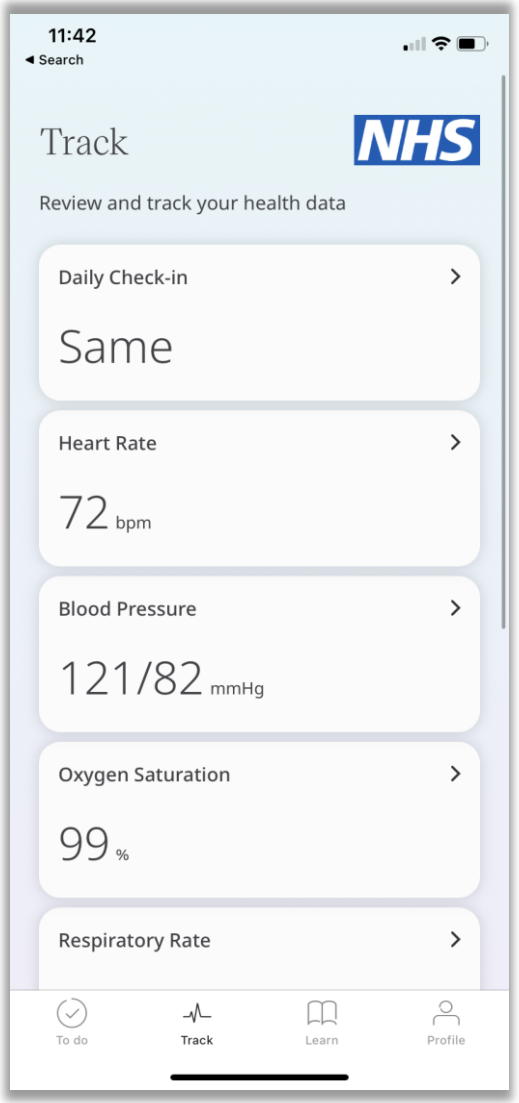
- Equipment and training are provided:
  - BP monitor
  - Thermometer
  - Pulse oximeter

- Contact numbers and escalation advice provided
- Handover is made to the Bionical nurses who will be monitoring the patient

2. Patient given equipment to monitor

3. Patient monitoring app downloaded onto their mobile

- Huma app allows us to monitor:
  - Blood pressure
  - Heart rate
  - Respiratory rate
  - Temperature
  - Symptoms



4. Patient goes home and starts inputting their vital signs

Benefits to the patient:

- Being in a **familiar** environment – patients recovering in their own home with **familiar** surroundings and home comforts
- No general ward noise from machinery/day to day tasks and other patients will enable **recovery and rest** for the patient on the Virtual Ward
- Patients able to have **easy communication** with Virtual Ward team with regular contact for the patient's **reassurance**
- **24/7 monitoring** of patient parameters – observations being monitored centrally by dedicated team, focusing on monitoring the patient, communication and raising concerns

5. Patient vital signs monitored at a central location

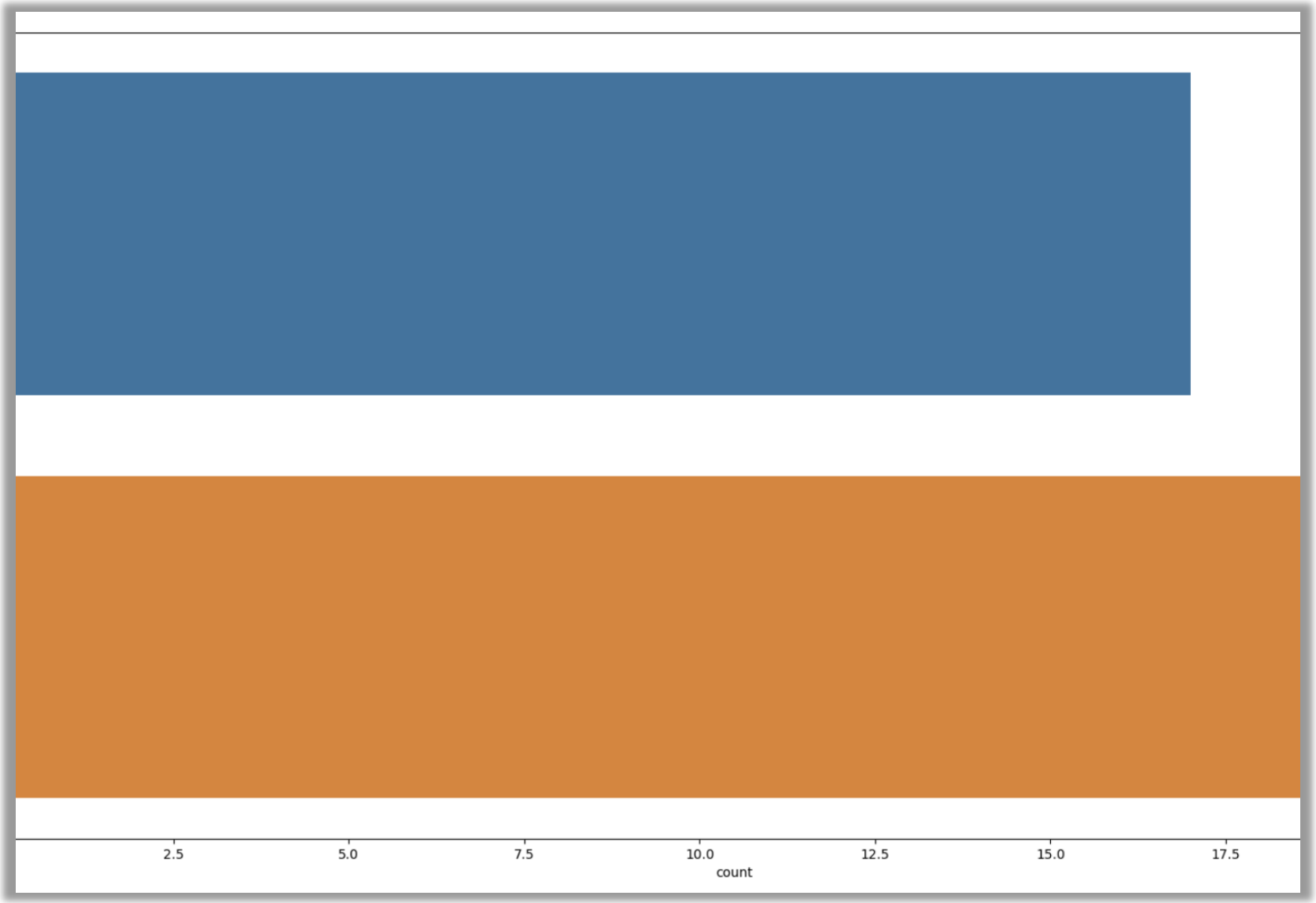
- Daily review by nurses and doctors

- Review enables us to:
  - Review investigations and liaise with the surgical team re further management
  - Symptom management
  - Reassurance and advice

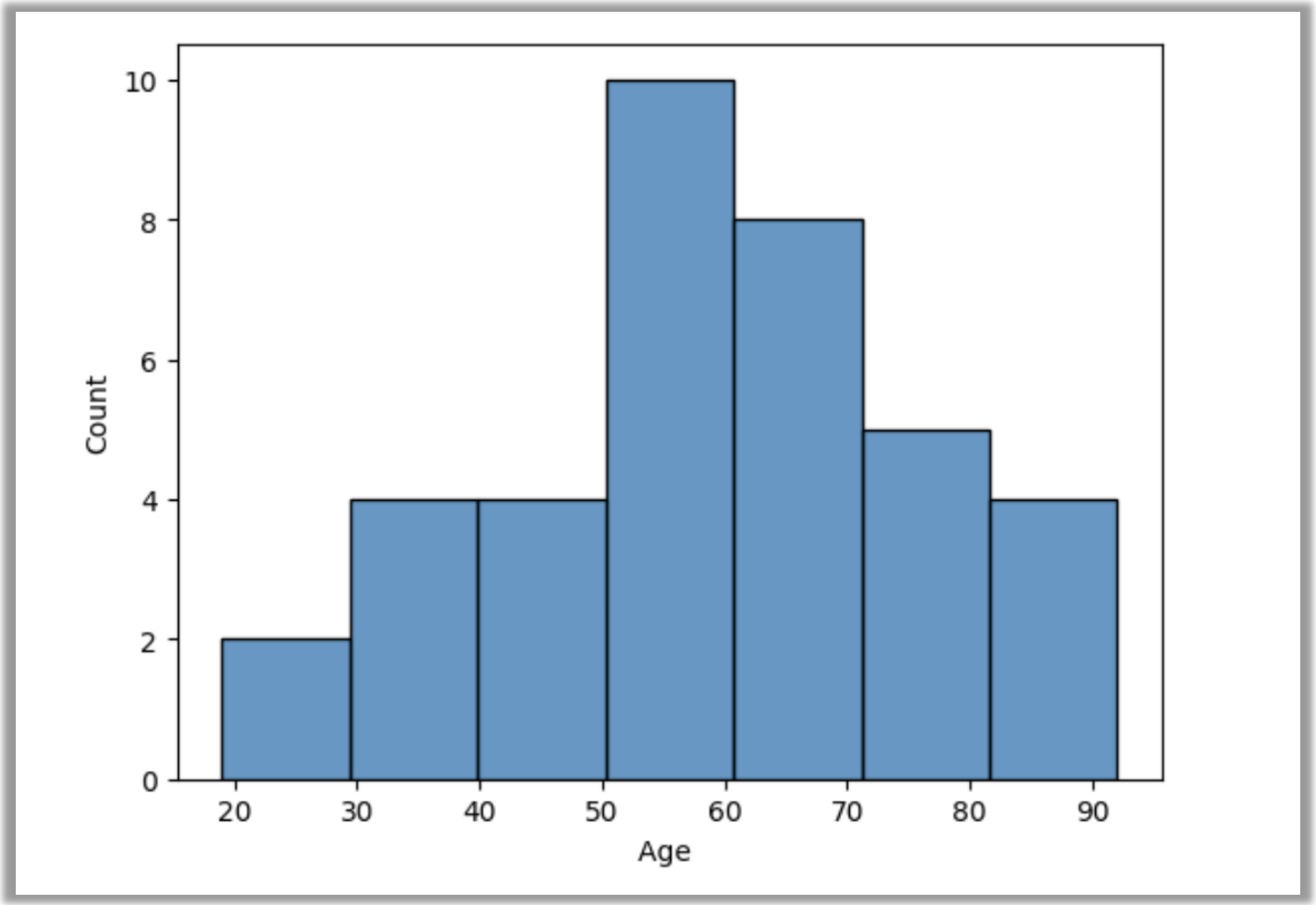
How has it gone?

Sex distribution

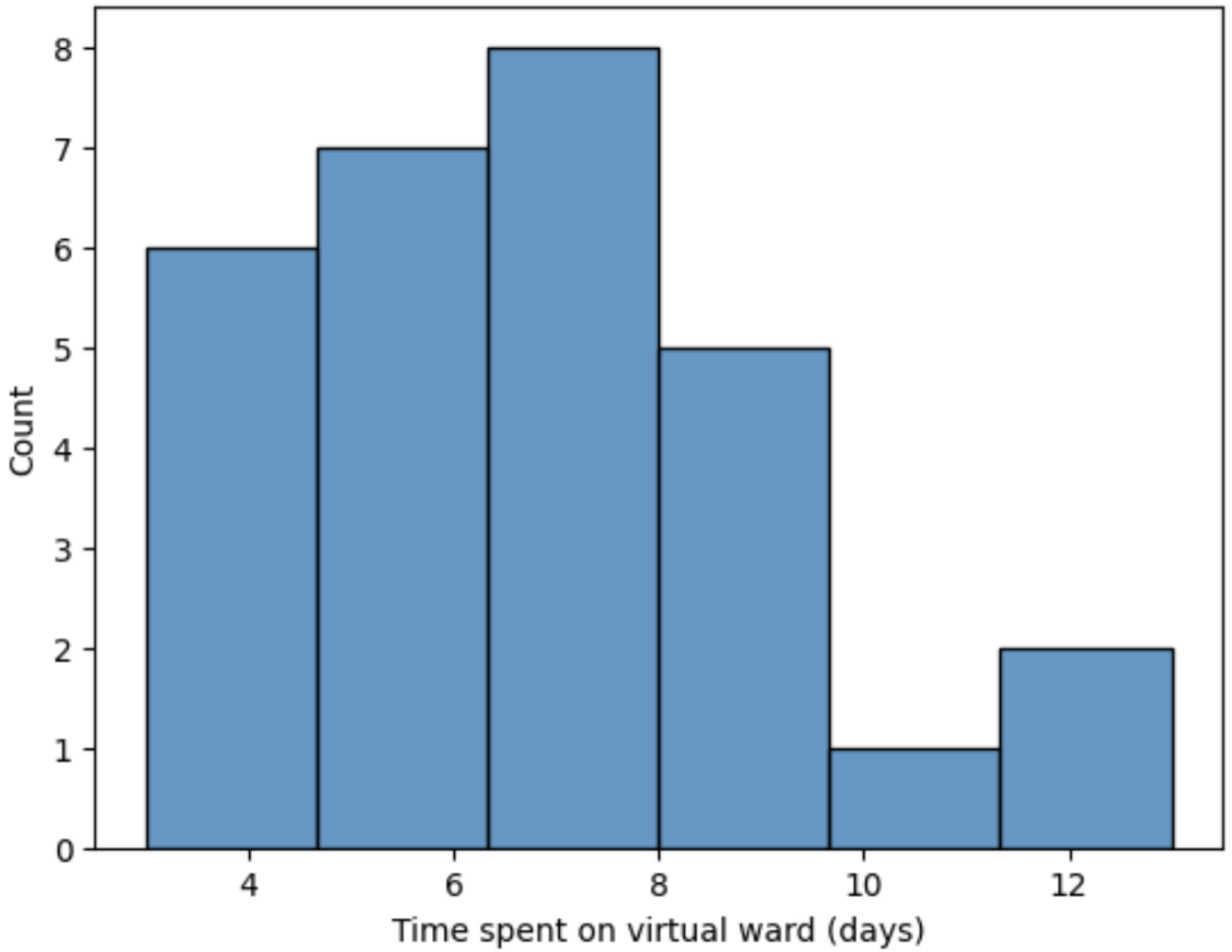
37 patients
- 17 males
- 20 females



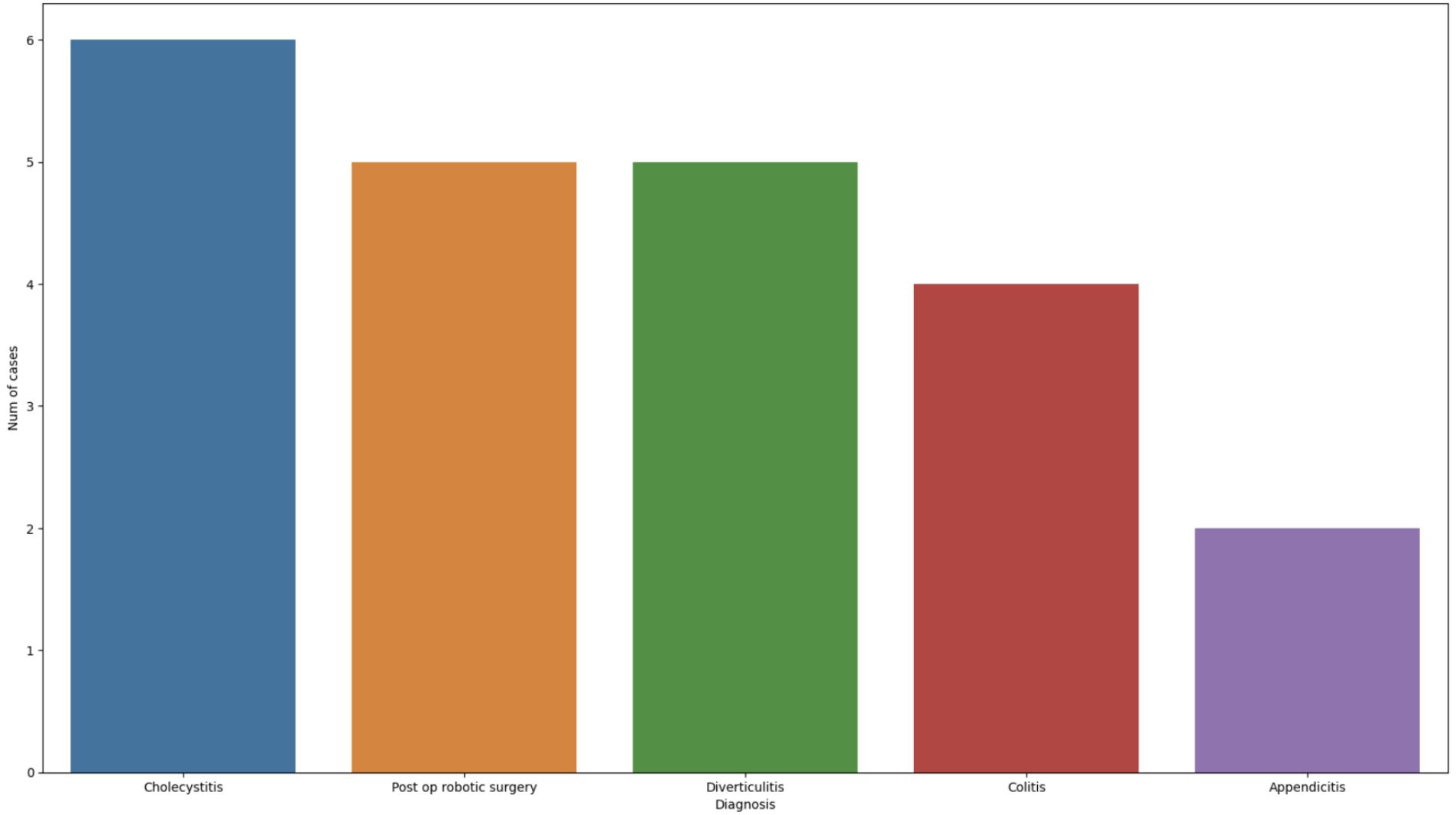
Age distribution



Time spent on virtual ward



Most frequent diagnoses on virtual ward



Patient feedback Jan/Feb 2023:

Early feedback shows that 80% of patients said the Huma App is 'easy to use' and helped them to 'better understand and care for their health':

"The care and attention to allow me to recover at home with this service was amazing. The messages after reporting daily obs gave assurance and confidence if my health deteriorated 24/7 and a Daily Doctor call allowed any questions worry and advice to be discussed"

"Good communication. All the kit worked well. Felt looked after. Regular contact with a doctor."

"The care and support from the Virtual ward was excellent and quite comforting to know somebody was checking on you."

Patient feedback

Service

Virtual Ward

Star Rating

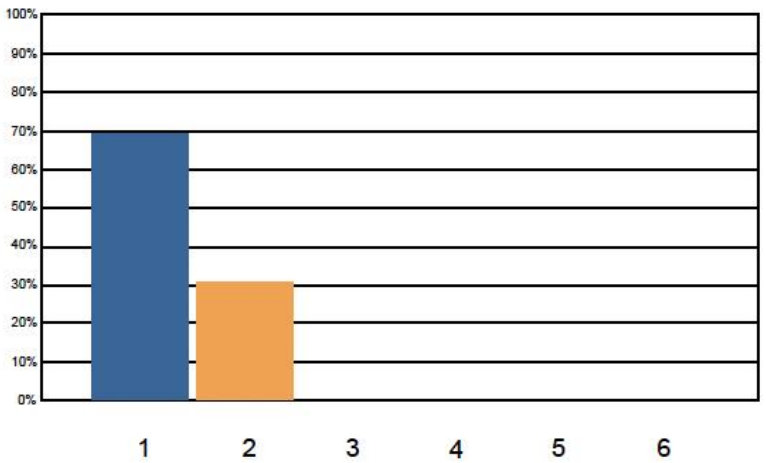
Positive

100.00%

Negative

0.00%

Overall Scores



Response Option	Responses	Percentage
1 - Very good	9	69.23%
2 - Good	4	30.77%
3 - Neither good nor poor	0	0.00%
4 - Poor	0	0.00%
5 - Very poor	0	0.00%
6 - Don't know	0	0.00%

Patient feedback

(Q1) The politeness and professionalism of your Nurse.	(Q2) The presentation of your Nurse (this means how they spoke to the patient/care over the phone).	(Q3) The privacy and dignity maintained by your Nurse (this means how they treated the patient/care with dignity over the phone).	(Q4) The clarity of explanation of the service which you have received from your Nurse	(Q5) How you felt 'listened to' by your Nurse.	(Q6) Your confidence in the skills of the Nurse	(Q7) Your overall experience of your Nurse.	(Q8) How easy it is to use the Huma app	(Q9) Your experience of the Huma app helping you to better understand and care for your health
4.7 / 5	4.7 / 5	4.7 / 5	4.5 / 5	4.8 / 5	4.8 / 5	4.6 / 5	4.3 / 5	4.3 / 5

On a scale of 1 to 5, where 1 is poor and 5 is excellent

Case 1

- 65-Year-old man
- *PMHx: Asthma, Myelofibrosis, Gout, Gallstones, Anaemia*
- History:
- Presented to hospital with RUQ pain + vomiting
- USS showed acute cholecystitis and gallstones with CBD dilatation
- Underwent a laparoscopic cholecystectomy + intraoperative cholangiogram on 22/12/2022
- He had a drain inserted from the surgery and also developed an AKI.
- Virtual ward intervention:
- Discharged to virtual ward and we were able to monitor his drain and urinary output. He returned to SAU after several days to have his bloods rechecked and his AKI had resolved, and the drain was removed.
- 3 days on virtual ward

Case 2

19 year old woman

PMHx: PCOS

History:
Admitted with sudden onset Right abdominal pain
Underwent an appendectomy

Virtual ward intervention:
Discharged day 1 post-surgery. Monitored observations. She was also noted to have some inflamed tonsils and so swabs were taken and started on antibiotics. Due to daily review on virtual ward we were able to chase swab results, look for evidence of post op infection, assess fluid status via BP and fluid input/output.

5 days spent on virtual ward

Case 3

58 year old woman

PMHx: Fibromyalgia, IBS, Colonic polyps, Cholecystectomy

History:
Admitted with PR bleeding, diarrhoea and abdominal pain. CT showed pancolitis.

Virtual ward intervention:
Discharged to virtual ward after 2 days in hospital. Observations were monitored. During one day where her symptoms were especially severe, she required escalation to surgical registrar on call. We reviewed the observations and continued management at home. She was prescribed anti emetics on the virtual ward to provide relief for her nausea which was effective. Gradually her symptoms improved

Time spent on virtual ward 13 days

Conclusion

Challenges and next steps:

- Establishing clinician confidence – generate evidence by means of audit to show the positive effect of General surgery virtual wards
- Establish diagnostic pathways to facilitate timely investigations once patients are ‘discharged’
- Focus on early supportive discharge of elective patients

Contact information:

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Hannah Chapman
Email: Hannah.Chapman@esneft.nhs.uk

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SPEAKING NOW

Dr Gurnak Singh Dosanjh

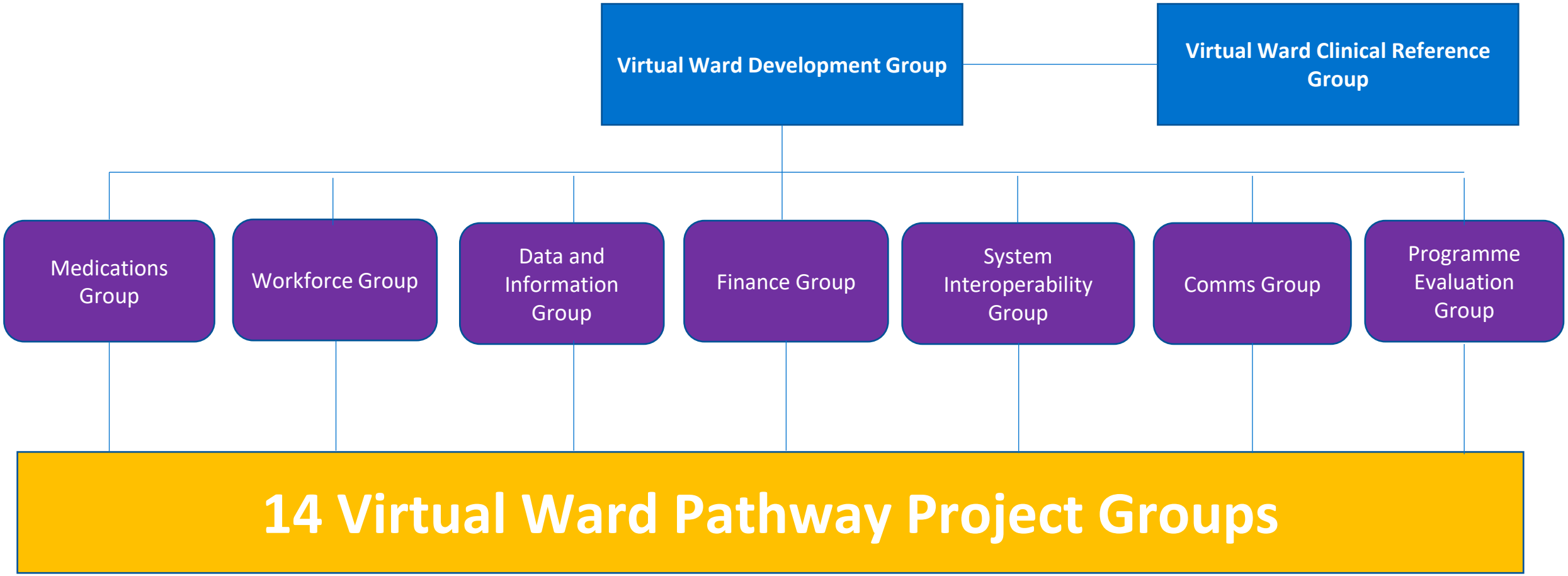
GP & ICB Clinical Lead for Home First
Leicester, Leicestershire and Rutland ICB

I will be discussing...

"Is The Patient At The Heart of Your Digital Transformation?"

Setting The Scene

Virtual Wards Programme Structure

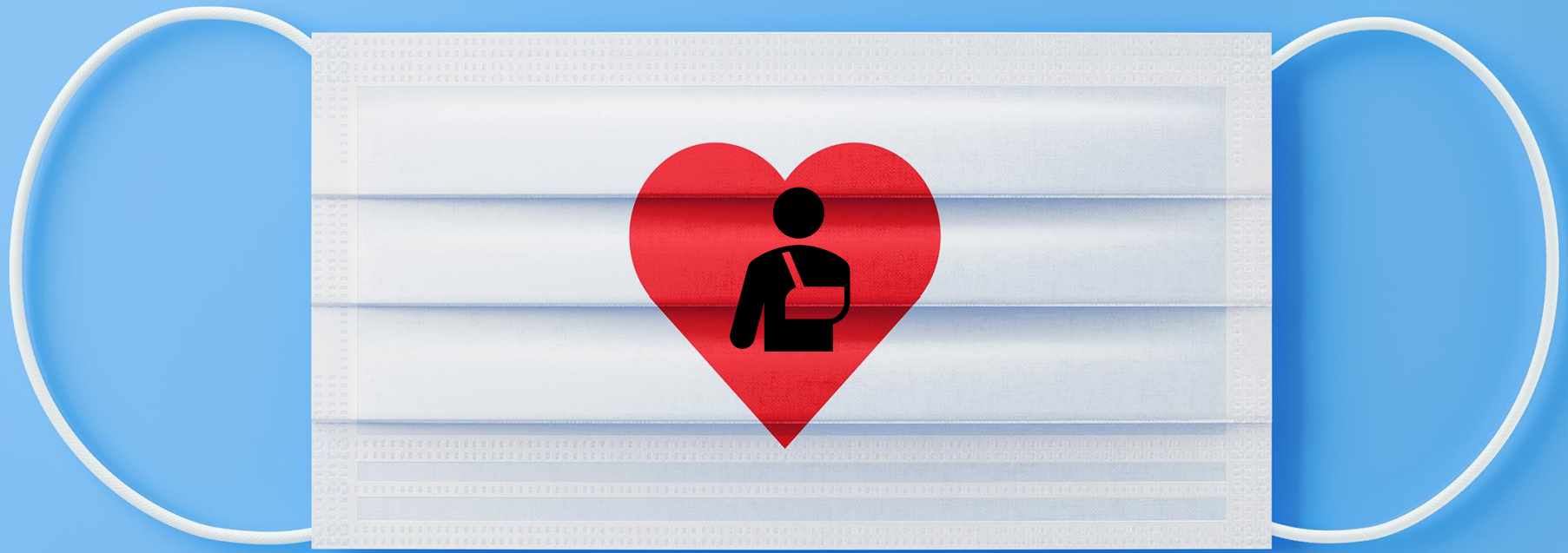


Setting The Scene

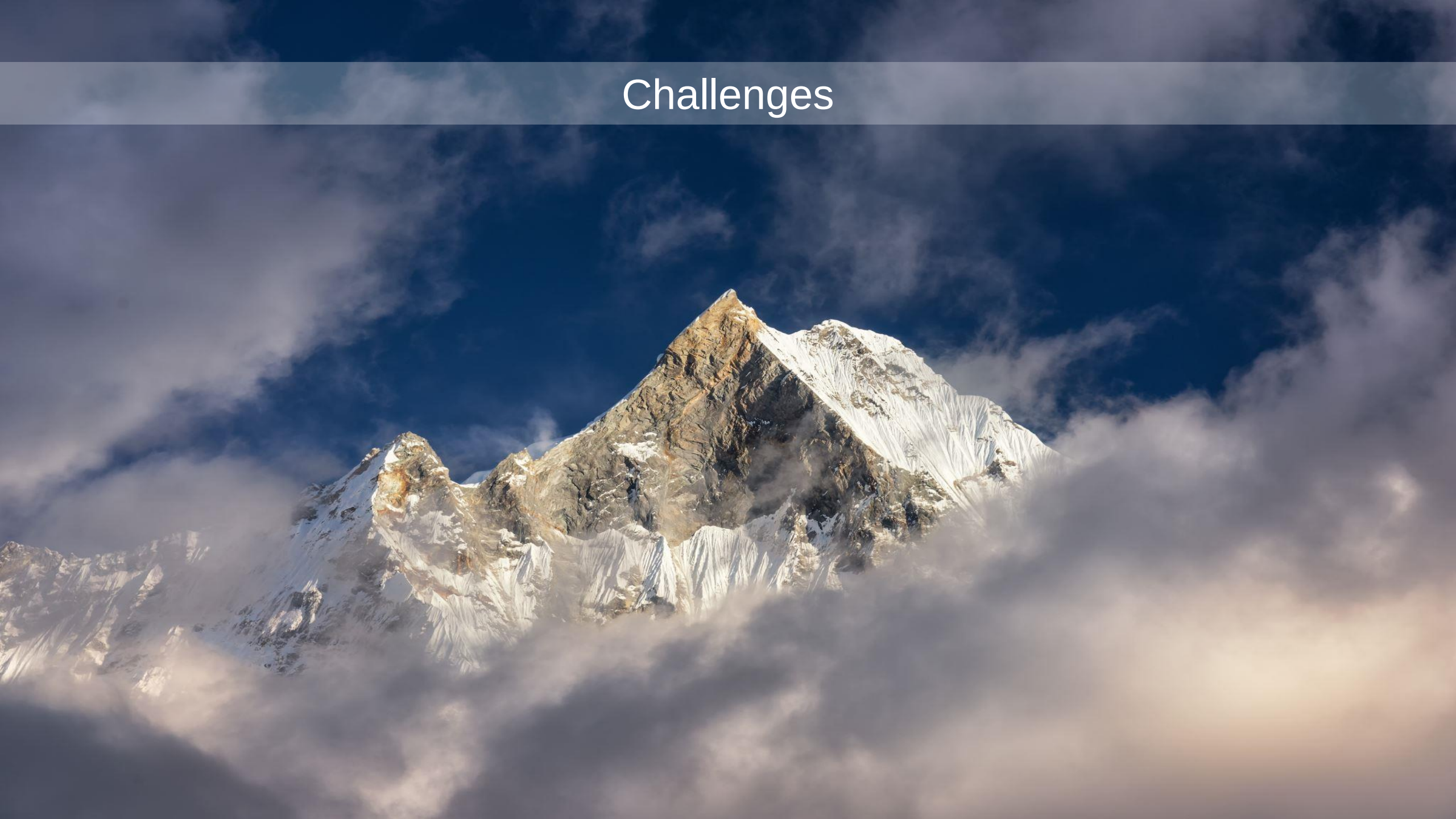
Pillars Of Transformation

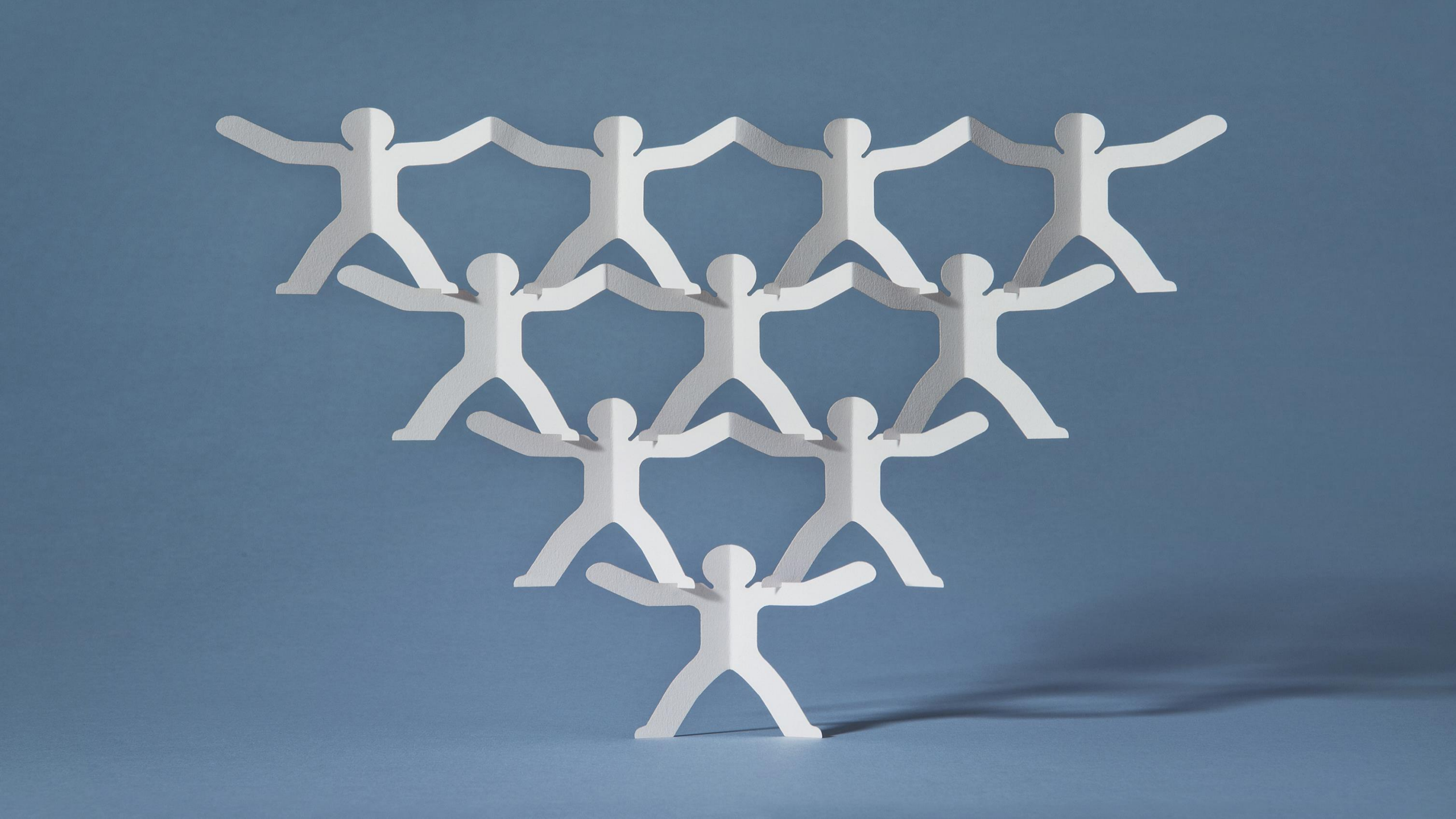
Methodology

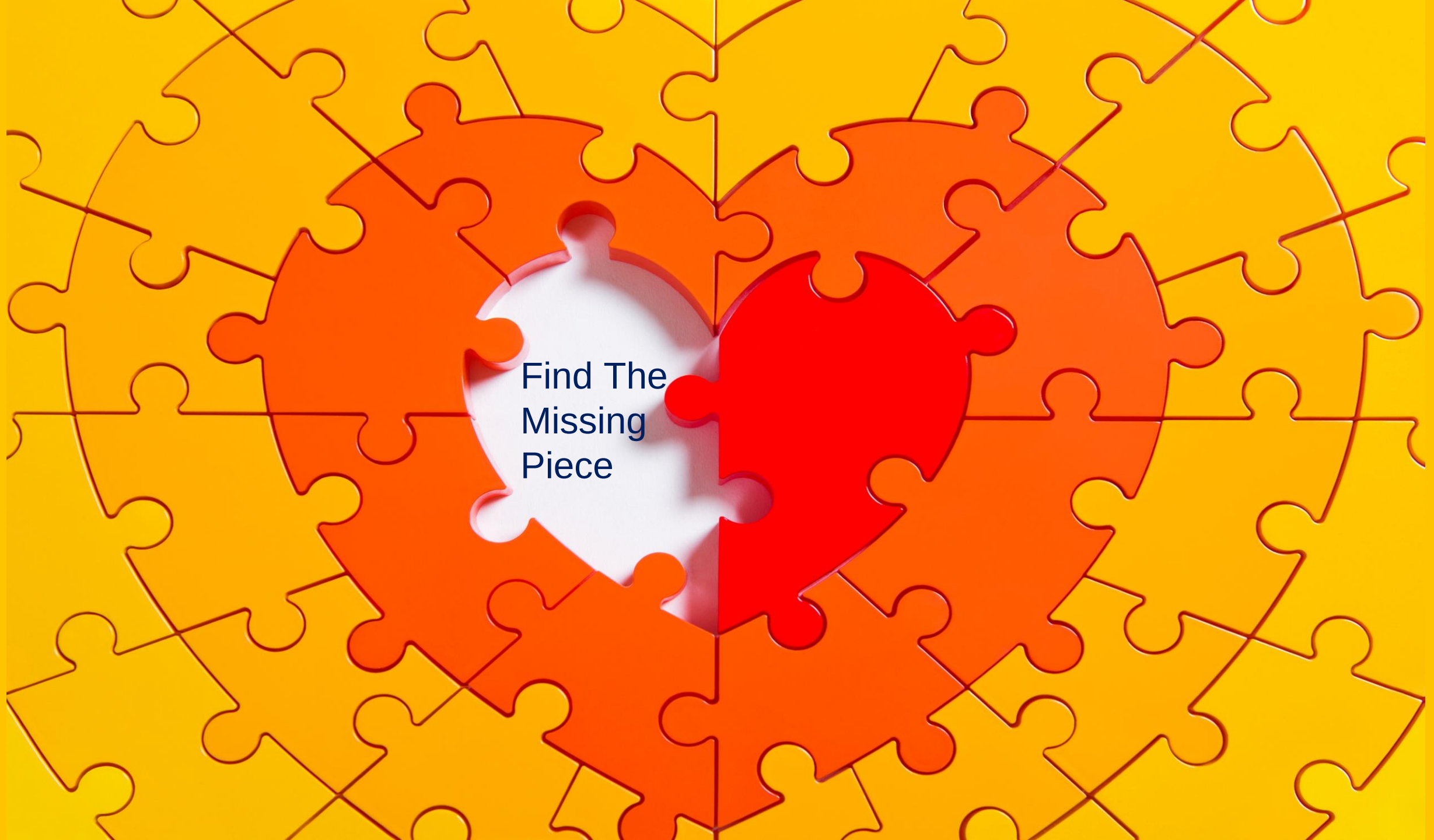
Technology



Challenges






Find The
Missing
Piece

Shared Learnings

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THANKS FOR ATTENDING

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