Meon Health Practice

Supporting your health & wellbeing

Scaling Digital Solutions for Chronic Disease Prevention

Introduction

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RediCareControl DTx

Type 2 Diabetic

Non-Diabetic Hyperglycaemia

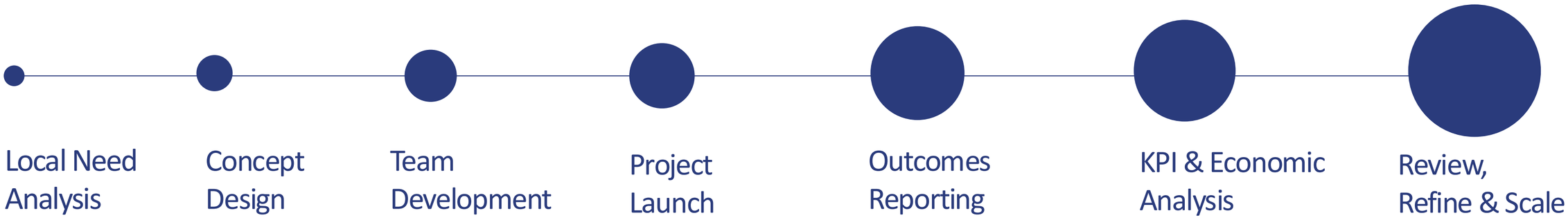
NAFLD

PCOS

Challenges and Goals

- Address the escalating prevalence of Chronic Diseases
- Shift from reactive to proactive care
- Move from analogue to digital care
- Empower patients through education
- Reduce demand on surgery

Co-Designing a Digital Prevention through Digital



Journey Through Digital

1 → 2 → 3 → 4 → 5 → 6

EMIS

Automated weekly searches in EMIS to identify eligible patients for proactive support.

Co-Branded SMS

Eligible patients are invited to join the programme via co-branded SMS campaigns sent through Accurx.

1-1 Online Consultations

Each patient is onboarded by a Health Coach and offered ongoing personalised consultations as needed.

Weekly Touchpoints & Content

Patients receive weekly nudges and access to tailored video content, supporting behaviour change and engagement.

Weekly Masterclasses

Live, interactive webinars deliver expert guidance and foster a strong sense of community, with 70%+ attendance.

Clinical Outcomes

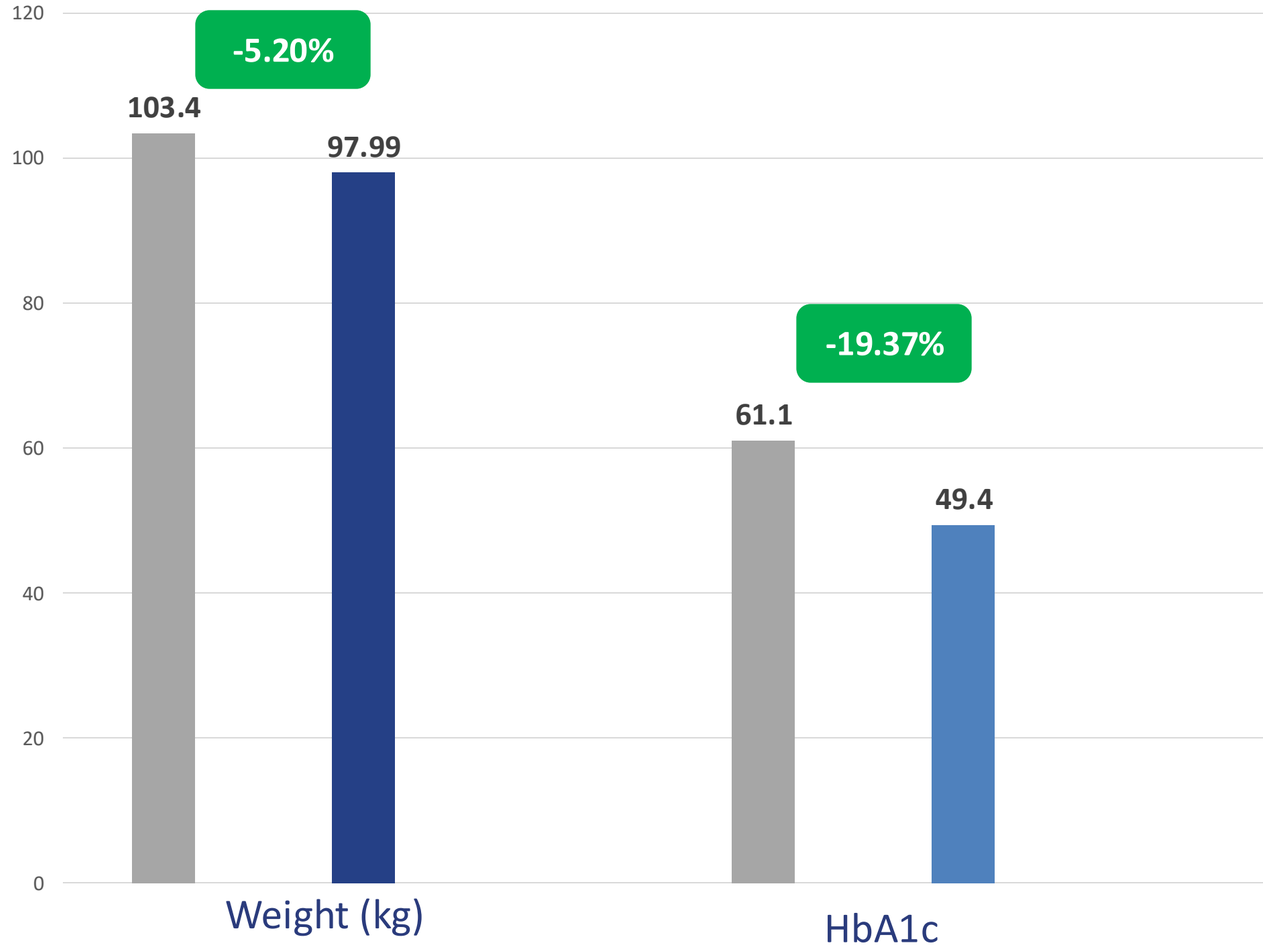
Fully transparent, digitally delivered, with measurable and continuously updated clinical outcomes.

and host of online resources available to patients 24/7

Clinical Outcomes: Type 2 Diabetic Patients

Weight & HbA1c, N = 53

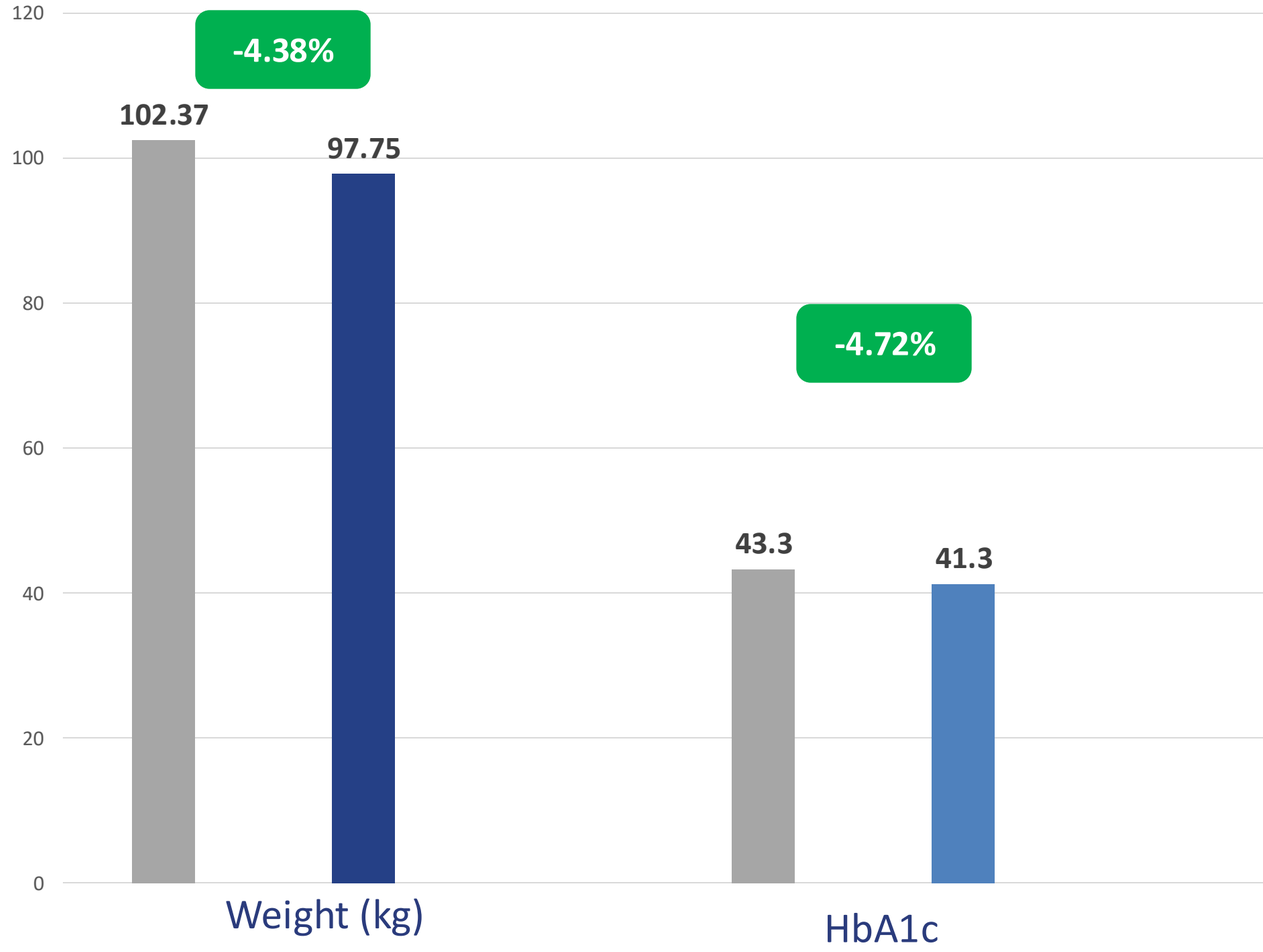
Average Changes T2DM	
Weight	-5.4KG (-5.20%)
HbA1c	-11.8 (-19.37%)
<48mmols/mol	21 (39.62%)



Clinical Outcomes: Non-Diabetic Hyperglycemia (NDH)

Weight & HbA1c, N = 27

Average Changes NDH	
Weight	-4.5KG (-4.38%)
HbA1c	-2 (-4.72%)
<42mmols/mol	11 (40.74%)



Value of Intervention and Partnership

Early Intervention

Regular EMIS searches support early identification of at-risk patients, enabling timely, tailored interventions that help prevent progression to more severe conditions

Patient Empowerment

Patients report improved understanding of their condition, greater confidence in self-management, and enhanced health literacy, driving better long-term outcomes

Flexible Delivery Tackling Inequalities

The flexible delivery model including digital support and live webinars, helps reduce health inequalities by making support accessible to diverse patient populations via a remote setting

Operational Efficiency

Integration with existing systems reduces administrative burden and frees up clinical staff. Fully supported through digital delivery, there is no need for in-person contact or clinical space. Regular calls drive collaboration and continuous improvement, helping to reduce inefficiencies.

Patient Engagement & Testimonials

“After just 3 or 4 months my hba1c came down from 101 to 49. I was delighted! Another three months later my hba1c had stabilized at 49 although by this time I had stopped taking both Gliclazide and Jardiance”.

“This programme has changed me and my health for the better and I will be eternally grateful for the opportunity to join”

“I have been astounded at how quickly my glucose levels came down and I do feel that I will be able to maintain this way of living”.

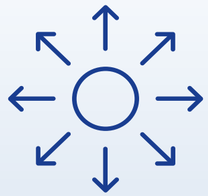
Scalability and Spread

AI Powered Health Coaching

We are expanding the use of AI-powered health coaching through "Anna," a digital health coach designed to support patients at scale. With the capacity to reach millions of people with Type 2 Diabetes across the UK, Anna offers a scalable way to reduce treatment costs and improve ROI.

Integrated Neighbourhood Teams

The programme is designed to align with place-based INT delivery models, integrating hospitals and community services to manage large patient populations. With robust data sharing, outcome tracking, and resource allocation, this model reflects the ambition outlined in the Fuller and Darzi reports, delivering verifiable savings and scalable impact.



Broader Impact

The programme's emphasis on prevention has reduced the risk of complications and disease progression, creating a scalable model for integrated care. Its adaptability for other chronic conditions enhances its potential for wider adoption across the NHS.

Data Analysis for Savings

Additional analysis of patient records will quantify medication avoidance, deprescribing savings, GP demand reduction, and secondary care savings. While literature supports these savings projections, real-world case studies will further substantiate them, ensuring conviction for scaling resources.

Recognition

The initiative has been featured at events such as the **Centre for Population Health in Bradford, where it won the Population Health Award (1st place).**

The data from the intervention has been presented at numerous international medical meetings:

- ***11th Annual University Hospital Waterford Research Meeting, January 2025***
- ***20th International Symposium on Atherosclerosis, Oman December 2024.***
- ***Centre for Population Health Bradford, December 2024***
- ***37th World Congress of Internal Medicine in Prague, October 2024.***
- ***Smart Health Summit in Dublin, September 2024***

CENTRE FOR POPULATION HEALTH

DEVELOPING LEADERS • IMPROVING LIVES • CREATING EQUITY

Summary

The **adaptable, population-scale framework** demonstrates how digital innovation can transform chronic disease prevention and management, while directly supporting NHS goals for sustainable, equitable, community-based care.

Through this submission, we aim to share best practice, inspire wider adoption across PCNs, and champion proactive, patient-centred models that enable earlier intervention and improved outcomes

THANK YOU

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