AGENDA ITEM
4.1

POPULATION HEALTH & PARTNERSHIPS COMMITTEE

POPULATION HEALTH MANAGEMENT: UPDATE

Date of meeting	26th July 2022

FOI Status	Open/Public

If closed please indicate reason	Choose an item.

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Approving Executive Sponsor	Executive Director of Public Health

Report purpose	ENDORSE FOR COMMITTEE APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Primary, Community, Population Health and Partnerships	30/10/2019	ENDORSED FOR APPROVAL
Primary, Community, Population Health and Partnerships	10/02/2020	ENDORSED FOR APPROVAL

Primary, Community, Population Health and Partnerships	07/07/2021	ENDORSED FOR APPROVAL
Population Health and Partnerships Committee	06/10/2021	ENDORSED FOR APPROVAL

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
PSRS	Population Segmentation and Risk Stratification
DHCW	Digital Health and Care Wales
SWIYC	Stay Well in Your Community
CHWT	Community Health and Welfare Team
GP	General Practitioner
MDT	Multidisciplinary Team
IPC	Institute of Public Care
IGRP	Information Governance Review Panel (for SAIL)
DPA	Data Process Agreement
DPIA	Data Protection Impact Assessment
SAIL	Secure Anonymized Information Linkage
LPHT	Local Public Health Team

1. SITUATION/BACKGROUND

1.1 This report provides an update on the population segmentation and risk stratification (PSRS) approach to Population Health Management in Cwm Taf Morgannwg University Health Board (CTMUHB) for the committee to see, discuss and endorse.

1.2 **Population Health Management** seeks to understand patient populations, groups or clusters by characteristics related to their need and use of health care resources. In CTM one PHM tool has been developed – the PSRS tool - which can help Primary Care Clusters, GPs, ILGs and other partners to decide how best to use limited time and resources to deliver anticipatory and pre-emptive care for patients. Segmenting the population based on a range of factors can identify groups by their holistic need and ability to benefit from anticipatory care.

1.3 The feasibility of the population segmentation and risk stratification (PSRS) approach was previously piloted in the Rhondda primary care cluster as described in the previous report.

1.4 As described in the last report, following the successful Rhondda Pilot the Data Quality Group and GPC Wales requested that roll out of the approach uses data from the SAIL Databank rather than create a new integrated dataset as done in the pilot. There is agreement that while the LPHT PSRS project team will have access to named GP Practice data for analytical purposes, only anonymised data will be released and will be safeguarded by data safeguarding/confidentiality rules. The technical solution was presented in a previous report.

1.5 A refreshed business case was submitted to the Welsh Government in June 2021 to implement this approach across other Health Boards. This is still pending and no further update on this element is provided in this report.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

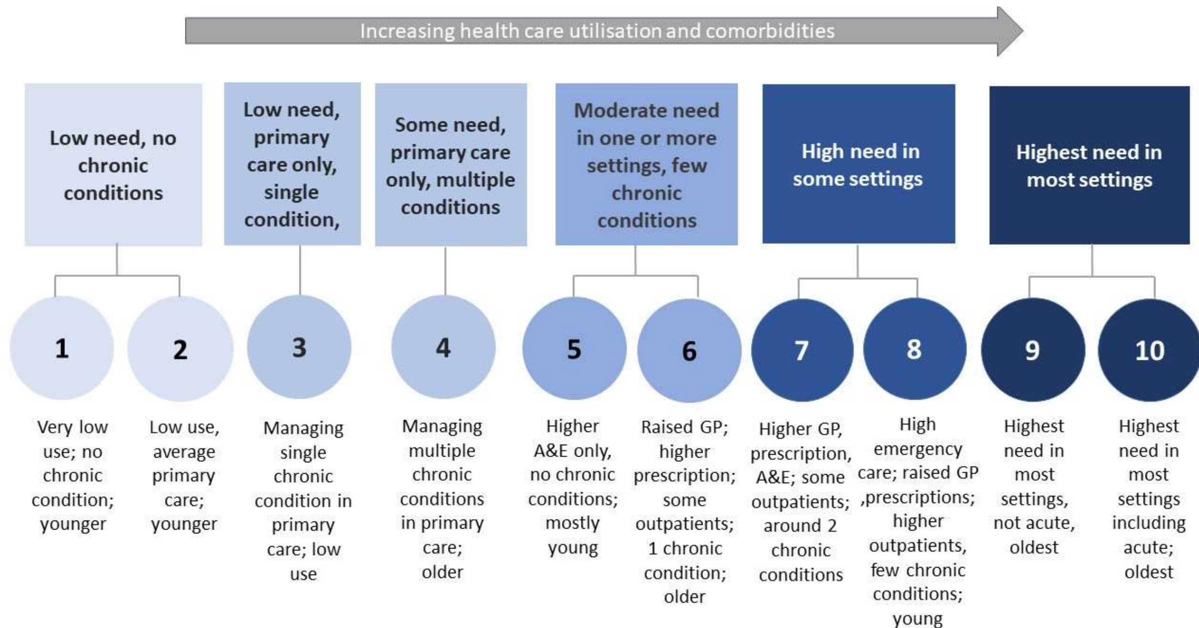
Implementation of PSRS in CTMUHB

2.1 Following signup for all bar one GP practice in CTM, the LPHT are now receiving data on a quarterly basis for all GP practices in the programme. The next extract is due September/October 2022.

2.2 All signed GP practices are now receiving patient level data on a quarterly basis using the DCHW portal. This allows individual practices to understand both the characteristics and proportion of patients across the segments as well as the patients at high risk of admission in the following year.

2.3 A summary of the initial data has previously been provided to Health Board executives and stakeholders detailing segments as shown below.

CTMUHB Data-driven segments



Percentage of patients in each segment and risk group by primary care cluster, RCT

% in each Segment	Cynon North	Cynon South	Rhonnda North	Rhonnda South	Taf Ely North	Taf Ely South	RCT	CTM UHB
Segment 1	24.4%	22.7%	23.9%	23.5%	28.0%	27.4%	25.3%	**25.4%**
Segment 2	17.7%	18.0%	17.3%	16.7%	16.2%	17.4%	17.1%	**16.5%**
Segment 3	4.5%	4.6%	4.6%	5.2%	5.0%	6.1%	5.1%	**5.6%**
Segment 4	13.1%	14.4%	13.9%	13.8%	14.0%	12.2%	13.5%	**13.4%**
Segment 5	8.5%	8.6%	7.9%	9.0%	6.3%	7.3%	7.9%	**7.7%**
Segment 6	14.2%	14.0%	14.6%	13.1%	14.8%	14.3%	14.1%	**14.2%**
Segment 7	6.5%	6.6%	6.5%	7.1%	5.5%	5.4%	6.2%	**6.5%**
Segment 8	3.7%	3.4%	3.4%	3.9%	3.0%	3.2%	3.4%	**3.2%**
Segment 9	4.5%	4.5%	4.6%	4.6%	4.5%	3.9%	4.4%	**4.7%**
Segment 10	3.0%	3.2%	3.2%	3.1%	2.8%	2.6%	2.9%	**2.8%**
Risk strata (%):								
High risk	5.4%	5.8%	5.2%	5.7%	4.7%	4.4%	5.2%	**5.0%**
Moderate risk	16.1%	17.1%	16.3%	16.3%	14.1%	13.4%	15.4%	**15.0%**
Low risk	78.5%	77.1%	78.4%	78.0%	81.2%	82.2%	79.5%	**80.0%**

Note: Segments based on health care utilisation and comorbidities; using primary care data from Jan - Nov 2021, secondary care data from Nov 2020-Nov 2021. Risk of emergency admission calculated using Johns Hopkins ACG System based on primary and secondary care.

Percentage of patients in each segment and risk group by primary care cluster, RCT

The full summary documents are available to be shared.

2.4 Population Health profiles have been created at local authority and cluster levels and will be shared with members for information. Information in the profiles includes population health measures as well as specific population segmentation data (the distribution of patients across segments, proportion within each risk strata and case mix adjusted analysis by practice). As stated above the practices are anonymized. The cluster level profiles have been shared with their respective clusters and the three Senior Practitioners from the PHM Unit have been supporting clusters to use data in the planning of services to those most at need, aiming to reduce inequalities.

2.5 Following discussion at PHM Steering group in June, it was agreed that work should begin to define the segments in more detail, and now data are available for the whole of CTM, to use it to support the identification of population cohorts and define 'what good looks like' for these groups.

2.6 A task and finish group has been set up to establish the initial focus for the use of the segmentation data. It was recognised that there remains a need to tackle high need, high complexity individuals (most likely in segments 9 and 10), however in order to implement more preventative interventions, a cohort also needs to be identified from other segments. Two approaches are being progressed currently; firstly, a backwards mapping of the patients referred to the Community Health and Wellbeing Teams (CHWT or MDT) to segment and risk stratum and secondly, a review of 'frequent (GP) attenders' in segment 7, high-risk group (where numbers allow). This segment comprises of individuals with high level of primary care use and also A+E attendances. They are relatively young, with high levels of deprivation, depression/anxiety and hypertension, potentially amenable to preventative measures and may not be being seen via the MDT process (tbc).

2.7 GP practices are being approached to volunteer support for one or both of these streams of work. It is recognised that the resource available across General Practice is extremely stretched, and there will be variations across CTM and within Clusters on which practices are able to allocate support to this project but it is important to note that the aim is to identify solutions which minimise demands on General Practices, a process which may vary by cluster.

2.8 A separate but parallel research project is being conducted by the LPHT to examine the predictive ability of segmentation including the development of the CTM UHB data-driven segmentation model to date. This methodological work was originally planned to be a separate project to investigate the predictive ability of segmentation. As the work progressed it was expanded to include the development of the actual segments to be rolled out. This work has been delayed due to re-prioritisation of the work plan to include in depth analyses of segments and cohort identification as described above.

2.9 The governance arrangements for PHM in CTM since October 2021 have included a regular stakeholder meeting as well as an overarching Steering Board for PHM. Note that PSRS is one component of PHM in CTM and progress will be reported via these new governance structures.

Evaluation

2.10 The potential for using utilization-based cluster analyses to segment a local General Practice-registered population in the Rhondda cluster was assessed as a pilot during April 2018 – July 2019. A process evaluation assessed the feasibility of the approach and compared the use of a traditional expert-driven segmentation approach with data-driven utilization analysis. The findings have previously been presented and are available upon request.

2.11 An independent evaluation of work streams in the SWIYC is being led by the Institute of Public Care (IPC) at Oxford Brookes University. The PSRS Workstream aims to evaluate the effectiveness of PSRS in identifying the health and care needs of the CTMUHB primary care-registered population. This is supported by two objectives:

(1) To evaluate the predictive ability of population segmentation.

(2) To undertake a process evaluation to inform wider roll out of this approach.

2.12 The evaluation does not include evaluation of specific interventions, which are implemented using the findings of the segmentation, over and above identifying the added benefit that segmentation offers.

Next steps

- Progress the MDT backward review and segment 7 work
- Continue evaluation of PSRS and use this to inform delivery.

- Await a decision from the Welsh Government regarding provision across Wales.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Key risk in the progression of PHM is the capacity of primary care to support work. Measures are being taken to alleviate the requirement on primary care, with support from the LPHT and other professionals (such as MDT leads or Cluster Development Managers) however it is inevitable that some small requirements will remain in some areas. The LPHT continue to engage regularly with GP practices via the cluster meetings and are planning to continue engagement alongside the Accelerated Cluster Development work.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Staying Healthy
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for all new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	EIA not required as this report is an update to population health management approach previously agreed. EIA to be completed in next stage of implementation.

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Creating Health

5. RECOMMENDATION

5.1 The Population Health and Partnerships Committee is asked to:

5.2 **NOTE** and **ENDORSE** the approach to Population Health Management outlined in this report.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board