Saxton Bampfylde

Road to Recovery

Integration, inclusion and innovation in the Healthcare sector

After 24 months of unprecedented change and challenge for the health and care sector there is much to reflect upon to help aid recovery. In this reflection we believe that there must be a clear emphasis on learnings – what worked and what didn't – and how these can be integrated in to delivering meaningful and people-centred models for the future.

Saxton Bampfylde is delighted to bring you a short series of interviews from senior leaders across a range of health and care settings to discuss and demonstrate the importance of learning, challenging and innovating to make a positive impact in their own organisations, and more broadly across the sector. Each interviewee has generously and honestly shared their experiences and learnings and we are very grateful to them.

Rachel Crossley

Joint Executive Director of Public Service Reform for Surrey County Council and Surrey Heartlands ICS

Rachel Crossley is the Joint Executive Director of Public Service Reform for Surrey County Council and Surrey Heartlands ICS. Rachel's role utilises her substantial experience in public sector, healthcare and strategic commissioning to facilitate better integrated models of health and care at a community level across Surrey.

We were delighted to have the chance to interview Rachel as we enter a new post-pandemic era of health and care. We talk to Rachel about some of the lessons that have been learned at local government level – and in some cases the hard way – with an emphasis on the positive responses and approaches that have arisen to enable better communication, collaboration to enhance the true sense of community health and care.

Rachel, you have been in the new role of Joint Executive Director of Public Service Reform for almost a year – can you share a bit about what your job entails?

My role bridges NHS and local government, with a strong focus on service integration and innovation. There are some specific areas under my scope, including: policy, innovation and transformation; data and analytics; public health and (possibly surprisingly) Estates.

Our policy team is focused on how we develop our Integrated Care System - Surrey Heartlands - locally and where and what we can influence nationally. We want to show how the NHS national policy direction is received and reflected at a local level through this work.

Innovation and transformation are particularly important in the health space and we are actively looking at the opportunities to partner with academia, research and industry. This has slowed down during the pandemic, but longer term it is vitally important to have these connections and think about the type of research we want to do.

We want to use our data, insights and analytics to create actionable insights and drive our way forward. Particularly in the area of population health management – thinking about what we know about our population to focus on and target where we invest in health and prevention work.

The Estates part of my role involves consideration of how our buildings and spaces can be better used to bring services into our communities. We work across our property teams and think more about place-making and community service integration, about what we want to be delivering in our area and how we can make a difference to health and care.

Each element of my role requires a form of translation between local authority and healthcare to find the best way through.

How has the relationship between NHS and local government evolved through the pandemic and how do you see the experiences of the pandemic shaping partnership working in the future?

While this role was new during the pandemic, I have been involved in health for a number of years previously. However, in this role public health reports to me so the pandemic was a very large focus. We were predominantly in incident mode and our key focus was to 'protect lives', much more obviously than we have ever done before. This removed a lot of the barriers, real and perceived, in terms of our culture, processes and systems. We worked together to support people and enable the best outcomes and that meant sharing data and information much more readily than we might have done typically. This was permitted and encouraged by the Government and at local government level it felt like the logical and rational thing to do. It meant we better understood and focused on specific strengths and priorities and how we could do those together - for example protecting hospitals or thinking about community-based support for people shielding. There are times when this information sharing can feel almost competitive as to our priorities, but during this period it was completely collaborative and focused.

The vaccine programme was one example of a great partnership between health and local government: it was a health programme, but local authorities had buildings and could facilitate things like parking and this helped move it forward at pace. We really valued each other's contributions and if we can maintain that ability to see the other's perspective it will bring real benefits.

What learnings has the pandemic brought or heightened about how health and care services are delivered in communities?

There have been learnings about what we turned off or stopped in response to the pandemic, for example certain health checks, and what more we could have done to support these areas in certain places. Those might have been the right restrictions and approach at the time but we have learned that in the future we need to think more clearly about how we bring services back online or use voluntary sector and partners more creatively.

Hindsight has shown we could have more closely considered mental health and the impacts this was going to have with children not being in school, people being isolated and the overall pressures of work, from home or otherwise, that were creating real challenges for people. This is a vitally important area for us to be considering and incorporating into our approach as we move forward.

The vaccination programme presented a very clear example of community delivery, where it works and where we have challenges. We had real success working with community leaders and managed to open up locations for people to access services and that has offered real lessons to us. For example, if the only way to get a life-saving vaccine was to have a bus that went directly to that community, this is something that we need to consider for other essential health checks. This has really encouraged us to explore access, consider what really worked well and how we can develop a better operating model going forward. At the same time, there are parts of our communities where we need to think more carefully about how we connect with them and encourage greater trust in public service.

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There was also an important collaboration between the media and public services during the pandemic and that helped message communication in our local communities considerably.

Surrey Heartlands was one of the first designated Integrated Care Systems (ICS). Can you tell us about the ICS vision more broadly, and how Surrey Heartlands is looking to do things differently?

Surrey Heartlands is made up of an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP). Each has a more defined remit, but overall it is the sum of the parts and the collaborative approach which has and will continue to make it a success.

The ICB focuses on Health and Care and keeping people safe and well at home, maximising flow through hospitals and enhancing that process, thinking about the wrap around services and coordinating are that is required.

The ICP focuses more on the determinants on our health, particularly on social and economic behaviours and it is able to bring together the other elements – voluntary sector, business, county council and local authorities around the table to discuss the overall strategy and how they can work together better and more effectively for collective and individual well-being.

As an early ICS we really were able to integrate the Council and the healthcare system together. Over the last two years the Leader of the Council was chairing the overall ICS and now chairs the ICP. This structure has given local government-elected members the opportunity to see how the NHS works up close and understand some of the challenges. It has been a very positive step in terms of enhancing the integration, highlighting what we each bring to the table, and enabling more proactive and constructive thinking on many areas covered in the new legislation.

We are really changing the dynamic and being much more local and thoughtful in our models and approach to health and care. It is important that we work together and think about our collective assets, be honest and communicate with our communities about what we can and can't do. There is a great opportunity to share information, digital insights and utilise data and analytics, but it does also present challenges as the use of digital or online can be seen negatively in a community sense. We need to find a way that we are face-to-face and connected with communities when we really need to be and make it easier to access services when really needed.

We hear a lot of talk about the importance of 'place', below the ICS level. How much emphasis is put on the localised approach in bringing about success in your ICS? Please share examples.

'Place' is hugely important and we have not solved this yet, but we are working on it. There is an important debate about what is effective to have at a 'place' level and what should remain at a 'system' level. For Surrey Heartlands 'neighbourhood' is potentially more important than 'place'. The 'neighbourhood' level is 30,000-50,000 population, similar to that of a Primary Care Network. That is where we are looking at growing health together, creating and developing our neighbourhood teams and thinking about our wider sustainability responsibilities including better prescribing, considering green spaces and how we use the environment to support people's mental health.

Population at 'place' level is about 300,000 people and that is where there is larger investment in areas such as housing to really support wider health. This is presenting some very interesting partnership conversations as we think about what the right things are to invest in for people's health.

Surrey Heartlands doesn't mirror the district and boroughs (the lower tier council structures within the county), which has presented some challenges, but ultimately it has encouraged and opened up more conversations about where we have and need services. Focusing on neighbourhoods brings us closer to individuals and communities and means we are responding to the needs of our population which is critical.

Inequality has been heightened at local and national levels during the pandemic, with health and care services as one of the key areas of focus. How can the sector respond to address this?

There is a greater need for more honest conversations to address this inequality. The NHS has a model called CORE 20 + 5 which encourages a specific approach is developed for the lowest 20 per cent of deprived areas in individual communities, with a focus on five key areas of medical priority.

In Surrey this has helped us to focus on our communities where there is lower life expectancy, lower incomes and where health outcomes are not as positive. We need to talk more with and in those communities and think about how we can help change those factors. In addition to the geographic locations, we have also identified a number of groups where we've seen a disproportionate impact on their health outcomes that are important for us to prioritise within our health and well-being strategy.

A local listening approach which is more meaningfully delivered is central to how we can make a difference. This is where data and analytics is so important as sometimes we cannot obviously see areas of deprivation as it is spread out but we must not lose sight of those – there is too much disparity and inequality between very wealthy and very deprived and we see it is not acceptable.

Doing integration well is hard work. What barriers did you find in the way of better collaborative working, and how were you able to dismantle them?

In my joint role, and in my previous health roles, collaborative work has always been really beneficial. However, I can clearly see across health and local government that there is different language, terminology and approaches that do not always translate easily. Even nationally our approach and legislation are different and that can mean taking a different direction, by planning for, responding to and funding things differently.

Again, the national vaccine programme opened our eyes. As a national organisation the NHS was able to operate as one cascade system, but that is not how councils operate. When you understand the benefits, and equally, the limitations of that it really does help to think about how you can utilise areas such as the autonomy of the council structure. However, if you don't make the time to understand that I think it really can be more challenging.

I spend a fair amount of time doing the translation and integration activity as I have a foot in each camp. I believe we need people to have more opportunity to understand both worlds so we can help find a new system which blends the two cultures: that feels like a real opportunity.

To address that I am actively putting in place joint roles so more people are in both camps. They are enjoying the variety, once they overcome the initial challenge of understanding new systems and terminology, and it is significantly enhancing the skills, behaviours and characteristics of our team

Biography

Rachel has worked in Surrey since 2003, in a range of local government roles before being appointed to the Joint Executive Director for Public Service Reform role in May 2021. In this role, Rachel is accountable to both Surrey Heartlands Integrated Care System and Surrey County Council for driving the continuous improvement of a public service model that supports the delivery of our integrated health and social care strategies. Key areas within her portfolio include public health, population health management, reducing health inequalities, strategic business intelligence and analytics, estates and driving innovation through the Surrey Heartlands Academy.

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Our Health Practice Team

At Saxton Bampfylde we know the importance of game-changing leadership appointments for the health and care ecosystem. Our dedicated team are proven partners in supporting critically-strategic appointments at the most senior Executive and Non-Executive levels in the Health & Care sectors. From start-up healthtech businesses to leading NHS Trusts; from private healthcare businesses to national institutes and emerging NHS system leaders.

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Our Track Record Includes:

University Hospitals Leicester NHS Trust, Chief Executive

Newcastle-upon-Tyne Hospitals NHS Foundation Trust, Chief Executive

Surrey County Council and Surrey Heartlands ICS, Joint Executive Director of Adult Social Care

Hampshire Hospitals NHS Foundation Trust, Chief Operating Officer

Countess of Chester Hospital NHS Foundation Trust, Chief People Officer

University Hospitals Bristol and Weston NHS Foundation Trust, Medical Director UK Research and Innovation; Chief Executive

Medical Research Council (MRC)
Executive Chair

Department for Health and Social Care, Chief Scientific Advisor

Deloitte, Clinical Partner

HCA Healthcare UK, Chair and Advisory Board

University College London Hospitals NHS Foundation Trust, Chair

North West London Acute Provider Collaborative, Chair

North West London Integrated Care System, four Non-executive Directors

University Hospitals of Derby and Burton NHS Foundation Trust, Chair; Non-executive Director