

# NHS Clinical Commissioners

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## Advancing population health management



# Foreword

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If you are looking for a definition of population health management (PHM), something many of us have done over the years, you might perhaps head to the NHS England website. There you will find PHM described as an ‘emerging’ technique that involves using data to design new models of care across organisations and sectors.

It is of course true that PHM is becoming more commonly discussed. It was a notable theme of the NHS Long Term Plan for England and, last year, the national bodies launched the first wave of a development programme intended to help advance the approach in local areas.

However, the reality, certainly for most clinical commissioners, is that the principles underpinning PHM have been on the agenda for some time. The idea of finding ways to better understand our populations and better meet their needs, capitalising on both managerial and clinical expertise, has always been at the very heart of what clinical commissioners do.

What does feel new is the scale of the ambition and the way in which that ambition is becoming embedded across many local health and care economies. The creation of primary care networks and CCG mergers, which enable clinical commissioners to work over a bigger and more coterminous area with the evolving integrated care systems, are making a difference here. So too is the growing focus on place.


Truly embedding population health management techniques is not a simple proposition, nor a one-off piece of work. It involves building shared understandings across what are often inconvenient sector and organisational boundaries. It requires the navigation of complex issues around data sharing and information governance. It necessitates real, system-wide leadership.

The stories in this report demonstrate the progress being made in making PHM part of care delivery, and the challenges that are being successfully surmounted. What these stories also show is that clinical commissioners are often well placed to build the coalitions necessary for success. That is not least because these are organisations with strong clinical leadership, embedded in real-world practice close to local populations.

This report serves as a valuable review of where we are and where we need to go – and how clinical commissioners can help us get there.



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# Summary

This report brings together population health management (PHM) stories from ten different areas of England. Together, they demonstrate the progress that has been already been made in advancing this approach to healthcare, and what more will need to be done.

They also demonstrate that:

- **Clinical commissioners are a key enabler of population health management approaches.**

With existing connections across both primary care and secondary care, as well as expertise in the information governance and data issues central to PHM, clinical commissioners are often seen as vital to creating the conditions for successfully implementing this approach.

- **There are already some examples of PHM approaches making a difference.** A theme that

came through time and again is that PHM is a journey and many places are right at the very beginning. But there are already some examples of impact on outcomes. In West Berkshire, for instance, an apparently homogenous group of people living with type 2 diabetes and weight problems has been separated out into two distinct cohorts, with different interventions introduced for each. Early results indicate improved health for both.

- **Information governance and data sharing issues remain a common roadblock, but those who have navigated it are sharing their expertise.**

PHM relies on data from multiple sources, but gathering, sharing and combining that information is complex. One planned PHM project in Birmingham and Solihull has been obstructed by issues around information governance and data sharing. West London CCG

reported that getting data sharing agreements in place there took two years, but those agreements are freely available online for other commissioners to adapt.

- **Where PHM approaches have been implemented, or the PHM journey begun, wider benefits are being seen.** Leaders in Dorset report a real enthusiasm among clinical staff for the approach. Indeed, several of those interviewed say that an unexpected benefit of PHM is increased satisfaction among frontline clinical teams, whose members are being empowered to make changes to pathways based on robust data as well as their on-the-ground knowledge. Discussions around population health as a concept also seem to be an enabler of closer collaboration between separate organisations and separate sectors, such as in the example from Sheffield within this publication.

## Definitions

As with so many terms in healthcare, ‘population health’ and ‘population health management’ can mean different things to different people.

For the sake of clarity, NHS Clinical Commissioners uses [The King’s Fund definition of the two terms](#).

That means we see population health as describing an understanding of wellbeing that takes into account a broad range of determinants. These determinants are likely to fall outside as well as within the area that healthcare organisations have traditionally influenced, and so adopting this sort of understanding will inevitably involve collaboration between organisations and sectors.

We consider population health management to be the use of data to identify specific groups within a population that may have similar characteristics and similar needs. This data is likely to be drawn from a range of sources, both inside and outside the NHS. Once identified, targeted interventions can be developed to increase the health and wellbeing of these groups, which are commonly referred to as ‘cohorts’. Again, it is likely these interventions will require cross-organisation and cross-sector collaboration.

# Getting a grip on the data in North West London

If population health management is a journey, as is so often contended, then Kavitha Saravanakumar contends the eight CCGs in North West London have been on that journey for some time. It was in 2012 that local leaders began talking about an approach that has evolved into what's dubbed 'whole systems integrated care', with a focus on ensuring all relevant parties can access the same information about an individual patient.

"We had the vision of proactive care so we could help ensure a healthier future for all our residents," explains Kavitha, deputy director of business intelligence and data management across the CCGs.

Part of realising that vision has been creating a data platform that combines information from primary care, acute hospitals, mental health hospitals, community providers and local authorities. This proved to be the foundation for a PHM approach.

"Once we created a data platform with integrated care data, then we could create a visualisation on top which would focus people's attention on specific cohorts," said Kavitha.

Some 95 per cent of the patient population across North West London is included on the whole systems integrated care (WSIC) dashboards, which initially launched in 2015. There are three ways in which professionals can visualise the data: direct care, which serves as a register of patients with ten specific long-term conditions; case management, which provides an assessment of patients whose condition or use of services is cause for concern; and population health management.

"Population health dashboards are mainly for the commissioners, to see if a pathway is working well and, if it is not working well, to see what we could do to redesign the pathway to ensure a good patient experience. So, we have got population health dashboards on eight or nine areas as we stand today, and the journey's ongoing," says Kavitha.

Diabetes is an area of particular focus. Some 45 per cent of the local population has the condition, explained in large part by the significant East Asian population in North West London.

The PHM part of the dashboard supports a better understanding of that 45 per cent. Kavitha explains:

**"We will look at trends over the last three, four years of data; look at the split of diabetes across type one, type two, and pre-diabetes; look at the split by ethnicity, gender and by CCG area. We will look at clinical indicators, such as how the diabetes patients are doing with their HbA1c checks, with their blood pressure check, and with their cholesterol check."**

Kavitha stresses this process simply identifies a cohort. To then take action – the 'M' part of PHM – is dependent on clinical leadership. "Intervention needs to be thought through and it should come from the clinicians through a transformation programme. So for example in diabetes we have got a whole diabetes transformation team who have embraced these dashboards, looked at the patient cohort, and then said: 'Right, this is what is happening with my patients, how am I going to intervene?'"

One of the initial answers has been to set up virtual clinics. These are held in GP surgeries to discuss patients whose condition is considered cause for concern, and involve specialist input from community and secondary care teams.

However, the biggest challenge on the PHM journey so far has been information governance. Kavitha says it took two years to get the relevant agreements in place for information to be shared. Conversations were crucial.

**"Through 2014 and 2015, that whole year was just people literally going to each provider, each GP practice, talking to them, getting them to sign up, explaining the vision."**

The agreements had to be updated when the general data protection regulation came into force. But any other commissioner wanting to tread a similar path can benefit from the work of colleagues in North West London; the CCGs have made the agreements publicly available on their website. If data sharing and population health management approaches are to spread rapidly across the NHS, then: "It's about not reinventing the wheel," contends Kavitha.



# Improving diabetes care for people in West Berkshire

When Dr Dan Alton and colleagues examined population health data in Berkshire West, a very specific group emerged that was in need of attention: patients with type 2 diabetes, who often had a background diagnosis of anxiety or depression, and who were overweight.

“That cohort was identified as at very high risk of complications from their diabetes, but also identified as not necessarily engaging as much as we would hope,” explains Dan, a practising GP as well as population health management clinical lead and chief clinical information officer for Berkshire West CCG.

Such patients were particularly present in two areas of the CCG’s patch: Reading South and Wokingham North. The conclusion could perhaps have been that the problems were the same in each area.

But for Dan, true population health management goes beyond simply looking at the data.

**“It’s using the data we have to understand the current health and social needs of our population, and then using some on-the-ground intelligence, being guided by our patients, so we’re acting in a person-centred manner.”**

The discovery of this very specific diabetes cohort was far from the end of the investigative process. Instead, clinicians began exploring further. “You dig a bit more into the data, so it’s this backwards and forwards thing between what’s the data showing, and what’s the real life, on-the-ground knowledge. You need an iterative process to find your cohort.”

The process was supported by the NHS England and NHS Improvement population health development programme, which Berkshire West became one of the first to trial in 2019.

And when the iterative process happened for this cohort, after speaking with patients, and with diabetes lead nurses in practices within PCNs, two very different pictures emerged.

In South Reading, it became clear that many of those in the group were from the Nepalese population. “We identified that for those patients, there were particular barriers to them having their diabetes reviewed – language barriers, cultural barriers, practical barriers.”

And so the population health clinical ambassador for that area developed a new programme specific for that Nepalese community, with help from its members and from a Nepalese nurse. The programme provides group education sessions backed up by the diabetes lead consultant at the hospital.

Over in Wokingham North, where the practice at which Dan works is based, the on-the-ground knowledge identified a different issue. “The area is between Henley and Maidenhead, so it’s economically affluent and it’s commuter belt.

**“For them the problem was that if you have your diabetes review appointments in the week, often in work hours, then they struggle to get to them.”**

Conversations with patients also showed they were interested in learning about how their stress and lifestyle choices were affecting their diabetes, not just being told to eat less sugar. Dan therefore led on creating a new intervention for this group. He set up a diabetes evening clinic, which provides group discussion as well as a GP intervention centred on lifestyle.

Early indications are that, for both groups of patients, their average blood glucose levels are now better controlled. But a variety of other outcomes are being measured to judge the programme’s effectiveness, including staff satisfaction.

“Our biggest issue, as with many other areas, is staff recruitment and retention. We’re finding that staff are more enthused by this [sort of population health management approach], because they’re developing it themselves. With these interventions, the process involves speaking to colleagues, speaking to staff.

**“I think that’s an understated benefit of a population health management approach. Because you’re building something [in which] you’re involving your staff very early on, it’s really leads to enthusiasm and a lot of energy.”**

The intention now is to further expand the use of PHM approaches in the local area. It’s a mission Dan argues will necessitate a ‘golden triangle’ of clinicians, data analysts, and commissioners, with the patient at the centre, and will potentially refocus the work of traditional teams in analytics, finance or clinical quality. That will, in turn, require time. “We need system leaders to have thinking space to develop these new ideas,” he concludes.

# Workforce empowerment in Dorset

There may be challenges in moving to a population health management approach, but the team in Dorset has found that engaging staff in the change isn't one of them. Frontline teams are said to have been energised by the opportunities to build an understanding of local communities backed by robust data.

"There's been a huge willingness from general practice, particularly, but also community services, to get involved with this work," reports Dr Karen Kirkham, assistant clinical chair for Dorset CCG and clinical lead for the local integrated care system (ICS). "That's because it involves looking at their own local populations and using the data in a new way, often a very refreshing way, to help those local teams gain new insights."

She speaks of the power of a 'triad' of clinicians, business intelligence analysts from within the CCG, and managers. "That triad comes together to help look at the data, interpret the data and ask questions of the data to help us work out what the best thing is to do for that local population."

Protected time for this work was critical to success, Karen says, particularly for clinicians: "We put extra resource in so they were able to be backfilled,"

Dorset integrated care system was one of the first selected to be part of a 2019 pilot of a PHM development

programme run by NHS England and NHS Improvement. Local leaders say the structured support that came as a result has been enormously helpful. But, they also stress that it is the local engagement that has been absolutely central, not least among frontline teams.

**“Local teams understand their populations, and they're very committed to the changes because they own them,” reports Karen. “Because often those clinical teams are very stable, it's possible to start to build a methodology of quality improvement that allows them to go on and continue with the same process, making it 'business as usual'.”**

For Sam Crowe, joint director of public health for Dorset and BCP Councils and senior responsible officer for the population health management programme, that ability for teams to engage with data is crucial. He therefore advises other CCGs considering population health management “to be wary of being drawn into an overly technical approach.”

**“Finding ways to make sure that we're genuinely developing ownership of how the data is used, among the teams that are most able to influence those outcomes, is really really important. We need to keep sight of the power of creating ownership around improving outcomes.”**

To ask quite how ownership has been driven in Dorset is to hear about the

importance of strong leadership, not least from the CCG. “We had fantastic engagement from clinical and managerial leaders and I think that was really visible and really important right from the beginning. That scene setting, but also that leadership piece was really tangible and important,” comments Karen.

The PHM programme in Dorset is a rolling one, building on the initial work with NHS England and NHS Improvement, and local leaders are clear on the next steps: “To build the capability and capacity of the GP teams to look at this in terms of business as usual and quality improvement, and hopefully improved outcomes,” says Karen.



# Collaboration to improve mental healthcare in Sheffield

There are plenty of definitions of population health management out there, but Jim Millns likes to opt for a relatively straightforward one: “For me personally, population health management is about commissioning services based on what we need, not necessarily what we’ve had available to us historically,” says Jim, the deputy director of mental health transformation and integrated commissioning in Sheffield.

He contends that involves building a shared understanding of local challenges and priorities. This is exemplified in the Sheffield Mental Health Transformation Programme, a collaborative piece of work across the CCG, the local authority and the main local provider. Since 2017, Jim has been jointly employed by the three bodies. Previously he had been solely employed by the CCG.

It is hoped that the programme will make it possible to improve outcomes, including by creating specific cohorts of patients identified through greater cross-sector working. In other words, using population health management techniques.

When asked what has supported this greater degree of collaboration, Jim points to a memorandum of agreement that he drew up in 2018 and which the CCG, local authority and main local mental health provider all signed.

“It aimed to articulate our new way of working, so actually in there was language along the lines of ‘we will not financially disadvantage one party by the actions of another’. It’s not legally binding, but it felt significant.”

In many ways, such efforts are an attempt to informally legislate new structures: “Trying to work in an integrated way is brilliant, but when the legislation isn’t there to support that way of working it can sometimes be really difficult, particularly when challenges do occur.”

But he hopes the sort of understanding embodied by the memorandum of agreement will underlie new work on local mental health provision. Late in 2019, South Yorkshire and Bassetlaw integrated care system, of which the Sheffield organisations are a part, was named by NHS England as one of the early implementer sites for work on new models of community mental health services.

**“It’s really, really interesting, certainly from a population and health-based perspective, because this is going to be the first local example of a mental health offer that will genuinely be different from [primary care] network to network.”**

**“That’s the way that mental health services, I think, in future need to start evolving,” he says, “rather than everybody will essentially get the same offer regardless.”**



# Building coalitions to provide even more targeted care in Leeds

Gina Davy is a believer in the potential of population health management to improve outcomes, but she's aware not everyone is a fan of the phrase itself. "We had quite a few philosophical debates around the term population health management," reveals Gina, the head of system integration at Leeds CCG. "It didn't sit necessarily comfortably all the time with people. However, I think in our experience, we had a working definition and actually the power was just in getting on and doing it."

Frank Wood, chief analyst for the CCG and the council, adds:

**“The point is we're trying to drive towards personalising care through integrating services. As long as you don't lose that in all the jargon, I don't really mind what the term is.”**

While last year Leeds became one of the first areas to complete the national population health management development programme, the CCG's work on implementing such approaches had begun some time before.

Data had been linked cross sector and the population segmented into key sub-groups with similar needs. Frank explains: "Our approach is to use the services of a regional office of NHS Digital to link national and local data flows, pseudonymise them so we can't reidentify people, but can compare service use between populations." There was a city-wide agreement that those living with frailty would be the first to focus on.

Commissioners then collaborated with providers and other partners to identify the outcomes that matter most to this group and developed a new care model to achieve these outcomes.

What the accelerator programme supported was a deeper exploration of this group, breaking down the cohort of people with frailty into even smaller groups and offering specific, targeted support.

The interventions being implemented are not new to Leeds. "Because we'd already agreed that we would start with improving outcomes for people living with frailty, we had already developed a high-level model of care," explains Gina.

**“So we've called this flexibility within a framework. Teams were free to test any intervention as long as it was one of the things that we'd highlighted as part of that piece of work. The framework aligns really strongly with national and international evidence about the best types of interventions for people with frailty, so things like care coordination, multi-disciplinary team working, case management, advance care planning.”**

Creating this model of care had involved creating a coalition between commissioners, providers and all others in the system. That meant population health management was perceived as a welcome catalyst to progress towards improving agreed outcomes – something those working in the system feel has been helpful in enabling engagement.

"We don't see ourselves as implementing a frailty model or implementing anything, really," says Becky Berwick, who is also a head of system integration in the CCG. "Our role is very much as conveners, facilitators, enablers, to actually get the people who do the work to come up with the solutions and introduce them to ways of working that will help them do that. Population health management is one of these."

Says Gina: "That our approach to PHM has been shaped and driven by leaders from across the CCG, public health, council and general practice has been central to our success."

"I think on reflection we've probably felt that in terms of looking at the overall impact of the programme, the data was probably only about 20 per cent of the contributing factor and 80 per cent was just creating the conditions for professionals to come together through a methodology and use their local insights and ideas to really harness that."

"There was just something about actually bringing together a range of professionals from health, social care, the third sector, housing and so on – people who are passionate about the local community they serve – and using the data as a springboard to be curious, ask questions and implement interventions that will help improve outcomes for local populations."





# Targeting need in Lewisham

As a GP and clinical director of Lewisham CCG, Dr Charles Gostling sees himself as wearing two subtly different hats:

**“In the GP role I’m very much an advocate for the individual, but I must also retain a very population-based hat in the course of my work.”**

That means, he says, being interested in the health outcomes of groups of people as well as of individual members of those groups. And in population health management he sees a method of ‘operationalising’ this interest by using multiple data sources to understand the precise needs of different groups to identify and implement changes in care, and to then track the outcomes of those changes.

He and colleagues have already started to do that in diabetes, taking data from the quality and outcomes framework by which GPs receive some payments; from national audits, including the national diabetes audit; and from data recorded during the delivery of direct care. It’s helped identify, for instance, a small group of patients who have blood test results indicative of diabetes but who have not been coded and formally diagnosed.

**“It’s not a massive number of people, but it’s a significant number of people in Lewisham where primary care has not recognised that there’s abnormal blood glucose results and have not coded people correctly and therefore they’re not receiving the right care.”**

Lewisham Health and Care Partners, which brings together the CCG, local council and key provider organisations, has a formal programme to advance these sorts of population health management approaches. “We are pulling in primary care data, acute data, community data, mental health, and looking to bring in social care data as well to examine our population health across all of those different organisations,” explains Rachel Crampton, population health and care programme lead.

A frailty dashboard has been created, which allows identification of groups of patients that specific care teams may be worried about. Members of the bowel and bladder team are already using the data to find people who are not under their care but who would benefit from being so.

In the longer term, the aim will be to not only identify such gaps, but to understand why they are happening and whether there are consistent characteristics among people who tend to fall into these groups.

For Charles, realising that ambition will involve a cultural change. He speaks of issues with “the comfort of sharing data, what it means to our population, how we begin to think in a way that embraces population health, rather than a purely operational way thinking about the patient in front of us, and being able to plan in a strategic yet an operational fashion as well using population health.”

He suspects effective clinical leadership will “prove absolutely essential” to any such shift. “I think it needs to be supported by our clinical commissioning groups and primary care networks from a provider side, to make sure that what we are trying to do is manageable.

**“Population health management will enable business as usual to become far, far more manageable, and actually make work far more meaningful and improve the experience people get from work. But at the moment we are at the beginning where you’re going uphill before you start going downhill.”**



# The start of a journey in Suffolk

It is early days for population health management in Suffolk, but a few different routes are being taken with a view to exploring its potential value. At West Suffolk Foundation NHS Trust, the electronic patient record is helping with the combination of acute and community data. Leaders at the trust and within West Suffolk CCG are exploring adding GP data, and starting to explore the possibilities afforded by the population health module that sits within the electronic system.

Ipswich and East Suffolk and North East Essex CCGs, meanwhile, are currently on the national 20-week PHM development programme. One of the major benefits so far has been linking primary and secondary care data.

The programme covers three primary care networks, but the decision has been taken to undertake similar efforts in another three PCNs, with extra support from a commissioning support unit.

Anna Crispe, assistant director of knowledge and intelligence within public health at Suffolk County Council, isn't yet sure which of these three approaches will yield the most benefits. She also has some concerns about sustaining any advances made once the national programme ends. Anna also sees some challenges in the way organisational structures currently sit.

"The complication from a Suffolk perspective is that not all of Suffolk is in our integrated care system. So there is part of Suffolk, which encompasses the former Waveney district, that is really our most deprived area, and they are in an ICS with Norfolk. We have been concerned that the piecemeal rollout of this work might inadvertently make those inequalities worse by

introducing informational inequalities on top of everything else."

But if such challenges can be overcome and PHM realises its promise, she is clear on the ultimate prize.

**“With my public health team, I lead on joint strategic needs assessments. For a whole year, we’ve been trying to create place-based needs assessments, trying to cover Suffolk at a smaller geographical level. But we can only go so far with that, because we don’t have detailed data.”**

**“So I can tell lots of parallel stories – I can tell you that in a particular area there’s 300 people with COPD and there’s 700 people with hypertension, but what I can’t tell you is how many of those people are the same people.”**

Practitioners could do so: “But only if they are motivated and able to interrogate their systems in such a way, but my experience is that is not always easy to do.”

There is hope that advancing population health management will make it easier for all relevant individuals in the system to be able to gain this sort of understanding. It would make the process of creating joint strategic needs assessments – used by both health and social care commissioners to plan services – more rigorous and evidence based, and enable the creation of more targeted interventions for specific groups.

For Anna, the local CCGs have been “really crucial” in working towards this goal. In part, that’s down to leadership: “We have an ICS population health steering group, and since last summer that’s been chaired by a GP, who’s also one of the CCG chairs,” she reports.

**“He’s extremely well networked, very passionate about all of this, very skilled at driving things forward and so he’s made a huge contribution, both intellectually but also just in terms of time. He’s been able to step back from some of his clinical work and have some time freed up to do this.”**

Given the complexities around data sharing to any population health management programme, the support offered by the CCGs’ information governance team has also been invaluable. “We worked hard to get all the information governance in place to support this work. The very good working relationships already in place there have meant we’ve stuck to target.”

With that ‘nuts and bolts’ work now complete, Anna anticipates commissioners will get even more involved in the project:

**“Once the PCNs start identifying cohorts and looking at pathways, I hope that’s where the commissioner element will come in even more.”**



# Clinical commissioners help to create the right conditions for PHM approaches in Lancashire

Dr Sakthi Karunanithi is unequivocal on clinical commissioners' role in the success of population health management: "It's all about them," he contends. "Without commissioners, this wouldn't happen. I think they're so fundamental in creating the conditions in which population health management occurs."

Sakthi is director of public health at Lancashire County Council but also the lead for population health across the Lancashire and South Cumbria integrated care system, which is one of those selected as an accelerator for PHM under a national NHS England and NHS Improvement programme.

It is work, he says, which has changed the dialogue locally: "Normally we use data [to create] league tables, and beat people on performance. But this has created a conversation about engaging, particularly clinicians, with the question about money and demand."

Giving "sense-making" time for these discussions has helped: "Being able to quiz [the data] and not just accept it as a directive, but accept it as a lens through which you can see things."

Since CCGs have established relationships with GPs and with providers, they can be well placed to drive these sorts of conversations and help melt traditional divisions. In Lancashire and South Cumbria, Sakthi speaks of how population health management is helping create "much more holistic practice."

**“I think people are discovering ways of delivering care that are much more personalised and much more holistic than what perhaps would have otherwise occurred. When clinicians face somebody in front of them within the four walls of the practice or hospital, all they have is a pen and a paper, which means a prescription or a procedure being prescribed. So I think this has helped us to have much more than a pen and a paper, to have that conversation and draw on the wider set of assets and resources and knowledge that's available in the local community and the wider set of teams working in the community.**

**“This is more of showing people what's happening with evidence and creating the conditions in which people who are delivering care can do that in as holistic and integrated a way as possible.”**

In Blackpool, for instance, clinicians are working with colleagues in housing associations to try to avoid crises for people living with mental ill health: "Basically, when people are turning up to A&E in mental health crisis we know these people may have other wider issues, particularly homelessness. But we really don't know for sure, because we don't have the data connected."

At present, he says, the system and process to connect GP information on mental illness with information on housing conditions is very rudimentary: "There is no formal information governance system yet, but it's all through joint working and sharing information that is legal and with consent."

"The way the rules of the game operate for local government and the NHS is a big challenge [to PHM], he says. "Structural solutions, financial solutions, [are needed] both nationally and locally to help us move forward."

But he's optimistic that the "slow but sure" work in Blackpool will yield benefits: "I think we will generate so much insight to help organise care for those residents that have got very specific needs – who we wouldn't have found if we just had a contract or a target."

For Sakthi, these sorts of population management approaches go to the very heart of the future model of health and care. And that's one of the reasons he is so convinced CCGs must be at the centre of these new ways of working: "Population health management is about the future role of commissioning. And to determine the future of commissioning, we need commissioners," he concludes.



# Encountering information governance challenges in Birmingham and Solihull

Nobody could accuse Birmingham and Solihull's clinical commissioners of a lack of ambition when it comes to population health management. In 2019, when the Midlands Population Health Management Academy was launched – a programme of PHM development support commissioned by NHS England and NHS Improvement – local leaders were clear on the area on which they wanted to concentrate.

“We didn't want to focus on a standard NHS pathway [such as for diabetes or urgent care] because we were doing a lot of that work already. We wanted to try and move into a new space,” explains Chris Stephen, head of business intelligence at Birmingham and Solihull CCG.

After discussions with the public health departments at both local councils, there was an agreement to focus on homelessness. This issue was chosen in large part because of the way it touches on many social determinants of health, and so necessitates a collaborative approach between a range of partners. “We knew it would involve working with housing departments, adult social care, public health and commissioners and ultimately providers,” says Chris.

**“And we specifically knew it would be a very interesting test case of how we could integrate data from the widest partners in health and social care.”**

The specification for the project envisaged integrating data from community providers, mental health, ambulance, 111, emergency care and GPs, then combining with housing data. The particular interest was in understanding what factors might predict someone likely to become homeless, and how people engage with services before and after a homelessness application.

As Chris explains:

**“We wanted to identify points of intersection at which we might be able to intervene, and to use the data to develop a case for cross-system investment that might ultimately lead to better outcomes.”**

There was also an interest, particularly from local authority partners, in exploring repeat homelessness: “We wanted to understand if certain types of support might lower the probability of becoming homeless again. Could we make referrals into social prescribing or financial advice, and prove those reduce the risk of homelessness?”

It was hoped a PHM approach would allow some of those questions to be answered: “We were going to use multiple of the technical elements of population health management,” says Chris. “We wanted to do stratification of people who made a statutory homelessness application, we wanted to stratify people by the reason for the application. That's because people entering homelessness due to domestic violence may be very different from people entering from health-related economic distress, are different again from people entering due to drug and alcohol issues.”

He says there was real enthusiasm for the project from colleagues in housing. But, ultimately, that shared vision and support from the PHM Academy was not enough to overcome a barrier familiar to many.

“The whole project was pretty much contingent upon being able to access pseudonymised, non-identifiable data for people who are making statutory homelessness applications. And then being able to match that to the wider



commissioning datasets that CCGs have access to through NHS Digital, but we have encountered very specific technical information governance problems which have to date proved insurmountable,” reports Chris.

The challenge is that CCGs do not have the right to access patient identifiable data. Since CCGs were set up as having no clinical delivery function (unlike their predecessor primary care trusts), it was an ability that was deemed unnecessary when the 2012 Health and Social Care Act was drafted. And while the Data Services for Commissioners Regional Offices (DSCROs) that sit within commissioning support units can access NHS numbers and pseudonymise data to then share with CCGs, they cannot do so for housing data.

**“DSCROs sit within commissioning support units but are technically an embedded regional presence of NHS Digital,” explains Chris. “But our DSCRO advised they can’t accept the data from a housing department because NHS Digital do not have a ‘direction’ to receive this type of housing data.”**

Directions are made nationally, specifying which data NHS Digital can and cannot collect, analyse and share. Chris has been told the lack of a direction around housing data means the DSCRO cannot support the homelessness PHM project conceived locally, and could not unless they were given a new direction.

It leaves Chris and his colleagues frustrated: “I have a housing department that wants to engage in a project; whose information governance (IG) leads have said we’re happy to share the data. I have a CCG that’s desperate to get hold of the data and do work with it, and everyone locally is more than happy to make this work. But some national systems haven’t yet established a comprehensive model for sharing information on wider determinants of health, and our reliance on the NHS Digital data flows mean we can’t access it through any other means,” he says.

None of which is a criticism of PHM: “Population health management is fantastic, the approaches are great, and we do use it where we can. It has huge potential to improve clinical commissioning decisions by answering some questions we’ve never been able to tackle before.

**“Within the analytical community we’ve wanted to do population health management since our careers began, but we’ve never had the IG and kit to be able to do it. We now have the kit, the computers are powerful enough at a local level to be able to do it, but the IG’s still not there.”**



# Merging towards strategic commissioning and population health management

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When Derbyshire's four CCGs merged in April 2019, leaders were keen to ensure benefits beyond the obvious: "One of the key questions was: 'What's the added value of doing this?'" reports Dr Chris Clayton, chief executive officer at Derby and Derbyshire CCG. "It's great to have brought them together and there'll be some organisational efficiencies, but it's not about creating a big CCG, it's about creating a strategic commissioner."

Population health and population health management will form part of those efforts, he anticipates. Certainly, there is a desire to ensure that social determinants of health are fully considered in all conversations about commissioning. Notably, the two local directors of public health are on the new CCG governing body as strategic advisers. "As opposed to being representatives of the local authority, they're there in their own independent right as strategic advisers. That was really important to us," says Chris.

Conversations with these colleagues are leading to a local understanding of the key social determinants affecting health in the local area, and a provisional suite of interventions that could help. Essentially, if it proves possible to do work on social determinants, this is where the CCG will begin.

"It doesn't necessarily mean that the NHS commissioner on their own would do it," stresses Chris. "Some we would do, some of it we'd work in partnership, some of it we'd expect local authorities or other partners to do. But we'd be taking a conscious and thoughtful approach to social determinants."

He feels clinical commissioners are well placed to foster such conversations, particularly as CCGs grow to cover larger areas: "I think it's the commissioner that sees the whole of this jigsaw and has the ability to work strategically with other commissioners, NHS England, local authorities and others.

**“ Providers are going to be very, very busy having conversations about integrated care. But actually we need the commissioners trying to set the scene for some of that work, and set out some of the wider outcomes that we want. That's where I think the clinical commissioner is quite unique.”**



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