System learning from the heartlands – data, decision making and leadership

GGI recently sat down with Claire Fuller, ICS CEO designate for Surrey Heartlands – leading the delivery of plans to transform care for more than 1.1M people across Surrey. In a wide-ranging conversation we touched on data sharing, public health planning, system leadership and more.

GGI: One of the challenges to emerge from the pandemic response was around sharing data. There are lots of barriers around data sharing agreements and data protection. But there are also structural issues, systems issues, trust issues and people issues too…

Claire Fuller: There are two aspects to this. There's data that you need for direct patient care and data you need for indirect patient care. I think they're sometimes muddled. I am a GP and the data I need when I've got a patient in front of me and the things I can share across organisations in the interests of direct patient care – they're quite easy. The complicated bit comes when it's about sharing indirect data and information about planning and population health. We need to improve data-sharing agreements across all practices and between organisations.

We have a Surrey office of data analytics, currently chaired by our chief constable, which includes the county council, the NHS and police, which brings together information from all of those bits to inform the population health management decisions. It's a real game-changer

It's always worth beginning with the problem you're trying to solve and then considering what data you need to inform that.

So, you'll get your feeds from our Surrey care records. In terms of direct care, that's got feeds from all the organisations so you get all the information you might want when you've got the patient in front of you.

But if you run a primary care network and you want to work out what your three biggest health inequalities are, that's then prioritising the data in a slightly different way.

It's the difference between using data to risk-stratify the population and then using that population list – how that then impacts on direct care. So, having identified the population that are at risk or have got that health inequality, what are you then going to do about it? Versus the identification of the population who are at risk. You've just got to be really clear about the distinction between the two.

Then there is the handling of operational pressures: 'I've got 27 people in intensive care over there, I've got seven over there, I've got 28 people waiting…' It's that live data that ultimately manages the system. It's immediate short term and long term – there are different timeframes for what you need different bits of data for. Ultimately, you don't bring about the change unless you can connect it to the direct patient record in this interaction.

GGI: There's something about how that shared care record can be used not only to provide better care to patients, but it's also about

clinicians and them having more accurate information at the point at which they need it at the right time. Again, thinking about partnerships and collaboration and different systems, how much of a challenge is that, aligning systems so that data can flow in the right ways?

CF: We're part of the LHCRE – the local health and care records exemplar. We've got a platform for the feeds from the different organisations. So, our Surrey care record gets about 11,000 hits a month of direct patient care, working with Graphnet who provide our interoperability platform to bring it all together.

GGI: Thinking about the longer-term planning stuff and about the purpose of ICSs and about the role around improving population health and tackling health inequalities, how do ICSs approach that in planning in relation to data? So, there's large areas, there's great variability within that concept of place, down to neighbourhood level. What kind of new or different data is there available in the system context? Is there new and different data with the partnership arrangements that are in place? How is that best used to support decision-making around priorities and around planning?

CF: We've always had good access to public health data. Our health inequalities data has always been led for us by public health, this has been an advantage for us with population health management, enabling us to consider proportionate universalism, actually identifying the communities and targeting interventions rather than repeating and continuing universal applications.

Our health and wellbeing strategy has three priorities and each one of those is aligned around population health inequalities. Those three priorities are making sure we lead a healthy life, that we have the best possible mental health, and making sure everybody achieves as much as they can. We worked out which populations were most impacted.

Then COVID came and we did community assessments and looked at the disproportionate impact of COVID on these very same populations and identified another population which was digitally excluded and then targeted interventions to these populations to specifically improve these health inequalities. So, it's quite focused.

GGI: Through COVID particularly that digital exclusion element has become far more of a pressing issue.

CF: Around 200,000 people in Surrey are digitally excluded from a population of 1.2 million. There are a number of things that contribute to digitally exclusion – including broadband access, affordability, patient choice... And, you're more likely to be digitally excluded if you live in an area of deprivation.

GGI: Does operating at system-level scale mean that dealing with things like digital exclusion related to poor infrastructure is easier because there's much greater lobbying power – and you're able to pool resources?

CF: That's exactly right. That's the importance of using the county footprint for the things that are county-wide. So, it is infrastructure and transport, in a two-tier system, housing is a district and borough issue, but certainly around transport, digital, green agenda and being able to work in partnership with the county council as well as us being a system, I think it gives you much more leverage.

GGI: In Wales there's a lot of deliberate coterminosity after they restructured local government with that in mind. But in England a few of the leaders we've spoken to have said that the lack of coterminosity between local government and healthcare organisations is a problem.

CF: Absolutely. This doesn't work without it.

GGI: In Surrey, as well as that coterminosity, it seems that there are also very good functional relationships and mutual respect between the sectors. What's at the root of that?

CF: I would say it's about the relationships and leadership. Many of us have been around for a very long time in Surrey, which I think makes a big difference. We've got joint members of the ICS executive with the county council

senior leadership team. So, the director of adult social services (DASS) sits in my team and the council's chief exec team and the DASS has accountability for continuing healthcare (CHC), mental health, learning disabilities and autism. The director of children's services has accountability for children's services jointly other than maternity and neonatal. So, we created joint teams.

CHC is a great example, I took on the CCG in July 2020, we had an unmitigated risk for about 13 million around continuing healthcare. There were about 100 disputed cases, with time and energy spent of apportioning blame rather than looking after people.

By getting the teams together, we identified seven different themes of dispute and agreed the principles of settlement to be applied in the future.

GGI: There must be a specific set of skills that system leaders need to exhibit. So, for instance, in an individual organisation, there is an element of partisanship, you have to have a part of that. There's something about being more inward-looking than outward-looking.

CF: Each organisation is actually a system. The southeast is a system. It just depends on where you sit. The whole of the country is a system. Even within a practice, there will be different conflicts that you will need to arbitrate and do system leadership for.

GGI: Is it more important, do you think, to have and create space for critical thinking at system level, though, to challenge certain assumptions, certain entrenched behaviours or structures? Because it's not easy to challenge things that are entrenched.

CF: I think it is at the moment because it's a newer footprint to work across. I think you need curiosity, critical thinking and flexibility of thought. There is kind of a blueprint for how you run a hospital well, but I don't think we've got a blueprint for how you run a system well. They are all different as well. Surrey has got a county council, whereas Sussex as a system has got three councils. So, there isn't one size fits all. That's where I think you need the creativity of thought.

GGI: Thinking about this consensus decision-making and the need to take that a bit further and make some more challenging decisions, is there something about lean governance and have you got too much involvement in decision-making, or do you think you've got that right?

CF: We've got way too much governance. Way, way too much, even though we'll simplify it. It's overly bureaucratic, and that's because we're still trying to involve everybody in every decision.

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