



PWYLLGOR DATBLYGU STRATEGOL A CHYFLENWI GWEITHREDOL STRATEGIC DEVELOPMENT AND OPERATIONAL DELIVERY COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Planning Objective 4L - Social model for Health and Wellbeing
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Professor Philip Kloer, Medical Director / Deputy CEO
SWYDDOG ADRODD: REPORTING OFFICER:	Anna Henchie, Principal Programme Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Strategic Development and Operational Delivery Committee (SDODC) requested a report to provide assurance on the status and progress of Planning Objective 4L. The main objective of the project is to provide the Health Board with an evidenced based understanding of what the social model for health and wellbeing means in practical terms to:

1. the Health Board itself
2. its work with partners - statutory as well as others
3. its work and role within the communities it serves.

The Committee is being asked to note the learning to date, and receive assurance on the next steps. As such the following reports have been attached for assurance:

1. *'Informing adoption of a social model of health and wellbeing: A systematic review of literature'* Commissioned from Aberystwyth University (Appendix 1)
2. *'Thought and systems leaders in Wales talk about a Social Model of Health and Well-being A thematic analysis of conversations with a purpose'* produced by Public Health colleagues, based on the outputs of a series of conversations held by Baroness Rennie Fritchie and Professor Philip Kloer (Appendix 2).

Cefndir / Background

In 2018 the Health Board committed to working towards becoming an organisation that delivered services aligned with the vision of a Social Model for Health and Wellbeing. At the time of publication 'A Healthier Mid and West Wales' called out the requirement to do further work on defining how that vision could be transformed to become an agreed, sustainable, and practical model, for use in all parts of the health and wellbeing System.

At present (and as evidenced in the reports) there is very little consistency in understanding - in terminology, process and measurement - of what and how we shift the way we, and others work. In addition, the urgent need to ensure this realignment of ways of working is financially

sustainable and provides true value is more important than ever. Our capital planning programme, our workforce planning goals and our partnership relationships requires us to produce a clear message that can be disseminated to all parts of the system for agreement and inclusion in decision making. This interdependency was highlighted in a piece of work undertaken through the Social Model for Health and Wellbeing Steering Group, whereby current planning objectives were identified and assessed in terms of their connection with the project's outcomes (Appendix 3).

A key theme from both the systematic review and the thematic analysis is that the work needs to reflect a 'bottom -up approach' and can and will only be achieved through real partnership working. This message was a main driver for creation of Planning Objective 4U (report included on agenda). In relation to the outputs from this PO (4L), this puts an emphasis on the expectation as well as the limitation of the information we have gathered - namely it cannot be seen as a 'top down' endpoint, but as a starting point for a co-produced product.

Asesiad / Assessment

The requirement to produce a report for consideration is pressing. A draft is due to be disseminated by the end of 2022. In order to reflect the planning cycle, there will be a requirement to present to Board in January 2023.

The production of an accessible version will require additional time, as its content will be predicated on the agreement of the Board, and the resource to enable the public facing document to meet accessible requirements.

In that spirit the next steps for the project are:

1. Production of a 'Discover report' based on the evidence to date, to enable the Board and our statutory partners to have a considered and consistent understanding of what the Social Model for Health and Wellbeing means to date, and to consider some suggested next steps as evidenced through the work.
2. Production of an accessible public-facing report to share with communities and stakeholders to underpin the work of Planning Objective 4U and any and all dependent programmes and projects.

Argymhelliad / Recommendation

The Strategic Development and Operational Delivery Committee is requested to receive assurance on the progress to date and that the project is meeting the target in terms of timescale and outcomes.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference:

Cyfeirnod Cylch Gorchwyl y Pwyllgor:

2.1 To receive an assurance on delivery against all relevant Planning Objectives falling in the main under Strategic Objectives 4 (The best health and wellbeing for our individuals, families and our communities) and 5 (Safe, sustainable, accessible and kind care), in accordance with the Board approved timescales, as set out in HDdUHB's Annual Plan.

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1. Staying Healthy 2. Safe Care 3. Effective Care 7. Staff and Resources
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Putting people at the heart of everything we do 3. Striving to deliver and develop excellent services 4. The best health and wellbeing for our individuals, families and communities 5. Safe sustainable, accessible and kind care
Amcanion Cynllunio Planning Objectives	4L Social Model for Health
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the body of the report.
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Datblygu Strategol a Chyflenwi Gweithredol: Parties / Committees consulted prior to Strategic Development and Operational Delivery Committee:	Social Model for Health and Wellbeing Steering Group SDODC 28 April 2022

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable

Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Informing adoption of a social model of health and wellbeing: A systematic review of literature

Dr Rachel Rahman, Dr Caitlin Reid, Professor Reyer Zwiggelaar & Professor Andrew Thomas

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1. Executive summary

Hywel Dda University Health Board (UHB) have identified a strategic ambition to work towards a social model of health and wellbeing. In doing so, the health board have recognised the need to ensure that the overarching approach and ambition is working towards a defined and recognised model underpinned by academic rigour.

To achieve this, a strand of work by Aberystwyth University has been commissioned to conduct a systematic review of the academic literature, designed to identify, and inform future strategic development. Aberystwyth University have a long tradition of research expertise in social and physical sciences, rural policy, and economics. More recently the university have developed an increased health focus through the development of their Centre for Excellence in Rural Health Research and increased taught provision of a variety of allied health and nursing programmes. The academic team for this programme of research comprise expertise from the Departments of Psychology, Computer Science and the School of Business and Management in recognition of the diverse body of research likely to comprise the literature in question. The team therefore contribute knowledge of a variety of methodological approaches and offer insights to organisational change and community development to guide informed recommendations.

The review seeks to address the research questions:

- How has previous literature conceptualised or defined 'a social model of health and wellbeing'?
- How has previous literature implemented, or evaluated the implementation of a social model of health and wellbeing?
- What global evidence of best practice exists around the implementation and evaluation of a social model of health and wellbeing?

Through a systematic process to search and review the literature, 222 eligible papers were identified for inclusion in the final review and data synthesis. Data was extracted to explore the country of origin of papers, the methodological approach taken, and the health and social care contexts within which they were set. The papers were then coded using NVivo software and later themed into commonly occurring topics in relation to the research questions.

In summary, papers were predominantly from America, the UK, Australia, Canada and wider Europe. The majority were narrative reviews with a smaller number of empirical research studies comprising qualitative, quantitative and mixed methods set in a wider range of health and social care settings. Five overarching themes were identified: 1) the lack of a clear definition of a social model of health and wellbeing; 2) the need to understand context; 3) the need for cultural change; 4) integration and collaboration towards a holistic and person centred approach; 5) measuring and evaluating a social model of health.

Key conclusions of the review centre on the need for organisations such as Hywel Dda UHB to decide how a social model will be defined within the organisation, how this dovetails with the current biomedical model, and whether the model will act as a descriptive framework or

will require further development to become a measurable operational model. The review highlights the importance of engagement and collaboration with end users and multidisciplinary health and social care staff to ensure that transition towards a new model is done with holistic needs of end users and organisational staff as a central value. Finally, the review highlights the challenges associated with the lack of a clear linear pathway to transitioning to a new model of care, emphasising the complex and unstandardised approaches to the implementation and evaluation of a social model that are likely to be necessary and in potential contrast to the current biomedical approach.

2. Introduction

2.1 Background to the review

Following years of sustained and increasing pressures, followed by unprecedented challenges of the Covid-19 pandemic, the UK NHS health system is facing significant challenges in terms of the sustainability of the current model of care (British Medical Association (BMA, 2022)). The incidents of chronic disease continue to increase alongside an ageing population with more complex needs, whilst recruitment and retention continue to be insufficient to meet the demand (BMA, 2022). The Covid-19 pandemic has only served to exacerbate pressures, resulting in delays in patient presentation (Nuffield Trust, 2022), poor public mental health (NHS confederation, 2022) and strain and burnout amongst the workforce (Gemine et al., 2021). However, preceding the pandemic there was already recognition of a need for a change to the current biomedical model of care to better prevent and treat the needs of the population (Iacobucci, 2018).

The biomedical model has been the dominant model in western healthcare systems and takes the perspective that ill-health stems from biological factors. Application of the model therefore focuses treatment on the management of symptoms and cure of disease from a biological perspective. However, despite its contribution in advancing many areas of biological and health research and understanding, the biomedical model has come under increasing scrutiny (Pedgorski, 2021). This is in part due to the growing recognition of the impact of wider social determinants on health, ill-health and wellbeing (Marmot, 2005; World Health Organisation (WHO), 2010). The continuing and arguably increasing inequalities amongst society provides a stark view of the role that social and socioeconomic deprivation play in predicting health outcomes. Life expectancy is over 18 years lower for individuals considered most deprived compared to those considered the least (The King's Fund, 2021). The social determinants at play are far reaching, including economic stability (access to quality education and employment), housing quality, access to transport and neighbourhood safety, access to quality nutrition, physical activity and health services, air and water quality, and social inclusion and non-discrimination to name but a few (WHO, 2010).

2.2 The semantics of models

The use of the term 'model' poses its own challenges and debates. Different disciplines attribute differing parameters to what constitutes a model and this in turn may influence the interpretations or expectations surrounding what a model should comprise or deliver (Stanford Encyclopaedia of Philosophy, 2006, 2020). According to numerous authors a model has no ontological category and as such anything from physical entities, theoretical concepts, descriptive frameworks or equations can feasibly be considered a model (Callender & Cohen, 2006; Contessa, 2010). At a basic level, a scientific model typically represents a physical or mathematical representation of a system, process or idea. The model identifies patterns within data to support prediction or explanation of association or causal outcomes. Whilst this scientific approach is frequently utilised in social science research, social sciences may also use the term model to demonstrate theoretical or descriptive associations or concepts. Whilst these are often developed and guided by

empirical data, models in this context often take the approach of *idealised models* aiming to simplify or conceptualise something complicated in reality with the view of communicating the principles in a more understandable way (Stanford Encyclopaedia of Philosophy, 2006, 2020; Clarke & Primo, 2012).

Systems models such as business process models or business reengineering models consist of a multi phased approach towards developing the 'model'. The initial phase is to develop and construct an accurate representation of the system or process in order to be able to characterise of 'model' the overall functionality of the system. This is normally termed a Current Reality Model and is used frequently in health care models and business modelling where the model represents or characterises the existing system and attempts to 'model' the inputs and outputs of that system. The second phase of a systems model considers the development of a future state model. In essence, this model is what the systems analysts would like to see as the new, improved or optimised model going forward. Generally, the future state model is an attempt to provide a solution towards improving the current system. Finally, this new or future state model should then have the capability to allow the model to be simulated. Simulation involves the inputs of a number of 'what if' scenarios that will enable the system analyst to determine and as accurately as possible, what the outputs of that model should be. It can be argued that 'systems modelling' represents a full cycle of modelling from developing a conceptual model of the current state to defining a future state model and then to use this model for simulating whether the model will provide the desired outputs from a given set of inputs.

2.3 Social models and frameworks in health and wellbeing

Numerous theoretical models and frameworks have been developed in order to capture the ethos of the wider contribution of social determinants of health. These include, but not exclusively, the biopsychosocial model (Engel, 1977), the social model of disability, social-ecological models of health (e.g., Dahlgren & Whitehead, 1991; McLeory et al.'s ecological model of public health, (1988), and the WHO's framework for action on social determinants of health (2010). These are briefly outlined below.

2.3.1 Biopsychosocial model

The biopsychosocial model was first proposed by Engel in 1977, challenging the biomedical model of health as inadequate to address the '*social responsibilities of medicine or psychiatry*' (Engel, 1977, pg. 129). In an attempt to better explain the subjective experience of an individual's illness the biopsychosocial model promotes the interaction between the biological, psychological and social-environmental factors that contribute to an individual's development of an illness. For example, highlighting the connection between the biochemical defect of diabetes, the psychology of when an individual may perceive or accept themselves as being ill and the social interaction between the physician and patient in modifying the behavioural response to the illness or treatment options. The model has been widely accepted as a conceptual framework in health and medicine; however, it has faced criticism about the lack of specificity regarding the interactional processes between the model's components (e.g., Farre & Rapley, 2017).

2.3.2 Social model of disability

Following reference to the social construction of disability outlined in a report by the Union of the Physically Impaired Against Segregation (UPIAS, 1976) the social model of disability has been developed by individuals with disability to challenge the exclusion of individuals from society, and to oppose the dominant medical model which approached the individual with the disability as a medical problem to be resolved (Inclusion London, 2022). The social model of disability moved this perception of disability away from the physical impairments of an individual to propose that disability is socially constructed and more broadly encompasses the physical and social environments that create a sense of disability for an individual. The model proposes disability less as a personal attribute instead highlighting the potential barriers that physical and social environments pose for an individual, and which contribute to the disability experienced. For example, an individual may experience a physical impairment, but it is only when that impairment is exacerbated by limitations of the physical environment, such as negative attitudes or inappropriate access to facilities that an individual will experience 'disability'. The model therefore challenges society to recognise how its structures and environments could be adapted to be more inclusive of individuals with impairments, thus removing this sense of disability and without placing the individual as a central cause of the 'problem'.

2.3.3 Social-ecological models of health

Models such as Dahlgren-Whitehead's model of health determinants and McLeroy et al.'s Ecological model of public health (Dahlgren & Whitehead, 1991; McLeroy et al., 1988) provides an illustrative representation of the societal impacts on an individual's health and wellbeing. They emphasise the individual as part of wider societal ecology of varying levels which interact and have reciprocal influential relationships. Dahlgren and Whitehead (1991) for example, place the individual at the centre of their model (e.g., attitudes, gender), with the role of lifestyle factors, social and community networks, living and working conditions, and general socioeconomic, cultural and environmental being illustrated as influential factors. McLeroy et al. (1988) also place the individual at the centre of their model with similar layers of interpersonal processes (e.g., close social networks and support systems), institutional factors (e.g., organisational processes and practices), community factors (e.g., relationships among organisations) and public policy as surrounding influences.

2.3.4 World Health Organisations' (2010) conceptual framework for action social determinants framework

The World Health Organisations' (2010) framework, demonstrates how social determinants of health influence health inequalities. The framework categorises social determinants into 'structural determinants' and 'intermediary determinants'. Structural determinants include the interplay between the socio economic and political context and an individual's socioeconomic position, gender and ethnicity. Whilst intermediary determinants refer to material circumstances (e.g., housing, and environment), behavioural factors (such as lifestyle, nutrition and access to social groups) and psychological factors (such as psychosocial stressors and social support). These concepts are used to develop a conceptual framework for analysis and action with the intention of reducing health inequalities.

2.4 Political context of social model of health and wellbeing

Public policy is also bringing awareness to the need for better recognition of social determinants of health. Following an independent review into health inequalities in England, Marmot (2010) highlighted the important role that social determinants can play in creating health inequalities. The review highlighted how previous approaches to target individual behaviours such as smoking, or diet are unlikely to be effective without wider societal change. The importance of early year's education and intervention, improving quality of housing, strengthening community resilience, and investing in the prevention of health were key focuses of the review. Although not framed directly within a Social Model for health, the review's recommendations align with the principles of a social model, highlighting a need for individuals to have autonomy over their lives, the need for sustainable and healthy communities, and strengthening the role and impact of ill-health prevention. The review specifically tasks the NHS with engaging people and communities in co-production of multi-disciplinary services designed to meet their needs, engaging with multisector agencies to improve service integration, and moving the balance of spend from acute care to primary and preventative care.

Policies such as The First 1000 Days: Foundations for life (2011) and the Welsh Government's Framework on embedding a whole-school approach to emotional and mental wellbeing (Welsh Government, 2021) have focused strategies on improving the social determinants of health and wellbeing for young children, recognising the importance of preventive health and social initiatives for this societal group. The framework for a whole school approach (2021) also recognises that schools alone are not responsible for children's health and wellbeing calling for wider sector collaboration to meet the complex needs of children and young people. Similarly, policies such as Welsh Government's Connected Communities: Loneliness strategy (2020a) have recognised the broad social determinants that contribute to how connected people feel, including digital literacy, transport infrastructures and use of community spaces, and emphasise the wide ranging sector collaboration that is needed to address such wide ranging determinants.

A number of policies have recognised that in order to meet the needs of communities and regions, health and social care partners need to consider where and when care is delivered, and by whom. The launch of the Six Goals for Urgent and Emergency Care policy handbook (2021-2026) sets out a need for integrated working across sectors to enable the coordination of rapid and appropriate responses for care, and discharge of individuals from emergency care back into their communities. Similarly, the call for improved integrated working is a central component of A Healthier Wales (Welsh Government, 2018), and the Strategic Programme for Primary Care (NHS Wales Primary Care One, 2018). The A Healthier Wales plan for health and social care calls for seamless working between health and social care to the extent that the organisations providing the care be indistinguishable to the end user. The importance of individuals being cared for through services in their local communities also features heavily along with the need to better measure and understand the values and needs that are important to individuals and communities.

The important role of cohesive and connected communities is a feature of policy documents, such as the Welsh Government's Connected Communities: Loneliness strategy (2020a). The strategy outlines 'Our Vision, The Wales we Want', which sets out a vision for a compassionate society, seeing care as a societal civic mission with the aim of developing a more connected and inclusive nation. The strategy emphasises the commitment of stakeholders ranging from the individual, to the deliverers of public and voluntary services, and government and highlights the need to create opportunity for shared working and collaboration. Importantly and in line with other policy

documents, the strategy emphasises the need for partnership working, placing individuals at the centre of decision making to help create a society without shame and stigma.

The key principles within the Well-being of Future Generations Act (2015) and the Social Services and Well-being (Wales) Act (2014) focus on improving well-being, and also place people at the centre of decision making about their lives. Specifically, the Well-being of Future Generations Act outlines five ways of working towards sustainable development, which include the need to balance short term and longer term needs, to involve wider society in developing and achieving well-being goals and working more collaboratively in communities and across sectors. The Health and Social Care Act (2020b) has also emphasised the need for improved voice of the public and has legislated for a citizen's voice body to represent the voice of the public in health and social decisions. The need to be open and honest with end users about their care is also emphasised. Similarly, the principles of Simply Prudent Healthcare (Bevan Commission, 2013) promotes the ambition to meet the needs of individuals through improved understanding of value and emphasises a need for a rebalance in the relationship between health professionals and patients towards improved co-production.

A number of policy documents emphasise the need for public bodies to better reduce inequality, improve equality and improve social relationships between individuals from differing characteristics. For example, The Equality Act (2010) sets out the Public Sector Equality Duty and places a duty on public bodies to eliminate discrimination, harassment, and victimisation and to advance equality of opportunity and relationships in society. The Social Model of Disability (see section 2.3.2) is well-established in the United Nations Convention on the Rights of Persons with Disabilities. The National Assembly adopted the model in 2002, making Wales one of the first countries in the world to do so. The Action on Disability framework and action plan) Welsh Government, 2019) aims to embed the model visibly across all areas of work, including Welsh public services and agencies. As noted above, the Social Model of Disability makes an important distinction between 'impairment' and 'disability' and recognises the social and organisational barriers that exists and which can prevent people's inclusion and participation in all walks of life.

It appears therefore that, whilst policy, with the exception of the social model of disability, may not specifically legislate or vocalise implementation of a specific social model, the principles and ambitions outlined align with the principles of social ecological and biopsychosocial models. The advocating for recognition of social determinants of health and wellbeing, embedding individuals and community at the centre of their health decisions and empowering communities to be resilient and inclusive with a view to reducing health inequality align with a number of the social models discussed. However, whilst ambitions, goals and targets are welcomed, there is less evident guidance about how complex organisations such as then NHS and its allied partners move strategically towards a more social model of health and wellbeing.

2.5 Aims and research questions

It appears therefore, that whilst providing commendable recommendations for a move towards a social model of health, less attention has been given to the practicalities of transitioning and delivering a social model in health and social care. As a result, this review seeks to explore the academic literature in order to better understand how a social model of health and wellbeing is conceptualised, implemented, and evaluated in the health and social care sphere.

The review seeks to address the research questions:

- How has previous literature conceptualised or defined 'a social model of health and wellbeing'?
- How has previous literature implemented, or evaluated the implementation of a social model of health and wellbeing?
- What global evidence of best practice exists around the implementation and evaluation of a social model of health and wellbeing?

3. Methods

A systematic search of the literature was carried out between January 6th, 2022 and January 20th, 2022. Using the search terms in Table 1 below, a systematic search was carried out using online databases PsycINFO, ASSIA, IBSS, Medline, Web of Science, CINAHL, and SCOPUS. English language and peer-reviewed journals were selected as limiters. No cut-off date was selected for the searches to provide a comprehensive picture of the current literature on the use of the social model of health and wellbeing.

3.1 Search criteria

Through discussion with Hywel Dda UHB and the preliminary reading of the literature around the social model of health and wellbeing, the search terms in Table 1 below were compiled to provide a comprehensive search strategy to capture papers on and related to the social model of health and wellbeing. The search terms aimed to capture the broad definitions of a social model of health and interventions based on this and related models. The search terms were also informed by the World Health Organisation's definition of health and wellbeing and Card's (2017) definition of health which states that good health and poor health occur as a continuum rather than a dichotomy and is based on physical and psychological wellbeing.

Table 1 Search terms

<p>"social model* of care" OR "social model* of health" OR "social model* of healthcare" OR "social model* of health care" OR "social model* of health and wellbeing" OR "social model* of health and well-being" OR "social model* of wellbeing" OR "social model* of well-being" OR</p> <p>"biopsychosocial model* of care" OR "biopsychosocial model* of health" OR "biopsychosocial model* of healthcare" OR "biopsychosocial model* of health care" OR "biopsychosocial model* of health and wellbeing" OR "biopsychosocial model* of health and well-being" OR "biopsychosocial model* of wellbeing" OR "biopsychosocial model* of well-being" OR</p> <p>"community model* of care" OR "community model* of health" OR "community model* of healthcare" OR "community model* of health care" OR "community model* of health and wellbeing" OR "community model* of health and well-being" OR "community model* of wellbeing" OR "community model* of well-being"</p>
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3.2 Selection and extraction criteria

The search results from each database search can be found in Table 2 below. After an initial sift through the database search results, 535 papers were identified.

Table 2 Search results

Database	Hits	Initial sift
PsycINFO	103	63
ASSIA	270	74
IBSS	31	7
Medline	225	62
Web of Science	206	97
CINHAL	170	70
SCOPUS	650	162
Total	1655	535

Given the potentially diverse range of research that could be considered as encompassing the ethos of a social model of health and wellbeing the search strategy adopted the approach that the review would specifically consider research that had explicitly self-identified as including, framing, or adopting a 'social model of health and wellbeing'.

Each paper was checked for relevance and screened. Papers that explicitly used the search terms outlined in Table 1 within the main body of the paper were included and all others excluded. Figure 1 shows the PRISMA flow chart of the systematic search process.

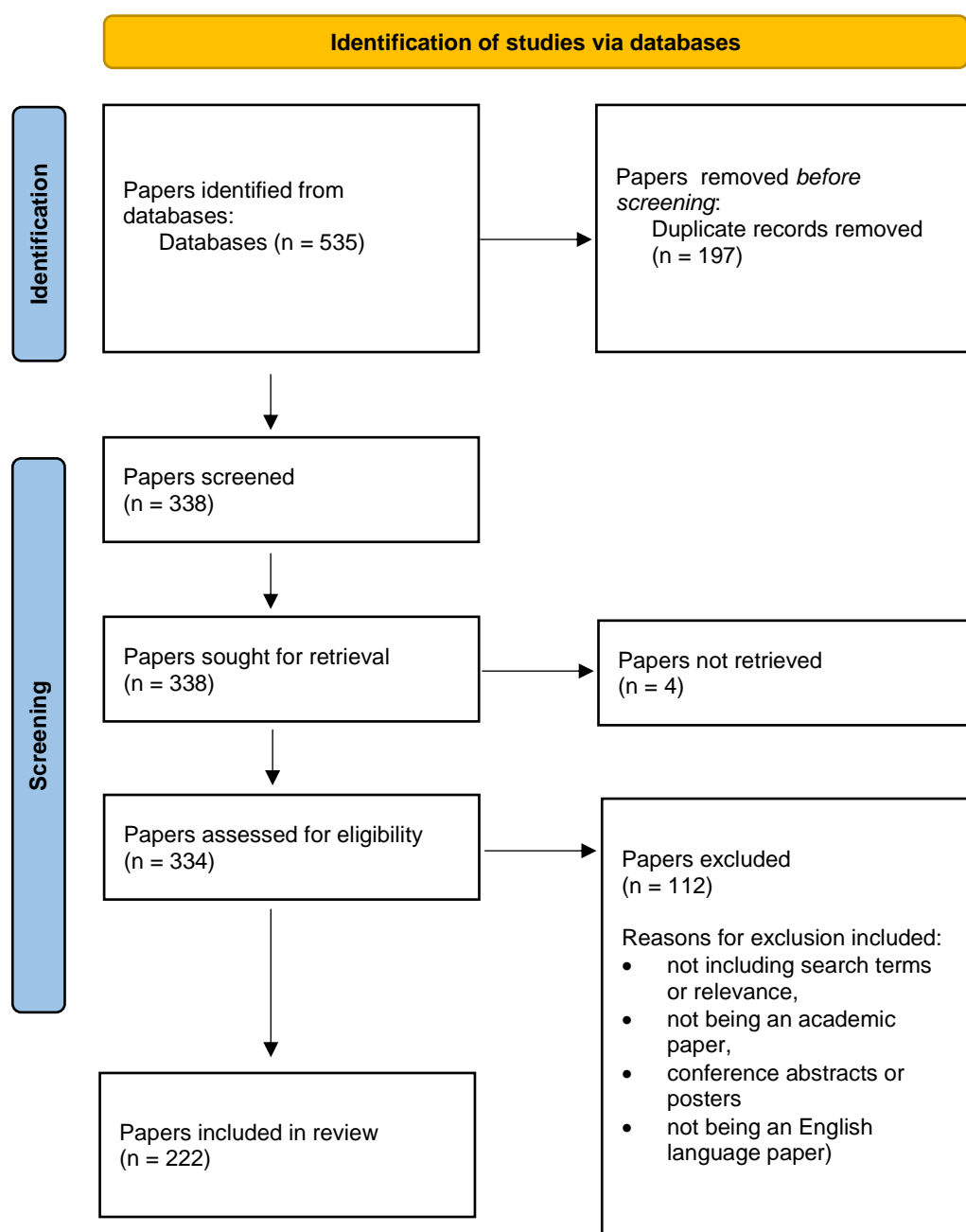


Figure 1 PRISMA 2020 flow chart of the systematic search process adapted from Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71

3.3 Data Extraction

A systematic search of the literature identified 222 eligible papers for inclusion in the final review. A data extraction table was used to extract relevant information (as outlined in Table 3).

Table 3 Data extraction table example

Aim of the paper	Focus and location of the research	Method	Service or specialty	Intervention or non-intervention	Type of paper	Model definition in practice	Key findings

3.4 Data Analysis

Quantitative studies were explored with a view to conducting a quantitative meta-analysis; however, given the disparate nature of the outcome measures, and research designs this was deemed unfeasible. All included papers were therefore coded using NVivo software with the identified research questions in mind, and analysed using Thematic Analysis (Braun & Clarke, 2006) to explore common themes of relevance.

4. Results

4.1 Summary of included research

Figure 3 shows the breakdown of papers according to country of the research. The majority of included papers were from America (34%), with the UK (28%), Australia (16%), Canada (6%) and wider Europe (10%) also contributing to the field. The 'other' category (6%) was made up of single papers from countries such as Nigeria, South Korea, UEA, Zimbabwe, Singapore, South Africa, Puerto Rico, Kenya, India, Hong Kong, China, and Brazil.

Most of the papers are reviews, with the majority being narrative reviews (n=90) and some systematic reviews (n=9). A smaller number of empirical research studies were included comprising qualitative (n=47), quantitative (n=39) and mixed methods (n=14) research. The remaining papers were comprised of small samples of, for example, clinical commentaries, cost effectiveness analysis, discussion papers, and impact assessment development papers.

Medical specialty or services of the papers include cardiology, mental health services, paediatric oncology, primary healthcare, urology, community services, public health interventions, disability prevention and rehabilitation, urban planning, long-term care, diabetes, gerontology, pain management, midwifery, health equity, nursing, paediatrics, orthopaedics, general practice, physiotherapy, arts, adult education on healthy behaviours, home-care, COVID 19, pandemics and health outbreaks, health psychology, neuroscience, gastroenterology, psychotherapy, and perinatal care.

The majority of papers referenced the guiding principles of a social model of health or care (n=73) or the biopsychosocial model of health (n=122). However, none of the papers included in the data extraction included a complete definition or implemented a functional model of a social model of health and wellbeing. Instead, papers tended to focus on a how a social model of health and wellbeing could be applied to or implemented within specific contexts of health and care, for example, in health promotion, resident-centred care,

mental health, integrative working, patient-centred care, environment, and patient-clinician relationships.

4.2 Meta-synthesis findings

The qualitative meta-analysis identified five overarching themes in relation to the research questions, some with underlying sub-themes. These are outlined in Figure 2.

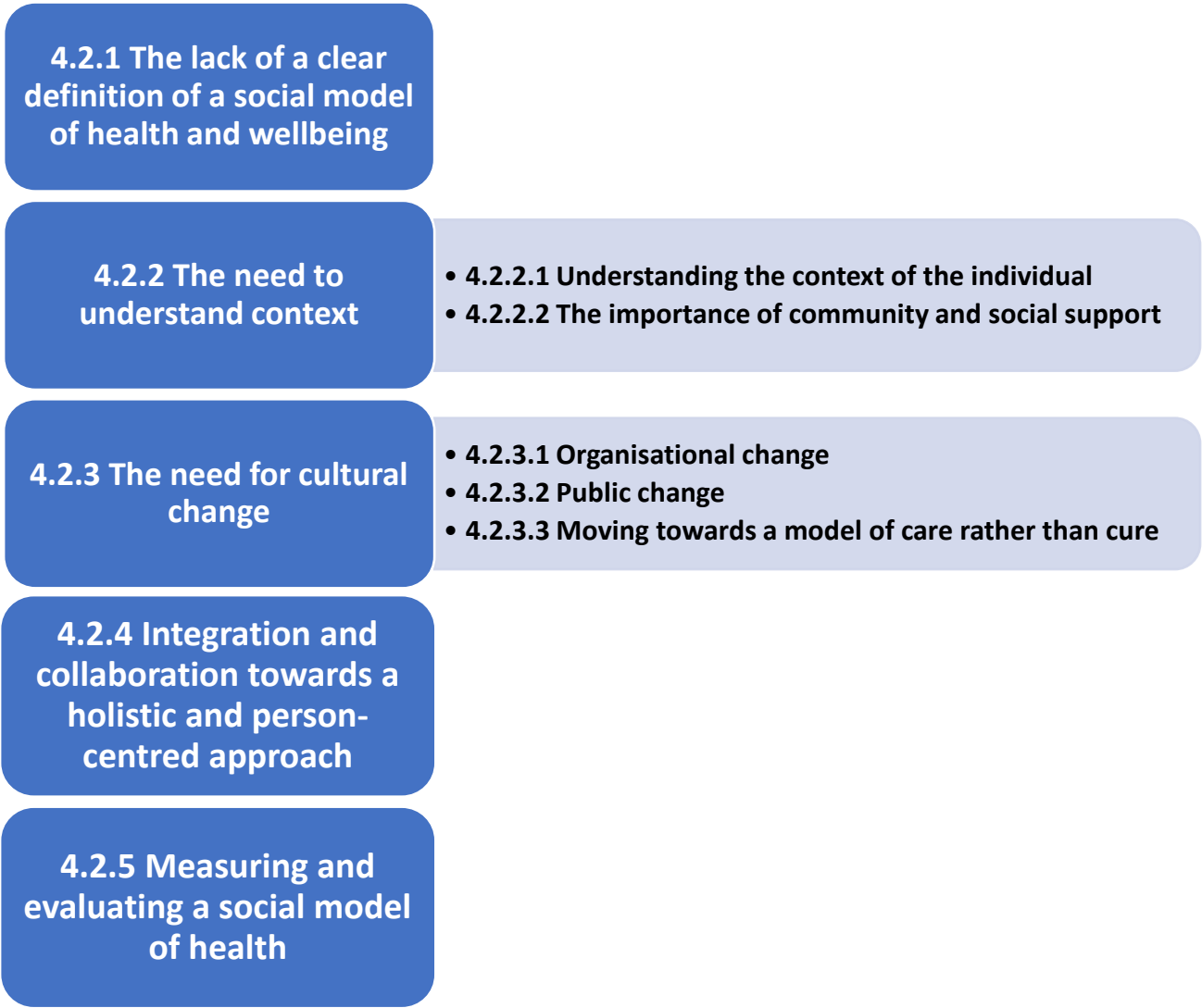


Figure 2: Overview of meta-synthesis themes and subthemes

An overview and discussion of themes follow with supporting extracts. To note that where extracts have been used, reference is given to the paper from which the extract was taken at the end of the extract; however, references to any citations incorporated within the extract have been left as per paper formatting and not referenced in addition.

4.2.1 The lack of a clear definition of a social model of health and wellbeing

There was common recognition amongst the papers reviewed that a key aim of applying a social model for health and wellbeing was to better address the social determinants of health. Papers identified and reviewed relevant frameworks and models, which they later used to conceptualise or frame their approach when attempting to apply a social model for health and wellbeing. Amongst the most commonly referenced was the World Health Organisation's framework (Solar & Irwin, 2010) and Brady provided an explanation for the importance of its consideration in regards to addressing health inequality.

The WHO framework highlights the importance of policy-based interventions as part of a multi-level population-based prevention strategy. Insufficient attention to policies that impact the conditions in which people live and their opportunities to be healthy could inadvertently generate or widen health inequities over time and across generations. This can occur even when the health of all communities is improving. (Brady et al., 2018, pg. 2954)

Namely, a society stratifies its population according to income, education, occupation, gender, race, ethnicity, and other factors. From these social stratifications, social hierarchies result. Position within the social hierarchy in turn shapes specific social determinants of health. Thus, the WHO framework separates structural determinants of health inequities, the distal factors rooted in a society's political, economic, and social structures (eg, macroeconomic and public policies), from social determinants of health, a more commonly understood term that refers to proximal factors rooted in one's social position (eg, living and working conditions). The WHO framework asserts that a society produces health and disease among its citizens. The framework also asserts that policymakers bear responsibility for creating and maintaining health equity among populations, as well as redressing the structural factors that produce under-resourced communities and health inequities. (Brady et al., 2018, pg. 2956)

Engel's bio-psychosocial model was referred to as a seminal framework by many of the papers, but was also critically evaluated for its lack of ability to fully address social needs. As a result, a number of papers reported using the biopsychosocial model to frame their 'social model' approach but with the addition of other supporting models to better emphasise the social elements (e.g., Robles, Kuo & Tobin, 2021). Supporting models referred to included the Social ecological model (McLeroy et al., 1988), Glass and McAtee's Society-Behavior-Biology Nexus (Glass & McAtee, 2006), and the Environmental Affordances Model (Mezuk, 2013),

In what follows, we begin by describing how Engel's model falls short in addressing the needs of the person in the context of their lived experience of dementia. Then we

move on to illustrate how the social ecological model allows us to better understand the person with dementia within their family relationships and social networks, which helps to capture a more comprehensive picture of the person's individual and relational needs regarding dementia care. (Pedgorski, 2021, pg. 3)

Papers made reference to specific models which they classed as 'Social Models' including Wilkinson and Marmot's (2002) Model of Social Determinants of Health which framed specific determinants of interest (namely social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport). Similarly, Dahlgren and Whitehead's 'social model' (2010) which illustrates social determinants via a rainbow of influential factors from the individual to the wider cultural and socioeconomic influences.

Other papers conceptualised the ethos of what constituted a social model. This included being patient or client centred (e.g., Cooney & McClintock, 2006), maintaining individual autonomy and services being organised around quality of life rather than symptom management (e.g., Wilson & Malmberg, 1993)

Long-term care for older adults is shifting away from the traditional, medical model to new, more social models, including such examples as client-centered (Keating et al., 1997) resident-centered (Bond et al., 1996) or person-centered care (Rantz & Flesner, 2004), and the "pioneer movement" (Gold, 2001). (Cooney & McClintock, 2006, pg 71).

Healthcare problems are seen as an interaction among personal, physical, environmental, and societal factors. The healthcare goal in the social model is to create positive change, even when a cure is not possible. (Elman, 2007, pg. 302)

However, of the papers reviewed, none formally developed a working *definition* of a social model of health and well-being, instead applying guiding principles and philosophies associated with a social model to their discussions or interventions. For example, Rogers (2008) outlines their work to develop 'social model thinking' in their drug prevention programme arguing that this provides a guiding framework that is key to articulating its benefits.

Adoption of social health thinking also gives a multidisciplinary health care workforce an effective conceptual framework to work within. A clearly articulated model is crucial in allowing us to explain our work, and why it is effective, to others. This is especially important given the increasing need to collaborate across service systems. (Rogers, 2008, pg. 57)

Blout & Bayona (1994) called for the translation of social models, in this case the biopsychosocial model, into a set of organisational practices that made the functional elements of integrating a model into routine service delivery more transparent.

In the field of health care, these elements are: a model (biomedical), an organization (a network of primary care physicians as gatekeepers to more specialized physicians, mental health providers, and the "high-tech" hospital), and a practice (the basic

routines of interaction between health care providers and their patients). The replacement of the biomedical model by a more integrated model, such as the biopsychosocial model, will be successful only when it is translated into an organization and a set of practices that will support and validate it. We believe the biopsychosocial model must be joined with integrated biomedical and psychosocial services, integrated both in the network of providers and at the level of the patterns of interaction in the consulting room, before a true alternative to the present system can evolve. (Blout & Bayona, 1994, pg. 173)

Health Impact Assessments (HIAs) were proposed as one method of integrating better consideration of social determinants into service organisation and formalise the adoption of a social model or social thinking. HIAs required assessments of how any policy or practice change would impact health outcomes such that decisions were considered alongside the wider social implications.

The aim of health impact assessment (HIA) is to assist policymakers and other decision-makers to formulate “healthier” decisions and thus maximize population health gain and, where possible, reduce health inequalities. In 1999, the WHO Regional Office for Europe published the Gothenburg Consensus Paper (GCP), establishing a general framework for HIA based upon a social model of health and the values of democracy, equity and sustainability (1). HIA can be undertaken at the project, programme, and national or even supra-national policy level. (Wright, Parry & Scully, 2005, pg. 471)

4.2.2 The need to understand context

4.2.2.1 Understanding the context of the individual

Numerous papers discussed that in order to move towards a social model of health and wellbeing it was imperative to understand the context of the individual, such as the complex interaction of social determinants of health and their influence on health and wellbeing outcomes.

The literature identified the complex multidisciplinary nature of a variety of conditions or situations involving medical care. These included, but not exclusively, chronic pain (e.g., Berger, 2007), diabetes (e.g., Baun & Freeman, 2021), cancer (e.g., Berrios-Rivera et al., 2008), childbirth and motherhood (e.g., Brand et al., 2014), mental health (e.g., Ning, 2010), older adult care (e.g., Mark, 2006) and dementia (e.g., Kùmpers et al., 2005).

If lifestyle and behavioral risk factors were not influenced by societal factors, then they should be randomly distributed throughout the population, without regard to social class. They are not. National surveys conducted in the US and Europe have demonstrated striking gradients in smoking, diet, and physical activity by social class (Marmot et al., 1991; Uitenbroek et al., 1996; Lynch et al., 1997; Lantz et al., 1998). (Chin, Monroe, & Fiscella, 2000, pg. 318)

Many acknowledged that the frequently used biomedical models failed to fully capture the holistic nature and need of patients as a data extract from a review by McCullough shows.

A social perspective on health Nurses referred to providing care from a social perspective as 'holistic care' (NP3) 'complete care' (NP3) and looking at 'the whole picture' (NP1). NP3 explained, "... we're looking at the psychosocial needs of the patient, [as well as] the physical needs of the patient." For NP2, nursing care included: ... saying: "What about their social stuff?" People didn't automatically think of that. Have they got money? Have they got transport? Where are they living?... have they got someone to live with? Is their Centrelink [welfare payments] sorted out? (McCullough, 2021, pg. 538)

Papers outlined some of the key social determinants of health affecting the specific population of interest in their own context, highlighting the interactions between wider socioeconomic and cultural factors and health and wellbeing outcomes.

The outbreak (referring to Covid-19) will expose so many families to extreme levels of poverty and malnutrition. There is need to learn from this pandemic and strengthen food security programmes in communities and nations. (Chigangaidze, 2021, pg. 104)

Homeless individuals are more prone to many factors including malnutrition to perhaps lowered immunity to catch infectious agents including COVID-19 due to waste disposal, weather extremes, contamination, increased prevalence of infections, and substance abuse with overall poorer quality of physical and mental health (Banerjee & Bhattacharya, 2020, p. 2). (Chigangaidze, 2021, pg. 108)

Socioeconomic and other environmental challenges complicate or compound pain and limit access to pain management. Conditions of poverty, isolation from family, friends, or health care professionals, inadequate accommodation, physically demanding labour, and limited access to support and work increase the likelihood of inadequately managed pain. (Craig et al., 2020, pg. 261)

Access to, and, availability of, public transport, irrespective of car ownership, had salience for all age groups. The availability of public transport was linked to health for it was seen as facilitating social contact. For instance, the Metrolink, an innovative and expanding light railway system, enabled people to visit relatives and friends who lived in different parts of Greater Manchester. Changes in the rail network had allowed shopping trips to be made to the open-air produce markets which are a feature of urban areas in Greater Manchester. (Fairhurst, 2005, pg. 34)

As a result of this recognition, papers advocated and highlighted the importance of end users, patients or clients being included in the development of social models, such that their social needs and determinants were correctly accounted for.

In Designed to Involve it is argued that participation and involvement through the use of community development methods can lead to better communication, and assist in the development of better targeted and more appropriate services, as well as helping

communities to tackle health inequalities from the bottom up (Scottish Consumer Council, 1999). Fisher et al. (1999) argue also that community development can provide a voice for marginalised groups, for example by empowering lay people to participate productively as local representatives on the management bodies of primary care groups. (Black, McKie & Allen, 2003, pg. 69)

The lack of understanding or consideration of wider social determinants of health and their implications for health conditions was believed to result in the increased risk of bias or stigma towards certain groups who did not fit the traditional explanations of a biomedical model. This was acknowledged to have implications for treatment options, patient perceptions and access to health care services. A move towards a social model was proposed to require a change by services to be more inclusive of wider society.

There is evidence of devaluing and discrediting practices directed at people with chronic pain who are socially marginalized... Charges by patients of racist, classist, heterosexist, cissexist, transphobic, sexist, and ableist biases by health care providers and others are not uncommon...uncertainty about sources of pain are likely when pain is not medically understood or diagnosable, leading to discounting reports of pain,28,50,76 and health care providers report they are less inclined to help, feel less sympathy, dislike patients, and suspect deception under these circumstances. {Craig et al., 2020, pg. 262}

In contrast, and in line with the philosophy of the ‘social model of disabilities’ description of a social model, some countries, organisations or interventions had attempted to overcome these stigmas and biases through improved community engagement and a change of discourse around ‘blame’ and ‘responsibility’ in at risk communities.

An examination of the routine practices and philosophy of ACCHS (Aboriginal Community Controlled Health Services) reveals that they locate the sources of Indigenous ill health in the wider power relations, processes, and structures of Australian society. The dismal status of Indigenous health is viewed as a social product; they argue that it is important to note that the poor health status of Indigenous people emerges from the social and material conditions of their existence and not from their “race,” biology, or culture. ... To blame Indigenous cultural traits, lifestyles, and personal habits for their high mortality and morbidity rates overlooks the vast pressures and incursions imposed upon Indigenous communities. The data and figures referred to previously in this article cannot be attributed to Indigenous laziness, lack of motivation, or personal irresponsibility, as some have suggested. Factors such as racism, discrimination, lack of employment and educational opportunities, criminal persecutions, and impoverished housing and living conditions, to name a few, are derivative of a legacy of dispossession and colonialism. (Khoury, 2015, pg. 477)

Interventions that had successfully addressed individual needs and successful embedded services in communities reported improved outcomes for end users and staff in the form of empowerment, agency, education and belonging.

Nonetheless, they described the Leg Club as a hospitable environment for staff and clients. Common emerged themes derived from staff members included 'education', 'camaraderie' and 'empowerment', signifying a collaborative learning environment allowing both patients and staff to grow. (Abu Ghazaleh, Artom & Sturt, 2019, pg. 6)

A sense of belonging and safe place to share and reflect on their own stories and learn from each other provided these young mothers with an opportunity to move beyond the socially scripted deficit narratives typically assigned to teenage mothers. Over months of field work, many of the young women identified new attributes and capabilities by opening up their life stories to fresh hopes, dreams and possibilities and beginning the journey of actively rescripting their story. (Brand et al., 2014, pg. 501)

Nurses working in clients' own homes perceived that in their work, in sharp contrast to the hospital setting, the locus of control is with the client, rather than the nurse: '[in hospital] a lot of them feel threatened that they have to agree to whatever treatment you suggest, in the community they're part of the actual process of deciding what course is best'. (Oberski et al., 1999, pg. 458)

4.2.2.2 The importance of community and social support

The role of the community was seen to be key in how social models were implemented. Elman discussed the varying definitions of 'community' with consideration of how these differing interpretations had relevance to service implementation.

The dictionary definition of community includes three separate notions...One definition is that a community is a unified body of individuals with common interests, a common location, common characteristics, a common policy, and/or a common history....A second dictionary definition of community includes the notion of society at large or the "bigger community." ... The third dictionary definition of community includes the notion of joint ownership or participation, common likeness, fellowship, or social state. (Elman, 2007, pg. 303)

In line with the varying definitions, papers discussed community in different ways. Some reflected on embedding services within communities and the importance of community voice in developing services to meet their needs, thus improving ownership, access and engagement. Others discussed how building a sense of community through a social model had positive implications for health and well-being through fostering improved perceptions of social support and empowerment. The importance or success of locating traditionally clinical services within communities was considered to be important for a variety of reasons.

it is argued that participation and involvement through the use of community development methods can lead to better communication, and assist in the development of better targeted and more appropriate services, as well as helping

communities to tackle health inequalities from the bottom up (Scottish Consumer Council, 1999). (Black, McKie and Allen, 2003, pg. 69)

Examples included Brune's overview of developing initiatives to instil community cohesion amongst adults in long term care. Discussion included 'eldershires' to empower older adults to have more ownership and autonomy in terms of their care within an intergenerational community. Similarly, discussion of 'Eden facilities' centred on intergenerational opportunities and engagement with the natural environment and animals to combat loneliness and boredom.

The Eldershire Community ...is a planned intergenerational community designed to promote an active and ongoing exchange among the generations. An Eldershire Community contributes to bettering the quality of life by strengthening and improving the means by which (a) the community protects, sustains, and nurtures its elders, and (b) the elders contribute to the well-being and foresight of the community ("Basic Tenets of the Eldershire Community Concept," 2008). An Eldershire is a community where residents work together to effect the realization of well-being, the elements of Culture Change in Long-Term Care Services which include identity, autonomy, security, connectedness, meaning, joy, and space ("Basic Tenets of the Eldershire Community Concept," 2008). Eldershire residents are empowered to collaborate in the design and ongoing development and management of their communities. (Brune, 2011, pg. 518)

Children, from pre-schoolers to high-schoolers, are often a key feature in Eden facilities, allowing residents to interact and share life experiences and knowledge including playing games, sharing stories, helping with homework, and working together in the garden "A home that opens its doors to pets, children, and the community has little room for boredom . . . Life in an Eden home is spontaneous" ("An Eden Alternative: Life Worth Living," 2003). (Brune, 2011, pg.512)

Building communities of individuals with common needs, either physically or through community groups, was considered to be an important way to foster a sense of social support, empowerment and connectedness and remove bias and stigma from certain groups. However, whilst community engagement was recognised as being central to developing a successful service or initiative, this involvement was not without it's challenges. The make-up of groups representing communities was critical for fostering a good working relationship and achieving the goals of the community. Authors and participants warned of the risk of vocal individuals with the communication skills and confidence to engage, pushing a personal agenda rather than representing the views of their wider communities.

The effectiveness of some approaches, including focussing community development on local organisations and non-health settings, was questioned. Some professionals working with community managed organisations believed that most decisions were made by vocal people with their own personal agenda ('bossy professionals' and

‘vocal locals’)...who did not really typify the community they were supposed to represent. (Hogg & Hanley, 2008, pg. 23)

There was also recognition that the transition to more community based care could be challenging for health and social care providers who were having to work outside of their traditional models of care and accept a certain level of risk. Many respondents viewed this opportunity to take increased risk positively. However, additional challenges were also faced when community preferences did not align with policy agendas. This required certain community level roles acting up as community ‘advocates’ or ‘catalysts’ brokering between communities and policy makers.

A key theme emerging in this study was the importance of relationship to facilitate the identification of community agendas and develop appropriate responses. The respondents of this study emphasised the importance of equity and partnership as key in their relationships with communities. They perceived this, together with working to the communities’ agendas, as power sharing with the community ...However, it was those ways of working that were also described as ‘risky’ and challenging as they attempted to work outside of ‘traditional’ professional boundaries. (Forester, 2004, pg. 143)

4.2.3 The need for cultural change

4.2.3.1 Organisational change

A number of papers referred to the need for a ‘culture change’ or ‘cultural shift’ within organisations in order to move towards social model of health and well-being. For example, in their paper exploring the change from a biomedical model to a more social model of health in long term care, acknowledging the benefits afforded to organisations that fully embraced the cultural change.

Interestingly, the authors also found that “the more a nursing home has adopted culture change principles, the greater the benefits that accrue to it, in terms of staff retention, higher occupancy rates, better competitive position, and improved operational costs” (Doty et al., 2008, p. 20). (Brune, 2011, pg. 515)

Papers identified how ‘culture change models’ were implemented as way of adapting to a social model. These were deemed to have had limited success but recognised that for culture change models to be effective, staff needed to be fully engaged with the entire move towards a social model, informing and shaping the mechanisms for the cultural shift as well as the application of the model itself.

it seems that what is most important is achieving the correct balance between the desired cultural change and the environmental and social realities within LTC (long term care) facilities. Our findings suggest that this may be best achieved through the development of mutually agreed upon culture change initiatives between staff and managers rather than attempting to implement a pre-defined CCM (culture change

model). (Caspar et al., 2009, pg. 174)

The medicalisation and ‘power’ within professional relationships was seen to be one area that had the potential to hinder effective collaboration towards a successful social model of health and wellbeing (e.g., Baldwin, 2019; Mark, 2006). These involved organisational imbalances of political or professional power which had the potential to diminish the ability of allied health, social and community professionals to work in a fully integrated way. This was also seen to impact how some physicians were able to relate to the holistic needs of their patients with Crowley-Matoka et al. (2009) highlighting the need for improved understanding of the biomedical culture currently in operation.

...our exploration of the role of biomedical culture in pain management problems suggests the need for another form of cultural competence as well; that is, for physicians to become more self-reflectively aware of the culture of biomedicine in which they themselves are immersed. To reduce the cultural distance between physicians and patients—and thereby enhance clinical communication, assessment, and management—physicians must unpack their own cultural baggage and examine its contents and the ways in which it affects their responses to and care of patients in pain (Crowley-Matoka et al., 2009, pg. 1318)

Authors advocated the need for reflection of the organisational values, such that these became central to the movement towards cultural change and supporting organisational staff to consider how their own roles could contribute to the wider organisational values of a social model.

To begin the change process, providers need to explore their current organizational culture including organizational values, norms, and artifacts. This exploration will help staff evaluate how their own organization’s culture promotes or hinders the ability of residents to live their lives as fully as possible. It is very difficult to look at long-term care objectively while working in the system day-to-day. (Brune, 201, pg. 521)

Our statement of values has been guided by the ideas and work of speech-language pathologists as well as by individuals in psychology, sociology, and medicine. We intend neither to prescribe exact methods for achieving specific outcomes, nor to provide a quick fix to the challenges facing our profession. Rather, we offer a statement of values and ideas relevant to assessment, intervention, policy making, advocacy, and research that we hope will stimulate discussion related to restructuring of services and lead to innovative clinical methods for supporting those affected by aphasia. (p. 279) (Elman, 2016, pg. 158)

Others felt that education was the critical route to implementing a cultural change at an organisational level. There was a recognition that medical education continued to take a predominantly biomedical approach, focusing on symptomology and ill-health.

The contemporary curricula for Health Sciences (medicine, nursing, allied health professions) are focused on the instruction of clinical expertise, especially to diagnose individuals' biological or psychological problems (medical model of health). While knowledge about social aspects of health is essential, skills such as communication or advocacy skills are necessary to tackle health inequalities. Taking a social history, for example, should be embedded in any health professional curriculum, but is currently often neglected in the formal education of health professionals. (Schoeb, 2006, p.g 58)

The consequence of this biomedical training was believed to be a profession who failed to fully consider or adopt the importance of wider social contributions and such were susceptible to bias and negative attitudes toward certain behaviours and members of the community.

In our view, health professions education has too often interpreted the biopsychosocial model as focused on biological and psychological factors, with insufficient attention given to social context. When implemented, this educational approach has produced health providers with enhanced compassion toward individual patients, but insufficient awareness of social causes of disease. Such providers may overemphasize the role of patient's lifestyle choices. A focus on health behaviors can generate negative attitudes, not only about unhealthy behaviors but also about the people who practice them. These negative attitudes may contribute to conscious or unconscious biases about working with the poor, and can interfere with establishing trust and rapport between providers and low-income patients. (Chin et al., 2000, pg. 321)

Based upon international research and experiences from both Norway and the United Kingdom, it is clear that shifting from a professional control to service-user orientation is crucial. Within this focus, allowance must be made for a shift in culture, helping the health professionals in their development and practicing of skills and competences from education to personal formation, by supporting them in maintaining, preserving, and furthering their professional focus and involvement. It is central to encourage and develop the ability to hope, be creative, caring for and showing compassion, with the intentions of creating conditions for living meaningful lives while struggling with mental health challenges. (Damsgaard, & Angel, 2021, pg. 2715)

4.2.3.2 Public change

Organisations were not the only consideration when it came to the need for a change in culture. Some papers made reference to the culture change required amongst the general public to move away from a biomedical model.

On a more strategic or discipline specific level, they identified the invisibility of midwifery (being seen) which was due in part to the medicalisation of childbirth and medical representation in all levels of politics, current workforce shortages and the poor public understanding about the role and scope of practice of midwives... That is,

perceptions of power limit how different specialty areas and specialised practitioners refer and collaborate on care. (Baldwin et al., 2019, pg. 201)

Patients who adamantly reject any psychological or behavioral approaches to pain treatment out of a belief that such approaches imply that their pain is not “real,” for instance, are also operating with the hierarchical mind–body distinction characteristic of biomedical culture. (Crowly-Makota, 2009, pg. 1318)

Despite this, authors recognised the need to achieve this through the general public being at the core of cultural change rather than being recipients of intervention or change. The importance of engaging with end users and including them fully in the design and organisation of structures was seen to be key to removing power imbalances and increasing the potential success of new models of service delivery.

Hence, participation and inclusion do not involve changing people to fit in, but changing the (health care) system and society to be inclusive....Within this context, a change can only happen by confronting and challenging health care systems to reduce barriers that impede and thwart people’s efforts to live independently and gain control over their lives and the resources needed. (Damsgaard & Angel, 2021, pg 2712)

Examples from community interventions highlight the important role of patients as part of the multidisciplinary collaboration, where enabling patients to collaborate with each other and with staff members aided a culture shift towards shared learning thus improving knowledge, access and reducing stigma and bias.

Collaborative working is the foundation of Leg Club culture. Patients and nurses work together in an open environment, where interactive learning is paramount. Treatment is undertaken collectively in an area where two or three people can have their legs washed and dressed in the same room, giving them the opportunity to compare healing and treatments. They are encouraged openly to discuss treatment issues with the care team, carers and other patients, and this offers them control over their own leg ulcer destiny. Treatment is undertaken with, rather than on, the patients. This shared treatment also provides an open forum where excellence in practice can be observed, recognized, critically evaluated and mirrored by all the nursing staff (Lindsay and Hawkins, 2003). (Lindsey, 2010, S.18)

Open spaces and nonjudgemental learning areas for young people can contribute to skills and values being caught and taught. Within the social context of the community service, the process of becoming and learning was organic and spontaneous, providing an intangible social and cultural resource in the young mothers’ life, which is in stark contrast to the transmission model that all too frequently occurs in traditional health educational exchange (Banks-Wallace 1999). This learning process not only mitigates the effect of isolation and the wider community stigma but also inspires the construction of empowering narratives, especially for the young women who have no clear plan and require supportive scaffolding to help map out a desired life path. (Brown et al., 2014, pg. 503)

4.2.3.3 Moving towards a model of care rather than cure

The move towards preventative care and the need to better consider the determinants of health and illness ahead of reacting to symptom or illness was seen to be central to a social model. Discussions about a return to delivering quality of life rather than quality of care were used to refer to the changing focus towards the holistic individual.

With the advent of antimicrobials and technological advances in imaging and surgery, American medicine in the 20th century transformed from a discipline concerned primarily with “caring” for patients to one concerned more with “curing” diseases [76,77]. This shift has resulted in a bias favoring conditions and patients with a clinical story for which a parsimonious diagnosis can be made and for which efficacious treatments exist (Crowly-Matoka et al., 2009, pg.1315)

Ultimately, we hope social health thinking and primary health practices continue to encourage staff, clients, funding bodies, and the communities they serve, to offer “care-based” responses to client needs, rather than simply treating symptoms without first attempting to understand their genesis. (Rogers, 2008, pg. 57).

An overarching distinction between these two approaches is that the medical model emphasizes quality of care, whereas the newer social models stress quality of life (Kane et al., 1998). Though quality of life is valued in traditional nursing homes, it is heavily influenced by safety concerns (Kane, 2003). Technical competency of medical services assumes priority in delivering quality care under a medical model (Wiener, 2003), but such factors as resident choice and autonomy, comfort, meaningful activity, opportunity for growth, and maintaining relationships all matter in social approaches centered on the resident (Lustlader, 2001) (Cooney & McClintock, 2006, pg.73)

However, the complexity of these social interactions was acknowledged, with recognition that addressing social determinants as part of a more holistic model required different approaches. Authors highlighted how the methods of evaluating application of a social model did not always relate clearly to methods of adoption in clinical practice, limiting the translation from research to applied policy and practice.

Participants highlighted that social interventions were inherently more complex compared with medical interventions yet this complexity was not reflected within the current evidence base, which tended to focus on disease prevention rather than health promotion. This created a challenge for practitioners ‘to adapt the “scientific evidence” to the real world!’ (James et al., 2007, pg. 582)

There was recognition that whilst health professionals might be aware of the interactions of various determinants of health, there was a lack of understanding or systems in place to help them to address them.

The findings show that physiotherapists recognised the centrality of patients’ psychosocial context and the ‘social’ mediators of back pain, such as work absence, which played a key part in affecting patient recovery. The implications of these

findings are that in order to achieve concordance with patients physiotherapists will need to use best practice recommendations in ways that take account of patients' pain experiences [30]. In other words a balance between patients' psychosocial issues and biomedical approaches to managing patients' pain problems are needed, though as yet physiotherapists may struggle to adopt strategies to identify and manage both the biomedical and psychosocial aspects of non-specific back pain that patients present with. (Sanders et al., 2014, pg. 9)

In the United Kingdom, there are very few interactive educational opportunities that focus on supporting changes in practice toward biopsychosocial models. In the United States, different states have different continuing education requirements, but based on our anecdotal experiences, few of these offerings are related to psychosocial models and how to integrate psychosocial principles into routine management of patients with low back pain. Uncertainty about effective interventions for patients who have psychosocial obstacles to recovery may well mean that clinicians do not see the value in routine assessment of these factors... Some of these psychosocial obstacles to recovery (eg, pain-related distress, perceptions of poor personal control, catastrophizing, fear of movement) are likely to be modifiable using physical therapy treatment approaches. Other factors, such as unemployment, low levels of perceived job control, and social isolation, may be much more challenging to address within the context of physical therapy services alone. (Foster & Delitto, 2011, pg. 794).

4.2.4 Integration and collaboration towards a holistic and person-centred approach

The importance of integration and collaboration between health professionals, wider organisations, services users and patients were emphasised in the ambition to achieve best practice when applying a social model of health and wellbeing. A number of papers identified the reported benefits of improved collaboration between, and integration of services which included improved continuity of care throughout complex pathways (e.g., Bambridge et al., 2012), improved return to home or other setting on discharge (Blount et al., 1994), and social connectedness (Agarwal & Brydges, 2018).

Numerous papers discussed the importance of multi-disciplinary teams who were able to support individuals beyond the medicalised model. One such example came from Baum & Freeman (2021) in their review exploring why Australian Community Health Systems have not flourished in high income countries. Despite the challenges identified, the benefit of multi-disciplinarily came across strongly.

One strength that did persist at all services was a focus on multi-disciplinarity. Staff reported generally much less hierarchical dynamics than would be typical in other health services such as hospitals, and enacted a range of strategies to provide holistic, coordinated care to clients, including joint appointments, case conferencing, and team planning for clients. This allowed, for example, a client with diabetes to see a dietitian, exercise physiologist, diabetes nurse educator, and podiatrist at the one service, to support many different aspects of their management of their diabetes. This provided a more whole-of person approach to care than can be achieved in more

selective primary medical care services.’ (Baum & Freeman, 2021, pg. 53)

A number of papers suggested specific professional roles or structures that they felt would be best placed to act as champions or integrators of collaborative services and communities. Suggested roles included nurse practitioners (Davis et al., 2015), psychologists (Negri et al., 2021), network therapists (Blout et al., 1994) and referral centres (McLeod, Baker & Black, 2006). For example, the role of ‘network therapists’ in research by Blout et al. acted as a link between secondary, primary and community level care helping to identify patient needs and supporting the integration of relevant services.

In many cases, the network therapist assembles and helps to organize the primary care system of a patient. This involves identifying the agency personnel and community helpers who are involved with a particular patient or family, and arranging a meeting to review the problematic situation. In this meeting, a common goal can be denned and the group can agree on the function and accountability of each person in relation to the goal. The network therapist also tries to identify community people, self-help groups, and former patients who are willing to be involved as resources for patients and for team members in situations where additional help may be needed. (Blount & Bayona, 1994, pg. 177)

Some papers also advocated the need for better integration of service organisation and funding such that a holistic approach to procurement and coordination of services and goods could be achieved, proposing that this would improve health outcomes and cost savings.

Instead of accessing multiple entities and funding streams to procure health services such as mental and behavioral health, home health, physical and occupational therapy, nutritious food, warm clothing, and transportation, this can all be coordinated by one entity, which is managing the coordination of services and a more coordinated payment on the back end. There is an opportunity for cost savings and a reduction of a duplication of services wherein this funding structure could help align costs with health outcomes needed in value-based care. (Barilla, Shah & Rawson, 2019, pg. 83)

Importantly, the role of the patient as an active voice in multidisciplinary working was also seen as an essential feature of patient centred care, where patients were fully integrated into the multidisciplinary approach.

A key to living well with any condition involves incorporation of the patient and family experience into the therapeutic plan. Therefore, the process of systemic healing is a collaborative endeavor (sic) among the patient with the condition, their family, the healthcare professionals, and the larger community, society and culture, with the overarching objective of ‘living well with the medical condition.’ All professionals and perspectives are included and are ‘equal partners’ with patients and families in the systemic healing model. (Goetz & Caron, 2005, pg. 57)

The participation of patients and their families is the lynchpin of any multidisciplinary

approach to chronic diseases. In fact, it is impossible to achieve the proposed aims when this is absent. (de Oliveira, 2009, pg. 185)

However, papers emphasised how for collaboration to work effectively there was a need for clear definition of roles amongst the team in question such that each member had clarity regarding their own responsibilities towards achieving the wider objectives.

'For each member of the interdisciplinary team to work effectively, an understanding of one's own role and the role of others is required. In this way, an understanding of the contribution of each team member allows for better functionality of the team which in turn will lead to more positive outcomes. (Baldwin et al., 2019, pg. 200)

4.2.5 Measuring and evaluating a social model of health

Individual papers applying and evaluating interventions based on a social model used a variety of differing methods to evaluate success. Amongst these, some of the most common outcome measures included general self-report measures of outcomes such as mental health (e.g., Cullen & Solomon, 2013), perceptions of safety (e.g., Cullen & Solomon, 2013), well-being (e.g., Davies, Knuiman & Rosenberg, 2016), life satisfaction (e.g., Smedemear, 2017), health related quality of life (e.g., Dent, Davison & Wilki, 2021), social networks & support (e.g., Fried, 2004). Some included condition specific self-report outcomes relevant to the condition in question (e.g., pregnancy-related anxiety (Duberstein et al., 2021), pain inventories (Geyh, 2012), rheumatoid attitudes scale (Geyh, 2012).

Objective clinical or economic outcomes, for example, number of healed ulcers (Gordon, 2006), blood pressure, weight (McKenzie, 2013) and attendance at services or interventions (e.g., Duberstein et al., 2021) were also considered.

Other papers considered the more in-depth experiences of users or service implementers through qualitative techniques such as in-person interviews (e.g., Duberstein et al., 2021; Nevin et al., 2018).

However, the complexity of developing effective methods to evaluate social models of health were recognised. The need to consider the complex interactions between social determinants, and health, wellbeing, economic and societal outcomes posed particular challenges in developing consistency across evaluations that would enable a conclusive evaluation of the benefits of social models to wider health systems and societal health.

The outcomes of complex interventions include a range of attributes (including health) that are diverse and potentially of value to stakeholders, society, and/or the individual. These attributes, as in our social prescribing example, often, according to Sen²⁹ contribute to all the possible functions for a person...Complex interventions with multiple outcomes require new methods of evaluation.⁶ These evaluation methods, tied to benefit measurement from causal inference, mean moving away from the traditional model of health economic evaluation alongside a clinical trial. Proper evaluation of complex interventions will be expensive and will require extensive data collection.⁴⁷ Nevertheless, putting the task into the "too difficult and too expensive" box risks funding interventions that are not cost-effective (or failing to

fund those that are). (Wildman & Wildman, 2019, pg.512)

In many settings, complexity is considered a vice. However, the biopsychosocial model demands that complexity be viewed as a virtue, albeit a challenging one. Funding agencies and review panels prefer impeccable methodologies and nonmessy samples. The appreciation that new problem areas inevitably are messy needs greater recognition by review panels and policymakers. (Suls & Rothman, 2004, pg. 123)

Evaluation of community initiatives did not always show improved health outcomes; however, they did reportedly improve access to hard to reach groups. The example below warns of the length of time that may be required to see a change in health outcomes amongst populations who have faced health inequality for a significant period of time, which may not be feasible within the timeframe of shorter term evaluations.

This study demonstrates that the interdisciplinary, community outreach midwifery-led model introduced in the Fitzroy Valley increased access to antenatal care for Aboriginal women living in a very remote area. Although increased access and screening for risk factors is the first step, there was limited data on the quality of the increased services provided, and as yet, no change in outcomes. This may reflect the impact of the multifactorial, long-standing socioeconomic determinants on health and the long time frame required to see changes in health outcomes. The continuous quality improvement approach to providing antenatal care enabled the identification of improvements needed to achieve best practice care, highlighting the importance of embedding research and continuous quality improvement into routine health service delivery. (Reeve et al., 2016, pg. 205)

Some criticised the methods of research with a focus on quantification and evidence based practice highlighting how this approach could fail to capture the complexity of human behaviour and the manner in which their lives could be affected. Similarly, there was recognition that evaluation of social models would be unlikely to meet the requirements of standardisation typically expected of scientific research.

The few examples previously outlined in this paper, however, highlight inherent problems with the attempt to 'technologize' human issues related to health and illness. This is because the quantification of responses (and in this way the determination of 'at risk' contingents), fails to address the 'reflective' and meaningful manner in which human beings typically respond to the events taking place in their lives. This is especially the case in terms of traumatizing events such as those often associated with health and illness. To get a person simply to tick a box about how they are feeling or coping misses the reality of how people actually deal with such experiences. (Corrley, 2001, pg. 252)

A further concern regarding the application of an evidence-based framework to health promotion was the perception that the parameters of 'evidence' were too narrow and not consistent with the diverse forms of knowledge that were required in

the delivery of effective health promotion interventions in favor of 'science'. (James et al., 2007, pg. 582)

Critical theory is vital to health equity work; it calls scientists to acknowledge the extent to which the prioritization of specific methods, epistemologies, and competencies in public health maintains and exacerbates health inequities by requiring that health, health care, and health behaviors be defined, understood, and valued according to dominant ideologies and norms. Like most systems, science has been constructed via the prioritization of specific values and ways of knowing that have historically privileged specific persons and populations (10, 24, 33). As a result, scientific practice has often marginalized or erased knowledges and lived experiences that lay beyond its scope: placing them "low down on the hierarchy, beneath the required level of. . . scientificity" [(34), p. 82] (Golden & Wendel, 2020, pg. 5)

5. Discussion

The aim of this systematic review was to better understand how a social model of health and wellbeing is conceptualised, implemented and evaluated in the health and social care sphere. The review sought to address the research questions:

- How has previous literature conceptualised or defined 'a social model of health and wellbeing'?
- How has previous literature implemented, or evaluated the implementation of a social model of health and wellbeing?
- What global evidence of best practice exists around the implementation and evaluation of a social model of health and wellbeing?

Analysis suggests that whilst the ethos, values and aspirations of a social model for health and wellbeing appears to have consensus, there is no single definition or operational model of a social model of health and wellbeing applied to the health and social care sector. Authors have consistently referenced models such as the biopsychosocial model, and social ecological models to help frame and guide service delivery. The decision about how best to conceptualise a 'social model' is important both in terms of its operational value but also the implication of the associated semantics. For example, use of the term 'social model' arguably loses site of the biological factors that are clearly relevant in many elements of clinical medicine. Similarly, there is no discussion in the literature about what would not be considered a social model of health and wellbeing, challenging the boundaries within which health and social care sectors may be required to function in addressing their wider social remit. This raises questions and requires decisions about whether implementation of a social model of health and wellbeing conceptually works alongside or, perhaps less likely, is intended to replace the existing biomedical approach. The need to reflect the biological determinants of health may raise questions about what a 'social model' can achieve that the 'biopsychosocial model' does not. Regardless, questions about how health and social care sectors practically work to this broad remit will continue to be challenging and decisions about a working definition that meets the needs of health and social care organisations will be needed.

Authors have advocated that a social model provides a way of 'thinking' or articulating an organisation's values (e.g., Rogers, 2008), as opposed to presenting an operational model for organisational implementation. Common elements of the values associated with a social model amongst the papers reviewed included recognition and awareness of the social determinants of health, increased focus on preventative rather than reactive care, and similarly the importance of quality of *life* as opposed to a focus on quality of *care*. However, whilst this approach enables individual services to consider how well their own practices align with a social model, we suggest that this does not provide large organisations such as the NHS, with multifaceted services and complex internal and external connections and networks, sufficient guidance to enable large scale evaluation or transition to a wide spread operational model of a social model of health and well-being. This suggests that the current use of the term 'model' in this context represents an idealised meaning of a model, simplifying a complex reality in a way that conceptualises ways of thinking about service delivery as opposed to modelling or evaluating implementation, as may be the case in organisational or systems models. This raises questions about how health and social care organisations wish to utilise the model; whether its function is to support communication of a complex ethos to encourage reflection and engagement of its staff and end users, or to develop the current illustrative framework into a predictive model that can be utilised as an evaluative tool to inform and measure the success of widespread systems change. If the latter, then further identification of the appropriate input, process and output measures relevant to the implementation of a model of health and social care will be needed. The three phased approach of systems models may be helpful when investigating and analysing healthcare models that are currently in existence, and to characterise models in one of three states namely: a) models that characterise existing methods of operation and functionality i.e current state models, b) models that describe existing functionality but also model the future state in order to propose a new or improved solution, and c) a model that not only models current and future states but also allows for simulation of the model to determine the quantifiable benefits that emerge from adopting the new approach.

Given the lack of an operational model, no papers that we identified evaluated complex wide spread organisational implementation of a social model of health and wellbeing, instead focusing on individual services, or specific organisational contexts such as long-term care in care homes or residential services. Despite this, common elements of successful implementation did emerge from the synthesis. This included the need to wholeheartedly engage and be inclusive of end users in policy and practice change in order to fully understand the complexity of their social worlds and to ensure that changes to practice and policy were developed with, as opposed to created for, the wider public. This also involved ensuring that health, social care and wider multidisciplinary teams were actively included in the process of culture change from an early stage such that the move to transition and develop novel approaches to care were done with the engagement, support and advocacy of the teams responsible for delivering them. The need for improved multidisciplinary, inclusive of varied roles, both internal and external to traditional health services were also emphasised. This was proposed to support improved continuity of care, and better opportunities to consider and address the holistic needs of a patient or client.

Finally, the move towards more community based delivery was advocated. Embedding services more evidently in the community enabled improved attendance and engagement, improved opportunities to increase social support and empowerment, and reduce inequality and stigma. This clearly proposes a significant change of mindset and removal of perceived and actual hierarchical structures that are historically embedded in health and social care structures amongst both organisational staff and the wider public. Whilst unpicking and removing socially embedded hierarchies will pose significant challenges in practice, this may also open opportunities to promote the appreciation and significance of previously undervalued roles enhancing their attractiveness as career pathways.

The evaluation of social model interventions or services were varied and widespread and were mixed in terms of the social and health related improvements reported. Whilst this echoes the complexity of social and ecological perspectives, the lack of standardisation of outcomes measured and methodological approaches limits the ability to evaluate social model implementation at scale and in line with traditional scientific rigor. This challenges the ability to conclusively demonstrate the economic, and health benefits of a shift towards a social model of health and wellbeing. However, many authors argued that the benefits of a social model in term of its societal impact was not necessarily achievable using the dominant 'scientific' tools, and timeframes of traditional clinical research which were typically designed to be aligned with traditional biomedical approaches. They advocated for the complexity and 'messiness' of a social model calling for different approaches to assessing and evaluating success that better reflected the holistic complexity of end user environments and experiences. It is evident therefore that transition towards a social model, in whatever form that might take, is unlikely to follow a clear linear pathway. The transition is likely to be staged, gradually cumulative and iterative which is likely to be uncomfortable, unpredictable and disconcerting in an organisation that is steeped in scientific rigor, and evidence based practice. The focus of a social model around quality of life as opposed to cure may form a central point of focus enabling a consistent outcome of interest that draws together the wider remit of service delivery.

In conclusion, the evidence of the review demonstrated consensus regarding advocating for a move towards a social model of health and wellbeing. However, further discussion is required about how this dovetails with a biomedical perspective and what mechanisms and processes are required to transition to a functional systems model if this is deemed favourable. There is therefore a need for complex organisations such as the NHS and allied organisations to agree a working definition of their model of health and wellbeing, whether that be a social model for health and wellbeing, a biopsychosocial model, a combination of the two, or indeed a new or revised perspective. Many of the principles associated with a social model outlined in this review could be useful point of consideration to support the development of their approach with further consideration about whether there is a need to develop a workable systems model or whether the guiding principles of an idealised model is sufficient to inform system change. Considerable work will be required to engage on a more equal footing with the general public, health and social care staff as well as wider supporting organisations in developing workable principles and processes that fully embrace the equality of a social model and challenging the 'power' imbalances of the

current biomedical model. Acceptability of a degree of risk and insecurity will also be required with careful consideration of how organisations will evaluate and assess the long-term impacts of such a transition.

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*A full table of references for studies included in the review will be provided as a supporting document. The references below refer to citations in the report which are in addition to the included studies of the synthesis.

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Thought and systems leaders in Wales talk about a Social Model of Health and Well-being

A thematic analysis of conversations with a purpose



A report prepared for Hywel Dda University Health Board

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Thank you to Phil and Rennie for the opportunity to be involved in the discovery phase of a move towards a Social Model of Health and Well-being in Hywel Dda. During the write-up of this report our dear friend, colleague and former Director of Public Health Ros Jervis sadly passed away. Her vision, bravery and boldness which led to the publication of 'Our Future Generations Living Well – A Health and Well-being Framework for Hywel Dda, 2019' provide strong foundations to realise this ambition. We hope this work goes some way towards the fulfilment of her legacy.

Executive Summary

In 2019, Hywel Dda University Health Board (HDUHB) approved 'Our Future Generations Living Well: a Health and Well-being Framework for Hywel Dda'. This 20 year vision for population health includes a strategic ambition to work towards a social model of health and well-being. This report forms part of the 'discovery' phase in the Health Board's action to take forward this ambition.

Methodology

The Medical Director, Prof Phil Kloer and Strategic Advisor to HDUHB, Baroness Rennie Fritchie undertook eighteen 'conversations with a purpose' with thought and system leaders in Wales during 2021/22 to gain insights into their views and opinions about a social model of health and well-being. The Hywel Dda Public Health Team then undertook a thematic content analysis of the qualitative data and wrote up the findings. These were presented back to the Health Board in this report, July 2022. It complements a systematic review of the literature conducted by Aberystwyth University.

Main Findings

The findings highlight that the NHS is valued for its role in providing a safety net at the point of crisis or emergency and in delivering societal benefits. Its main asset is its workforce and it is generally well regarded and trusted. However, the current 'system' including health, is deemed over-complicated, bureaucratic and slow. It works in silos and lacks collaboration and overall accountability. Short-term funding exacerbates fragmented services with a short-term focus and the dominant medical model perpetuates a reactive and remedial approach. The system fails to engage with communities and individuals or value people's lived experience which results in reduced trust and poorer outcomes. The policy and legislative landscape in Wales is conducive to a move towards a social model of health and well-being and this would be welcomed by participants in this study. They feel that the current system is not taking advantage of this unique opportunity and as such is failing to meet the scale of the current challenge.

Ambition and bravery will be needed to achieve change but the time is right to be doing this. The new model should be underpinned by the principles of equity, prevention and of reducing inequalities. It should encompass the broader concepts of wellness and well-being with a focus on the whole person and the whole population, in the context of the wider determinants of health. Partnerships and collaboration are the right approaches but these need to be improved and extended beyond the traditional models. The shift will require a change in culture and practice across the system and workforce. The involvement of communities in the form of co-design and co-production is imperative and should facilitate the re-distribution of power and resources towards them. Asset sharing should be facilitated and accompanied by revised governance and accountability across the system.

Discussion

The value placed on the NHS for its role as a safety net is important in the context of a shift to a social model of health and well-being. Although not described as an insurmountable

barrier, shifting the emphasis towards **prevention** and away from acute and urgent care was acknowledged as a tension in the current system. The rationale for change is strongly articulated by the participants in these conversations who described the dominance of a medical model, with a remedial focus, as not working for many people. Structures and processes are described as disabling, resulting in a system which, in their view, never gets 'upstream' and is failing to meet the scale of the challenge. Ambition and bravery are necessary to achieve change, but the timing, in relation to the recovery from the Covid-19 pandemic and the preparation of Well-being Plans by Public Services Boards (PSBs) in Wales means that the time is right to be doing this.

Putting **individuals at the centre** and taking an asset-based approach to building relationships, partnerships, and structures that increase people's trust, power and control are vital. This should be accompanied by a **holistic approach** which aims to understand people in the context of their whole lives and the wider determinants of health.

The new model should encompass the broader concepts of **wellness and well-being** which will improve outcomes but will necessitate a different way of thinking about how success should be measured. There is an appetite to move towards joint accountability arrangements across organisations and communities. The belief that **communities** hold the answer and are central to an effective model was a strong message from participants. The plea is to 'do with and alongside' as opposed to 'doing to' communities.

There is very general agreement that we need more effective **collaboration** and that working together and **partnerships** are the right approach but that these may require looking beyond the traditional models to more innovative ones. The **workforce** is viewed as the NHS's greatest asset, but it needs support to achieve the changes in practice and culture necessary to embed the new model, including leadership at all levels to manage and drive the change.

Next steps

HDUHB are already further ahead on this journey than some other parts of Wales. The components which participants describe as central to a new model are already embodied within the strategy and policy direction internally and in partnerships locally. HDUHB should capitalise on the appetite for change and ambition described in this report by demonstrating strong leadership, modelling the way and supporting others in the transition towards a social model of health and well-being.

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1. Introduction

In January 2019, as part of the development of the Healthier Mid and West Wales Strategy, Hywel Dda University Health Board (HDUHB) approved 'Our Future Generations Living Well: A Health and Well-being Framework for Hywel Dda'. As part of this 20 year vision for population health, there is a strategic ambition to transform its way of working and move to a social model of health and wellbeing.

To further this ambition, the following Planning Objective was set in September 2020:

'Design and implement a process that continuously generates new proposals that can be developed into planning objectives aimed at constantly moving us towards a comprehensive "social model for health" and cohesive and resilient communities. The process needs to involve our local population as well as a diverse set of thought and system leaders from across society'.

The UHB recognises that to achieve this wholesale shift, support and partnership working across the system, together with insight and understanding of what it looks and feels like for communities, patients and staff is needed. It also wants to ensure that the overarching approach works towards a defined and recognised model underpinned by academic rigour. The 'discovery phase' of this work therefore, includes two parallel strands of work:

- A systematic review of the literature conducted by Aberystwyth University and
- A Series of 'conversations with a purpose' undertaken with thought and system leaders in Wales to further two aims - intelligence gathering and garnering support for the work ahead.

Prof Phil Kloer - Medical Director and Deputy CEO, and Baroness Rennie Fritchie, in her role as a Strategic Advisor to the Health Board, undertook eighteen semi-structured 'conversations with a purpose', between June 2021 and February 2022. At a meeting of the group overseeing the discovery phase on the 15th November 2021, the Public Health Team were asked to independently analyse the transcripts using robust research methods and to report the findings. This report sets out the approach taken, the findings and some considerations when taking the work forward. It was presented to the Health Board on the 11th July 2022.

2. Methodology

2.1 Introduction

The focus of this work was to gain an insight to the opinions and perspectives of thought and system leaders in Wales on a social model of health and well-being. The philosophy and design for the 'conversations with a purpose' had been agreed prior to the involvement of the Public Health Team so the Strategic Advisor and Principal Programme Manager have kindly summarised their approach taken in section 2.2 below.

The Public Health Team's role was to apply robust methods to analyse the data collected and to report back the findings, in the form of a written report. Section 2.3 onwards outlines the methods chosen for analysis of the data and the techniques used to derive the key themes presented in the findings.

2.2 Conversations with a purpose

2.2.1 Participants

Candidates for inclusion in this work all met similar criteria - they were whole system leaders and thinkers, with clear expertise in areas of public life that impact on the social determinants of health and wellbeing. In addition, they had a specific interest in public life in Wales. As a result of this simple yet focussed criteria, conversations were held with individuals representing Welsh Government, Local Government, Public Health and the Third Sector. Specific population groups and characteristics were also represented in conversations with Faith leaders, disability rights, mental health, housing and criminal justice. In total, eighteen interviews were undertaken, with a total of twenty one participants - twelve women and nine men.

2.2.2 Structure

The conversations were undertaken over a period of nine months between June 2021 and February 2022. Due to the Covid-19 pandemic all were undertaken virtually. Four key questions were posed to each interviewee; chosen to elicit professional, personal and system wide insight on the current delivery of health services in Wales and the proposed shift to a social model. Each conversation started with the same introduction to ensure that the context for each interviewee was similar and the 'ask' from the Health Board was the same.

Interviews differed in length dependent on whether there were individual or multiple interviewees and how much people had to say. Conversations were not recorded (apart from one, at the request of the interviewee) but were, in the main, scribed by a member of the Engagement & Transformation Programme Office of the Health Board.

2.2.1 Content

Introductory script - The idea of a Social Model of Health and Well-being is not new. The concept of viewing health as more than simply a physical issue was promoted in the early part of the 20th Century. The current NHS operates on a “factory model of care and repair” as the whole-person approach to health has been lost over time. There were concerted efforts made in the 1970s and 1980s to realign thinking, but they did not cut through in any great way. The Health Board is approaching the design and delivery of this work ‘humbly’, clear in the knowledge that the answers and expertise do not sit within its own organisation. This point was reiterated throughout the conversations.

Following on from the introduction the following four questions were posed in order:

1. With the different models in mind [medical vs social] what are the positives and negatives of the current system.
2. If the model were to shift more to a social model, which groups would be likely to benefit most? (This could be age or disease, or deprivation groupings)
3. Which partnerships are necessary to help it [shift to a social model] to happen?
4. Who would need to be influenced and how, to support this as a future Welsh approach to health?

Because of the conversational nature of the exchange, data was captured as it was spoken and no attempt was made to fit it under specific question headings either during the conversation or when it was transcribed. Some participants had asked for sight of the questions in advance, but most did not.

The conversations were held under Chatham House Rules. Participants were given assurances that their responses would be treated in confidence unless permission was granted to share identifiable feedback. To reiterate this point, the interviewees were given a personalised reason for having been invited to meet. Their professional experience was linked to the work the HDUHB is undertaking. The requirement to do this differed depending on the interviewee. Some participants were clear about why they were involved, others were less clear why they were invited to speak about health services. Participants were invited both in the introduction and again at the end of the session, to continue the conversations with the Health Board and join in with the programme of work going forward.

2.3 Design choice – data analysis methods and techniques

In November 2021, when the Public Health Team were asked to undertake data analysis, some conversations had already taken place, some were underway and others were being planned. The choice of a data analysis method was based on our understanding of the aims of the overall work - that it was exploratory in nature and that an inductive approach was being used, one in which findings are generated from the data collected rather than starting with established theory. We also understood that data was being created through semi-structured conversations and collected in the form of written notes over a defined time period.

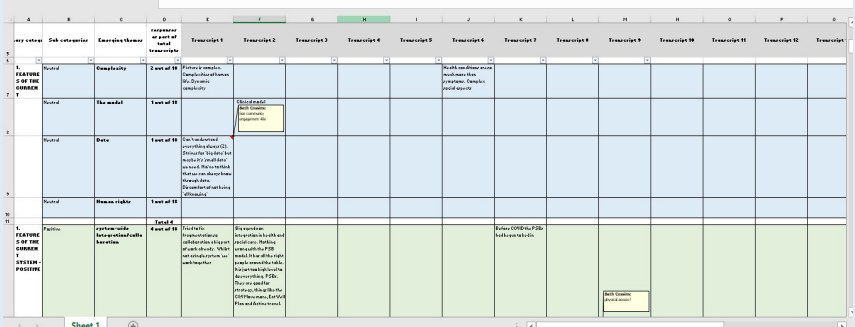
Based on this, it was agreed that thematic content analysis of the ‘conversations with a purpose’ transcripts was the most appropriate method as it enabled a descriptive

presentation of qualitative data. An inductive approach which involved the search for and identification of patterns in the data in order to then identify themes was adopted. This offered the flexibility to generate some meaningful insights from the wide-ranging responses to the four questions asked during the interviews.

2.4 Data analysis process

Once the notes of the interviews were typed up as transcripts by the Principal Project Manager they were sent to the Public Health Practitioners for analysis. In total, eighteen transcripts were analysed between December 2021 and April 2022. The six step process to thematic analysis (Braun and Clarke, 2006) was used as a framework for data analysis, detailed in the following table.

Steps	Description
i. Familiarisation with the data	Transcripts were read and re-read carefully and independently by both practitioners to get an overall sense of the content. Ideally, all the transcripts would have been received and reviewed at the beginning but this was not possible as the conversations with a purpose were on-going.
ii. Generating initial codes	<p>An initial sample of six transcripts were reviewed to begin identifying codes to cover words, phrases or sentences that appeared interesting and meaningful and to provide an indication of the context of the conversations. These form 'tags' so, for example, <i>fragmentation</i> and <i>silo working</i> appeared as words or phrases repeatedly used by participants to describe the current system.</p> <p>Inductive or open coding. Codes are based on the qualitative data itself rather than being pre-determined. The set of preliminary codes were applied to new transcripts as they became available. As the process progressed new codes were added, for example '<i>quality of care</i>' and '<i>inequalities</i>' and some were split to account for subtle differences in meaning within the context of the transcript. For example, initially '<i>rigid</i>' encompassed the idea of formality in partnership structures, but this was split to reflect that formality also encompassed data around membership and hierarchy in later transcripts.</p> <p>Additionally, a few early codes that did not appear very often or at all in the remainder of the data were discarded, for example <i>human rights</i> was initially a code but was specific to the context of Covid-19. Although the specific code was discarded, the data on this contributed to the discussion under the sub-theme of inequity and discrimination. This process was repeated until all 18 transcripts were coded.</p> <p>Both Practitioners alternated in their roles of either taking the lead for 'coding' the interview transcripts or cross-checking a coded transcript. This proved valuable in identifying additional codes that may have been missed if they had only been read by a single person. This introduced a built in 'check and challenge' allowing any different interpretations, including preconceptions and thus potential bias to be identified, discussed and reduced.</p>

	<p>As the number of transcripts increased an excel spreadsheet, illustrated below, was designed to compile the coded data, enabling content across all 18 transcripts to be viewed in one document. The columns helped identify commonalities and variables across the data. It acted as a visual illustration of the main points and common meaning that recurred throughout the data.</p> 
iii. Searching for themes	<p>The collated codes were reviewed and analysed to identify patterns among them and to start coming up with themes. Relevant data extracts were sorted (combined or split) according to overarching themes.</p>
iv. Review and revise themes	<p>A two phase, deeper review of identified themes was then undertaken. Phase one involved checking themes in relation to the coded extracts and phase two was across the data set as a whole.</p> <p>At this stage in the process some interim feedback was requested by the Medical Director who was keen to get a sense of emerging themes ahead of planned feedback to the Transformation Steering Group in the UHB. There was a strong correlation between the emerging themes and what those undertaking the conversations with a purpose and recording them felt that they had heard which provided reassurance.</p>
v. Defining and naming themes	<p>Here, the themes and sub-themes were further refined and defined to begin to tell a unified story of the data.</p>
vi. Writing the report	<p>It is usual at this stage to draw upon the literature review in order to contextualise findings and to be able to interpret results in light of other relevant studies, theories and concepts. This is not possible here as decisions were made to keep the two work streams separate and to report independently. For this reason, the report is confined to the analysis of the findings in relation to the 18 interviews only.</p>

2.5 Limitations

The selection of the methods used for setting up the ‘conversations with a purpose’ including the selection of participants and interview questions were undertaken prior to the involvement of the Public Health Team. The transcripts did highlight some variation in relation to the questions asked of participants – they were not always asked by the same person in the same way. Additionally, there was varying latitude for open

questions and follow-on. In drawing up the list of participants attempts were made to have representatives from males and females and from different population groups and characteristics. However, not all those invited chose to participate. The BAME and LGBTQ communities, for example are unrepresented in the sample.

It was recognised that a clinician-led conversation about a social model of health, which clearly embraces more than a clinical or medical intervention, might make it more challenging for participants to think outside the medical model. An Attempt to mitigate this potential bias was made by Baroness Fritchie delivering the introduction rather than Prof Phil Kloer.

However, the presence of a clinician and the fact that some participants had received the questions in advance may have led participants to respond to questions based on what they felt were the 'right answers'. The introduction to the interviews may have inadvertently 'led' participants to respond in a particular way.

We have endeavoured to present an independent, objective view of the data using a recognised methodology. We recommend that these findings are viewed as initial content to guide further conversation with these and/or other participants rather than 'research'. The study design may have benefitted from input from specialist research expertise to ensure replicability and generalisability of results given the relatively small sample size.

3. Findings

Some participants reflected on the complexity of human life and illness – *‘Health conditions are so much more than symptoms’* - and therefore the difficulty of designing a successful system, before giving their response to the specific questions. This humility was echoed in a comment about data – *‘We can’t understand everything always’* and the need to accept the *‘discomfort of not being all-knowing’*. Analysis of the data produced the five themes, which are discussed in detail in the remainder of this section. A summary is offered at the beginning of each theme in order to help place the findings in the context of the overall report.

Theme 1 What is working currently?

Summary

When describing the features of the ‘system’ that were felt to be working currently, the focus was almost exclusively on the NHS and the role it provides as a **safety net** at the point of crisis or emergency – being free at the point of access and in delivering societal benefits. Its **main asset is its people/workforce**.

The **quality of [NHS] care** is deemed to be good and [it] is generally well regarded and trusted. The provision of continuity of care through primary care is important in communities.

The **policy and legislative landscape** in Wales, through the Well Being of Future Generations (Wales) Act (2015)), the Social Services and Well-being (Wales) Act (2016) and A Healthier Wales (2018) are conducive to a move towards a social model of health and well-being.

The majority of responses under this theme focussed on two attributes. Firstly, the role of the NHS in *‘doing the right thing’*, being *‘free at the point of access’* and delivering *‘societal benefits’*. It was recognised by participants mainly for its role in providing acute or emergency care - *‘everyone loves the NHS at the point of emergency - care at the acute end is excellent’*; *‘there at the point of crisis’*. This concept of the **NHS as a safety net** is built upon by others who describe it as *‘well regarded and trusted (in the main)’* that people can turn to in an emergency or crisis.

Secondly, the **quality of care** and care giving was described positively *‘no problems with the NHS. The medical treatment is good’*; it [the NHS] *‘provides a surprising number of people with really good quality of care’* and provides *‘humane treatment, especially in hospitals’*. Primary care was noted as a strength and for *being ‘incredibly vital to communities. It is at*

its best when it offers continuity and knows the whole person. That leads to better health outcomes’.

In relation to care giving, participants described the **NHS workforce as its biggest asset** using phrases such as ‘*A big strength of the NHS is its workforce*’, ‘*the main asset of the NHS is its people*’ and ‘*people that are exceptionally good at performing the roles*’. However, there is also a recognition that to change the system requires an equal amount of change in those working within and leading it. Leadership at all levels was felt to be needed in order to achieve what was described as a ‘*paradigm shift*’.

There was a recognition that the **legislative and policy landscape** in Wales through the Well-being of Future Generations (Wales) Act 2015, the Social Services and Well-being (Wales) Act, 2016 and A Healthier Wales (2018), along with its size provides a unique opportunity ‘*to change a nation*’. It was acknowledged that these policy drivers have already resulted in varying forms of collaboration and integration (particularly in health and social care) which, although existing largely to ‘fix’ fragmentation, provide foundations to build upon. Some participants felt that strategic partnership structures such as ‘*Public Service Boards (PSBs) may have begun to bed in prior to Covid-19*’ and may have ‘*the right membership*’ and be ‘*good for strategy*’. Others, had a different view and thought about these structures more negatively. These are discussed more fully, under theme two.

Theme 2

What is not working currently?

Summary

The ‘system’ including Health is deemed **over-complicated, bureaucratic, slow, works in silos and lacks accountability.**

The structures and partnerships put in place reflect this and are bureaucratic; formal; rigid; over-complicated and **lack vision and boldness.**

The resulting overall system is **reactive**; lacks integration, collaboration and engagement and there is **an unwillingness to share assets including budgets** fuelled by a **lack of joint or overall accountability.**

Short-term funding and **silos working** perpetuate fragmented services with a reactive, **remedial and short-term focus.**

Continuity of care has reduced and the system fails to value people’s lived experience resulting in **reduced trust and poorer outcomes.**

Despite the conducive policy and legislative landscape in Wales the system is still **failing to meet the scale of the challenge.**

The structure of the public service system as a whole is viewed as **bureaucratic, overly complicated and lacking accountability**, including within the NHS itself. These were felt to be hindering the pace of change which is deemed too slow. The system is felt to be *'fragmented'* and organisations continue to work and think in silos – there is *'massive expertise in health'* but *'all in silos. Nobody much talks to each other'*. There was a recognition that if *'the dots were joined'* then it would *'feel more like a social model of health'*.

The structures and partnerships set up to facilitate collaboration and system change reflect the negative qualities identified in the system itself. They are described as **rigid, formal, over-complicated and lacking vision and boldness**. Several respondents voiced an opinion that PSBs and Regional Partnership Boards (RPBs) are *'not working'* and *'could do better'* and that they *'could be more visionary'*, even going so far as to say that *'it needs a fundamental review'*.

Several respondents said that although accountability and governance is in place within individual organisations there is a **'lack of accountability...in Wales' public sector** referring to joint accountability across the system. That the health system may be failing to collaborate adequately with partners is represented by comments about the *'difficulty local authorities have in engaging with Health'* and they are *'often the last to the table or a no-show'*.

The resulting system is **'reactive' and set up to 'remedy rather than prevent'** and this is manifested through funding priorities which are focused on the *'remedial end rather than getting upstream'*. There is a view that there are real **challenges in sharing resources, including funding** - *'Health is the big beast'* - to the detriment of funding to other parts of the system, particularly social care, and that Health is *'not perceived to share resources for [the] common aim'*.

Participants reflected that from the point of view of the service user, services are **fragmented**, difficult to navigate and *'the ambition to join up health and social care has not yet become a reality'*. This lack of a joined-up system resulting in a poor user experience is acknowledged in comments such as *'public perception and expectation do not always match the experience'* and *'poor service isn't a result of not caring but our systems'*. The breakdown of continuity of care in Primary Care was mentioned by several respondents as a negative development and one that is *'at the expense of patient outcomes'*.

A disease-focussed system was not felt to be working for many - *'the NHS and Primary Care in particular struggles to respond to the whole person'* and *'taking a disease-led approach requires a cure'*. This is a particularly acute problem in mental health where the bio-medical model is *'not on strong ground'*, *'wider determinants rarely get addressed'* and accessing a service like CAMHS requires a diagnosis *'or the message is 'come back in 2- 3 years when you are a lot worse''*. The idea that the NHS puts *'people into neat boxes'* and as a reactive system *'shrinks the model of health'* so that the multiple factors *'being faced by a patient goes out the window'* reflects this lack of a holistic approach.

The way performance is measured, particularly targets that *'never really address or tackle the crucial issues'* - described as *'hit the target but miss the point'* - are identified as a failing of the current system. This includes potential inaccuracies in understanding through *'drawing a false picture,'* but also by not including the contribution of the third sector to NHS targets. Again, this suggests **a lack of overall or joint accountability** - the system *'lacks teeth'*.

The **scale of the challenge** to make the change needed is not underestimated and is expressed in the view that whilst *'it takes an age to turn an oil tanker'* we have *'not been doing as much as the challenge requires'*. One example of this is that *'progress to meet the WBFGA objectives has been at a slow pace in all Health Boards'*. Furthermore, that there are currently *'no incentives to shift the model'*. Funding was cited as a barrier to the ability to take a longer-term view because *'change is often required on a short term basis due to short-term funding'*.

Theme 3

What would a new system look like/include? – key features

Summary

There is a desire to remedy the weaknesses in the current system, but also significant ambition in what a new system should set out to achieve. This is best summed up in the quote *'to provide the same chance for a well lived life'* which incorporates two important sub-themes.

Firstly, the idea that everyone deserves the 'same chance'- the principle of **equity** and also reducing inequalities,

Secondly, the idea that the new system should focus on the 'whole person' and *'whole population'* taking account of the **wider determinants of health**. This demands a *'whole-system'* approach.

It should set out to achieve more than *'merely the absence of ill-health'* and encompass the concepts of **wellness and wellbeing**, with a focus on **prevention**.

It should be founded on meaningful **engagement and participation** and **accountability** to the individuals it is there to serve.

Some participants proposed that *'the social model [of health] should be a way of reducing inequalities'* but also raised it in the form of a question *'can the social model reduce this [inequality]?'* Whilst the data doesn't provide any answers to this question, it does point to

the potential of a social model of health with a focus on the *‘whole person’* and the *‘wider determinants of health’*, to at least address issues such as disadvantage, marginalisation, exclusion and mistrust of the system. All form barriers to accessing help, support and services which in turn, contribute to inequity.

In relation to the current system, the dominant view was that *‘the NHS is not so much a wellness service’* but an *‘illness service’* with a reactive and remedial focus. This is in contrast to aspirations for the new system to be focussed on achieving **wellness and well-being** – *‘We want Wales to be ‘well’, whatever well means to anybody’*; *‘Help people be well’*; *‘How we help people to stay well? We have not cracked this yet’*; *‘How can you help me be well?’* Although very few participants defined what this meant, some offered examples of what it may encompass: *‘We know that connection, relationships, purpose and being valued all help us to stay well’*, suggesting that wellness is made up of more than health and includes the social fabric of people’s lives. Alongside this was the belief that *‘prevention is better than cure’* and that the new model needs to focus on preventing poor health and wellbeing at any early stage – from childhood. Addressing *‘the causes of the causes’* as well as individual behaviours was advocated.

There was a suggestion that *‘moving the system to focus on well-being and health will pay dividends’* and generate greater return on investment. However, some participants acknowledge that just like health, wellness and well-being mean different things to different people and are often individually defined. Added to this is the fact that they are newer concepts in the context of policy and strategy in Wales. This points to a need for a different way of thinking about how we measure the outcomes and successes of any new system embodied in the quote *‘we have an obsession with targets. Hit the target but miss the point.’*

The challenge of measuring progress across the system with a range of partners, all of whom have individual performance indicators was acknowledged. However, there was an appetite to move towards measuring **outcomes** as opposed to performance and to joint accountability arrangements across organisations. Such arrangements should be able to deal with changes in political leadership and include **‘accountability to the service user or community first’**. This is linked to the role of citizenship and democracy in the new model and the need to create better accountability to people themselves, but also to actively seek opportunities to involve them in the governance and accountability arrangements and structures: *‘What governance chances exist for our population? People can be school Governors or Community Councillors’*. One participant reflects a sense of loss of such governance:

‘We have lost something important in the governance structures [of the NHS] that were so important in its inception. How do we reduce the corporate distance?’

This quote expresses a perceived distance between the current structures and the people that they are there to serve and an ambition for the new system to redress this gap.

The need to address both medical needs and the **wider determinants** of health was highlighted in the following quotes: *'we cannot dump the medical model', 'you want a system tackling both (wider determinants and care and repair)'* but that in a social model of health *'we would start by thinking about the **whole population** – what does it want and need?'* This idea of 'whole' existed throughout the data in the form of *'whole population'* and *'holistic'* or a *'whole-person'* approach. Fundamentally, this was an acknowledgement that a new model would need to place individuals at the centre, but also view them in the context of their whole lives, acknowledging the fundamental impact that the wider determinants of health such as housing, employment, income, relationships play in people's ability to achieve and maintain health and well-being. This would need to be reinforced by changes in practice and culture in the system, the need for structural change to support a whole population approach, but also changes in practice and culture to prevent single issue or silo thinking and to ensure consideration of the part that the wider determinants of health.

To facilitate this people should be able to access support through a *'no wrong door'* or *'one point of contact'* approach which **connects them to the right part of the system**, aiding access to a range of services or interventions. In the view of many participants these should not simply be health services but broader social aspects – *'deliver a urine sample and join a choir'* – to meet individual needs. The example of social prescribing was given as one way of mobilising and mainstreaming this approach.

The need for a social model of health to include more **engagement and participation** - that the **citizen** needs to be *'at the heart'* and *'in the centre and co-producing care'* - was an important underpinning principle. This was linked to the idea *'that human experiences should be viewed as expertise and needs to be valued'*. This places individuals and their lived experience at the core. This was reinforced in data relating to the structures needed to facilitate involvement and the view that they should not be *'top-down'* and that health organisations should *'let go'* of control. This was built upon further when participants talked about the need for a **different distribution of power and assets** within a social model of health and well-being with a shift towards communities themselves having more control.

Theme 4

What needs to happen for a shift to a new model to be achieved?

Summary

There a sense that **real ambition and bravery** will be needed to achieve change but that the **time is right** to be doing this as we emerge from Covid-19 and have the opportunity to align with statutory planning in PSBs.

The challenge to achieving change raises the recurrent tension between **ambition and the demands placed on the system to manage the here-and-now**.

There is very general agreement that **working together and partnerships** are the right approach but that these need to be improved and extended beyond the traditional models.

The **involvement of communities** was a significant theme, not only in relation to engagement, but also in terms of the potential within a new model to test out innovative place-based initiatives that might include the re-distribution of power and resources towards communities.

A **change in the funding** to allow this shift to happen as well as making it easier to share assets and resources across the system was strongly advocated. Finally, many individuals and traditional parts of the system were seen as playing a part in making change happen, but there was also a strong lobby for **co-production and co-design with communities** and for the involvement of non-traditional organisations.

There is definitely a sense in these conversations that this change requires **ambition and courage**. *Being brave and going to the frightening places*, *'being big, bold and brave'* and that this might mean *'challenging WG officials – how is this in line with what is right?'* There appears to be an appetite for doing *'something significant'*, taking *'a long-term view'* and for building energy and momentum for change summed up in the phrase *'press the re-set button'*.

Participants also feel that having this conversation is *'timely'*, *'the time is now'* and *'it is important that you are asking this now'* - a reflection on the opportunity to take account of the learning from Covid-19 and to align with Well Being Plans currently being developed by PSBs. The words of warning - that change could be seen as *'adding to the responsibilities of the NHS'* - highlights the real **tension between ambitions for the future versus managing the demands of the here-and-now** expressed in theme one, particularly the value placed on the role of the NHS in managing acute and emergency care versus the need to *'find the headspace to turn the tap off to shift'*. The challenge of change, which encompasses a shift

in focus and funding towards prevention and longer-term is not under-estimated. One thing that participants felt could assist this was strong leadership at all levels with an appeal *'not to give up and not to lose focus.'*

A person-centred approach - the need to *'start with the person, not the system'*, engage in *'What Matters conversations'* and start with *'a story of a patient which shows a determination to value lived experience'*. Connected to this was the importance of building partnerships, relationships and structures that increase *'people's trust, power and control'*.

There is very general agreement that we need *'more effective joint working'*, that **working together and partnerships** are the right approach but that these *'could be improved'* even that we *'need to shake them up'*. Outside the formal partnerships this might involve gathering *'a coalition of the willing'*, finding *'the frustrated champions'* and the *'unusual suspects'* and even *'pairing creatives with public service institutions'* – so looking **beyond the traditional models** to more innovative ideas that would allow for different types of input.

Finally, the importance of **involving communities** was paramount: *'communities hold the answer'* and *'involve communities, community workers and people with lived experience'* and *'embrace the messages we are hearing from communities'* reinforces that ***'we cannot do to, we must do with communities'***. There is a real aspiration to move towards a **shift in power and resources** and a different approach to governance to facilitate *'responses run by the community itself'* using models such as community asset transfer or community sharing initiatives. Participants reflected on the positive way that communities had mobilised during Covid-19 to put in place support structures in the absence of usual statutory provision. The flexibility and innovation of the third sector and communities needs to be harnessed and built upon in the new model.

For this transformation to happen the need for a fundamental **change in the funding system** to facilitate the sharing of budgets, assets and resources, especially *'between local authorities and NHS'* was advocated. There was also a plea for *'a shift in funding to other determinants of health'* or *'we are always downstream'*. In recognition of the need to shift the model towards the community there was a suggestion of *'a shared ownership model'* or *'community ownership'* model where communities are supported and then empowered to manage services/provision for themselves.

Theme 5

Where would be a good place to start?

Summary

There was far less data under this theme which may indicate that whilst the component parts of a social model of health are not new to participants in these conversations, the terminology and concept as an entity in itself may be less familiar.

In terms of getting started there were a range of views represented by the following comments: that we need **'quick wins'**; to **'target low-hanging fruit'**; **'and to take 'a long-term view'**.

There was a consistent advice to **start small**: it *'needs to be in bite-sized pieces'*; *'keep it pretty tight in the first phase'*; and to *'pick a few golden nuggets that resonate in partners' daily business'*; *'the magic happens locally'*.

Some suggestions for where to start were with *'good stories – where the process or culture are working well'*, *'early years'* and *'focus on social prescribing'*.

Many respondents mentioned **examples of promising practice**, specific organisations, projects, places and case studies that they regard as successful innovators and that may hold clues as to where to start. These have been compiled by the Engagement and Transformation Programme Office of HDUHB.

A range of people and organisations were mentioned as needing to be engaged to effect change (see Appendices) including traditional statutory and third sector organisations, but one issue mentioned by a few participants was the perceived resistance to change posed by middle managers within organisations – *'the concrete middle gets in the way'*- and the need to address this to achieve real change. Leadership at levels in the system was also felt to be vital in achieving such large-scale change.

4. Discussion of Findings

The value placed on the NHS for its role as a safety net is important in the context of a shift to a social model of health and well-being. Public expectations of the role of the NHS in this regard are high and reflected in the profile of the NHS politically and in the media. Although not described as an insurmountable barrier, shifting the emphasis towards **prevention** and away from acute and urgent care was acknowledged as a tension in the current system. Additionally, the demand on the system in terms of managing the 'here and now' makes it challenging to create the time and space to plan and do things differently. Political cycles also inhibit the ability to plan for the longer-term as changes in Government and political leadership often result in changes in strategy and policy direction.

The rationale for change is strongly articulated by the participants in these conversations who described the dominance of a medical model with a remedial focus - on deficits and what is wrong, and then trying to fix the problem as not working for many people. They attribute the current system with creating dependence and a sense of entitlement that results in disempowerment and a self-perpetuating cycle of demand coupled with insufficient capacity to be able to respond. Structures and processes are described as disabling, resulting in a system which in their view is failing to meet the scale of the challenge. Being big, bold and brave and having ambition was felt necessary to achieve change, but the recovery from Covid-19 and the development of Well-being Plans by Public Services Boards in Wales currently makes the timing feel right.

The need to '*start with the person, not the system*', to put **individuals at the centre** and engage in conversations about what matters to them highlights a determination to value lived experience and to take an asset-based approach. The focus should be on building relationships, partnerships and structures that increase people's trust, power and control.

Embedded in this is a **holistic approach** - understanding people in the context of their whole lives, including the wider determinants of health. The new model should encompass the broader concepts of **wellness and well-being** which participants feel better facilitate this focus on the whole person. There was a suggestion that moving the system in this direction will improve outcomes and generate a greater return on investment. However, some participants acknowledge that just like health, wellness and well-being mean different things to different people and are often individually defined. This points to a need for a different way of thinking about what we value and how we measure success within a social model of health and well-being.

The belief that **communities** hold the answer and are central to an effective model was a strong message from participants. The plea is to 'do with and alongside' as opposed to 'doing to' communities. This includes actively listening and responding to need, but participants go further seeking co-production and co-design and a real shift in power and resources towards communities. This could utilise models such as shared ownership, community asset transfer or community sharing initiatives so that community owned and led mechanisms are a central component of the new model.

There is very general agreement that we need more effective **collaboration** and that working together and **partnerships** are the right approach but that these may require a shake-up in structure and membership, looking beyond the traditional models to innovative ideas that would allow for different structures and types of input.

The **workforce** is viewed as the NHS's greatest asset but equally the change in culture and practice needed within the workforce to achieve a social model of health and well-being is not underestimated. It is described as a 'paradigm shift'. Enabling people to spend time in others roles or organisations was one proposal for creating a greater understanding of strengths and challenges in different parts of the system. It might also be a means of introducing the role of 'critical friend' within partnership working and mitigating the effects of single issue or single individual organisation perspectives. Linked to this was the need for education and training to equip staff with the competencies and support needed to deliver the new model, including leadership at all levels to manage and drive the change.

The challenges of measuring progress across the current system with a range of partners, all of whom have individual performance indicators was acknowledged. There is an appetite to move away from this towards joint **accountability** arrangements across organisations with a focus on outcomes. Such arrangements should be able to deal with changes in political leadership to prevent the short-termism associated with initiatives funded and reviewed within political cycles.

Social value, with a focus on improving wellbeing, equality and the environment may align more closely to a social model of health than traditional performance measures. In the view of participants, the involvement and engagement of communities and people themselves in conversations about what matters to them, might offer renewed insight into what future success might look and feel like. This should include accountability to the service user or community first and links to the role of citizenship and democracy in the new model. The need to actively seek to involve individuals and communities in the governance, accountability arrangements and structures was a shared ambition for the new model in order to re-balance the '*corporate distance*' between organisations and the individuals they serve.

Much of what was described by participants in the 'conversations with a purpose' is already embodied within policy and legislation in Wales through the Well Being of Future Generations (Wales) Act, 2015; the Social Services and Well-being (Wales) Act, 2016 and A Healthier Wales, 2018 so the fact that people recognise and view them as positive is beneficial to achieving any change. However, for many, it begs the question as to why more has not been achieved already. Although many people described the negative features of the current system, very few offered a critical appraisal of a Social Model of Health and Well-being. This could indicate overwhelming support or could point to the bias discussed in the limitations section of this report and a desire to be 'in favour'. This should not detract from the findings but reinforces the need to test out the findings with a wider group of people, including staff, partner organisations and most importantly the communities of Hywel Dda.

5. Next Steps

Fortunately, HDUHB are already further ahead on this journey than other parts of Wales. The components participants describe as central to a new model are already embodied within *A Healthier Mid and West Wales: Our Future Generations Living Well, 2018* and the accompanying *Health and Well-being Framework for Hywel Dda, 2019*.

The UHB should capitalise on the feeling that the time is right and the ambition to be big bold and brave by taking the first steps in system leadership to re-ignite some of the momentum gathered prior to Covid-19. The strong support for a focus on the wider determinants of health and inequalities underline the need to engage with a wide range of partners, particularly Public Services Boards and the communities of Hywel Dda in the next stage of this process. The previous intention for large scale engagement with communities should be revisited in view of the very strong message in this report about the central role that communities will need to play in the future model.

Many of the thought leaders who engaged in the 'conversations with a purpose' are interested and willing to continue to participate, if invited. Presenting the findings of this report back to them to test its resonance would be a worthwhile step in re-engaging them in discussion aimed at building a consensus view to share with a wider audience. Offering the tangible data in this report may provide 'food for thought' and help move the thinking towards 'the how' as this aspect was notably underdeveloped in the data.

As a Public Health Team we advocate The Well-being Lens (mobilising the whole system) which was developed to accompany Our Future Generation's Living Well: a Health and Well-being Framework for Hywel Dda in 2018/19 as a useful tool. It was designed to help 'change the conversation' away from a focus on illness towards wellness and well-being. It reflects the principles and approach of the Framework and aims to reorient 'the system' to take a preventative approach; embodies the sustainable development principle of the WBFGA (Wales) Act 2015 through the 5 Ways of Working – collaboration, integration, involvement, long-term, prevention; Focuses on the whole person/whole population and a system-wide approach; Incorporates the 4 Prudent Health Principles; Takes an asset-based approach and has an ambition to reduce health inequalities.

Many examples of inspiring and successful practice from elsewhere were identified during these conversations. We suggest that exploration of these could be vital in drawing upon valuable experience and building on their learning whilst remaining cognisant of the unique values and policy opportunities we have in Wales.

This shift towards a social model of health and well-being is a departure from traditional ways of working. It will require a wholesale shift and some trust in the process that the desired outcomes will emerge over the longer-term. HDUHB will need to demonstrate strong leadership, model the way and support others in the transition.

References:

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Hywel Dda University Health Board (2018), *A Healthier Mid and West Wales: Our Future Generation Living Well*, HDUHB

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Welsh Government (2018), *A Healthier Wales*, GOV.WALES

Welsh Government *Social Services and Well-being (Wales) Act 2014*, GOV.WALES

Welsh Government, *Well-being of Future Generations (Wales) Act 2015*, GOV.WALES

Appendix 1

Summary of key themes

	Title	Sub-themes
Theme 1	What is working currently?	<ul style="list-style-type: none"> The NHS provides a safety net – free at the point of access and it delivers societal benefits. There at the point of crisis or emergency Quality of [NHS] care is deemed to be good and is generally well regarded and trusted. Its main assets are its people. The provision of continuity of care through primary care is important in communities The policy and legislative landscape in Wales through the Well Being of Future Generations (Wales) Act (2015) and A Healthier Wales (2018) are conducive to a Social Model of Health
Theme 2	What is not working currently?	<ul style="list-style-type: none"> The ‘system’ including Health is over-complicated, bureaucratic, slow, works in silos and lacks accountability. It is failing to meet the scale of the challenge The structures and partnerships put in place reflect this – bureaucratic; formal; rigid; over-complicated and lack vision and boldness The resulting overall system is reactive; lacks integration, collaboration and engagement and there is an unwillingness to share assets including budgets fuelled by a lack of joint or overall accountability Short-term funding and silos working perpetuate fragmented services with a reactive, remedial and short-term focus Continuity of care has reduced and the system fails to value people’s lived experience resulting in reduced trust and poorer outcomes
Theme 3	What would a new model look like/include? - key features	<ul style="list-style-type: none"> The principle of ensuring greater equity and reducing inequalities should underpin the model [It] should set out to achieve more than ‘<i>merely the absence of ill-health</i>’ with a broader ambition which includes the concepts of wellness and well-being There is a need to focus on the whole population and whole person, taking account of the wider determinants of health This, in turn, demands a whole-system approach and structures that enable people to connect easily with the right parts of the system to meet their needs

		<ul style="list-style-type: none"> The model should be founded on meaningful engagement and participation with accountability to the individuals it is there to serve.
	Title	Sub-theme
Theme 4	What needs to happen for a shift to a new model to be achieved?	<ul style="list-style-type: none"> Real ambition and bravery will be needed to achieve change but the time is right to be doing this The challenge to achieving change surfaces the recurrent tension between ambition and the demands placed on the system to manage the here-and-now There is very general agreement that collaboration and partnerships are the right approach but that these need to be improved and extended beyond the traditional models Many existing parts of the system were seen as playing a part in making change happen but there was also a strong lobby for co-production and co-design with communities and for the involvement of non-traditional organisations. A change in the funding to allow the sharing of assets and resources and to facilitate a shift of power and resources towards communities is strongly advocated.
Theme 5	Where would be a good place to start?	<ul style="list-style-type: none"> There may be a need for 'quick wins' and to 'target low-hanging fruit'. If you want to transform you need a 'long-term view'. Start small and make it manageable - 'bite-sized pieces' Align it with the daily business of partners. Many respondents mentioned examples of promising practice which have been compiled by the Engagement and Transformation Programme Office in HDUHB.

Appendix 2

Who needs to be influenced?

Who	Number of interviewees who mentioned
Senedd members	2
Welsh Government	2
RPB and PSBs	1
Regulators	1
Auditor General Wales	1
Senior Leaders	1
Advisors	1
Boards/elected members	1
Independents	1
Police	2
Charities/third sector	1
Local Authorities	2
Local Authority Chief Executives and Leadership	1
Service providers in direct contact with people	1
GPs	1
Education	1
Fire Service	1
Staff	1
Service Users	1
Vice Chancellors	1
'Concrete middle'/middle managers	2
PSB Co-ordinators	1
The Media	2
Public/communities	5
Community influencers	1
Those who have benefitted from a Social Model of Health approach	1
A broad cross-section/stakeholder group	2

Appendix 3

Who benefits the most?

Who	Number of interviewees who mentioned
Most disadvantaged/vulnerable/deprived	7
Older people	4
Children and young people	3
People who struggle to access traditional services	3
Vulnerable	2
BAME and other minorities	2
People with disabilities	2
Carers	2
Lonely/isolated	2
Homeless	1
Least engaged	1
Everyone	1
Children with SEN	1
Women	1
ACES	1
Crime	1
Substance misuse	1
People physically distant from services	1

A potential framework for implementing a Social Model of Health & Well Being in HDdUHB

‘A starter for 10’

Beth Cossins

November 2022

	Individual level	Population level
Within the NHS	Adapt NHS care to account for patients/individuals social needs	Use NHS resources to improve social conditions in the community
In Partnership	Connect patients/individuals with resources to address social needs	Align local resources to improve population health

A reminder of the themes that emerged from the conversations with a purpose

What needs to underpin the new model?

A focus on:

Improving equity

Prevention

Reducing inequalities

Wellness and wellbeing

A holistic approach – whole person/whole community/whole system

The wider determinants of health and wellbeing

Collaboration

Overall/shared accountability

What might help move us in the right direction?

Bravery and the need to be bold

Cultural change

Increased trust

Valuing the lived experience

Meaningful collaboration

Revised governance

Measuring the right things – outcomes

Greater community involvement

A difference distribution of power – vesting more power in communities

Simpler structures

Improved/different collaboration

Improved overall accountability

Linking the framework to the themes that emerged from the conversations with a purpose

	Individual level		Population level	
Within the NHS	Using information/data on social circumstances to inform treatment and care:	<ul style="list-style-type: none"> • Social context • Holistic assessment • What matters to you? Conversations • Valuing lived experience • Shared decision making • Co-design • Communication 	NHS as an anchor institution:	<ul style="list-style-type: none"> • Fair employment • Training and development • Local procurement • NHS estates • Commissioning • Communication • R&D • Value Based Healthcare • Including social and economic needs in planning how to reduce waiting times
In Partnership	Connect patients/individuals with resources to address social needs:	<ul style="list-style-type: none"> • Social prescribing • Community Connectors • Self support • Individual and Community Assets • Building trust • Facilitating access to community resources 	Joint planning with partners to address local needs:	<ul style="list-style-type: none"> • Collaboration • Pooled budgets • Integration • Joint planning • Joint strategies • Develop community infrastructure • Community ownership

Links to Planning Objectives in HDdUHB

	Individual level	Population level
Within NHS	1E 1G 1H 2B 2D 2J 2K 2M 3A 3E 3N	2A 3G 3J 3M 4D 4T 5I
In Partnership	4Q 5C	4J 4K 4N 4R 4S 4V 5H 5R 6G 6H