Notes from workshop with Department of Health Directors General and Directors, 19th July 2012

Adaptive Leadership and Positive Deviance

Building “communities of capability” and systems leadership

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Executive Summary

Two complementary concepts

Adaptive leadership
Keith Ruddle explained a view of a new form of leadership in a highly complex and increasingly devolved world, where the citizen is expected to contribute more to their own wellbeing and that of the community, both in their individual life-styles and in supporting others, and where top-down, technical change approaches are not appropriate or often problematic.

Key elements of this leadership approach, described as “adaptive leadership” by Ronald Heifetz, of the Kennedy School of Government, are encompassed in the NHS Change Model. The challenges suggesting adaptive change might include radical service or business innovation, new cross cutting propositions, and transforming culture. In turn these require:

- A long-term purpose
- Shift in mindsets
- Many stakeholders, different solutions
- Innovation and boldness
- Local breakthroughs

The group discussed what this meant for them as system leaders using Ruddle’s model, set out on pages 5 and 6.

Positive deviance
Positive deviance is a versatile technique for facilitating community behaviour change and building “communities of capability”.

The group concurred that although PD shared features with widely known techniques such as appreciative enquiry and coaching, its focus on working with groups rather than problem individuals, and on amplifying what works at a practical, detailed level, made it a new, energising and effective means of delivering behaviour change at the front line. By making small changes in practice, PD opens up enormous possibilities in terms of attitude and hope, and creates lasting bonds between community members. The question remained as to the role of the DH management team in disseminating this approach.

Conclusions from group discussions
As system leaders we need to:
- Set a long term purpose and provide a clear strategic view of which of many “wicked” problems we want to focus on
- Change or influence organisational behaviour across the system, including through and with arms’-length bodies
- Communicate opportunities to learn, and be opportunistic in supporting, and being seen to support, local action and initiatives
- Act as a catalyst, creating insightful conversations
- Commission better

Some possible areas for consideration are set out in section 4 of this document.
1. Summary: The role of “system leaders” in the new world

Keith Ruddle

Evolving perspectives on change

There have been many different approaches to change and the number of options for managing it has increased exponentially in the last twenty years.

At the same time, the rollercoaster of public service reform has altered the expected role of government from provider to moderniser, alongside a shift in the relationship between state and citizen, and the viewpoint of the citizen from “I need” and “I want” to “I can”.

The nature of what is seen as a “difficult change problem” has also evolved. There is now plenty of knowledge and experience related to large “technical problems”, such as responding to an outbreak of bird flu, driven by an ‘expertise’ – a command for action, but these skills and a programmatic approach are unlikely to be so effective with complex, community and prevention issues such as reducing or eliminating obesity.

The nature of the obesity problem is highly complex, as the analytical diagram (from Foresight) below shows:
If we compare the nature of the problems:

<table>
<thead>
<tr>
<th>Two imperatives for change</th>
<th>1 Bird flu hits the UK</th>
<th>2 Eliminate obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 months to immunise the whole population</td>
<td>20 years to create a societal shift for national well-being</td>
</tr>
<tr>
<td>Short term pressure</td>
<td>Long-term purpose</td>
<td></td>
</tr>
<tr>
<td>Major effort</td>
<td>Shift in mindsets</td>
<td></td>
</tr>
<tr>
<td>Known solution</td>
<td>Many stakeholders, different solutions</td>
<td></td>
</tr>
<tr>
<td>Predictable action</td>
<td>Innovation and boldness</td>
<td></td>
</tr>
<tr>
<td>Bias to command and rules</td>
<td>Local breakthroughs</td>
<td></td>
</tr>
</tbody>
</table>

the situations require a very different response from leaders and actors:

<table>
<thead>
<tr>
<th>Bird flu hits the UK (technical)</th>
<th>Eliminate obesity (adaptive/transformational)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis, incremental productivity, efficiency, process streamlining, transactions</td>
<td>Type of change</td>
</tr>
<tr>
<td>Known knowledge</td>
<td>Radical service or business innovation, new cross cutting propositions, transforming culture</td>
</tr>
<tr>
<td>Standardisation and consistency</td>
<td>Focus of change</td>
</tr>
<tr>
<td>Teach the expert solution and motivate</td>
<td>Leaders’ role</td>
</tr>
<tr>
<td></td>
<td>Set purpose, challenge and coach</td>
</tr>
</tbody>
</table>

To lead adaptive change requires the right hand side response, whereas technical change requires the left hand side of the table.

A four-quadrant change model was used in the discussion (as below)

**What leaders do to make change happen**

![Four-quadrant change model diagram](image-url)
After discussion of how the style and content of each quadrant would vary according to the nature of the change required, using the example below, the model was populated in the discussion for an example first of technical change (bird flu response) and then for a societal change response to obesity (see next page).

**Styles for Radical Change**

**Programmatic/Technical Leadership**

- Navigation
  - full-time programme management
  - critical path networks
  - operational and financial
  - macro-measures

- Enablement
  - ‘infrastructure’ redesign

- Leadership
  - planning and monitoring
  - detailed hands on control
  - hierarchical command structure
  - “need to know” involvement
  - following instructions and procedures
  - top-down messages

**Transformational/Adaptive Leadership**

- Navigation
  - change as part of normal responsibilities
  - co-ordination through communication
  - balanced scorecards
  - macro-measures

- Enablement
  - facilitation and knowledge management

- Leadership
  - scenarios, intent and direction
  - values and purpose
  - collective leadership
  - encouragement and coaching
  - extensive involvement
  - breakthrough cultures
  - self-initiated change and learning

**Context**

- predictability
- urgency for radical improvement
- short-term targets

- Ownership

- certainty and flux
- fast-changing industry
- long-term shareholder value

**Leadership**

- Effective role models, living values
- Sponsoring and championing purpose
- Holding people accountable for change
- Coach, challenge, counsel effectively
- Communicate need, vision, benefits etc

- Strong involvement & engagement
- Demonstrating innovation and breakthrough
- Learning and self improvement
- Buy in and understanding of change
- Alignment with vision and purpose

**Enablement**

- Redesign of product and processes (eg curricula)
- Right investment in infrastructure (IT, resource, organisation, facilities)
- Enough people with the right new skills
- Support for training, learning and sharing
- Right incentives & performance management

**Ownership**

- Planning and monitoring
- Detailed hands on control
- Hierarchical command structure
- “Need to know” involvement
- Following instructions and procedures
- Top-down messages
This matrix, created through group discussion, in the context of the Department of Health’s obesity strategy, gives examples of what each quadrant could consist of:

<table>
<thead>
<tr>
<th>Navigation</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and development</td>
<td>Setting the purpose</td>
</tr>
<tr>
<td>Shifting monitoring of outcomes</td>
<td>Collective leadership and Alliances</td>
</tr>
<tr>
<td></td>
<td>Convening and encouraging debate and collaboration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enablement</th>
<th>Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge transfer</td>
<td>Many initiatives</td>
</tr>
<tr>
<td>Facilitation</td>
<td>Demonstration examples</td>
</tr>
<tr>
<td>Enablers and accelerators</td>
<td>Positive deviance approaches</td>
</tr>
<tr>
<td>Learning</td>
<td>Social movements</td>
</tr>
</tbody>
</table>

And the locus for implementation will be in areas beyond the Department’s direct control, e.g. with
- Food manufacturers
- Food retailers
- Schools
- Faith groups
- Voluntary sector
- Community organisations
- Youth organisations
- Family support organisations

The NHS has developed a change model whose aims and content reflect the group’s discussion about the nature of the changes that Department of Health policy needs to address, and how to achieve them.

Our ability to improve has to move to a new level; we need to find ways to further:
- create more of the conditions and partnerships where change can flourish
- activate the energy and brainpower of our workforce, people who use our services and our NHS partners in support of the changes we want to make
- link up our change activities across the whole system in a way that isn’t just about compliance, avoids unintended consequences and makes the sum greater than the parts
It sets out to achieve the kind of environment that would be delivered by the “adaptive leadership” (right hand) examples of applying Keith Ruddle’s leadership model. The Department of Health may well use the same framework to achieve a common language in addressing the adaptive challenges summarised below:

**Mapping different change imperatives in your health system**

<table>
<thead>
<tr>
<th>Technical</th>
<th>Adaptive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems wide</td>
<td></td>
</tr>
<tr>
<td>Systems ‘technical’ levers:</td>
<td></td>
</tr>
<tr>
<td>Tariffs/Outcomes</td>
<td></td>
</tr>
<tr>
<td>Regulation</td>
<td></td>
</tr>
<tr>
<td>Commissioning</td>
<td></td>
</tr>
<tr>
<td>Market making</td>
<td></td>
</tr>
<tr>
<td>New accelerated training models</td>
<td></td>
</tr>
<tr>
<td>New tariffs &amp; commissioning rules</td>
<td></td>
</tr>
<tr>
<td>Overhead cost cutting</td>
<td></td>
</tr>
<tr>
<td>Staff flexibility models</td>
<td></td>
</tr>
<tr>
<td>Service line reporting</td>
<td></td>
</tr>
<tr>
<td>Reconfigurations &amp; mergers</td>
<td></td>
</tr>
<tr>
<td>Service line reporting</td>
<td></td>
</tr>
<tr>
<td>New end to end pathways</td>
<td></td>
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<tr>
<td>Reinventing community work</td>
<td></td>
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<tr>
<td>New paediatric models</td>
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<tr>
<td>Innovative new services</td>
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<tr>
<td>Innovative new services</td>
<td></td>
</tr>
<tr>
<td>Self health management</td>
<td></td>
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<tr>
<td>Dementia and obesity strategies</td>
<td></td>
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<tr>
<td>Health/social care – new work models</td>
<td></td>
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<tr>
<td>Acute to polyclinic to home</td>
<td></td>
</tr>
<tr>
<td>Innovative new services</td>
<td></td>
</tr>
<tr>
<td>Health and social care system</td>
<td></td>
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<tr>
<td>Direct mgt</td>
<td></td>
</tr>
<tr>
<td>Hands on Planning</td>
<td></td>
</tr>
<tr>
<td>Perf mgt</td>
<td></td>
</tr>
<tr>
<td>Dept of Health SHA/NHSCB/LAs</td>
<td></td>
</tr>
<tr>
<td>Adaptive leadership</td>
<td></td>
</tr>
<tr>
<td>Purpose, outcomes &amp; values</td>
<td></td>
</tr>
<tr>
<td>Catalyst and challenge</td>
<td></td>
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<tr>
<td>Adaptive influences</td>
<td></td>
</tr>
<tr>
<td>Role models</td>
<td></td>
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<tr>
<td>Positive deviance</td>
<td></td>
</tr>
<tr>
<td>Local alliances</td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td></td>
</tr>
<tr>
<td>Behavioural economics</td>
<td></td>
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<tr>
<td>Social movements</td>
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</tbody>
</table>

As systems leaders, the group discussed their role in rising to the adaptive challenges.
A note of the questions generated is set out in section 3. A key question emerged:

**How do we get behaviour change without a supporting "left side" (technical) business process?**

Into this context, we introduced Positive Deviance.

### 2. Summary: the Positive Deviance approach

**Jane Lewis**

Helen Bevan, Chief of Service Transformation at the NHS Institute, makes a connection to Richard Walton’s 1985 Harvard Business Review article, “From compliance to commitment” which provides another perspective on the kind of leadership needed to deliver improvement and sustained high performance. In essence it is the same as the “right side” examples using Keith Ruddle’s model. She has recognised positive deviance (PD) as a tool to deliver this kind of leadership and summarises positive deviance thus:

*Positive deviance (PD) is a proven five-step, evidence-based facilitation process to*

- find people who perform better than their peers within the same context and the same resources
- discover in detail what they do and how they do it
- and then to design learning for others to share the practices

*Whilst there may be obvious mavericks or outliers in organisations or communities, to be truly positively deviant, there has to be evidence that their practices are successful. Successful practices are often not recognised by their owners as being anything special, may not be spotted by their peers, and may not always follow the rules, but they work.*

*Whilst it is a relatively straightforward process in concept, to work with PD requires a specific and different mindset from traditional improvement and engagement approaches, which honours and respects the group or community’s knowledge and encourages hope and behaviour change through action.*

*It differs also from asset-based approaches such as appreciative inquiry, because it starts with defining a problem specifically and tightly. It is very practical and allows immediate progress, based on small changes in practice that make huge differences in outcomes and behaviour.*

Worldwide, it has delivered:

- 80% reduction in malnutrition in Vietnam, and an average of 50% reduction in 41 developing world countries
- Between 30% and 73% reductions in transmission of MRSA in three US hospitals, in months, rather than the two years taken by a parallel Toyota Production System project that achieved 50% reductions
- 30% reduction in girl trafficking in Indonesia

Pascale, Sternin and Sternin (2010)
Woodward Lewis have used PD in both organisational and community contexts in the UK.

We introduced the case studies about the Gosport young parents, the “speed PD” exercise on messy play and the Home Office domestic and gang violence pilots. Detailed case studies are available at www.woodward-lewis.co.uk/case-studies/.

They achieved:

**Young parents**
- Creation of the largest support group of teen parents in the borough (14 members)
- Creation of a copyrighted support programme for school pupils, developed by the teen parents group, in line with National Curriculum requirements, delivered in the school with the most at risk students and requested by the other two community colleges in Gosport; now being used more widely in Hampshire by staff
- Development of presentation, facilitation and counselling skills in the group
- Potential for all of the group to be accredited as level 3 teaching assistants
- 8 of the group went on to take social care qualifications at college

**Children’s attainment/messy play**
- Creation of a new group of eight mothers with fourteen children under 5 (three sets of twins) that still meet and support each other, one year on, after the Children’s Centre that was the focus of the exercise was outsourced and programmes halted
- The best rate of retention of all the programmes on offer at the time (100%)
- Measurable changes in practice (increase in practical engagement in play) and confidence, socialisation of children over a three-month period, and informally over a year

**Home Office pilot**
- Creation of community groups with up to 25 members, to raise awareness of DV and to find ways of preventing entry into gangs, that have continued after the end of the formal project
- Identification of the community’s leverage points and development of safe approaches for increasing reporting of domestic abuse by enabling victims to get help (increasing reporting by 15% in Blaenau Gwent and significantly in Cambridgeshire)
- Changing the relationship between the authorities and survivors by recognising that they are not passive victims, but women who have possibilities and strengths
- Changing the tone of social marketing and communications to connect more effectively with women in abusive relationships – see illustration on the next page:
They all demonstrated that the mindset and approach are very effective in opening up small improvements that lead to significant changes in attitude, practice and culture. However, the process as taught to us has needed adaptation to become more focused, and efficient, whilst maintaining the flexibility, creativity and empowerment that it brings, and in keeping with the ethos of PD, these alterations have been inspired and implemented by project group members.
The five steps of positive deviance appear straightforward:

1. **Finding the right people/start point**
   - Aligning the exercise to the intent. Who needs to be involved? Where might we start? Leadership roles?

2. **Finding the Focus**
   - What is the “right” problem? Finding community evidence and data. What is our desired outcome?

3. **“Treasure Hunt”**
   - What is the norm? Are there positive exceptions? What do they do? How do they do it?

4. **Sharing the “how”**
   - What can we all do? How do we do it?

5. **Measurement and reinforcement**
   - Have we achieved our aims? Are we still getting better?

6. **Scaling up**
   - How can we expand the PD approach? How can we build on the results? Building local facilitation expertise

However, as we found, they are not all that easy to implement:

"When PD is explained to you, you think you understand because it sounds logical and simple. Then when you actually do it you realise that you didn’t understand it, because doing it is completely different to what you have experienced before. You have to actually do PD before you truly understand it.”

– experienced change management specialist in Home Office project

What makes PD truly different and value-adding lie in the core principles that underpin it:
The discussion at the workshop highlighted that the key features of positive deviance community work are to:

- Build communities of capability – groups that support each other and share learning, and that continue to exist after the “project” ends
- Enable people to change their minds without a sense of loss
- Start to address complex issues in a holistic way that would normally be the territory of a number of different agencies
- Demonstrate that “I can” – to pull out people’s strengths without creating heroes, and overcome the sense of helplessness that affects people

To act your way into a new way of thinking provides a practical, bottom-up answer to creating a culture without the top-down processes. There is the safety of an evidence-based process that can be mentored by hierarchical leaders.

One of the key issues, though, is that of system drivers, which links closely to the role of the Department as system leaders. Current system drivers are not configured to deliver results that are not pre-determined, or to liberate bottom-up, community driven initiatives that may impact on the future role of a wide range of organisations and individuals. They reward short-term cost savings and achievement of to-down targets.

PD supports most areas of the NHS/DH change model, and provides a tool that bridges the left and right sides of the leadership model, a means of “letting one thousand flowers bloom” in the context of financial constraint.

3. Questions and ideas emerging from group discussions

The final part of the afternoon debated the issues of systems leadership, positive deviance and scalability, with the aim of creating meaning and sense for the group.

The main “frequently asked questions” were:

**The role of the “new” Department of Health systems leaders**
- How can we act as a catalyst without being programmatic?
- What might we lose by shifting towards an adaptive leadership approach?
- What incentives should we put in place? What is our responsibility for making them work?
- What is our role in respect of orchestration amongst other bodies?
- What is our power of intervention?

**Working with “bottom-up” change**

It is part of government policy to have community-level action so:
- How to make the most of Total Place/Community Budgets?
- What barriers to change might we (unintentionally) put in place?
- Where should we put money?
- Where to seed and start activity?
- How to replicate successful “hows?” Pilots? Prizes?
- What data should we provide?
- How do we create an evidence base to show what works?
• How do we respond to community-driven metrics, what will be the influence on research and development?
• What problems can we apply positive deviance to?

The discussion that ensued arrived at some high-level conclusions about the Department’s role in systems leadership which will be taken forward and discussed further.

4. Further considerations and possible next steps

Discussions will continue about the Department’s enabling role in the new policy environment. We hope that the workshop will stimulate new ideas and ways that policy aims can be achieved, by using adaptive leadership and facilitating the liberation and/or creation of “communities of capability”, for example:

• How does the Department engage with Public Health England in its role in providing expert advice and services and showing national leadership for the public health system? How might it influence how the agency does its job?

• The Academic Science Health Network is being created, with the aim of improving patient and population health outcomes by translating research into practice and developing and implementing integrated health care systems; how can the Department support the network to get established, to work effectively and to ensure that innovation and learning are diffused into the wider system?

• Is there a way of accelerating the changes needed in the world of social care and integrated health care? Could a bottom-up, adaptive approach provide some more options?

• Will an adaptive approach help the Department to influence key stakeholders, and provide new insights in how to work with the framework of other agencies and create better relationships?

The group will be having further discussions about the next steps. You could consider:

• Holding a series of wider briefings about adaptive leadership, positive deviance and related ideas for working with complex and “wicked” problems and current priorities

• Ensuring these concepts form a major part of the methods, pedagogy and deliverables of the new innovation and improvement agency
5. References

Bichard, M; Bell, D; Ruddle, K; Bundred, S; Wilkinson, G; Collins, P (Ed): Byrne, L (Ed); (2004) *Reinventing Government Again*, Social Market Foundation, London

