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White Paper

The Case for Proactive Care Monitoring

Dr Greg Edwards
Chief Medical Officer at Doccla

Key Takeaways

1. Proactive care monitoring prevents deterioration and reduces avoidable hospital admissions.

2. It differs from virtual wards by offering longer-term, lower-intensity support for chronic conditions.

3. Proactive care models typically combine tiered monitoring, medicines optimisation, nurse-led education, MDT escalation, and monthly health coaching.

4. Risk stratification and patient enrolment are supported by population health data.

5. Outcomes include fewer admissions, reduced emergency attendances, improved patient confidence, and high satisfaction.

Introduction

The rising burden of chronic illness presents an urgent challenge for health systems. Just **5% of patients account for more healthcare spending than the remaining 95% combined**[1]. Among this high-cost group, **70–90% live with at least one chronic condition**[2], and managing these conditions consumes **70–80% of NHS expenditure**[2]. By 2040, the number of people living with major long-term illnesses is **expected to rise by 37%**[3] - nine times faster than the working-age population.

Healthcare for chronic conditions has traditionally been reactive - intervening after a patient's health deteriorates or following a hospital admission. Historically, challenges such as fragmented healthcare services, limited access to real-time patient data, inadequate integration across health and care sectors, and resistance to adopting digital health technologies have hindered proactive approaches. Virtual wards are a recent innovation in this space, enabling short-term monitoring for patients that are acutely unwell and would otherwise be in a hospital bed. In contrast, proactive care monitoring focuses on continuously managing long-term conditions before patients reach a crisis point. By regularly tracking health metrics and supporting patient self-management through individualised care plans, proactive monitoring enables early identification of deterioration and timely intervention - helping to prevent exacerbations from escalating into crises or requiring hospital admission. This approach can keep patients out of hospital and living independently for longer. In fact, recent estimates suggest that **proactive remote patient monitoring can save 20-40% of total healthcare costs**[1], underscoring its powerful impact for both patients and health systems. The emphasis is on preventing emergency events rather than reacting to them - a shift that improves quality of life and reduces strain on healthcare services.

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Proactive Care vs Virtual Wards

Virtual wards serve a different purpose and are typically time-limited. They offer a safety net during an acute event, often following hospital discharge or in place of an admission. These models are designed to support patients during a defined episode of care, usually over a short time frame.

In contrast, proactive care monitoring is an ongoing programme that identifies and supports patients at risk before they reach a crisis point. Rather than reacting to deterioration, proactive models use regular health monitoring, individualised care plans, and patient engagement to prevent escalation altogether. While both virtual wards and proactive care use remote technology, proactive monitoring is broader in scope and better suited to patients with chronic conditions who need longer-term support.

Together, the two models can form part of a seamless digital care continuum - patients may move from proactive care into virtual ward support during an exacerbation and then step back down into lower-intensity proactive monitoring once stable.

Aligning with NHS Strategy and Policy

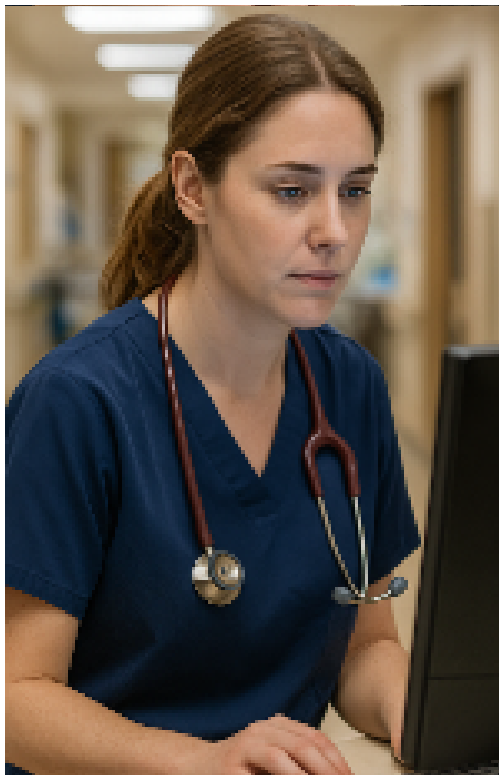
The recently published Neighbourhood Health Guidelines 2025/26 emphasise a shift towards integrated, **community-based care with a strong digital component**[4]. NHS England's forthcoming 10-Year Health Plan (due Spring 2025) is also expected to reinforce this direction, with a continued focus on prevention, digital transformation, and care closer to home. These frameworks highlight three fundamental shifts:

From hospital to community

From analogue to digital

From treatment to prevention

Remote patient monitoring squarely supports all three. It enables more care to be delivered closer to home, facilitates early intervention, and uses digital innovation to address chronic disease more efficiently. The NHS England guidelines further recommend remote monitoring and patient-initiated follow-up as **tools to improve access, experience, and outcomes**[4].



Why Proactive Monitoring?

Chronic illnesses such as heart failure, chronic lung disease, and diabetes often follow a relapsing-remitting course with periodic flare-ups or hospitalisations. Proactive monitoring programmes observe patients' vital signs and symptoms at home, enabling early detection of any concerning changes. Clinicians receive alerts or trend data in real-time and can intervene promptly - for example, by adjusting medications or scheduling a timely clinician review - before a minor issue becomes a full-blown emergency.

This early intervention has been shown to lead to a **30% reduction in emergency department visits**[5] and a **41% reduction in all-cause hospital admissions**[6]. Patients benefit from better symptom control and peace of mind knowing their health is being actively watched over. Importantly, proactive monitoring also improves equity of care by reaching patients who may struggle with frequent in-person visits - bringing care to the home environment. Overall, shifting from episodic, reactive care to a continuous preventative model helps break the cycle of crisis management and creates a more sustainable approach for long-term conditions.

Benefits of Proactive Monitoring

1 Early Intervention and Risk Prevention

RPM detects early signs of deterioration, enabling timely treatment changes that **prevent exacerbations and admissions**[5].

2 Patient Empowerment

Patients become more engaged when they can interact with and better understand their own health data, **improving self-management, health literacy, and adherence**[7].

3 Reduced Hospital Utilisation and Cost

Previous Doccla proactive monitoring projects have evidenced up to a **29% reduction in non-elective admissions and a 20–30% reduction in A&E attendances**[8].

4 High Patient Satisfaction

Over 80% of patients in proactive monitoring programmes report feeling **more confident and supported**[8] in managing their health at home.

"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 counseling because I would not leave the house, I just gave up. Now I even think different, I have a life, and I went out for the first time to see my son and his wife."

Patient from Living Well with COPD proactive care cohort

Identifying Patients

A key first step in proactive care monitoring is identifying and enrolling the right patients. Population health data and predictive analytics can be used to risk stratify the patient population. This involves analysing electronic health records, hospital admission data, long-term condition registers, and demographic factors to identify individuals most at risk of deterioration or hospitalisation. Widely used tools in UK healthcare, such as Patient Needs Groups (PNG), QRISK and the Electronic Frailty Index (eFI) leverage comprehensive datasets to enhance the accuracy and effectiveness of patient identification.

Patients with recent exacerbations, multiple long-term conditions, high frailty scores, or frequent A&E attendances are flagged as candidates for enrolment. Once identified, patients can be proactively enrolled into monitoring programmes through coordinated efforts between care providers and remote monitoring services. This streamlines enrolment, reduces administrative burden for NHS teams, and ensures the intervention reaches those who would benefit most - including individuals who might not otherwise engage with traditional, clinic-based care.

Proactive Care Models: Condition-Specific vs Disease-Agnostic

Proactive care programmes vary in scope:

- Condition-specific models (e.g. heart failure, COPD, diabetes) use tailored pathways and disease-specific thresholds.

- Disease-agnostic models are designed to manage patients with multiple conditions or high health needs, using broader monitoring protocols and escalation based on general health deterioration.

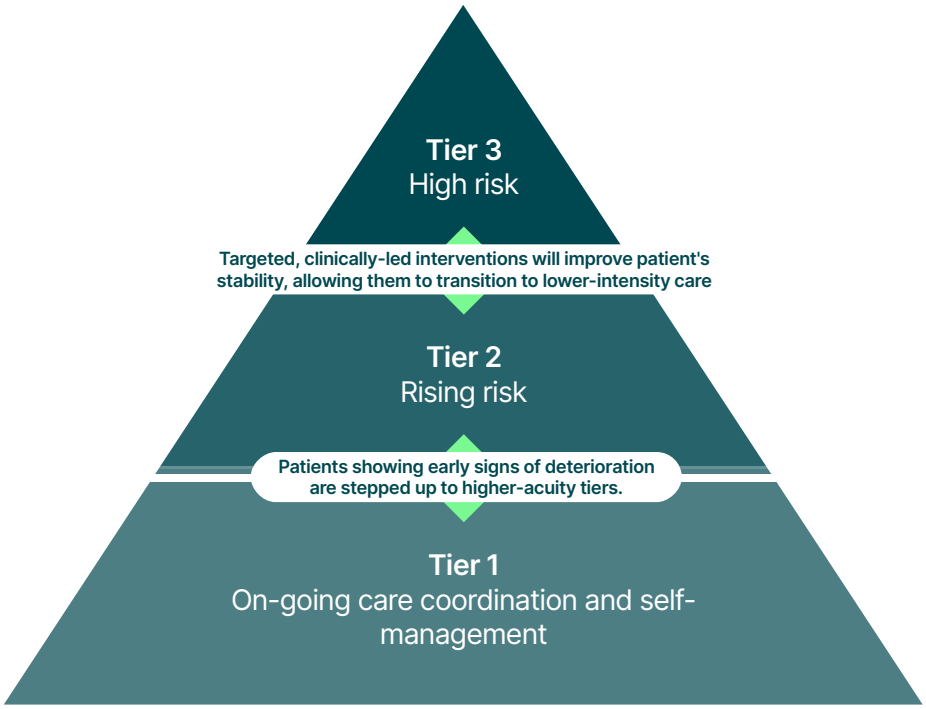
For example, in a heart failure programme, weight and symptom tracking may allow clinicians to intervene before fluid overload occurs. In contrast, a disease-agnostic model used in frailty or multimorbidity settings would monitor observations and general wellbeing relating to the overall health status of the patient, triggering responses regardless of specific diagnoses. Both approaches can be effective, depending on the population served and system maturity.

"I think taking the time to discuss my condition with the Doccla nurse, and taking regular readings helped to focus on what I could do differently to help myself."

Patient from Living Well with COPD proactive care cohort

A Tiered Model

Effective proactive care often uses a tiered approach to stratify patients by their level of risk and support needs. Patients can be enrolled into different tiers of monitoring intensity and then step up or down between tiers as their condition evolves. Patient education plays a critical role in the model and has been **shown to improve self-management and reduce hospitalisations**[9, 10]. As patients gain confidence and skills in managing their health, the monitoring intensity is gradually reduced, preventing dependency on the service and encouraging long-term independence.



Tier 3 – High-Intensity Monitoring
For the highest-risk patients, this 12-week programme involves frequent vital sign monitoring (e.g. blood pressure, weight, oxygen saturation), regular contact with clinicians, and fortnightly reviews. Medication optimisation, health coaching, nurse-led education, and escalation to specialist MDTs support recovery and stabilisation. Patients may step down sooner if deemed stable.

Tier 2 – Moderate-Intensity Support
Designed for stable or improving patients. Monitoring is weekly or monthly, with less frequent clinical reviews. Focus is on maintaining gains, self-management, and continued education. Patients move to Tier 1 if stable, or escalate to Tier 3 if needed.

Tier 1 Low-Intensity Monitoring (Maintenance)
For lower-risk patients, this stage places a strong emphasis on self-management, empowering individuals to actively monitor and maintain their own health. Patients are encouraged to engage with educational content, webinars, and symptom tracking tools, with infrequent data submission and minimal clinical contact unless patient-initiated. Safety-net monitoring remains in place, with clear pathways for escalation if deterioration is detected.

Multidisciplinary Approach

Proactive monitoring programmes are multidisciplinary by design. Day-to-day, much of the patient contact is handled by specialist nurses or health coaches, but they operate within a wider team that can include general practitioners, specialists, pharmacists, physiotherapists, dietitians, and more. Regular multidisciplinary team meetings (MDTs) are convened to discuss patients who are not progressing as hoped or who have complex needs. With proactive care spanning various aspects of a patient's life (medical, lifestyle, psychological), an MDT approach ensures a holistic review. By having specialists lead or participate in these reviews, the programme can escalate care effectively and coordinate across services. This strategy aligns with national guidelines for chronic disease management and **improves outcomes**[4].

In many health systems, the lack of shared electronic patient records (EPR) between secondary, acute, and primary care teams presents a barrier to seamless coordination. Proactive care monitoring platforms can help overcome this challenge by providing a shared dashboard that acts as a single source of truth for patient interactions. The system facilitates task management across geographically dispersed teams, ensuring all team members have visibility of patient status, actions taken, and next steps. A clear audit trail of interventions supports accountability and enhances patient safety. In this way, the benefits of proactive care extend beyond remote monitoring alone, offering an integrated model that supports effective care coordination and communication between professionals.

The Role of Health Coaching

Health coaching supports patients to set goals, build healthy habits, and improve confidence in managing their condition. Coaching is typically delivered through regular one-to-one sessions by trained clinicians or coaches. Topics range from physical activity and medication adherence to diet and mental wellbeing. It complements the clinical model by translating advice into action. In many models, monthly 30-minute coaching sessions are offered, as required. Evidence shows that health coaching **improves lifestyle behaviours, enhances self-efficacy, and reduces admissions**[7]. It empowers patients to sustain long-term improvements even after formal coaching ends.

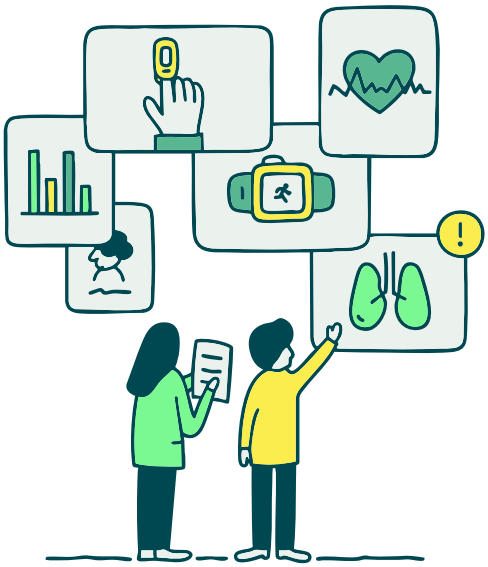
Person-Centred Care

Patients living with long-term conditions often experience a fragmented care journey, bouncing between services without clear coordination - a "pinball" effect across the system. Proactive monitoring offers a more cohesive, joined-up approach that organises care around the individual rather than the service.

At the heart of this approach are individualised care plans, tailored to each patient's unique circumstances, health goals, preferences, and lifestyle. Rather than applying a one-size-fits-all model, proactive monitoring uses ongoing patient feedback and health data to adjust care plans continuously, ensuring relevance and responsiveness. This personalised strategy enhances engagement, adherence, and satisfaction by recognising each patient's autonomy and actively involving them in decisions about their health.

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

Patient from Living Well with COPD proactive care cohort



Integration

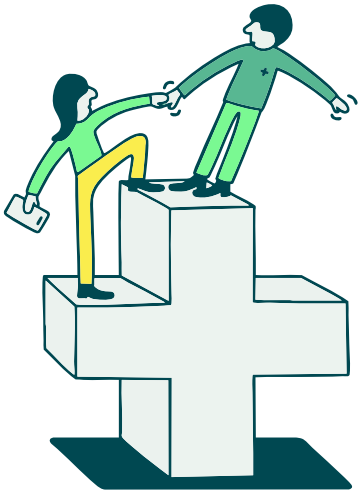
Integration is fundamental to the success of proactive care monitoring. For digital health interventions to be safe, efficient, and scalable, they must be integrated into existing health and care systems.

First, integration with electronic health records (EHRs) is essential. Clinicians across services need access to a unified view of patient data, including remote monitoring results, symptom trends, and intervention history. Modern platforms should support interoperability with NHS systems to ensure seamless information flow, reducing duplication and enhancing continuity of care.

Second, integration must extend across sectors - primary care, community care, mental health, social care, and secondary care. Proactive monitoring is most effective when it is embedded into a broader care ecosystem, with clear protocols for escalation and communication. This reduces fragmentation, supports coordinated care planning, and ensures the patient remains at the centre of their care journey.

Effective integration also ensures alignment with existing care pathways, enabling proactive monitoring to augment - not replace - regular clinical touchpoints. As integrated care systems mature, proactive models will play a pivotal role in delivering joined-up, preventative care.

Addressing Healthcare Inequalities



Proactive care monitoring offers a unique opportunity to address longstanding healthcare inequalities. Traditional models of care often disadvantage individuals who face barriers to attending frequent in-person appointments - including those with mobility limitations, low income, rural isolation, or caregiving responsibilities. By shifting care into the home and allowing for flexible, digitally enabled monitoring, proactive models can close the gap for underserved populations.

Risk stratification approaches can also be designed to identify individuals who are not only clinically vulnerable but also socioeconomically disadvantaged, ensuring that support is targeted where it's needed most. For example, data from the BNSSG Living Well with Chronic Obstructive Disease (LWwCOD) programme showed that **around 40% of participants were from the most deprived cohorts**[11] (Index of Multiple Deprivation deciles 1–3), demonstrating the potential of proactive models to reach underserved groups.

Additionally, tools like patient apps, translation features, and culturally competent health coaching can improve accessibility and engagement across diverse populations. Embedding equity into the design and delivery of proactive monitoring is key to making digital transformation inclusive and impactful.

Conclusion

Proactive care monitoring represents a paradigm shift in managing chronic illnesses – from passively waiting for crises to actively preventing them. By using technology and combining it with robust clinical support, proactive programmes can intervene early and avert many deteriorations that would otherwise lead to emergency admissions. The tiered approach allows healthcare teams to prioritise resources and attention to those who need it most, while still providing a safety net for lower-risk patients.

Proactive care programmes have demonstrated measurable benefits: a **29% reduction in non-elective admissions, a 20–30% drop in A&E attendances, and over 95% patient satisfaction**[8]. Patients experience better symptom control, fewer hospital visits, and greater confidence in managing their health. Healthcare systems benefit from reduced pressure on acute services and cost savings.

The future of chronic care will depend on models that are scalable, flexible, and digitally enabled. Proactive monitoring offers exactly that. By investing now, the NHS can embed a sustainable model that delivers better outcomes, better experience, and better value. This shift is critical for the sustainability of the NHS, as it enables more efficient use of resources, reduces pressure on acute services, and supports long-term population health outcomes.

For further information please contact greg@doccla.com

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