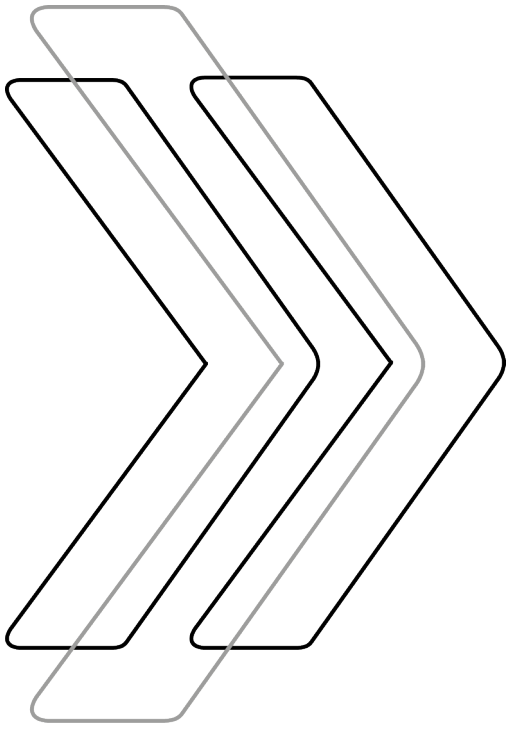
The King's Fund

Ideas that change health and care

Leadership and development of the Cardiff and Vale health and care system



Author

Ben Collins

May 2021

This independent paper was commissioned by the Cardiff and Vale University Health Board commissioned this independent report. The views in the report are those of the author and all conclusions are the author's own.

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

www.kingsfund.org.uk @thekingsfund

Contents

1 Introduction

Half an hour's drive north of Cardiff, the town of Tredegar in the Monmouthshire valleys is the birthplace of the UK's model of publicly funded health care. In the late 19th century, Tredegar's steel and mine workers created the Tredegar Workmen's Medical Aid Society, a subscription scheme for local people to receive health care when needed. By the 1920s, it offered the services of doctors, a surgeon, pharmacists, a physiotherapist, a dentist and a district nurse and access to treatment at its own hospital or at larger hospitals in Newport and Cardiff.

Aneurin Bevan was born and raised in Tredegar, worked as a miner with the Tredegar Iron and Coal Company and served on Tredegar's Hospital Management Committee. When Bevan became health secretary in Attlee's Labour government in 1945, this was the model of universal health care he extended to the UK's four nations, with the NHS in turn providing inspiration for other public health systems around the world (Thompson 2015).

Seventy-six years later, the economic and ethical arguments in favour of collectivist, universalist provision of health care remain as strong as ever. However, health and care services face new challenges. Since the 1940s, people have developed more complex health and care needs. Across the UK, the response of public authorities has been to add new services in a piecemeal fashion, creating a patchwork of disconnected services, locked within institutional silos. These structures have contributed to fragmented care, poor co-ordination, duplication of effort and avoidable delays, among many other inefficiencies (Edwards 2014).

Social entrepreneurs such as Hilary Cottam and Robin Murray highlight other limitations to the health and care services that have developed in recent decades:

- the tendency to apply professional perspectives to people's problems and preconceived 'production line' solutions, rather than asking people what the real problems are and what might help
- the tendency to do things to people rather than working in partnership with them or harnessing the resources of families and communities
- the creation of systems that make it harder to deliver humane, compassionate, relationship-based care (Cottam 2018; Murray *et al* 2010).

Back in the late 1940s, the social entrepreneurs of Tredegar bitterly opposed the replacement of their locally governed and locally delivered services by a nationwide system, fearing precisely that the new structures would lead to distant, bureaucratic and unresponsive care. If they could speak to us now, perhaps they would argue that some of those premonitions had proved true. This report describes the recent journey of the Health Board and health and care services in Cardiff and Vale in addressing precisely these challenges.

The Cardiff and Vale University Health Board commissioned this report, which attempts to capture its emerging approach to leadership and culture, including ways of working, structures and processes. It covers briefly the impact this is having on the health and care system's models of care delivery. It is based on interviews with 18 leaders from across the health and care system, including executive and non-executive leaders at the Health Board, senior managers and clinicians, frontline staff delivering services and staff delivering support services. We also spoke to partners from outside the health system, including other public services, the voluntary sector, advisers and contractors. We quote some interviewees directly in the report with their permission.

The report charts the dramatic progress that Cardiff and Vale has achieved since the Health Board published its strategy for transforming care, *Shaping our future wellbeing*, in 2015 (Cardiff and Vale University Health Board 2015). Over the past six years, it has put in place many of the foundations that have helped high-performing health systems in developed countries to improve outcomes for their populations. Those investments already appear to be delivering returns. In 2015, Cardiff and Vale had more than 4,000 patients waiting more than 36 weeks for treatment after consultant referral (National Assembly for Wales

2015). By the start of the Covid-19 pandemic in early 2020, there were just 300 patients on the waiting list (StatsWales undated). In addition, in 2015, it was running an annual deficit of £42 million (Cardiff and Vale University Health Board 2016). By 2019, it was in financial balance (Cardiff and Vale University Health Board 2019).

The investments in staff, culture, ways of working and infrastructure also appear to have paid dividends during the Covid-19 pandemic. Staff should be proud of their and the system's achievements over the past 12 months. These have included:

- the accelerated introduction of a new system for planned access to urgent care
- new arrangements for joint working between primary care and hospital services
- the establishment of a 2,000-bed surge hospital at the Dragon's Heart Stadium in Cardiff in 20 days
- the transfer of many forms of surgery to a Covid-free 'green' site.

Interviewees explained that Cardiff and Vale was able to continue almost all urgent and planned surgery, while keeping patients safe and ensuring very few hospital-acquired Covid-19 infections.

Despite this considerable progress, Cardiff and Vale has only been developing the culture and apparatus of a high-performing, integrated health system since 2015. If Cardiff and Vale can finish this stage in the journey, it will surely provide inspiration for public services across the UK and beyond. That would be a contribution to match the legacy of Tredegar a few miles away.

Overview of the Cardiff and Vale health and care system

The Cardiff and Vale University Health Board is responsible for overseeing and delivering public health care services for a population of around half a million people in Cardiff and the Vale of Glamorgan in Wales. The health board

manages an annual budget of around £1 billion as well as overseeing capital investment in health services. It delivers services through:

- the University Hospital of Wales, a major 1000-bed teaching hospital in Cardiff
- the University Hospital of Llandough, a district general hospital with around 500 beds in Penarth
- the Noah's Ark Children's Hospital for Wales, a specialist children's hospital with around 200 beds in Cardiff;
- eight hospitals delivering community, mental health and dental services
- fourteen health centres delivering a wide range of community-based care including screening, diagnostics, paediatrics and support for people with long-term conditions
- district nursing, acute response and other services delivered within people's homes.

The health board also commissions and oversees primary care services from 60 GP practices, 107 community pharmacies, 70 NHS dentists and 66 optometric practices.

2 New direction

Interviewees who remember the Cardiff and Vale health system of the 2000s described, sometimes with some affection, a quite traditional model of leadership and service delivery. The senior leaders of the system at this time were, we were told, committed NHS managers with a top-down, directional approach, a particular interest in the running of the hospital's services and a focus on relatively narrow measures of operational and financial performance. One interviewee who remembers the old days described the Health Board as 'more of a hospital board than an organisation that oversees the whole system'. Primary care and, to some degree, community and mental health services, felt left out. There was limited focus on bringing different services together to act as a coherent system and few resources were dedicated to innovation in service delivery.

Two key things happened to set a new trajectory for Cardiff and Vale in the mid-2010s. The first inflection point was the development, under the former chair, Maria Battle's, and the former chief executive, Adam Cairns' leadership, of a new strategy, *Shaping our future wellbeing*, for 2015 to 2025 (Cardiff and Vale University Health Board 2015). The strategy presents a compelling set of arguments for reforming health and care services to meet the changing needs of the local population, with a focus on keeping people healthy, delivery in the community and the home where possible, service integration and innovation. As well as setting out priorities for service change, the strategy articulates a clear set of principles for delivering them, including partnership working across services and with the community.

The second, and arguably most important, turning point was the appointment of Len Richards, an experienced health services leader, as chief executive of the Health Board in 2017. Len brought experience as a senior hospital leader in the UK and other countries and as a health and care system leader in Australia. Since his appointment, he has developed existing leaders within Cardiff and Vale and also brought in new leaders with different perspectives such as the recent

human resources director, Martin Driscoll, who joined from the Welsh steel industry, and the director of innovation and improvement, Jonathon Gray, who brings experience from the Institute of Healthcare Improvement and the Billions Institute in the United States and the Counties Manukau District Health Board in New Zealand.

The people at the top are only one part of a large health and care system such as Cardiff and Vale, which brings together thousands of staff, dozens of organisations and hundreds of services, to support its population. Nevertheless, those at the top can have a profound impact on the culture and direction of the system. In traditional pyramid organisations, where power is concentrated at the top, they are arguably the only people with the authority and levers to trigger a major shift in direction (Laloux 2014). Len's personal style and prior leadership experience, along with how he has built his senior leadership team, are key determinants of the direction taken, including the approaches to culture, ways of working and improvement described below. Meanwhile, the appointment of key senior leaders such as Martin Driscoll and Jonathon Gray has helped to broaden perspectives and, helped the health system to build new partnerships as a source of inspiration for improvement.

3 Seeking inspiration

Len Richards described spending his first few months in Cardiff and Vale talking to people to understand the history and challenges the system faced. He remembers being struck by how well people understood the philosophy set out in the *Shaping our future wellbeing* strategy (Cardiff and Vale University Health Board 2015), but also the gap between the strategy and existing models for delivering services. People were signed up to the principles and could talk persuasively about the strategy. But the most common comment was that they did not know how to implement it. They felt they did not have the authority, expertise or resources to start implementing the strategy in the design and operation of services. Len decided that he needed to show frontline staff a system that had overcome some of Cardiff and Vale's challenges, where the philosophy had been translated into changes in services.

Arguably the most important thing that Len did early in his tenure was to establish a long-term learning partnership with the health system in Canterbury in New Zealand, which had already successfully implemented a similar strategy for moving care to the community, system working and embedding quality improvement in the 2000s. In the first instance, Len took six leaders to Canterbury – including representatives from primary care, social services and the hospital – to see how a very different health system operates. In Len's words: 'When we came back, they were raving about what we had seen. We just felt what they were doing was what we were trying to do in Cardiff.'

The group spent the next month talking to staff across Cardiff and Vale about what they had seen. They highlighted three main areas that seemed fundamental for Cardiff and Vale's next phase of development. The first was creating a culture of empowering frontline staff to innovate, with senior leadership providing them the support they needed to change services. 'When we talked about this, everybody smiled because it was the opposite of how we were actually operating.' The second was developing data systems that would give frontline staff the information they needed to make evidence-based changes

to services, in particular precise daily information about how patients were moving through services rather than aggregated, historical information. The third was bringing together clinicians from across the system, in particular from primary, community and hospital services, to develop more coherent pathways of care.

None of the high-performing health systems The King's Fund has studied achieved greatness by copying and pasting solutions from other parts of the world. Health and care services are complex networks, shaped by their own history and rooted in their own places and communities. Attractive solutions from other systems rarely fit neatly into local services without adaptation. Nevertheless, a common feature of highly innovative organisations is a willingness to look for inspiration beyond their boundaries.

Almost all the high-performing systems we have studied built partnerships with other health services and other sectors at key points in their development. Many have also been active participants in learning networks that bring together ambitious systems, such as the Institute for Healthcare Improvement's breakthrough collaboratives and the Healthcare Anchors Network in the United States. For example, the Southcentral Foundation in Alaska formed partnerships with other health care providers such as Care Oregon, Harvard University, the Institute for Healthcare Improvement and the retail sector. Canterbury in New Zealand learnt from manufacturing and construction. And Virginia Mason in the United States famously learnt from aviation and car manufacturing.

Cardiff and Vale appears to us to have gone further than almost any other health and care system in the UK in building a substantive learning partnership with an international health system. It has now sent more than 30 staff to Canterbury in different phases to learn first-hand about its approach. Staff from Canterbury have also spent months in Cardiff and Vale, helping staff implement aspects of its model. (Leaders from Canterbury also describe learning from Cardiff and Vale's approach, including its quality improvement processes.) It is striking how much impact this partnership has had on the system in a short time. What is particularly notable in comparison with other initiatives in the UK is that staff across the system, not just those who have visited Canterbury, talk passionately

and with granular detail about the Canterbury approach and how they are adapting it. Since his appointment in 2019, Jonathon Gray has also been instrumental in broadening these strategic partnerships, building links with the Billions Institute in the United States and the Singapore health system among others.

4 Creating a social movement

Charles Janczewski or 'Jan', a former Lloyds Bank director, joined the Cardiff and Vale University Health Board as interim chair in mid-2019 before becoming the permanent chair in 2020. He described his own early impressions of the Cardiff and Vale system two years after Len Richards' arrival: a remarkable chief executive, a compelling vision and the early stages of transforming a complex system's culture and services. While senior leaders bought into the vision, Jan wondered how many people throughout a large system had been won over to the strategy or the ambitions for culture and service change. In Jan's words: 'The biggest opportunities lie in middle management. If their approach isn't in tune, it becomes difficult to implement transformation. So how did we win over the middle tier and support people with potential across the system?'

One of Cardiff and Vale's responses to this challenge is its 'Amplify 2025' programme, which aims to build a social movement for the type of whole-system transformation set out in the *Shaping our future wellbeing* strategy (Cardiff and Vale University Health Board 2015). Rachel Gidman, the assistant director for organisational development at the Health Board, described the first, two-day launch event for the Amplify programme in mid-2019. The Health Board brought together 80 potential change agents from across different health services, the local authorities, the third sector and the community to discuss how to reconfigure care around the needs of patients and communities. Rachel remembers the astonishing energy in the room as people who had never crossed paths before shared knowledge and developed ideas for change.

Before the Covid-19 pandemic disrupted plans, the next phases of the project were to hire a warehouse anduse this as a way of engaging a much broader range of staff and the public from across Cardiff and Vale in discussions on the future shape of services. (The plan was similar to the Canterbury Health Board's Showcase 2020 exercise, where the health board brought around 2,000 staff

through a warehouse with mock-ups of health services to discuss the future of care (Timmins and Ham 2013). As Wales recovers from the pandemic, there is now a chance to revisit those plans. The Health Board is also applying the Amplify model to a new programme to engage staff and communities across Cardiff and Vale on the future shape of clinical services and the construction of a new hospital to replace the University Hospital of Wales' current facilities in the next 10 years.

As Len Richards explained, one of the objectives of the Amplify programme is to broaden and deepen understanding of the *Shaping our future wellbeing* strategy across the health and care system and build a movement to support transformation. Another objective, in Len's words, has been to 'raise expectations' about what the system expects from frontline staff, with a particular focus on encouraging staff across the system to think ambitiously about how they can improve services for patients and spend a proportion of their time on innovation alongside their day jobs.

5 Culture and ways of working

One issue that staff were quick to call out was a culture of top-down decision-making, underpinned by bureaucratic processes that make it difficult to gain approval for service changes. Staff would need to seek permission from one of the Health Board's medical committees to secure resources or approval for such changes. These committees would typically require staff to write detailed business cases to justify their proposals. Staff had come to see this process as an overwhelming barrier to change. They felt they would never be able to provide the necessary information, the process would take months and they would likely run out of energy before the committee formally refused the plans.

One of the senior leadership team's responses to these challenges has been to champion the transition to a culture of high trust and low bureaucracy. Leaders and staff across the system talk enthusiastically about this ambition. There has also been an active strategy to celebrate frontline staff who take the initiative to improve services without seeking permission, provide them with resources and help them to spread successful innovations across the system.

It is also possible to point to an emerging set of principles, gaining currency across the system, on how staff should innovate to improve services. For example, staff delivering mental health services have developed closer joint working with patients to see issues from their perspectives and put patients and their interests at the heart of actions and decision-making. Staff are also building broader partnerships across professional groups and services as a basis for improving care, and focusing on patients' time as one way of homing in on inefficiency and poor care.

These principles appear to be evolving organically, rather than through formal processes. They reflect the influence of Canterbury and the process of learning from and codifying what seems to work in practice. Research suggests that such

guiding principles can play an important role in complex systems that seek to delegate authority and encourage widespread innovation. They provide a guiding framework for staff pursuing innovation across a large system, helping to ensure some consistency and that individual activities reinforce the whole (Plsek 2001).

In Canterbury, New Zealand, substantial changes to systems and processes underpinned the commitment to moving to a culture of high trust and low bureaucracy. For example, there were changes to payments, contracting and performance oversight, to give people more autonomy and freedom to innovate.

While the institutional context in Cardiff and Vale is quite different, the Health Board has started to review systems and processes to ensure that they align with and support the desired culture. For example, there has been a concerted effort to reduce the need to complete detailed business cases, and to pare back the requirements where business cases are still needed.

The Health Board has recently commissioned advisers to look at how the Board and its committees spend their time, what decisions flow up to them and how they might focus their efforts while empowering services to lead change. As discussed briefly below, the experience of leading health services through the Covid-19 pandemic may also present interesting insights on how the systems and processes that influence organisational culture might evolve.

Alongside these initiatives, there have been initiatives to encourage leaders across the system to reflect on their leadership styles and develop a set of leadership practices that empower staff and support frontline innovation. In 2018, the Health Board completed a diagnostic of leadership styles, climate and culture, which highlighted directive, pace-setting leadership approaches as well as distinct micro-cultures. This has led to work to help leaders adopt a broader set of styles, with a greater focus on coaching, mentoring and other forms of enabling leadership. There have also been concerted efforts to address aggressive leadership styles and bullying. One interviewee explained that, in the past, some senior leaders would leave staff in tears. If that happened now, she believed that the behaviour would be addressed head-on.

A final, critical piece in the jigsaw is the gradual creation of a stronger sense of common identity across staff and services in the health and care system. There is increasing evidence that a strong sense of shared identity is a key enabler of effective partnership working and innovation across complex systems. Conversely, the tendency of human beings to form narrow allegiances based on in-groups and out-groups is a significant barrier to collaboration. Bringing people together to work on a shared vision, creating movements in favour of change and inculcating common behavioural norms are all important mechanisms for creating shared identity across large groups. So too are some of the practices discussed below, such as encouraging regular, face-to-face interaction between staff across institutional boundaries (West forthcoming).

6 Building shared infrastructure

Research from The King's Fund and others has highlighted the role of vision, leadership, decision-making, guiding principles, ways of working and culture in the development of high-performing health and care systems. However, it has also highlighted the importance of shared infrastructure in bringing complex systems together. The research has emphasised the role of shared measurement systems, small teams whose role is to look across groups of services for improvement opportunities, and institutions within complex systems whose role is to support system-wide learning and innovation (Collins 2018; Kanier and Kramer 2011).

One key strand of the Health Board's work in this area has been investment in data systems that bring together information from across different services' information technology (IT) systems, present an authoritative view of current performance and provide insight that frontline clinicians can use to improve their services. In 2019, the Health Board contracted with a new partner –– to establish an improved data platform for the system. This brings together live data from across services to provide a picture of patients' journey through a pathway of care services, identifying opportunities for improvement across these services. For example, it is possible to take a cohort of patients with a particular disease and see which services they have visited, what happened to them, how long they stayed at each stage and how their path through services influenced time, costs and health outcomes.

Cardiff and Vale have only been developing this new data system for the past two years, while it has been an established part of the Canterbury system for a decade. Nevertheless, the new data system is revealing new opportunities to improve services. Comparing Cardiff's and Canterbury's data on hospital bed occupancy revealed unusual patterns in Cardiff's bed occupancy over the Christmas period. This led to an improvement project, 'right bed first time', to

prevent people being placed in the wrong beds during critical periods, something that increased their length of stay and health costs. This has allowed the hospital to reduce capacity by 70 beds.

Alongside this investment in data, the Health Board has also established a small change hub to support system-wide quality improvement. This brings together project management staff who work with the Board to ensure effective oversight and support for strategic improvement projects. It also provides direct support for frontline teams delivering improvement projects. Like many of these major initiatives, this is at an early stage. The team are making the case to receive recurrent funding for the hub going forward and to build a more substantive team of improvement advisers rather than relying on external resources.

Taking inspiration from Canterbury, the Health Board has established the Cardiff and Vale Convention, which brings together clinicians from across primary care, community services and hospital services to work together on improvement. Like the Canterbury Initiative (Timmins and Ham 2013), its aims include:

- putting groups of clinicians from across services in the driving seat, with responsibility for system-wide change
- building the strong relationships between clinicians across services to support partnership working and innovation
- developing agreed pathways of care to improve patients' journey through services.

This work was at an early stage when the Covid-19 pandemic struck. Nevertheless:

- clinicians and staff across health and care services have collaborated to improve how they use resources and work together to support child health
- primary care and hospital doctors have worked together to agree clearer protocols for the management of cardiology patients in primary and secondary care
- staff across the system have worked together to institute a system of planned referral into urgent care services – CAV 24/7 – preventing

unnecessary face-to-face contacts and crowded emergency departments during the Covid-19 pandemic.

Like the Canterbury Initiative, one of the outcomes of work so far has been redesigned pathways of care. However, interviewees argued consistently that relationship building across the system was as an important output as redesigned clinical protocols, with staff across services developing greater trust, a shared vision and sense of responsibility for the totality of services, and the ability to work more flexibly and adaptively with each other day to day. As this programme gathers pace, an additional objective will be to systematise and spread a 'Cardiff and Vale Way', capturing the language tools and processes that everyone will use to support collaborative improvement. (The Health Board's emerging approaches to quality improvement, innovation and spread of innovation are covered in more detail in our companion report on improvement and innovation in the Cardiff and Vale health and care system.)

7 Emerging new models of care delivery

Cardiff and Vale's efforts to empower staff, create a culture of innovation and improvement, and put in place the necessary supporting infrastructure for system working are still at a very early stage. The system has only been focusing on these issues for the past six years. Nevertheless, the new strategic focus and investments appear to have accelerated innovation within the system, including across primary, community and hospital services. Projects include the development of new cluster models in primary care, new approaches to supporting people with mental health problems and a wide range of initiatives to improve hospital services alongside the cross-cutting work described above.

Most of these projects are ongoing and with the end state yet to be determined. Only in a few cases have successful new care models been codified and approaches spread across the system. Nevertheless, it is possible to pick out a number of emerging common themes in how staff are changing services.

- Many ongoing innovations in new care models, for example cluster models in primary care and new locality teams for mental health and community services, focus on: bringing together a broader group of professionals to deliver team-based, wrap-around care for people close to their homes; delivering more joined-up, holistic care; making better use of staff skills; and minimising the need for people to travel to hospital services.

- Other projects focus on bringing staff from across traditional care boundaries together within meaningful virtual teams, where staff work together to: spot deficiencies in how patients flow through services; identify opportunities to better manage the co-ordination of care; and make better use of scarce resources, for example hospital doctors providing training and support to GPs so that they can continue to treat more complex patients closer to home, which in turn frees up resources and reduces delays in

seeing patients in secondary care.

- A number of these projects, including the cluster model for primary care in South West Cardiff and some new mental health services, are expanding their focus to deliver holistic support that addresses underlying social causes of ill health alongside medical care. These include: the development of social prescribing as an integral part of primary care within South West Cardiff; joint work between health services and housing associations to support people at risk of losing their tenancies; and new mental health services, among others.

- There is an increasing focus in a number of projects on the relational as well as the technical dimensions of care. Within new multidisciplinary models of teamworking in primary, community and mental health services, one objective is for a core team to hold a sustained relationship with the patient and their family, minimising the disruption to these relationships when patients are routinely referred out to specialist services. This is so that teams accumulate insight into their patients, build trust and influence with the patient and their family, and are able to develop tailored approaches that address what really matters to them.

- Some projects are starting to harness the resources of peers, service users and communities to help deliver effective care, alongside or as an alternative to medical professionals' care. These projects are happening, for the moment, in primary care social prescribing services and in mental health services such as the new Cardiff Recovery and Wellbeing College, but the approach is surely applicable to a broader range of patient groups and services.

- Some projects are starting to recognise the need for more tailored approaches to caring for the most deprived people in the Cardiff and Vale population, rather than using uniform models, for example how to make it easier for the most deprived people in society to access preventive health services or rapid mental health support.

As these and other projects mature, it may be possible to decrypt a distinct philosophy of care in the Cardiff and Vale system. Like the principles for system-working discussed above, this might also provide a useful framework to help staff across services innovate in care delivery in ways that are consistent and mutually reinforcing. For example, will it be possible in time to set out a set of guiding principles – such as the importance of sustained relationships, continuity of care, combining health and social support, minimising referrals and responding to what matters to people – which might help shape and guide innovation efforts?

8 Responding to the Covid-19 pandemic

When the scale of the Covid-19 pandemic started to become clearer in early 2020, senior leaders at the Health Board resisted pressure to institute a traditional approach to crisis management where a small team makes decisions within a command-and-control model. Instead, building on the new ways of working described above, the senior team adopted an open, collegiate approach where it invited anyone with an interest to attend its daily Covid planning meetings. Clinical staff met regularly in a large lecture theatre, while this was still permitted, to share what they were hearing from colleagues in China, Italy and Spain, and discuss interpretations of the emerging evidence.

The Health Board did not wait for central government to develop models of the likely impact of the pandemic but developed its own models of the possible spread of the virus and the capacity needed in health services. Neither did it wait for central authorities to determine what steps to take, for example to develop surge capacity or reconfigure other services. As Abigail Harris, the executive director of strategic planning at the Health Board explained, the approach was to ask groups of frontline clinicians to decide what needed to happen and test their preferred approach, with the executive team providing cover and support.

As the potential impact became clear, Jonathon Gray, the director of innovation and improvement, highlighted the need for rapid action to increase bed capacity for Covid 19 patients. He began to bring together clinicians from across services to start sketching out possible solutions. At this point, the 'R rate' was doubling every few days. Unless it could rapidly increase bed capacity, there was a risk that the Cardiff and Vale system would be in the same position that Italy and Span faced in a few weeks. Interviewees described a meeting on a Sunday afternoon with Jonathon, Len Richards, a construction firm, and other contractors in which they discussed how to build a 2000 bed surge hospital, which would need to become operational in four weeks.

Jonathon and colleagues described arriving at The Principality Stadium on the following morning, and starting to piece together roles, responsibilities and a plan of action in the rugby teams' changing rooms and the prison cells for less well-behaved rugby fans. Over the next few days, the team developed a rhythm and structure for the project drawing on Jonathon's experience of working on intensive projects at the Institute for Healthcare Improvement and the Billions Institute in the United States. Staff with the appropriate skills were given genuine autonomy for delivering discrete parts of the project, such as developing the clinical model of care, overseeing the construction of the hospital and recruiting the workforce needed to run the hospital. Three times a day, the group attended a stand-up meeting to share what they had achieved, what they were going to do next and the support or resources they would need.

Victoria Le Grys, a programme director at the Health Board, supported Jonathon in co-ordinating different strands of the work programme. As she explained, there was no time to develop a detailed programme plan or Gantt charts setting out timescales and interdependencies. Nor was there time to follow the normal processes for developing options, identifying a preferred approach and presenting this to senior leaders for approval. Instead, the approach consisted of identifying the people available with the best skills and expertise for parts of the project, and working iteratively together in real time, making rapid decisions based on the best available evidence and addressing interdependencies by having the right people in the same room three times a day. There was a similar pattern to other major projects, which are discussed in our companion report on improvement and innovation in the Cardiff and Vale health and care system.

For many interviewees, these achievements during the pandemic highlight what staff can deliver when there is clarity of purpose and when traditional constraints on their freedom to innovate are relaxed. This is a common perspective from the pandemic, where staff across health and care systems in the UK worked incredibly hard to set up surge capacity and keep people safe. For an outsider, they also highlight the likely benefits of the investments in intangible and tangible infrastructure that the Cardiff and Vale University Health Board and other health systems have made in recent years. Although we have not yet completed detailed reviews, there is anecdotal evidence that systems that had

already developed the vision, relationships, ways of working and supporting infrastructure to support system-wide improvement and innovation could deploy these assets in their response to the pandemic.

The Health Board has already started to collect surveys and bring together evidence on what has worked during the pandemic. A survey of 80 senior leaders after the first wave of infections indicated that hierarchies had flattened, decisions were made faster and silos had eroded, but also that things were going back to normal quickly after the peak. The examples collected surely also point to a set of alternative approaches to service change that might be codified and embedded within the health system. The approach at the Dragon's Heart Hospital has similarities with the swarming model for delivering rapid quality improvement that Toyota has developed, applied to a major project. In each of these examples, staff appear to have replaced traditional planning approaches to redesigning services, where the model is specified in detail on paper in advance, with approaches based on iterative testing and refinement. If these rapid-cycle approaches can be preserved, one question will be how to ensure that patients and the community are actively involved within them.

9 Conclusion and looking to the future

This report has described key milestones in the Cardiff and Vale's leadership journey as it transforms health and care services into an integrated, learning system. Within six years, these changes have encompassed introducing new approaches to leadership, developing ways of working and culture to support system working, and putting in place the backbone infrastructure needed to support system-wide improvement. It is already possible to trace the impact of these investments in improved performance and the system's ability to respond collectively and creatively to the challenges of the Covid-19 pandemic.

Yet, as leaders and staff readily acknowledge, Cardiff and Vale is only mid-way through this transformation journey. Most of the high-performing international health systems The King's Fund has studied – Canterbury in New Zealand, Jönköping in Sweden and Southcentral in Alaska, among others – pursued system transformation for a decade or more before the full impact became apparent. In many cases, the journey to high performance was the painstaking work of two or three decades.

For an outside observer, Cardiff and Vale appears to be in the midst of two forms of revolution. The first revolution involves recasting fragmented health and care services as a coherent, integrated learning system, with the aim of addressing fragmentation and inefficiency in modern health and care services. For this revolution, challenging though it is, there is an established path to follow. High-performing health and care systems such as those mentioned above have developed proven approaches that we can adapt. Cardiff and Vale has been able to make accelerated progress on these issues, in part thanks to its strategic partnership with the Canterbury health system.

The second revolution is at an earlier stage and is even more ambitious. It involves, among other things:

- reframing the relationship between public services and individuals and communities
- reconceiving the problems that health and care services seek to fix
- working in broader partnerships
- finding radically new ways of addressing complex social problems.

As discussed in other King's Fund work, this also involves leveraging the resources of public services, in combination with other community assets, to address the underlying causes of poor health and wellbeing – tackling drivers of illness such as poor childhoods, lack of opportunity, unhealthy environments, social dislocation, inequality and discrimination head-on, rather than simply trying to palliate their effects (Naylor and Wellings 2019; The King's Fund undated).

We can see Cardiff and Vale grappling with these questions in the way staff are starting to reshape primary, community and mental health services and in new partnerships between health, housing and the voluntary sector, which are revealing new ways of supporting the most deprived people in the population. The leaders of the new Dragon's Heart Institute, among others, are starting to think about how the health system and other partners could better support the economic and social resilience and sustainability of Cardiff and Vale's communities. Here, Cardiff and Vale and other ambitious health systems around the world are at the forefront of innovation. There is no clear path to follow, even if there are bright spots of innovation in Wales, other nations of the UK and other countries to provide inspiration.

Right now, for an external observer, Cardiff and Vale appears to be a system with ambition and dynamism to confront these challenges. It has some outstanding senior leaders and a growing body of expert innovators, and staff across its services are eager to try new approaches. While it has been exhausting, many staff are exhilarated by the experience of responding to the Covid-19 pandemic, including the opportunity to work more flexibly and creatively.

This head of steam could be harnessed, or it could evaporate. People from within and without the system still need to be won over. The system faces external pressures that could knock it off course. It would be very easy to revert discretely to previous ways of working once the pandemic is over. From the perspective of a visitor to the system, the following are some of the issues that leaders across Cardiff and Vale might give consideration to in the next few years.

1 Sustaining leadership and direction

Despite fantastic progress, the current transformation journey still depends on the vision and commitment of a relatively small cadre of leaders at the top of the Health Board and within services. Lack of external understanding of Cardiff and Vale's approach and leadership change within the system are surely the greatest risks that will throw the system off course. Are there opportunities to mitigate these risks, for example through further leadership development or succession planning?

2 Systematising new ways of working

The system has made strides in articulating how staff should work together and for what purposes. It has also started to define how staff should work together to support system-wide innovation and improvement, including adapting the business case process and convention. Is there scope to do more to clarify how ways of working, systems and processes should change to align with the ambition of working as a 'high trust, low bureaucracy' system? Could the system's experiences and achievements during the Covid-19 pandemic help to clarify what an alternative set of ways of working and processes might look like?

3 Aligning culture with structures

The Health Board has already made some significant changes to organisational structure to align with its vision of empowerment and system working. However, it retains a traditional organisational structure with decision-making authority held by committees organised around particular services and professional groups. In the longer term, can the Health Board achieve its ambition of devolving power and authority in the system through commitments and culture

change? Or does it also need to look carefully at the systems and structures that force decision-making up to a small number of senior leaders?

4 Codifying the emerging philosophy of care

The Health Board has made great progress in setting out a broad vision for service redesign, focusing attention among other things on the need to focus services around patients, shift care closer to home, avoid wasting time and stripping out other forms of waste. Based on recent innovation, would it now be possible to articulate an emerging philosophy of care for the Cardiff and Vale system, something that would point staff towards fruitful forms of service innovation, discourage approaches that are inconsistent with the broad direction of travel and further support rapid service change?

5 Forging new relationships with communities

The system has articulated its commitment to working in closer partnership with local communities. Like other health and care systems, there is less clarity on how services should go about this and what tools they should deploy. Is it possible to articulate the foundations of a system-wide approach, drawing on bright spots of innovation across the system, for example on how service users and local communities can play leadership roles in overseeing services and how their resources can be harnessed during service redesign?

6 Developing approaches to social entrepreneurship

The Cardiff and Vale system has already made huge progress in implementing structured approaches for quality improvement across pathways of care. Alongside this work, services have embarked on processes of more radical innovation to rethink people's underlying needs and how best to serve them. Is there scope now to codify and embed a set of principles and approaches for these more radical forms of social innovation, alongside innovation and improvement in existing medical services?

7 Clarifying the health system's anchor role

As described above, senior leaders are starting to focus on how the health system can harness its resources to support the economic and social resilience and the sustainability of local communities. How should the system implement an anchor mission and where should it focus its efforts?

8 Working in broader partnerships

If it is to achieve these more ambitious objectives, what partnerships will the health system need to develop or deepen to deliver them, for example with other public services and the voluntary, community and social enterprise sector?

10 References

Cardiff and Vale University Health Board (2019). *Cardiff and Vale UHB annual report: April 2018 to March 2019*. Cardiff: Cardiff and Vale University Health Board. Available at: www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/CAV_ANNUAL_REPORT_2018_2019_WEB.pdf (accessed on 18 March 2021).

Cardiff and Vale University Health Board (2016). *Cardiff and Vale University Health Board: Annual report 2015–16*. Cardiff: Cardiff and Vale University Health Board. Available at: www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/CAV%20Annual%20Report%202015-16.pdf (accessed on 18 March 2021).

Cardiff and Vale University Health Board (2015). *Shaping our future wellbeing*. Cardiff: Cardiff and Vale University Health Board. Available at: https://shapingourfuturewellbeing.com/what-were-doing/our-vision (accessed on 18 March 2021).

Collins B (2018). *The Montefiore health system in New York: a case study*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/montefiore-health-system-case-study (accessed on 10 March 2021).

Cottam H (2018). *Radical help: how we can remake the relationships between us and revolutionise the welfare state*. London: Virago.

Edwards N (2014). *Community services: how they can transform care*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/community-services (accessed on 18 March 2021).

Kanier J, Kramer M (2011). 'Collective impact'. *Stanford Review of Social Innovation* winter. Available at: https://ssir.org/articles/entry/collective_impact (accessed on 10 March 2021).

Laloux F (2014). *Reinventing organizations: a guide to creating organizations inspired by the next stage of human consciousness*. Brussels: Nelson Parker.

Murray R, Mulgan G, Caulier-Grice J (2010). *The open book of social innovation*. London: The Young Foundation. Available at:

https://youngfoundation.org/publications/the-open-book-of-social-innovation (accessed on 18 March 2021).

National Assembly for Wales (2015). 'NHS referral to treatment waiting times'. National Assembly for Wales website. Available at: https://senedd.wales/media/ppwdonnl/rn15-017.pdf (accessed on 18 March 2021).

Naylor C, Wellings D (2019). *Lessons from the Wigan Deal*. London: The King's Fund. Available at: www.kingsfund.org.uk/projects/lessons-wigan-deal (accessed on 18 March 2021).

Plsek P (2001). 'Redesigning health care with insights from the science of complex adaptive systems' in Institute of Medicine (US) Committee on Quality of Health Care in America, *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academies Press. Available at: www.ncbi.nlm.nih.gov/books/NBK222267 (accessed on 10 March 2021).

StatsWales (undated). 'Referral to treatment'. StatsWales website. Available at: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment (accessed on 18 March 2021).

The King's Fund (undated). 'Healthy communities together'. The King's Fund website. Available at: www.kingsfund.org.uk/projects/healthy-communities-together (accessed on 18 March 2021).

Thompson S (2015). 'The mixed economy of care in the South Wales Coalfield, c.1850-1950' in Lucey DS, Crossman V (eds), *Healthcare in Ireland and Britain from 1850: voluntary, regional and comparative perspectives*, pp 141–60. London: Institute of Historical Research. Available at: https://pure.aber.ac.uk/portal/en/publications/the-mixed-economy-of-care-in-the-south-wales-coalfield-c18501950(063c3879-e266-4fdc-8cae-8e4c76ae1019)/export.html (accessed on 8 March 2021).

Timmins N, Ham C (2013). *The quest for integrated health and social care: a case study in Canterbury, New Zealand*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/quest-integrated-health-and-social-care (accessed on 18 March 2021).

West M (forthcoming). *Compassionate Leadership Across Boundaries*.

11 About the author

Ben Collins joined The King's Fund in 2015 as a project director, working for the Chief Executive and across the Fund, including on policy and supporting the NHS in developing new care models.

Before joining The King's Fund, Ben worked as a management consultant. He has advised central government and the national bodies on a wide range of issues including economic regulation, provider finance, the provider failure regime and new organisational models. He has also worked with NHS purchasers and providers on strategic and operational challenges.

In his earlier career, Ben was a fast-stream trainee and manager within central government and an adviser at the European Commission. He has academic training in industrial economics and business strategy