Using data to promote proactive care in Frimley Health and Care ICS

Priorities for using data in Frimley Health and Care

Earlier intervention

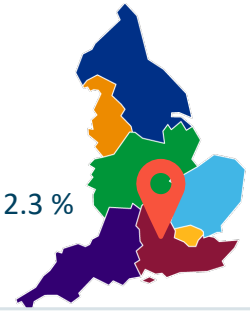
Using data to understand patients' needs more holistically and move from reactive to proactive care

System transformation

Using data for the planning and delivery of services to optimise effectiveness and efficiency according to needs

ICS key facts

NHS England region: South East
Population size: ~808,000
Urban neighbourhoods: 93.4%
Neighbourhoods in most deprived quintile: 2.3 %
No. of places: 5



Developing the data infrastructure

- **Connected Care** is Frimley Health and Care's digital transformation programme consisting of three tiers of infrastructure:
  - Population Health (PH) platform
  - Shared Care Record (ShCR)
  - Resident facing data platform for people enrolled in remote monitoring at home
- **Data sharing agreements** support the flow of data from ICS providers into the ShCR and PH platform, including from acute trusts, primary care, mental health trusts, community trusts and local authority (LA) adult social care. Only a small proportion of GPs are not routinely sharing data.
- **Streamlined connection** for HCPs to access the ShCR from their Electronic Patient Record (EPR) systems via 'one button'.
- **Third-party supplier** provides services to support the ShCR and PH platforms.

"We've moved from it being a shared care record to a place where professionals can virtually work together and where we can integrate care around our residents"

A risk segmentation system was developed during the COVID-19 pandemic to proactively offer people in the high-risk segment with a positive Sars-Cov-2 infection a pulse oximetry device. The approach is now used within several other proactive care initiatives and is embedded into the ShCR to complement clinical decision-making.

Proactive care initiatives

- **Frailty remote monitoring:** Residents in the community with frailty and at high risk of hospital admission are identified using the PH platform. Lists are sent to GPs who can then invite residents to enrol for remote monitoring. After an initial pilot of 2,500 people, Frimley now has ~7,000 residents enrolled in remote monitoring.
- **Improving the pre-operative pathway:** Data within ShCRs are being used by secondary care clinicians to help understand patients' needs and identify interventions that can help reduce the risk of deterioration.
- **Locating new services:** Use of resources data, patient data and wider demographic data linked and mapped to identify where to locate new services to mitigate winter pressures.
- **Improving health inequalities:** Linking council data of housing insulation to health data of children with asthma to enable GPs to offer asthma health checks to the most vulnerable first.

"You can use your understanding of risk stratification to much more rapidly get people to the level of care that they need rather than waiting"

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Understanding Patient Data

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What's enabled progress?

- **Trust and collaboration:** An open, honest and collaborative approach has helped foster trusting partnerships between system partners/providers, including the ICB, over time. Data strategies, priorities and use cases are co-developed with partners from a purpose and need-based perspective, often through 'population health jamming sessions' with data being used to refine plans. The central team refrains from using shared data for performance management, which is viewed as important for maintaining the trust needed for maintaining data sharing agreements.
- **Clear stance on information governance (IG):** 'Early and heavy investment' in IG, including legal ratification, combined with open conversations around risk appetite, have helped reduce uncertainty and create an enabling yet robust environment for data sharing and use.
- **Demonstrating the benefits of using data:** A half-day data 'show and tell' conference was organized and led by the Chief Medical Officer (a GP) with at least one representative from each GP practice within the ICS. Concepts, benefits and practicalities of adopting a proactive care approach using PH data were introduced. Data packs were provided, including information on creating patient lists and using risk stratification to guide prioritization. The conference reportedly helped to foster a 'system identity' and reassured GPs they had system support.
- **Horizontal integration (across systems):** A single partnership agreement and governance structure across three neighboring ICSs has helped to accelerate the spread of progress and improve economies of scale, for example by embedding risk segmentation into ShCRs across the three.
- **Leadership:** The data and digital team is represented within the delivery and transformation function at board–level, helping to embed data and digital activities within business as usual

"Trust between partners goes above and beyond just how we do data sharing effectively, it's trust around the totality of our working relationship between system partners"

What's next?

- **Diversifying the data**: Linking with wider LA organizations and emergency services to build a richer dataset
- **Democratising the data:** Continuing to promote the use of data by clinicians to make proactive care easier
- **Workforce**: Increasing the number of data scientists with analytical and AI skills for predictive modelling
- **Public engagement**: A public communication campaign around how data is being used in their ICS
- **Spread and scale**: Sharing progress with other ICSs to help improve their proactive care capabilities

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