



# G-Cloud 15

## NHS Population Health Management

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# Established Eclipse Accreditations, Governance and Procurement Status

## GP IT Futures

Lot 1 Qualification

## NHS Digital Assurance

Phase 1 Assurance December 2016

Phase 2 Assurance October 2017

Full Rollout Approval (FRA) Certificate issued  
Nov 2017

## NHS England Section 251

Prescribing Services are accredited as a supplier  
of risk stratification solutions.

## Data Security and Protection Toolkit 2023-24 (v 6)

## Approved NHS Health Research Authority Database

## CyberEssentials Certification Plus

## ICO. Data Protection Register

## SCCIO129 Clinical Risk Management

## Teleradiology Services

East of England NHS Collaborative  
Procurement Hub

## NHS SBS Technology Enabled Care Services 2 Framework Agreement Reference: SBS10144

LOT 1 Remote Clinical Monitoring

LOT 2 Alarm Receiving Centre Platforms

LOT 3 Digital Alarm Solutions and Peripherals

LOT 4 Intelligent Activity Monitoring

LOT 5 Patient Controlled Personalised Records

LOT 6 One Stop Shop / Combined Solution

## Clinical Digital Health Solutions (CDHS) Framework

3.5 Patient Support System Solutions

3.6 Specialist Clinical System Solutions

3.7 Shared Care Record System Solutions

## NHS England Community Diagnostic Centres Framework

Pathology

Physiological Measurements

## G-Cloud framework supplier (RM1557.15)

## Crown Commercial Services (CCS) Spark DPS

## NHS SBS Medicine Optimisation Prescribing Decision Support Systems 3

Lot 1: Medicine Optimisation System

Lot 2: Data Population Health Medicine

Optimisation System



# Service Background

Population Health Management requires integrated insight across pathways, services, and outcomes to support proactive, preventative care. Effective PHM depends on the ability to identify risk early, prioritise intervention, and validate impact across populations over time.

Historically, PHM activity has been limited by siloed datasets, retrospective analysis, and insufficient linkage between insight and implementation. This can reduce the ability of systems to act at pace or demonstrate measurable improvement.

ECLIPSE provides a centralised, NHS England-aligned population health management platform supporting analysis, prioritisation, implementation, and validation at scale. The platform integrates primary care, secondary care, prescribing, and demographic data to provide a comprehensive view of population need.

Advanced analytics and risk stratification enable identification of high-impact opportunities across pathways, while integrated patient engagement supports targeted intervention. Outcomes are tracked longitudinally, enabling validation of impact on utilisation, cost, and patient outcomes.

ECLIPSE supports PHM delivery across multiple NHS programmes and geographies, providing commissioners with consistent, actionable insight aligned with national priorities for prevention, integration, and equality of care.

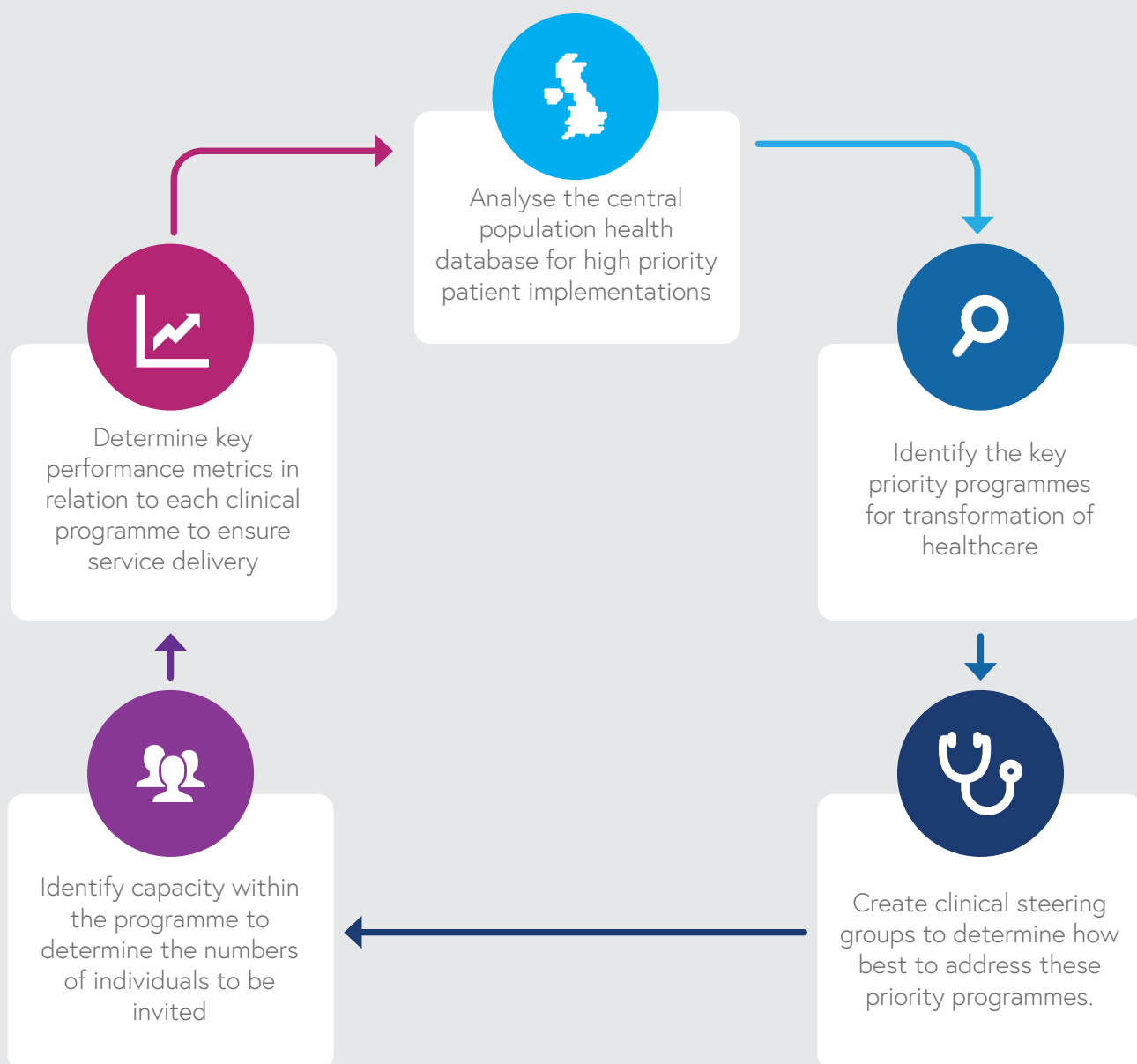
# Programme Identification

The first step in modelling is to assess the differing costs for each region and each NHS organisation responsible for delivering the service to identify opportunities for cost savings.

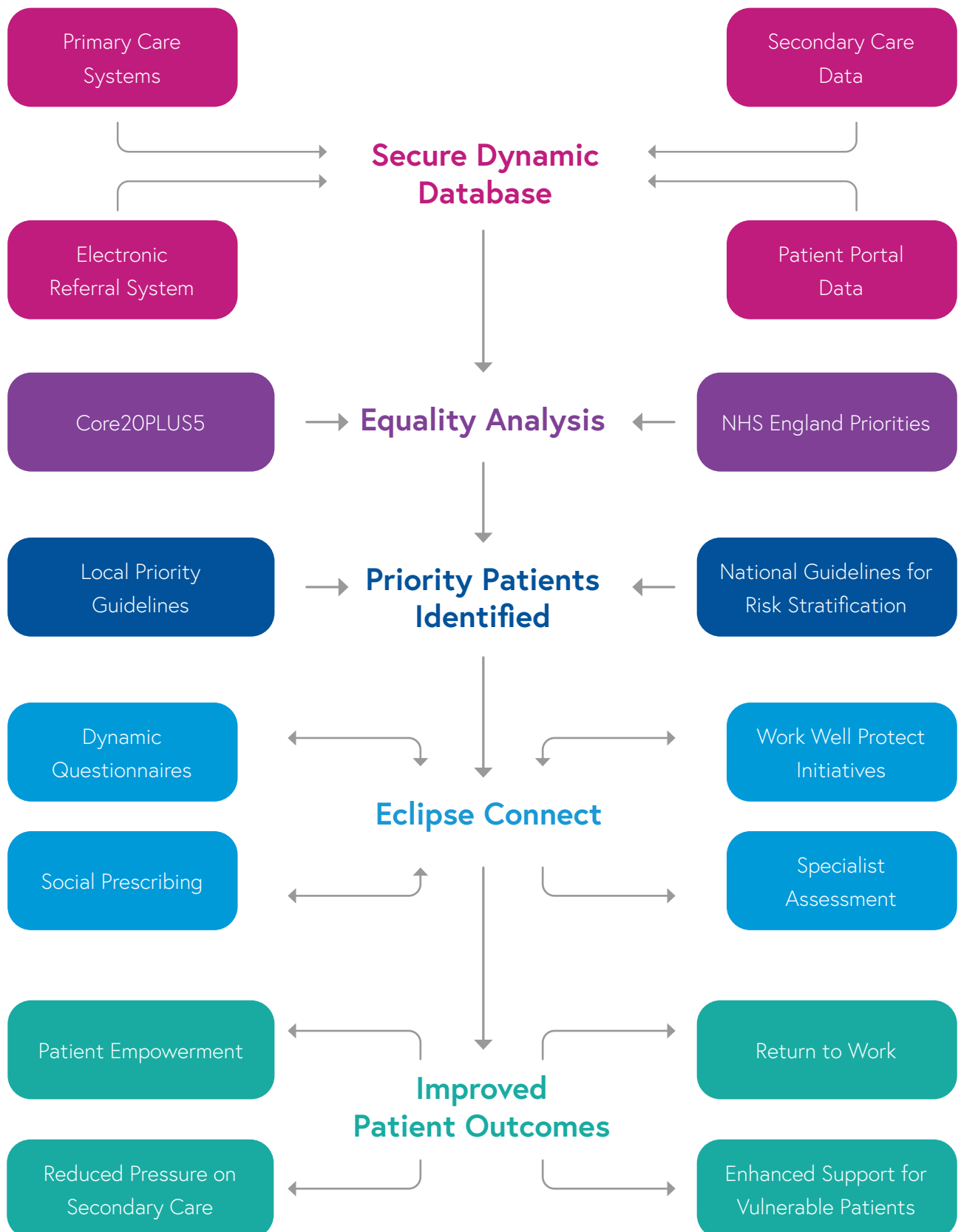
This can assist in identifying where a region can focus in relation to reducing negative variability and getting significant cost optimisations through high impact low workload implementations.

Having Identified a Priority Programme there then needs to be a detailed analysis identifying which key implementations are required and the requirements needed to deliver.

## Steps to identify key programmes:



# ECLIPSE System Flow



# Ensuring Equality & Reducing Variability

ECLIPSE applies a standardised, objective approach to support the delivery of equitable care across entire populations. The platform enables consistent implementation of clinical pathways while allowing configuration to reflect local population need.

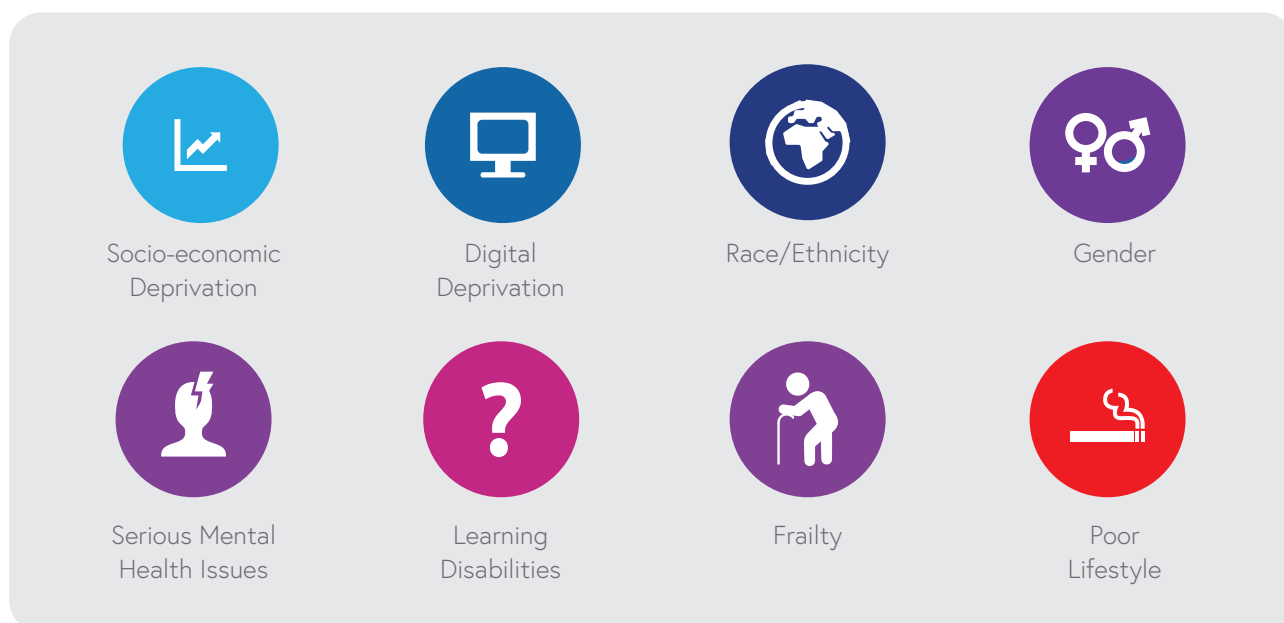
The service is built around a patient-centred model that prioritises identification of risk, proactive engagement, and shared accountability. This ensures that care delivery is driven by need rather than access, engagement capability, or digital confidence.

By engaging patients in their own healthcare through appropriate risk identification, monitoring, education, and feedback, ECLIPSE supports improved diagnosis, communication, and outcomes without increasing workload for NHS services.

NHS England has identified defined vulnerable patient cohorts requiring enhanced support. ECLIPSE enables these cohorts to be identified, analysed, and prioritised through integrated population health data and equality analysis.

The patient engagement platform continuously validates the effectiveness of questionnaires, interventions, and support materials. This enables ongoing refinement of engagement strategies and targeted interventions based on real-world patient responses and outcomes.

Equality impact can be assessed and monitored across a range of protected and vulnerable characteristics, including:



This approach supports NHS organisations in reducing unwarranted variation, improving equality of access, and delivering measurable improvements in outcomes for underserved populations.

# How Eclipse Works

**The following section provides a high-level overview of how the Eclipse system works to:**

1. Improve patient outcomes
2. Improve capacity and access for NHS services
3. Reduce admission rates
4. Improved workforce sustainability
5. Improved equality of care

# Step 1: Data Aggregation

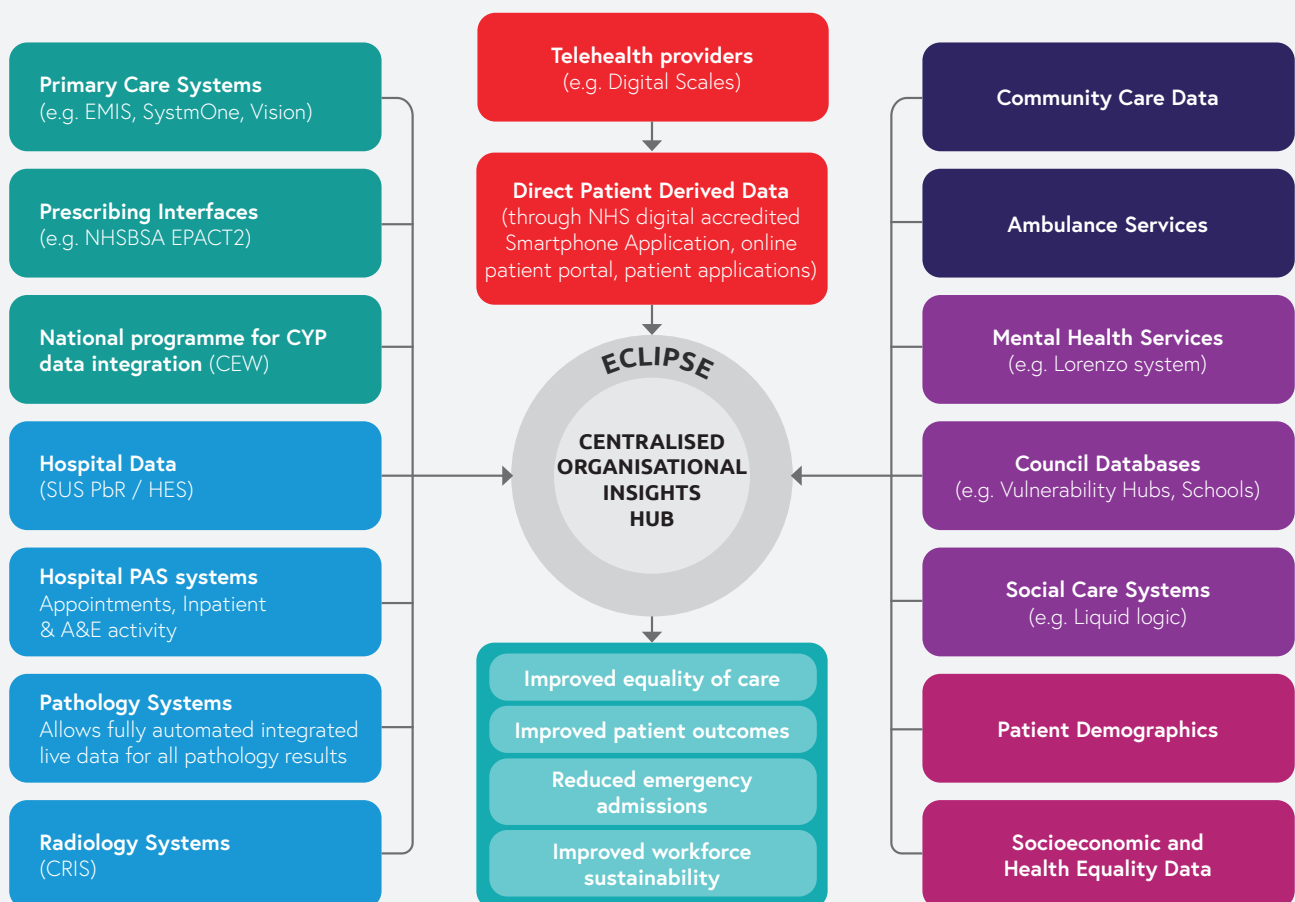
The platform securely aggregates patient-level, local population-level, and large-scale population data from a wide range of sources, including primary care, secondary care, community services, social care, and patient-derived data.

Individualised patient records are created that enable analysis at:

- Patient level.
- Practice, PCN, and ICB level.
- Regional and national population level.

Access to comprehensive, integrated population data is essential to delivering high-impact clinical programmes. The platform supports detailed healthcare modelling, prioritisation, implementation, and tracking of outcomes across pathways.

Create individualised patient portals containing all the relevant data in relation to:



Eclipse has the ability to integrate with each of the above data services, enhancing the data curation of your centralised data hub.

## Step 2: Data Curation

Data is curated to ensure accuracy, completeness, and relevance for clinical and operational decision-making.

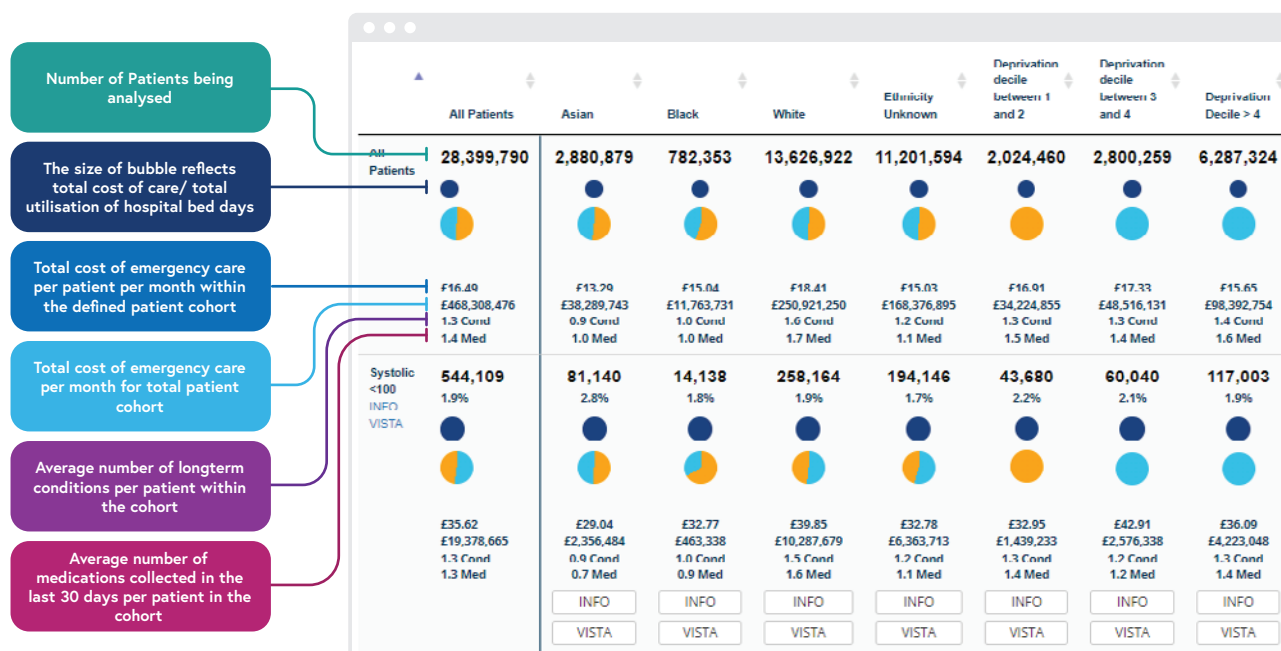
This includes:

- Validation of data quality.
- Identification of missing or incomplete data points.
- Use of a data priority matrix to focus on the most clinically relevant fields.

Automated patient engagement at regional scale supports consistent data completion, improving data quality without increasing workforce burden.

## Step 3: Risk Insights for Quantitative Precision Based Programmes

The platform uses advanced analytics to model both population-level and individual risk, helping commissioners identify high-impact clinical programmes. It provides clear insights into the risk of hospital activity, the risk of preventable harm, and opportunities for targeted intervention. Analysis can be carried out at national, regional, and local levels, supporting informed commissioning decisions and effective prioritisation of resources.



## Step 4: Programme Risk Stratification

Whole-population modelling enables structured risk stratification based on:

- Clinical risk.
- Anticipated impact of intervention.
- Preventable harm.
- Equality and deprivation indicators.

This supports targeted programme deployment, ensuring resources are focused where they deliver the greatest clinical benefit and economic value.

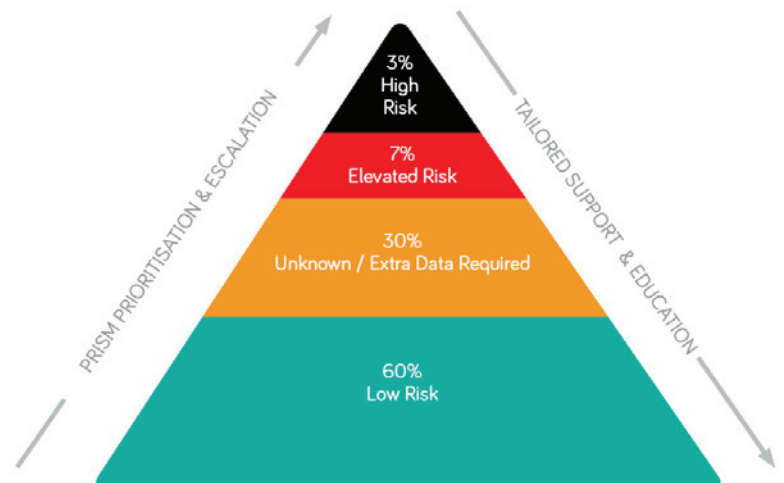
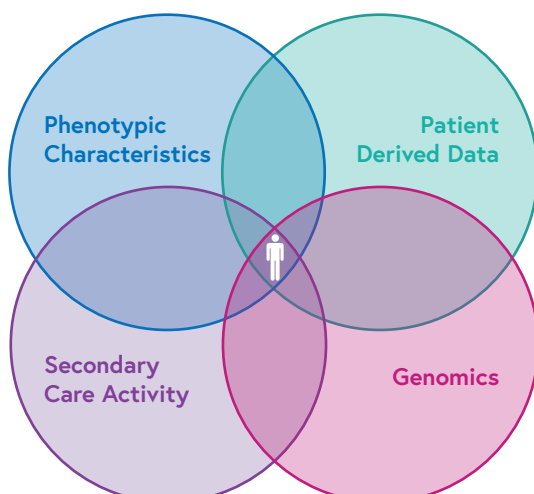
At an individual level, dynamic risk profiles enable intelligent prioritisation across pathways and services.

## Step 5: Personalised Risk Stratification

Multiple risk factors are automatically combined to create high-, medium-, and low-risk patient groups. These parameters are continuously refined through feedback loops linked to outcome data.

This approach supports:

- Review of patients waiting for appointments in line with regional specifications.
- Identification of high-risk patients requiring specialist intervention.
- Ongoing refinement of risk profiles based on real-world outcomes.



## Step 6: Identification & Prioritisation

The platform undertakes a structured gap analysis to identify patients requiring review or additional information. Standardised criteria are applied to support consistent prioritisation across pathways and services.

Patients from vulnerable cohorts and areas of higher deprivation can be identified to enable targeted support. This ensures that healthcare capacity is focused on individuals with the greatest clinical need and potential benefit.

The PRISM risk stratification tool can be used to define cohorts that are not currently compliant with best practice interventions. Patients are grouped into very high, high, medium, and low-risk categories to support prioritised action.

Vulnerable cohorts, including those within Core20PLUS5, can be filtered and stratified separately to support focused delivery of equitable care.

## Step 7: Patient Engagement



Effective patient engagement is critical to the success of prevention, wellbeing, and clinical improvement programmes, particularly for harder-to-reach populations.

The platform supports motivational patient engagement, enabling healthcare professionals to work in partnership with patients to better understand care needs, goals, and barriers. This strengthens patient involvement in care planning and improves adherence to agreed interventions.

Patient engagement is delivered through a secure, web-based patient portal, supported by structured questionnaires, education, and feedback tools. This enables large-scale engagement while maintaining patient privacy and clinical oversight.

## Step 8:

# Automate Results Back onto the Shared Care Record

The patient application is fully integrated with primary and secondary care systems, enabling dynamic engagement and timely updates to the shared care record.

The Connect service supports identification of patients who may benefit from technology-enabled care by:

- Engaging patients who have expressed interest.
- Supporting implementation and data integration.
- Generating alerts and management plans linked to patient outputs.
- Validating programme impact, including equality of care analysis.
- This supports coordinated, joined-up care across services.

## Step 9:

# Prioritisation of Access to Services Based on Risk

All key information relating to patient reviews is collated within the platform.

Patient questionnaires are automatically assessed, with required actions clearly highlighted. This supports consistent clinical decision-making and prioritisation of access to services based on risk.

A standardised approach ensures that patients receive timely and appropriate intervention, supporting improved outcomes and more efficient use of clinical capacity.

The screenshot displays a patient dashboard with a grid of clinical metrics and a section for additional reviews. Each metric card includes the test name, value, date, and a status icon (red exclamation mark for high risk, yellow exclamation mark for medium risk, green checkmark for low risk, or red exclamation mark for urgent action).

| Metric                     | Value      | Date       | Status        |
|----------------------------|------------|------------|---------------|
| Blood Pressure (GP)        | 160/84mmHg | (09/11/23) | High Risk     |
| Haemoglobin                | 9.9g/dl    | (23/11/23) | High Risk     |
| eGFR                       | 86         | (21/12/23) | Low Risk      |
| ALT (GP)                   | 24         | (09/11/23) | Low Risk      |
| ACR Score                  | 2.0        |            | Medium Risk   |
| Cholesterol (GP)           | 4.3mmol/L  | (26/05/23) | Low Risk      |
| Weight (GP)                | 57kg       | (09/11/23) | Low Risk      |
| Potassium                  | 5.4mmol/L  | (21/12/23) | Medium Risk   |
| Serum Sodium               | 133mmol/L  | (21/12/23) | Medium Risk   |
| TSH                        | 0.59       | (26/05/23) | Low Risk      |
| HbA1c (GP)                 | 72mmol/mol | (09/11/23) | Medium Risk   |
| GI Bleed Index             | 4.1        |            | Medium Risk   |
| Current Smoker             |            | (26/05/23) | Urgent Action |
| Estimated QRISK3 Score (%) | 60         |            | High Risk     |
| Medication Review          |            | (05/05/23) | Low Risk      |
| Flu Jab                    |            | (05/10/22) | Urgent Action |
| eFI Score                  | 0.194      |            | Medium Risk   |
| Deprivation                | 6/10       |            | Low Risk      |

**Ethnicity:** White

**Additional Reviews**

- Diabetes Review
- Epilepsy Review
- Covid Review
- Palliative Care Review
- Structured Medication Review
- Anaemia Review
- Pregabalin Review

## Step 10: Action Plans (Personalised Care)

Personalised action plans are generated to support structured, proactive care delivery.

These plans include:

- Standardised reports.
- Automated reminders.
- Clear identification of outstanding tasks.

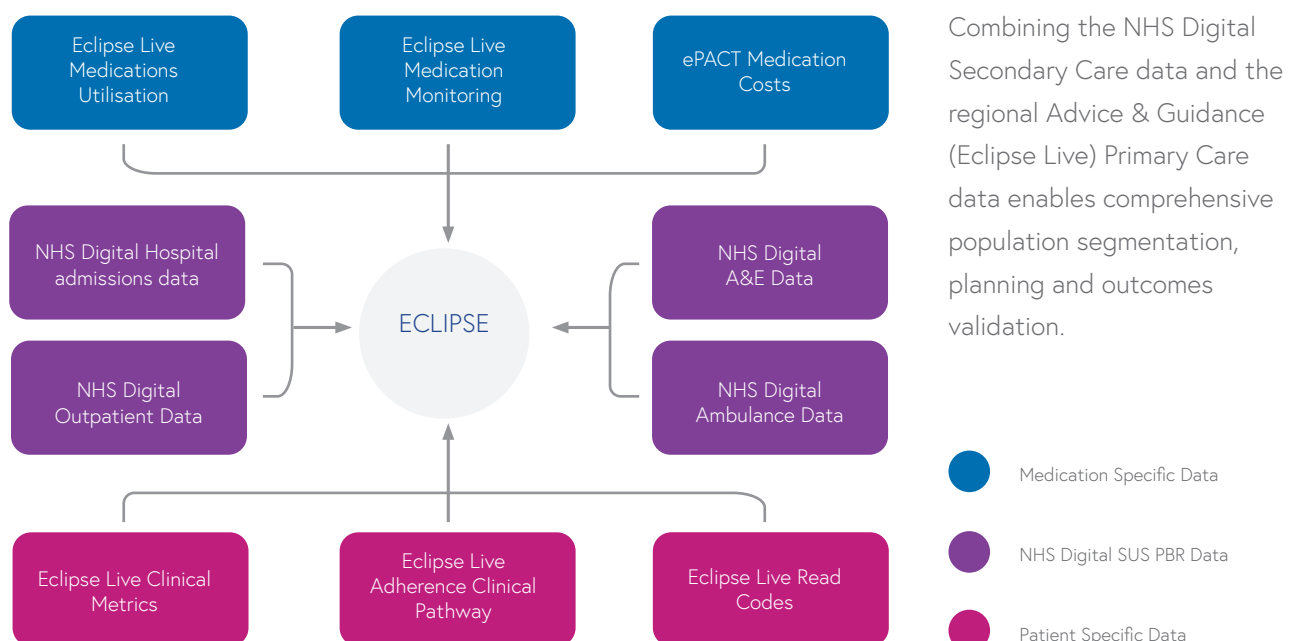
This supports continuity of care and ensures that agreed actions are completed in a timely and consistent manner.

## Step 11: Assess Outcomes

The interface enables NHS organisations to monitor implementation, outcomes, variability, and cost at pathway, programme, and population level.

Outcomes data can be used to assess admissions avoidance and calculate cost savings, supporting validation of programme impact. Analysis can be undertaken at national, regional, and local levels.

By combining NHS Digital secondary care data with primary care and regional datasets, the platform supports comprehensive population segmentation, service planning, and outcomes validation.





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