Building a resilient system

Building a resilient system: reflections and insights from health and care leaders

October 2020

Liz Knight, Danny Silk and Anne Rainsberry

Contents

1. Impact and lessons from Covid-19 2

2. Introduction to the resilient system 3

3. Person-centred, place-based care 4

4. Empowered and engaged workforce 7

5. Shared assets: estates, data and finance 10

6. An evolving leadership approach 12

7. The journey ahead 14

8. About the authors 16

9. Acknowledgements 17

About this report

In preparation for this report, we spoke with 38 key leaders across health and social care. They shared their reflections from the early days of the Covid-19 pandemic and their insights on how they are shifting their approach, both to their work and to their leadership style. We also organised a three-part roundtable series to address top themes and guiding principles. You can view the list of leaders from our interviews and roundtables in the Acknowledgements section.

From this work, we have drawn together the collective thoughts and experiences into the concept of a "resilient system". This encapsulates new ways of collaborating at all levels to deliver person-centred, place-based care that builds on the lessons of the pandemic.

> *"Our system has had to come together to respond to a very different situation. Conversations have become more real and delivery orientated. We're bringing together clinical directors and others across the system but without distracting from local understanding and delivery. We must be systematic, collective and safe."*
>
> *"This has been a very emotional journey, for me and for our staff, and through reflection, I have recognised the importance of leading through influence and asserting with emotional intelligence and empathy."*
>
> *-Trust CE*

1. Impact and lessons from Covid-19

During the first half of 2020, the Covid-19 pandemic swept across the world. The impact on the NHS and social care was profound. Leaders and their teams reconfigured services overnight, created additional capacity and adapted immediately to a highly volatile and uncertain environment. United by a common purpose and a set of circumstances both unprecedented and extreme, people worked together to enact changes that previously seemed impossible. NHS and care staff were hailed as heroes for the actions they took and the lives they saved.

"Things that we thought would take us a month, we actually did in day." -Trust CE

However, the focus on Covid-19-related activity came at significant human cost. Business-as-usual activity halved, meaning many more people today are waiting longer to receive care. [1,2] The pause in screening and treating cancer patients has raised notable concerns and will inevitably reverse upward trends in early detection, care and survival rates. The rapid discharge of older people into care homes without adequate testing in place resulted in a higher rate of infection in a very vulnerable group of people and contributed to the significant excess deaths seen during the first wave of the pandemic.[3] The pandemic has disproportionately affected Black, Asian and minority ethnic (BAME) groups as well; for example, Covid-19-related death rates for black men are 3.3 times that of white men.[4]

"A seminal moment was when the impact of the virus on BAME population became known. It was like a shock wave that ran through us." -Trust CE

The focus over the summer was on the restoration and recovery of services, though infection rates are now rising again. With the current arrival of the annual flu season, the immediate priority for organisations across health and care is to deliver urgent care services over the winter of 2020/21. Time to think is scarce, but it is crucial that leaders take actions over the winter that are in a direction of travel that will support future changes. Restoration is important, but so too is sustaining the improved ways of working that have resulted from the health and care response to the pandemic.

"Strategically we know where we are headed. We need to work with the grain of that so that when we surface next spring, after a second wave, we have gone in the right direction." -Trust CE

[1] British Medical Association, The hidden impact of COVID-19 on patient care in the NHS in England: https://www.bma.org.uk/media/2841/the-hidden-impact-of-covid_web-pdf.pdf

[2] The Guardian, Non-urgent England hospital admissions drop by 725,000: https://www.theguardian.com/society/2020/jun/30/non-urgent-england-hospital-admissions-drop-by-725000

[3] Office for National Statistics, Deaths involving COVID-19 in the care sector: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsoccurringupto12june2020andregisteredupto20june2020provisional

[4] CF Healthcare Consulting, Ethnicity and mortality: understanding and addressing ethnicity and mortality in hospital activity during Covid-19: https://carnallfarrar.com/media/1618/201019-understanding-and-addressing-ethnicity-and-mortality-in-hospital-activity-during-covid.pdf

2. Introduction to the resilient system

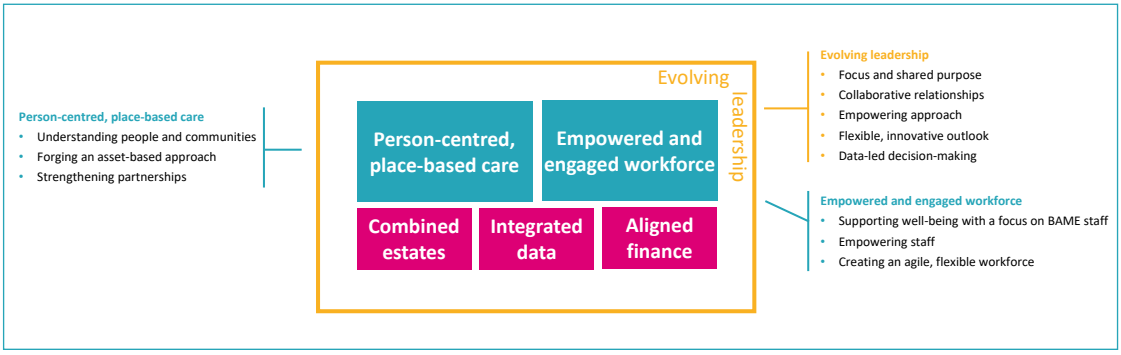
Even before the pandemic, health and care organisations came together within systems to tackle long-standing and deep-rooted issues. There was a general sense of uncertainty and scepticism about yet more initiatives to encourage collaboration and integration. However, during the pandemic, systems were able to work together differently to solve problems and deliver transformational change.

"We've shifted in mindset to think about exactly what the challenge is we need to solve and then getting all the partners around a table to tackle it, rather than having lots of forums with broad membership that have no purpose or problem to solve." -ICS SRO

"If we see ourselves as leaders in places, we don't need to wait for national planning guidance."
-Regional Director

As systems start to restore services, it is critical to ensure that positive innovations are sustained and extended. Systems also need to prepare for possible future pandemics, or other crises. We can think of this as system resilience. System resilience is an active, integrated approach to responding to crises, including surges in demand, without losing core functions. Resilient systems are able to shift service delivery and flex the workforce as needed to respond to rapid change. Resilient systems will deliver a balance between doing things once across the system and ensuring local flexibility.

Exhibit 1: The resilient system



To develop resilient systems, leaders need to focus on person-centred, place-based care, one that is supported by an empowered and nurtured workforce and underpinned by place-based estates, integrated data and aligned finance.

The way in which leaders lead is also evolving, along with a real energy to take the opportunity given by the pandemic to do things differently. Leaders are moving towards more focus, more collaboration, more empowerment, a flexible and innovative approach and data-led decision making.

3. Person-centred, place-based care

We start with a focus on people in their communities and the delivery of services that wrap themselves around vulnerable people. Place-based care ensures seamless, timely and integrated pathways across primary care, secondary care and social care. Instead of forcing people to navigate complex and siloed services, place-based care focusses on the person, their family and their communities. Leaders of resilient systems support this by collaborating and remaining committed to shared success over organisation-specific performance. The pandemic highlighted the importance of 'place' as a way to bring together professionals to deliver local services to a local community by:

- Understanding people and communities
- Forging an asset-based approach
- Strengthening partnerships

Understanding people and communities

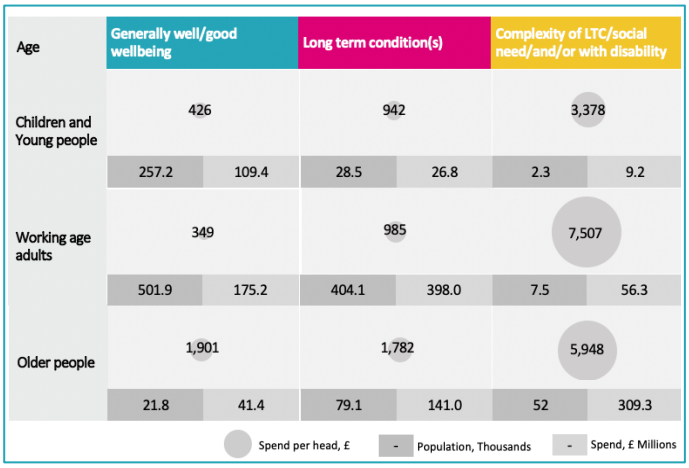
"We use a citizen panel with thousands of people, and it represents the demographics of our population. We have over-recruited in areas where we are challenged to ensure the right voices and diversity of opinion are heard." -ICS SRO

Unlike Local Authorities, the NHS tends to deal in illness, not people or places. But keeping people well requires an understanding of the whole person rather than just a condition. We believe a better understanding of local communities will be crucial in re-building services to support health and well-being and to tackle health inequalities. Going out into communities to engage people in this conversation also means that resources are more likely to be directed where they can help most.

When re-building services, resilient systems need to:

- Understand the nuances of local communities in the round and across the public sector
- Understand the different needs of specific groups by segmenting people to provide appropriate care and improve outcomes
- Assess where resources are currently spent (across health, care and also other areas such as education and housing) and begin pooling budgets for optimal use of resources

Exhibit 3: Population health segmentation output



- Have difficult conversations about where to target resources, with a focus on improving equality of health provision and outcomes
- Build social and community infrastructure to keep people healthier and well, preventing social isolation and loneliness

"We have talked about inequalities for some time. There has been an uncomfortable truth about disparities in funding. We have now got shocking and widening inequalities and so we can't avoid it. We need to understand that data and look at actually what that really means for how you access care." -CCG Chair

Forging an asset-based approach

Leveraging the assets of a community, its people and places, is a crucial part of the way forward for delivering health and well-being to diverse communities. Funding social scaffolding is an example of how to support the well-being of local people in a cost-effective way. Resilient systems need to invest in services such as befriending and early support for vulnerable young people. Simple investments, such as buying slippers for older people at risk of falls, can connect local people to a sense of place and prevent later ill health. Joint working with local authorities through joint commissioning and Health and Wellbeing Boards (HWBs) will reinforce and augment this approach. This type of working was used very effectively, and with great success, as part of the Wigan Deal.

"Never underestimate the power of communities. During Covid, there were millions of people in their own homes who needed support. People stepped in. Communities did a lot and providers can too often forget the power of working with communities and partnering with them." -Trust CE

Exhibit 4: Person-centre, place-based care in action: the Wigan Deal

Asset-based working	• A major drive to recognise and nurture the **strengths of individuals, families and communities** • Health and care workforce could hold different conversations given an **understanding of the community** • **Shared information on community assets** available through online market place and digital applications
Permission to innovate	• Wigan Council leaders created a culture in which frontline staff are **empowered to make decisions** • **Positive risk-taking is encouraged** when potential benefits to clients outweigh potential harms • Moving from a "blame culture" toward one that **emphases learning** from what has not worked
Investing in communities	• **£12m investment through the Deal for Communities Investment Fund** to solve social problems • A **collaborative approach to commissioning** where voluntary and community sectors are partners • Focus to **grow citizen leadership** through roles like community health champions
Place-based working	• Partner organisations **worked flexibly across organisational boundaries** within local neighbourhoods • Community Link Workers joined the workforce to **provide facilitated support to clinicians and patients** • **Involvement from police, housing, employment and welfare services** brought greater coordination

GPs and Primary Care Networks (PCNs) will be key to forging this asset-based approach. They will need to be more focussed on inequalities, asset-based work and partnership working. This means working with other entities in the system, such as social care and community teams, to deliver services to communities. Resilient systems

will need to be clear about the role of PCNs and how they are part of the system decision-making processes.

"More GPs are focussed on inequalities and asset-based work, but many don't feel trained for this and there is the challenge of workload." -National leader

Anchoring communities

The large provider organisations (acute, community and mental health) all have a key role as anchor organisations within communities and networks. They have responsibilities not only as care organisations, but also as employers and community partners who have a fundamental role in tackling inequalities, supporting communities and developing provider collaboratives and pathways. Resilient systems will support providers to develop these system roles and responsibilities. For example:

"As the country's biggest employer, we need to step forward now and ramp up retraining and support in this change for the economy." -Trust CE

- considering how to recruit and leverage skills from other sectors that are experiencing redundancies as part of the pandemic (for example, airline staff)
- reflecting on the staff demographics and how this mirrors the demographics of local communities, from where the majority of their staff are drawn
- giving greater consideration to the role of volunteers and community groups

Strengthening partnerships

Leaders often cite the freedoms that organisations had during the pandemic to deliver change and work together to solve problems. Partnerships strengthened, relationships developed rapidly and trust was readily given, even as leaders were limited to virtual interactions. Resilient systems will need to align incentives and priorities to sustain these trends. Tactically, they must put arrangements in place that suit local circumstances whilst making sure that the primary focus is on getting things done rather than on processes and structure. Organisations will need to act in the interests of the system to meet the needs of people in local communities, which might mean giving up some of their own autonomy (for example, with joint waiting lists).

Aligning incentives and decision-making

Moving forward, resilient systems will align incentives for joint prioritisation of issues, with equal importance given to health and local government concerns. For instance a goal may broaden from discharge metric to a grander vision of alleviating poverty. This alignment is also required nationally, including for social care funding. Joint posts across leadership teams will enable effective joint decision-making. Leaders must align financial resources whilst acknowledging that the NHS has comparatively more resources and different financial targets and accountabilities.

"There is a financial challenge due to difference in financial regimes… LAs can't go into deficit, which causes a strain on partnerships working." -ICS SRO

"We are still treating local government and social care as second-class citizens. During Covid, they just didn't get the same care, funding and prioritisation as health." -Trust CE

4. Empowered and engaged workforce

We believe a fully engaged workforce is crucial to deliver services within places and contributes to the building and sustaining of resilient systems. An engaged workforce drives improved patient experience, improved outcomes and greater satisfaction for staff. During the pandemic, a renewed sense of purpose meant people exhibited massive goodwill and worked together to achieve impressive outcomes. Key to this was the engagement of people with a common aim and the freedom to do things differently. This engagement did come at a price, and people are exhausted. There is also a sense that many of the positive workforce changes are reverting back to the way they were before the pandemic. A step change in workforce engagement is therefore required to build resilient systems whilst protecting positive changes by:

"At the height of the crisis, there was an enormous amount of goodwill [amongst staff]. But that glorious period didn't last for very long and it has become a lot more difficult as people have become more emotional and more aggressive. They're tired." -National leader

- Supporting well-being with a focus on BAME staff
- Empowering and valuing staff
- Creating an agile and flexible workforce

Supporting well-being with a focus on BAME staff

The health and care workforce went through an emotional journey during the pandemic. There were concerns about personal safety, the deaths of patients and colleagues (particularly BAME staff) and the pressures of lockdown. There is a need to recognise the trauma that people have gone through and meet this with understanding and support. Before the pandemic, there were already critical shortages in staff across health and social care. There were high stress levels and high staff turnover[5], and this is likely to be exacerbated by people's responses to their experiences during the pandemic. In re-building services, there needs to be a focus on well-being with mental health support for staff becoming more important. Resilient systems will support people to:

"Sometimes we over-focus on pace setting and then forget about the consequences that it has on our people." -Trust CE

- connect with other people
- be physically active
- learn new skills
- give to others
- be mindful (i.e., pay attention to the moment)[6]

[5] The Health Foundation, COVID-19: Five dimensions of impact: https://www.health.org.uk/news-and-comment/blogs/covid-19-five-dimensions-of-impact

[6] NHS, 5 steps to mental wellbeing: https://www.nhs.uk/conditions/stress-anxiety-depression/improve-mental-wellbeing

Focus on experiences of BAME staff

Covid-19 has disproportionately impacted BAME staff, and early tracking of related deaths revealed that death rates for BAME staff were 2-3 times higher than that of white colleagues.[7] When re-building services for the long-term, resilient systems will need a range of initiatives to tackle this issue such as:

- undertaking impact assessments to better understand the issues facing BAME staff
- working with BAME staff to develop solutions to issues and ensuring a BAME voice on key decision-making bodies
- supporting BAME staff to take action and feel empowered to make change
- implementing and monitoring processes to track the impact of changes, including the setting and of targets for change

"BAME staff make up 25% of our workforce, which is significantly higher than our local population, so we are working towards ensuring that we reach 25% in our senior ranks as that reflects the higher of the two." -ICS SRO

Empowering staff

There was a monumental effort from the workforce during the early days of the pandemic. Working patterns changed overnight, with rapid credentialling and movement to accommodate needs. Retirees came back to work and medical students graduated early to support the effort. People were united by a common purpose at individual, team and organisation levels. During the pandemic, leaders realised what their staff are able to achieve given the freedom and tools to conduct their work.

"It is easier to be resilient if you feel valued."-CCG Chair

As the initial period of empowerment wears off, resilient systems will need to think about how they encourage, promote and reward empowerment across teams. Through compelling communications, recognition and appreciation, teams will believe these behaviours and mindsets are here to stay and not simply a one-off during crisis.

Focus on clinical leadership

The power of clinical leadership is often discussed, but the NHS has historically struggled to make clinical leadership a reality. During the early days of the pandemic, capacity, workforce and experience were shared, often through clinical networks or clinicians getting together to put things in place outside of usual decision-making structures. Strong clinical leadership is missing in many systems, with clinical leaders reluctant to take on leadership roles and uncertainty around the role of

"Covid showed yet again how essential clinical leadership is … they were energised, and when given the authority to lead, they did." -ICS SRO

[7] Tim Cook, Emira Kursemovic and Simon Lennane, Heath Service Journal: https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article

GPs. To move forwards, resilient systems will need to urgently identify and appoint clinical leaders, with the freedom to innovate without micro-management.

Creating an agile, flexible workforce

There were significant workforce challenges prior to the pandemic. The NHS was already projecting a 100,000-person shortage in staff, on top of a 120,000-person shortage within social care[8]. Resilient systems must also plan around an ageing workforce, in line with the rest of the country[9]. Factors most contributing to decisions on retirement are health and wellbeing, workload and burnout, though added flexibility could help retain older workers for a longer period of time.[10]

"For community health care, we have been underinvesting in them for years and therefore they have a massive staffing and resourcing gap to deliver everything that people are asking them to deliver." -ICS SRO

Staff worked incredibly long hours during the pandemic. However, some were less able to contribute to the pandemic response due to a lack of transferable skills. Continuing professional development (CPD) is mandatory for professionals working in the NHS, but there is little requirement to conduct inter-professional CPD. There has also been significant year-on-year cuts to funding for continuing professional development, with Health Education England's workforce development budget falling from £205m in 2015/16 to £83.5m in 2017/18 (with a small increase in 2019)[11].

Resilient systems will need to think very proactively about how they ensure their existing workforce are properly equipped, engaged and empowered to conduct their work. Urgent additional investment in CPD is required to address the skills gap. Resilient systems will also give urgent consideration to where the gaps are in the workforce and how they will be filled. Planning for this is usually most sensibly done at a system level.

[8] The Health Foundation, Going into COVID-19, the health and social care workforce faced concerning shortages: https://www.health.org.uk/news-and-comment/charts-and-infographics/going-into-covid-19-the-health-and-social-care-workforce-faced-concerning-shortages

[9] Chartered Institute for Professional Development, Avoiding the demographic crunch: Labour supply and the ageing workforce: https://www.cipd.co.uk/Images/avoiding-the-demographic-crunch-labour-supply-and-ageing-workforce_tcm18-10235.pdf

[10] British Medical Association, Supporting an ageing medical workforce report: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/the-ageing-workforce/supporting-an-ageing-medical-workforce

[11] Royal College of Nursing, Continuing Professional Development in England: https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2019/december/007-995.pdf?la=en (PDF download)

5. Shared assets: estates, data and finance

We believe that resilient systems need to rethink their existing assets and identify high-impact initiatives to fit with the new way of working. These include:

- Combined estates
- Integrated data
- Aligned finance

Combined estates

Resilient systems need to expand their view of estates to encompass all facilities, including those beyond their own organisations. By incorporating community-based spaces such as village halls, community centres and homes, systems will develop a more comprehensive understanding of collective assets. These can then be used, both for business-as-usual, and in crisis situations such as a pandemic. A full understanding of available estates means systems can allocate capital spend according to need rather than organisations feeling compelled to vie for heavily restricted funds that prioritise new buildings.

"There is a lack of integrity at the heart of the capital planning process. ITU should be in large specialist hospitals only. Surgery should be centralised and we need high volume day case and elective centres." -Regional Director

Resilient systems will need to consider where scarce capital is best spent. There will likely be continued use of virtual appointments, a split of emergency and elective activity and the need to build flexible accommodation. There is a growing view amongst leaders that the scope and aims of the Health Infrastructure Plan (HIP)[12] capital investment needs to be revisited to agree whether it is still useful to pursue a series of large hospital builds, especially given the focus on primary care, prevention and home treatment. Leaders also feel they need a firmer national mandate to move ahead with creating "Covid-secure" hospitals.

"Full red or green sites are too big of a change without a firmer national mandate to push it through." -ICS SRO

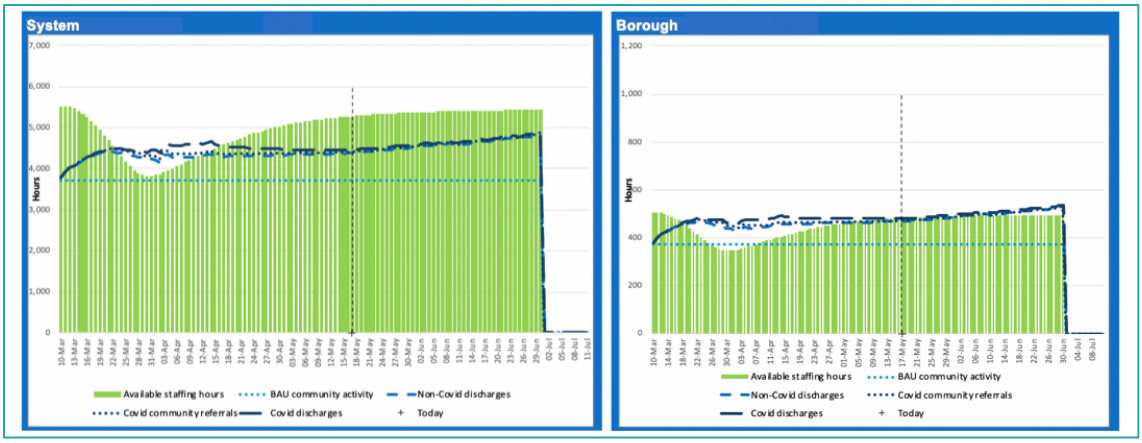
Integrated data

During the pandemic, there was a lack of high-quality, near real-time data to support decision-making. This meant that at the start of the pandemic, people were making decisions without decent information. During the pandemic, there was a rapid development of information sharing which meant people were making decisions with highly relevant and useable data, often for the first time.

"During Covid, we got used to having decent management information." -National leader

[12] Department of Health, Health Infrastructure Plan: https://www.gov.uk/government/publications/health-infrastructure-plan

Exhibit 5: Example outputs of integrated data planning tools



Resilient systems need to leverage near real-time data and analysis, especially as an early warning system. Access to integrated data to support integrated planning and delivery is critical, one that tracks infections, cases and the impact on requirements for care. Developing this requires a combination of datasets, analytical tools and capability of information governance to be unlocked. This approach necessitates the engagement of a wide range of parties, namely trusts (acute and otherwise), CCGs, Local Authorities and GP practices (as they organise themselves into PCNs).

Aligned finance

The successes of the pandemic response need to be understood in the light of the removal of spending restraints. However, much of the financial system, such as Payment by Results (PbR) and individual Cost Improvement Programmes (CIPs), were removed, allowing organisations to work together more effectively. Moving forward, resilient systems will need to align finance and incentives across organisations, including partners outside health services, to ensure that local funds are spent most effectively for local people. They will do this by:

"Suspending PBR has had a massive impact on behaviours. A lot of people would benefit from lower-level interventions incentivised by not having PBR." -Regional Director

- Considering the entire 'pot' of money spent on health and wider determinants
- Devising and expanding outcomes-based agreements that can more concretely address wider determinants of health
- Adopting a longer-term focus with stronger incentives to reduce health inequalities (alongside national changes to the financial system)
- Focusing on cost management rather than activity, incentivising earlier intervention (and requires continued removal of Payment by Results)
- Clarifying accountability for financial performance within the system, which needs to sit with the system, underpinned by CCG contracting arrangements

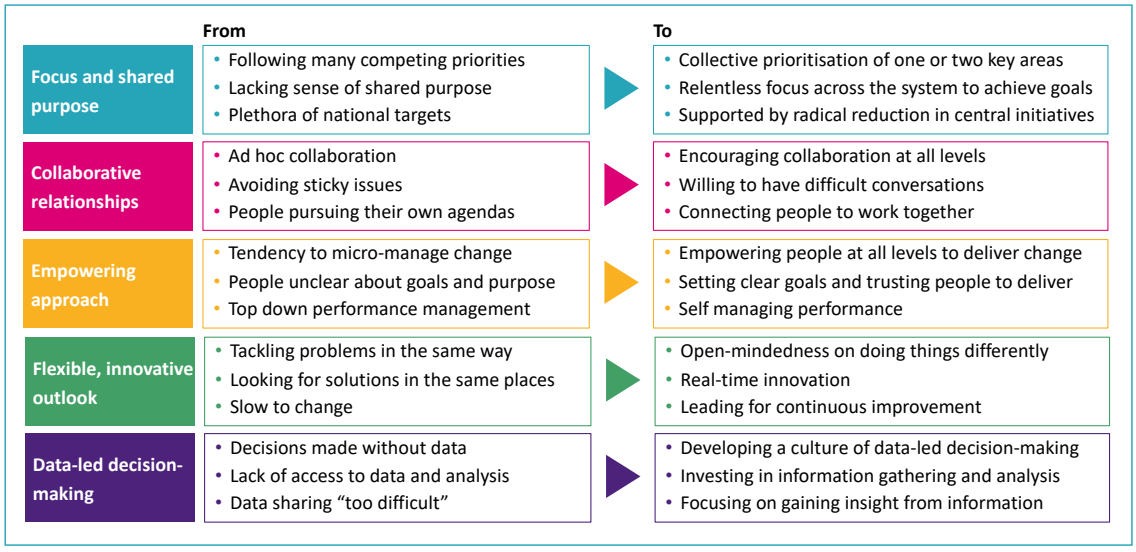
"There needs to be clear expectations of organisations if the money goes off in the systems and clarity about what happens if we don't meet financial requirements." -ICS SRO

6. An evolving leadership approach

Leaders say the pandemic has changed how they lead. To restore services whilst protecting transformational changes, leaders must be more intentional about how they plan, empower and implement change. Leaders will evolve their styles to support resilient systems by prioritising five key areas:

- Focus and shared purpose
- Collaborative relationships
- Empowering approach
- Flexible, innovative outlook
- Data-led decision-making

Exhibit 6: How leadership styles are evolving to support resilient systems



Focus and shared purpose

Systems often have long lists of 'priorities' that cover most of the work of all the partners rather than single-mindedly focusing on a few key priorities. The pandemic showed that transformation can happen overnight if people are aligned and focussed on achieving one thing. Leaders of resilient systems will need to prioritise one or two areas and then relentlessly focus across the system to achieve their goals in these areas. Leaders believe there also needs to be a radical reduction in central initiatives, priorities and targets to allow systems to focus on a small number of local priorities.

> *"Covid showed that if we have a single objective, we can align systems effectively." -Regional Director*

Collaborative relationships

The pandemic enhanced collaboration and relationships as people and organisations came together to focus on a single goal. Leaders need to think about collaboration and relationships at all levels, through teams, with partners and with communities. Alongside collaboration and relationships, leaders of resilient systems must be willing to have the difficult conversations, about priorities and funding, about what to try and fix first. Leaders will also need to prioritise to make sure they have the personal capacity to develop key relationships.

"Covid enhanced collaboration as people were centred on one goal, and the ruthless focus on this goal has led to people being emotionally connected to the purpose of the business once again." -Trust CE

Empowering approach

There is a strong theme of empowerment throughout the resilient system. Leaders need to be empowered to run their system, and people within the system empowered to deliver change. Leaders of resilient systems also need freedom to set targets and performance manage themselves rather than working within a set of rigid national mandates.

"I think the biggest lesson of Covid is that if you give people a clear goal and you trust them, and look after their needs, people will do the most amazing things." -Trust CE

Flexible, innovative outlook

During the pandemic, people had to be flexible, with priorities changing by the hour. With that flexibility came innovative ways of doing things, an open-mindedness to doing things differently and a move to continuous improvement as changes were made in real-time. This led to help from unlikely places and overnight changes that had not previously been thought possible. Leaders of resilient systems will need to keep that open mind and flexible approach to deliver future transformational change.

"These transformations won't endure unless we are careful to make them, and the pressure to return to 'normal' is making that very challenging." -Trust CE

Data-led decision-making

Leaders have enjoyed having access to high quality, near real-time information during the pandemic. Decisions are better if they are made based on the evidence about what is actually happening. Leaders of resilient systems will need to invest in information gathering and analysis and develop a culture of using data to make decisions.

"We need to focus on data and insight from information. We need to make good decisions based on data." -Trust CE

7. The journey ahead

The Covid-19 pandemic created a seismic change in the way health and care services are delivered. Transformation happened overnight, and people came together in a remarkable manner. Through our interviews and roundtables, we have identified the key ingredients needed to build resilient systems.

Resilient systems require person-centred, place-based care, with people working together locally to deliver services. People are commonly viewed as patients, a unit of need, rather than human beings as part of society. Leaders need to gain a deep understanding of people and communities, forge an asset-based approach and strengthen partnerships. Local authorities and the NHS worked together well during the pandemic, but areas of misalignment in incentives remain. Effectively harnessing community assets will be crucial to delivering services that prevent more costly intervention down the line.

An empowered and engaged workforce is also essential for resilient systems. Health and care staff have been through trauma, and there is urgent need for empathy, appreciation and respect. Leaders must support employee well-being, with a particular focus on BAME staff. Beyond support, staff should feel empowered to make decisions and be trusted to do what is in the best interest of local people. Finally, leaders must promote a shift to an agile, flexible workforce, particularly as systems adjust to rapid and unpredictable shifts in care delivery and planning. Systems will need to address the gaps in the workforce, both in terms of roles and skills.

Leaders will need to rethink their existing assets and consider new ways of planning and working. A vision of combined estates that encompasses all community facilities will ensure space is used well and capital is allocated according to need. Stronger linkage and usage of integrated data, particularly between acute, community, social and primary care, will help deliver the level of personalisation and insight needed both for individual care and community-level planning. A more aligned finance process, including outcomes-based arrangements, longer-term focus and clearer lines of accountability, will pay dividends in establishing resilience at a system level.

How leaders think about collaboration and its importance within systems will influence people's approaches to leadership itself. A common focus and shared purpose across the workforce, and a commitment to more cross-organisational relationships, will instigate a more empowered culture, one that adopts and embraces a flexible, innovative outlook. Such an environment will result in an enhanced ability to make

progress. With less bureaucracy and more delegation, collaboration and partnerships in place, data-led decision-making will become an embedded competency.

Even with the hardships and uncertainty ahead, there are compelling reasons to believe that health and care partners can take the lessons from the Covid-19 pandemic to change services for the better. Leaders and their teams have seen a glimpse of what is possible, and with the right vision, priorities and relationships in place, the journey to build resilient systems is well within reach.

8. About the authors

Liz Knight is a Principal at CF, where she leads our offers focussed on creating world-class services. She has worked with many systems to develop resilience and has served as Programme Director or strategic advisor on several high-profile reconfigurations.

e: liz.knight@carnallfarrar.com

Danny Silk is a Manager at CF. He has worked extensively with leaders across the UK and internationally on transformation programmes related to person-centred design, organisational development and analytics.

e: danny.silk@carnallfarrar.com

Anne Rainsberry, PhD CBE is a Managing Partner at CF leading our work on performance improvement and organisational development. Anne has over 32 years' experience in the NHS, holding leadership roles at system, regional and national levels.

e: anne.rainsberry@carnallfarrar.com

9. Acknowledgements

We owe a great deal of gratitude and appreciation to those health and care leaders who have spoken with us over the last few months.[13]

Adam Doyle
Alwen Williams
Sir Andrew Morris
Andrew Ridley
Ann Radmore
Anne Eden
Ben Morrin
Ben Richardson
Bev Evans
Sir Chris Ham
Dr Claire Fuller
Claire Murdoch
Sir David Sloman
Prof Donna Hall
Fiona Edwards
Frances O'Callaghan
Hannah Farrar
Hugh McCaughey
Dame Jackie Daniel
Dr Jo Andrews
Dr Jo Sauvage
Julian Hartley
Prof Kate Ardern
Dame Lesley Regan
Prof Martin Marshall
Mike Parish
Nigel Edwards
Dr Nina Pearson
Richard Barker
Richard Murray
Rob Webster
Roland Sinker
Dame Ruth Carnall
Sam Higginson
Sara Todd
Steve Russell
Theresa Grant

We would also like to thank Joel Lever, Isabelle Hubbard, Luke Doney, Rosie Webber, Ellie McHarg, Vic Cody, Will Browne, Jack Pickard, Talia Louki, Farhan Chatha and Charlotte Osborne for their support throughout the interview and research process.

Finally, we offer our utmost appreciation to all staff and workers who are responding to the pandemic, both directly and indirectly.

[13] We have excluded health and care leaders who asked to remain anonymous.