Welcome to the NHS Virtual Wards to Virtual Hospitals Strategy Conference

05th March 2026
The Studio, 03rd Floor, 7 Cannon St,
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Chair Opening Address

Gurnak Singh Dosanjh
Deputy CCIO | Digital Healthcare Consultant | CSO | ICB Clinical Lead
NHS Leicester, Leicestershire and Rutland

Keynote Presentation

Mr David Cruttenden-Wood

Clinical Director Of Virtual Healthcare HHFT. Acute, General & Colorectal Surgeon. NHS England Regional Clinical Advisor (UEC)
Hampshire Hospitals NHS Foundation Trust (HHFT)

WardAnywhere 2026: The NHS Virtual Wards to Virtual Hospitals Strategy Conference

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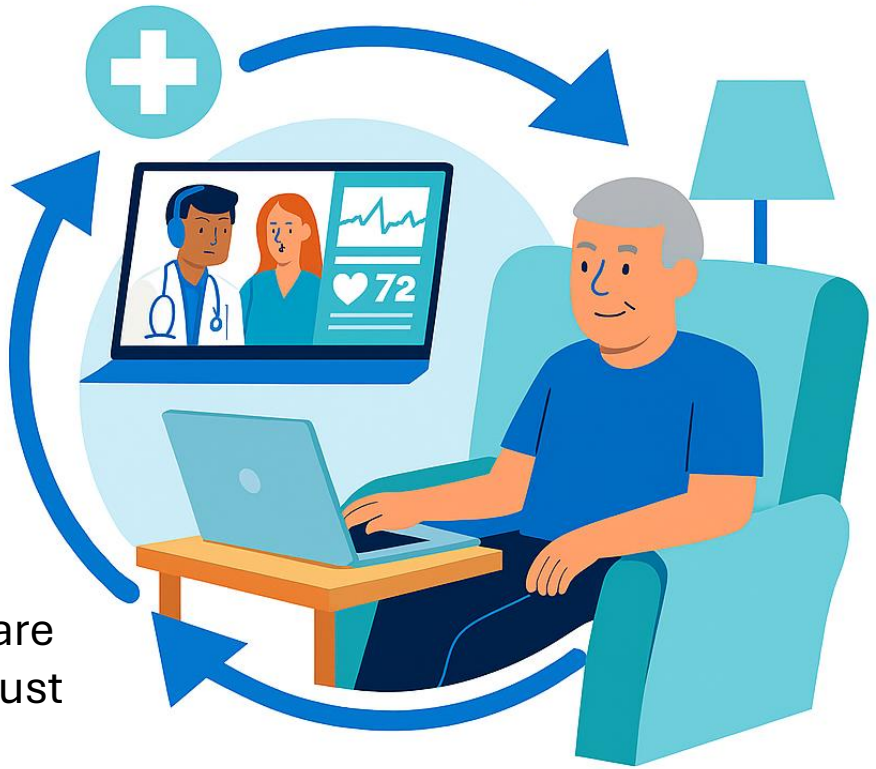
5th March 2026

Unified Wellness
Integrated virtual care for all

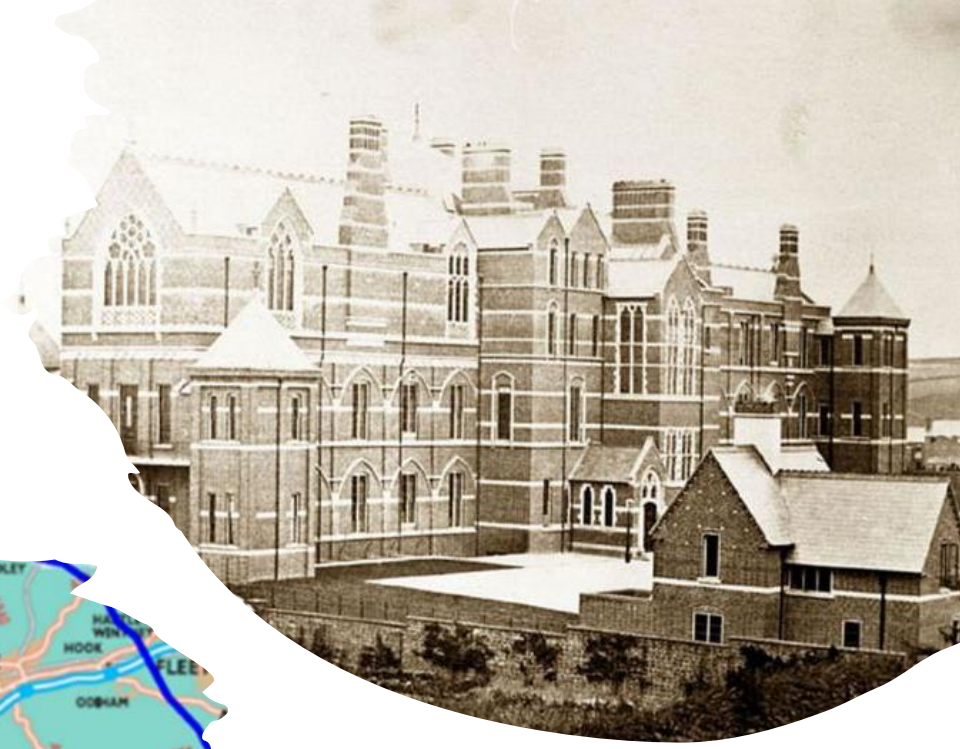
Expanding safe, seamless, resilient wrap around care for the right people, at the right time in the best place.

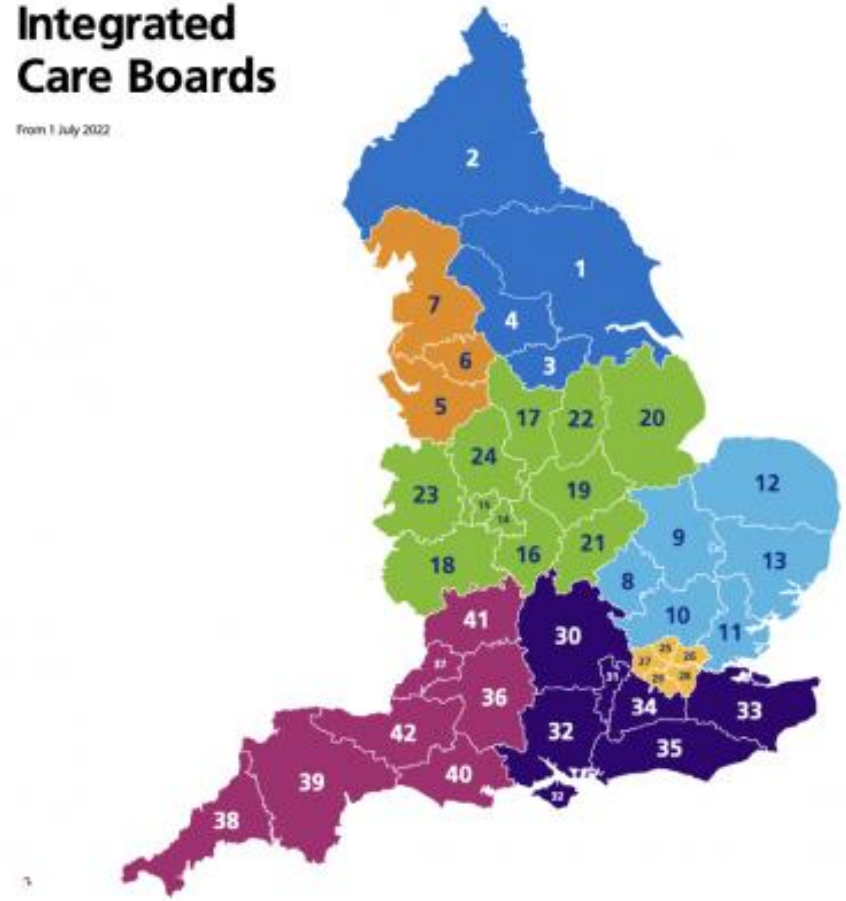


David Cruttenden-Wood
Clinical Director for Virtual Healthcare
Hampshire Hospitals Foundation Trust
5th March 2026

Vision for Health and Wellbeing – Fit for purpose

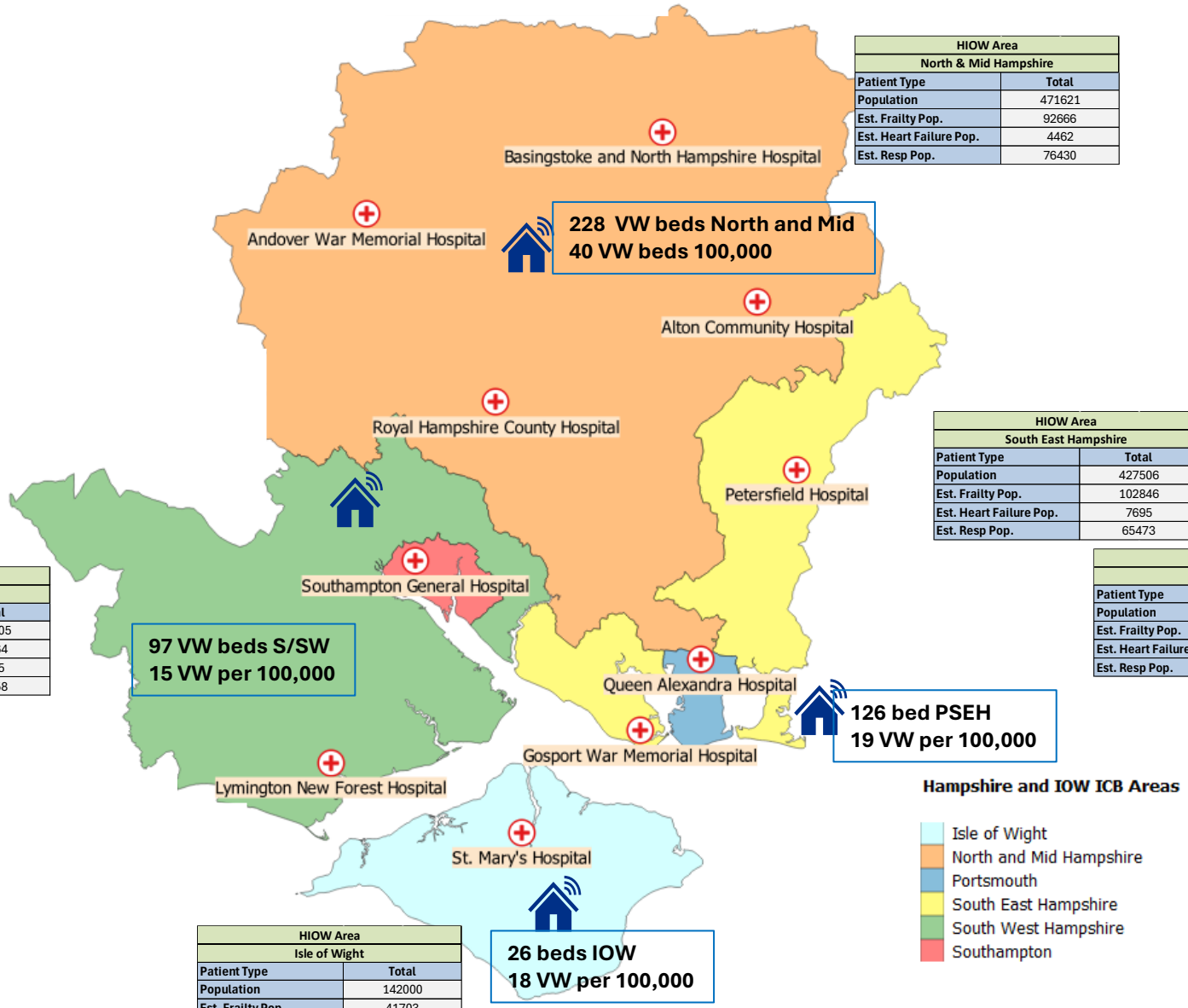
Multiple Journeys





Current landscape....

Hampshire and Isle of Wight



HIOW Area	
North & Mid Hampshire	
Patient Type	Total
Population	471621
Est. Frailty Pop.	92666
Est. Heart Failure Pop.	4462
Est. Resp Pop.	76430

HIOW Area	
Southampton	
Patient Type	Total
Population	278983
Est. Frailty Pop.	36638
Est. Heart Failure Pop.	2799
Est. Resp Pop.	32575

HIOW Area	
South West Hampshire	
Patient Type	Total
Population	293905
Est. Frailty Pop.	79764
Est. Heart Failure Pop.	5605
Est. Resp Pop.	41958

HIOW Area	
South East Hampshire	
Patient Type	Total
Population	427506
Est. Frailty Pop.	102846
Est. Heart Failure Pop.	7695
Est. Resp Pop.	65473

HIOW Area	
Portsmouth	
Patient Type	Total
Population	229269
Est. Frailty Pop.	34374
Est. Heart Failure Pop.	3011
Est. Resp Pop.	31362

HIOW Area	
Isle of Wight	
Patient Type	Total
Population	142000
Est. Frailty Pop.	41703
Est. Heart Failure Pop.	2495
Est. Resp Pop.	21789

Virtual Ward Spectrum for acute illness

How does it work across our system

Hampshire Hospitals NHS Foundation Trust · South Central Ambulance Service NHS Foundation Trust · Hampshire and Isle of Wight Healthcare NHS Foundation Trust · Hampshire and Isle of Wight · North Hampshire Urgent Care · Hampshire County Council

One team approach

Lower Acuity Illness

- Self Manage in Community
- Patient-led and managed
- Access to safety netting
- Online/supportive Info
- Clear guidance on how to action any deterioration

High Acuity Illness

- Monitored by VirtualCare@Home team
- Regular monitoring
- Patient-led, daily submissions
- Clear guidance on how to action any deterioration
- IT enabled support
- Clinical team in place
- Specialist support available if needed

Hyper-acute illness

- Monitored by Virtual Ward team
- Active monitoring
- Clinician-led, with active support for deterioration
- IT enabled support
- Clinical team in place with specialist involvement

Virtual Care – care continuum

NHS Hampshire and Isle of Wight

Virtual wards

Level 1:

Self Care (Remote Management)

Population based approach

Advice and Guidance

self management with access to Primary Care

Level 2:

Remote Self Monitoring

Know your own numbers, share your numbers

Long term condition self-management

Level 3:

Intense Virtual care

Remote Monitoring with clinical specialist oversight

High Risk, Specialist Care, Care Homes, etc

Level 4:

Hospital at Home :

High Acuity / Alternative to hospital admission

Clinician led care delivered Face to Face and / or virtually.

Digitally enabled (remote monitoring / rapid access to hospital level diagnostics)

Level 5:

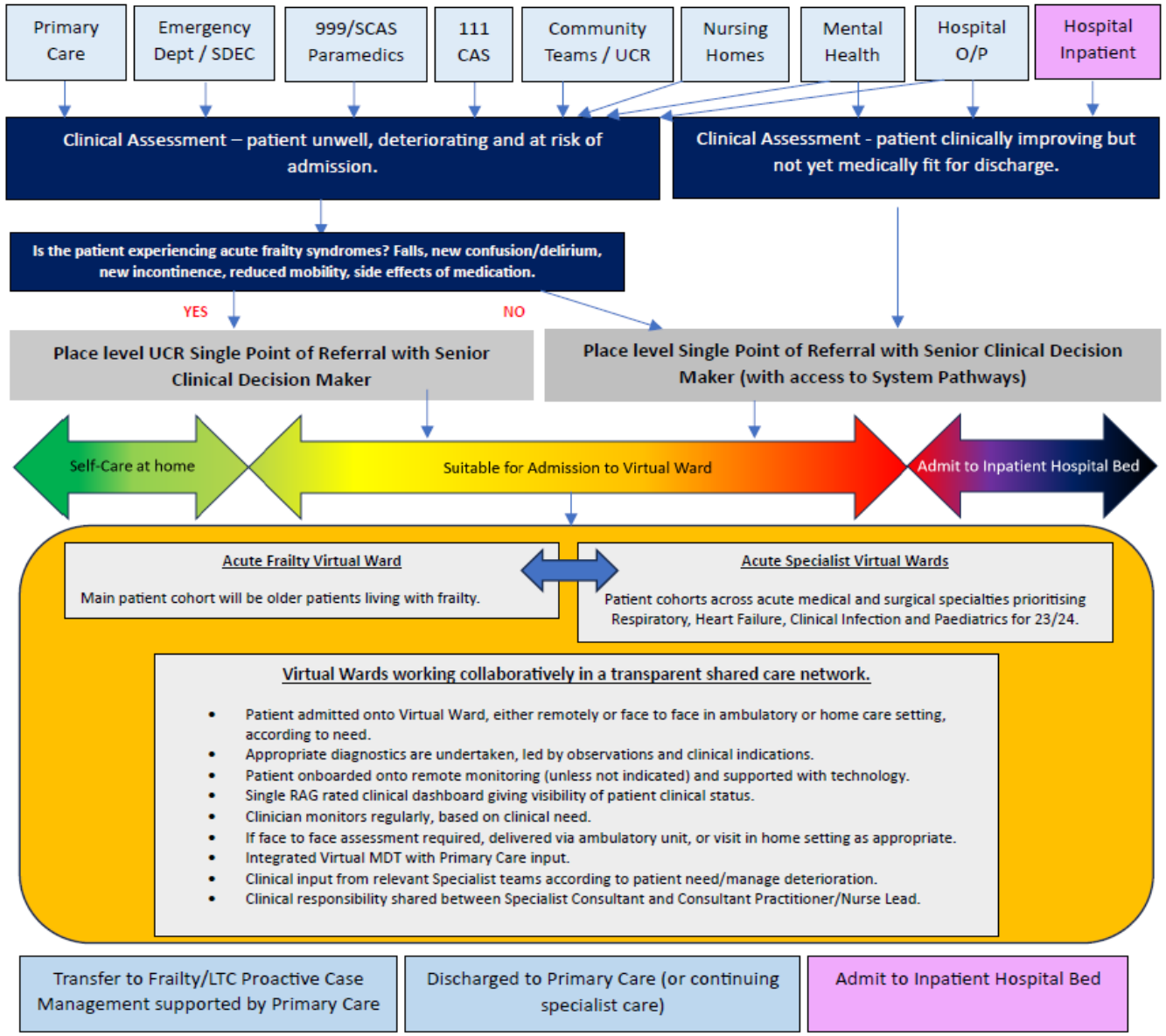
Acute Admission (all SDECs)

E.g. Frailty, Surgical, Medical

Step up and Step down of care

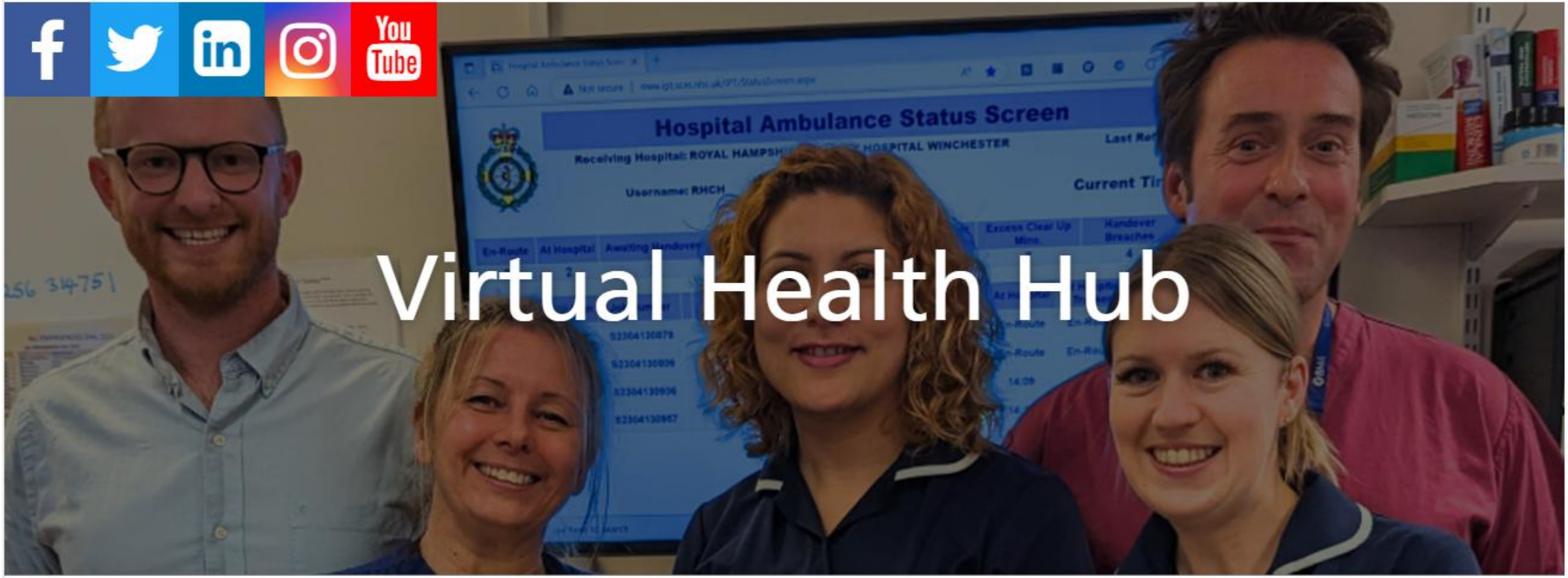
Diabetes Management, Weight Management, BP @Home, BP checks in community settings & Primary Care	Remote Monitoring without clinical intervention	High Risk Patients, Diabetes, Heart Function, Renal, Care Homes etc...	For example: Frailty , Respiratory, heart failure.	Acute Hospital Admission

Virtual ward vision



Our Journey

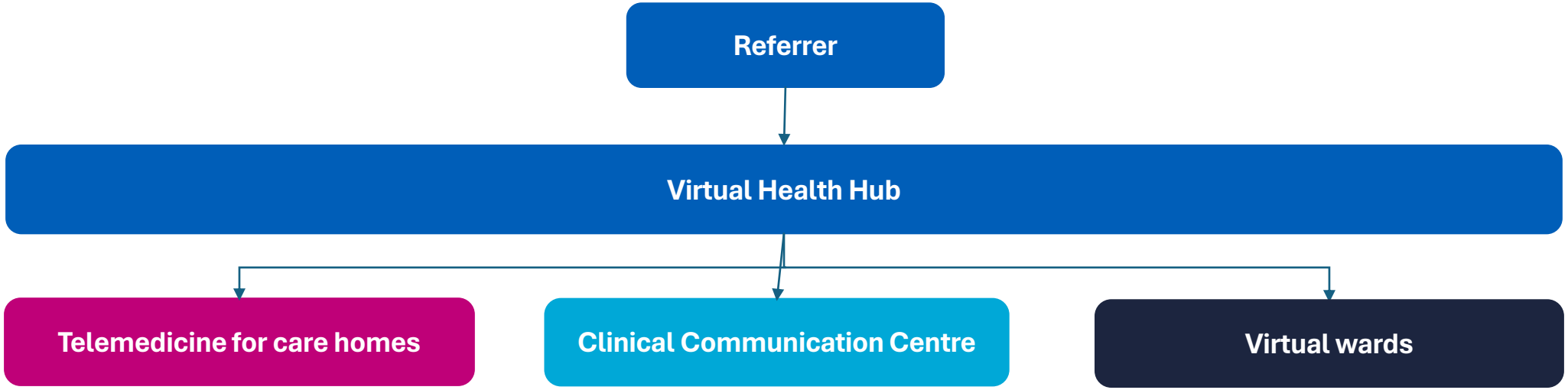
NHS
Hampshire Hospitals
NHS Foundation Trust



Our Virtual Health Hub:

How We Deliver Virtual Healthcare

Hampshire Hospitals NHS Foundation Trust



Clinical advice and treatment for **acutely unwell** care home residents

Who: Residential, nursing, learning disability care homes and South Central Ambulance Service

Coverage: north, mid, south and south west Hampshire

Single point of access to secondary care for **urgent advice** or **admission**

Who: GPs, community teams and South Central Ambulance Service

Coverage: north and mid Hampshire

Remote monitoring to support **early discharges** and **prevent** hospital attendance/**admissions**

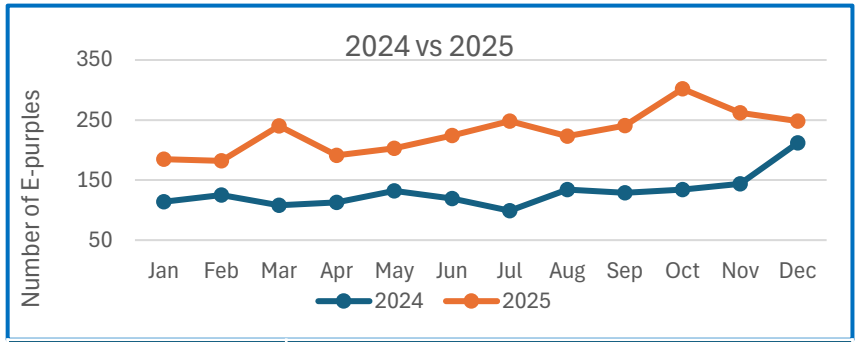
Who: GPs, South Central Ambulance Service, community and hospital teams

Coverage: north and mid Hampshire

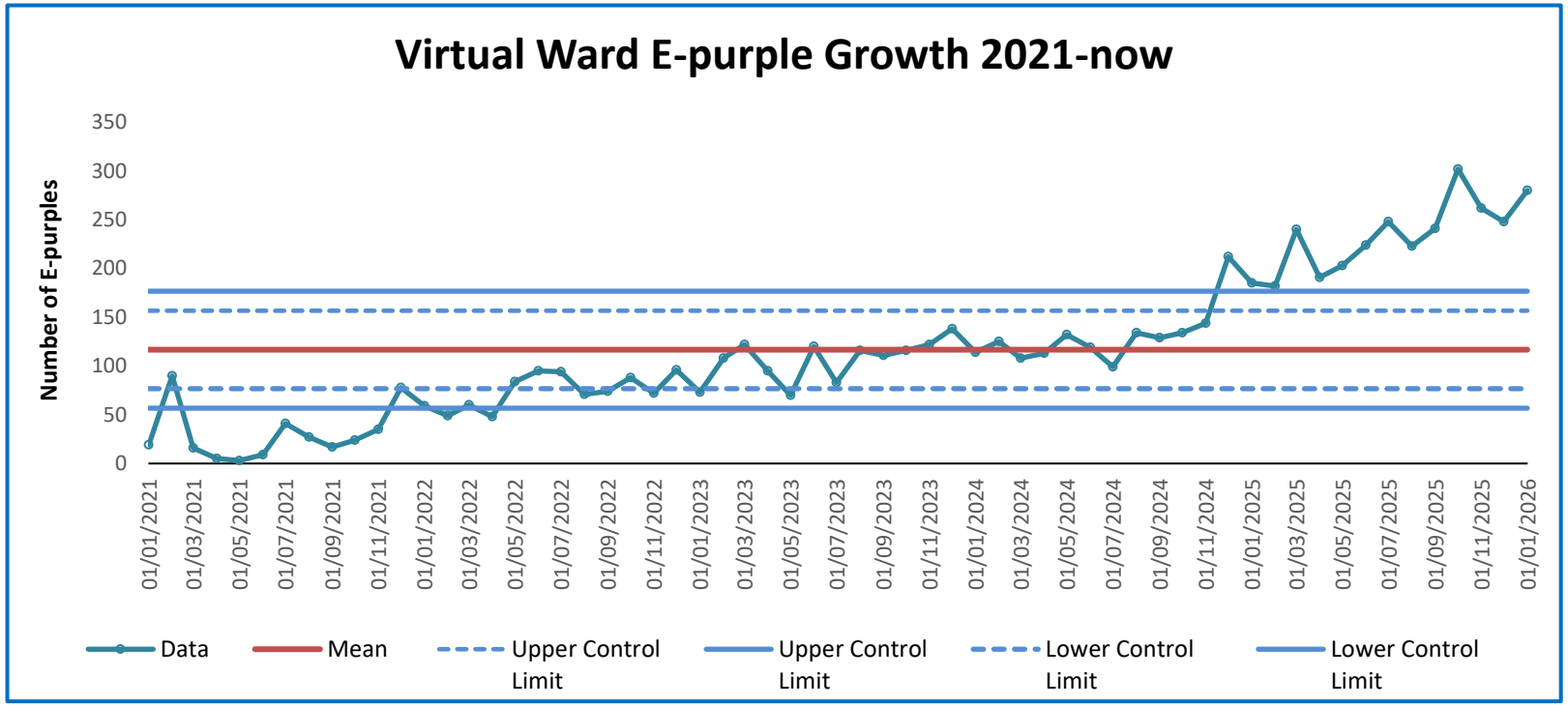
Our Virtual Wards

- Frailty/Orthogeriatric
- Frailty
- General Surgery
- COPD
- Care Home
- Complex Wound
- Acute Diagnostic
- Paediatrics
- OPAT Plus
- High Intensity User
- Infectious Diseases
- ARI / Respiratory

Activity – Virtual Wards



Key dates	Activity
Jan 2021	Covid Recovery and GIM
May 2021	Frailty
July 2021	Heart Failure
Nov 2021	COPD
Dec 2021	Orthogeriatric
May 2022	HIU pilot 1
July 2022	Acute Diagnostics
Dec 2022	HIU pilot 2 and Monkey Pox
Jan 2023	ARI
Oct 2023	Complex Wound
April 2024	Trelours
Aug 2024	General Surgery
Jan – March 2025	Trust discharge events & meeting with PFF's
April 2025	Doctor training commenced
June 2025	Colorectal Enhanced Recovery
Dec 2025	Comms Plan



Virtual Ward E-purple Growth														
Year/Month		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
	2021	19	90	16	5	3	9	41	27	17	24	35	78	**364**
	2022	59	49	60	48	84	95	94	71	74	88	72	96	**890**
	2023	73	108	122	95	70	120	83	116	111	116	122	138	**1274**
	2024	114	125	108	113	132	119	99	134	129	134	144	212	**1563**
	2025	185	182	240	191	203	224	248	223	241	302	262	248	**2749**
	2026	280	217											**497**
Total		**730**	**771**	**546**	**452**	**492**	**567**	**565**	**571**	**572**	**664**	**635**	**772**	**7337**
2024 vs 2023		56.2%	15.7%	-11.5%	18.9%	88.6%	-0.8%	19.3%	15.5%	16.2%	15.5%	18.0%	53.6%	22.7%
2025 vs 2024		62.3%	45.6%	122.2%	69.0%	53.8%	88.2%	150.5%	66.4%	86.8%	125.4%	81.9%	17.0%	75.9%
2026 vs 2025		51.4%	19.2%											-81.9%

Launch

Mixed clinical workforce of GPs, nurses and administrators

May 2021

First month with all substantive staff

1 band 8a
1 band 7
6 band 6
3 administrators
1 project manager

January 2022

First consultant nurse employed

1 band 8b

1 band 8a

1 band 7

7 band 6

3 administrators

1 project manager

May 2022

Band 7 work force increased

1 band 8b

1 band 8a

2 band 7

7 band 6

3 administrators

1 project manager

August - September 2022

Second consultant prac and B7 increase

2 band 8b

1 band 8a

3 band 7

7 band 6

3 administrators

0.5 project manager

October 2025

Formalised OSM support and B6 increase

0.5 Operational services manager

2 band 8b

1 band 8a

3 band 7

8 band 6

3 administrators

0.5 project manager

High Quality Service Fit for Purpose

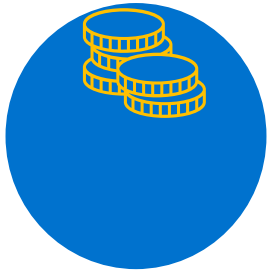
Adoption formula:

Clinical credibility + Reduced friction + Visible peer success + Protected autonomy = Adoption

THE VALUE OF VIRTUAL WARDS
Growing evidence base

Virtual Ward Rapid Evaluation with NHSe & Wessex AHSN

Hampshire Hospitals NHS Foundation Trust

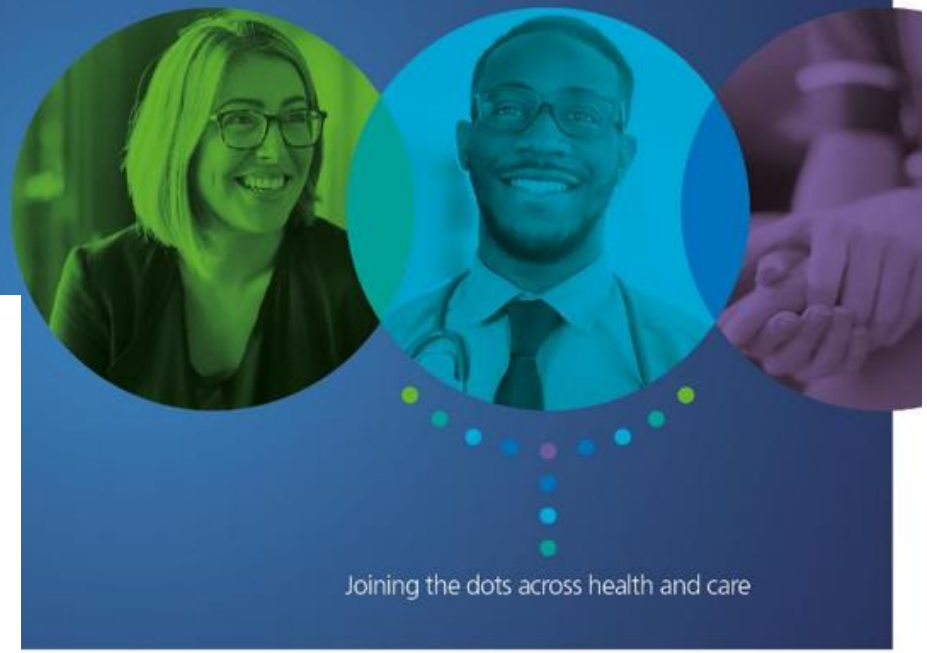


63 week quantitative data period = 1,113 patients were admitted to the VWs

- Overall estimated **VW cost saving of £1,678,297**
- Step down bed saving of 676 days (minimum), a **cost saving of £225,88**
- Step up inpatient bed day saving of 4,351 days, a **cost saving of £1,452,407**

- Length of inpatient stay (bed days) savings: **3.7 days saved/patient**
- Mean VW **LoS** for **step down** patients ranges between **7.8 days (covid early discharge) to 10.0 days (heart function)**
- Mean VW **LoS** for **step up** patients ranges between **5.5 days (COPD) to 8.5 days (heart function)**
- **30-day readmission rate** for step down patients for 21/22 is **16.1%,** lower than the 19.8% readmission rate for 20/21
- 22 patient deaths, a **mortality rate of 2%,** lower than the HHFT actual of 2.8% for a similar period.

Virtual Wards – Research Insights



Little existing research around staff and patient perceptions of Virtual Wards

- Understanding the (perceived) benefits and barriers of virtual wards
- Exploring the service experience of virtual wards to inform improvements
- Developing messaging to optimally communicate virtual wards to different audiences
- Strengthening partnership work around virtual care across all parts of the system

Most importantly, virtual wards offer a huge benefit to the NHS

Frees up hospital beds for critically ill

Virtual wards reduce hospital admissions & enable early discharge from hospital.

Provides cost efficiencies

It is much cheaper to care for patients in their own home rather than in a hospital setting.

Easier to manage longitudinal care

Virtual wards can help patients manage long term conditions and are more effective for longitudinal monitoring.

Restores patient trust in the NHS

Virtual wards can help to restore trust as they offer regular contact with HCPs and continuity of care.

RELIEVES PRESSURE ON NHS

"Wards are desperate for beds and virtual wards free up beds in hospitals and help to ensure that the most critical patients are treated in hospital, so virtual wards make a lot of sense" – **Sister, NHS at Home, BNSSG**

"I've been a GP for a long time and in the 90s you would see a sick child and then because you're worried you would say can you come back later today so I can check on them again. There isn't the time and resources to do that now, but I suppose that the virtual ward is doing more of that and keeping a continual eye on the patient which is reassuring." – **GP in ED, HHFT**

"Virtual wards staff say I'll phone you back in 2 hours time and they do that – that is really surprising to patients and relatives. There is a big issue around trust in GPs … so this can help change mindsets about the NHS." – **Frailty Consultant Nurse, HHFT**

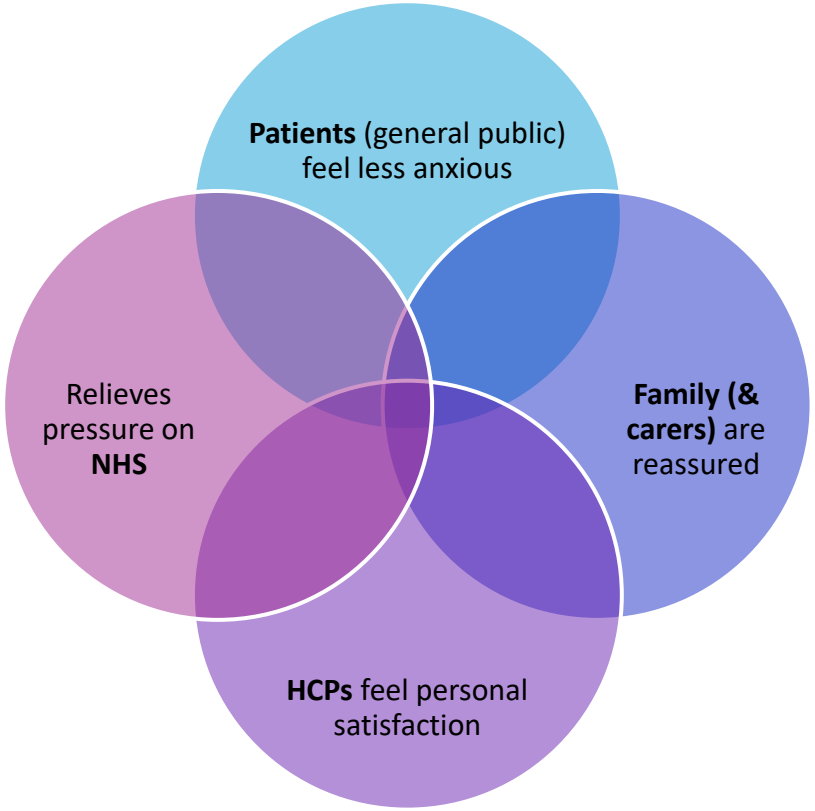
View of virtual wards

Patients, HCPs & General Public are more able to cite (perceived) benefits vs. barriers/downsides.

Indeed, the benefits of virtual wards are multidimensional.

They offer many positives for patients, the patient's family, carers, the NHS as well as HCPs working on virtual wards.

"Patients don't want to be in hospital. On a virtual ward they can have their home comforts and be with family, see their pets, and they remain active" – ***Senior*** **Clinical Assessor Virtual Ward, HHFT**



PPL

May 2024

South East Region Virtual Wards Evaluation

Final Report

Key findings – impact and cost-benefit evaluation

Key conclusions

1. Virtual wards in South East England are **associated** with **a positive impact on non-elective (NEL) hospital activity – on average 1 NEL admission 'avoided' was shown to be *correlated* with 2.5 virtual ward admissions,** with some more mature virtual wards achieving a 1:1 association between the 'avoided' NEL admissions and virtual ward activity.
2. There is evidence of **positive net financial benefits** associated with the regional virtual ward provision – overall total **annualised** net benefit of £10.4 million, for the virtual wards analysed.
3. **It is clear that the longer they run, the more likely virtual wards are to show impact**, as volumes of admissions going through virtual wards increase, and costs per admission start to fall.
4. **Black & minority ethnic (BME) people are consistently underrepresented in virtual ward patient cohorts.** However, there is are significant gaps in ethnicity data recorded in patient level data.
5. **Core-20 representation in virtual ward patient cohorts is more mixed**, however it is more consistently reported.

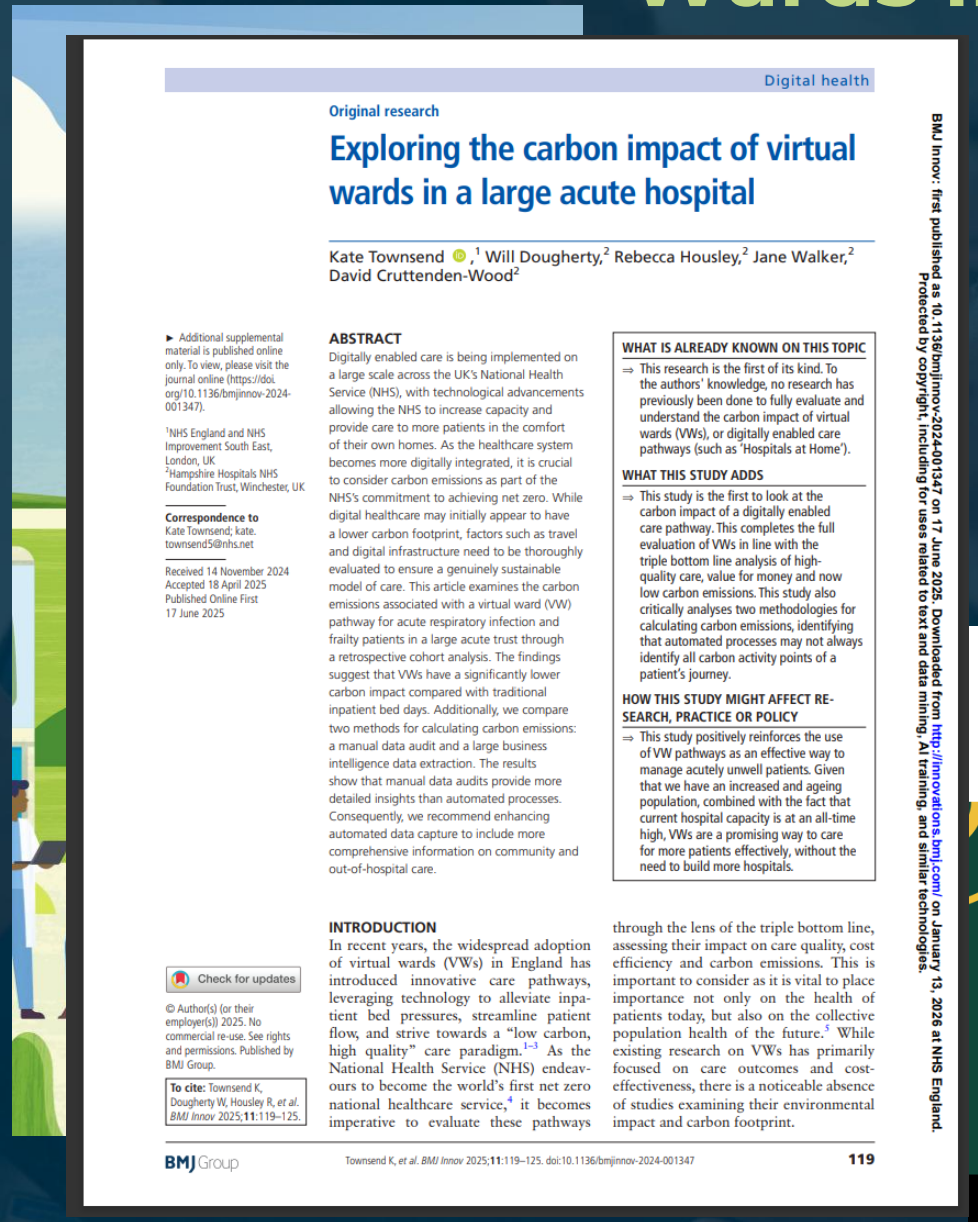
The impact evidenced in this evaluation varies greatly between geographies and pathways – with our qualitative evaluation understanding reasons driving this variation.

Headline figures

Number of virtual wards analysed	**29**
% of all virtual ward admissions in the South East admitted to virtual wards analysed as part of this evaluation (as of 26th February 2024 snapshot from national 'SitRep' report)	**64%**
Total annualised virtual ward admission avoidance admissions across virtual wards analysed	**22,794**
Estimated avoided NEL admissions per year associated with admission avoidance admissions of virtual wards analysed	**9,165**
Estimated gross benefit per annum associated with admission avoidance admissions of virtual wards analysed	**£24.5m**
Estimated gross cost per annum associated with admission avoidance admissions of virtual wards analysed	**£14.2m**
Estimated net benefit per annum associated with admission avoidance admissions of virtual wards analysed	**£10.4m**

PPL

Exploring the Carbon Footprint of Virtual Wards in Hampshire Hospitals



Original research

Exploring the carbon impact of virtual wards in a large acute hospital

Kate Townsend [1], Will Dougherty,[2] Rebecca Housley,[2] Jane Walker,[2] David Cruttenden-Wood[2]

► Additional supplemental material is published online only. To view, please visit the journal online (https://doi.org/10.1136/bmjinnov-2024-001347).

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ABSTRACT

Digitally enabled care is being implemented on a large scale across the UK's National Health Service (NHS), with technological advancements allowing the NHS to increase capacity and provide care to more patients in the comfort of their own homes. As the healthcare system becomes more digitally integrated, it is crucial to consider carbon emissions as part of the NHS's commitment to achieving net zero. While digital healthcare may initially appear to have a lower carbon footprint, factors such as travel and digital infrastructure need to be thoroughly evaluated to ensure a genuinely sustainable model of care. This article examines the carbon emissions associated with a virtual ward (VW) pathway for acute respiratory infection and frailty patients in a large acute trust through a retrospective cohort analysis. The findings suggest that VWs have a significantly lower carbon impact compared with traditional inpatient bed days. Additionally, we compare two methods for calculating carbon emissions: a manual data audit and a large business intelligence data extraction. The results show that manual data audits provide more detailed insights than automated processes. Consequently, we recommend enhancing automated data capture to include more comprehensive information on community and out-of-hospital care.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ This research is the first of its kind. To the authors' knowledge, no research has previously been done to fully evaluate and understand the carbon impact of virtual wards (VWs), or digitally enabled care pathways (such as 'Hospitals at Home').

WHAT THIS STUDY ADDS

⇒ This study is the first to look at the carbon impact of a digitally enabled care pathway. This completes the full evaluation of VWs in line with the triple bottom line analysis of high-quality care, value for money and now low carbon emissions. This study also critically analyses two methodologies for calculating carbon emissions, identifying that automated processes may not always identify all carbon activity points of a patient's journey.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This study positively reinforces the use of VW pathways as an effective way to manage acutely unwell patients. Given that we have an increased and ageing population, combined with the fact that current hospital capacity is at an all-time high, VWs are a promising way to care for more patients effectively, without the need to build more hospitals.

INTRODUCTION

In recent years, the widespread adoption of virtual wards (VWs) in England has introduced innovative care pathways, leveraging technology to alleviate inpatient bed pressures, streamline patient flow, and strive towards a "low carbon, high quality" care paradigm.[1–3] As the National Health Service (NHS) endeavours to become the world's first net zero national healthcare service,[4] it becomes imperative to evaluate these pathways through the lens of the triple bottom line, assessing their impact on care quality, cost efficiency and carbon emissions. This is important to consider as it is vital to place importance not only on the health of patients today, but also on the collective population health of the future.[5] While existing research on VWs has primarily focused on care outcomes and cost-effectiveness, there is a noticeable absence of studies examining their environmental impact and carbon footprint.

Check for updates

To cite: Townsend K, Dougherty W, Housley R, *et al*. *BMJ Innov* 2025;**11**:119–125.

Climate action Hampshire Hospitals

FOR A GREENER NHS

NHS Hampshire Hospitals NHS Foundation Trust

'Virtual ward' bed uses 4 times less carbon than traditional inpatient bed

Health Care Without Harm

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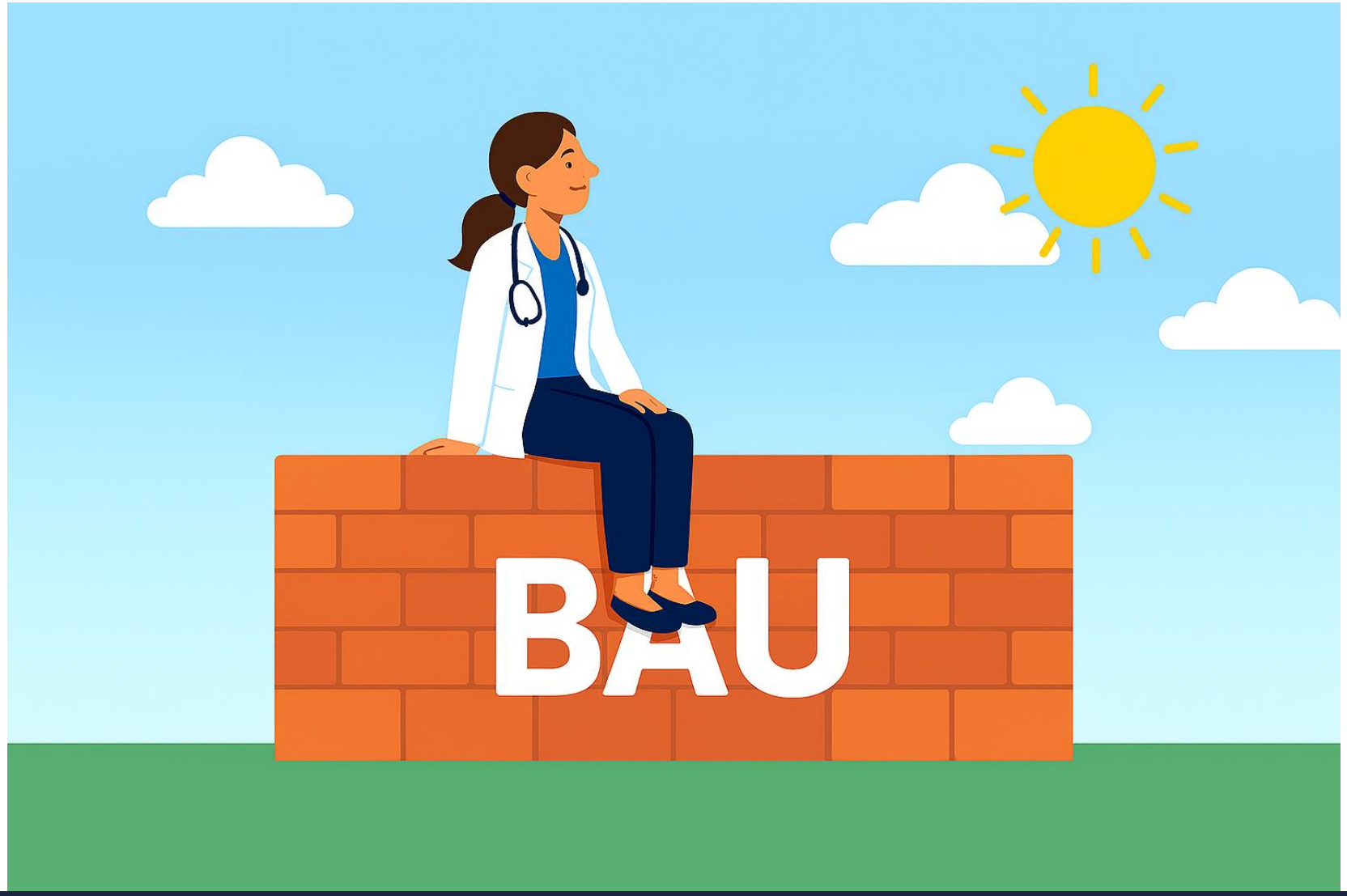
Health Care Without Harm seeks to transform health care worldwide so that it reduces its environmental impact, becomes a community anchor for sustainability, and a leader in the global movement for environmental health and justice.

Exploring the Academic/Educational benefits of Virtual Wards

UNIVERSITY OF WINCHESTER

University of BRISTOL

Fit for the future?



Continuity of care to enable whole system left shift

Proactive case management

Dynamic integrator

Homeless and prison population

Unmet needs

Unmet needs

To proactively work with this cohort and really **understand what they need** and to **de-escalate issues before a crisis occurs**

To build **closer links** with health, social and community teams (including SCAS) and form **robust networks** creating true integrated working

To **reduce 999 calls** and possible **ambulance conveyances**

To identify those at **greatest risk of ED attendance** and **non-elective admissions**

To understand **gaps in current services** provision for future system support

Drive equality and individual voice - empower individuals to self-manage to enable sustainable discharge

To **prevent and reduce unnecessary GP attendances** and **avoidable non-elective admissions**

System left shift

GP practice	ED attendances	Patients	Average attendances per patient	Number of NEL admissions	Total LoS	Individual patients	Av LoS per patient
Adelaide Medical Centre	37	2	18.5	11	15	1	1.4
Badgerswood Surgery	0	0	0.0	11	148	1	13.5
Balmore Park Surgery	0	0	0.0	10	62	1	6.2
Bramblys Grange Medical Practice	66	2	33.0	59	294	5	5.0
Branksomewood H/Care Ctr	38	1	38.0	17	88	1	5.2
Burdwood Surgery	0	0	0.0	10	32	1	3.2
Chawton Park Surgery	0	0	0.0	13	54	1	4.2
Chineham Medical Practice	20	1	20.0	47	265	4	5.6
Crown Heights Medical Centre	213	8	26.6	92	354	6	3.8
Friarsgate Practice	53	2	26.5	17	27	1	1.6
Gillies & Overbridge Medical P/Ship	141	5	28.2	44	117	4	2.7
HMP WINCHESTER	79	1	79.0	25	32	1	1.3
Kingsclere Health Centre	29	1	29.0	11	125	1	11.4
Mortimer Surgery	0	0	0.0	12	24	1	2.0
Park Surgery	0	0	0.0	11	17	1	1.5
Shakespeare Road	48	2	24.0	24	92	1	3.8
St Clements Partnership	45	2	22.5	28	212	2	7.6
St Mary's Road Surgery	100	3	33.3	48	105	2	2.2
St Mary's Surgery	45	2	22.5	20	100	2	5.0
St Paul's Practice	85	3	28.3	13	13	1	1.0
Stokewood Surgery	59	1	59.0	12	60	1	5.0
Tadley Medical P'Ship	75	3	25.0	38	126	2	3.3
The Andover Health Centre Medical Pract	22	1	22.0	28	174	2	6.2
The Fryern Surgery	0	0	0.0	31	204	3	6.6
Twyford Surgery	0	0	0.0	12	47	1	3.9
Western Elms Surgery	24	1	24.0	13	18	1	1.4
Wilson Practice	0	0	0.0	17	86	1	5.1
Castle Practice	46	1	46.0	0	0	0	0.0
Eastfield House Surgery	21	1	21.0	0	0	0	0.0
Greenway Community Practice	25	1	25.0	0	0	0	0.0
Shepherds Spring Medical Centre	27	1	27.0	0	0	0	0.0
St.Andrew's Surgery	62	2	31.0	0	0	0	0.0
Wickham Surgery	19	1	19.0	0	0	0	0.0
No GP/ GP not known	44	2	22.0	13	28	1	2.2
Total	**1,423**	**40**	**35.6**	**687**	**2,919**	**50**	**4.2**

Theme for proactive system support:
patient one vs patient two

Patient one

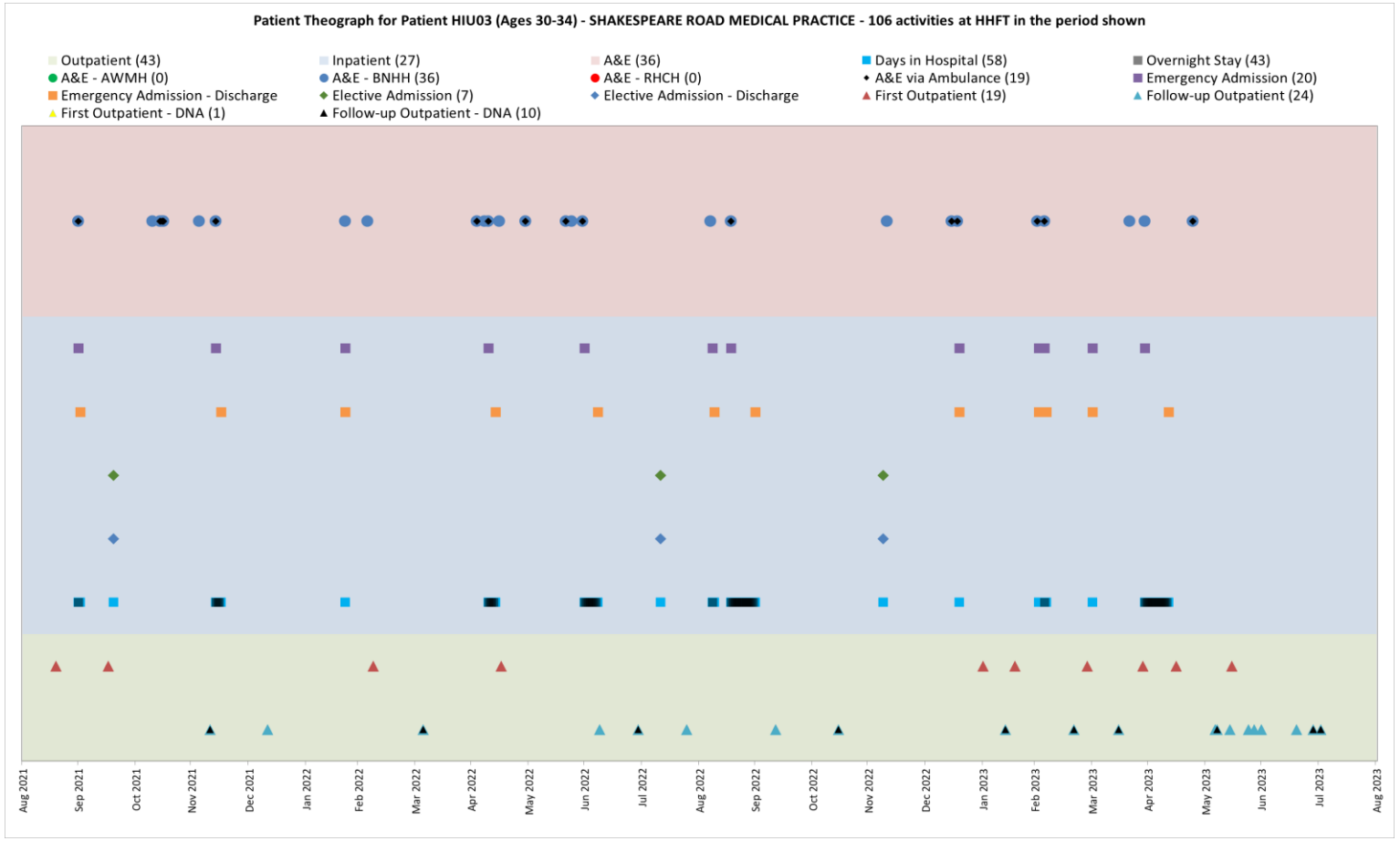
- Older, 56
- Unemployed
- Lives with working relative
- Debt
- Binge drinking, opiates.
- Polypharmacy
- Passive sick role, secretive, defensive
- Poor insight & no motivation
- Autistic?
- Deflected phone calls
- No M/H involvement
- Did not engage with pain clinic
- Needs reminding appointments

Patient two

- Younger, 31
- Unemployed
- Lives with working relative
- Supported by family
- Illicit drugs inc ketamine
- Polypharmacy
- Impulsive – regret
- Converses with comprehension
- ADHD?
- Changing phone numbers
- Engages with M/H
- Partial engagement with pain clinic
- Needs reminding appointments

Patient case study

- This chart outlines **the ED, inpatient and outpatient activity** which occurred in the three years up to 31st August 2023.
- We can determine that the **frequency of hospital activity has significantly reduced** since May 2023 with one ED attendance, no inpatient admissions.
- However there have been three outpatient follow ups which patient 2 did not attend.



Creating a paradigm shift in to drive virtual healthcare forward

1. **Define a Clear Future Model (Not Just Incremental Improvement)**

   Paradigm shifts succeed when the target state is explicit and compelling.

   Key action:
   Define the future around patient journeys, not organisational structures.

2. **Change Incentives Before Changing Behaviour**

   We are often rewarded by activity rather than outcomes.

   Key principle:
   People don't resist change—they resist misaligned incentives.

3. **Break the "Silo Architecture" Problem**

   Siloed healthcare persists because:
   - Data systems are fragmented
   - Governance is fragmented
   - Accountability is fragmented

   Practical step:
   Design workflows that cross organisational boundaries by default.

Creating a paradigm shift in to drive virtual healthcare forward

4. **Make Digital the Operating Model (Not a Layer)**

   Many programmes fail because digital is added on top of legacy processes.
   This turns digital from a tool into the primary delivery mechanism.

5. **Build Clinical-Led Transformation (Not IT-Led)**

   Healthcare changes only scale when clinicians own the model.

6. **Create Visible Early Wins (“Proof of the Future”)**

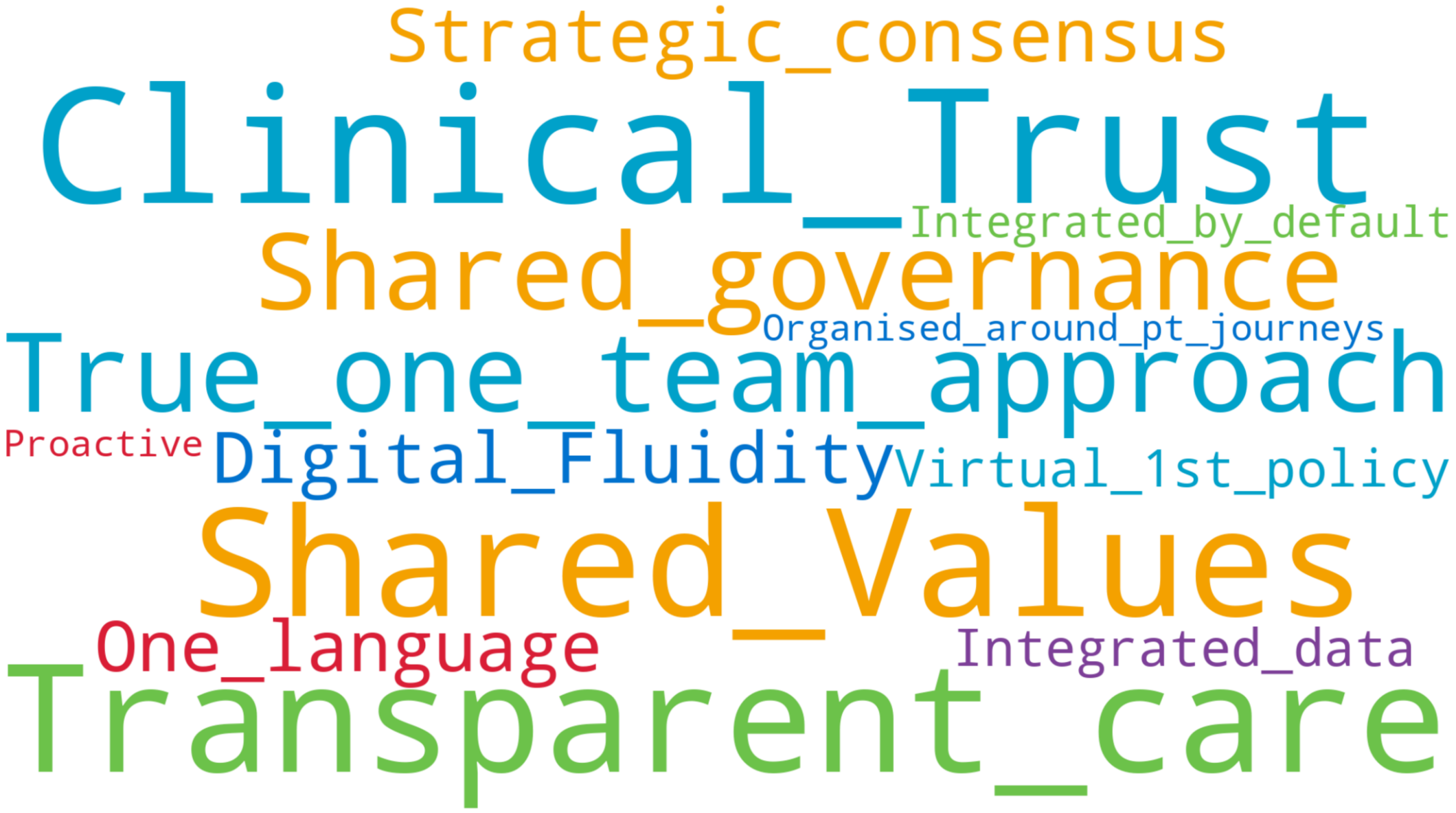
   Large systems change when people see the new model working.
   Short-term proof reduces long-term resistance.

7. **Treat Culture as Infrastructure**

   Technology transformation is often 20% technical, 80% behavioural.

How far along are we?

What needs to be true
to allow equitable,
fair & fluid healthcare
across neighbourhood's and systems
to maximise health & well-being?

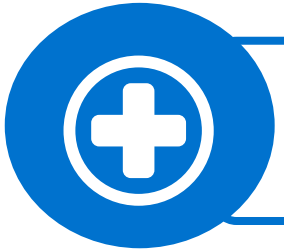

Strategic_consensus
Clinical_Trust
Integrated_by_default
Shared_governance
Organised_around_pt_journeys
True_one_team_approach
Proactive
Digital_Fluidity
Virtual_1st_policy
Shared_Values
One_language
Integrated_data
Transparent_care

Thank you

Questions?

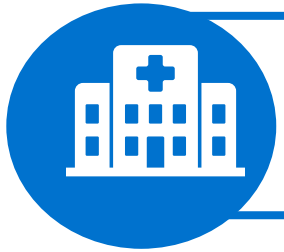
Virtual Ward data

32,000 Patient consultations



Over 8,000 Patients supported

LoS Step down 5-7 days Step up 6-10 days



7% Required hospital escalation

January 2021 - Dec 2025

CCC and CBC data

Hampshire Hospitals NHS Foundation Trust

Over 50,000 Referrals

Over 11% Prevented attendance with medical advice

11% Straight to SDEC as a planned attendance

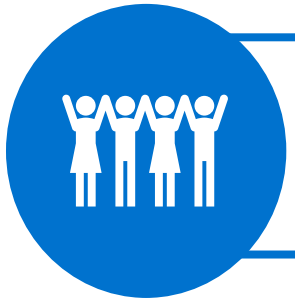
18% Avoided HHFT (CBC)

January 2023 – Dec 2025

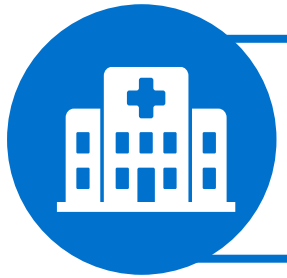
Telemedicine

Hampshire Hospitals NHS Foundation Trust

22,800 Residents supported



11,200 GP consultations prevented



1500 of our consultations prevented a home calling 999

April 2020 - Dec 2025

Unified Wellness:
Integrated virtual care for all

- **Session Overview:**
- Expanding safe, seamless, resilient wrap around care for the right people, at the right time in the best place.
- **Key Points:**
- To describe the journey we have all gone through to realise sustainable virtual care that has a strong governance structure.
- How best to reinforce and create the paradigm shift required to drive virtual care forward.
- What needs to be true to allow equitable, fair & fluid healthcare across neighbourhood's and systems to maximise health & well-being.
- Reimagining healthcare without walls fit for the future.

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SCAN ME

Skill Clinic

Claire Beard
Virtual Ward Manager
Norfolk & Norwich NHSFT

Alison Davis
Clinical Quality Improvement Lead
University Hospitals of Leicester NHS Trust

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Refreshments & Networking

CONVENZIS

Welcome to the NHS Virtual Wards to Virtual Hospitals Strategy Conference

05th March 2026
The Studio, 03rd Floor, 7 Cannon St,
Birmingham, B2 5EP

CONVENZIS TRAINING

Please scan the QR Code on the screen below to register your interest for our accredited training courses.

HESUK

Powered by - CONVENZIS

Join the Healthcare Engagement Society (HES)

- **What it is** – A secure, year-round platform bringing NHS professionals together across six specialist communities.
- **Why it matters** – Stay connected beyond today's event, share challenges, and learn from peers facing the same priorities.
- **Your benefits** – Exclusive access to interviews, insights, best practice, and real-time discussion threads with colleagues nationwide.
- **How to join** – Simply scan the QR code, choose your community, and start connecting today.

SCAN ME

Chair Morning Reflection

Gurnak Singh Dosanjh
Deputy CCIO | Digital Healthcare Consultant | CSO | ICB Clinical Lead
NHS Leicester, Leicestershire and Rutland

CONVENZIS

Case Study

doccla

Case Study

Dr Elinor Beattie
Emergency Medicine Consultant

AF@home

The Gloucestershire Virtual Wards

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Case Study

enovation®
care to connect

enovation®
care to connect

Virtual Wards, Neighbourhood Teams and the space between

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Leadership Lessons from the Front Line

Rob Taylor-Ball
Consultant Nurse
Dorset HealthCare NHS Foundation Trust

Simon Chambers-Bellis
Consultant Nurse
Dorset Healthcare

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Case Study

Ortus-iHealth

Case Study

Dr. Debashish Das
Consultant Cardiologist, Barts NHS Trust
CEO & Founder Ortus-iHealth

Ortus-iHealth

Making Virtual Wards Work at Scale

From evidence gaps to AI-enabled delivery

ortus-ihealth.com

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Lunch & Networking

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SCAN ME

Chair Afternoon Address

Gurnak Singh Dosanjh

Deputy CCIO | Digital Healthcare Consultant | CSO | ICB Clinical Lead

NHS Leicester, Leicestershire and Rutland

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Case Study

Luscii
an OMRON Healthcare Service

Delivering the NHS Three Shifts at Scale: An Integrated Approach to Remote Monitoring

Phil Goodwin - Senior Business Development Manger,

Graphnet Health

Graphnet Health: An Overview

Graphnet Transforming Care

Luscii an OMRON Healthcare Service

What we do

1. **Shared Care Records**
2. **Population Health**
3. **Remote Patient Monitoring**
4. **Care community workflow**

Usage

1. **11** — **11** Integrated Care Systems
2. **20M** — **20,000,000** using our Shared Care Record
3. **17M** — **17,000,000** patients using our Population Health Solution
4. **150,000** — **150,000** hands-on clinical users
5. **150,000** — **150,000** patients have been monitored remotely

Graphnet's Footprint in England

Graphnet Transforming Care

Luscii an OMRON Healthcare Service

Greater Manchester

Cheshire and Merseyside

Staffordshire & Stoke on Trent

Black Country

Northamptonshire

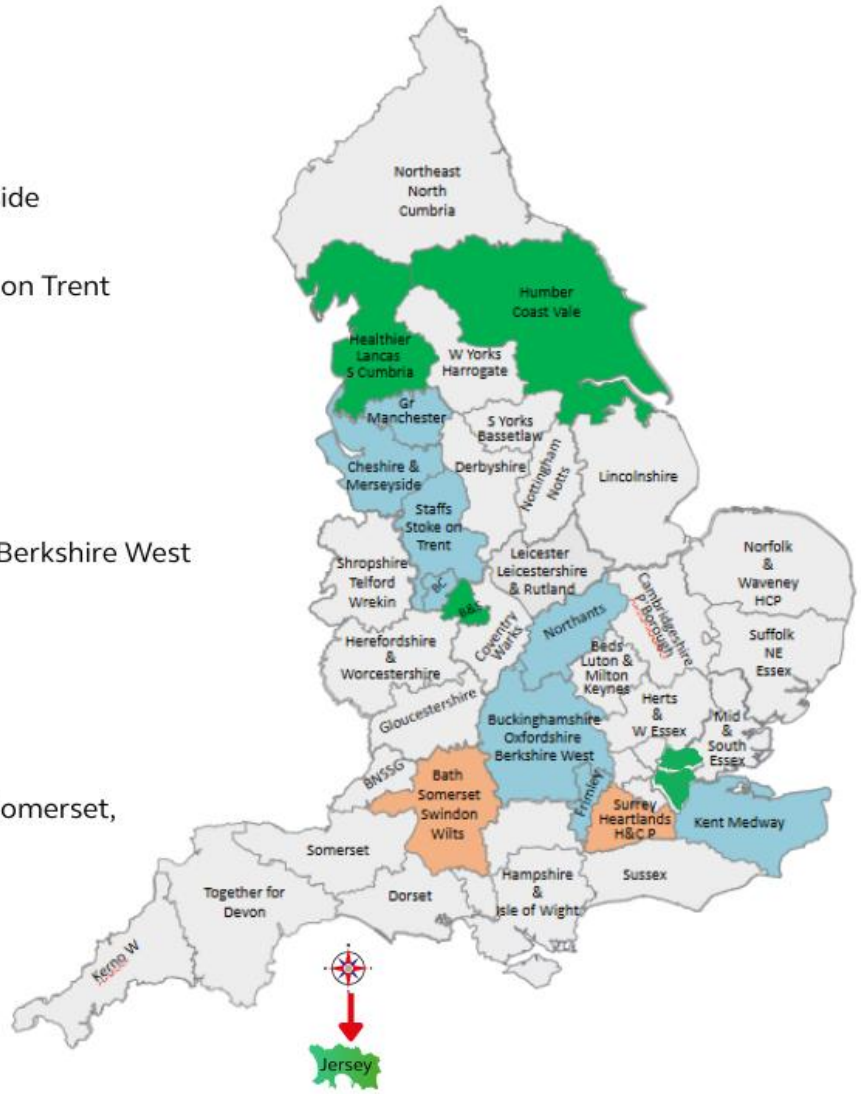
Bucks, Oxfordshire & Berkshire West

Frimley

Kent & Medway

Bath and Northeast Somerset, Swindon & Wiltshire

Surrey



Humber & North Yorkshire

Lancashire & South Cumbria

Birmingham & Solihulll

North East London

South East London

Jersey

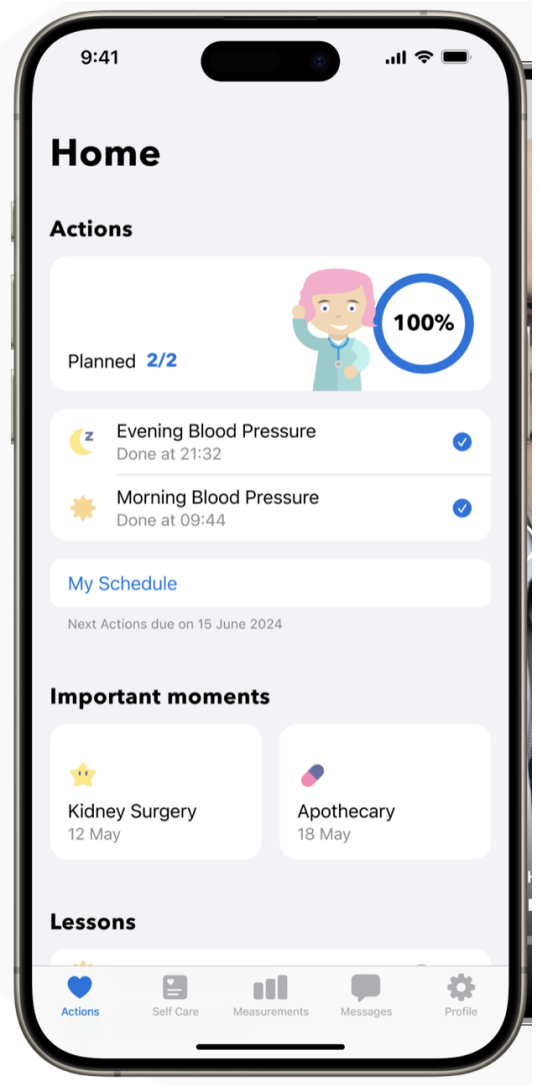
ICS Region Using Graphnet SCR & RM

ICS Region Using Graphnet RM

ICS Region Using Graphnet SCR

Three Pillars for Remote Patient Monitoring

1. **Monitor**
2. **Coach & Guide**
3. **Support**



Graphnet Transforming Care

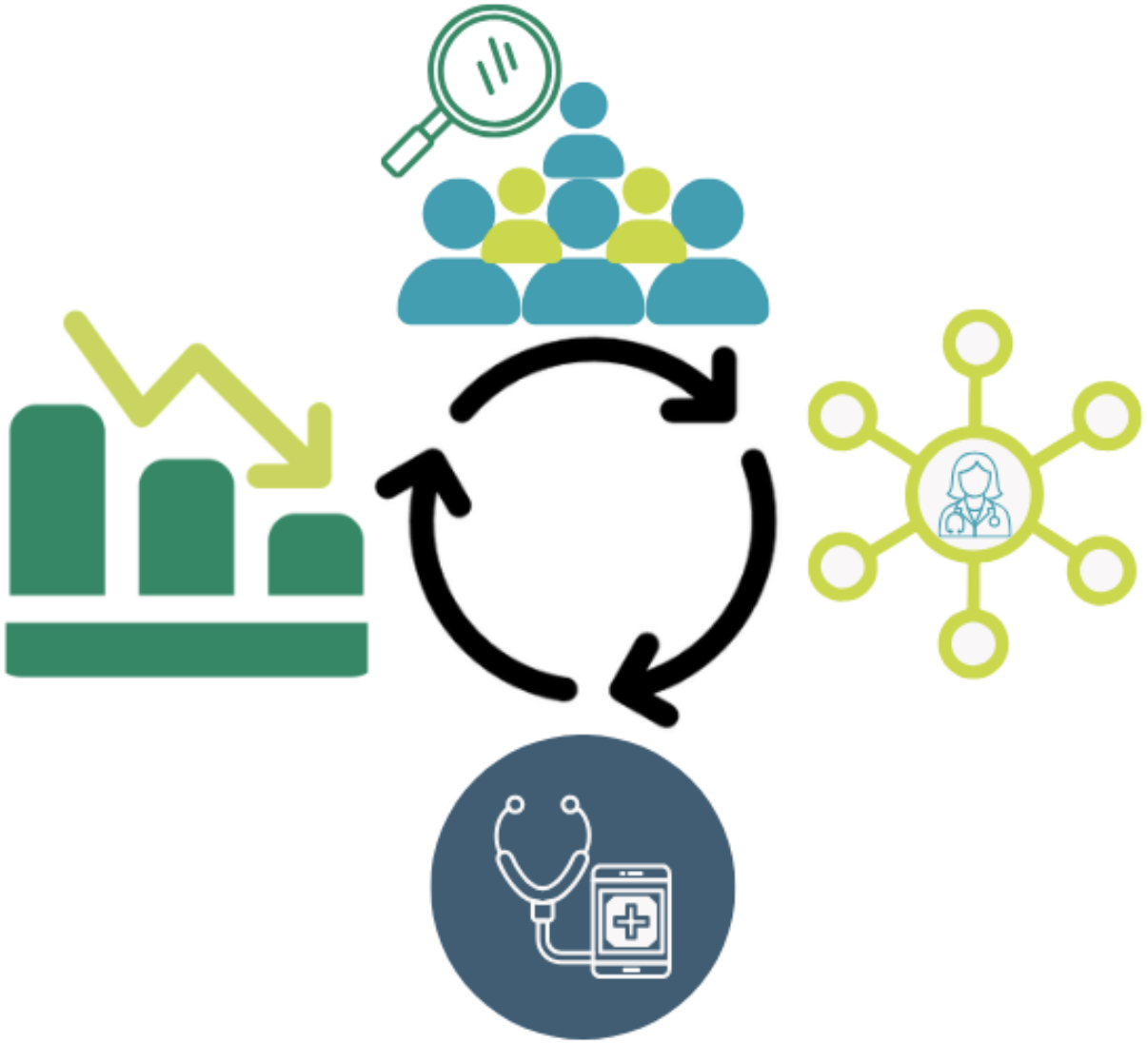
Luscii an OMRON Healthcare Service

1. OMRON CONNECT

The clinically trusted health companion app **valued by consumers and professionals**

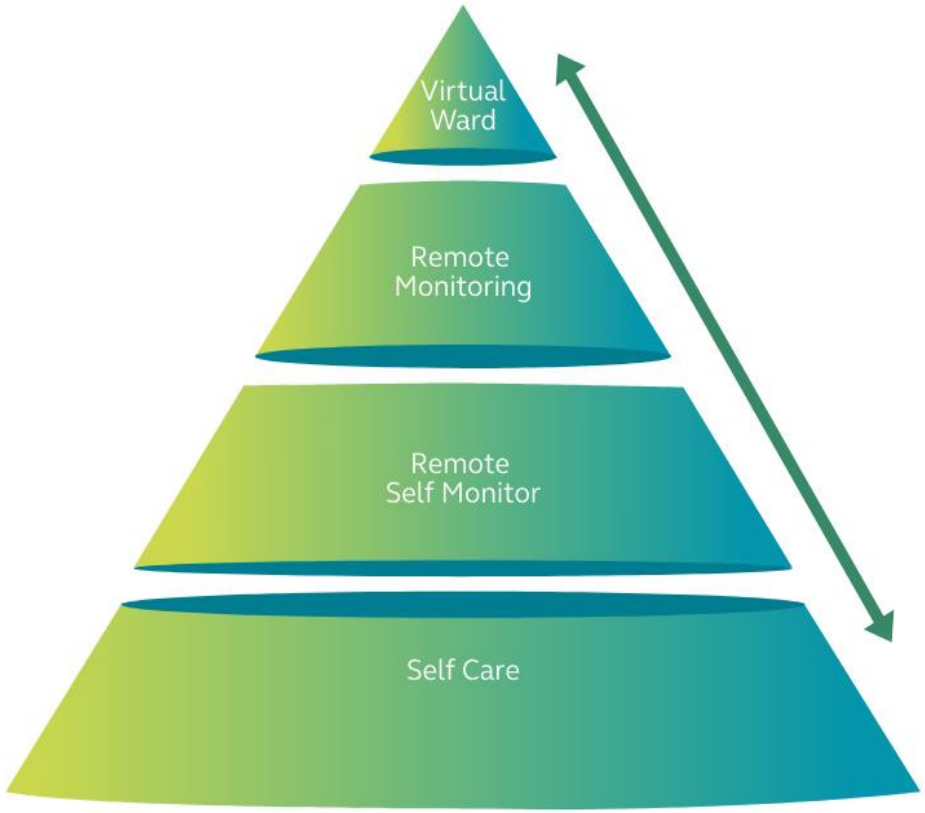
- COLLECT - Replacing the paper logbook via data from OMRON and non-OMRON devices
- GUIDE – Expert-led premium Health Programs built around Clinical Intelligence™
- SHARE – Easy sharing of data and insights with family, and healthcare professionals

Reducing pressures on secondary care



Continuum of Care

Escalating & De-escalating across Virtual Care Pathways



System Wide Digital Tools

- A single digital system allows residents to escalate up and down levels of care within the system
- The Digital Health Team continue to support the resident and the escalation point may change as the resident's need change
- Frequency of remote monitoring may increase as the resident becomes more acutely unwell
- Residents are most likely to engage in virtual care with consistency and familarity
- Residents remain safe across transfer of care points as they are supported by the digital health care team using a single digital solution
- Once residents are self-actualised and well, they can move to remote monitoring without clinical intervention

We know it works.....

Graphnet Transforming Care

Luscii an OMRON Healthcare Service

Frimley Health and Care

38.6% reduction in A&E attendances 53.7% reduction in admissions

26.7% reduction in outpatient appointments £5–8m annual savings

We know it works…..

Graphnet Transforming Care

Luscii an OMRON Healthcare Service

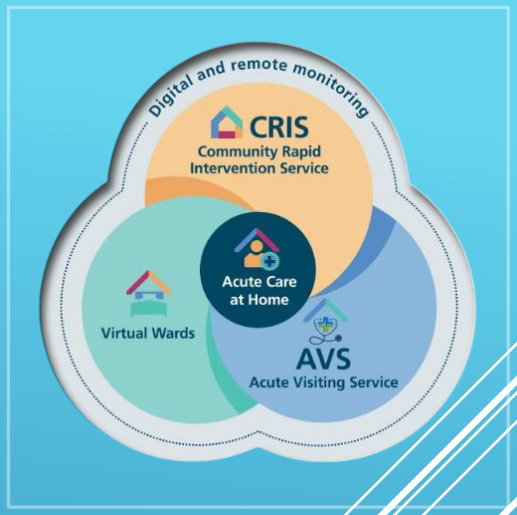
NHS

Kent and Medway

69 % reduction in emergency department visits

68.4 % reduction in walk-in centre visits

70 % reduction in emergency hospital admissions for the cohort



ACUTE CARE AT HOME VIRTUAL WARD

LUSCII TRANSITION

Implementing innovative virtual care systems effectively

Presented by:

Kingsley Marshall – Asst Programme Manager

Julietta Newton – Modern Matron

Who We Are – Our Role in the LUSCII Transition

As ACAH leads, we jointly coordinated and delivered the transition from Docobo to LUSCII:

- **Kingsley (Kings) Marshall** – Assistant Programme Manager: Led Programme planning, build, IG, SOPs and go-live readiness.
- **Gina Reynolds** – Operational Manager: Oversaw operational alignment, pathway workflow design and team readiness.
- **Julietta (Jules) Newton** – Modern Matron: Provided clinical leadership, pathway validation and safety assurance.

Together, we led the transition from an ACAH perspective, ensuring the move to LUSCII was safe, clinically sound and operationally robust.

WHO WE ARE

ACUTE CARE AT HOME (ACAH)

We deliver Urgent Community Response (2hr UCR), Virtual Wards, and the Acute Visiting Service.

We serve Staffordshire & Stoke-on-Trent.

We operate consultant-led pathways across acute medicine, frailty, surgical, and respiratory cohorts.

Virtual Ward referrals are managed by North, Central and South teams.

Our designated Referral Hub coordinates UCR and AVS requests.

WHY WE MOVED FROM DOCOBO TO LUSCII

- Docobo was being phased out nationally.
- LUSCII supports flexible pathway design and remote monitoring.
- Improved patient usability and mobile-first approach.
- Aligns with Shared Care Record integration roadmap.
- No additional costs incurred during the transition.

HOW WE DELIVERED THE TRANSITION

- Ensure IG alignments were in place
- Updated SOPs for onboarding, monitoring, escalation and discharge.
- Rebuilt Docobo pathways in LUSCII with improvements.
- VW teams (North, Central, South) trained before go-live.
- Go-live completed 5 January 2026 with no disruption.

IMPROVEMENTS SINCE TRANSITION

- Faster pathway updates and more flexibility.
- Better clinical oversight through dashboards.
- Improved patient engagement via app.
- Stronger foundation for wearables and SCR integration.

HOW THINGS ARE GOING SINCE GO-LIVE

- Over 50 patients onboarded and actively monitored since go-live.
- Additional LUSCII training delivered to all Virtual Ward teams.
- Scoping work underway for wearable device development and evaluation.
- Export and secure transfer of legacy Docobo data completed.
- All remaining tablets updated and transitioned to LUSCII software.
- Integration development for OHC (One Health & Care) now in progress.

Our Thanks to Graphnet & LUSCII

We want to express our sincere thanks to both the Graphnet and LUSCII teams. Throughout the entire transition — from planning, build, testing, training and go-live — they have been incredibly supportive.

They provided rapid technical assistance, hands-on education, and patient-safety-focused guidance at every stage.

What's been equally important is the support that has continued post-transition. They've worked with us on pathway refinement, troubleshooting, and our future development plans, including wearables and enhanced reporting.

Their partnership has played a huge part in the success of this programme, and we can't thank them enough.

WHAT'S NEXT

- Expansion of respiratory, heart failure and surgical pathways.
- Enhanced ICS reporting and data insights.
- Wearable device integration.
- Improved cross-site clinical connectivity.

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SCAN ME

NHS Deep Dive

Kirsty Osborn
Deputy Director Urgent Care
DHU Healthcare

Emma Wardale
Virtual Ward Clinical Lead
DHU Healthcare

Transforming Falls Management:
Implementing Novel Pathways in the Community Virtual Ward

Wards Anywhere 2026 Convenzis NHS Virtual Ward Strategy Conference

Kirsty Osborn - Deputy Director Urgent Care, DHU Healthcare
Emma Wardale - Virtual Ward Clinical Lead, DHU Healthcare

We are DHU

DHU Healthcare is a not-for-profit Community Interest Company delivering NHS urgent and emergency care, primary care, community and out-of-hours services and NHS 111.

Operating 24/7 across the Midlands and beyond, DHU serves more than 15 million people and supports more than 3,500 colleagues to deliver compassionate, high-quality care.

January-March 2026

DHU Community Virtual Ward: From Pandemic to Permanent

Evolved Virtual Care

- Built from pandemic-era infrastructure
- Extended to frailty, falls, palliative, surgical and paediatrics
- 24/7 multidisciplinary oversight and remote monitoring
- 3,655 admissions since October 2022 – only 4% admission to hospital

The Virtual Ward Model: Core Components

- Defined inclusion/exclusion criteria
- Structured observation schedules
- Daily MDT review
- Rapid escalation protocols
- Remote and face to face contact

The problem: Frail older adults are often left on the floor too long after falls or head injuries

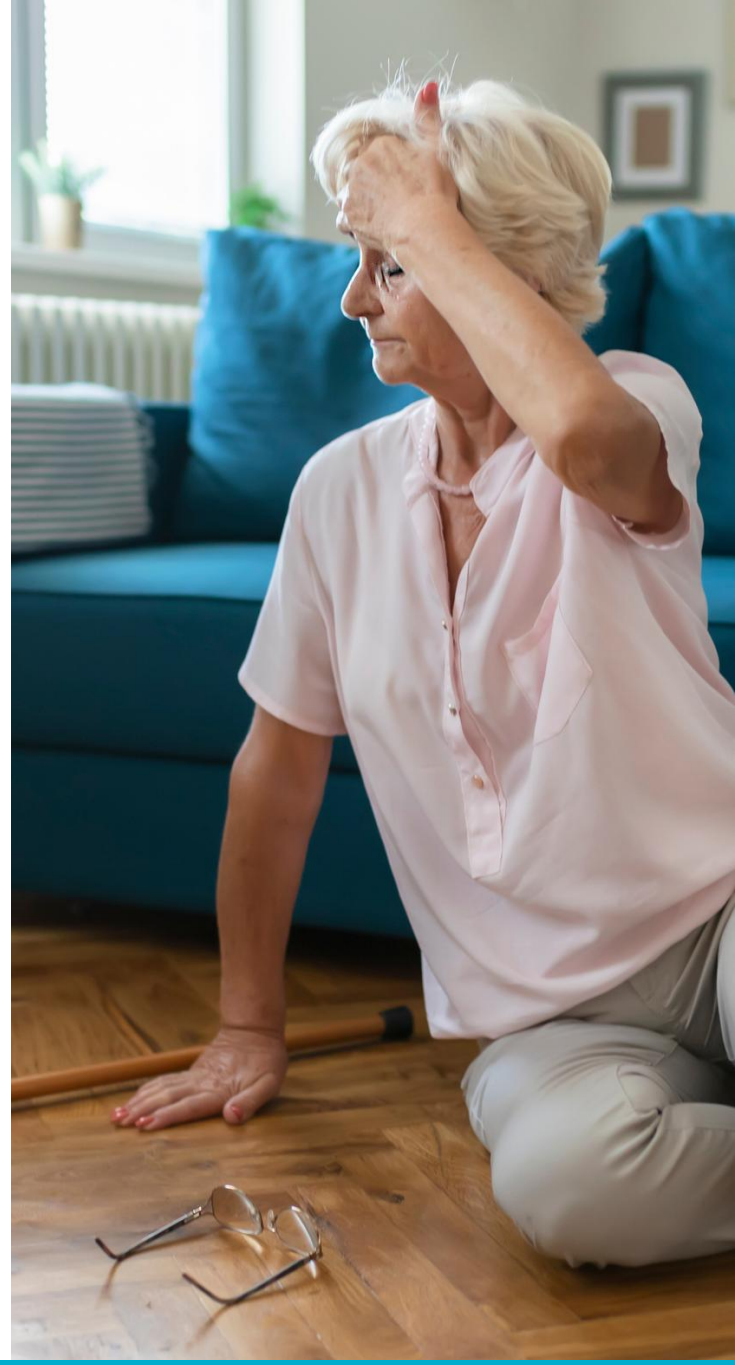
Patient Risks

- Dehydration
- Rhabdomyolysis
- Intercranial Bleed
- Unnecessary Hospital Admission
- Avoidable Harm (Long Lie)

Service Risks

- Ambulance Delays
- Emergency Department Overcrowding
- Unnecessary Hospital Admission

“Older people were waiting hours for help when they needed minutes.”

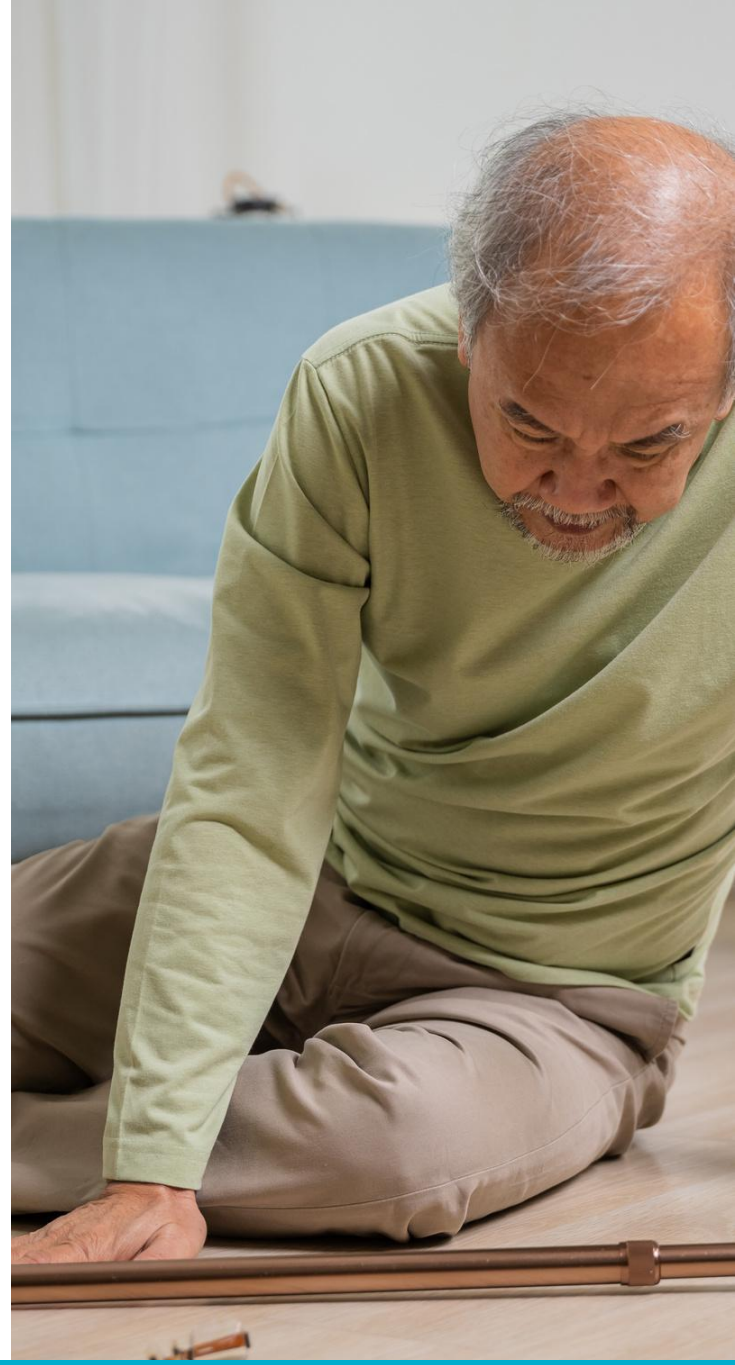


Why change was needed

Older adults disproportionately affected

Prolonged floor time → dehydration, rhabdomyolysis, fear

Anticoagulated head injury → precautionary admissions



The System Problem

Traditional model: risk-averse, conveyance-first pathways

No definition of 'long lie' – open to interpretation

Default conveyance → short-stay admission

Limited therapeutic benefit

Bed and ED flow pressures

Poor patient experience

Our innovation: What we did and how

Community Virtual Ward

Nurse-led
Roaming Car

Rapid At-Home Assessment

Point of Care Testing, Neuro Observations, IV/SC Fluids, ECG, Bladder Scan

Integrated Service

East Midlands Ambulance Service, GPs, and Community Nursing

Re-Imagining the Emergency Response

Falls and Long Lie Pathway, Fall and (potential) Head Injury on Anti-coagulation Pathway

Outcome Highlights

536 patients supported between March 2025 – January 2026

Average **2-hour** response time

7.7 % transfer to secondary care - 2.9% of these directly to place of care

44% engaged with technology

100% referred to other services

Cost benefit per patient – traditional pathway £6400, **new pathway £425**

Further Outcomes

Fall and long lie patients managed: **n = 424**

Anticoagulated head injuries: **n = 112**

70-79 years - **41%**

80-89 years - **25%**

Living alone: **79%**

Referrals from ambulance: **58%**

Escalation to ED: **4.8%**

Overall admission avoided: **495 people**

Deaths: **4 (Expected)**

CVW length of stay: **8.3 days**

Impact Across the System: Benefits

Demand - avoids ambulance conveyance, ED attendances and non-elective admissions. Community shift

Equity and access - targets high-risk groups, delivers rapid care at home to reduce complications, neighbourhood working

Outcomes - improves patient experience, maintains independence

Cost - lower cost than an inpatient stay, shifts to proactive care

Key Enablers

Engagement with key providers including ambulance service, Falls response, 111/CAS, ED

Education to teams - ease of access e.g. direct line, QR code etc

'Perfect week' model Front door presence by ambulance/VW leads, challenge decision making

Face to face element is crucial to enable urgent assessment, point of care testing, prompt monitoring

24/7 service - access to overnight/weekend support
- Acute Response Car (ARC)
- Level 1 falls referrals

Links created into acute Frailty services to avoid ED admission (e.g., Frailty SDEC, AFU)

Local system support and effective **communication systems**

Patient and carer education and empowerment

Data and continuous improvement

Making a difference

Positive Patient Stories

↓

Good Experiences and Feedback

↓

Improved Staff Morale

Margaret (pictured right), 79, avoided admission

> I got hospital quality care at home.

Get in touch

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SCAN ME

NHS Deep Dive

Dr Birte Morris

Service Line Director for Acute Virtual Ward | Clinical Lead for SPOA, UHP Plymouth - Devon

University Hospitals Plymouth NHS Trust

WardAnywhere2026: The NHS Virtual Wards to Virtual Hospitals Strategy Conference

Patient flow & Care Coordination

We put people first
We take ownership
We respect and value each other
We are compassionate
We listen, learn and improve

University Hospitals Plymouth NHS Trust

Preventing the Front Door: Mobile X-Ray as a Gateway to the Virtual Ward

Preventing Admissions, Delivering Care at Home

A collaborative initiative between Derriford Hospital and Livewell Southwest.

Providing rapid community diagnostics, holistic assessment,

and proactive frailty management.

We put people first
We take ownership
We respect and value each other
We are compassionate
We listen, learn and improve

Play video from 2 mins 43 seconds to 3 min 40 - Derriford Hospital's x-ray car service saves hundreds of beds by treating elderly patients at home | ITV News West Country

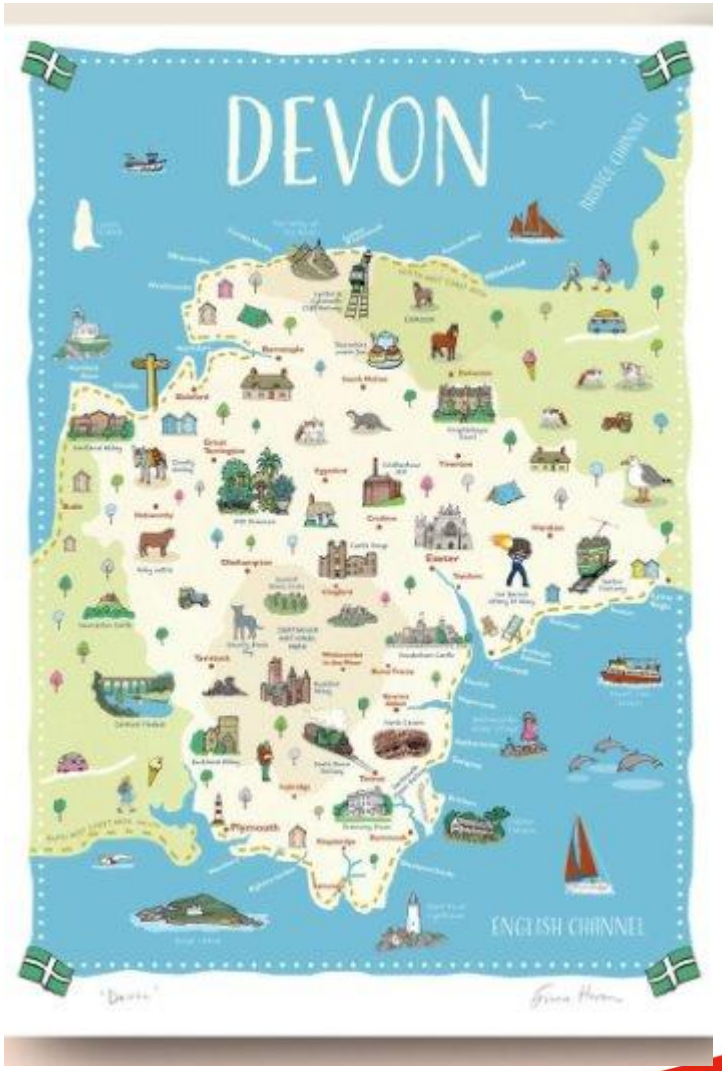
University Hospitals Plymouth NHS Trust

Sheila is:

- One of first patients
- Care Home resident
- 45min away from UHP
- Comfortable in her own surroundings
- Receiving full care with better outcomes

We put people first
We take ownership
We respect and value each other
We are compassionate
We listen, learn and improve

Not a Geography lesson but…



University Hospitals Plymouth NHS Trust

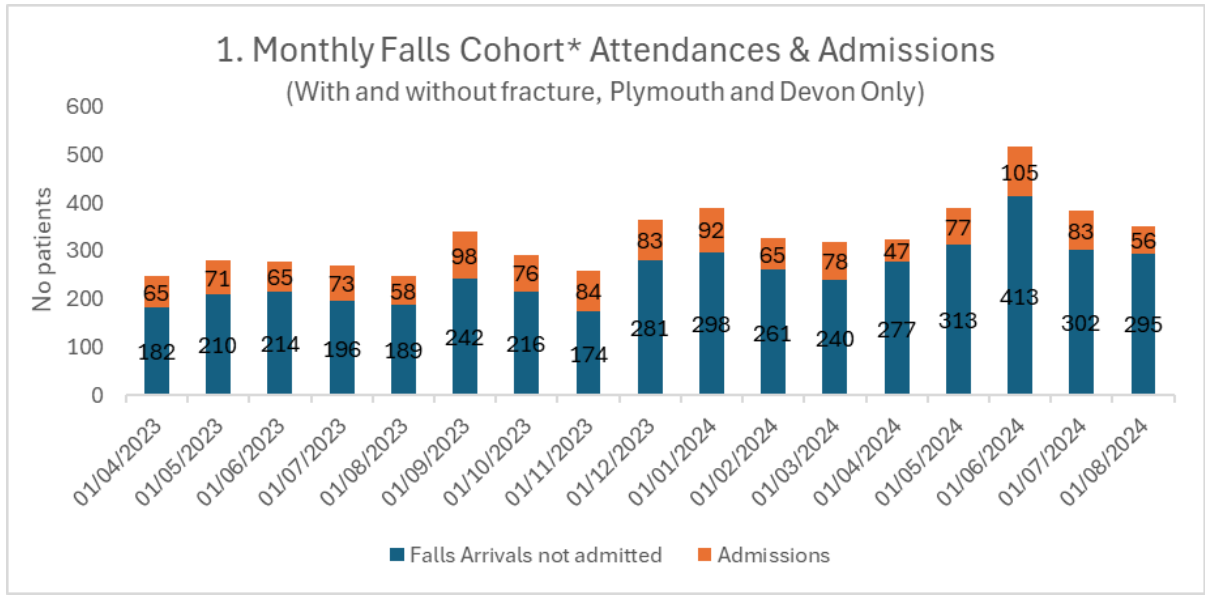
We put people first
We take ownership
We respect and value each other
We are compassionate
We listen, learn and improve

Why this matters?

Demand for change in management of falls

University Hospitals Plymouth NHS Trust

- In 2023, 2000* patients aged 55+ attended ED following a fall, with no fracture found after examination
- 1,300 of those patients arrived by ambulance (3.5 per day)
- 1,000 we admitted as in inpatient
- Falls arrivals in the elderly population have also been increasing (chart 1)
- On average this patient group stays 12-14 days once admitted to hospital
- Patients with no fracture may not need admission
- Some fractures can also be conservatively managed out of hospital
- RHCT pilot



*55+ ED falls, excluding NOF, with XR, with and without fracture, excluding Ortho theatre, admits to ICU or CCU and deaths. Excluding Paeds, prisons or police admission

We put people first
We take ownership
We respect and value each other
We are compassionate
We listen, learn and improve

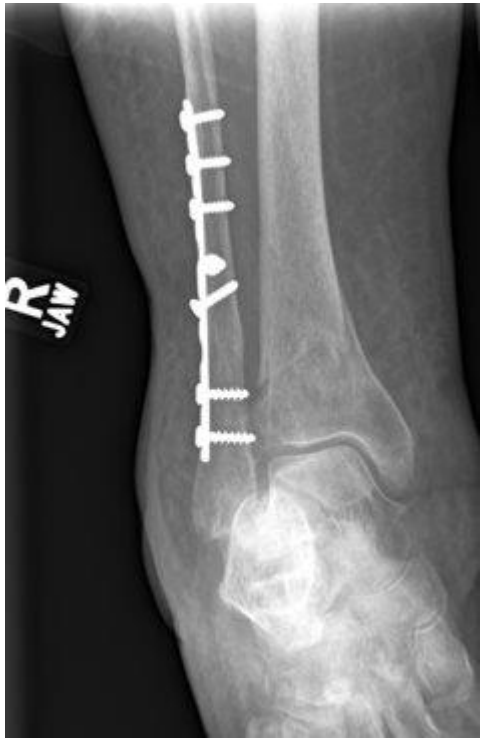
X-Ray car service: 12 month pilot

University Hospitals Plymouth NHS Trust

- Attend frail and vulnerable patients who have had a fall at home or in a care home setting
- Staffed by Radiographer/ Imaging Care Assistant 9am-5pm, 7 days a week
- Clinical risk is held by the Acute GP Service, supported by ED team and Virtual Ward
- Livewell Southwest's Urgent Community Response team attend for POC testing
- Provide Multidisciplinary review and holistic care planning
- Service launched on 30th Oct 2024

We put people first
We take ownership
We respect and value each other
We are compassionate
We listen, learn and improve

Patient case study – initial x-ray and fracture clinic follow up all performed at patients' home



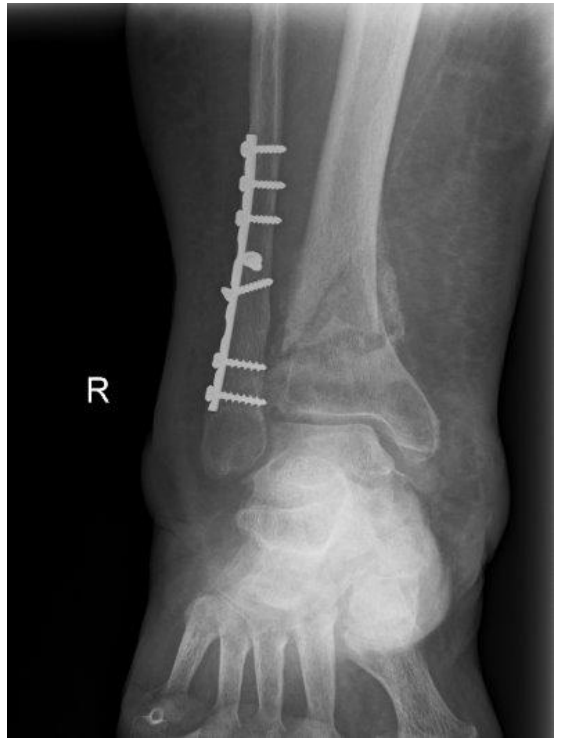
91 yr patient in care home, pain in ankle following witnessed fall

X-ray showed minimally displaced distal tibia #

PT transferred via hospital transport to local MIU for plaster

6 week later cast was removed by community care team and post cast images obtained via the x-ray car service

Discussed with Ortho, patient managed in boot with physio from community care team



What we have achieved in the first year

University Hospitals Plymouth NHS Trust

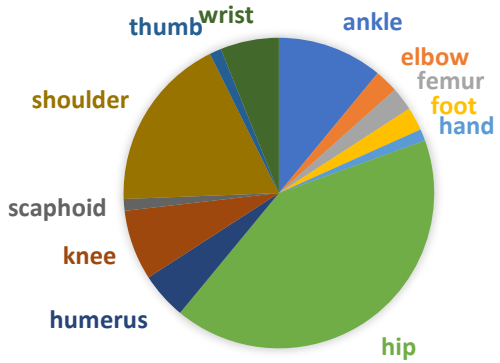
83% avoided hospital attendance

6% attended ED/MIU/UTC for treatment (manipulation or cast)

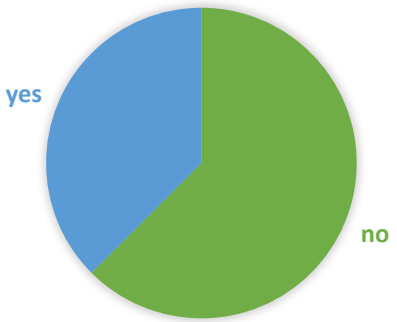
5% admitted for surgery

6% attended ED for further imaging and senior review

BODY PART IMAGED



FRACTURE VS NO FRACTURE



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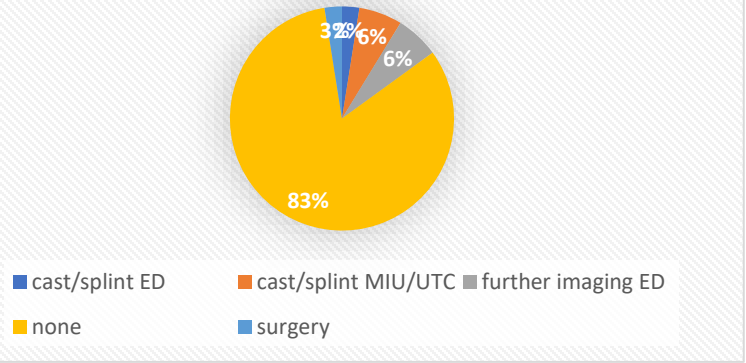
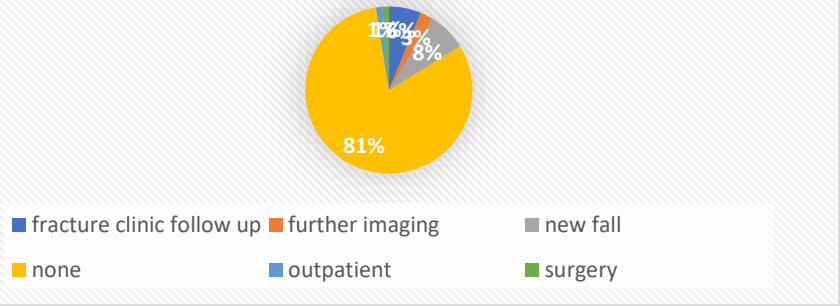
Patient had follow up for x-ray car fall (same day or day after)



Patient had follow up or hospital visit (within 1 month of x-ray or 6weeks post #)



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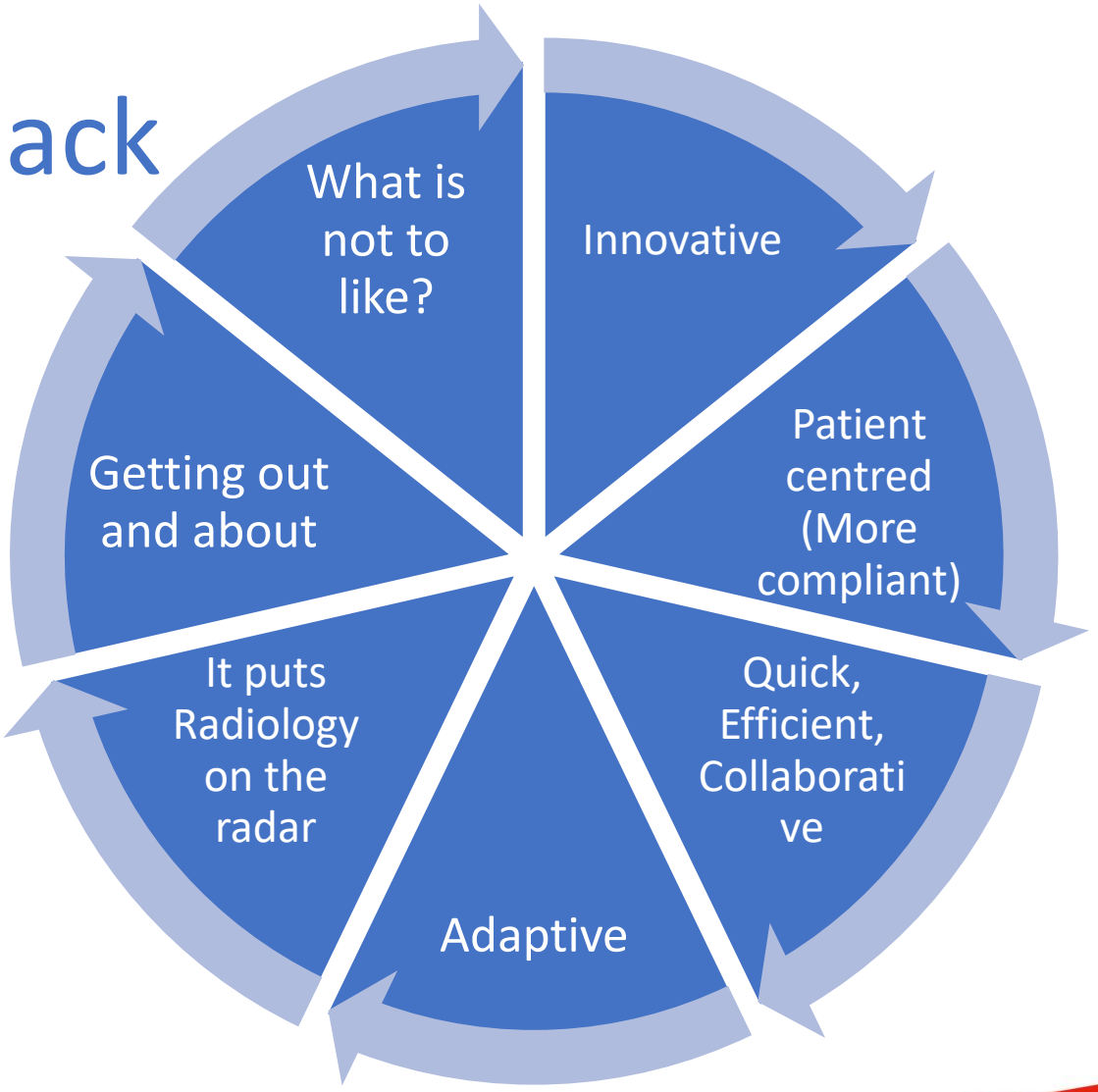
We respect and value each other
We are compassionate
We listen, learn and improve

Staff feedback



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Patient feedback

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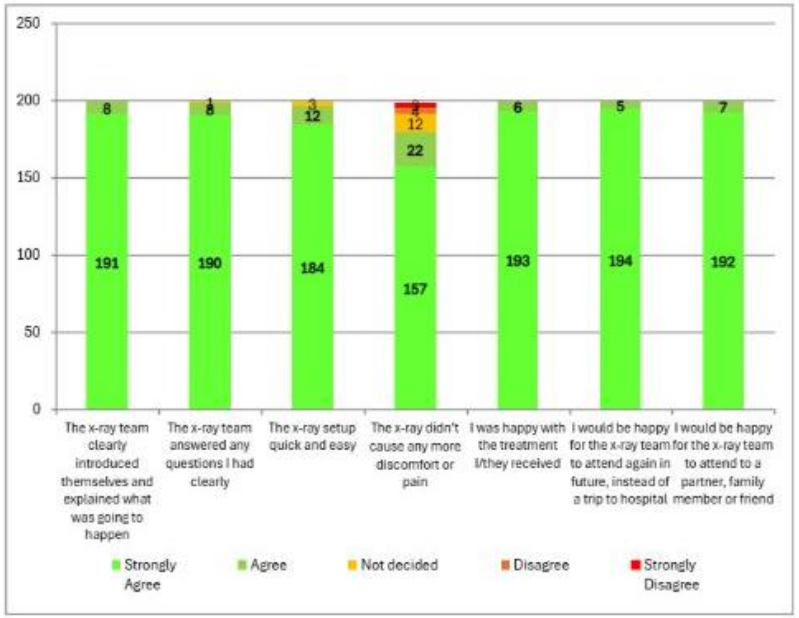
Question	Strongly Agree	Agree	Not decided	Disagree	Strongly Disagree	Total
The x-ray team clearly introduced themselves and explained what was going to happen	191	8				199
The x-ray team answered any questions I had clearly	190	8	1			199
The x-ray setup quick and easy	184	12	3			199
The x-ray didn't cause any more discomfort or pain	157	22	12	4	3	198
I was happy with the treatment I/they received	193	6				199
I would be happy for the x-ray team to attend again in future, instead of a trip to hospital	194	5				199
I would be happy for the x-ray team to attend to a partner, family member or friend	192	7				199

- Quality service, excellent idea
- brilliant service, very personable thank you
- Brilliant and efficient service. everything explained and very thorough with all stages of x-ray being undertaken. mum in short term carehome had xray within an hour of request. thank you
- been good service
- Very satisfied with service provided, long may it continue
- Excellent service, Thank you :)
- amazing service, reassured resident and was very speedy :)
- completed by medical team at hospice. Fantastic prompt service! Thank you so much. This avoided sending my lady throug when she is in her last weeks of life. It allowed us to make a conservative mx plan without using hospital resources
- the service was fast and convient for the resident



"Very good service and saved a trip to hospital."

"They were very professional and treated my resident with care. Process was quick."

"very understanding and patient with our resident and didnt rush him.."

"Very quick, great service thank you!!."

"Excelllent thank you"

"Quick and efficient service,"

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Service success

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How did we succeed?

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- Collaboration with multiple teams
- Extremely positive feedback from patients
- Alternative pathway for suitable patients avoiding hospital admission, resulting in reduction in bed days for this cohort of patients
- Link with Virtual Ward providing holistic, pro-active care in the community
- Key enabler Gateway Hub/ SPOA
- Winner of the HSJ digital award for “Improving urgent and emergency care through digital”

Where will we go from here?

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- Overnight referrals
- Chest Xray
- Xray in Community Hospital for NG tube
- GP in a car
- Extra funding for Community Services
- MIU support

Case study - LD patient pathway

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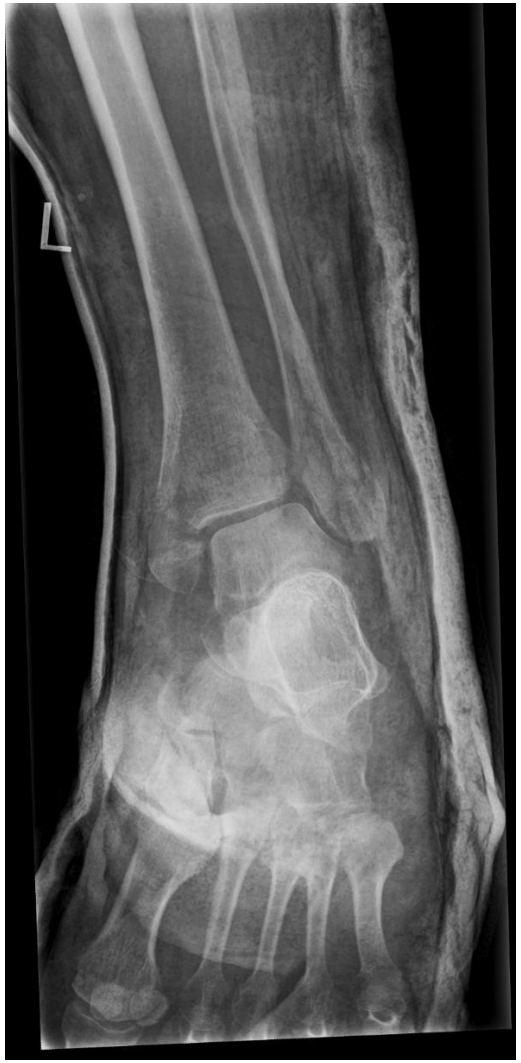

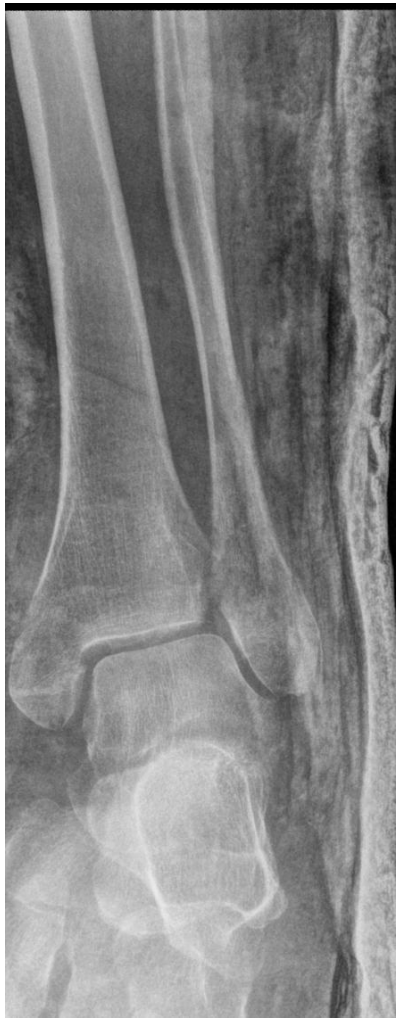

- 66yrs old patient with severe learning disability and health anxieties
- Admitted to hospital for surgery
- Patient very agitated throughout her hospital stay
- Managed instead conservatively in a cast
- Follow up Xray undertaken in patient's home
- Great example of how the x-ray car pathway can be used in bespoke ways to aid the treatment and care of patients with learning disabilities or complex needs.

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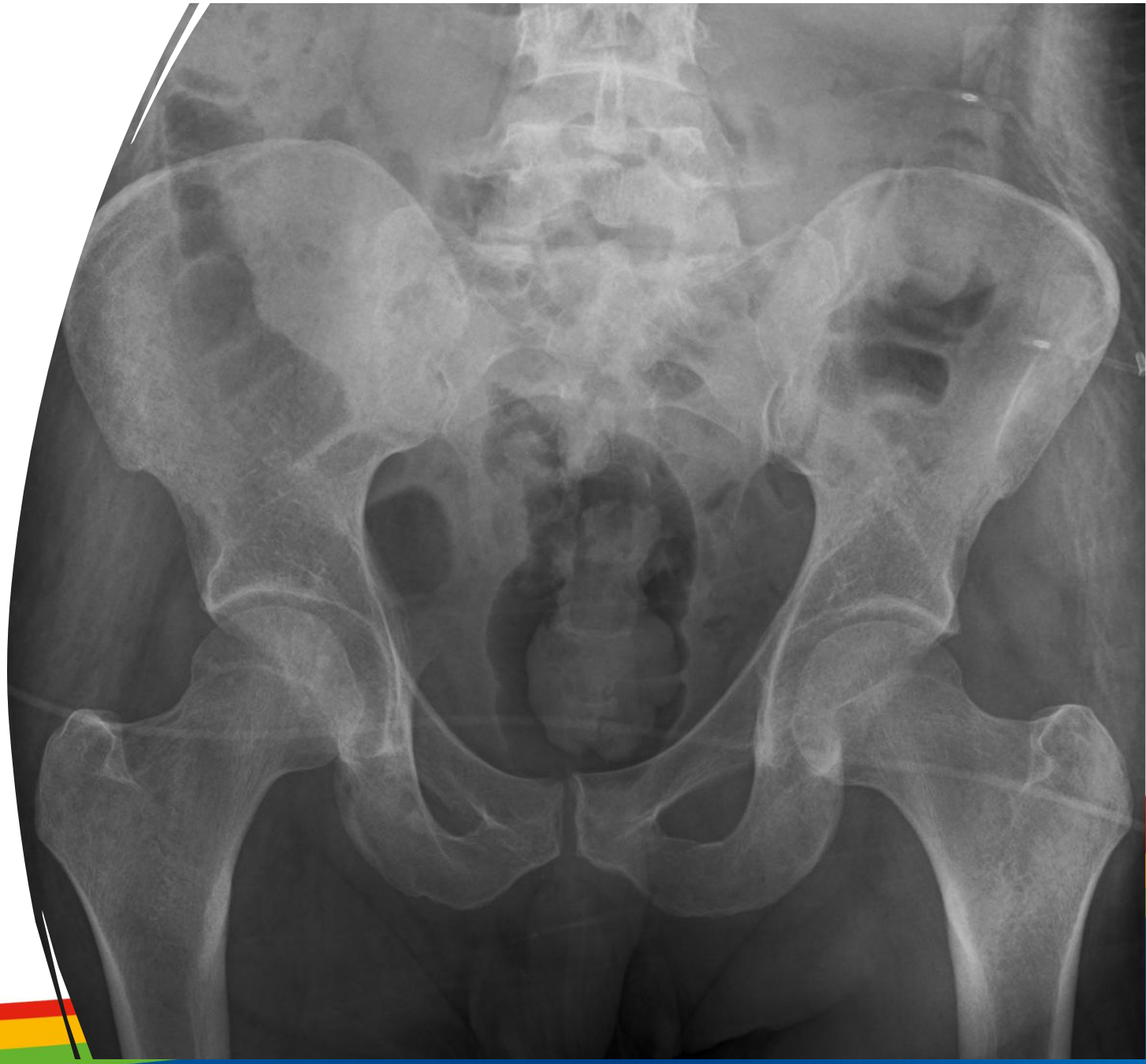
Case study - St Luke's Hospice

- 35-year-old patient with AML and end of life
- Sudden pain in left hip, worse on rotation, non weight bearing
- Pathological fracture
- X-ray normal
- Great pathway for this patient as no need to convey them to ED and pain was appropriately managed in hospice setting



Remember Sheila...

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Any questions?

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05th March 2026
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