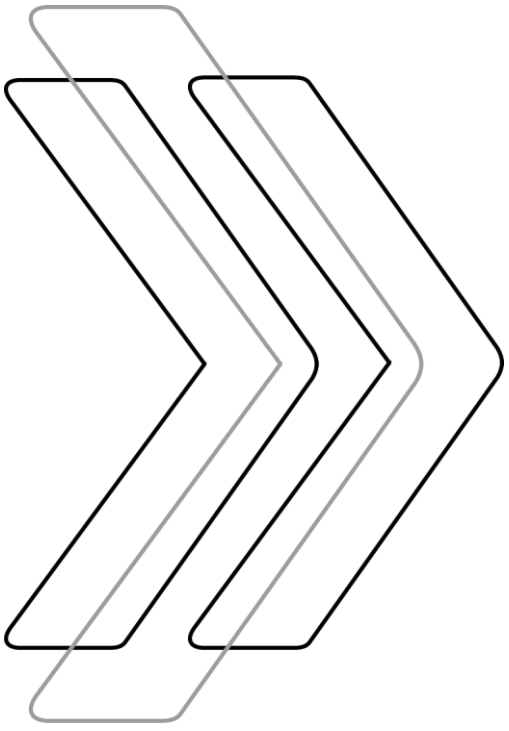
The King's Fund

Ideas that change health and care

Transformation and improvement in Cardiff and Vale

A review of work to embed a preventive approach within primary and community services



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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.

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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 second area set out above – work to embed a more preventive approach within primary and community services. It can be read alongside *Transformation and improvement in Cardiff and Vale: a review of work to create an integrated health and care system*, which focuses on the first 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

Interviewees recognised the need for this vision to be embedded across all partners within the Cardiff and Vale system. 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 overall engagement with the vision. 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.'

Efforts on prevention and population health in particular require the involvement of a wide range of partners, and buy-in to a shared vision for this is critical. Interviewees emphasised the need for prevention to become everybody's business in order to move forwards. We heard that while there are some key people in the system who 'get' the importance of prevention and a population health approach, this needs to be more widespread. This is partly about a cultural shift, for example among the clinical workforce:

> *What I would like to see is that every clinician, no matter where they are, even if they're at the most tertiary end of things, can see they've got that role in prevention, and that it's part of what we do, day in and day out. In primary care, they do an awful lot of things already, but there's more that could be done.*

A question was also raised as to whether the vision for engaging communities – key to work on prevention – was there:

> *I don't think we have a clear-enough vision. We've got a lot of the components but I don't think we have a really settled view as to how we need to work together to really get into that community development space that really kind of creates the solutions within communities rather than people coming into the statutory sector.*

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 (and relatedly), 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.'

Within this context, we heard about the problem of national targets that encourage a focus on managing short-term pressures such as waiting lists. Staff burnout and workload are also a particular issue in primary care and can make it very 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. It can also encourage systems to be 'hospital centric', shifting energy and resources towards the acute end of the spectrum and undermining efforts on prevention (Lent *et al* 2022).

Going further: embedding a shared vision

Work to embed a more preventive approach within primary care and across the Cardiff and Vale system will rely on a shared view of what this should look like. As one interviewee described it, 'prevention and early intervention, and different non-medical solutions', must become a big part of 'the ethos'.

The Fuller review on the next steps for integrating primary care in England highlights the importance of a shared ambition (Fuller 2022). The review emphasises the need for neighbourhoods, starting with primary care networks (similar to primary care clusters in Wales), to develop a sense of 'shared ownership' for improving the health and wellbeing of the local population. This includes supporting a culture of collaboration and building relationships between primary care and wider system partners. The review also highlights the need for a cultural shift towards a more holistic approach to supporting the health and wellbeing of the local community.

Engaging staff

Transformation and improvement in Cardiff and Vale: a review of work to create an integrated health and care system sets out some of the key factors that the literature has highlighted which can help systems and organisations in embedding a shared vision. These include engaging staff in the development of the vision as well as ongoing work to ensure that this becomes 'business as usual'. It emphasises the importance of engaging staff at all levels within

organisations across the Cardiff and Vale system, and provides examples of some of the practical approaches that can be adopted.

In the context of primary care specifically, the literature on transformation and improvement work highlights the highly pressured environment and workload within primary care as a particular challenge. Staff feeling that a change is likely to increase their workload or present them with additional or competing demands is likely to be detrimental to progress (Baird *et al* 2022b). This resonates with what we heard in our interviews: 'The day job, and I mean that for everybody, but primary care is busy, they're in a phase of recovery, from the pandemic, really, really busy.'

Similarly, research on approaches to prevention within the NHS in England found that negative staff attitudes towards prevention was a common barrier to the implementation of prevention initiatives, including feelings that such initiatives lacked value or would add to their workload (Faculty of Public Health undated). One study exploring the views of GPs in relation to the promotion of help seeking for the onset of rheumatoid arthritis found that although the GPs involved in the research acknowledged the need for early intervention, they questioned the evidence on the impact of delays. They also expressed concern at the potential impact on the workload of primary care if patients were seeking help for potentially very common symptoms (Stack *et al* 2014).

Within this context, it is particularly important that staff working in primary care are engaged in both the overall vision for embedding prevention and the development and implementation of specific prevention initiatives.

3 Integrated working

Primary care's critical role in preventing ill health depends on working with partners and professionals across the Cardiff and Vale system. The Primary Care Model for Wales, delivered through primary care clusters, promotes the development of multi-professional primary care teams (National Primary Care Board 2018). This has been driven in part by pressure on GP services and the need to ensure the sustainability of primary care, but also by the focus on a social model of care in which patients have access to a much wider range of professionals (Wales Audit Office 2019). The nine clusters across Cardiff and Vale have invested in a wide range of staff, including mental health practitioners, pharmacists, first-contact physiotherapists, social care representatives and carer champions (Public Health Wales 2019). Despite this, we heard that joint working within the clusters varied:

> *You know our clusters have different levels of maturity in joint working. And sometimes it's because personalities, sometimes it's… about how do you get focused attention on a few things, knowing what you're, the cluster population need is? How do you then get alignment? How do you get that leadership?*

Section 3 in *Transformation and improvement in Cardiff and Vale: a review of work to create an integrated health and care system* discusses relationships within Cardiff and Vale at a system level and highlights some opportunities for developing these further. In particular, the report considers ways of strengthening engagement with the VCSE sector. While the focus is on this relationship at a system level, some of the lessons included will also apply to relationships at a more local level, including between primary care and local VCSE organisations. Partnership working between the two is key to the delivery of work to promote health and wellbeing.

Going further

Multidisciplinary teams

Research on integrating additional roles into primary care networks in England highlights some of the enablers and challenges to making the best use of these roles (Baird *et al* 2022a). While primary care clusters in Wales have been established for much longer than primary care networks, some of the findings may still be relevant. The research highlights the importance of a shared overall purpose across the team, and clarity about the purpose of the additional roles

and where they could add value. Some case studies recommend taking a system-wide approach, deploying clinicians across different parts of the system beyond individual practices and primary care networks. The work also underlines the need for a change in culture and new approaches to teamworking, requiring clear leadership, as well as the importance of managerial, human resources (HR) and peer support for the effective integration of these roles (Baird *et al* 2022a). Similarly, the Fuller review on the next steps for integrating primary care in England recommends that in order to deliver more integrated neighbourhood teams, primary care networks will need to be supported by a range of 'back-office' functions such as HR, quality improvement, data analytics and finance (Fuller 2022).

There may also be other skills that can be brought into primary care to support work on prevention, including the skills required to support behaviour change. Evidence shows that primary care practitioners in the NHS have often lacked confidence in having effective conversations with patients about weight, diet and other health behaviours (Lawrence *et al* 2022).

Research on approaches to 'Making Every Contact Count' has shown the benefits of health and social care staff being trained in 'healthy conversation skills' to support people in taking more control over their own health through behaviour change. A pilot study in Wessex involved training 18 GPs in healthy conversation skills. The participants reported using these skills in consultations after the training, helping them to build rapport with patients, encourage patients to 'open up' about their physical and mental wellbeing and engage them in making plans to address this (Lawrence *et al* 2022).

One feature of the most innovative models of general practice is a shift towards proactive and planned care, often involving a fundamental shift in 'ethos'. In practice this has involved making full use of electronic records, with administrative staff contacting patients in advance of appointments to ensure that necessary checks have been completed or prompting them to get their immunisations. It has also included health care or medical assistants taking basic observations on the arrival of patients and rechecking their records for any tests required. These models have also involved health coaches to provide ongoing and follow-up support to patients (Baird *et al* 2018).

Community-centred approaches

Community-centred approaches take an 'asset-based' approach, making use of both the individual's assets, such as their knowledge or social networks, as well as community and neighbourhood assets, such as VCSE organisations or green spaces. Social prescribing is a good illustration of a community-based approach and one that Cardiff and Vale has made good use of – the work in the Cardiff South West primary care cluster being a particularly good example of this.

However, there are other models that may offer additional learning for the clusters in Cardiff and Vale.

For example, in Pudsey in England, the Robin Lane Health and Wellbeing Centre is a medical centre that incorporates the Love Pudsey charity and is the base for a patient-based volunteer programme. The model aims to care proactively for the local population and act on the wider determinants of health and involves more than 30 volunteer health champions who run health and wellbeing activities. The practice also has a Practice Participation and Involvement group, which is involved in the planning and delivery of services. The practice provides a wide range of services alongside routine appointments, including a walk-in service for urgent issues, counselling services, a dancing group for patients with mobility issues and befriending services (Baird *et al* 2018).

The box below describes community wellbeing practices in Halton in England – another example of a community-based approach.

Community wellbeing practices in Halton

Halton community wellbeing practices are funded by Halton Clinical Commissioning Group and provided by Wellbeing Enterprises, a community interest company. The model brings together non-medical, community approaches across the GP practices in Halton, with the aim of strengthening clinical outcomes by helping to tackle the wider determinants of health.

Practices are supported by a group of community wellbeing officers, who are an integral part of the practice. Community wellbeing officers have access to patient records and attend practice meetings. The model involves the following.

- Once referred into the service, the individual has a one-to-one session with a dedicated community wellbeing officer who undertakes a structured 'wellbeing' assessment of their needs and assets/strengths. This results in the development of a personalised wellbeing plan.
- The individual receives help from their community wellbeing officer to navigate the support available from the public sector and within the community locally. From the point of referral, community wellbeing officers work with the patient for approximately four weeks and review their progress regularly.
- Support includes the provision of social prescribing, such as access to various educational and social inclusion courses.
- Individuals also have access to a range of volunteering and social action projects. These involve mobilising local people to support services through peer support, running community projects and self-help groups.

An evaluation of the model suggests that it has delivered some very positive outcomes (Wellbeing Enterprises and Halton Clinical Commissioning Group undated). For example, 66 per cent of patients report improvements in their wellbeing, 60 per cent report reductions in symptoms of depression and 55 per cent report improvements in their health status. Feedback from GPs has also been mostly positive, with staff agreeing that the model has improved patients' access to community-based services.

(Wellbeing Enterprises and Halton Clinical Commissioning Group undated; Baird *et al* 2018)

4 Bringing about change

Choosing initiatives and things to work on

Approach

We heard about several examples of progress towards Cardiff and Vale's ambition to embed a preventive focus across the health and care system, and primary care in particular.

For the most part, these initiatives appear to have been developed 'bottom up', pushed forward by enthusiastic teams and individuals who had identified an opportunity to make a change. We heard about individuals working to 'sell the message', making the case for long-term funding when transitional or grant funding came to an end to ensure that this work could continue. (One consequence of this approach is that progress across the system has been characterised by 'pockets' of activity, as described in section 5 of *Transformation and improvement in Cardiff and Vale: a review of work to create an integrated health and care system*.)

We also heard about changes evolving over time, rather than following a fixed plan set out at the beginning. Independent Living Services, for example, saw a number of services added over time, in response to the needs of service users:

> *We've organically grown, identifying what the needs of a person are, as opposed to us thinking what we needed to do for people and telling the public how we're going to work. We learnt all of this from the public informing us how they needed to grow, what they needed to be independent.*

We heard different views on how far the culture and ways of working in Cardiff and Vale support individuals and teams in taking the lead on pushing forward change. One interviewee told us:

> *I get that real sense that there is a sense of really trying to… grow those individuals that show that leadership, even if they're not in leadership positions, you know, and really foster that… there is a shift towards trying to recognise and grow and support those individuals [the people in the background rather than just the visible leaders].*

However, we also heard the view that many staff felt quite limited in terms of what they could change, and one interviewee described the culture in some areas as 'risk averse'.

The approach to bringing about change, with individuals and teams identifying and responding to opportunities locally, appeared to dominate, rather than there being a systematic approach. Some linked this to a lack of clarity as to how the vision for the system should be implemented, and how to choose which priorities to focus on:

> *[Initiatives are] in line with the strategy… but they're not part of the strategy. The strategy has not said this is how we will get from A to B.*

> *There are several principles in this work I think, that it would be good to iterate that we don't always stick to. One is we can't do everything. So what are we going to focus on that will give us some gain?*

Information driving decisions

Different types of information are being used in decisions about which initiatives to pursue and prioritise, ranging from the data set out in the population needs assessment, to operational data demonstrating the impact of specific changes on service use, and self-reported wellbeing scores from people who use services.

The views of patients and the local community are also being fed into decisions about changes, and Independent Living Services is a good example of the needs and feedback of people who use services shaping the development of a service. However, this did not come through as a strong theme in our research, suggesting that there may be opportunities for Cardiff and Vale to go further in routinely including the perspective of patients and the local community in decision-making.

We also heard the view from one interviewee that the system tended to focus on services rather than on population groups. This was seen as a missed opportunity when it came to embedding a more preventive approach within the system.

> *What they've always done, is looked at it from the service perspective, and they've broken the hospital down into its boards, you know, and have that board structure thing that they do, clinical boards? What they need to now do is flip the model and go, here's a population of people that look like this, how do we meet their needs, and what does that mean for our system?*

Going further

Programmatic approaches

Literature on moving towards a population health system highlights the value that a systematic, programmatic approach can offer, rather than relying on

committed individuals to take action that is not necessarily co-ordinated (Buck *et al* 2018).

There are some lessons from research on priority setting for health systems at a national level. This outlines some of the principles involved in making decisions about where to invest limited resources, including:

- strategic fit with the aims of the organisation
- clinical impact
- community need
- resource implications
- value for money.

However, research also demonstrates that different stakeholders can have different and potentially competing objectives, and therefore emphasises the importance of procedural fairness. A fair process model may include features such as: decisions being made using principles people can understand; decisions and the rationale behind them being transparent and publicly available; and there being opportunities to revisit and revise decisions (Gibson *et al* 2004).

The literature also distinguishes between approaches that focus on outlining principles to guide prioritisation efforts, and those that define how to put these principles into practice. One study of the approach taken in eight countries concluded that abstract principles for priority setting developed at a national level did not appear to have a big impact on policy in practice, whereas processes defined at the national level did (Sabik and Lie 2008).

In the context of decisions about which initiatives to prioritise at a regional and local level, systems in England are developing their own frameworks for prioritisation. The Hertfordshire and West Essex Integrated Care System, for example, has piloted a set of principles and a prioritisation framework to support local decisions about changes to services or pathways (Hertfordshire and West Essex Integrated Care System 2019a, 2019b). These are set out in a template to provide staff within the integrated care system and at a 'place' level within the system (places typically cover the same area as a local authority) with a framework for decision-making and to ensure that a holistic review of all key areas is undertaken. The areas included in the template are:

- strategic fit
- evidence of effectiveness on health and wellbeing
- anticipated health benefits / health gains
- quality, safety and patient experience
- cost-effectiveness
- affordability
- impact on health inequalities
- feasibility.

Other health and care systems are taking multi-channel approaches to supporting the embedding of prevention in services. This includes developing toolkits to help clinical staff build their capability in this area. For example, Health Education England, in collaboration with the Royal College of Paediatrics and Child Health, has developed a toolkit to support paediatric clinical trainees to build their knowledge and skills in advising on and promoting healthier behaviours and in considering the impact of wider determinants of children's health status.

In addition, integrated care systems in England are assessing themselves against a 'maturity matrix', which includes domains specifically focused on the prevention agenda. This is helping to create a shared understanding that action on prevention is a key component of defining 'what good looks like' at every level of health and care systems, and provides a mechanism for holding leaders to account on delivering on plans to develop a more prevention-focused approach.

Supporting staff to take changes forward

As Cardiff and Vale's experience shows, teams and individuals can play a critical role in identifying opportunities for change – for example, working out how people can be supported to remain independent for longer – and driving these forward. The Fuller review on the next steps for integrating primary care describes the 'entrepreneurial and innovative spirit' that has tended to characterise primary care in England (and this would apply in Wales too) and highlights the importance of developing a culture that provides a safe environment for people to learn and experiment (Fuller 2022).

Research by The King's Fund in 2021 celebrated the progress that Cardiff and Vale had made in putting into place some of the key factors that support innovation and improvement (Collins 2021), including:

- the approach of senior leaders
- the culture of the wider system
- the degree of connectedness within the system
- the resources available to support innovation.

Work to support frontline staff in leading transformation projects has included: celebrating staff at the forefront of innovation; giving staff permission to make changes; and providing some resources to enable this, for example small amounts of seed funding.

However, this approach has resulted in 'pockets' of activity, suggesting that not all staff feel supported or able to act in this way. As such, there may be more that the system can do to nurture this activity on a more consistent basis. The

King's Fund's research also noted that the next stage would be to establish an environment in which the majority of staff feel that they should be spending a proportion of their time actively engaged in innovation and improvement (Collins 2021). The box below sets out the Southcentral Foundation's approach to creating such a culture.

The transformation in Wigan also provides lessons here, as a key feature of their experience was a change in the working culture for staff. This focused on building trust and giving staff the confidence and permission to act on what they heard from people who use services and make changes. It also meant showing staff that they would be supported in this even when things did not go as planned; the council worked to develop a culture in which staff were not blamed when things did not work, but instead used these examples as opportunities for learning. There was an effort to move towards the concept of positive risk-taking based on consciously weighing up the potential harms and benefits of an action (Naylor and Wellings 2019).

The literature on transformation within health and care systems also highlights the importance of supporting staff and teams in, and building, an enabling environment. This includes maintaining a focus on the motivation of staff, for example by celebrating successes. It also means recognising the 'emotional burden' that transformation work can place on staff, and giving people the time they need to think through the purpose of the work (Dougall *et al* 2018).

Improvement culture in the Southcentral Foundation, United States

The Southcentral Foundation is a non-profit health care organisation in the United States that supports an Alaska Native and American Indian community through what is known as the 'Nuka' system of care. Southcentral has focused on developing capabilities among staff for continuous improvement and embedding a culture that supports this approach. The approach adopted is different from that in many other high-performing health care systems, and is shaped by the system's view on the nature of the chronic conditions that drive most primary care activity: rather than seeking to standardise treatment pathways, the approach in Southcentral acknowledges that a significant part of the challenge is the way individuals behave. The approach therefore focuses on training staff to work together to problem-solve and experiment, encouraging flexibility in how they respond to the needs of individuals.

Efforts to imbed an improvement culture have included:

- making a focus on improvement and innovation clear in job descriptions, in interview questions during recruitment processes, in team and individual objectives and in performance appraisals

- setting the expectation that all staff should be familiar with basic improvement techniques and to apply them in their day-to-day jobs (in contrast to a model which assumes that improvement is the responsibility of just a few individuals with improvement skills)
- introducing new members of staff to improvement methods during induction, which are reinforced for all staff at Southcentral's annual reorientation
- providing in-house training on improvement tools, quality management and making use of data
- establishing a central improvement team of advisers and specialists who support frontline teams in delivering improvement projects, for example by helping them define objectives, make proposals for change, monitor progress and performance, and apply particular improvement methodologies.

(Collins 2015)

Using data to support a population health approach

Linking datasets to support a preventive focus

Research highlights the important role of shared data – and making full use of data insights – in taking a population health approach. This includes using data to identify and target the needs of a population, plan services and interventions, and monitor the impact of actions taken.

This approach is benefiting people who use specific clinical services in Cardiff and Vale. For example, patients with certain eye conditions are benefiting from information being shared more seamlessly across primary and secondary care settings, as they can receive faster diagnoses and specialist input (Welsh Government 2022). This work is also supporting closer working between optometrists and acute care ophthalmologists to jointly manage designated high-risk eye patients.

There may be an opportunity for Cardiff and Vale to make greater use of the Lightfoot platform, which brings together data sources from across the system. One interviewee told us that the system has made great progress in integrating data, including recently incorporating social care data. But they also noted that to date it has tended to take a service-based rather than a population-based approach, and as a result is only 'scratching the surface' of what can be done.

In this subsection we describe the approaches that other health and care systems have taken to using data to inform and support population health management and a more preventive focus in service delivery.

Lewisham and Greenwich NHS Trust in England is one example of a trust using an integrated dataset tool (HealthIntent, which brings together primary care, secondary care, community care and mental health data) to strengthen its focus on particular patient cohorts. Like the Lightfoot platform in Cardiff and Vale, this is a near real-time integrated dataset, which allows users to build queries and evaluate the impact of interventions.

This has facilitated projects focused on managing people with long-term conditions and supported the system in intervening early, for example on type 2 diabetes. The trust used the tool to develop a diabetes dashboard compiling data from different health records and test results, which in July 2021 led to the identification of 4,387 pre-diabetes patients, 82 undiagnosed diabetes patients and 1,070 women with gestational diabetes mellitus who had not had a follow-up screen for diabetes (NHS Confederation 2022).

The Discovery East London programme is a clinical partnership that supported the creation of a linked dataset of real-time health information across five boroughs in East London. The aim of the programme is to improve the quality of

care and understand wider population health needs by seamlessly sharing information across health care settings and professional groups.

Since the programme was developed in 2016, 95 per cent of practices in the boroughs have signed up to the scheme, which allows staff in secondary care settings and approved pharmacies to see GP records. Anonymised health care datasets have been combined with data on socio-economic information to explore the relationship between deprivation and morbidity in local populations.

The programme has realised benefits to direct care, through better information-sharing across primary and secondary care settings reducing duplication and administrative costs and improved relationships between clinicians and patients – for example, because of a shared care record there are fewer instances of patients having to 'repeat their story'. The wider benefits of the programme include an increased ability to identify and follow up patients that vaccination or screening programmes have missed who could benefit from these interventions.

Similar work has been undertaken in Kent and Medway with the development of the Kent Integrated Dataset (KID) and the Kent Research Network for Education and Learning (KeRNEL). The KID is a collaboration between Kent County Council, the University of Kent and East Kent University Hospitals NHS Foundation Trust to link datasets from different providers to track patient journeys. This linked data has been used to: conduct economic analyses of frailty across a more comprehensive range of services; estimate the prevalence of rare conditions to support decisions around the funding of specialist treatment; and compare the risk of non-elective hospitalisation by general practice (Lewer *et al* 2018).

More fundamentally, the KID has enabled public health teams in the local area to:

- test 'what works' in the county (eg, evaluating the impact of home safety visits that Kent fire and rescue services have carried out)
- assess the impact of services, such as falls prevention, by comparing outcomes between service recipients and similar people who do not receive the services
- calculate average per-person costs across a wider range of care settings
- identify gaps in provision for particular client groups, for example patients with autism spectrum disorders.

Data of this sort is a key input into decisions about what initiatives to focus on. This is especially important in the context of population health and prevention, where impact can be harder to measure, particularly if realised over a longer period of time, making it harder to 'make the case' for a particular intervention. A study of population health approaches to system planning and decision-making in Canada found that in order for population health information to be valuable in decisions about the allocation of funding (and able to 'compete' with data on the

cost-effectiveness of health interventions), it needed to focus on evidence-based actions, rather than a description of the problem (Huynh 2014).

Improving analytical capacity to make better use of data

The ability of systems to make use of data insights depends on a number of factors, in addition to the availability and quality of data – although in many cases this continues to be a key 'roadblock' (NHS Clinical Commissioners 2020). One of the lessons from Lewisham and Greenwich is the importance of ensuring that the system has the resources and capability to act on insights from the data (NHS Confederation 2022).

Montefiore

The Montefiore Health System (Montefiore) in the Bronx, New York, has invested significant time, thought and financial resources in how it can better use data to improve its delivery of preventive services.

Part of this work involved the development of a new information technology (IT) infrastructure to develop shared care records that would provide access to admission information, lab tests and medication records, as well as allowing staff to request tests, prescribe medicines and support patient care delivery. The data that was collected formed what Montefiore leaders describe as 'a clinical looking glass' – a software tool that helped staff to carry out searches of aggregate data to better understand opportunities for better patient care – for example, how many patients with diabetes have their sugar levels controlled effectively.

But a further key part of this work was investing in sufficient analytical capability and capacity. The Montefiore team includes a chief data scientist who leads a team of 30 staff, including database managers, biomedical statisticians, programmers and engineers. A fifth of the team is solely responsible for preparing data so it can provide meaningful insights into how to better manage services. The team also supports the evaluation of new interventions, for example peer support programmes where mentors from the community with diabetes contact other patients with diabetes to discuss how they are managing their condition. Assessing how these interventions improve the management of haemoglobin levels helped Montefiore make decisions over whether and how to spread the approach to other patient groups – including people with hypertension and children with asthma (Collins 2018).

Project Breathe

A different example that highlights the potential for better analytical capacity and capability to improve a preventive focus comes from the Project Breathe programme. Cystic fibrosis often requires several routine specialist-led check-ups for adults. Royal Papworth Hospital NHS Foundation Trust is attempting to improve care for patients with the condition by using Bluetooth home-monitoring

devices and an artificial intelligence-driven approach to predicting flare-ups. Early evidence suggests that the approach can predict the development of pulmonary exacerbations up to 10 days before they become clinically apparent.

The Health Foundation has identified some key factors for success if analysis is to better support the challenges facing the NHS (Keith *et al* 2022). These include:

- improving underlying infrastructure
- building better implementation infrastructure
- developing the analytical workforce and better harnessing their skills
- focusing on data-driven innovation as a service
- fostering a responsible approach to innovation to ensure everyone benefits in terms of their health.

Previous research has also highlighted important cultural factors that affect the use of data to improve services. For example, it is important that the clinical leadership within the system understands and is bought into the value of using data in this way (and feels confident and supported in acting on insights). Engagement from staff and partners in the value of this work is also important in the face of pressures on capacity and challenges with interpreting data (NHS Confederation 2022).

Summary

The examples above describe how data and analysis can support a more preventive focus by:

- linking data across different care settings to gain a better understanding of care needs and costs
- identifying patients and populations who could benefit from different approaches to service delivery
- supporting a culture of improvement that tests, evaluates and spreads innovative practice.

The Cardiff and Vale system already has some of the key conditions for success in using data to support a more preventive focus in primary and community services. The data platform that has been established in collaboration with Lightfoot provides a suite of information that can help monitor trends and predict demand for services under different scenarios. It is increasingly incorporating data from a wider range of sectors to paint a fuller picture of activity in the local health and care system.

We have not formally compared the Lightfoot platform to other platforms that pursue similar aims. But drawing on the experience of other parts of the UK and international health care systems we believe it would be helpful for leaders in the Cardiff and Vale system to consider the following questions.

- Are there further opportunities for data platforms within Cardiff and Vale to draw on a wider range of sources and care settings that span the health and care system?
- Is there sufficient analytical capacity and capability to maximise the potential that linked datasets offer?
- Is there sufficient implementation support for staff in Cardiff and Vale to act on the data?

Engaging with patients and communities

In England, the primary care networks that have been most effective in improving population health and tackling health inequalities have been those that work in close partnership with local communities and have a focus on co-production (Fuller 2022). Similarly, research on innovative models of general practice has found that a consistent feature across all models was the investment of time and money in working with local populations (Baird *et al* 2018). This recognises the importance of genuine co-production, as well as the need to reach out to certain groups and address the barriers some can face in accessing health care.

Transformation and improvement in Cardiff and Vale: a review of work to create an integrated health and care system emphasises the importance of partners engaging with patients and local communities in a joined-up way across a local system, particularly when it comes to planning and understanding the impact of work to deliver more integrated health and care (*see* section 5). Working in partnership to engage with local people is also critical when it comes to work on prevention and delivering a population health approach. The multidisciplinary team model adopted by the Montefiore system in New York has been seen as key to delivering population health management effectively because it helped ensure that developing relationships and engagement with local people were the responsibility of a team of people, rather than relying on sole practitioners (Collins 2018).

Research highlights the value of involving patients in the design and development of preventive interventions, particularly where these require behaviour and lifestyle changes (Speake *et al* 2016). This includes working with local people on health creation and building an environment to keep people healthy. The box below provides an example of an approach to doing this in East Surrey.

Co-creation approach to health and wellbeing in East Surrey

The Growing Health Together (GHT) programme in East Surrey is an approach to prevention and health creation that is founded in working with local people and communities. Clinicians within each of the five primary care networks in East Surrey have regular protected time to work with local people to co-create evidence-based conditions for health and wellbeing. A quality improvement methodology and population health data support the work.

This work has three priorities: health, supporting social, physical and mental health for everyone; equity; and sustainability. GHT has been supporting the five primary care networks to work with local people and community organisations through five collaborative partnerships. These are working on different projects aimed at improving health and wellbeing, depending on the needs and capabilities of the different areas. Examples include developing a good neighbour scheme, working to provide support for pregnant women and mothers who have fled violence, and developing a community garden.

Learning from the work so far is that developing relationships between statutory and non-statutory groups and the local population has required dedicated time and funding. It has also highlighted the value of local people and professionals working together as equal partners to understand what works and what doesn't.

(Growing Health Together 2022; Fuller 2022; Mahmood 2022)

Incentivising and supporting moving care out of acute settings where appropriate to support a more prevention-focused approach

Several health care systems are pursuing the goal of moving an increasing share of health care activity out of hospital settings and into the community. This work is being done in the hope that care closer to home will lead to better patient care, better patient experience and lower costs. Moving more care into the community is also part of wider efforts to take a more preventive focus within health and care systems, so health care organisations place more emphasis on supporting the health and wellbeing of their local residents in addition to treating them when they fall ill.

In our interviews with people in the Cardiff and Vale system we repeatedly heard a commitment to moving care closer to the community where clinically appropriate, and supporting primary and community health services to take a more preventive focus. But we also heard frustration that current financial

incentives and funding approaches within the health and care system too-often stymied this process.

This debate is a feature of many UK and international health care systems. In this subsection we highlight approaches that other systems are taking to better incentivise and support efforts to move care into the community and support a preventive approach in these care settings.

Building the case for change and making commitments to change funding profiles

A recent evidence review suggests that significant additional investment is needed in out-of-hospital settings to deliver anticipated benefits to patient care (Imison *et al* 2017). A community-based services may have lower unit costs compared with hospital-based services, the review also found that it is possible to overestimate the economic benefits of community-based care in the short to medium term because of over-ambitious assumptions about reductions in hospital overheads or fixed costs. The review concluded that:

- it was important for health and care systems to give sufficient time for significant changes to health care delivery to 'bed in' and deliver results
- it was important to avoid using limited measures of success (eg the impact of preventive measures on emergency admissions to hospital) and use a wider set of metrics that assess the value (ie outcomes delivered for a given set of resources) generated from changes to health care delivery.

The Scottish Government has tried to adopt these lessons in its Medium Term Health and Social Care Financial Framework 2018 (Scottish Government 2018). The framework notes that many activities undertaken in hospital could be delivered in community settings and that a more 'concerted, sustained and comprehensive' approach to health improvement is needed to support public health and prevention initiatives.

To support these initiatives, the Scottish Government made a commitment to reshape expenditure across the health and social care sector in the medium term, with a rebalance of spending towards care delivery outside of hospitals. To demonstrate its commitment, it specified that it would reduce the share of spending on hospital services to less than half of frontline spending, with a corresponding increase in funding for community health services over the next five years (Scottish Government 2018).

Since its inception, this spending target has continued to receive significant scrutiny and attention and has been included in the Scottish parliament's assessment of the performance of the NHS in Scotland (Scottish Parliament 2019) and annual reports from Information Services Division (ISD) Scotland. For 2022/23, planned spending will see more than 50 per cent of frontline allocations directed towards community care. The focus has also been reflected

in the plans of local integration joint boards, which include details of the share of spending on community and primary care.

The changing direction of funding has supported an increased focus on developing services out of hospital. This has included:

- dedicated funding for training more primary care professionals
- enhanced community support models
- retaining a shift in the balance of care in the national NHS Scotland Recovery Plan following the Covid-19 pandemic (Scottish Government 2021).

Financial incentives to support more preventive approaches in primary and community settings

In many health care systems, particularly those where care providers are not structurally integrated into a single organisation, embedding a more preventive approach to primary and community care services requires the pooling of resources across different organisations.

This type of collaborative working can be supported by pooled budgeting arrangements that incentivise organisations to both focus on improving the health and wellbeing of their populations – rather than increasing health care activity – and consider the impact of services and care needs that lie outside a provider's own 'slice' of budget activity (Tebaldi and Stokes 2022).

Gesundes Kinzigtal

Gesundes Kinzigtal is an example of a health care system pursuing this approach. Gesundes Kinzigtal is an integrated care system, in the form of a joint venture between health management companies and physician networks, which serves roughly half of the 70,000 population of the Kinzigital region of south-west Germany. Over the past 15 years, Gesundes Kinzigtal has adopted a population-based approach to health services that requires the collaboration of health care providers (including GPs, hospital providers, independent sector providers and pharmacies), local authorities and other local providers (including gyms, sports clubs and self-help groups).

This broad collaborative has helped the health and care system expand beyond traditional health care services and invest in health and wellbeing coaches and 'social care management' services for people with complex social problems (Tebaldi and Stokes 2022). The model includes substantial emphasis on shared decision-making between patients and health care providers (eg, through shared 'target agreements' for the self-management of conditions and taking up a healthier lifestyle) and health education, with a health academy established to promote knowledge among clinicians and the public on health maintenance and improvement (Meyer 2017).

Gesundes Kinzigtal changed its financial arrangements to support a greater focus on collaboration and prevention by adopting a 'virtual budget'. Under this financial mechanism, any savings from lower health care spending on patients insured with Gesundes Kinzigtal can be shared between the reimbursing authority and the health system. In essence, this is a shared savings contract that rewards health care providers for improving the health of their population by investing in preventive services.

Tebaldi and Stokes (2022) note that this approach differs from some taken in the UK, for example the Better Care Fund, where different agencies in health and social care pool historically separated budgets to joint-finance health and care services. The purpose of pooling budgets in Gesundes Kinzigtal, similar to some of the accountable care organisations in the United States, is to expand the range of preventive services that are supported by historical budgets (Tebaldi and Stokes 2022).

Evaluations of the programme have suggested improvements to both the health of the population and system costs (Meyer 2017). Health improvements include:

- falls in mortality for patients enrolled on the programme
- better management of chronic conditions
- lower prevalence of fractures in insured patients with osteoporosis
- lower cost growth than expected given previous projections for this population.

Shared savings programmes in accountable care organisations in the United States

Accountable care organisations (ACOs) are groups of health care providers in the United States who collaborate to provide more co-ordinated care to patients. Under the Medicare programme – the federal health insurance programme in the United States for defined populations, including older patients – ACOs have been transitioning to a value-based care model to reduce spending and improve care quality.

Under the Medicare Shared Savings Program, health care providers can form partnerships to enter into multi-year contracts to provide health care services. A portion of any savings or losses that are generated can be shared by the health care providers, to create an incentive to lower costs while maintaining or improving quality. ACOs now have a default contract period of five years and there is a requirement for most ACOs to take on downside risk (ie where the ACO shares in any losses if spending is higher than a pre-determined benchmark) by their third year if they do not choose to do so earlier.

Under these contracts, ACOs are accountable for the total cost of care for their contracted population – even if organisations outside of the ACO structure

provide the care. This creates an incentive to form strong collaborative partnerships.

The ACO contract structure incentivises a preventive focus directly (eg certain preventive health programmes are directly included as quality measures, such as wellness screenings and health checks) and indirectly (eg a wider focus on reducing health care utilisation will result in greater operating margins for health care providers).

A wide range of policies and operational changes have been supported by this new contracting and reimbursement approach. But with a specific focus on embedding a preventive approach in primary and community settings, a report on ACO development has highlighted the importance of engaging beneficiaries and addressing behavioural health issues (Chiedi 2019).

- Engaging beneficiaries – many ACOs have placed greater emphasis on annual wellness visits (which is more than a physical examination and focuses on understanding a patient's needs to support their continued health and wellbeing) to support better patient–physician engagement. ACOs have also invested in educating beneficiaries on health care topics, including condition management in diabetes. This work has included a wider range of providers than traditional health care, including motivational interviews from care co-ordinators and work with local supermarkets and dieticians to support patients to take up healthier food options.
- Addressing behavioural health and the social determinants of health – ACOs are trying to better meet the needs of patients, including those with mental health and substance use disorders, by recruiting behavioural health providers, offering training to existing primary care staff to become more skilled at recognising conditions such as depression or anxiety, and using telemedicine services to allow behavioural health providers in neighbouring areas to provide virtual support to beneficiaries in the local system. ACOs have also taken action to integrate behavioural health care services into their primary care settings so that social workers, case managers, behavioural health providers and primary care physicians can offer multidisciplinary clinics to better meet the range of patient needs.

An example of this new way of working comes from the Department of Vermont Health Access's 'Vermont Blueprint for Health'. The Blueprint is an integrated primary care system that connects primary and community providers and services to deliver care for the rural and 'micropolitan' populations in Vermont (Robinson *et al* 2021).

The Blueprint brings together:

- community collaboratives, which help identify local priorities and play a role in allocating resources
- community health teams, who help co-ordinate health and social services (eg, housing services for people with chronic conditions)
- services to support healthier families and programmes for priority groups, including people with opioid use disorder.

The Blueprint participated in the Medicare Multi-Payer Advanced Primary Care Practice Demonstration. As part of this work, funds from the programmes were used to hire additional staff for primary care practices and community health teams, including behavioural health specialists, wellness nurses, social workers, dieticians, pharmacists and health coaches (Robinson *et al* 2021). As noted in other evaluations, increased investment in community services led to increased access and health care use for some members of the population who were likely to have high levels of previously unmet need. But despite the increased expenditure, overall reductions in inpatient and outpatient hospital spending meant the investment in more integrated preventive services led to net savings.

Summary

Caution should be taken before comparing health care systems, which can often differ substantially in their structures and operational, political and societal context. Nevertheless, our review of the evidence suggests areas where the Cardiff and Vale system might consider further action to better support a more preventive approach being embedded in local primary and community services, as follows.

- Bringing organisations together around a shared financial incentive – in the Scottish, US and German examples given above, a common goal was to invest in community-based care and support a greater system-wide emphasis on prevention. This goal was then supported by the system setting concrete targets for changing health and care spending patterns or changing financial contracts to incentivise activities that promote wellness.
- Rewarding the right behaviours – rather than focusing on a narrow set of traditional health care metrics (eg, reductions in the growth of non-elective hospital admissions), the health and care systems we reviewed used a more comprehensive basket of metrics to assess the performance of the health and care system and support and monitor efforts at preventing ill health. This included the use of leading process indicators (eg, attendance at wellness checks, enrolment in wellness activities or reported patient experience) and lagging outcome indicators (eg, measures of morbidity for chronic conditions, mortality or functional status).

- Engagement and education – a strong theme running throughout the examples was an investment of time and money in supporting patients and health care professionals to learn more about the benefits of a focus on wellness and health promotion activities. These programmes were often supported by partners who do not play a large role in traditional health care delivery in a UK context (eg, gym operators and supermarkets).
- A long-term perspective – even where financial resources are available, it takes time to build up services and support in communities and for these new services to be adopted and used. By setting medium-term financial plans and establishing multi-annual contracts (which, in the case of some early ACO contracts, protected providers from financial 'downside' risks), other health and care systems have demonstrated a long-term commitment to investing in a more preventive approach and have acknowledged that it will take several years for this new approach to be fully established.

5 Conclusion

Our research highlights the significant areas of progress being made in Cardiff and Vale towards taking a more preventive focus in primary and community services.

For example, there is existing infrastructure in place to support more co-ordinated and prevention-focused activity. Primary care clusters have been in existence for a comparatively long period in a UK context, and have brought GP and other primary care services together to organise care for local populations. This work is now being expanded to include a broader range of professional groups, through the Accelerated Cluster Development programme, to help promote the wellbeing of individuals and communities in Cardiff and Vale and other parts of Wales.

There are also specific service areas within Cardiff and Vale that demonstrate a commitment to more person-centred care that focuses on wellness and not simply treatment. These include:

- social prescribing schemes, including referrals to exercise sessions
- community wellbeing coaches to help families and children who want to improve their wellbeing and activity levels
- schemes to help avoid social isolation.

All of these speak to the desire, as one interviewee put it, for the Cardiff and Vale system to have an ethos that supports 'prevention, early intervention and non-medical solutions'.

Our work across two associated research projects (one for this report and the other for the separate report *Transformation and improvement in Cardiff and Vale: a review of work to create an integrated health and care system*) 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, led by the RPB, Cardiff and Vale has taken some important steps in bringing together data across the 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.

Embedding a shared vision and engaging staff

In our interviews we heard from different clinical and managerial staff who clearly 'buy in' to efforts that embed a more preventive focus in primary and community services. But we also heard that immediate operational priorities can crowd out a preventive focus and that more could be done to embed a this focus as 'part of everybody's business'.

Other health and care systems are taking multi-channel approaches to supporting the embedding of prevention in services, and elements of these may be worth considering to support a more preventive focus in Cardiff and Vale's primary and community services. These include developing toolkits to help clinical staff build their capability in this area and using maturity matrices that help put a focus on prevention at the heart of what emerging integrated care systems will be held to account for delivering.

Exploring more programmatic approaches to choosing prevention priorities

As is clear from its annual reports on public health, the Cardiff and Vale system has demonstrated a concerted focus on important areas of prevention, including, for example, supporting the mental health of children and young people and childhood immunisation.

There may be opportunities to take a more programmatic approach to choosing future prevention initiatives that draw on a wide range of inputs (eg through greater engagement with communities and clinical groups) and which draw on linked datasets to explore options for high-impact changes to population health (eg as in East London, Kent and Medway, and Montefiore).

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, which already exists across partners, building a clearer picture across the system of the experience of people who use services. 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 financial resources more collectively to support prevention initiatives

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 how other health systems such as that in Scotland have set broad targets to change the balance of spending across acute and non-acute services, to support greater investment in services that keep people well. And there may be lessons from how other systems, such as Gesundes Kinzigtal in Germany and some ACOs in the United States, have changed contractual and payment regimes to reward health care services that invest more in upstream prevention (eg, health coaching and wellness checks) and reduce activity in other parts of the health and care system. We recognise that the national contractual arrangements that apply to Cardiff and Vale might constrain how far these efforts can be pursued. As noted in our case study on Tameside and Glossop in *Transformation and improvement in Cardiff and Vale: a review of work to create an integrated health and care system*, we believe it is still worth considering whether the full scope of existing legislative, financial and regulatory frameworks is being used to support a more preventive focus being embedded in local primary and community services.

Strengthening a culture of innovation

In previous research 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 our own research, which identified a number of areas of progress that enthusiastic individuals and teams had pushed forward.

Nonetheless, there is an opportunity to go even further in this work 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.

Unlocking the potential of data to support a preventive focus

Cardiff and Vale has made significant progress in bringing data together 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
- bringing data together from different care settings and providers to paint a more comprehensive picture of population health needs
- using analytical capability to understand 'what works' when it comes to work on prevention.

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About the authors

Lillie Wenzel joined The King's Fund as a Fellow in 2014. Her work at the Fund has included a project exploring the impact of financial pressures in the NHS on patients' access to quality care, and research into patients' experience of NHS admin. Lillie is also the programme lead for one of The King's Fund's strategic priorities, Tackling the worst health outcomes.

Before joining the Fund Lillie worked in the health team within PwC's advisory practice, where she supported NHS organisations on a range of assignments including public procurement projects, organisational and commercial change and strategy development projects. While at PwC, Lillie spent 18 months on a secondment to the Department of Health's NHS Group where she worked on provider policy.

Siva Anandaciva is chief analyst in the policy team, leading on projects covering NHS funding, finances, productivity and performance.

Before joining the Fund in 2017, Siva was head of analysis at NHS Providers – the membership body for NHS trusts and foundation trusts – where he led a team focused on NHS finances, workforce and informatics. Previously, he was an analyst in the Department of Health working on medicines policy and urgent and emergency care.

Siva is a member of the Office of Health Economics policy committee and chairs the National Payment Strategy Advisory Group for NHS England and NHS Improvement.

Dr Loreen Chikwira joined The King's Fund in 2022 as a research assistant in the policy directorate, and she became a researcher in October 2022. Her interests lie in how intersectional approaches are employed in implementing policies and addressing health inequalities. She is also interested in how voices of marginalised communities can be brought to the fore of social policy and practice, with a focus on using research methods that are inclusive.

Loreen is an academic who has taught in social science disciplines of sociology and psychology over the past 10 years. She has also worked with various statutory and voluntary, community and faith organisations on addressing inequalities in policy and practice.