Leadership – a case of systemic failure?

William Tate

When systems fail, the public are usually fed a rotten argument: 'It's only one bad apple'. Think of the lone News of the World 'rogue' reporter who hacked celebrities' phones. This defensive balm (and barmy) response provides political cover for the 'system'. "An individual acting alone" presents an easy target for media scapegoating. But if you use a search engine, increasingly you find 'systems' and 'systemic' peppering commentators' and politicians' statements. Does this hint at a new level of maturity and awareness?

So what does the word 'system' mean when applied to human organisations, and what is its significance?

Systems operate at several levels, with ebbs and flows of policy and practice which often contradict each other. There are currently reforms to the legal, educational, health, welfare systems, and so on. Take schools and teachers for a start. We read of UK Education Secretary Michael Gove wanting to speed up the system by which 'bad' teachers can be sacked. Cutting 'red tape', he claims, will allow head teachers to act more decisively ('Schools get power to remove poor teachers within a term', The Guardian, 13 January 2012). This performance system sits within the wider education system, which itself may be contributing to producing those 'bad teachers'. In parallel, a change in Ofsted's rating system during school inspections elevates the criticality of teaching, creating an expectation that more teachers will be identified as 'not outstanding'.

In the field of nursing, improving care to patients is not simply down to individual nurses. Prime Minister David Cameron points out that 'If we want dignity and respect, we need to focus on nurses and the care they deliver. Somewhere in the last decade the health system has conspired to undermine one of this country's greatest professions. It's not one problem in particular. It's the stifling bureaucracy' ('Nurses to make hourly rounds under Cameron plans', The Guardian, 6 January 2012).

In the case of responsibilities for child protection, the government is offering greater decentralisation to local authorities. At the same time, local authorities' responsibility for schools is being withdrawn. Within organisations, enlightened high-level leaders make system changes that they hope will liberate leadership and management action at another level.

But there is more to systems and leadership than examples such as these. There are wider and deeper issues concerning systems that every manager needs to be aware of and understand.

Systemic failure and the default model

When thinking about an organisation's management and leadership competence (individual, collective and systemic), it is the individual who inevitably becomes the first port of call. That metaphor is apposite right now. The Costa Concordia's captain, Francesco Schettino was immediately blamed for the cruise liner's foundering on rocks off Italy's Amalfi coast. From the way the 'abandon ship' process was handled, Schettino appeared not to fit the heroic leader model. But why was the liner so close to the shore? Speculation has been rife about whether Schettino was making a personal 'salute' to the island, perhaps to one of the company's former masters who lived there.

Image removed of luxury liner Costa Concordia

When the outcome of the enquiry emerges, we may find that, among the tempting siren voices, the organisation and its cultural traditions played a role in the decision to steer a risky course close to the rocky shore. The captain has reportedly told the investigating judge that there was 'insistence' by the firm on carrying out such manoeuvres because it was a good way to promote its cruises ('Costa Concordia captain claims company ordered 'salute' to island', The Guardian, 23 January 2012). But

what complex mix of forces were at work in Schettino's psychological and physical hinterland? Viewed through a systems lens, the truth is rarely simple.

Be on the lookout for systemic causes

Look out for systemic elements as well as rocks in these choppy waters – individual, team and beyond. When disaster strikes, and individuals are assumed to be at fault, a variety of systemic explanations often begins to emerge and contributes to the wider picture.

Consider the three examiners who were suspended by a major Examining Board in December 2011. An inquiry was launched into the exam system in England after it was thought that teachers were given secret advice on how to improve their pupils' results? ('Examiners suspended over 'secret advice' ', The Guardian, 9 December 2011). It emerged that the country's three exam boards are in competition with each other to increase their market share of schools buying their exams. Those boards' existence depends on schools achieving good results. In other words, there are potentially hidden incentives in the system and a clear conflict of interest. Who knows what words of advice might have passed down to the individual examiners in how to help teachers? Try to imagine the examiners' appraisal if 'their' schools produce poor results. Will they be assessed as upholding high standards, or of failing to understand their employer's commercial interest?

Again, there is a system operating here, buried within the wider examinations system. Should the three examiners be treated as 'bad apples' in order to reassure the public, or is there something more systemic going on that calls for treatment? And what is the government's responsibility for reforming a dysfunctional examinations system?

Take the case of the Virgin high-speed Pendolino train from Euston to Glasgow which derailed on the west coast mainline near Grayrigg in Cumbria in February 2007, killing an 84-year-old woman and injuring 86 other passengers. A Network Rail employee is reported to have admitted failing to check the points that day ('Grayrigg train crash inquest jury retires to consider verdict', The Guardian, 3 November 2011). It looked like an individual human fault, where blame could easily be allocated.

Image of crashed Virgin train from *The Guardian* on 4 November 2011

But at the coroner's inquest, the employee, who was also the track supervisor, said that his team had been understaffed and that workers were not given the right tools or sufficient time to check and maintain the lines. It turns out that the employee had sent an email to his bosses one year before the crash telling them to "stop ducking the issue and sort out this shambles once and for all". The Office of Rail Regulation (ORR) has accordingly taken criminal proceedings against Network Rail, which has admitted liability. Yet the trade union leader involved claims that "There remain systemic problems which have failed to be addressed since this derailment and they have been compounded by the ORR-driven cuts regime" ('Network Rail to be prosecuted for fatal Grayrigg train crash', The Guardian, 14 January 2012). Metaphorically, there are wheels within wheels, and systems within systems. There always are.

In cases such as these, what are the leadership issues? How do organisations view the matter of leadership? What should leadership have done and be doing? What is its role in learning and implementing lessons, and in ensuring a functioning channel is available and used for critical feedback? How is the leadership capacity of individuals, teams and the organisation developed, expanded and released? What is the leadership culture? And how is leadership spotlighted and held to account?

What we find when we explore systems

When you dig down, what you find in every system – school examinations, rail, banking, defence procurement – are other less obvious and less talked about systems that are very powerful in determining how the organisation performs. These systems enjoy a two-way relationship with leadership action. So while an organisation's leadership faces outwardly, it must also examine itself and consider how its own process is working and how it too needs to learn, improve and enhance its capability.

Systems often constrain managers when they attempt to take on a leadership role. Think of the well-reported case where some police officers were prevented by police regulations from rescuing a drowning child in shallow water, and could only stand by while they waited for fully trained and equipped fire and rescue service officers to arrive.

Image from Daily Mail, 1 October 2011

'Police officers in one of Britain's biggest forces have been warned not to hold out a hand to drowning swimmers - in case they are pulled into the water themselves. The guidance is contained in a health and safety policy document which says officers should also think twice before throwing a lifebelt, 'New safety rules tell police not to hold their hand out to drowning swimmers.'

(*Daily Mail*, 1 October 2007)

It seems to me that there are at least five important factors affecting this case. First, an organisation that is risk-averse. Secondly, uniformed police in close radio contact with their control room about the situation they find themselves in. Thirdly, a bank of controllers whose advice to officers is governed by a manual of standard operating procedures. Fourthly, a perceived risk of a policeman (assuming a male) or his widow losing her rights if her husband is injured or loses his life in an incident where he has acted in breach of standard operating procedures. And fifthly, a quasi-military structure where the first commandment is that the hierarchy must be preserved. In such organisations – as Lawrence Peter (of *The Peter Principle* fame) put it – "super-competence in an employee is more likely to result in dismissal than promotion, a feature of poor organisations, which cannot handle the disruption. A super-competent employee violates the first commandment" (Peter & Hull, 1969:47). The deadly combination of factors in the policing system makes it difficult for an otherwise courageous officer to use personal discretion to waive the rules and use initiative. In the public mind this looks like a lack of leadership; but in the blame game, it is the system that is at fault.

Shifting a long-standing traditional culture is hugely difficult, though not impossible. One can take steps to weaken hierarchy, replace a manual of rules with guidance (as I did in British Airways), encourage and reward discretionary decision-making, and so on. But the starting point is to develop system awareness.

The fish tank metaphor

Likening the organisation to a fish tank is a powerful way of communicating the systemic idea. Instead of simply observing the 'fish', it is important to see beyond the fish and notice the quality of the fish tank and what surrounds the fish, something that our gaze does not naturally do since mostly we only notice and become obsessed with the fish. Most fish tank owners however not only notice the fish, they also take responsibility for providing their fish with a high-quality environment, removing toxins and adding nutrients. Owners of fish tanks know that the quality of what surrounds the fish accounts for whether they live or die, whether they swim in a lively manner, and whether they look bright and in good health. If the water is toxic, the fish will suffer. What responsible and wise owners do not do is blame the fish for their poor appearance or performance, or take the fish out from time to time to give them a spot of training, tell them to smarten up and look more lively, and then plop them back in the same dirty water, as this author William Tate explains in *The Search for Leadership: An Organisational Perspective* (2009).

Some of the contents of the 'fish tank' (aka the organisation, seen as a system)
• Food • Toxins • Murkiness • Predators and bullies • Small fry • Hiding places • Power struggles • Territorial disputes • Hierarchies, pecking orders and food chains • Injunctions, rules, protocol, and bureaucracy • Official and unofficial groups • A dark, shadow side • Favoured in-groups and low-status out-groups • Admiring, curious, sceptical and critical onlookers

The fish tank stands for the organisation when seen as a system. The metaphor raises questions about its design, operation and management that go deeper than the well-understood matter of an organisation's climate, and more than merely nourishing the fish. The tank needs to be more clearly seen and understood by managers as a system, one that almost certainly offers scope for improvement if the fish are to be able to see their way, navigate their daily journeys, handle the political currents, enjoy themselves and feel safe.

What does it take to change the system?

Consider three familiar HR leadership-related activities: training, coaching, and appraisal.

Leadership development

Leadership development is often undertaken as an add-on, to one side of the main game. Development may be set aside until there is a stable organisation base. By contrast, a systemic approach to leadership development is OD-led and is designed to improve the way the system liberates, focuses and applies leadership as an integral part of the process of changing the way the organisation runs.

Where traditional development notices and improves individual 'fish', a systemic approach notices and improves the fish tank, the connections and relationships, and all those things going on around and

between the fish and with other fish. In human organisation terms, this involves not only working with individuals but also working on the relationship between employees and their managers, across hierarchical levels and boundaries; with the business's purpose, goals, journey and future; and with the organisation's rules, regulations, policies, etc. The development intervention aims to improve the organisation's utilisation of leadership, release managers' leadership abilities, their potential and energies; and identify where leadership is being wasted and stop it.

Examples of what systemic leadership interventions may be concerned with
• How safely can people disagree with their boss? • What does no one dare talk about? • Where are feedback channels not working? • How can coordination be improved across boundaries? • How can the organisation get better at learning from its mistakes? • How can leadership be more widely distributed? • How can the hierarchical structure work more effectively? • How rigorously is accountability practiced? • How clear is it where responsibility lies for the healthy functioning of the system (in the kind of terms described above)?

Leadership coaching

Team leadership expert Peter Hawkins (2011:13-18) is clear that:

> No longer do the main challenges in organisations lie in the people or in the parts, but in the interfaces and relationships between people, teams, functions and different stakeholder needs. … So much of the literature and leadership training is based on seeing and developing leadership within individuals. The industry of leadership development, including coaching … has failed to move fast enough to address the changing challenges and needs.

Professor Hawkins goes on to point out that what people call leadership development is really leader development. Leadership does not reside in individuals; leadership is a relational phenomenon. Individual coaches over-focus on the individual client and under-serve the organisational client.

I see a systems perspective adding three elements to coaching:

Perspectives in systemic coaching
1 Recognising that a management team is itself a system and also part of a wider system, and coaching team members in those relationships (inside and outside the team). 2 Understanding the range of systemic theories, models, and tools available to coaches in their questioning and reflective processes, whether working with individuals or teams. 3 Coaching managers in seeing and understanding their organisation systemically and helping them in their task of improving the way their organisation works.

Appraising leadership

If the above analysis and logic holds for coaching, it follows that the same analysis for individual-skill dominated performance appraisal for managers cannot be far behind. A challenge is long overdue to

the assumption that the most important driver of performance in the organisation is the individual's competence, training, goals, and results. It is more important that organisations are well led than that they have good individual leaders (Tate, 2010:48-53).

Managers have several responsibilities. Often it's only the first that gets discussed.

Managers' multiple responsibilities
• To fulfil your job as an individual manager. • To be collegiate, making it easier for other managers to be successful in their jobs. • To achieve things jointly with other managers. • To make the fish tank healthier for all their fish. • To challenge the status quo, to ensure that tomorrow is better than today. • To seek and achieve continual improvement in their organisation.

A systemically aware appraisal process can let colleagues join in. The manager's leadership role should be explored in relation to organisational improvement and change. And system issues should be brought into the conversation.

POINTS TO PONDER

- How open are organisations and the HR profession to being challenged by this systemic mindset?
- How ready are leaders to abandon the heroic model and let the system take the strain?
- What is the quality of the 'fish tank' in which you personally are required to swim?
- Should the world manage without scapegoats and instead hold systems responsible?

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LEADERSHIP – A CASE OF SYSTEMIC FAILURE

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Here are (5) things failure can teach you about leadership that can make you a better person too.Â I help organizations build high-performance leaders, teams and cultures focused on inclusion and the power of individuality. Leadership in the Age of Personalization. Share to Facebook. Share to Twitter. View Systemic Failure Research Papers on Academia.edu for free.Â Many well-known cases of â€˜medical manslaughterâ€™ have shown that systemic issues play a significant role in contributing to fatal errors in healthcare institu- tions. The most prominent NHS scandal, Mid Staffordshire, demonstrated that more. Many well-known cases of â€˜medical manslaughterâ€™ have shown that systemic issues play a significant role in contributing to fatal errors in healthcare institu- tions. The most prominent NHS scandal, Mid Staffordshire, demonstrated that wrongful prioritization of resources and staff shortages had contributed to the deaths of between 400 and 1200 patients d Taking systemic risk seriously is the ultimate governance test. Those who pass it know to shut down a city or an entire country when there are still only a few cases of a highly contagious virus present. Sara Cody, the public health officer for Californiaâ€™s Santa Clara County, and New Zealand Prime Minister Jacinda Ardern did precisely that in the face of COVID-19.Â Austriaâ€™s early failures helped create an infection hotspot in the Alps. The countryâ€™s leadership quickly learned its lesson, finding itself in the enviable position of being able to carefully reopen its economy before many others. Reply. A new reply to this comment has been posted. In cases of systemic failure, individual executives who operate at a lower sub-system level may be free of responsibility and blame. They may argue (correctly) that it was the wider system that failed. They may claim that particular systems that integrate with their own work let them down.Â (Extract from Chapter 12 â€˜Leadership and Systemsâ€™ in The Search for Leadership: An Organisational Perspective, Triarchy Press).