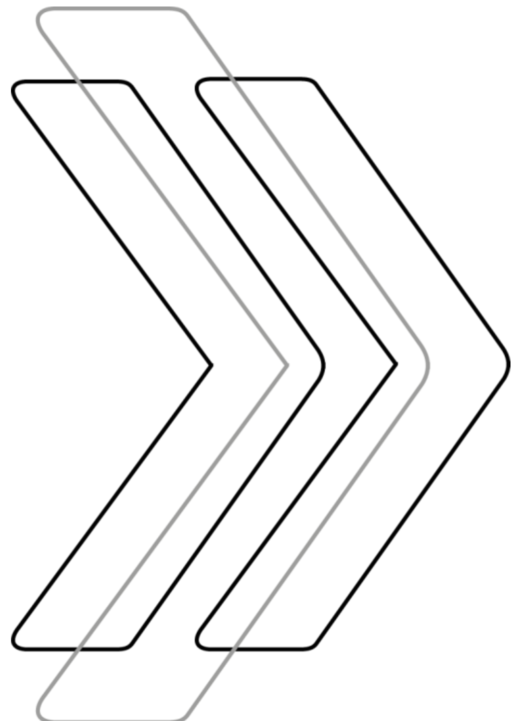
The King's Fund

Ideas that change health and care

Transformation and improvement in Cardiff and Vale

A review of work to create an integrated health and care system



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November 2022

This independent report was commissioned by Cardiff and Vale Regional Partnership Board to support its work to create a more integrated health and care system and to embed a more preventive approach within primary and community services. The views in the report are those of the authors and all conclusions are the authors' own.

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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1 Introduction

Health and care in Cardiff and the Vale of Glamorgan

National context

Collaboration has been a key focus of Welsh policy for health and care since devolution. Some of the main decisions and policies that have shaped integration include a reorganisation in 2009, which established seven local health boards with responsibility for purchasing and providing health services across a geographical area (eliminating the purchaser/provider split) and giving them a legal duty to co-operate with local authorities to plan services. Five years later, The Social Services and Well-being (Wales) Act 2014 established regional partnership boards (RPBs), which are co-terminous with local health boards and bring together a range of local partners.

The Well-being of Future Generations (Wales) Act 2015 requires Welsh public bodies to improve social, cultural, environmental and economic wellbeing. The Act established public service boards, co-terminus with local authorities, with the purpose of supporting joint working between health, social care and other local services such as fire and rescue and the police. These boards play a key role in supporting wellbeing and addressing health inequalities; they are required to conduct local needs assessments and must publish an annual local wellbeing plan.

The Public Health (Wales) Act 2017 is a key part of the approach to prevention in Wales, addressing specific public health issues such as obesity and tobacco use. The Act highlights the importance of public bodies working collaboratively and with communities and the public to address and prevent long-term challenges related to health inequalities, poverty and climate change.

The Act was followed in 2018 by *A healthier Wales: our plan for health and social care*, which encourages a whole-system approach to health and social care provision, with prevention, early intervention, reducing poor health and equitable access central to the design and delivery of services (Welsh government 2018). The plan places a focus on ways of working, including integration, collaboration, the involvement of the public and balancing short- and long-term strategic plans.

Cluster arrangements

Since 2010, primary care in Wales has been arranged in 64 primary care clusters, based on locality footprints serving populations of between 30,000 and 50,000 people. These are primary care led and bring together all local services

involved in health and care across a geographical area. Clusters are seen as central to delivering the Primary Care Model for Wales, a model that evolved over several years before being formally endorsed by the National Primary Care Board in 2018 (National Primary Care Board 2018). The model aims to ensure a whole-system approach to sustainable and accessible health and wellbeing, promoting multi-professional primary care teams and working across organisational boundaries to improve access to services and reduce pressure on general practitioners.

Audit Wales carried out a review in 2019 and found that progress in implementing the model was patchy (Wales Audit Office 2019b). In 2021, accelerated cluster development (ACD) was introduced to support the more rapid implementation of the Primary Care Model for Wales, including by strengthening clinical engagement. The ACD programme also saw the introduction of pan-cluster planning groups at county level, intended to increase alignment between cluster arrangements and provide the local footprint for the delivery of RPB priorities. Bringing together senior leaders from the NHS, local authorities and third sector (or the voluntary, community and social enterprise (VCSE) sector), these groups are intended to provide integrated system leadership and have responsibility for agreeing a county population needs assessment, developing integrated plans and commissioning services.

Local context

Cardiff and the Vale of Glamorgan (Cardiff and Vale) has a total population of more than 475,000, which is ethnically diverse in comparison with the rest of Wales.

The region covers two counties. Cardiff County includes the capital of Wales, with inner-city areas in the south being some of the poorest districts in Wales. In contrast, the Vale of Glamorgan is largely a rural county with an economy that is based on agriculture and chemicals.

The main structures involved in the health and care system are as follows:

- The Cardiff and Vale RPB supports partnership working across the health and care system.
- The Cardiff and Vale University Health Board (UHB) plans and delivers a range of services across the system.
- Two local authorities, Cardiff Council and The Vale of Glamorgan Council.
- Each county has a Public Services Board supporting partnership working relating to the determinants of the health and wellbeing of the population.
- There are two localities in Cardiff (North West and South East) and one in the Vale. Within each locality there are three primary care clusters,

and therefore nine clusters across Cardiff and Vale. Community health services and local authority social care services operate conterminously within these localities.

- There are nine primary care clusters across Cardiff and Vale – six within Cardiff and three in the Vale.
- As of 2021, there were two pan-cluster planning groups, one covering Cardiff and the other covering the Vale

The Cardiff and Vale RPB is made up of different partners from health, the two local authorities, and third sector and carer representatives. It is responsible for carrying out population needs assessments, an assessment of the stability and sufficiency of the care market and ensuring effective collaborative working among local partners, with the aim of delivering care services to better meet the needs of local people and improve their health and wellbeing. In line with national requirements, The RPB is also required to develop its social value forum, by emphasising the role of the third sector and people with lived experience of services, thereby embedding social value into its remit and priorities.

The Cardiff and Vale UHB is responsible for the planning, commissioning and delivery of a wide range of health and care services across Cardiff and Vale, including primary care services, acute care, mental health services, health centres that deliver community-based care, district nursing and other services in people's homes. It also provides specialised health services for Wales and some for the UK as a whole. In addition, the UHB is responsible for improving population health and leads or supports a range of public health functions in collaboration with local partner organisations. The UHB's approach to public health is set out in the Cardiff and Vale Local Public Health Plan (2019–22) (Cardiff and Vale University Health Board 2019a), which forms part of the UHB's Integrated Medium Term Plan (Cardiff and Vale University Health Board 2019b) and includes a number of major work programmes including those focused on tobacco use, healthy eating and health inequalities.

In line with national policy, the Cardiff and Vale health and care system is working to deliver more integrated care to the local population through better joint working across a range of local partners. This includes a focus on prevention and improving the health and wellbeing of the local population.

A number of local strategies and plans set out how Cardiff and Vale intends to address national priorities on integration and prevention locally. This includes the UHB's Shaping our Future Wellbeing Strategy (2015–25) (Cardiff and Vale University Health Board 2015), which sets out clear objectives for the Health Board, with a strong emphasis on working with partners to achieve them. There is a focus on prevention and wellbeing, integration and new models of care that put communities and people's needs at the centre. The UHB's vision for Cardiff

and Vale is centred on providing equitable health and care, regardless of where people live.

Overview of the research

Within the context set out above, the Cardiff and Vale RPB commissioned The King's Fund to carry out research into its progress on delivering a more integrated health and care system, and within this, embedding a focus on prevention within primary care, and to identify opportunities for going further in these areas.

Aims

The purpose of the research was to provide an independent view on the Cardiff and Vale health and care system's approach to transformation, with a particular focus on two interrelated areas of work:

- creating a more integrated health and care system
- embedding a more preventive approach within primary and community services.

Within each of these areas, the aims of the work were to:

- identify areas where the Cardiff and Vale system is making substantial progress
- highlight opportunities for Cardiff and Vale to progress further, drawing on the literature and the experience of health and care systems elsewhere.

Approach

The research comprised:

- a review of Cardiff and Vale's relevant health and care strategy documents
- interviews with 12 people from across the Cardiff and Vale system, and with someone working in an integrated provider organisation in England
- a review of English-language literature focused on delivering integrated care, the funding and finance systems to support this, partnership working and approaches to choosing initiatives
- drawing on knowledge and intelligence within The King's Fund on other examples and best practice in the two key areas set out above.

About this report

This report is focused on the first area set out above – work to create a more integrated health and care system. It can be read alongside *Transformation and improvement in Cardiff and Vale: a review of work to embed a preventive approach within primary and community services*, which focuses on the second area. Given the inter-relationship between the two areas, the reports cover some similar themes. Where relevant, some of these are discussed in more detail in one of the reports and summarised in the other, with clear signposting for the reader.

2 The vision

The vision for health and care in Cardiff and Vale

Cardiff and Vale's RPB aims to improve the health and wellbeing of the local population and improve care by ensuring that local partners work together effectively. It has three core life-stage-based themes: Starting Well, Living Well and Ageing Well. Under the last of these sits the @Home programme, a major programme aimed at reshaping the way in which health and social care are delivered in the region. This aims to provide place-based joined-up care, between health, social care, the third sector and communities, to enable people to receive care at home or near home. The RPB's overarching objective is that people live the best lives they can in their homes and communities (Cardiff and Vale Regional Partnership Board undated).

Cardiff and Vale UHB's Shaping Our Future Wellbeing Strategy (2015–25) (Cardiff and Vale University Health Board 2015), Cardiff Council's Ageing Well strategy (Cardiff Council 2022) and the Vale of Glamorgan's Reshaping Services strategy (Audit Wales 2020), as well as the national Healthier Wales plan (Welsh government 2018) all contribute to the delivery of successful partnership working.

To achieve this vision, the Shaping Our Future Wellbeing Strategy is focused on delivering joined-up care, based on the principle of 'home first' (Cardiff and Vale University Health Board 2015). It sets out four key objectives:

- to focus on the population – addressing inequalities, delivering outcomes that matter to people and improving the health and wellbeing of the population
- to ensure that services meet the needs of the population
- to ensure that the health and care system provides the right care at the right time, reduces harm and waste and is sustainable over the long term
- to create a culture where there is collaborative working to deliver care, using digital technology as an enabler and providing an environment for research and innovation.

Prevention is a key part of the approach to delivering this vision, with a focus on behaviour change, creating environments that support and promote health and looking at the wider determinants of health. This requires action on a range of issues beyond health and care services, such as housing, education and poverty. Delivering this work involves a range of local partners, with local authorities playing a particularly important role.

The nine primary care clusters within Cardiff and Vale also have a role to play through their work on a range of projects, including those focused on improving screening and immunisation rates and strengthening social care prescribing.

Engagement in the vision

Collaborative working underpins the Cardiff and Vale system's vision for more joined-up care. In line with this, the interviewees involved in our research recognised the need for the vision for Cardiff and Vale to be embedded across all partners within the system, working through the RPB. One highlighted the importance of buy-in from leaders in particular, given the reliance on decisions that individual statutory organisations make:

> *Ultimately the RPB doesn't have any statutory powers. It can't say this is what we're doing. Those strategy powers remain with the sovereign organisations. So those executive leads from each of those sovereign organisations that sit around the RPB, they've got to be convinced, and they've got to drive it within their organisations.*

When asked, most interviewees could describe a vision for Cardiff and Vale and what it meant for them and the part of the system in which they were working. However, we heard different views on engagement overall. One interviewee told us it was generally understood, but another saw engagement as patchy: 'I think it's understood in some parts and then not understood in others.'

A few interviewees told us that there is a particular lack of clarity around what 'integration' means in practice, and whether the ambition is co-operation, collaboration, co-location or something else. One interviewee described this issue as the 'elephant in the room' and suggested that the system would struggle to make real progress until this question was resolved.

Managing competing priorities

For some, however, the challenge is less around what Cardiff and Vale's vision is, and more about whether and how it is put into practice. They said this was linked to two issues: first, whether or not there is a clear plan for translating the vision into action; and second, whether or not the system is able to maintain a focus on this vision in the face of competing pressures:

> *[The] vision has been stated in the kind of, in the UHB strategy. That's pretty clear… What we don't do is refer to that on a business-as-usual basis because we're still stuck firefighting.*

> *The incentive is to catch up on waiting lists... and if you've got to do that quickly and the timeframes are very, very short, then of course people will do just more of the same thing because you haven't got time to redesign the system to do things differently.*

Within this context, we heard about the problem of national targets that encourage a focus on managing short-term pressures such as waiting lists, as well as staff burnout, both of which can make it difficult for those working in the system to find the 'energy' or headspace for more transformational work. This environment can lead to silo working, rather than supporting partnership working and a more integrated approach.

Going further: embedding a shared vision

A clear vision that is widely understood and has full buy-in from partners across the Cardiff and Vale system will underpin efforts to work in an integrated way. It is also key to making progress in the face of competing pressures. Research highlights the importance of those working in partnership having a shared purpose and vision, which are developed in a collaborative way, building on an understanding of the needs of local people (Charles *et al* 2021). Some of the key factors that can help systems and organisations in embedding a shared vision, highlighted by the literature, are set out below.

Engaging staff

The literature emphasises the engagement of staff in the development of a vision as an important first step in embedding it within and across organisations. Not only does this approach recognise the highly valuable perspective that staff offer when it comes to understanding the needs of local people and opportunities for improvement, but it also helps ensure that the vision is developed in terms that are meaningful to those working within the system (Ham 2014). Our interviewee from an integrated mental health, community, primary care and acute trust in England emphasised the importance of listening to feedback from frontline staff when it came to 'articulating the why'.

However, engaging staff in a vision for change is not a one-time event; embedding a shared sense of purpose within the culture of an organisation or system, such that it becomes 'business as usual', is key (Collins 2015).

The partners within the Cardiff and Vale RPB have developed strategies for engaging their staff. For example, the UHB has a Staff Engagement Strategic Framework (2017–20), developed alongside the Shaping our Future Wellbeing Strategy (Cardiff and Vale University Health Board 2015), which sets out some principles and measures for staff engagement across the UHB (Cardiff and Vale University Health Board 2017). This highlights the importance of leaders showing a clear commitment to the system's vision, and emphasises the role of managers in demonstrating engaging behaviours. Cardiff Council also has a programme of staff engagement, supported by a health and wellbeing strategy, which is aimed at promoting the wellbeing of its staff while at work. The engagement of staff is seen as critical to delivering the council's Capital Ambition, a five-year programme for the city made up of several wellbeing objectives, a number of

which will be delivered through the council's work with the RPB (Cardiff Council 2022, 2018).

A commitment to Cardiff and Vale's vision from leaders and managers is critical, especially at times of disruption and significant change, such as during the Covid-19 pandemic or in the face of financial pressures. This applies across all partners, including those at a system level, within the RPB and UHB, and at a primary care cluster level. It is important that leaders in each of these areas are communicating the same vision and embedding it into their plans and programmes. However, it is also important that organisations engage all staff in the vision, including those delivering frontline care. There may be an opportunity for partners within the Cardiff and Vale system to go further in engaging staff at all levels.

The experience of Wigan Council, which has transformed its approach to delivering local public services since 2012, provides some lessons on the practical ways in which organisations can go about engaging staff in a vision for change (*see* box below).

Staff engagement in Wigan

The King's Fund's research on Wigan's experience of transforming public services (Naylor and Wellings 2019), underpinned by a new relationship with the public known as the 'Wigan Deal', highlighted the following actions the council (and beyond) has taken to bring about a change in culture among staff.

- It has made efforts to bridge the gap between senior management and wider council staff, and to engage staff in the vision and ethos of the Wigan Deal. This includes 'Listening into Action' sessions, which give staff the opportunity to ask questions of the chief executive and senior management team and to offer suggestions. These sessions take place across the council and within individual directorates.
- It has a significant focus on internal communications and marketing – for example, a weekly email bulletin to staff within the organisation including stories of staff members putting the vision into action.
- It has incorporated Wigan's core principles in all human resources material and processes, including recruitment, induction and appraisals.
- It has shifted from having skills-based recruitment to having values-based recruitment, with job specifications including a section on the council's culture.
- It has placed a strong emphasis on induction – with Wigan Deal training and a half-day session on the council's values and behaviours.
- It has introduced a 'staff deal' based on the same principle of reciprocity.
- It has identified champions/advocates to promote the message to others – an incremental approach to building support.

The King's Fund's research on this and staff surveys suggest that this approach has led to a strong sense of pride and positivity among staff. Staff surveys also show a high level of understanding of 'what the deal is'.

The experience of rolling out Rapid Assessment, Interface and Discharge (RAID), a transformational mental health service at Birmingham and Solihull Mental Health NHS Foundation Trust in partnership with Sandwell and West Birmingham Hospitals NHS Trust, also offers some lessons on embedding a vision for change such that it becomes 'business as usual'. This includes nurturing a sense of pride among staff, using data to demonstrate the impact of changes and motivate staff, and training staff to build their confidence in working 'beyond their comfort

zone', in this case assessing a wider caseload of mental health conditions (Dougall *et al* 2018).

Engaging patients and communities

There is extensive research on the importance and benefits of working with patients and the public in developing a shared vision for change. Interviewees acknowledged the necessity of centring the voices of patients and communities in the vision. However, they also highlighted the challenges they faced in engaging with the public.

> *I think it's more challenging with the public to be honest with you, because I think they've got used to services in a particular way. So, I think, you know, we need to do more around that, I think, to sell the benefits, or for them to be able to understand why we do things differently.*

> *I believe that if you can listen to the patient voice, listen to the colleague voice, that will help to give you a gravitational pull to the right place when other things are pulling you away*.

Various approaches and models have been developed to support partnership and collaborative working with patients and communities. The 'community paradigm' is an approach that identifies key principles for public services in working effectively with communities and building relationships (Lent and Studdert 2019). These include a recognition of patients and communities as active agents of change, rather than as passive recipients of services. When patients and the public are viewed as partners, they are more likely to take responsibility for their health and can also help drive the vision in their local areas.

Work by The King's Fund highlights some of the key points to consider for effective engagement with patients and the public. These include ensuring that there is a clear purpose to engagement, as this will determine the approaches used, and making use of diverse methods to ensure that different groups are able to participate. It is important that engagement work is seen as 'everyone's business', and not just the responsibility of the patient engagement or patient experience team within organisations. It is also important that patients and communities are involved at both a strategic and an operational level (Wellings 2018).

In Wigan, the council sought to transform public services through a new relationship with the local community. The need to provide health and care in a different way based on relationships with all stakeholders drove the deal. The local authority and partners focused on four elements of change: the ability to innovate, asset-based working, investing in communities and place-based working. Their approach to working with patients and communities involved:

- shifting the focus away from working on communities, to building relationships with communities
- recognising and nurturing the strengths of individuals and communities
- investing in the local third sector through a dedicated community investment fund
- increasing their citizen leadership through different roles, for example community health champions and dementia friends.

What has made it successful is their consistency of approach and implementation over the past six years.

The box below sets out the approach that NHS Dorset Clinical Commissioning Group has been taking to engaging with its local community.

Patient and public engagement in Dorset

NHS Dorset Clinical Commissioning Group (CCG) has developed a strategic approach to putting the views of local people at the centre of its health system. In particular, this included the establishment of Our Dorset Public Engagement Group (PEG) in 2017, which is made up of 25 local people with lived experience across the Dorset area. The group meets virtually every two months and face-to-face once a year.

The role of the PEG is to provide advice and challenge on public engagement planned across the system and to ensure that local people are being informed about and engaged in the development of services in an appropriate way. For example, the group recently provided feedback on the CCG's winter pressures campaign and on community engagement in relation to the Covid-19 vaccine. The PEG has also held some 'view-seeking sessions' on different aspects of work going on in the system locally, such as a new outpatient assessment clinic and a new Dorset digital engagement plan.

The PEG has developed a guide to putting local people at the centre of discussions, which the CCG's senior leadership team endorsed (NHS Dorset Clinical Commissioning Group 2022). This includes key prompts for staff such as:

- equality and diversity – determining whether all nine of the protected characteristics under the Equality Act 2010 are being considered
- access – considering people's travel needs
- information technology (IT) – considering the use of digital technology in planning care
- physical and mental health – ensuring that all needs are considered in care planning.

(NHS Dorset Clinical Commissioning Group 2022; Our Dorset 2022a, 2022b).

3 System working

Structures

The Social Services and Well-being (Wales) Act 2014 established the Cardiff and Vale RPB along with six others across Wales in 2014. This formalised existing partnership boards and was intended to accelerate the integration of health and care.

RPBs bring together a range of local partners. The Cardiff and Vale RPB includes Cardiff Council, the Vale of Glamorgan Council, the Cardiff and Vale UHB, the Welsh Ambulance Services NHS Trust and third sector and carer representatives.

A 2019 parliamentary review of health and social care led to an increase in the powers of RPBs, although health boards and local authorities remain primary commissioners of health and social care (Reed *et al* 2021). This means that statutory powers remain with the participating organisations, and buy-in from executive leads in decisions that the RPB makes is key. However, the RPB provides an important framework for system working and a focus for the development and delivery of shared goals.

> *It only exists as a meeting. But actually, it's symbolic of something much greater: it's what the RPB agrees to do between those meetings in terms of what's important to our population and how we're going to work together. So it is theatre, it's absolutely theatre, but it does, it makes us get in that room, it makes us identify what it is we have to do together that we absolutely can't do individually.*

A small number of interviewees shared their views on the effectiveness of the RPB. One highlighted the breadth of membership of the RPB, and the inclusion of citizens' voices in particular, as providing a rich opportunity for bringing about change.

However, another told us that the meetings do not provide the space for innovative thinking and challenge that they might do: 'Meetings are more programme based as opposed to almost like challenging each other to find newer ways and inventive ways of doing things.'

For the most part, however, interviewees focused on the relationships between the organisations within the system that underpin the RPB and work towards a more integrated system, rather than the ways in which the RPB operates. This theme is discussed below.

Relationships

As is the case in many health and care systems, we heard that the strength of relationships between organisations within the Cardiff and Vale system varies. We also heard that these relationships can be personality driven and in some cases are reliant on strong relationships between individuals: 'It's the same as any complex relationship – you have parts which are brilliant and parts where you just can't open the door.'

In general, relationships between the statutory organisations in Cardiff and Vale were described in quite positive terms. Examples provided of collaborative working included weekly meetings between executives from the UHB and local authorities (which one interviewee told us 'speaks volumes') as well as a number of integrated posts between the UHB and the local authority in the Vale.

The statutory sector was seen as working particularly effectively in response to the Covid-19 pandemic, with an 'excellent partnership' operating between the NHS and local government. One interviewee suggested that this experience had demonstrated how well these organisations can work together when focused on a shared problem, but they also expressed concern that this progress might be lost over time as the context changes.

The relationship with the third sector

However, the clear view from the third sector representatives we spoke to was that the sector is not treated as an equal partner within the system or given an equal or meaningful opportunity to contribute to decisions. The sense from these interviewees was that decisions often happen elsewhere and that the statutory sector dominates them.

> *[It can seem like the third sector is there because they're] required to be in the room as opposed to because there's a real will to involve [them].*
>
> *Third sector is brought in after a particular decision has been taken and the shape of a project has already been decided… whereas really the added value of having third sector and stakeholder involvement [is] in co-design right from the beginning.*

A question was also raised as to whether umbrella or third sector representative organisations are always the best mechanism for providing the third sector perspective, rather than supporting others within a very diverse sector to engage.

Silo working

Despite some relationships operating very effectively, we heard from several interviewees that silo working remains a challenge within the Cardiff and Vale system. Different issues were cited in this context, including:

- funding and organisations feeling the need to retain control over their own budgets (*see* the section on shared resources in section 4)
- organisations having different accountabilities
- organisations working to different targets
- organisations having different ways of working and organisational cultures.

> *It's a bit of a chicken and egg [situation] possibly but when we look at resource allocation, as long as health and social care are separate, then people are constrained by their own boundaries.*

The issue of silo working was raised in relation to the experience of patients specifically, as it hampers the potential for delivering seamless care:

> *What we currently have is people are basically bounced around the system. I think that's predominantly because of various areas across the whole system, you know, health care, social care and including [the] community and third sector as well, is that… Inevitably, people end up working in silos and very much focusing on their own bit of the system.*

Going further: strengthening relationships across the system

Research on system working highlights the importance of multi-agency partnerships being grounded in strong relationships between organisations and individuals (Charles *et al* 2021). As set out earlier, beginning with a clear vision and shared sense of purpose – something that partners can return to when other pressures threaten to pull them in different directions – is critical.

The research also emphasises the importance of placing an explicit focus on the development of relationships. This is something that often begins with leaders, but it is important that there are also mechanisms for ensuring that this happens at all levels, including among frontline staff (Charles *et al* 2021). Our interviewee from an integrated mental health, community, primary care and acute trust in England told us that, which will bring the three types of organisations together, 'part of what happened was a big "getting to know each other" period of time. And almost at every level, we'd spent that time getting to know each other and getting to know the different agendas.'

The box below draws together some lessons from the literature on what those working within systems can do to strengthen the relationships between partners.

Strengthening relationships

A review of the literature identified the following actions and ways of working that those within systems can adopt to strengthen relationships and promote effective partnership working.

- Dedicate time to the specific purpose of developing relationships, in formal and less formal contexts. This includes individuals taking time to get to know one another as ‘people and not roles’, understanding motivations and helping to identify the wider set of skills that individuals have and can be drawn on (Maybin *et al* 2022).
- Pay attention to relationships on an ongoing basis, including through reflective conversations to discuss how relationships are working, revisiting the purpose of the partnership and, where necessary, reframing approaches to joint work. It is important that there is dedicated time and space for these discussions to prevent operational issues overtaking them (Maybin *et al* 2022).
- Good communication is key. This means open and frequent communication and the sharing of information and best practice. This could include protocols for information-sharing. The literature highlights the link between communication and the development of trust between partners (Alderwick *et al* 2021).
- Other principles include having clear decision-making practices, recognising and pre-empting conflict and agreeing a set of principles for managing this in advance.

Involvement of the third sector

One theme in the literature is the importance of multi-agency partnerships functioning as equal partnerships, with a collective approach to leadership. Collective leadership involves the distribution of power among partners, with responsibilities, ownership and accountability being shared (Silva *et al* 2021). In the context of system or place-based working, this means bringing together leaders with different views and perspectives to work in partnership and address complex challenges. Research on developing placed-based partnerships highlights the areas of finance, convening meetings and participation in the leadership group as key responsibilities that partners need to consider at the place level and ensure that responsibilities for these areas are shared among partners (Charles *et al* 2021).

The King's Fund's programme, Healthier Communities Together (HCT) – a partnership with the National Lottery Community Fund supporting the development of place-based partnerships in five areas in England – has found that, in practice, relationships between the NHS, local authorities and third sector organisations are often difficult, and in general fail to capitalise on the strengths of the third sector well enough (Maybin *et al* 2022). This chimes with the perception we heard from some interviewees in Cardiff and Vale, as set out above.

One of the early learnings from the HCT programme is that where there is an imbalance of power between partners, with one (or more) feeling less able to contribute than others, it is important to name this dynamic and ensure that it does not become embedded. Steps taken within the HCT partnerships to ensure they are more equal and collaborative have included:

- reopening discussions about when and how partners should convene and communicate
- recognising the 'opportunity cost' for VCSE organisations in contributing, which may be greater than it is for statutory organisations (*see* below)
- approaches to meeting facilitation that consciously prioritise that all voices are heard (Maybin *et al* 2022).

When it comes to the participation of the third sector within health and care systems, it is also important to recognise the diversity of the sector. Research highlights the value of systems including a mixture of these often very different organisations within partnerships, rather than relying on a single representative organisation (Charles *et al* 2021). As part of this, it is important to consider the resource implications for VCSE organisations participating in collaborative forums. These can be significant and therefore it may be necessary to actively support VCSE participation and ensure that it is sustained over time, for example by remunerating people for their time (Charles *et al* 2021). In Wigan, the Wigan Deal includes a commitment to strengthening the VCSE sector and the local community itself. For example, Wigan Council's Deal for Communities Investment Fund provided funding to support community groups and projects, and in turn has supported a more collaborative approach between the council and the VCSE sector (Naylor and Wellings 2019). The investment fund has now closed, and Wigan has since established a community recovery fund, and in 2022 launched 'The Deal for Communities Recovery Fund - Thriving and Resilient Communities' to support voluntary and community organisations in line with a set of core themes (Wigan Council 2022).

Engagement with the adult social care sector

Difficulties in the relationship between health and social care came out less clearly as a theme in our research, and there are good examples of progress in

joint working between the two sectors. The Cardiff and Vale RPB's Regional Outcomes Framework draws together measures across health and social care to support commissioning and work to improve health and care across the system (Cardiff and Vale Regional Partnership Board undated).

> *What we've done, which again, shows the ambition of Cardiff and Vale, and they are actually going to get a bit of value out of this, is we have brought that social care data into that big relational database [a database that stores and provides access to data that is related]. And the RPB has done a beautiful job of building an outcomes framework, which is actually about outcomes for populations, and not service delivery.*

However, we also heard that social care could lose out to health, particularly when it comes to funding:

> *I would say that probably where there has been some disinvestment in social care over the years, it's always been to the benefit of health and there's never any benefit going back into social care. Health always seems to be the beneficiary. So if you save hospital bed days, whatever terminology you want to use, health has that benefit, nobody else does.*

Work by The King's Fund has identified some of the challenges that adult social care (ASC) providers are experiencing in working with integrated care systems in England (Bottery and Blythe 2022). Similarly, a recent report from Care England and the Homecare Association has highlighted the opportunity for further engagement between integrated care systems and the ASC sector in England, noting that in many areas, dialogue between the two is limited (Grayson and Abdulhamid 2022). These pieces of research highlight some opportunities to improve partnership working between the two sectors, which may also apply to the Cardiff and Vale RPB.

The King's Fund's research identified a range of barriers that, overall, resulted in a transactional relationship between integrated care systems and ASC providers, with the latter feeling that their role was not always appreciated. These included cultural differences between health and care and a sense among ASC providers that there is a lack of understanding from those in the health system about what ASC providers do and a lack of trust in the expertise of their staff. The diversity and capacity of the ASC sector was also identified as an issue; smaller providers had limited time to participate, while bigger ones were sometimes having to engage with multiple integrated care systems (Bottery and Blythe 2022).

Actions proposed in response to these challenges (Bottery and Blythe 2022) included:

- integrated care systems improving communication and engagement with the ASC sector
- working to strengthen understanding between the two sectors

- developing structural options for the involvement of ASC providers in integrated care systems.

These are broadly consistent with the recommendations that Care England and the Homecare Association put forward (Grayson and Abdulhamid 2022). This work suggested that integrated care systems should work directly with ASC providers to agree engagement mechanisms, rather than relying on the local authority representative on the integrated care board within the integrated care system. It also called for integrated care partnership boards to work with ASC providers to agree an engagement plan with them and recommended the establishment of provider forums to nominate a representative to the integrated care partnership board. It also put forward the idea of a paid position being created, held by someone in an organisation providing ASC, to support furthering the ASC agenda within new place-based arrangements and educate partners on the issues facing the sector.

4 Bringing about change

Choosing initiatives and things to work on

We heard about several examples of progress in delivering Cardiff and Vale's ambition for a more integrated health and care system. To a large extent these appear to have been developed 'bottom up', pushed forward by enthusiastic teams and individuals who had identified an opportunity to make a change.

Transformation and improvement in Cardiff and Vale: a review of work to embed a preventive approach within primary and community services discusses opportunities to develop the approach to bringing about change in Cardiff and Vale, including by:

- adopting a more programmatic approach to decisions
- providing more support to staff in taking forward changes
- making better use of data
- strengthening the approach to engagement with local people and communities.

Adjusting financial arrangements to better support transformation and integration in health and care services

Strong foundations to build on

Many health care systems are struggling with the challenge of how to invest adequate resources to transform and integrate services. We found examples of where Cardiff and Vale is already creating the right conditions to support these efforts.

The Welsh government's Integrated Care Fund (ICF) aimed to support integrated working between social services, health, housing and third sector and independent providers (Wales Audit Office 2019a) (this was replaced in April 2022 by the Regional Integration Fund). An independent audit by Audit Wales (formerly the Wales Audit Office) found that the ICF had had a positive impact on partnership working and integrating services at a national level; the views of Cardiff and Vale RPB members on partnership working were among the most positive of all the Welsh regions surveyed during the audit (Wales Audit Office 2019a).

Cardiff and Vale's use and management of the ICF were identified as a strength in the audit, which cited:

- good communication between ICF regional leads and project leads
- consistent project management methods being used

- good oversight arrangements.

In our interviews, we heard other examples of where access to dedicated funding for transformation was making a difference. Staff with knowledge of local work to expand social prescribing described how the funding 'allowed people the time and headspace to come together and actually work out how to build on [existing] relationships'. In particular, the funding was a stimulus to form closer working relationships between the NHS and local authority to support social prescribing.

The funding was also used to support initiatives including Independent Living Services and the Pink Army – the latter being a team providing information and support to patients and their families. Interviewees noted that the initiatives supported by this funding had helped build a greater sense of collaboration between professionals from different parts of the health and care system.

> *We put in those bids [for funding]. So through that vehicle then, obviously, you create connections with the partnership and develop a set of shared principles and key drivers… the partnership that we've had with integrated health and social care from the very beginning has grown, that there's a shared trust and respect.*

However, Audit Wales also identified that access to the ICF for third sector organisations was limited. In addition, although some ICF projects are moving towards mainstream funding support, other projects are still dependent on the continuation of the ICF and there is a risk of these existing projects crowding other projects that could benefit from the fund. Both of these issues echo wider observations we heard in our interviews about engagement with the third sector and efforts to scale and spread good practice within Cardiff and Vale, which are discussed in sections 3 and 5 of this report.

Funding uncertainty can hamper efforts to improve care

Access to dedicated transformation funding has enabled progress to be made. But in our interviews we heard examples of three challenges this funding approach can present to service delivery and planning.

First, transformation efforts are dependent on the continued existence of this funding source. As one interviewee put it:

> *[U]ncertainty over funding is a challenge. … and we have very much had to just, sort of, go ahead in the belief that somebody somewhere is going to fund this going forward.*

Audit Wales further noted that there was often a lack of an 'exit strategy' for schemes that relied on dedicated transformation funds.

Second, the existence of ring-fenced funds means local organisations have not yet been required to 'risk' or reallocate material amounts of their own budgets to support wider efforts at system-wide transformation. As one interviewee noted:

> *So it's not made us have to really rethink how do we, if we come up with something that really works, like [a new model of care] that's been based on external money. We haven't had to put our hands in our pockets to back that, so the risk has been low to the organisations.*

Third, the transformation funding can sometimes appear with little notice and comes attached with conditions that can limit the scope for innovation. One interviewee also noted that funding pots might be announced at the start of the financial year but delays in receiving the accompanying guidance meant improvement initiatives could not begin until October to December. Other interviewees noted:

> *[Transformation funding has] tended to be small pots of short-term funding around particular policy issues. And a funding pot will be announced, we run around saying what do we want to do with it, we do it, and then it comes to an end, but doesn't really change anything apart from it might unearth a bit of good practice or a new way of working.*

> *We get a lot of funding, which is extremely welcome, but it comes with an extraordinary number of strings and tends to have requirements which are about very specific solutions, because I think for all that people think that is the right thing to do, but it doesn't allow that testing out of options sometimes, you know. It is a bit too specific. It really should be about getting very high-level outcomes and then get some steps along the way that will prove that you're getting there. That would help.*

A sense of shared resources is still emerging

Although many of the partnership structures are in place to promote collaborative working, our interviews suggested that the Cardiff and Vale system is still a long way from managing its resources collectively. As one interviewee said: 'We're still very much sitting on our own organisational piles of money and planning, and strategising around that, rather than thinking, "How do we look at our collective resource?".' We heard broadly consistent explanations as to why this was the case.

First, there was a perceived loss of control through more collective financial management approaches, which was coupled with concern over financial accountability arrangements that still focused on organisations rather than systems. Interviewees noted:

> *I think there's fear because people fear they're going to lose control of their budgets.'*

> *[Y]ou're still watching your back really and whether that's because of the finances or… well, mainly because of the money actually, but, yes, mainly because of the money, you're watching your backs because you know you're going to get your ass whooped if you don't hit your targets.*

Second, interviewees also mentioned the practical complexities under current financial and legal requirements to manage budgets, which could stand in the way of more collaborative financial approaches. One interviewee further noted that it would be more practical to develop more collaborative clinical models and build the 'case for change' before changing financial arrangements to better support these models.

But a third consistent message came through, which was more positive. While it was still emerging, interviewees showed considerable interest in the potential for more collaborative financial arrangements to benefit local services and the local population: 'How do we think about the total Cardiff and Vale pound and how we deploy it against where it's going to have greatest impact? It's that old adage about turning taxpayers' money into good outcomes for its population, isn't it? So?'

Interviewees were also able to point to green shoots where 'financial siloes' had been put aside to redevelop services. Redesigned services for children and young people, equipment services and the proposed Vale Alliance were cited as particular examples. Interviewees also brought up the Pink Army, mentioned earlier in this report, as a small but important example of what the future could hold. We heard that while the Pink Army was supported through local authority transformation funding, the health sector had also financially supported the initiative through its winter pressures funding allocation. This health investment continued even after the winter pressures funding ended, which helped maintain a larger Pink Army service. One interviewee noted:

> *So to me, that was a massive milestone. There's mutual respect and trust but also, the beneficial outcomes are for their organisation and ours to have those posts there. So our next key driver is to put in sustainability bids so Cardiff Council and the health board jointly fund those posts and not be reliant on any sort of Transformation or Integrated Care Fund.*

Overall, our interviews and analysis of available documents suggested that the Cardiff and Vale health and care system has further to go in collectively using its resources to support the transformation of services. But there is evidence that senior leaders in the system see the benefits of a more collective approach to resource management and are starting to demonstrate this with a series of small-scale initiatives. In the next subsection we highlight some examples of other health and care systems that have also pursued more collective financial management arrangements.

Learning from other systems that have changed funding arrangements to support more integrated working

We have drawn on the research literature and previous work from The King's Fund to highlight funding and financial approaches that other health care systems have taken to promoting a greater sense of shared resources, system working and integrated working.

Pooling budgets

Pooled budgets and joint financing arrangements involve combining funding from different organisations for a defined purpose. One of the key purposes of pooled budgets is to incentivise different agents to make allocation decisions in partnership to achieve shared outcomes (Stokes *et al* 2019).

Pooled budgets are not new in health and care. But interest in them is growing because of a recognition that more integrated working is needed across the organisational boundaries that exist within health care and between health and social care.

Because many bodies involved in planning and delivering health care are statutory public sector organisations, it is essential that the right governance and financial management arrangements are in place to support pooled budgeting within the existing legal framework.

The Better Care Fund

Although many examples of pooled budgets exist (eg joint financing arrangements for learning disability services and community equipment services), in England the principal mechanism to support pooled budgeting across health and social care organisations is the Better Care Fund (BCF). This is similar to the Integrated Care Fund in Wales which is discussed above.

Agreements made under Section 75 of the NHS Act 2006 are the basis for the BCF. Under the Section 75 agreements (which provide a legal framework for pooling resources and delegating certain NHS and local authority health-related functions to other partners to help improve care) in existence at the time the BCF was introduced in 2015, NHS bodies and local authorities were asked to contribute to a common fund that could be used for services related to both health and social care. For 2022/23, a minimum of £7.2 billion will be committed to the BCF in England, with £4.5 billion of NHS funding, £2.1 billion from a grant to local authorities and £570 million from the Disabled Facilities Grant.

Evaluations of the BCF have largely found that pooling funds can catalyse more integrated ways of working across sectors, although there is little evidence that it leads to short- to intermediate-term reductions in the use of secondary care services or in health care costs (Forder *et al* 2018).

Those involved in one evaluation reported that the BCF had encouraged them to go further in working with partners, expanding existing arrangements or developing new services. Common areas where the BCF prompted activity included helping to facilitate communication, improving collaboration between health and social care providers in some areas and increasing opportunities for the joint commissioning of services (Forder *et al* 2018).

When looking at the outcomes of this more integrated way of working, the study found that areas that spent more BCF funding per person had fewer delayed transfers of care (indicative of improved integrated working between health and social care), but there was no difference in emergency hospital admissions. There were perceived to be improvements in patient experience through collaborative working in the form of multidisciplinary teams and single assessment processes.

The researchers identified some key factors that were seen as supporting the implementation of the BCF. These included:

- strong local leadership, project management and governance
- good relationships and communication
- early engagement of stakeholders
- a supportive organisational culture
- the resources and capacity for implementation.

They also identified that challenges to the operation of the BCF included: financial pressures; other initiatives aimed at integration, which could be seen as competition for local resources; and national metrics seen as limited in terms of what they captured.

Integrated commissioning funds

The BCF is a national framework that sets out a minimum level of resources that local authority and NHS commissioners are expected to jointly share and administer. Some areas of the English health and care system have chosen to go further and faster.

Several health economies in the English health and care system have used the concept of a 'shared pound' to unite health and care organisations behind a common goal, as the following examples illustrate.

- The Leeds Pound – this an effort to collectively use resources across the health and social care system, which has, for example, supported investment in shared digital health records across health and care settings. The underlying principle governing this approach is the 'idea that the money available for public services should not be thought of as belonging to separate organisations, but collectively to the people of Leeds' (Local Government Association 2014).

- Sheffield’s single budget for health and social care in defined service areas – Sheffield has created pooled budgets to support preventive care, independent living solutions (eg, community equipment and adaptations), active support and recovery, and continuing health care (Humphries and Wenzel 2015).
- Devon and Plymouth’s ‘one system, one budget’ vision – this has involved the co-location of council and NHS commissioning staff and the creation of integrated funds to support commissioning strategies for children and young people, complex care and community-based care (Humphries and Wenzel 2015).
- Nottinghamshire Sexual Violence Support Services – there has been a proportionate split of funding across the council and NHS to support a new co-ordination hub that provides a single point of access for survivors of sexual violence where they can receive therapeutic support and other services (Local Government Association and Integration and Better Care Fund 2022).
- Croydon’s Accountable Care Partnership – this is an alliance between health and care organisations including the council, the NHS commissioner, primary care providers, secondary care providers and Age UK Croydon. The alliance focuses on improving the health and wellbeing of local people aged over 65 and is underpinned by a legally binding Alliance Agreement that includes commitments to make decisions on a unanimous and ‘best-for-outcomes’ basis. The partnership has reported reductions in the length of hospital stays and in the number of patients needing longer care packages (Local Government Association 2018).

In addition to the examples above, which have often involved pooling funds for a tightly defined set of services, Tameside and Glossop took a more comprehensive approach to pooling funds (*see* the box below).

Commissioning in Tameside and Glossop (Robertson and Ewbank 2020)

In 2017, Tameside and Glossop Clinical Commissioning Group (CCG) and Tameside Council developed a different approach to commissioning health and care services. Following the appointment of a joint chief financial officer across the CCG and council, a Tameside and Glossop Strategic Commission oversaw the commissioning arrangements and the development of a new Integrated Commissioning Fund.

The Integrated Commissioning Fund pools the total resources of the council and CCG. But because of the legal requirements at the time of the fund's establishment, three separate components of the fund were created:

- The Section 75 agreement includes approximately 50 per cent of the fund. A joint strategic commissioning board can make decisions on these resources, which are binding on the CCG and council.
- Aligned services cover those elements of funding that cannot be included in a Section 75 agreement – around 40 per cent – and the strategic commissioning board makes recommendations, which the constituent organisations ratify (examples include some elements of acute care such as surgery and radiotherapy, and children's services).
- In-collaboration services include funding – approximately 10 per cent – that has been delegated from national NHS bodies (eg, funds for primary care commissioning and the schools grant). The strategic commissioning board makes recommendations, which are remitted to the CCG and relevant national body for decision-making.

Leaders in the Tameside and Glossop system reported that since the establishment of this new funding and commissioning approach, it had become easier to: (i) concentrate on issues that affect the overall health of the population, taking a focus on people who use services rather than a service focus, for example improving housing and nutrition for people who sleep rough and reducing hospital bed days for this population; (ii) implement changes to services that span the responsibility of different organisations in the system, for example the reconfiguration of intermediate care beds.

A formal evaluation of the Care Together programme – the overarching programme for integrated working in Tameside and Glossop – has been commissioned from the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC) for Greater Manchester.

Changes to financial arrangements

As well as changes to funding arrangements, changes to financial arrangements are also often needed to support efforts at transforming and integrating services. One example of this approach is Blue Cross Blue Shield.

Blue Cross Blue Shield

In the late 2000s, Blue Cross Blue Shield of Massachusetts in the United States developed an 'Alternative Quality Contract (AQC)' that would change reimbursement for health care services from a largely fee-for-service model to a population-based payment model for a defined group of patients. The purpose of the new contract was to better align financial and clinical goals.

Under the AQC, a global budget was established to cover all services and costs for delivering health care to members covered by the scheme. The global budget is set based on historical care cost spending and contracts are multi-year (usually five years). Providers who accept an AQC contract can retain any savings if costs are lower than the contracted value, and they are responsible for costs that exceed the value.

In the first eight years since the introduction of this new contract, organisations with an AQC have demonstrated lower annual spending per enrolee than a control group. In the early years of the contract this was primarily due to lower prices (eg through referrals to lower-priced providers within the organisations that agreed to join the AQC) and in later years it was due to lower utilisation (eg, fewer laboratory and imaging tests and emergency department visits). Most quality measures improved in these organisations compared with control group, including the share of eligible enrolees who met quality criteria for chronic disease management and outcome measures for hypertension and the control of glycated haemoglobin among enrolees with diabetes (Song *et al* 2019).

A recent evaluation has suggested that changing the payment and contracting system to be pan-organisation, multi-year and comprehensive in scope has helped organisations to lower medical spending growth and improve care quality for a defined population (Song *et al* 2019).

English integrated care system reforms

In the English NHS, reforms set out in the Health and Social Care Act 2022 and updated guidance from NHS England have attempted to increase the emphasis on the role of system working in financial performance and management (NHS England 2022). This has included the following.

- The share of funding that is allocated to local systems has been increased, with fewer directions on how this funding should be used. For example, integrated care systems rather than national bodies will increasingly hold and administer budgets for capital investment and specialised

commissioning. Local systems will also be given greater freedom to allocate funding to different 'places' (geographies that usually house a population of between 250 and 500,000 people) within the integrated care system.

- An aligned payment incentive system and aligned incentive contracts have been developed to replace the national tariff and standard contracting approach, which were in existence before the Health and Social Care Act 2022. Under these approaches, rather than using case-based payments linked to levels of health care activity, providers are given a fixed sum of funding based on agreed levels of activity and a variable payment if actual activity levels exceed or fall below original plans. The aim of this approach is to give providers greater certainty over their level of income while rewarding innovations that reduce costs for the overall health and care system, for example reducing outpatient follow-up appointments where this activity is not clinically necessary.

- There have been changes to the regulatory system that place greater emphasis on the financial performance of systems rather than individual organisations. These include:

  - setting and monitoring performance against system-level financial targets
  - changes to the licensing regime for providers to promote an expectation that providers will work to deliver the agreed financial position of the system even if that position represents a financial deficit for a given organisation
  - the introduction of a System Collaboration and Financial Management Agreement, which aims to ensure system partners work together to meet shared financial objectives.

Summary

The financial arrangements that health and care systems pursue are tied to their local political, operational and economic context. In many cases, the changes to financial arrangements we have outlined in this subsection took considerable time and piloting before they were fully operational. And changes to financial management are often accompanied by other changes to health and care systems, such as:

- consolidation of the number of providers and commissioners
- the blurring of commissioner–provider divisions
- structural changes to integrate services within a single organisation.

For these reasons, caution should be exercised before adopting the approaches that other health and care systems have taken to managing their financial resources to support the transformation and integration of services.

Accepting this caveat, we would observe that there are elements of the approaches that other systems have taken that are relevant to the Cardiff and Vale context and some broad lessons to be drawn.

First, the right measures of success should be used. There is little evidence that sharing financial resources and more collaborative working will substantially reduce hospital utilisation or health care costs. Systems that are sharing resources to support integration instead emphasise the impact of collaboration on value, that is, the level of health care outcomes that is generated for a given set of health care resources.

Second, while it is understandable that joint funding arrangements are often tied to specific policy or service priorities (eg improving care for people aged over 65), systems such as Tameside and Glossop's have demonstrated the benefits of allowing health and care leaders greater discretion over where transformation funding is targeted to improve the health of local residents.

Third, changes to how financial resources are managed require the alignment of funding allocations, regulatory regimes, payment systems and contracting to ensure that the funding and financial signals sent to senior leaders in the health and care system are consistently supporting efforts at more collaborative and integrated working. This is not within the gift of the Cardiff and Vale system itself and will require the Welsh government to consider whether there are additional levers it could use to better support more integrated health and care services.

5 Embedding change

Using data to monitor and evaluate interventions

Different types of data are being used to demonstrate the impact of efforts to develop a more integrated health and care system in Cardiff and Vale. For example, we heard about the success of the approach to social prescribing and multidisciplinary working in primary care in the Cardiff South West primary care cluster, which is reflected in lower hospital admission rates compared with the other clusters in Cardiff and Vale (Collins 2021). We also heard that there has been an improvement in self-reported wellbeing scores among people who use services, particularly those supported through the social prescribing programme.

Cardiff and Vale's data platform, developed in collaboration with Lightfoot, supports the use of data to demonstrate the impact of initiatives such as that in the South West cluster. This is a relational database (a database that stores and provides access to data that is related), which connects data across the health and care system and overlays time series analytics. The platform enables the tracking of individual patient journeys and also makes it possible to interrogate the data – for example to observe the impact of a particular initiative – in real time. The system will also generate forecasts, which means it is possible to create a 'counterfactual' or 'no-change scenario' to compare against the outcomes of a particular initiative.

The investment in this platform in itself signals a clear commitment from those in the Cardiff and Vale system to work in an integrated way, and provides significant opportunities for using data to support this work (*see* below). However, despite this, we heard from a few interviewees that data is lacking across the system, is too dispersed, is of insufficient quality or is not timely enough. We also heard that there is limited analytical capacity or capability for making the most of the data that does exist.

> *It can be a challenge to get the data in a timely enough way to see the impact of what we're doing, and sometimes even to make the case. So the lack of analysts in the system to provide this data sometimes is the issue, the availability of data at the right level.*

In terms of the types of data being used, while there were some references to gathering and using feedback from patients and people who use services to evaluate interventions, this did not come through as a strong theme. (This data is not collated via the Lightfoot platform but there is scope for viewing it alongside it.) One interviewee highlighted this as an area for improvement: 'The voice of our population, our public, and the quality and the experience of

services, we're really trying to take a triple-stroke–quadruple-aim approach to this. And again, it's an area that we do really need to strengthen.'

Spreading and scaling what works

The word that several interviewees used when talking about Cardiff and Vale's progress towards a more integrated health and care system was 'pockets' of activity. This links in with the finding that initiatives tend to be taken forward by enthusiastic teams or individuals, as described earlier in this report, rather than through a systematic or programmatic approach.

We did hear about work to roll out successful initiatives, for example the model being used in the South West cluster:

> *And we've got two other clusters that have started that model now. It's very much at the beginning of it, tailoring it to each cluster's needs, so recognising clusters are different geographies, different populations, and it isn't a one size fits all, but there's some kind of basic principles that we need to spread and scale across.*

Interviewees emphasised the importance of local context, and the need for tailoring initiatives to local circumstances: 'It's finding key individuals within each of those areas who are going to take this on because that's so important. There needs to be local ownership so it can then be adapted to those local needs and it'll work very differently in different clusters.'

However, while a few interviewees talked about the importance of rolling out successful initiatives in this locally appropriate way, we didn't hear about a clear programme for scaling up the existing 'pockets' of work. One interviewee highlighted this as a barrier to progress: 'Everyone's too scared to do that, and then they do a pilot or a test of change… and the problem is nobody ever does that on [a] sufficient scale to prove anything.'

The @Home programme is intended to support the implementation of the RPB's priorities and to scale up and roll out a consistent integrated locality-based model of care. However, none of our interviewees referred to it within this context. This highlights the value of not only working to communicate and embed the vision for the system, but also ensuring that the programmes and approaches that are intended to support its delivery are well understood.

A theme that did come out clearly in our interviews was an appetite from those working in Cardiff and Vale to learn from examples outside of their system. Cardiff and Vale has entered into a learning partnership with the health and care system in Canterbury, New Zealand, and some interviewees referred to lessons they had drawn from the health and care models being used in Bromley-by-Bow and Frome in England.

Going further

Making use of data

Shared data is critical when it comes to working in an integrated way, and siloed data is often a key barrier to effective working between health and care partners, and seamless care for local people.

The UHB's investment in the Lightfoot platform is a significant step towards sharing data across health and care to support the planning, delivery, monitoring and evaluation of services and interventions. However, there may be opportunities to make further use of the functionality of this platform, in particular by monitoring the impact of interventions in real time, as noted earlier, including using the system to provide a 'counterfactual', diagnosing issues and enabling a quick response when the data suggests an intervention is not getting the results anticipated.

Analytical skills

Making the most of shared data is not only about having the necessary infrastructure, it is also about having the right skills and resources, and a culture that supports and values using data where appropriate. As one interviewee noted: 'If you've got clinical leadership that gets using data and is brave enough to just do the right thing, and doesn't let the barriers get in their way, that's when you get the really big change.'

Transformation and improvement in Cardiff and Vale: a review of work to embed a preventive approach within primary and community services discusses the issue of analytical capability and capacity in more detail.

Engaging local people and communities

Section 2 of this report discusses the importance of working in partnership with local people, including to shape a vision for change.

Feedback from local people should also be used to understand the impact of interventions and changes, and should be key to any assessment of integrated working. The perspectives of people who use services and the local community are vital when it comes to understanding what is needed, determining whether people are receiving joined-up care in practice and identifying opportunities for improvement. Desired outcomes should be articulated in a way that links to improved experiences of care, as defined by local people (Social Care Institute for Excellence 2019).

It is also important that systems do this work to engage with local people in a joined-up way. The King's Fund and Picker have developed a guide that highlights the importance of understanding people's views of how services are working together, as well as their experience of individual services. It

emphasises the importance of partners within a system listening and learning together (Thorstensen-Woll *et al* 2021).

The Cardiff and Vale RPB's Regional Outcomes Framework sets out eight key outcomes, underpinned by indicators, which all partners have agreed on (Cardiff and Vale Regional Partnership Board undated). Data across the health and care system is drawn on to measure the direction of travel for each indicator. There may be an opportunity to further incorporate or align to this work, data that captures the views of local people. The box below describes the approach to collating data on the experiences of patients and people who use services across the health and care system in Leeds.

A balanced scorecard in Leeds

In Leeds, the Health and Care Partnership Executive Group has developed a balanced scorecard to understand the experiences of local people as they move across the health and care system (Thorsten-Woll *et al* 2021). This draws together information on the experiences of patients and people who use services from a range of sources to inform system improvement and includes:

- using written and video narratives to hear real-time stories from people's health care journeys
- carrying out multi-agency and multidisciplinary case-file audits
- analysing compliments and complaints that come through the Leeds City-wide complaints group
- building on the Friends and Family Test and the Leeds Adult Social Care Outcomes Framework (Leeds Observatory undated), using a range of measures across partner organisations to capture quantitative measures of people's experiences of integrated care.

A learning culture

A culture of continuous learning will support work to learn from initiatives and scale and spread those that are successful. The literature highlights different approaches that systems can use to embed a learning culture, which may offer an opportunity to continue to strengthen the approach to learning across Cardiff and Vale.

A feature common to high-performing health systems internationally – such as those in Montefiore in New York and the Jönköping region of Sweden – is the systematic bringing together of staff from across different service areas to make connections and learn collectively. In both Montefiore and Jönköping, staff meet

regularly to share practices and discuss how to improve services. In both cases, this model has been used repeatedly and consistently for several years, which may be a factor in their success, and in both cases improvement experts support the work. These experts facilitate the process of group learning, provide project management assistance and support measurement, to ensure the groups retain their focus (Collins 2018).

Action learning sets are another approach to group learning. These encourage groups of people to work through real-life issues and openly share and reflect on their experiences, with a view to taking action (Social Care Institute for Excellence 2019). Involving individuals from across the Cardiff and Vale system in this approach would also be a means of developing a collaborative approach to problem solving.

Buddying between organisations may offer another opportunity. A review of the buddying programme introduced as part of the special measures regime in England found that it can be a key means of encouraging shared learning and driving improvement. The review recommended that this approach should be adopted more widely in the provider sector, beyond those facing significant performance challenges (Foundation Trust Network 2014).

The review highlighted some of the factors involved in a successful budding relationship, including:

- the development of strong personal relationships, including through face-to-face meetings between 'top teams'
- 'cultural fit' and aligned values between organisations in a buddying relationship (this was more important than geographical proximity and similarities in size and structure)
- clarity about the purpose of the buddying arrangement.

6 Conclusion

Our research highlights the significant areas of progress being made in Cardiff and Vale towards delivering more integrated care, for example through the Pink Army and Independent Living Services, as well as the RPB's Regional Outcomes Framework.

Our work has also identified some of the key strengths of the approach and culture in Cardiff and Vale that have enabled this progress. Compared with other systems, Cardiff and Vale, led by the RPB, has taken some important steps in bringing together data across the health and care system, including social care data – something that the literature and experiences elsewhere highlight as critical to the success of an integrated system. In addition, a culture that supports innovation within the UHB and locally within primary care clusters, with individuals taking responsibility for pushing forward changes to benefit patients, is behind many of the examples of progress we heard about.

However, drawing on wider research and lessons from other systems in the UK and internationally that are also pursuing the ambition of delivering more integrated care, there are a number of areas where Cardiff and Vale may be able to push this work even further. These are set out below.

Strengthening the relationship with the third sector

A clear finding from our research is the opportunity to improve the engagement of the third sector in the work of the RPB. The consistent message from the third sector representatives we spoke to was that their involvement too often feels tokenistic, and that they are not given an equal or meaningful opportunity to contribute to decision-making. There is a sense that, as a result, significant value is being missed out on, something that resonates with wider research on the role and participation of the third sector in partnerships with the statutory sector.

Research highlights some of the ways of working that can support a different relationship with the third sector. They include: devoting time explicitly to developing relationships; examining and periodically re-examining approaches to decision-making and the sharing of responsibilities; and, importantly, naming unequal power dynamics when these emerge to ensure they do not become embedded. This can include taking some very practical steps to facilitate more equal participation from the third sector, for example, through providing financial support as Wigan Council has done.

It is also important to recognise and take advantage of the diversity and richness of the third sector, rather than relying on the involvement of representative bodies.

Closer working with patients and communities

Working in partnership with patients and communities is a feature common to many high-performing health and care systems. Within these systems, engagement with local communities is 'business as usual', a key part of the approach to planning, delivering and evaluating work to improve care. Research emphasises the importance of continuous engagement with communities and, critically, in the context of work to deliver more integrated care, doing this in a way that is joined up across partners.

There is an opportunity for Cardiff and Vale to go further with work to engage with local people and patients, bringing their voice more routinely into work to deliver integrated care. The Public Engagement Group established in Dorset is one example of a model that provides a clear mechanism for local people to check and challenge the work of their local health system. There may also be an opportunity to bring the patient's perspective more clearly into work to understand and assess the impact of initiatives aimed at delivering more integrated care. This may involve developing new approaches to collecting the views of patients, but a key part of this work will be consistently and coherently bringing together information on the patient's perspective that already exists across partners, building a clearer picture of the experiences of people who use services across the system. There may be an opportunity to bring this into Cardiff and Vale's existing Regional Outcomes Framework, or to develop a standalone 'scorecard', as Leeds as done, which focuses on the experiences of those using the health and care system.

Managing resources collectively

Our research found that, to date, the Cardiff and Vale system has only made limited use of approaches to managing resources in a collective way. While transformation and grant funding has enabled significant progress in delivering more integrated health and care, it has also meant that individual organisations have not yet been required to 'risk' their own resources. There is an opportunity for Cardiff and Vale to further explore the options for taking a more collaborative approach to funding, drawing on the experience of other areas. In particular, there may be lessons from the comprehensive approach taken in Tameside and Glossop, which went beyond pooling funds for a narrow set of services to developing a new funding and commissioning approach.

The findings from our research set out in this report highlight two further opportunities for further progressing work to develop a more integrated health

and care system and embed a more preventive approach, particularly within primary care.

Strengthening a culture of innovation

Previous research by The King's Fund highlighted the progress that Cardiff and Vale has made in creating an environment that supports individuals to innovate and make improvements (Collins 2021). This is consistent with the findings of the research set out in this report, which identified a number of areas of progress that had been pushed forward by enthusiastic individuals and teams. Nonetheless, there is an opportunity for Cardiff and Vale to go even further in what they do by making improvement the work of the majority of staff rather than the few. Learning from other systems, steps that could be considered include being explicit about this focus in recruitment and induction materials, and providing staff with basic training in improvement techniques.

Doing more with data

Cardiff and Vale has made significant progress in bringing together data from partners across the system via its Lightfoot platform, including social care data. Research identifies shared data as critical to the development of a more integrated health and care system. However, there may be an opportunity to make greater use of data, and in particular to use it to support population health management and a more preventive focus in service delivery. This includes using data to focus on population groups rather than services, and to understand 'what works' when it comes to prevention.

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