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Systems Leadership: A view from the bridge

An OPM Paper

By Sue Goss

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Introduction

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We live in difficult, turbulent times. Since the financial crash in 2008, public services have faced unprecedented cuts, many of which have yet to bite. Austerity, driven by a desire to reduce public borrowing, threatens to continue for many years to come – radically transforming the relationship between public services and citizens, and in the process, transforming the roles and functions of many thousands of staff and their managers.

Leaders are struggling to innovate, integrate, manage demand and find new solutions. Public sector managers, both in the UK and abroad, talk about being caught in a perfect storm of increasing public need, demand and expectation, coupled with decreasing resources and capacity. Leaders are wrestling with persistent ‘wicked issues’ that shape-shift and defy resolution, and which cannot be resolved by single agencies acting alone¹.

It is exciting that across the public and third sectors, we are beginning to accept a new way of thinking about the leadership required, applying the theory of ‘systems thinking’ to the practical reality of trying to achieve complex change. For both practitioners in OD and leadership development and for leaders themselves, there is an important opportunity now

to exchange learning about how to lead well in these difficult times. This is not simply about toolkits and ‘hot tips’ – there is a need for new theory to help explain what is happening, as well as carefully observed learning from practice. I have been working alongside colleagues in a network of ‘system enablers’ and working on a range of ‘whole system’ projects, beginning with [Total Place](#), then [Community Budgets](#), then [Local Vision-Local Leadership](#) projects, and now with [integrated health pioneers](#). It feels for many of us playing this ‘system enabler’ role that we occupy a bridge between leaders and the practitioners and supporters of OD and leadership development in side organisations – practicing ‘live’ interventions but also reflecting on how leaders learn, adapt and change. This paper is an attempt to contribute some practical lessons from current practice, building on the excellent literature that is developing.

Systems leadership has been defined as:

“The collaborative leadership of a network of people in different places and at different levels in the system creating a shared endeavor and cooperating to make a significant change”.²

It isn’t easy. But managers and politicians are increasingly realising that without it, the profound changes that need to take place in public services will not be possible.

The characteristics of systems leadership are different from those that have often succeeded within a single organisation or a limited project. Logic-based linear approaches to problem solving don’t

The alternative to linear top down direction is not chaos, but a self-conscious and carefully planned set of interventions.

work within highly complex systems with multiple players and many, often conflicting, pressures and motivations.

The sort of leadership that is required has been called ‘adaptive leadership’ or ‘emergent leadership’ or ‘systems leadership’, but the most important characteristic is that the change attempted has not exactly been attempted before. This means that while there is learning, there is no fixed template or agreed way of doing things – we are in uncharted terrain. Systems leadership is almost the opposite of command and control, since in system change no-one can see the whole picture and no-one knows everything about how to make the change happen. It can’t be outsourced or delegated since the energy and creativity needed has to work all the way up (and down).

Because change involves a group of leaders, rather than a single leader, it is not enough to have a powerful vision and simply charge ahead. It is important to take others with you, to create a shared endeavor and strong, trustworthy relationships. Leaders are often working ‘beyond the boundaries of their authority’³ in situations where they are no longer ‘the boss’ but have to win consent from communities, partners and stakeholders – sometimes in situations that pose risk to their reputation, even career. This sort of leadership therefore always involves a choice. It is possible for faint-hearted senior executives or professionals to play safe, act defensively, avoid risk, and ultimately, do nothing. Leadership is exercised when individuals decide that change is possible – that the prize is sufficiently important, and that the alternatives will be damaging to the public, or

to the social outcomes they believe in. Once the decision has been taken to lead, the work is to figure out exactly how to do that.

The alternative to linear top down direction is not chaos, but a self-conscious and carefully planned set of interventions. At the same time, these interventions have to be highly flexible and responsive – connecting the whole system together from the bottom to the top and back again.

The work done by the Colebrook Centre and Cass Business School for the Virtual Staff College in drawing together the latest evidence provides an excellent basis for thinking about Systems Leadership.⁴

From the literature, from international case studies and from real examples of systems change, we can identify six dimensions of systems leadership:

- 1. Ways of feeling** – about strong personal values;
- 2. Ways of perceiving** – about listening observing and understanding;
- 3. Ways of thinking** – about intellectual rigour in analysis and synthesis;
- 4. Ways of relating** – the conditions that enable and support others;
- 5. Ways of doing** – behaving in ways that lead to change; and
- 6. Ways of being** – personal qualities that support distributed leadership.

However, these cannot be treated as alternative ‘preferences’ or ‘character strengths’. It is not possible to respond, “I’m going to concentrate on ‘ways of relating’ because thinking doesn’t interest me much”, or, “I’m not much good at observing, I just like to get on and do things!”. These are not simply skills, but dimensions of systems experience in which things will be happening. Leadership attention needs to be paid to all of them. The advantage of a ‘network of leaders’, as we will come

¹ ADCS Virtual Staff College (2013). *Systems Leadership: Exceptional Leadership for Exceptional Times Synthesis Paper* (p.6)

² Systems Leadership: Virtual Staff College

³ Heifetz, R. A., & Laurie, D. L. (1997). The work of leadership. Harvard Business Review

⁴ Systems Leadership: Virtual Staff College

to see later, is that within that network all of these dimensions can be attended to, even if one person can't attend to them all.

So, from two years of practical experience in supporting 'systems leadership', what are we learning?

1) Ways of Feeling

Start with values

Because system leadership involves risk, it is important that people believe in what they are doing. Unless there is a compelling reason to take a path that is difficult and strewn with obstacles, people won't take it. So when a group of leaders decides to take action, they begin to work as a team when they share values, which is seldom achieved in formal meetings or formulaic ways. They need to understand each other as people and where they come from and what they believe in – discussing, in depth, what they are really trying to achieve and why. This helps to build a shared understanding about a shared endeavour that may last for years rather than months. It is often helpful to start with a small group conversation that can go deep, until the leadership group, whoever they are, really understand each other and are confident about what they share. But then it needs to go wider and it is important to connect to the values of the professionals, managers and staff as well as service users and carers, which creates a strong sense of shared purpose.

When change is very difficult, and the counter-pressures are very strong, it takes hope, belief and courage to make change happen. This can't come from a single person – system leadership is all about encouraging, evoking and nurturing the leadership from a wide network of people, all of whom share a set of values and beliefs about the need for, and the potential for, change. Everyone will need time

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to explore how change might work, to voice their doubts, to feel heard, to identify what they want to change and to feel part of building the alternative.

Feelings and beliefs are not always positive

While positive values do much to build up people's courage and motivation, the experience within 'ways of feeling' can also sometimes be negative. Once we are in the territory of emotion, we have to recognise that among the positive emotions in play there may also be fear, anxiety, and sadness. Accessing and talking about these emotions can be very important in building relationships and alliances that are strong enough to cope with the serious difficulties that will be confronted along the way.

Belief is complex and needs unpacking

Belief is relatively shaky at the moment. In one leadership summit, we ended up spending quite a bit of time dealing with the question of belief. What it would take to make people feel confident that change might work? We explored three different sorts of belief:

1. Belief that the goals we are trying to achieve are good goals;
2. Belief that it would be possible to make the change in current circumstances; and
3. Belief that it will actually happen.

Belief has different origins in different cultures and local government culture tends to rest belief in the power of executive action; that a good plan well executed is likely to work. Clinicians, however, tended to rest their belief in 'evidence'; they want to see evidence that this had been effective before. When you are trying something new, it is hard to show evidence of success, but clinicians can be uncomfortable when told to take 'a leap of faith'. In fact, between the two 'extreme' ends of nailed down clinical certainty and 'a leap of faith' are a range of very sensible ways to work out how things will work in practice.

If people think it won't work it probably won't work!

The reality is that people are not going to act courageously if they don't believe others will do the same. It is easy to dismiss scepticism as negative, but actually, a forensic examination of how change is expected to work is probably needed. The danger is that plans are formulated the way they would be within a single organisation, with assumptions made about how the system will respond – and these assumptions can be wrong.

Belief is built through a process of exploring and testing the assumptions built into the new model until all the key players have been involved in creating it and feel that it will work. This can be through hypothetical exercises, for example, using live case studies or imaginary ones, engaging people in 'walking through' new systems, and designing and running simulations and 'test-drives'. These have to involve the full range of clinicians and front line staff who will be responsible for making new systems work. Through running a simulation, in one London borough to test drive a new care model, we found a dozen blockages that we hadn't anticipated – all of which would be enough to slow down success. Now we know we can change them.

One GP make the helpful analogy with GP practice:

'GPs are gamblers – they often don't have a definitive diagnosis, so they have to make an educated guess. But they don't stake everything on a single throw. They might say "try this and come back if this doesn't work" or, "let's give you medicine on this assumption but send you for a test just in case". They can't simply play safe every time as the resources are just not there.'

Heifetz talks about 'getting away from the dance floor and onto the balcony' – getting a vantage point from where you can watch the activities and reactions of others.

2) Ways of Perceiving

A key leadership skill is that of observing what is really happening (as opposed to what is supposed to be happening). It is easy, as you rush from meeting to meeting, to believe the diagrams and the project plans, and not to notice the real human behaviours that are taking place – the arguments, the absences, the protective silences and the failures to deliver. In complex open systems, there is no single source of energy or power and the results depend on the interactions of many players. It is as important to watch the patterns of these interactions as it is to direct activity. Heifetz talks about this as 'getting away from the dance floor and onto the balcony'⁵ – getting a vantage point from where you can watch the activities and reactions of others. Often it is the role of the 'system enabler' to observe what is really happening and to help the whole system see patterns that they may have missed. But this isn't a role that can stay with enablers or consultants. For a leadership system to be effective, leaders need to be able to provide the 'noticing eye' for themselves.

We are used to thinking that the more meetings we are holding, the more papers we are writing and the more business cases we are considering, the more work is being done.

A key discovery about complex systems is that each player can only see parts of the system from their vantage point. Therefore, having the capacity to share what others can see and build a picture of the ‘whole system’ gives real diagnostic strength.

From noticing, leaders need to build a diagnosis, learning to understand why things are happening and looking at underlying causes. Often, as enablers, we use techniques such as multiple-cause diagrams⁶ or system maps to help leaders to track possible patterns, dead-ends, feedback loops and obstacles. It may take quite a bit of reflection to understand the cause of a problem – simply holding a monitoring meeting and barking orders at the junior managers who attend is unlikely to help! Is a particular organisation disengaged? Are their clinicians on board? Do they have other system imperatives which are in conflict? If, instead of seeing delivery problems as evidence of ‘bad faith’ we use them to understand the system better, we can begin to uncover the real system dynamics and look realistically at the leadership interventions needed to make a difference.

Watch out for ‘avoidance activity’

The sense of complexity and confusion makes us want to make things clear and create order. It is therefore tempting to put more and more emphasis on project management and work-streams and milestones, which give a comforting impression of progress. We are used to thinking that the more meetings we are holding, the more papers we

are writing and the more business cases we are considering, the more work is being done. But Heifetz warns about the problem of ‘avoidance activity’. It is a fair bet that if meetings go round and round in circles, or constantly discuss the same thing without making progress, that an important issue is being avoided.

Often, what is being avoided is the hard, difficult thinking or the scary face-to-face conversations, or the challenge involved in recognising that what we do now doesn’t work. What is alarming is how seldom senior managers and clinicians set aside the thinking time to do this. As with all systems, the more of it you can see, the more likely you are to understand the linkages and connections. So for more junior staff it is much harder to understand how the whole system works than for senior managers with more a ‘balcony view.’ I have witnessed a health and social care integration project that moved from high level abstract ideas and diagrams to a multiplicity of work-streams on finance, HR, performance indicators without anyone actually agreeing what the new model of care really looks like. Why? And why did no-one mention it?

It is always worth thinking ‘what is really happening here?’. In this case, we found that senior managers with the power to make decisions were hazy about the detail of current models of care and keen to delegate the work on new models to more junior, operational managers. They, in turn, understood the current system but were hazy about what the alternative they needed to deliver was. Instead of a real, difficult exploratory conversation that brings both sorts of knowledge together, there was a ‘dialogue of the deaf’, with strategic managers holding ‘monitoring meetings’ and becoming frustrated at the lack of progress, while operational managers (and consultants) wrote endless vague papers – going round in circles – because they lacked the authority to make real choices. Real creative thinking seldom happens in formal meetings, so an important question to ask is ‘where is the real thinking going on?’ and ‘what is the quality of that thinking?’. OD professionals

could play a role here – creating the space to build understanding by bringing managers and staff together and orchestrating the right conversations.

3) Ways of Thinking

When systems are complex, we need to recognise that our usual ways of doing things don’t work the way we think we will.

Plans are really just ‘statements of intent’.

John Atkinson has been drawing on the work of Myron Rogers⁷ to look at how systems work and to find ways to understand what we are seeing. The usual public sector way to make change happen is to draw up a plan or a strategy. In a single organisation with top-down control, as long as the plan is realistic and adequately resourced, the chief executive usually has the power to make sure it is implemented. But in systems, that is not the case. There is no single boss. John Atkinson argues that in complexity, we still tend to rely on our plans and strategies as fixed points, but unless they are responding to what the system is actually doing, they become more like ‘statements of intent’ than a description of what actually happens. We can find that plans are not implemented, and things don’t happen as we expect. Complexity is not, of itself, a problem; it creates order, but in a messy, unpredictable way.

We need to understand a complex system, rather than trying to force it to comply. John Atkinson describes it as more like a living organism that will respond with its own logic. Often, in systems, too much of the wrong sort of pressure can create feedback loops or unintended consequences that make things worse, not better. Cause and effect can be separated by quite long time delays, making it hard to see what causes what.

When trying to win support from GPs who were demanding ‘evidence’, it helped to ask them to articulate the process they use when making a diagnosis, and to use a similar approach to the change process.

In trying to understand a system it is important to recognise that it looks different depending on where you are in it. To understand it requires multiple perspectives – what you see is what you know. In other words, you do not understand what you see, you see what you understand. Keep asking ‘how do we know?’, as what people say they do, and what they really do is often very different.

We discovered that, when trying to win support from GPs who were demanding ‘evidence’, it helped to ask them to articulate the process they use when making a diagnosis and to use a similar approach to the change process. This included exploring the options and narrowing them based on what they could be sure about; identifying the potential dangers; seeking advice from others; understanding the user perspective then discussing it and deciding on first steps; feedback – check; review –rethink; second steps – feedback using the new information; and so on...

Clarity is over-rated

The convention of good project management is that clarity is essential, and much time is spent on away days agreeing a clear set of objectives. But often, at least in the early stages, there is no real clarity and there probably isn’t agreement about objectives. Different parts of the system care about different outcomes. And while there are things in common, it’s often just a fudge to say ‘we all agree’. The important part of system change involves ‘meaning’ – both in terms of what it means for us and why we

are committed to it – and what it ‘means’ in terms of the change we will create. Language is important, because much of the language we have to describe strategy in public services is virtually meaningless and has no emotional impact at all.

The language has to make the meaning real and make others want to join in. The chair of one CCG I know uses as his litmus test of the hospital admission prevention service: “Will this stop housebound Mrs Evans from having to go to A&E if she gets a urinary tract infection and needs antibiotics?”. He is not going to give up until it does.

Clarity for now

However, ambiguity doesn’t mean vagueness. There are two important sources of clarity. One is the long term collective endeavour – ‘what are we signing up to work on?’ – probably for many years ahead. The second is ‘clarity for now’ – ‘what are we choosing to put our energy into in the short term?’, ‘what are we all doing and with what resources can we achieve this?’ – so that we can get on with the process of implementation.

People can only take uncertainty for so long. To make things happen, leaders have to make practical decisions and clarify enough things ‘for now’ so that everyone knows the boundaries and can get going. Not everything can be fluid at the same time. But some of these decisions are provisional and you might have to change your minds – the front line might find out things are not working and need help – so implementation is not the end of the process. Leaders need constant and real-time feedback loops about how it’s going on the ground.

There is just an inherent and permanent tension between evolutionary solutions and getting on with doing practical things. If you move too quickly into delivery you might impose the wrong interventions. Move too slowly, everyone starts to lose belief. But the first attempt may not work and it may need to be unpicked quickly, so leaders need to be able

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to move fast to rethink. Getting that ‘moment of transition’ right is an art in itself, and one that we are all struggling with.

However creative and ‘emergent’ the process, there comes a point when further progress can only be made through intentional leadership and indeed, within the paradigm of managerial leadership. “The clouds have lifted for the adaptive leaders and they can see where to go on the horizon; the political leader has gained his senior executive colleagues’ agreement to a fundamental value of sustainability, emergent leadership has enabled people to decide on what they are collectively seeking to achieve and how to start on the journey to get there”⁸. At this point, when purpose and plan have crystallised, they can be passed down to be managerially led, project managed and performance tested.

4. Ways of relating

Networks are more important than structures

In a complex system, the meetings are not necessarily the places where leadership takes place. The ostensible leaders are not the only, or even the most important leaders, and the real work takes place in informal rather than formal settings. It is important to understand this, because many very busy senior people spend their lives racing between meetings without time to prepare or think in advance, and are then surprised when the

meeting doesn’t achieve anything. In any system there are a number of leaders at different levels across the system. Some might be politicians or service users, senior clinicians or social workers, charismatic doctors or brilliant managers. The leadership needed to make system change work doesn’t depend on a single powerful individual or even a senior governance group. It depends on a myriad of leaders at all levels, all acting to make the change happen with a clear narrative and a strong personal sense of endeavour. This rarely happens by accident. A crucial element of success is the capacity of system leaders to recognise each other, understand the contribution and value of other leaders and begin to build a network capable of collaboratively moving obstacles. By seeing the network as a connected set of people rather than a series of structures it is possible to make sense of the different levels, to connect horizontally and vertically, to create the right spaces for the right conversations to be had, and to find ways to resolve difficult and discomforting issues. This means informal meetings, conversations, and careful design of formal meetings. It is important to make sure the right people are in the room (and talking to those who are not), getting the right work done in advance, and to understand each other’s perspectives. The most important meetings are often in Costa Coffee.

A journey, not a destination

We are learning through integrated health and social care projects that we don’t always get complete agreement at the beginning. Key leaders and organisations have agreed to walk together for some of the way and may agree to divert their journeys if their own goals change or if relationships strengthen, but they may begin with different ideas about the end-point. Sharing ideas about destinations is helpful because people can begin to see each other’s vision. Good sessions with stakeholders, users and carers can begin to define ‘what brilliant would look like’ – but there is no ‘final’ destination. Our path will change over time as we

learn more and find new ways to do things. The shared endeavour is the journey and it is defining the journey that takes time and care – the story of why we are embarking on that journey and what it will bring for us.

Often leaders know that ambiguity can be helpful; different organisations have to be able to please their different regulatory masters and be held to account by different publics. Relationships also need to be strong enough to withstand the tensions that will develop. However, leaders don’t have to absolutely agree with everyone else’s objectives and they often have different short term goals. What’s important is that they understand what it is they have agreed to do together. Think of the Good Friday Agreement – an agreement which has allowed huge strides to be taken in building the social institutions that can support peace, but which is, at its core, an agreement to disagree. These are two different interpretations about the future of Ireland, but with an acceptance that they are both legitimate and that the society has to encompass both.

If you do what you’ve always done, you get what you’ve always got.

5. Ways of doing

There is a familiar adage in organisational development that ‘if you do what you’ve always done, you get what you’ve always got’. So in order to change the outcomes we achieve, we need to learn to work in very different ways. That might changing what we think the ‘work’ is, for example, writing fewer papers and spending more time in conversation. In the system experiments underway, one of the most important lessons is that conventional meetings seldom move things on. We need to learn to work, and to meet, in different ways.

Changing mind-sets may mean, in part, changing what we believe happens when we ‘do work’ and changing the process of meetings from those we are used to, to those that are capable of making a breakthrough. So if we want to achieve change, we have to think differently. This means creating self-consciousness about how we think now and being willing to examine the strengths and weaknesses of that way of thinking, when it is most helpful, and when it is not going to be enough. By creating a language around different ways of thinking we can begin to recognise when we are using each approach and see the value of others who are introducing other ways of thinking about a problem and designing the appropriate ‘thinking spaces’ for it. If we want to explore differences, for example, we may want to design a process that will achieve that rather than just talking.

For a meeting to be useful – it has to change something

A really good meeting changes the way people think, gets people to see something they haven’t seen before, or builds a new understanding by exploring a difference. They are rarely successful if run like a committee; there needs to be time and space for thinking. We tend to run meetings as ‘progress chasing’ with lots of agenda items, items for information, lots of papers – but they are meetings in which people say very little of what they really think and learn very little about what other people think.

And yet, if no-one can see the whole system then our own perspective is not a safe place to start. Good thinking will come from combining the different ways of seeing and perspectives of the different players. This is not a win-lose game. A good starting place is that everyone is probably right – everyone can see something that is true, important and worrying. It’s just that we can’t see it all.

If we think of what a workshop used to mean – a place where something physical, like a table or a bench was actually made – we can begin to create meetings that ‘make’ things.

In systems change when so much is at stake, the real breakthroughs come when people can build something new from the learning that comes from difference. So exposing difference is important. We tend to just try to find consensus and to agree a set of goals and shared objectives, but in reality the differences are far more interesting.

To find differences, we have to design meetings in different ways, such as workshops, and we have to do real work to uncover different perspectives and understandings. We need to use techniques such as appreciative enquiry, asset-mapping, customer journey mapping, systems thinking, problem finding and co-design – not simply consultation and discussion. If we think of what a workshop used to mean – a place where something physical, like a table or a bench was actually made – we can begin to create meetings that ‘make’ things.

6. Ways of Being

What are systems leaders doing when they are ‘leading’?

How do we catch leadership in action? What are we observing when we see systems leadership happen? The Virtual Staff College paper is excellent at describing the sort of leadership that we need. However, since, as we suggested earlier, systems leadership is always a choice, it is very hard to identify a ‘failure in system leadership’ since it is almost always an absence; a withdrawal of energy or a decision not to intervene. So we need not only

think about the characteristics of system leadership, but about the circumstances within which it can be encouraged and supported.

Leaders need to be comfortable with themselves

At times of stress you want leaders to be focused on the task, not on their own needs. But to do that they need to be able to look after themselves and to find ways to thrive. They need to pay attention to their own emotions and treat themselves well, so that they are able to pay attention to the emotions and needs of others. Often this means acknowledging what is difficult, identifying their own reactions and feelings, and enabling others to do the same.

It means in any diagnostic process a good leader is always diagnosing not only the system, but themselves. “How does this affect me?”, “what does it make me feel?”, “what actions can I take that will make a difference?”. It means acknowledging to oneself what is at stake, what the level of risk is, and choosing actions that we can live with and that make personal, as well as organisational, sense.

Leaders need to lead collaboratively

Organisational leaders do a lot of thinking about how they are going to deploy themselves within their organisation to make change happen. They might think, “James is solid, he knows what he’s doing; but Paula could do with some support from me, and I need to get the politician’s on board, and we need some sort of public event, at which my role will be to...etc. etc.” – and most of this will go on in their head, rather than in the public domain. But in a system no single person’s view of what is needed in terms of leadership will be sufficient. So leaders need to learn to lead collaboratively. They need to have conversations out loud with other leaders that mirror the conversations they have in their heads, which requires very high levels of trust and integrity.

Leadership, in the end, is always an action. It could be the time taken to listen to someone and change their perception of your organisation; it could be a phone call; it could be the finding of resources for a crucial part of the work; or it could be talking to the front line or supporting partners to persuade national or regional bodies to back off when problems are being generated. Coordinating those actions and trusting others to act alongside you makes it safer, more enjoyable, and more effective.

When systems leaders take the time to reflect on their leadership actions they are able to think carefully and well about how to make things happen.

My observation is that when systems leaders take the time to reflect on their leadership actions they are able to think carefully and well about how to make things happen. And in those few leadership groups where they are close enough to work it through together, things start to go right. The quality of those conversations is all important.

How do you lead when you don’t know the answer?

Leadership is sometimes the courageous process of identifying and naming problems, or of drawing attention to the elephant in the room (if there is one). Heifetz sets out a series of important leadership actions when you are moving into the unknown⁹:

1. Frame the key questions;
2. Disclose threats;
3. Disorientate current rules;
4. Expose conflict; and
5. Challenge norms.

Leaders, like everyone else, need to do these things safely – in ways that don't create risks to themselves or to others and in ways that are helpful. But Heifetz also talks about 'cooking the conflict', i.e. not flinching from the difficult conversations when interests conflict.

Leaders often feel that it is their job to direct the actions of others and to know the answer. So how do you lead in situations when you don't know the answer?

System leaders need to choose their own leadership interventions – saying and doing the things that will move things on; but they also individually and together need to create the conditions for the systems leadership of others. Often this is seen as a benign process of making people feel confident and supported, and encouraging the exploration needed to understand things properly. It is about creating – and demanding – the time and space for others to think and explore. But it can also be less comfortable. It may be about challenging conventional ways of doing things and making it possible for things to be done differently, which might create tension and conflict.

The importance of disturbance

Systems tend to be very strong. Many people have built their lives and careers doing things the way they do, and systems are highly resistant to change. So disturbance is important, since without a disturbance to the system it's very unlikely that people will be willing to challenge assumptions or to change established ways of doing things. Thomas Kuhn¹⁰ was the first to point to the idea of a 'paradigm shift'. He says that in science, as in other systems, people tend to explain away facts that don't confirm their theories over many years, until the accumulating evidence that theories are inadequate becomes overwhelming. Only then is shift to a new way of thinking possible. Disturbance is therefore useful, but at the same time difficult to cope with, as the disturbance that makes change

Systems tend to be very strong. Many people have built their lives and careers doing things the way they do, and systems are highly resistant to change. So disturbance is important.

possible also makes people anxious, and anxiety is a bad state of mind when you are trying to experiment. The disturbance that is leading to new thinking about the integration of health and social care has come from the scale of the cuts in social care and the pressures on the health system – a disturbance so great that it is forcing people to think in very radical ways. But those pressures are making people anxious and defensive, so that it becomes harder to trust others. As a result there is a tendency to back away from radicalism, to do the minimum, the easy, and to argue that because of the scale of the cuts it is impossible to sustain collective leadership or working across boundaries. So effective systems leadership has to help people manage their anxiety in such a way as to enable creative, courageous thinking without minimising the scale of the challenge. Acknowledging, and then managing, fear is an important element in courage.

Cherish the maverick idea

The temptation, faced with disturbance and the potential for chaos, is to want to manage away the uncertainty. It is reassuring to believe that we know how to deal with our environment, and that we have expertise that will enable us to tackle new problems. It is likely then, that experts will come up with answers to problems that are based on what they have experienced in the past. Project managers will design a project, clinicians will design a pathway, social workers will create an assessment process, and regulators will create a dashboard.

Often the demands of government and regulators puts pressure on to create early answers – a five year plan with detailed metrics, for example. But if the problem is sufficiently complex, the straightforward linear solutions are unlikely to work. The best solutions are likely to come from thinking that crosses professional and organisational boundaries – the synaptic leap that reframes the problem – or finds a solution left field. Often the voices that lead to this are the lone voices, the outsiders, or users and carers, and when we are in a hurry it can be very hard to hear them. In one project where we were encouraging innovation inside a local authority it was a group of workers in one of the depots that came up with the most creative idea. Often those voices go unheard. It is particularly worth engaging seriously with users, carers and voluntary sector perspectives, not just to 'win consent', but to listen very carefully to their lived experience and to co-create solutions that will work for their situation and their lifestyle.

A mind-set, not a skill

Systems leadership will almost always co-exist with other sorts of leadership, so systems leaders need to recognise when a situation requires system leadership approaches, or whether other approaches are needed. Systems leaders will also need to appreciate the leadership skills that others bring, and find ways to enable them to use their skills effectively. Holding together a group of people with different approaches and skills is not easy, even within a single organisation, and doing it across organisations is even harder. So it helps if teams understand each others' strengths and are able to 'deploy each other' effectively without feeling defensive or challenged.

When obstacles emerge it is the role of the leadership network to find a way to tackle them. This may be the subject of leadership discussion as the 'right' way to respond to obstacles depends on the situation. Sometimes it's about building courage and taking a risk, sometimes it's about

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slowing down to bring more people on board, and sometimes it's about finding a different way to do things. Imagine you are exploring through the jungle and after days of hacking through the undergrowth you reach a river – do you wade across or double back and try and find an easier route? It depends on the river...

Some useful practical suggestions

Much of the leadership discussed above is about responding to individual situations – toolkits and frameworks are of little help. But there are some useful lessons that seem to emerge from the practical experiments taking place on the ground – from Total Place to the Health Integration Pioneers. So here are some suggestions:

Change needs to happen everywhere and in parallel

One of the most useful pieces of learning from being a system enabler in health and social care integration is that change needs to begin everywhere, as bits of the system can go cold if it's too staged and too sequential. People who were excited at the beginning may feel like their 'bit' of the system is not changing and that attention is focused elsewhere, so they drop out, or lose interest. An important lesson was learnt in one partnership board, where the CCG and local authority felt they were making brilliant progress, but the acute hospitals suddenly stopped coming to meetings. We phoned, and took key leaders out for coffee and realised that whilst we'd all agreed with the initial objectives, the first phase of the programme was actually alienating the hospital trusts. The first phase was all about risk stratification systems and key worker job descriptions, and the hospital trusts felt that their priorities, which were around reducing A&E admissions and speeding up

discharge, were being ignored. So some difficult conversations later, we decided to go live on the speeding up discharge workstream in parallel, and everyone came back to the table.

Changing by doing – involving everyone in the work

It is very difficult to build relationships in conventional meetings. There is something very formal about an agenda with papers which are introduced by their authors and then debated for a few minutes before moving on – it becomes almost impossible to say anything difficult or different. It is as if feelings have to be left at the door and a formal bureaucratic language takes over. Yet relationships are about trust and respect and about understanding how other people think and what matters to them. Relationships are built doing the real work, so it helps to create spaces in which people from different agencies can come together to do real work.

In the case of a Multi-Agency Safeguarding Hub (MASH), this was about bringing together workers from all the agencies involved to work through real (anonymised) cases and to share out loud the thoughts and concerns that each case created for each agency. Through doing this we discovered that the police thought about risk differently from the way health professionals thought about it and that head teachers saw things differently to social workers, so we were able to begin to repair relationships that had been breaking down. In a London borough, we set up a series of co-production sessions with users, carers, professionals, clinicians, GPs and the voluntary sector, to design different bits of the model. In another, we created an interactive training programme for the new key workers who would be working alongside primary care and asked them to work with us to design their jobs, agree the role and help each other to develop the skills they needed.

Systems leaders are able to give things away, act with magnanimity, recognise the needs of other organisations, whereas operational managers will be more likely to fight for their organisation's budget, or way of doing things, want to clear away the ambiguity.

You need both strategists and doers

Good strategic managers need to know what's actually happening on the ground, but they don't know all the details. What's the skill mix in a discharge prevention team? Who makes referrals? What are the working hours? Is OT involved?

Realistically, directors are not going to spare the hours needed to develop models in detail. So you may find that while you keep refining the diagrams, the model still stays vague because the leadership team lacks doers. So there is a need to identify operational people, who share systems leadership skills and the values, but are able to get on with the practical tasks, for example, setting up the admin systems for MDTs, and agreeing the design of care plans etc.

The doers need to be connected up with the strategic leaders because I've noticed different cultures of response within the two groups, partly because of seniority and authorising environment.

On the other hand you need strategists, since senior managers find it easier to see the long term goals and are able to give things away, act with magnanimity, recognise the needs of other organisations, whereas operational managers will be more likely to fight for their organisation's budget, or way of doing things, or want to clear

away the ambiguity. This is often the source of tensions between organisations and strategic leaders are needed to smooth the way.

Getting started

Each system leadership project will be unique and will need a design that matches the local circumstances, personalities, pressures and goals. One important discovery is that time needs to be spent designing the 'system leadership' approach. It needs to be recognised that this is not about conventional project management (although that may play a role), but about making sure that all the elements of systems leadership are being paid attention, and that the network of system leaders is cohering effectively enough to lead to purposeful action.

Some version of the following elements is probably necessary:

1. **A shared space** for the most senior strategic systems leaders;
2. **A doers group** that is able to organise the practical work;
3. **One or more co-production spaces** with front line professionals and managers – ideally working across organisational boundaries;
4. **Feedback loops** so that the system leaders can hear from the front line in real time; and
5. **System enablers or orchestrators** who act as observers and are able to be calm, creative, and notice what is happening to the systems.

Systems Leadership – Ways of Learning

Systems leadership is at core a learning process, so reflecting on learning seems to be a really important part of the work.

What is shocking is how little time is being put aside for reflection in many major systems changes and how powerful the 'wilful blindness' has already become. I have been working in a number of places where those people exposed to system leadership thinking, and therefore reflecting hard, are struggling to get other senior leaders around them to reflect or learn.

From watching and working with systems leaders on the Local Vision- Systems leadership projects, as well as reflecting on my own learning, we seem to be:

- **Observing** – paying close attention to what is actually happening (as opposed to what is supposed to be happening or what we think is happening);
- **Reflecting on personal experience** – 'what just happened?', 'what did I do?', 'what did others do?', 'how did it feel?';
- **Listening** – asking others what they think is happening and listening to their experience and views;
- **Asking for help in understanding** – exploring things that seem strange;
- **Opening ourselves to difficult and discomfoting discoveries** – recognising when things are going wrong rather than hoping for the best;

- **Getting in touch with our deepest values and purpose** – wondering about what we are doing and why;
- **Sense making** – reading the environment and others, and looking for patterns creating a narrative;
- **Planning** – working out from what we have learnt might work next; and
- **Reflecting in action** – stopping to think about what is happening in the moment: 'is it working?', 'what is the impact of what I'm doing?', 'what do I do next?!'

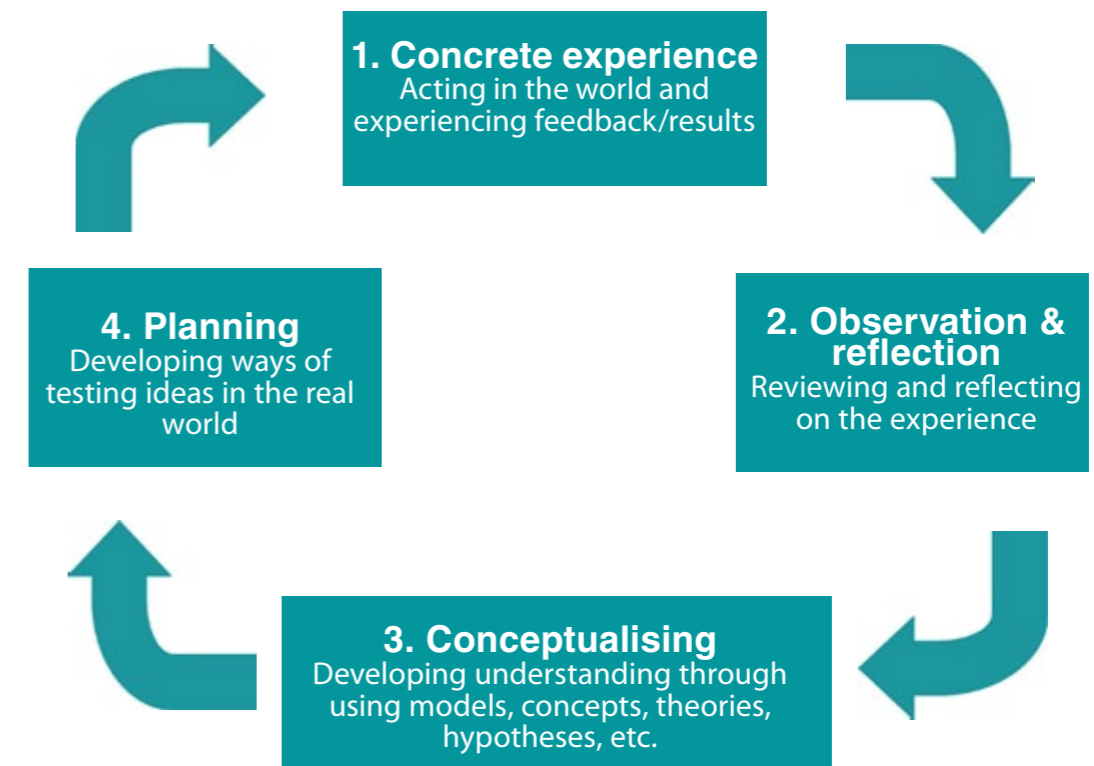
I have also been struck by Mary Fillmore's paradigm 'the usefulness of crying over spilt milk' and her sense that we need to reflect as different characters:

- **The biographer** – 'what does this tell me about me?';
- **The historian** – 'how did this start?', 'what does it mean in the sweep of things?';
- **The ariel photographer** – linking to the bigger picture;
- **The story-teller** – creating a narrative; and
- **The sage** – extracting the learning.

It seems that we need to do an awful lot of personal reflection – but that is not enough on its own. These things are too hard to understand on our own and we are gaining real value from collaborative reflection and shared sense-making. The enabler meetings are very important in helping us to build shared understanding of what is happening.

So perhaps learning in systems leadership involves:

- **Make space for and support personal reflection** – coaching, buddy pairs, quiet time, reading; and
- **Make space for and support collaborative reflection and shared sense making** – team coaching, awaydays, action learning.



Kolb's Cycle of Learning

Another useful reference point is the Kolb learning cycle, which illustrates how, in systems leadership, we might ask questions that relate each stage of the learning cycle to the six dimensions of systems leadership:

1. **Personal core values** – ways of feeling;
2. **Observations, 'hearing' and perceptions** – ways of perceiving;
3. **Cognition, analysis, synthesis** – ways of thinking;
4. **Participatory style** – ways of relating;
5. **Behaviours and actions** – ways of doing; and
6. **Personal qualities** – an overarching way of being that forms the essence of both professional and personal style and approach.

So we might ask ourselves some of the following questions:

Concrete experience – in the moment

- What am I feeling right now?
- What can I see and hear?
- How can I make sense of this – what patterns can I see?
- What is happening to relationships?
- Who is doing what?
- What is the mood or essence of what is going on?
- Observation and reflection.
- What else, outside the ‘moment of action’ do I feel?
- What else, now I have time to reflect, do I notice?
- What am I learning about the way the system works?
- How are relationships developing and changing?
- What has been the impact of actions so far?

Conceptualisation – sense making

- What is causing these feelings?
- What are the system drivers and pressures and how do they impact?
- What keeps repeating?
- What patterns can I see in how people respond, and how this changes relationships?
- What assumptions am I carrying?
- Where do I get stuck?
- What needs to shift?
- How do I or others need to be to enable this shift to happen?

Planning

- What do I want to happen next?
- What would be good ways to make that happen?
- How do we break or disturb systems pressures or cycles?
- What could happen that would make a difference?
- What is my role in this?

About OPM



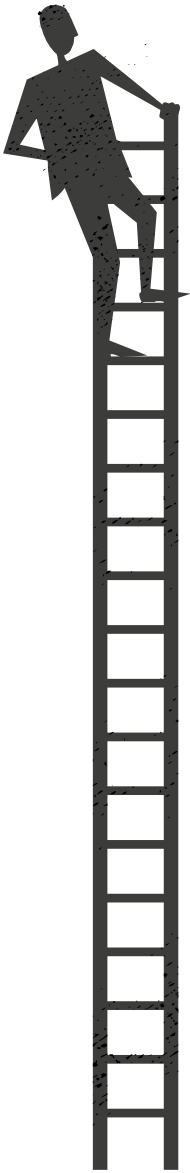
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