NHS Confederation

Newton

Unlocking prevention in integrated care systems: A guide to balancing short- and longer-term impact

Emerging thinking, tools, and best practice examples for leaders across integrated care systems

October 2024

Introduction

Local leaders at neighbourhood, place and system level are primed to deliver the major shift from treatment to prevention, envisaged by the new government.

Our recent research project with 22 ICSs by NHS Confederation, University of Stirling, University of Southampton and Newton, has shown that even within the current challenging financial and operational pressures, system leaders across integrated care systems (ICSs), local government and the voluntary, community and social enterprise (VCSE) sector are prioritising prevention through collaborative approaches. The key enablers to facilitate this shift are collaborative leadership, deliverable evidence-based initiatives and high-quality, data-driven impact evaluation. National health and care policy is aligning to support this.

National health and care policy is aligning to support this. The Hewitt review of ICSs and Lord Darzi's investigation on the NHS make a strong case for greater focus on prevention and call for a shift in resources to enable it.

The projections for health and care demand are stark, driven by an ageing population and increasingly complex needs. By 2040, 9.1 million people in England will be living with a major illness, 2.5 million more than in 2019. The social care workforce will need to increase by 27 per cent (480,000 jobs) by 2035 on current trends. The strong sentiment from research participants on the need for action was: 'if not now, when?'

With a new government focused on shifting towards prevention and care closer to the community, and with an upcoming ten-year health plan that will help deliver this, now is an opportune time for system leaders to consider what immediate levers they can use to start making a real impact on population health outcomes.

What's included in this guide

This guide translates the findings of our research into the practical steps ICSs can take to make the shift towards prevention. It outlines how system action can unlock prevention and, by taking a proactive targeted approach to prevention, improve outcomes and relieve some of the pressures of today, while building momentum for long-term transformation.

It explores practical considerations, grounded in the realities of today's pressures, for leaders looking to move forward decisively with the delivery of their strategic prevention agenda by demonstrating impact in the short term. It includes emerging thinking and prompt questions to support leaders in system-level discussions, together with case studies to bring to life examples of how system partners are driving forward progress in practice, based on Newton's work around targeted, proactive prevention.

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Defining prevention

Our research outlines a range of definitional, financial, operational and cultural challenges to achieving the shift from treatment to prevention, which are intensified in the context of today's severe financial and operational pressures.

The fact that prevention means many different things to many different people was seen by those involved in the research as one of the key barriers to systems achieving the shift. Making distinctions between different types of prevention is therefore helpful and there is broad agreement about what these various forms entail.

While systems will focus on all three (or four) types of prevention, this distinction is helpful given the different conditions and ways of working required to successfully deliver each. For example, primary prevention and focus on the wider determinants of health will require systems to work with a broader range of partners across housing, planning, the environment, transport, education and so on. Secondary and tertiary prevention will require advanced data segmentation to inform (largely clinical and social care) interventions targeted at specific populations.

The research report highlighted the vast amount of positive work happening in the prevention space, but also the range of approaches being taken. Some approaches involve investing in primary prevention to improve population health over the coming years, while others focus on target cohorts and aim to deliver impact with secondary and tertiary prevention.

Wider determinants of health	These are the social, economic or environmental factors affecting health, such as housing, employment, education or parks and green spaces.
Primary prevention	Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups.
Secondary prevention	Systematically detecting the early stages of disease and intervening before full symptoms develop. For example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure.
Tertiary prevention	Softening the impact of an ongoing illness or injury that has lasting effects. This is done by helping people manage long-term, often complex health problems and injuries such as chronic diseases or permanent impairments, in order to improve their ability to function, quality of life and life expectancy.

Reference: The Local Government Association

How can prevention be unlocked in the reality of today's pressures?

The NHS Confederation's recent survey on the state of integrated care systems found that many were struggling to balance 'tackling today' with 'building for tomorrow' in the context of performance management focused on short-term issues and short-term financial flows, which impede longer-term planning on areas such as prevention.

The concept of a 'split-screen thinking' approach to prevention was raised during the research to describe maintaining a focus on both tactical short-term and strategic long-term needs and allow them to inform each other. Doing both is challenging for systems that already feel resource poor. However, it is necessary to ensure the most efficient and effective use of resources.

Organisations and systems have talked about this challenge for years and have often struggled to prioritise and allocate resource effectively to overcome the tension between immediate impact and long-term transformation. Prevention is a prime example of this and is often stuck in the 'long-term strategic' box. But there is much cause for optimism, as can be seen in the innovative approaches to preventative work presented in this guide and in the research report.

A proactive, targeted approach to prevention to improve outcomes sooner and help ease the pressures of today

Considering current pressures, it is understandable that systems will have an increasing focus on how to make an impact on outcomes and ease pressures on the system in the short term through secondary and/or tertiary prevention approaches.

Based on the research report findings and Newton's own work with systems, some proactive, targeted prevention approaches can show real benefit in a timeframe of six-to-18 months, as well as build the momentum and learning for large-scale transformation in the long term.

We identified three key drivers to achieve short-term impact, while keeping the long term in mind:

1. **Prioritising the population**
   How do you target prevention efforts to support a system's current context?
2. **Demonstrating impact**
   How do you enable and show the impact to build the case for future investment?
3. **System leadership**
   How do system leaders support immediate impact as well as a transformed future through prevention approaches?

We will describe how to tackle each of these in turn.

1. Prioritising the population

How do you focus prevention efforts in a way that fits a system's current context?

The current pressures on capacity and finance are compelling leaders to **focus their efforts where the greatest, and quickest, impact will be seen**. This means focusing on preventing escalating need and supporting the most people to the most independent and cost-effective outcome as quickly as possible, while building headroom to progress further preventative focus in future.

Every system has a different context, a different population and therefore target cohorts, and will be at a different stage with current preventive models so should prioritise for impact in a way that fits its current context.

Emerging thinking

Prioritising action for the greatest short-term impact on preventing need

To unlock progress in the short term, systems have seen success by prioritising preventative action based on **the scale of impact on reducing the likelihood of people's deteriorating health and care need** (and therefore reducing system demand for reactive care) rather than spread across several small-scale, cohort-specific initiatives.

Much work on prevention and population health management (PHM) has focused on segmenting the whole population into specific groups of needs, geographies, existing conditions, demographics and so on (see the Kaiser pyramid, on p7). This gives rich insight and is incredibly valuable for supporting more vulnerable groups and tackling inequalities. This work is also valuable for future all-encompassing primary prevention models.

However, solutions often have long lead times to benefit, or small-scale impact in the context of the whole population due to the size of cohorts being targeted.

Today's pressures allow us to consider different starting points:

- The **people** most likely to drive reactive demand in the system: what groups of people could be proactively supported in order to deliver the greatest overall improvement in health and care outcomes, supporting reductions in system demand in the short-to-medium term?
- The most effective **evidence-based interventions** for providing much-needed support and avoiding or reducing reactive demand: what interventions are known to have a big impact? Can the people that will benefit from them be identified?

Short-to-medium term impact may be best achieved with these types of proactive, targeted approaches, harnessing data and technology to find the individuals driving today's and tomorrow's demand. With the benefit seen in the system sooner, it can release capacity and build the case to move further down the pyramid, achieving longer-term and even greater impact preventing the high-needs users of the future.

The role of data and new technology

Advances in artificial intelligence (AI) and technology, such as machine learning and large language models, **are an asset for people delivering and overseeing prevention work. For example, in generating additional insights on the local population** to enable the right prioritisation. Given that ICSs have very different starting points, it is much easier to identify specific segments of the whole population based on locally defined priorities or highly visible issues. For example, people 65+ years old, in a certain postcode, with a certain high-needs condition. It is much harder to pin down the group of people likely to drive the most demand, with no

other constraints or the 'usual' boxes of characteristics. This is where new technologies, particularly AI, are becoming invaluable.

Managing complexity: To understand where to prioritise for the most impact, detailed, person-level data is often required. The high-impact cohort is unlikely to fit a higher-level category or characteristic, whereas understanding every individual's history, needs, recent contacts and so on gives a deep, personalised view of their potential to access services and drive demand. This involves a huge amount of joined-up data and building complex models that the latest digital tools can support. However, the analysis is often overly complex in the pursuit of perfection in understanding the whole population. It can be helpful to ask, 'what is good enough?' from the insurmountable amount of data to make the decisions required. For example, some systems have built accurate predictive models with primary care data in isolation, where that is sufficient for the required outcome.

Making use of new digital tools: As many areas go through an AI revolution, the sector is likely at the tip of the iceberg with the role of these technologies in preventive work. They are particularly valuable in bringing a deep individual understanding to finding a high-impact cohort, predicting future demand and targeting interventions. There have been excellent recent examples of the use of natural language processing to read millions of lines of case notes, and machine learning models to accurately predict the individuals likely to require treatment in the future (see case study on p8).

Participants in the research were quick to reflect that just having the data available means little if it is not accompanied by effective skills and infrastructure to enable usability by actors across the system – and that those capacities are currently spread very unevenly across ICSs.

For more on this topic, see research by Understanding Patient Data.

Some participants of the research reflected that technology is not the solution on its own. Prevention is not solved by cutting-edge analysis or procuring a digital product. Instead, it is a small but essential part of a wider redesign of models of care, prioritising resources and implementing new pathways.

A note on data sharing and information governance

Two factors make data analysis for prevention especially powerful and actionable:

1. **the need for data to be person and contact level specific**
2. **the ability to integrate and share that confidential data between organisations.**

These two factors also frequently cause information governance blockers and delays to action.

Often the blockers arise from a lack of awareness and discussion between digital and information governance (IG) specialists, and the wider overall and operational leadership teams. Specialist roles can take decisions that have strategic implications for operational delivery and the whole system, and operational leaders can lack the knowledge of what is legally required and what routes exist to unlock data sharing, so frustration can build.

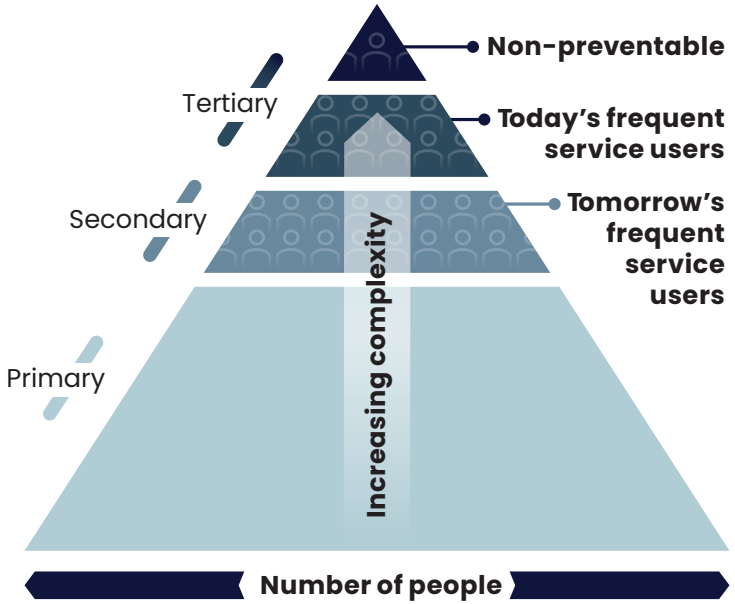
The latest technologies and approaches can bring significant benefits but often require large amounts of personal information to be shared. However, there are ways through, for example, seeking section 251 support (NHS Act 2006), which can provide the legal basis for sharing data without the need to approach every individual for consent. Many systems are advanced in their data sharing but this can be a blind spot for others, causing further frustration between leaders, delays in progress, or even non-compliant data sharing.

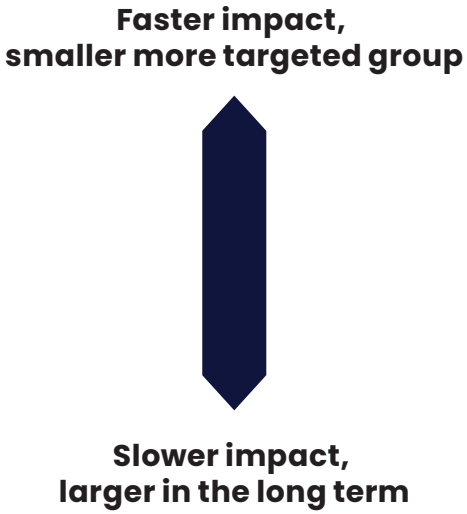
Tools for local impact

Considering the right cohort can improve outcomes and reduce reactive demand sooner

The approach of prioritising a high-impact cohort of people can be described using the Kaiser Pyramid model shown below.

The Kaiser Pyramid





The report describes the possibility of **'tertiary and secondary preventive interventions as a 'bridge' to wider primary prevention over time'**. This is by no means the only answer but would lend itself to starting higher up the pyramid – focusing efforts on known needs or risks of escalation to deliver shorter-term benefit and capacity in the system.

This is only a tool to stimulate discussion and reflect on current initiatives – there are positive exceptions where some early benefit can be seen from primary prevention approaches. The long-term answer for a fully preventive model of care will likely major on primary prevention with a huge impact in the long run when implemented at scale but this is many years away and requires the incremental action to get there (split-screen thinking).

At the very top is the 'non-preventable' cohort where specialist, intensive or acute care is required for the highest needs that could not have been prevented. Next are the users already known to be driving large amounts of demand. Their health and care needs are complex and they are more likely to be in need of proactive, personalised care and support. With the right scale of data and focused analysis, it is possible to identify the group(s) that will be accessing services the most in the short term and what interventions would have the greatest overall impact, supporting them to stay safe and well.

The layer below can be thought of as 'tomorrow's frequent service users'. With the power of the latest technologies, predictive models can be built to identify the group of people who have deteriorating health needs and require more services in the near future, where preventive interventions could be most impactful.

For both layers, recent innovative approaches have not looked to find common characteristics of those most in need of services and deliver blanket interventions, but instead taken a very personalised approach. This involves continuously identifying the individuals currently using, or most in need of, services across the system and delivering proactive, personalised care and support.

Questions for reflection by system leaders:

- What cohorts are your prevention initiatives currently targeting? How were those decisions made? Is there a line of sight to the scale of impact they will have on individual outcomes and system demand?
- Are you harnessing the latest digital tools to support prevention? Is the technology or the clever insight seen as the solution on its own? Is the pursuit of perfection in the analysis and understanding of the population getting in the way of 'good enough' data to take action?
- Is the impact and evaluation timescale from your prevention initiatives understood? Do you have enough focus at the top of the pyramid where benefit can be found sooner to better support individuals and release capacity?

Not all preventive approaches take years to pay back. By starting with focusing further up the pyramid, we might prevent individuals' needs escalating and the case for working further down the pyramid can be built.

Systems taking incremental action

Norfolk

Norfolk County Council, working with wider ICS partners, is leading a programme of work focusing on falls prevention to proactively support people in the community. A third of people over 65 fall every year, deeply impacting a person's confidence, mobility and wellbeing, and costing health and social care over £4,000 per fall.

The programme centred on three elements enabling the system to deliver a preventive service:

1. A better understanding of residents

Through a secure digital platform, the team was able to harness natural language processing to 'read' the case notes for all residents known to adult social care and put this together with existing data about the person. Machine learning enabled the team to process millions of data points and words from a person's record to extract meaningful insight on their strengths, needs and interests. This built up a previously unattainable depth of understanding, enabling the team to

predict who was most likely to have a fall. By testing the model on historical falls data, the team was able to predict seven in every ten people who will have a fall and could therefore benefit from proactive support.

2. Intervening to mitigate risks

Norfolk engaged two teams to complete a holistic conversation with participants identified by the predictive model. These teams completed semi-scripted conversations to talk to the at-risk individual and understand what support they might benefit from, then offer targeted interventions.

Of those individuals, 93 per cent were eligible for a preventive service such as chair-based exercises from occupational therapists, or home safety assessments from the fire service. In the first phase of the falls pilot, over 150 people took up at least one referral offered to them by the team and 70 people had interventions delivered.

3. Measuring the impact

At the point of their follow-up call, 100 per cent of those receiving interventions quoted no falls since their intervention. Residents subsequently reported a 15 per cent reduction in their fear of falling; one of the main leading indicators for having a fall. Furthermore, satisfaction with the programme was high, with 71 per cent of people citing that the support they received was beneficial.

As well as a clear benefit for residents, there is also a compelling financial case behind this approach. The pilot identified £600,000 - £700,000 of financial benefit for adult social care, excluding health benefit.

An essential part of demonstrating the impact and building the financial case was measuring how outcomes and ongoing care costs changed for those receiving the targeted support. The financial benefit has now been directly measured, with those who received a targeted intervention showing a £175 decrease in weekly care costs compared to those outside of the pilot

The council now has ambitions to roll out this approach more widely to other groups that could benefit from early targeted support in this way, such as those living with physical disabilities.

2. Demonstrating impact

How do you enable and demonstrate the impact to build the case for future investment?

Most of the barriers to prevention shared by participants in this research related to challenges beyond understanding the population and knowing what to do. Delivering an impact, measuring it and demonstrating the case for change at scale can face many blockers.

The research uncovered significant frustration with the desire emanating from government to show 'cashable savings'. Participants shared that efforts to develop more qualitative measures of improvement do not allow for a quantified investment case, and often will not evidence the improvement in the required timescale. With budget constraints and operational pressures high, there is a desire (and a great deal of resource required) to report upwards with increasing granularity on activity metrics to ensure performance. For many, preventive approaches do not lend themselves to this kind of quantitative evidence required for business cases to be built quickly. However, there are examples of systems taking an iterative approach to find this evidence for their prevention efforts, and it starts with enabling the impact itself.

Below are some areas that can support building the case, following on from prioritising the population for impact.

Emerging thinking

Creating the impact

There are emerging approaches to prioritising the local population that give deep insight into the drivers of demand and how future escalation can be prevented more quickly. Beyond this clarity on what will have the biggest impact, clarity on how to have that impact is also required.

Systems making progress have dedicated the right resources from clinical, operational and transformation teams to co-designing the new process, new pathway, new interventions or new ways of working that will tangibly support the identified individuals to avoid crisis and escalating need or reduce ongoing access to services. This might be local integrated neighbourhood teams (INTs) with capacity carved out to take a multi-disciplinary team (MDT) approach with well-known service users at risk of frequent hospital admission, or a centralised team taking a very targeted approach to deliver support to those most at risk of new crisis. There have also been powerful examples of systems assessing which specific interventions are most likely to have an impact on a person's outcome to ensure the community teams can target the population with the most effective intervention (see Essex case study on p14). It is helpful to consider the capabilities required to achieve preventive interventions that are accessible, available and effective, both in a pilot and when scaling up.

The agile approach of 'start small, test, measure and iterate quickly' is particularly valuable for these preventive initiatives due to the need to ringfence resource to make it happen, and the perception that impact is not immediately visible. A small proof of concept that shows an impact appears to be most helpful to systems in gaining momentum and further buy in, especially when partners see the alignment of the immediate action to the long-term ambition. This can be a powerful way to deliver in-year benefit from a prevention agenda.

Demonstrating the impact on demand and outcomes

The research report notes: **'It is difficult to connect a long-term preventive agenda to short-term (often NHS-focused) measures of performance or success. Some system leaders describe frustration with the dominant currency of evaluation and the 'artificial precision' of measures of £ per quality adjusted life year (QALY). It is not always possible to quantify the health impact of complex and joined-up measures in this way.'**

When aiming to have impact sooner with tertiary prevention approaches (further up the pyramid), it can be easier to find tangible measures of success when you are targeting a specific group. For example, if the data model is built to pinpoint the individuals at risk of escalation, the same model can be used to measure their ongoing contacts with services and any impact the preventive interventions have had on their outcome, ongoing level of care, and long-term setting.

When measuring benefits, it may be helpful to consider split-screen thinking. For example, has the system aligned on long-term ambitions for prevention and measures of success that would show this, centred on improved outcomes? Can the tangible measures from pilots and incremental action prove more immediate impact that is contributing to the long-term ambitions?

To satisfy the levels of evaluation often required for a successful business case against competing system priorities, success can be achieved by measuring the impact on a headline performance measure that can be linked to both outcomes and finances. For example, showing that the pilot work has prevented escalation and that improved outcomes are likely to follow this, but also demonstrating the impact on admissions, the size of care packages, the long-term setting of those with high needs, or the number and type of community contacts. This has been achieved through comparing pilot groups to control groups and tracking the ongoing contacts for target individuals. (See Norfolk case study on p8)

Building the financial case

The research found that 'making the case' pragmatically often runs into the fundamental problems associated with the commissioning model: that pilots are often small-scale, have limited time horizons for impact, and lack a secure financial footing to reap real benefits.

With some of the approaches in this guide, there is an opportunity to be led by the results that need to be seen in the short-to-medium-term, and ultimately what the inputs for the financial case will need to be. Therefore, when designing the initial changes and iterations, it is important to ensure the right data and evidence is collected from the start that will allow measurement of changing demand and costs that should come as a byproduct of achieving prevention.

Inform and continue the long-term model redesign

The above points focus on the shorter-term aspects of unlocking impact from prevention given the current environment, however, they are also an essential part of building a future preventive model of care. Continuing the split-screen thinking approach can ensure the more immediate action is not a one-off and has lasting value. Alongside the immediate action it is essential to continue the transformation journey as much as possible, which will require significant resources and complex whole-pathway redesign over time as learnings and solutions develop in systems and nationally. Where possible, there is significant value in continuing the short-term efforts and the transformation journey in parallel.

Tools for local impact

Points for discussion to help leaders steer prevention programmes and challenge their teams on the impact the work will have and how that will be demonstrated:

Creating the impact

Consider how impact will be delivered:

- Beyond identifying the people where escalating need or future demand could be prevented, is there a robust and specific plan to deliver new interventions for those people?
- Have the required resources been ringfenced to deliver interventions, even on a small scale?
- Is there a manageable pilot that can create impact quickly, avoiding the complexity and timescales of standing up a large-scale change?

Demonstrating the impact on demand and outcomes

When measuring benefits. consider split-screen thinking:

- Has the system aligned on long-term ambitions for prevention and measures of success that would show this, centred on improved outcomes?
- Can the tangible measures from pilots and incremental action prove more immediate impact that is contributing to the long-term ambitions?

Building the financial case

Consider what results partners and finance leads would need to see to be assured that prevention is working:

- Can the preventive impact be measured? Is the data captured to show the improved outcomes for people, and show it is cost effective and/or reducing future demand?
- Has it been collected in a way that allows scaling up to potential system-wide impact for a business case?
- What baselines or control groups will be required to make a powerful case?
- Can the predictive models and data sharing in place for benefits tracking be used for targeting the interventions as well?

Systems taking incremental action

What are local systems demonstrating?

Essex

In Mid and South Essex, the integrated care board (ICB) team continues to put measurable improvements in outcomes at the heart of their approach. Following big strides in recent years with improving urgent and emergency care (UEC) and intermediate care outcomes, Essex began to look at prevention opportunities to prioritise based on impact and demand. Noting that 63 per cent of A&E admissions stem from 5 per cent of the 65+ population, targeted prevention looked to proactively improve care of and reduce further demand from these high-intensity service users.

The team then set out to understand which interventions would have a positive impact for these people, and how that could be measured and demonstrated. The specific focus was to understand:

- whether the interventions currently undertaken have an impact on outcomes
- whether the likelihood of escalation could be predicted, and therefore who would benefit from which pro-active intervention to avoid hospital admission?

Measuring the impact and building the financial case

By connecting datasets across the system, combined with detailed frontline studies, an evaluation of the impact of community-delivered frailty interventions on patient and system outcomes was established for the first time:

- Falls risk assessments – potential to reduce expected admission rate for applicable patients by 35 per cent.
- Advanced care plans – an average of five days of inpatient stay saved for every patient in their last six months of life.
- Structured medicine reviews – potential to reduce expected admission rate for applicable patients by 25 per cent.

This clarity on impact from each intervention gave the team the confidence to dedicate ongoing resource to delivering the proactive interventions and build further impact.

A machine learning model allowed prediction of over seven-out-of-ten patients who will be admitted to acute hospital in the next three months, based on health history, demographics and some wider determinants of health. This enabled the delivery of preventive community interventions in a very targeted way that also helps address inequity of access.

By rigorously determining the interventions that would have biggest impact, putting them in place in a targeted way and measuring the impact of each one, the estimated system benefit when implemented across the ICS is £11-17 million through reduced demand on health and care services, providing enhanced support to over 5,000 individuals annually.

3. System leadership

How do system leaders support short-term impact and a transformed future through prevention approaches?

The role of leaders could cover just about every topic relevant to successful prevention in health and care systems. This section focuses on a few specific areas for leaders to consider in the pursuit of tangible impact from prevention.

Emerging thinking

Aligning system partners

Like many of today's biggest challenges facing health and care, successful preventive models will require strong system working. Some of the costs may be borne by particular partners. For example, social care support may prevent people accessing NHS services – something systems might address through pooled budget arrangements. The solutions will often require, or be improved by, input from different organisations and the benefits will nearly always be shared by various partners in the system. The time commitment required from leaders is significant. More than ever, pressures within organisations are making it difficult to maintain good communication and ensure successful partnerships. Few leaders have experience working across all areas of the health and care system, making it more difficult to understand the nature of challenges faced by others and harder to identify the solutions for the greater good of the system rather than for the organisation.

Ensuring the right people are round the table from neighbourhood, place and system level is an important factor. It is essential to build a coalition of the willing who can build trust and enact the required changes within their organisations for prevention to have the desired impact. Successful groups avoid becoming bogged down in structures and governance. They take ownership of the prevention agenda; collective ownership to deliver a measurable improvement; and individual responsibility for delivery of change in their organisation. It also should not be the sole responsibility of one or two individuals in a system, rather, it requires different skillsets and the coming together of different conceptions of what 'prevention' is across health and social care.

Another essential factor is agreeing collective aims, or a vision for the work, and maintaining commitment to those. A focus on outcome-based aims will avoid distraction and frustration by conflicting priorities and unintended consequences. Systems making progress are focusing efforts where the system pressure and energy currently is, particularly where a shorter-term impact is sought. For example, it may be right to prioritise reducing acute hospital admissions with tertiary prevention approaches given local pressures and levels of focus. This can create capacity for the longer-term focus and build the momentum and the case for wider prevention at scale.

Making prevention everyone's business

As our research found:

'Some participants expressed concern that making prevention everyone's business can mean that it is tricky to pin down who has prevention in their portfolio and that no one takes responsibility for key choices and outcomes. Here, we find a difficult balancing act: prevention needs to be part of the day job of more people, but you also need someone or an organisation to oversee the whole system and strategic direction.'

For ICBs, recent cuts have squeezed areas like prevention to have less formal ownership or to be a smaller part of someone's role. The balancing act described in the research requires clarity of leadership and roles within the

prevention agenda. Often, prevention is seen as a specialist subject in the strategic box of a certain portfolio. An alternative view is that prevention, if unlocked in the right way, is core to operational delivery of services and core to system finances as one of the biggest levers on current and future demand.

Aiming for preventive progress and performance measures to be part of the day-to-day operational review cycle could bring about the mindset shift from strategic, more conceptual model redesign, to incremental action and measurable impact.

Making it everyone's business and bringing prevention to the fore at all levels of operational management will enable more tangible impact. However, there is still a requirement for accountability to make it happen and ensuring someone, or a group, takes a lead on a consistent strategic direction across the system. Consider if this role could be with operational leaders as much as digital and strategic leaders to bring about the right balance.

Aiming for scalable change, without stifling local innovation

Prevention is not a new idea and every system has been moving forward with different initiatives at different scales and paces. Innovation and enthusiasm for preventive approaches are often found in local pockets across many 'passion projects' which are fuelling the cultural shift. While leaders should encourage this shift and not stifle innovation and empowerment, there is a risk that a scattered approach of local interest creates an incoherent approach to prevention, with less overall impact from significant resources. The impact of these projects alone is unlikely to see the scale of shift required. There is a role for leaders to play in prioritisation, protecting resources around the most impactful initiatives, and systematically scaling up the smaller projects that are working.

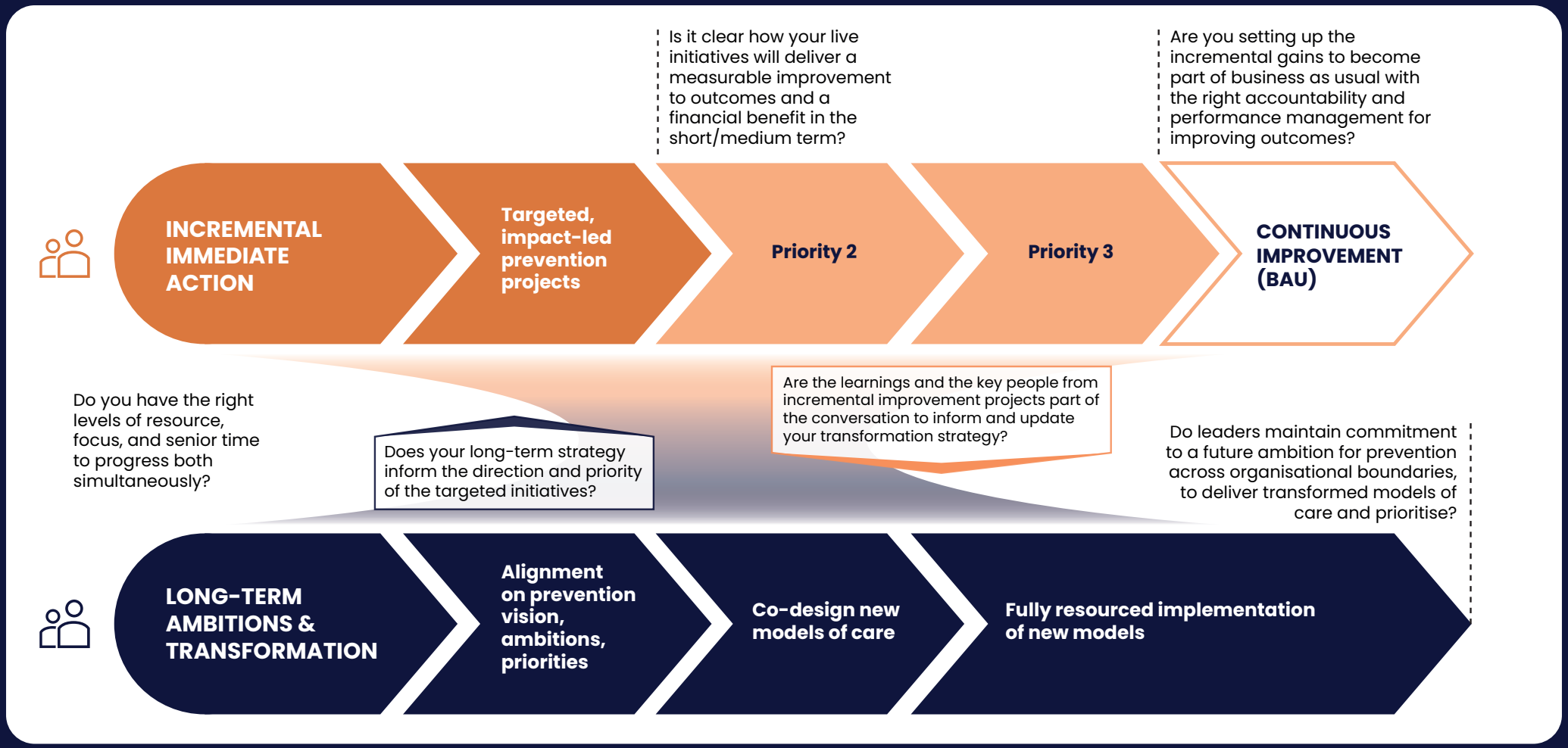
Ultimately, systems have to prioritise work that will tackle both today's and tomorrow's pressure. Incremental change must use resources efficiently, be well controlled and be aligned towards releasing capacity and delivering a future high-impact preventive model, otherwise local passion projects will distract, confuse and frustrate.

The leap of faith, but with 'good enough' evidence

> Prevention may represent a political 'leap of faith' that few policymakers are willing to take and require a level of systemic capacity that is difficult to find.

There are many examples of organisations and systems where huge amounts of effort and progress have taken preventive work up to the point of further investment, only for leaders not to take the final leap of faith. The research highlights the need for 'bravery' to tackle unsustainable service models and move towards preventive models. Leaders should take the leap of faith to enable progress but should not do so completely blind. This work has uncovered how some are starting to deliver and evidence impact from prevention. Confidence that the interventions and service models being tested will have a significant impact for outcomes as well as reducing pressure is imperative for leaders to begin preventive work at scale. However, the evidence will never be perfect and so bravery will be required. As long as the evidence is good enough, the leap of faith will be in the right direction.

Considerations for leaders balancing immediate pressures alongside the need for long-term change:



Tools for local impact

Discussion tool for system partners

The right leaders:

- Do you have the right people around the table to understand where the most impactful opportunities are, and to deliver the change required? Primary care, social care, public health, acute and mental health providers etc.
- Have you convened the right 'coalition of the willing' – a small, senior group who can build trust and push forward targeted delivery in an agile way?
- Who is owning the prevention agenda and responsible for driving it? Is it seen as owned too much by one organisation or team? Is there a role for the ICB or a provider collaborative to ensure the system view?
- Being clear that it is a short- and long-term priority, do the right leaders have the required capacity to ensure success? Does this include operational leaders who will help drive, and benefit from, changes in demand?

Alignment on aims:

- Does prevention come up in the conversation around your system's most urgent challenges? If not, why not? Are current preventative efforts relevant to those urgent challenges? If not, why not?
- Is prevention happening in a series of 'passion projects'? Do you have clarity on which ones are delivering the most value and should be bolstered and expanded? Do you have a set of aims for prevention that would help steer and prioritise the projects with the greatest impact?

Systems taking incremental action

Birmingham

Birmingham and Solihull Integrated Care System (ICS) has developed its model for integrated neighbourhood teams (INTs) with a vision for people to live longer, healthier, happier and more independent lives – and prevention is core to this vision. The ICS has launched a pilot of the approach in two PCNs.

Multi-disciplinary teams (MDTs) now deliver the model to support people to stay well and independent in their communities. The team first identified individuals with a range of complex health and care needs who were frequently accessing a wide range of services, to ensure they could support them at the right time with the right intervention, improving outcomes for this group while simultaneously avoiding unnecessary hospital attendance and admissions and development of greater care needs.

Individual organisations had looked at groups with the highest service use before. However, in a first for the system, patient-level data was linked across primary care, acute providers, community health, mental health and social care. Linking the data in this way identified a different cohort of people to target when system-wide demand is considered, since within one organisation, these individuals can be transient. The type and cost of each contact was fed into a cost-weighted prioritisation model.

Scaled up, there is an opportunity for INTs to support 20,000 frequent system service users, preventing at least 15 per cent of the 850,000 contacts they have with health and care services every year. Residents

in the INT pilot reported an overwhelmingly positive experience – with an average feedback score of 4.3 out of 5 for the support they received from the INT.

While the work is still at a relatively early stage, results from the two pilot PCNs in east and west Birmingham are already showing a significant stabilisation in service use for individuals who are receiving an INT intervention. Findings range from a reduction of 32 per cent in primary care appointments through to a 15 per cent reduction in ED attendances, as well as fewer inpatient spells and bed days, outpatient services and community contacts.

The work so far has only been possible because of a strong foundation of partnership working and support from system leaders in Birmingham and Solihull. The system has been strengthening partnerships and maturing their system working for many years. There are three examples that have positively contributed towards this being more successful:

1. **A firmly held belief (which translates into action), that to sustainably deliver services well into the future takes a joint effort across primary, secondary, social and voluntary sector services.**

2. **By designing services around delivering the best possible outcomes for residents, not around existing organisational sovereignty, structures or financial flows.**

3. **Providing opportunities for organisations to take a lead on different priorities and allow those lead providers to pull together the right multi-agency teams to deliver the goals.**

Building on this foundation of collaboration and journey towards integration, the INT programme is being delivered as part of the Community Care Collaborative.

This is a partnership between primary care, community health services, community mental health services, social care and the community and voluntary sector.

Led by Birmingham Community Healthcare Foundation Trust (BCHC), the collaborative is working to deliver better integrated health and care services in localities and neighbourhoods across Birmingham and Solihull. This will make it easier for people to access the care they need, when and where they need it and by the right person. It will also enable people to stay well for longer and more independently, in their own homes.

As part of the collaborative approach, the Birmingham and Solihull system is expanding the role of six existing health and care locality hubs across Birmingham and Solihull. These hub teams are working with local health and care partners to help manage urgent care demand, liaising with GPs, care homes and local acute hospitals in the localities. They are helping to co-ordinate a person's community care and delivering patient-facing services that offer same-day appointments for those who need them.

INTs are being aligned to each of these locality hubs with east and west Birmingham locality hubs already home to the respective INTs.

From the very beginning, there was clear agreement from all partners that the collaborative had the remit to design and deliver the INT programme for the benefit of the whole system and for residents.

Leadership alignment and involvement was a key part of the success of the INT programme to date. Over 200 members of staff across the system were involved in the design process, from across social care, primary care, acute provider, community provider, mental health provider, voluntary sector, and the ICB, One of the early workshops involved this group exploring the journey of a resident in detail, allowing the right 'coalition of the willing' to set the vision for delivering proactive prevention, grounded in the experience and outcome for the resident.

Even with the successful journey of collaboration and integration in Birmingham and Solihull to date, there are challenges to overcome as they push the boundaries of innovation and delivering new models of care at scale. For example, at the end of the design phase, the team was still discovering and understanding other preventive initiatives in other organisations and other parts of the system that may overlap in scope and benefit with the INTs. There is still a need to get the balance right between lots of pockets of local innovation driven by a broad movement towards prevention and a consolidated, focused effort on key projects that will deliver the most impact for people and for the system. Communication and joint working across transformation portfolios will continue to support this.

Another challenge has been reconciling financial benefits and investment required for INTs between partners. The movement of funding between organisations can often be a challenge, where the benefit is seen in one budget due to an increased investment from another organisation.

"The integration of community health and care services continues to be promoted to help improve patient centred care, reduce costs, reduce admissions to hospital and facilitate timely and effective discharge from hospital.

One of our key priorities in this initial pilot phase is to support the teams to work in this new inter-professional and inter-organisational collaboration approach as well as gain a deeper understanding of each other's roles. We are also engaging with local citizens to shape services that meet their needs in a holistic way rather than treating specific complaints in isolation. Our Community Care Collaborative approach to delivering more integrated care at Neighbourhood and Locality is part of the government's long-term plan to integrate community-based teams to meet the lifetime social, community, health and care needs and challenges of local citizens."

Chief Transformation Officer,
Birmingham Community Healthcare Foundation Trust

What next?

This is an evolving area and leaders will need to continue building knowledge and understanding as new ideas and examples of best practice emerge. In making progress, systems and places will need to respond to their local contexts and new government direction. Continuing to learn from each other and sharing best practice will be key to achieving the national ambition for systems to be at the heart of shifting towards a more preventative model of care.

The NHS Confederation will work closely with its members and partners in government to ensure the upcoming ten-year health plan delivers the government's shift to prevention.

The partners involved in this project are committed to supporting this effort.

To get involved in the NHS Confederation's work on prevention, please contact:

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To discuss how the targeted prevention approaches outlined in this guide would apply to your local context, please contact:

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About us

NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

For more information visit www.nhsconfed.org

University of Stirling

The University of Stirling is committed to providing education with a purpose and carrying out research which has a positive impact on communities across the globe – addressing real issues, providing solutions, and helping to shape society. More than 80 per cent of Stirling research is rated worldleading or internationally excellent (Research Excellence Framework 2021), and we have twice been recognised with a Queen's Anniversary Prize.

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University of Southampton

The University of Southampton is a large, comprehensive, interdisciplinary university. It is a founding member of the Russell Group within which it ranked fourth for research impact in 2021. Its world-class research has foundations in curiosity-driven research, disciplinary excellence and interdisciplinary collaboration. It ranks in the top 1 per cent of global universities.

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Newton

Newton is a strategic delivery partner for health and care systems, helping to deliver change which tackles the intense pressures of today, while innovating for a brighter future. We work alongside all system partners to tackle their most pressing challenges, such as improving productivity or urgent and emergency care. We also help to fundamentally reimagine and redesign how services are delivered, for example, by moving care closer to home or shifting towards proactive, targeted approaches to prevention.

For more information visit www.newtonimpact.com

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Registered charity no. 1090329