doccla

Proactive Care. Redefined.

Integrated, Digital-First Neighbourhood care

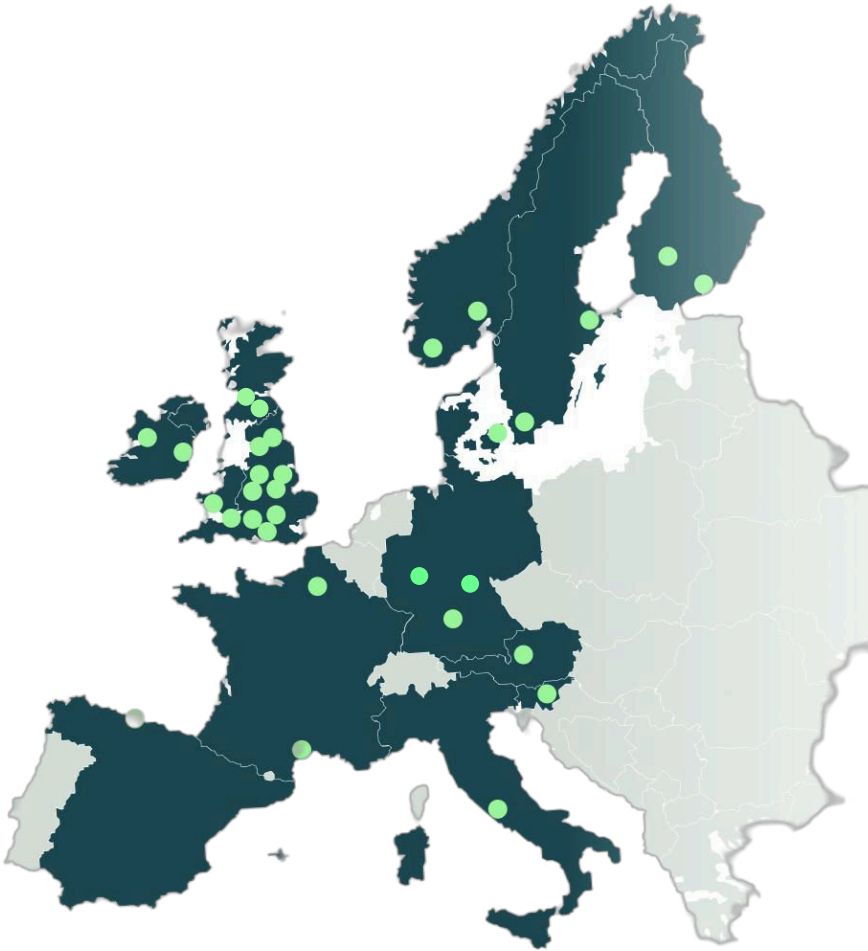
Chloe Smithers, Partnerships Lead

Doccla: Europe's leader in Virtual Care, a trusted partner to the NHS

4,000,000
Patient days monitored

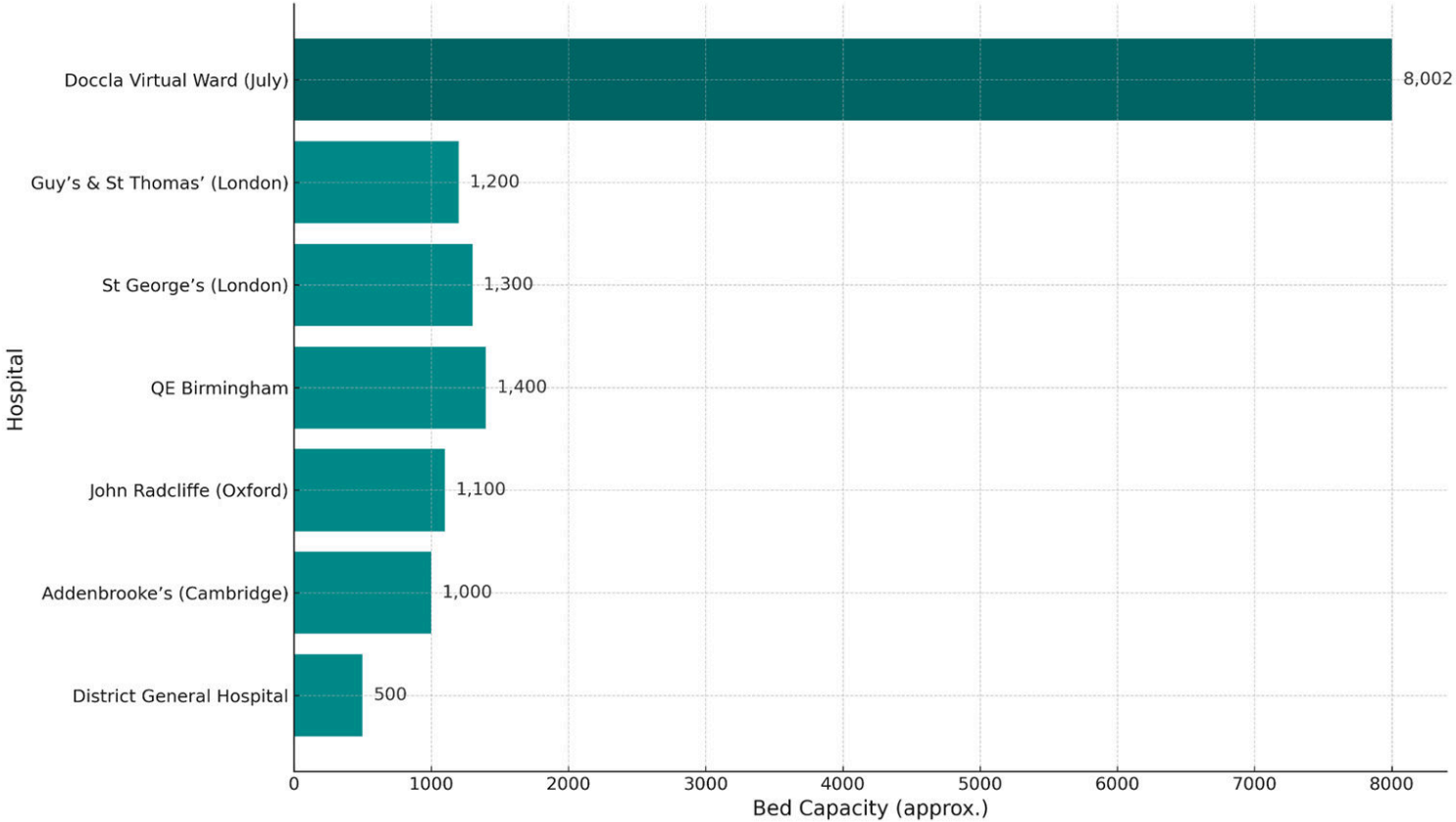
400k
Vital signs monitored per week

>60%
Coverage in NHS England, HSE, Scotland and Wales



NHS · HSE · SVS · Tays · Wiener Gesundheitsverbund · Für die Stadt Wien · Gemelli · SIEMENS Healthineers

‘From bricks to clicks’: delivering virtual care at scale



Care across the continuum:

Supporting the ‘person’ rather than a single episode of care

Lower acuity

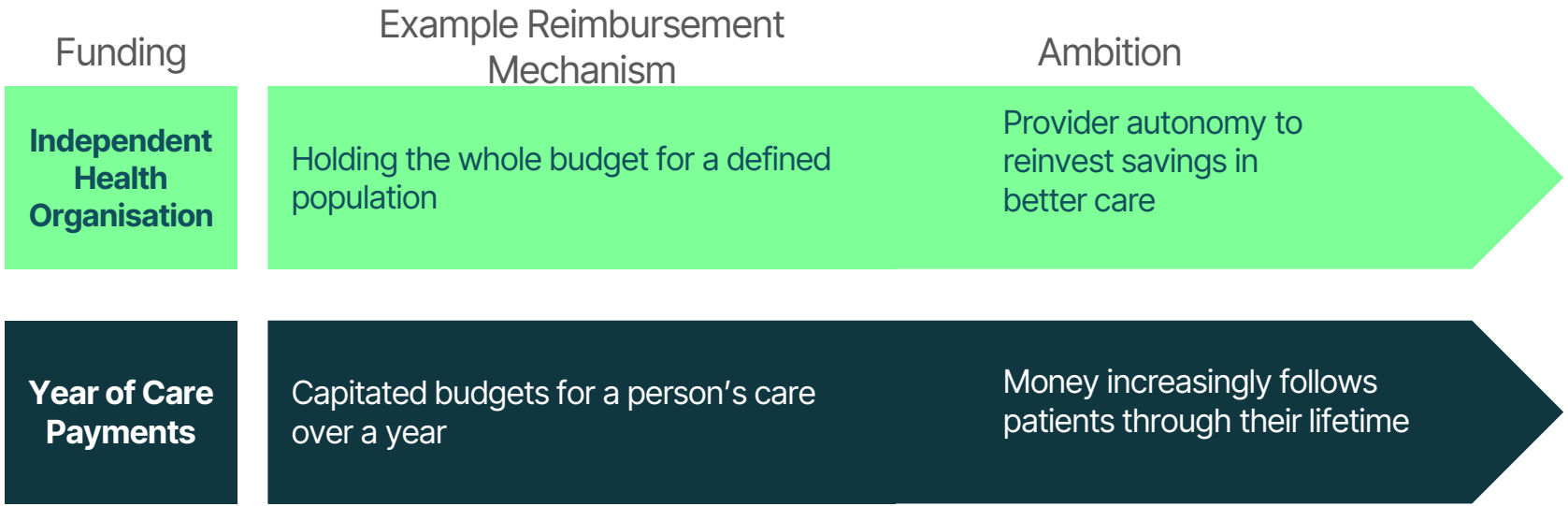
Higher acuity

Self-management
for stable patients with chronic disease

Remote management
for patients at rising risk

Virtual wards
to support early discharge or alternatives to admission

10 Year Plan: Reimbursement mechanisms that prioritise outcome over activity



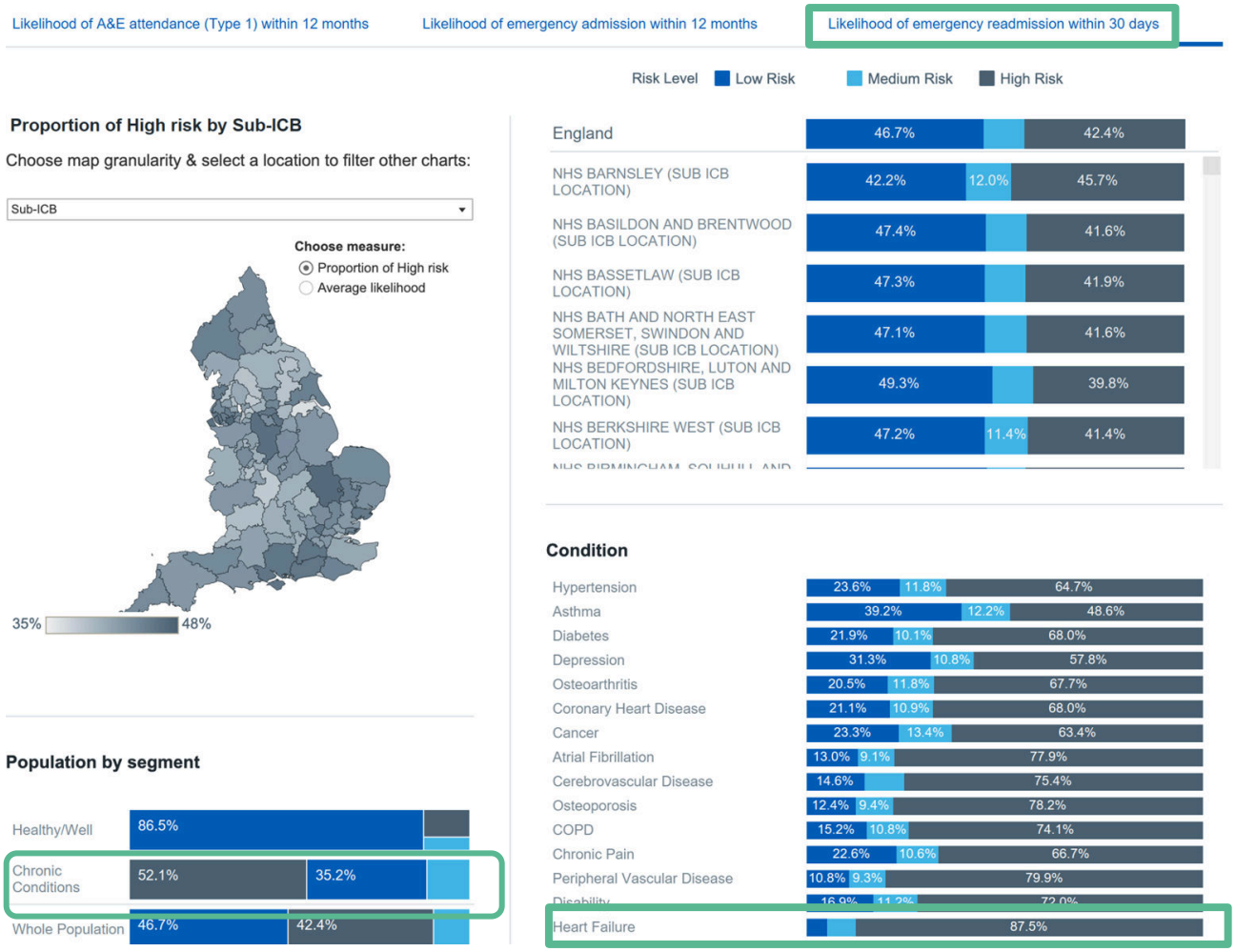
A Rising Challenge: Patients at the Apex of Need

5% of patients cost more than the all others combined.

Of these, 70 – 90% live with a long term condition.

Chronic disease cases projected to rise 37% by 2040, nine times faster than the working-age population.

Analysis by The Health Foundation



>60% of patients with chronic conditions are qualified as ‘high’ or ‘medium risk’ of emergency readmission within 30 days

78% of heart failure patients are at high risk of NEL admission in the next 12 months.

Increasing to **87% of heart failure patients with** high risk of readmission.

What do we mean by Proactive Care?

The Neighbourhood health guidelines 2025/26 outline six core componenets of proactive care delivery

NHS England

Population Health Management
Data-driven identification of high-risk cohorts

Neighbourhood MDTs
Integrated teams coordinating care across sectors

Primary Care Development
Enhanced access and integration with community services.

Standardised Community Health
Expansion of urgent community response and virtual ward services.

Digital Infrastructure
Shared records & telehealth to improve coordination & access.

Intermediate Care
Step-up/down services with a Home First approach, minimising hospital stay.

Regulated by Care Quality Commission

Translating this vision into reality: virtual neighbourhood care for patients most at risk

Risk stratification

Identifying patients at highest risk that could benefit from proactive intervention.

Outreach & enrollment

Multimodal outreach and engagement to enroll patients on the service.

Multidisciplinary support

Specialist MDTs - consultants, GPs, CNSs, remote monitoring nurses, and health coaches - address patients' holistic needs.

Ongoing self-management

Patients equipped with materials and tools to self-manage their condition proactively.

Population segmentation

Patients are grouped by risk profile to enable targeted care delivery.

Needs assessment and care planning

Patients triaged to appropriate care intensity. Personalised Care Plans developed.

Clinically 'Optimised'

Patients receive clinical interventions, on top of the self-management tools, tailored to their risk profile.

Real-time data monitoring for improvements and resourcing. Targeted interventions for maximum ROI.

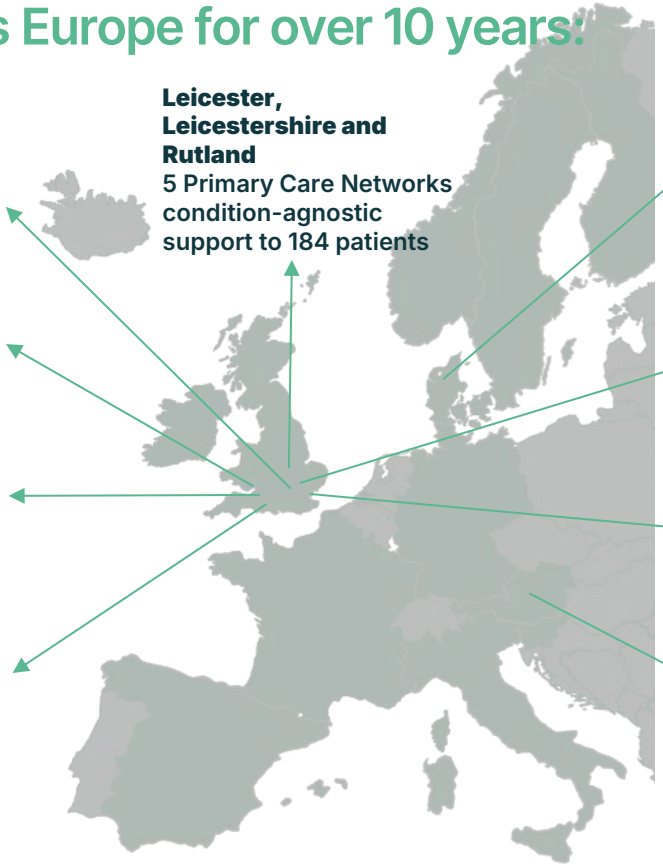
Doccla has been delivering Proactive Care programs for patients with LTCs across Europe for over 10 years:

One Health Lewisham
Condition-agnostic service supporting care home residents at risk of admission

BNSSG ICB
COPD programme supporting most deprived cohorts. 40% patients within IMD1-3

Gloucestershire ICS
2 Integrated Neighbourhood Teams. Targeted to support 210 at-risk frail residents in receipt of domiciliary care

Somerset ICB
Creating continuum between PCN and Somerset FT for 50 at-risk heart failure patients



Leicester, Leicestershire and Rutland
5 Primary Care Networks condition-agnostic support to 184 patients

Denmark
At-scale Heart Failure deployment
RCT showed 35% reduction in Total Healthcare Costs
in 275 patient sample

Hertfordshire Community Trust
75-bed Frailty hub and 157-bed COPD hub
Targeted to support patients most at risk of admission
50 patient National Vanguard Heart Failure program

Waltham Forest GP Federation
34 GP practices COPD programme
(enrolling now)

Vienna
Heart Failure programme for the entire city of Vienna
(enrolling now)

Proactive Frailty: LLR ICB

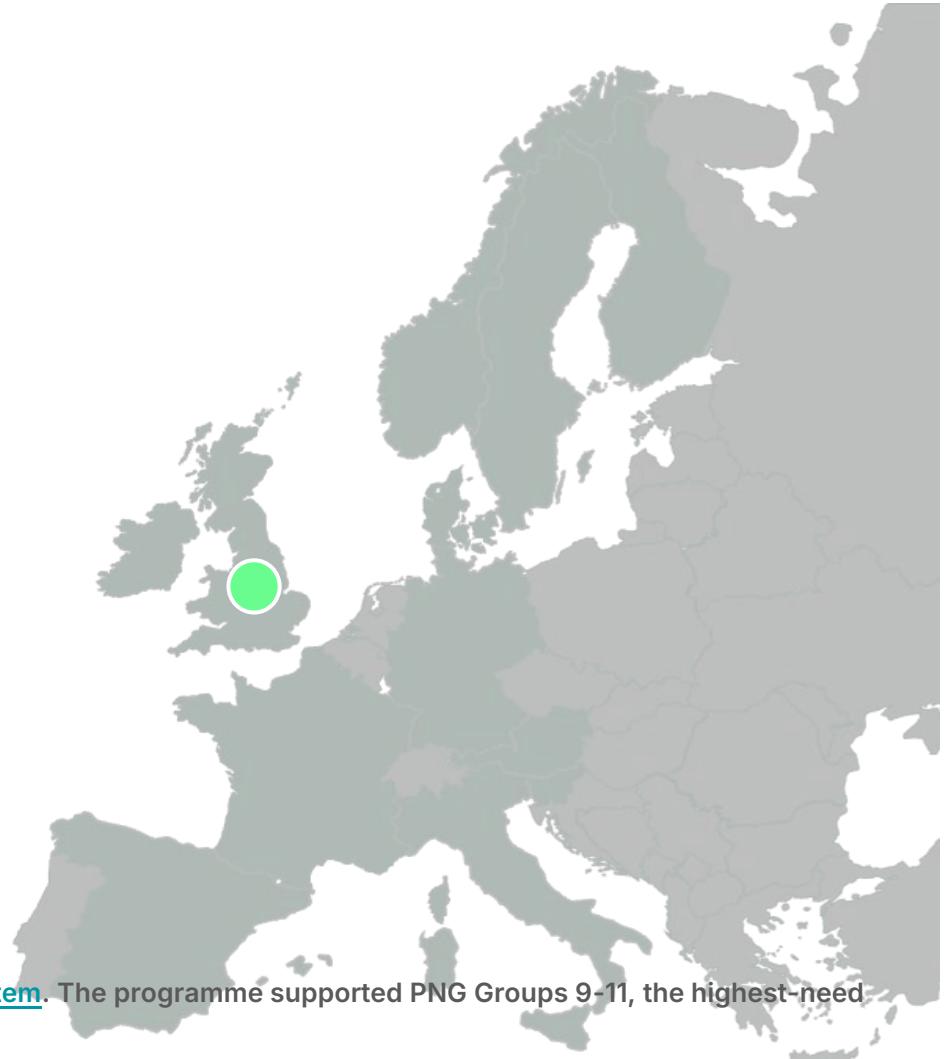
Focus on frail, multimorbid patients in PNG 9-11*. Patients received remote monitoring, health coaching, medicines optimisation, care plan management and MDT review.

61%
Reduction in bed days

81%
5/5 star patient feedback

89%
Reduction in GP appointments

40%
Reduction in NEL admissions



*Patient Need Groups as defined in the Johns Hopkins ACG System. The programme supported PNG Groups 9-11, the highest-need groups on the PNG scale.

Living Well with COPD: BNSSG ICB

Targeted COPD patients with at least 1 NEL admission in the last year (top 17% of cohort). Personalised care plans and Remote Monitoring deployed based on Tiers of Acuity. Formed continuum of care with local VW provision.

34%
reduction in NEL admissions

18%
Ambulance conveyances

19%
from Index Multiple Deprivation-1

77%
Reported LWwCOPD helped to manage their overall health better

Improving liver disease management: Barts Health NHS Trust

Remote monitoring supported patients with decompensated liver disease after hospital discharge. By tracking symptoms and vital signs at home, clinicians could intervene earlier, reduce admissions, and improve recovery outcomes within standard NHS care pathways.

57%
reduction in ED admissions

29%
fewer Decompensated Patients at 30 Days

50%
fewer liver-related deaths
in the RPM group within 90 days

And most importantly, patients feel the impact

>80%
Reported that the programme helped them to manage their COPD better

77%
Reported that it helped them to manage their overall health better

95%
Rate the service as good/very good

"I have learnt different breathing techniques to help me, and also different foods that will help....

It has helped me in so many ways and has given me confidence going forward

Since I started on the course I have a better understanding of my condition.

It has helped me so much, I packed in smoking, changed my diet and thanks to the nurses who came to see me I get counselling because I would not leave the house, I just gave uo. Now I even think different, I have a life, and I went out for the first time to see my son and his wife"