Of Clocks and Clouds

Leading System Level Change in Health and Care

Learning from the Northern Triangle
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This independent report explores a key question:
How do we achieve meaningful change when the solutions to our most pressing challenges lie beyond the *effective* jurisdiction of any single leader or organisation?

Beyond theory
This report is not an academic paper on what system leadership should look like. It is a rigorous, co-produced analysis of what the lived experience of system leadership actually looks like - navigating the complex reality of intense operational and financial pressure.

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Foreword

We came together almost two years ago because we shared a problem none of us could solve alone. Leading system improvements across Lancashire and South Cumbria, the North East and North Cumbria, and across Scotland, we offered three independent vantage points and approaches. Yet we were all facing the same recurring question: why is meaningful change so hard to land at scale, even when we know what 'good' looks like?

System-level change is hard. Inspired by a global community of disruptive thinkers, and supported as part of the Q Community's UK and Ireland network of those leading national improvement efforts, we began meeting for connection and support, driven by a compelling curiosity to learn. The system you seek to change is the one you are accountable to. In each other we found a partnership, and through trust, created a space to think, to challenge each other with honesty and created a place to learn. We learned that effective change at the system level is not about 'doing things better'; it is about 'doing better things together'. It is a different species of work, and it asks something different of us as leaders.

We also learned that you cannot pull on a single thread and expect a system to change. If leadership, governance, and measurement are still tuned to the old way, the system will quietly pull the work back to its starting point. Every component must shift in balance: from the predictability of 'clocks' to the complexity of 'clouds.'

This work asks a great deal of those who lead it. We have watched colleagues with the right instincts burn out, worn down by the systemic inertia of the old way. Surviving and thriving in this complexity requires moving from isolated effort to a deeply shared, collective leadership. Sustaining yourself and each other is not a distraction from the work; it is the work.

With financial support from the Health Foundation's Q community, we commissioned this report to provide an independent analysis grounded in the experience of those doing the work. Thanks to the remarkable openness of the leaders interviewed, the authors produced something unexpected: a mirror held up to the reality of system improvement with profound humanity. These are not portraits of perfection, but honest reports of three attempts. Read them that way.

Finally, this report is not a framework or a toolkit; it is a provocation. If, on closing it, you find yourself calling someone in your own system to talk it through, it has done its job.

The work continues. If you are shifting toward a more relational approach that puts people at its heart, please reach out. We would be glad of your company.

Ailsa, Diana and Kathryn

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Executive Summary: Leading Beyond Jurisdiction

The strategic challenge

How do we lead and deliver meaningful change when the solutions to our most pressing challenges lie beyond the effective jurisdiction of any single leader or organisation?

While the policy intent for preventative, integrated, community-focused models of health and care, commonly referred to as 'Left Shift', is clear, the gravitational pull of the acute sector remains dominant in system leadership. This tension reflects intense operational and financial pressure and the persistent attempt to manage human complexity through linear clock-like tools and approaches.

Leaders are caught between the rhetoric of left shift and the reality of waiting time and financial targets that keep attention fixed on hospital performance. Many leaders we interviewed acknowledged that effective system stewardship demands a difficult trade-off, including a willingness to sub-optimise organisational performance or finances in order to enable shifts in care that serve whole system purpose.

Two species of work: Clocks and Clouds

A fundamental clash between two dominant system logics explains why transformative change remains so elusive:

- **Clock Logic:** Assumes systems are predictable and controllable. Change is driven through metrics, standards, and technical levers, much like adjusting the workings of a clock.

- **Cloud Logic:** Assumes systems are complex and adaptive. Purpose is shaped together, and change emerges through relationships, trust, and shared learning.

Human problems are rarely technical puzzles; they are contested, value-driven situations where there is often no consensus about what the 'problem' even is. Navigating this requires a leadership disposition of authenticity and humility: a recognition that real system work begins by understanding how different people experience the system before attempting to redesign it.

The reality: navigating the 'Intractable Elephants'

Meaningful change begins by acknowledging the systemic tensions created by this logic mismatch. These 'elephants' represent the uncomfortable truths of modern leadership:

- The Gravitational Pull of the right shift: Why the 'Master Clock' of acute targets consistently overrides the long-term prevention agenda.

- The Poverty Paradox: The necessity of leading beyond clinical pathways to confront the socio-economic determinants of health.

- The Stewardship Paradox: The challenge of being held accountable for a system where you lack direct authority over partners.

- Inequality of Capacity: The gap in improvement capacity and capability between heavyweight acute infrastructure and under-resourced community and social care.

The evidence: learning from the Northern Triangle

We analysed three regional approaches to bridging the gap between mechanical necessity and relational reality:

- Lancashire & South Cumbria (Pathway Level): Using Engineering Better Care, a four-step (later five-step) systems-engineering approach to bring technical rigour and multi-perspective clarity to complex clinical issues. It provides a structured framework to navigate the highly relational space of multi-organisational pathways.

- North East & North Cumbria (Regional Level): Adopting a Human Learning Systems approach to foster an inclusive learning community. This was developed in response to a striking paradox: the region boasts some of the top-rated provider organisations in the country yet simultaneously faces some of the starkest health inequalities. The initiative aims to build the relational capital needed to address what truly matters most to local communities.

- Scotland (National Level): Implementing a holistic framework called the Scottish Approach to Change focused on a 'People-led' approach to transformation. This approach seeks to embed improvement capability directly into the national infrastructure as a standard component, underpinned by a culture of 'Compulsive Curiosity.'

Leading the shift: from hierarchy to stewardship

To bridge the gap, leaders must move from 'managing transactions' to recalibrating system conditions, as detailed in our Six Pillars of Leadership for System-Level Change. This requires a shift in leadership practice and the dismantling of some of the system conditions that restrain it, moving from the certainties of hierarchy toward a practice of stewardship. By spanning boundaries and building relational capital, leaders can shape the environment that allows collective, integrated action to emerge.

Four key lessons

- Recalibrate Leadership Approaches: Diagnose the nature of the problem first; apply relational methods where complexity and interdependence dominate.

- Optimise the System, Not the Provider: Prioritise collective outcomes to break the financial stalemates that stall the left shift.

- Distinguish System Change from "QI at Scale": Recognise that system-level improvement is a "different species" of work requiring a shift in leadership disposition.

- Accept You Cannot Micro-Manage an Elephant: Redirect infrastructure away from granular oversight toward shaping the system conditions that allow collective action to emerge.

To conclude

This report moves beyond theoretical ideals of system leadership to provide a rigorous, co-produced analysis of the lived experience of leading within the messy reality of intense operational and financial pressure. The work was commissioned by senior leaders across the North of England and Scotland who initiated the Northern Triangle, a strategic learning collaboration supported by The Health Foundation and the Q community.

Report sections:

- **Why This Work Matters**
- **Of Clocks and Clouds**
- **Intractable Elephants**
- **The Northern Triangle – Three Approaches to System-Level Change**
- **Leading the Shift**
- **Four Key Lessons**

About this report:

The **'Northern Triangle'** is a strategic learning collaboration funded by The Health Foundation and the Q community and led by senior leaders across three distinct and evolving health and care systems across the North of England and Scotland.

Commissioned by the Northern Triangle improvement leaders, this report is grounded in the lived experience of 15 senior leaders from across Scotland and the North of England. Their insights are supplemented by a small number of informal interviews from the wider health and care system, including providers, commissioners, and national bodies.

Through in depth, reflective conversations, we explored the practicalities and complexities of leading improvement across traditional boundaries. These interviews offer a unique window into a landscape shaped by an enduring tension between what we describe as the predictability of 'clocks' and the complexity of 'clouds.'

We are grateful to all interviewees for the depth of reflection, experience, and openness they brought to this research.

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Nick Downham is an independent improvement specialist and Director of Cressbrook Ltd. He supports teams and systems internationally to improve operational efficiency, safety, and health inequalities. With a background in quality engineering and two decades of experience in health and social care, Nick is the co-author of Improving Quality in Healthcare (Sage, 2024).

Emily Rowe is an Assistant Professor at the University of Warwick. Her work explores how relationships and collaboration shape performance within system-level structures, including Integrated Care Boards (ICBs) and provider collaboratives. She is a member of the Health Spotlight Advisory Board at the University of Warwick and the Society for the Study of Organising for Health Care (SHOC).

Section 1

Why This Work Matters

Why This Work Matters
Of Clocks and Clouds
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Four Key Lessons

How do we lead and deliver meaningful change when the solutions to our most pressing challenges lie beyond the effective jurisdiction of any single leader or organisation?

Understanding why system-level improvement is so important requires looking at how we've approached change over the past thirty years. Traditionally, the focus has often been on mastering technical skills to 'do things better.'

While this technical foundation remains essential for the functional parts of our system, it is no longer enough to address the challenges of system-wide change. Our current policy context, often defined by concrete assertions, short-term timelines, efficiency drives, and repeated restructuring - is built on the belief that clearer accountability and stronger technical levers will deliver attractive solutions to the results we seek. However, there is a growing tension between these clock-like planning tools and the complex, interconnected nature of our current challenges, which frequently require us to 'do better things together.'

One senior leader summarises this fundamental shift:

> Gone are the days when we have the luxury of planning at a service level. Somebody's problem is always somebody else's solution and vice versa, and you can't fix your own problems in isolation of the system anymore."

Our report finds that while policy explicitly demands a Left Shift toward community-led resilience, our structural environment creates a gravitational pull back toward the Right, prioritising the improvement and protection of predominantly acute institutions (Clock Logic) rather than working collectively across the system (Cloud Logic) (**See Box 1:** The Language of this report).

Box 1: The Language of This Report

Throughout the report, we use a metaphor adapted from Karl Popper's 1965 essay 'Of Clocks and Clouds' to illustrate conflicting ideas about how to manage change. Rather than a simple dichotomy, these represent points on a continuum - different lenses for different challenges.

Clock Logic (Complicated and Predictable)
Clocks are orderly, regular, and highly predictable. When a clock breaks, we fix the specific gear to restore order. This logic is essential for the functional parts of our system, providing the transactional interaction to meet the institutional and political desire for grip and control. Success looks like the adherence to pre-determined metrics and standards within tight tolerances.

Cloud Logic (Complex and Unpredictable)
Clouds are constantly moving, irregular and unpredictable. This logic is essential for relational, 'wicked' problems like population health and integration, where simple mechanical fixes often fail to address underlying complexity. Success looks like adaptability, simplicity and person-centredness in service of system purpose.

The Left Shift
The national strategic direction of travel for the transformation of health and care in both England and Scotland. Used to summarise the desired shift in focus from hospital to community and from reactivity to prevention.

The System Tension
Intense political, media and managerial focus on acute performance targets often exerts a gravitational pull that stymies the 'Left Shift', drawing resources and attention away from the necessarily slower, relational work required for person-centred system-level change.

The Leadership Challenge
In health and care, the clocks and the clouds are inseparable. Effective system leadership is the art of navigating the spectrum between them - maintaining the 'Clock' where reliability is vital, while creating the 'Cloud' space where long-term change can grow.

What do we mean by system-level improvement?

In this report, the term system is used in two distinct but related ways. In the first sense, it describes a regional or geographical health and social care system, for example an ICB footprint or a whole country such as Scotland. In the second sense, system is used as it is in systems thinking and leadership. This refers to a set of interrelated parts that together form a coherent whole with a shared purpose (Senge et al., 2015).

Two important points follow from this definition. The first is the inherently complex nature of system level change, where problems and solutions rarely sit neatly within a single service or organisation. The second is that without a clear and shared purpose, there is no system, only a loose collection of parts.

Aligned to this Russell Ackoff famously states:

> If we have a system of improvement that's directed at improving the parts taken separately, you can absolutely be sure the improvement of the whole will not improve"
>
> **Ackoff, 1999**

A different species of work

System-level improvement does not simply mean applying the tools and techniques of improvement 'at scale.' It is a different species of work. This multi-organisation, multi-sector, and multi-agency work cannot be 'mandated' through a single line of command. It requires a fundamental shift in how we perceive the NHS. One senior leader we interviewed recalled a speech from a former head of the NHS who admitted to a common leadership fallacy:

> I believed the NHS was one big organisation that I'd sit at the top of... I'd issue some instructions or edicts, pulses and levers, and the lever would actually be connected to something, and everything would change. [I] quickly became disabused of that and realised that the NHS is an industry sector. It's not an organisation."

If the NHS is an 'industry sector' rather than a single machine, then the traditional tools of the Master Clock, the edicts, pulses, and levers, are no longer sufficient. When we attempt to fix problems in isolation, we ignore the reality that, in an industry sector, one person's problem is almost always someone else's solution. However, as our report discusses, in a health and care system under intense pressure to deliver, there is a natural pull toward clock-like certainty: neat plans, clear instructions, and guaranteed timelines. This is often a necessary response to the demands of performance management.

The strategic intent - left shift

While the specific policy rhetoric varies across the border, whether framed as the 'Three Shifts' in England (Hospital to Community, Analogue to Digital, Sickness to Prevention) or the 'Christie Principles' and 'Place-based' reform in Scotland, the strategic direction is similar. It is a purposeful left shift.

Often discussed as requiring structural or technical changes, moving 'to the left' - shifting from acute dominant reactive models of care, towards preventative, community-led resilience - is a deeply relational challenge.

The left shift brings leaders face-to-face with 'wicked' problems like frailty, multi-morbidity, and the socio-economic determinants of health. These issues do not sit neatly within the jurisdiction of any single organisation; they are 'Clouds' that require a move away from the mechanics of doing things better (institutional efficiency) toward a systemic approach of doing better things together (system-level stewardship).

The implementation gap

While the policy direction of the left shift and population health is refreshingly clear, its implementation remains a significant challenge. This ambition to shift models of care is frequently stalled by the persistent logic of the Clock at the expense of the foundational 'Cloud' conditions - such as trust and collective stewardship - required for system-level success.

One senior leader described this disconnect between policy and practice:

> "If there are conditions for success being set, none of them are currently being established."

This disconnect between policy and practice echoes what is often described as the implementation gap. It is supported by a consistent, rigorous body of evidence from both Scotland and England over the past decade. The Feeley Review, reflecting on Scotland's cornerstone Christie Commission (2011), summarised the nation as having 'good strategies but poor implementation' (Scottish Gov 2021).

In England, organisations such as The King's Fund (2024 & 2023), the Nuffield Trust (2025), and the NHS National Improvement Board (2024), alongside public health leaders such as Michael Marmot (2020), all make similar observations about the difficulties of maintaining focus and realising shifts in care. While we must be careful not to create a false dichotomy - strategy, political context, and delivery are always intertwined - this powerful consensus illustrates the distinct and enduring challenge of implementing improvement at system-level.

Box 2. Building on Foundations:

Why doing things better is not enough
Over three decades, the NHS has developed an extensive body of knowledge on improvement theory. This has been shaped by national initiatives such as the Modernisation Agency, NHS III, NHS IMPACT, GIRFT, and the Patient Safety Programme, as well as by Scotland's Christie Commission, Feeley Review, and the Renewal Framework, and by policy leadership from The Health Foundation, the Q Community, NHS Confederation, The King's Fund, Nuffield Trust, and others.

The implementation gap
There is a broad consensus across these bodies that the current strategic direction - the 'three shifts' from hospital to community, analogue to digital, and sickness to prevention - is a sensible path forward. However, as we move from a focus on improving pathways within individual organisations to the challenge of system-level change, we enter a space where our understanding of the 'how-to' is still evolving. As Russell Ackoff famously noted, the local optimisation of parts often results in a global loss for the system. Our focus on the logic of the 'Clock' has improved these individual parts, but the gap exists in the relational spaces between them.

A shift in leadership
Ultimately, the 'Implementation Gap' exists because the gravitational pull of our current systems of accountability rewards the certainties of the clock, even when we are operating in the turbulence of the cloud. Bridging this gap requires a fundamental shift in leadership disposition - moving away from a perceived 'certainty' and toward a practice of Stewardship. Success in this space is found not in the grip of a single organisation, but in the strength of the relational tissue between organisations.

Through our in-depth interviews with senior leaders, we explore the practical realities that take us beyond improving the machine to focus on how we lead for improvement across a system.

Learning from the Northern Triangle

The 'Northern Triangle' is a strategic learning collaboration funded by the Health Foundation and Q community, led by senior leaders across the North of England and Scotland. Its aim is to facilitate cross-border learning by sharing the practicalities of leading system-level improvement.

To that end, this report draws on 15[1] in-depth reflective conversations with system leaders in Scotland and the North of England, exploring the lived experience of leading improvement at the system-level. These interviews provide a unique window into a landscape defined by an enduring strategic tension that we articulate as 'the art of navigating the clocks and the clouds.'

We are thankful to all interviewees for their deep consideration, vast experience, and honesty and openness, which are central to this report and central to our goal of producing something that is practically useful to system leaders in the UK and potentially, around the world.

The structure of this report

This is not a theoretical paper on what system leadership should look like. It is an analysis of what it actually looks like to lead in the messy reality of intense operational and financial pressures.

- **Section 2: Of Clocks and Clouds.**
  We explain this metaphor in a more detail and illustrate its application in the context of system-level improvement.

- **Section 3: The Intractable Elephants.**
  We identify the systemic barriers that frequently stall progress.

- **Section 4: Three Approaches to Change.**
  We examine the distinct methodologies being piloted across the Northern Triangle.

- **Section 5: Leading the Shift.**
  We explore the specific traits required to lead in the cloud-like reality while meeting the 'clock-like' demands of the system.

- **Section 6: Four Lessons.**
  We summarise the findings of this research into key 'take-homes' for leaders at all levels.

[1] Plus a small number informal interviews from the wider national system.

Section 2

Of Clocks and Clouds

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Of Clocks and Clouds

Throughout this report, we use the metaphor of Clocks and Clouds. This is not merely a philosophical exercise; it is a practical lens for understanding why leading change at a system-level fundamentally differs from managing an individual organisation.

The metaphor

Many approaches to management reflect a belief that everything is knowable, predictable, and manageable. In 1965, philosopher Karl Popper challenged this by proposing that physical systems exist on a spectrum:

Clocks are orderly, regular, and highly predictable. When a clock breaks, we fix the specific gear to restore order.

Clouds are unstructured, constantly moving, and unpredictable. They represent the messy (irregular), human-centred reality of healthcare where simple 'mechanical' fixes - like time-based performance standards - often fail to address underlying complexity.

Popper's central thesis, that even our most orderly 'clocks' are fundamentally composed of unpredictable 'clouds', is a vital takeaway for a system leader. It reminds us that while a mechanical clock is a closed system that cannot 'learn' to be a better clock, human systems are 'open'. People learn, react, and change their behaviour based on new information.

> A clock cannot learn,
> but a human system must.

Two species of work: The jurisdiction gap

To lead effectively, senior leaders we spoke to acknowledged that system-level change is a different 'species' of work. While we have mastered the mechanics of improving the 'Body Corporate' (individual trusts or units), the rules of the game change at the system level. As Table 1 illustrates, this isn't just a change in scale; it is a change in nature, moving from mandated service delivery to negotiated co-production.

Table 1: Primary Characteristics of Single Organisation vs. System-Level Improvement

Feature	Single Organisation	System-Level Improvement
Primary Goal	Efficiency: 'Doing things better'.	Outcomes: 'Doing better things'.
Nominal Value	Determined by the organisation or specifier (especially in secondary care).	Co-determined with other system partners, people, and communities.
Orientation	Improve what we do.	Change what we do.
Jurisdiction	Centralised within the organisation.	Distributed across multiple partners.
Knowledge	Centralised and specified.	Distributed and unspecified.
Leadership	Planning and Deployment.	Collaboration and Co-Production.

These two species of work do not just coexist; they frequently collide. In our data, we identified four 'Intractable Elephants', systemic tensions that arise when we try to apply clock-like mandates to cloud-like realities.

Section 3

Intractable Elephants

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Intractable Elephants

The Four ‘Elephants’: Why System Problems are so Intractable

These four ‘Intractable Elephants’ represent the specific moments where the mechanical expectations of the clock (the mandate) collide with the complex, human reality of the cloud (the system). They highlight the gap between having a mandate to change and having the actual jurisdiction to deliver it.

1. **The gravitational pull of the right shift:** This is the conflict between immediate, high-visibility acute targets (the ‘Master Clock’) and the long-term mandate for community-based prevention.

2. **Uncomfortable truths:** Addressing the root causes of ill health requires leaders to confront the ‘uncomfortable truths’ of poverty and social deprivation that no clinical pathway can solve alone. Navigating this shift requires moving away from the ‘fixing’ trap of institutional control and toward co-production with communities served.

3. **The stewardship paradox:** The challenge for leaders who seek to coordinate a complex system but have ‘muddled jurisdiction’ and no direct authority over independent partners.

4. **Inequality of capacity for improvement:** The massive gap in capacity and capability for improvement, for example, between the ‘heavyweight’ infrastructure of acute hospital trusts and the under-resourced Primary and Social Care sectors.

Elephant 1: The Gravitational Pull of right shift

The national direction of travel for both the NHS in England and NHS Scotland points clearly to an intentional left shift. Yet in practice, central performance priorities such as ambulance handovers, A&E waits, elective waiting times, and GP same-day access[2] continue to pull leadership attention and resources away from left shift work.

Our interviews identified persistent, interlocking forces working against the national mandate for left shift, moving the focus of care provision from hospital-based treatment to community-based prevention. Participants emphasised resisting the right shift, recognising the opportunity cost of hitting short-term targets at the expense of investing in community prevention models that could solve the problem long-term.

> So right now... there's a debate... that you could execute a 'Right Shift' to fully deliver everything that's been asked for in relation to waiting times, and we've got to fight that off... because the opportunity cost of doing that in terms of the other ['Left Shift'] goals that we've got in our strategy is massive."

These structural barriers create an environment where, as one participant noted, ideas often land in a system that is "not set up for success". We have categorised these into three primary areas of friction:

- Performance management of 'parts' versus system-level improvement: The conflict between meeting immediate, high-visibility acute targets and the long-term investment required for population health.
- Financial 'stalemates' and 'double running' costs: Where competing priorities and tightly controlled budgets among different actors prevent the flexible movement of resources.
- Incentive misalignment: The persistence of activity-based tariffs and other legacy levers that inadvertently support the status quo rather than community-based prevention.

Performance management versus system-level improvement:

> Performance indicators and metrics all sit within an acute [focus]... we've got two-hour, four-hour, [and] 12-hour standards. We've got length of stay, Referral to Treatment (RTT) times, and two-week wait pathways. They're all acute focused."

This persistent focus on high-visibility reactive metrics is keenly felt by regional leaders and is further intensified by the public's heightened awareness of hospital performance. This creates a cycle where the system reverts to its clock-like default: a mode of reactive grip that prioritises immediate mechanical alignment over the messy, relational work of proactive integration.

2 GP access may seem like left shift, but the monitoring and pressure on speed of access to appointments means that many GPs report they are forced to focus less on their proactive and planned care systems.

As one participant observes, the warm words of policy often lack the structural gears needed to override these deeply ingrained public expectations, amplified by the media, and that matter to politicians.

> If you look at the planning guidance, for all of the warm words around left shift, delivering those community-based and home-based, proactive personalised models of care, there are no concrete delivery mechanisms in place. There's no real attention paid to them. So, if what we measure, what we hold people accountable for delivering, and how we allocate our resources is based on [waiting times] ... then the system is reinforcing what we've always done. Now, why is it doing that? Well, I think there's a huge challenge because we as healthcare professionals might be sold on the model, but that's not necessarily true for the public."

This indicates that even those ostensibly at the 'helm' of the health and care system feel 'locked in' by legacy governance structures that reward stability in the acute sector over community-based innovation and improvement. As a result, the ICB has the challenge of resisting a performative role in favour of a transformative one.

Our interviews with senior leaders highlighted a constant conflict between long-term strategic aims and the need for short-term oversight. This gap can cause ICB leaders to feel pressured to monitor performance for providers - essentially managing 'widgets' instead of driving system change.

Similarly, our interviews in Scotland highlighted a compounding element to this, indicating that the majority of available analytical capacity is focused on the performance management of acute trusts, rather than being available for system-level change work.

> If they're going to set 10-year paths and talk about three-year planning, then please don't come and shout at us weekly and monthly on widget movements and 14 patients in A&E... If you want us to be strategic, longer-term and population health improvement-focused, somebody else is going to have to do the weekly, monthly and quarterly management of the system. The two are mutually exclusive."

The quote above captures a performance paradox: can healthcare leaders be visionary architects of long-term health (the 10-year path) while also being the on-call mechanic for weekly A&E figures? If leaders are being forced to do both, they are likely doing neither effectively.

The recent shift of provider performance oversight to NHSE regional teams potentially offers an opportunity to move beyond localised performance management, allowing the system to focus on the cultural and financial changes needed to support the left shift from acute reliance to community care. Whether regional teams can truly resist the habit of top-down performance management remains an open question. The pull of the master clock is further driven by the need for professional survival. As one participant bluntly noted, a leader will not lose their job for failing to collaborate, but they will for missing a financial or quality target.

Financial ‘stalemates’ and double-running

Participants identified financial stalemates between parts of the system as a core barrier to system-level improvement. This creates a jurisdiction mismatch. One partner is mandated to improve community based prevention, aligned to a cloud-like logic, while another partner holds the budget and remains driven by activity based incentives, reflecting a clock-like logic.

> You have this financial stalemate where nobody has the capacity to do the work. Even if they did, they would not be the benefactors, so there is no incentive to act.”

This dynamic is reinforced by legacy payment assumptions that reward hospital activity. Even within block contracts, a focus on throughput means that keeping people safe at home remains a cloud-like aspiration that carries a clock-like financial or operational penalty for the acute trust.

> ..at the moment, the way we [hospitals] have currently got it all set up is where you get paid for units of activity coming through the door, that doesn’t encourage that [keeping people safe at home mindset] at all.”

While the cloud-like goal of person-centred care is generally shared across a system, the clock-like reality of annual, siloed budgets prevents the necessary flow of resources. Our participants called this the ‘double-running’ challenge - the age-old dilemma of transitioning between old and new models of care, or even meaningfully prototyping new models of care. While integrated models - such as the one seen in Walsall, called ‘Walsall Together’ - provide a viable alternative to this stalemate, many leaders find the transition itself remains underfunded.

> The challenge that I think we all face at the moment is that double running challenge in the sense that [local authorities] would have to create new services. To deal with these new models of care while still maintaining their existing provision. The challenge for the NHS is that until some of these services come on stream, [hospitals are] still going to need to provide the inpatient care.”

The reality of funding constraints leads organisations to resort to merely “tinkering around the edges” and an all-too-common retreat into operational silos. In this survival mode, partners are predominantly focused on protecting their own clock-like budgets at the expense of engaging in cloud-like collaboration.

The double-running challenge is felt not only in NHS providers such as acute trusts and general practice, but also in social care, which has borne the brunt of over a decade of austerity. When resources are this depleted, there is no ‘slack’ to fund the transition. The result is a system where everyone is ‘sold’ on the strategy, yet no one is financially empowered to make the first move. This transforms system-level change into a personal risk for leaders, rather than a collective financial opportunity.

Elephant 2: Uncomfortable truths

This intractable elephant is the disconnect between the clock-like mandate to treat illness and the cloud-like reality of what causes it. Under the banner of the national 10-Year Plan's three shifts, however, moving upstream brings leaders face-to-face with uncomfortable truths, most notably the profound impact of social determinants on health outcomes.

The poverty paradox

Our participants expressed a clear awareness that the 'Master Clock' of acute crisis - ambulance queues and A&E waiting times - is fuelled by the cloud of social deprivation. As one leader observed, the clinical crisis is often a socio-economic one in disguise:

> Poverty is what's driving people into the A&E in droves... If you look at the stats again and again it's people from our most impoverished communities."

Acknowledging and working with the complex root causes and symptoms of poverty requires health leaders to move beyond traditional clinical boundaries. It requires a transformative shift in identity: moving from a 'mechanic' who focuses on fixing individual patients to a 'steward' who influences the broader life context of populations. However, many view the starting position between communities and leaders as distant:

> We are so removed [from populations]. That's the danger of leadership... we have become so removed from the people that we serve that we're no longer their friends, we're no longer part of them, and they're not part of us. I think that is the single biggest shift we need to see in leadership."

The use of a national patient activation measure (PAM) illustrates the problem of misalignment between clock-like measures and complex, cloud-like problems. The Patient Activation Measure is designed to assess people's level of engagement with their own health and well-being. It grades individuals on a scale from 0 to 5, with 5 being the highest level of activation. But as one senior leader points out, in areas of severe deprivation,

> people are often at minus 5... they might be in the grips of addiction or really severe mental health, or behaviours that are quite self-destructive often through no fault of their own..."

This interview with a senior regional leader, also a practising GP, illustrates how a clock-like measure operates on the misguided assumption that many in traumatised or impoverished communities have the self-actualisation to seek the help they need, before they encounter a crisis that leads them into the hands of emergency services. They go on to describe the difficult relational work of moving people from a "state of total disengagement to zero, where they will even think about having a blood test."

This insight led this GP's team to develop a 'patient reach model' to engage individuals through deep relationship-building for about two years before standard clinical interventions can even begin. This approach requires leaders to listen to what might be described as uncomfortable truths about the lived realities of people in these communities, acknowledging that this discomfort is the precursor to authentic stewardship - a willingness to move beyond tokenistic and time-bound engagement mechanisms to confront the profound ways in which current services may be failing people:

"We listen to communities. We make ourselves deeply uncomfortable with the truth of what we hear. We have a humility to listen in a way that we are the ones that have to change."

Box 3 presents a case study from Northumbria that starkly illustrates these uncomfortable truths, demonstrating the staggering financial and human cost of maintaining a clock-like compliance culture in the face of complex social deprivation, and describing an alternative way of working together for change.

Box 3: A Cloud-Like Approach in a Clock-Like World

Changing Futures Northumbria was an experimental 'proof of concept' tackling multiple disadvantage. Historically, siloed services created a "lose-lose situation," where fragmented support left individuals in crisis while exhausting service capacity.

Refusing 'clock-like' eligibility
While the national framework mandated a '3 or more' condition checklist, the team rejected this rigid screening as unethical: "We weren't willing to say, 'I'm sorry, you're not bad enough for our programme. Come back when you're worse.'" Despite fears that this defiance would disqualify their funding bid, their commitment to relational ethics was precisely what won over the judges.

The evidence: quantifying failure demand
To engage senior leaders, the programme mapped the 'system fingerprint' of three individuals over 15 years. This provided a shocking benchmark of failure demand:

- **£4 million: The cumulative cost for three people who remained in worsening crisis.**
- **400 A&E visits: One individual's presentations in just six months, seeking the safety the system failed to provide elsewhere.**
- **15 years: One case, costing the equivalent of 15 years of a police constable's salary across multiple agencies.**

The data proved the system was "spending a lot of money to keep people in crisis."

A liberated way of working
The intervention replaced traditional assessments with a 'cloud-like,' relational approach focused on what matters to the individual. To build trust with a cohort that often avoids formal services, the team utilised a "detached" approach, spending time in the specific public spaces and gathering spots where people naturally congregated.

Crucially, the team was intentionally composed of people with lived experience of multiple disadvantage working alongside those from professional backgrounds. To ensure true integration and respect for this expertise, the program refused to use junior 'peer' roles; instead, everyone was employed as caseworkers on an absolute parity basis, receiving the exact same salary and grade. This created the maturity and credibility needed to bridge the gap between 'hard-to-reach' citizens and formal services.

The struggle for legacy
Despite a 76% reduction in unplanned hospital admissions for the cohort, the move toward 'normalisation' hit a 'financial stalemate.' In a siloed system, the organisation investing in the work was not the beneficiary of the savings, meaning there was "not even an incentive for people to do it." Ultimately, the 'gravitational pull' of acute-led targets overrode long-term prevention; leaders felt unable to pivot because they were "completely engaged with the people coming through the door." The programme remains a provocation: until commissioning moves away from 'too many clocks' pointing in the wrong direction, transformative change will remain an act of leadership bravery rather than just 'the way we do things here.'

Elephant 3: The stewardship paradox (Jurisdiction vs. accountability)

At its core, system-level improvement requires a fundamental shift in how power is exercised and how decisions are made. Participants consistently identified the value of a convenor, a role that fosters social capital through boundary-spanning actors operating inter-organisationally. However, the ability to perform this role is currently undermined by a stewardship paradox: regional bodies are held accountable to the master clock (performance and budgets) but cannot hold jurisdiction over the cloud-like nature of the system.

The 'convenor' as a neutral space

With improvement infrastructure concentrated in hospitals, system-level programs are often dismissed as 'acute-led.' To move from an acute-centric 'right' to a community-based 'left,' the system requires a neutral convening space. As one hospital Chief Executive noted, a regional convenor (such as an ICB) can provide a 'hierarchy of equals' that dilutes traditional institutional power:

> "...if it's ICB convened, then everybody is in there on an equal sort of hierarchy. [It] will be seen as a more distributed power across primary care, community care, mental health, and the voluntary sector... rather than it being convened by the acute trust."

Outside of the ICB, effective convening across organisational boundaries requires 'boundary spanners' - individuals who act in an impartial role to facilitate conversations. Crucially, this is not just about hierarchy but jurisdiction; actors often need to consciously 'dilute' their institutional status to earn the trust of community partners:

> "I've described myself as an improvement liaison person... because actually when you've got a director coming in from an acute hospital, they're coming in from a certain angle and I try to dilute that down."

A contested identity: England's fluid landscape

In NHS England, the capacity to act as convenor is currently under threat. Integrated Care Boards (ICBs) have experienced a volatile five-year lifespan, marked by "dramatic and brutal headcount reductions" and a central policy shift toward becoming 'strategic commissioners.' This move threatens to hollow out the relational capability of ICBs, leaving only the blunt 'clock' of hard commissioning levers. As one leader observed, the survival of the organisation has become a distraction from the improvement of the system:

> "ICBs have necessarily become a bit distracted with everything else that's going on. Reducing headcount by 50% are fairly big things to be dealing with."

It goes without saying that these changes are at best distracting and personally challenging; they may also leave a structural gap in the capability to engage regional systems on collective priorities beyond the use of hard commissioning levers.

The Scottish context: plurality and stewardship

This tension is not unique to England. In Scotland, health leaders advocated for a plurality of expertise, arguing that while technical Quality Improvement (QI) is a critical tool, it must be balanced with strategic design and relationship-building to be effective at a system-level. This acknowledges that leading across a system is fundamentally different from leading an organisation; it is about Stewardship, rather than relying on tangible, controllable hierarchy.

The consequence: A retreat into 'grip'

Across both contexts, the result is a system-wide identity crisis. If system-level bodies lose their mandate and the capacity to be relational 'convenors,' they risk defaulting to being 'mini regulators.' In England, this is being accelerated as performance oversight shifts back toward NHSE regional offices under the NHS Oversight Framework. Lacking the social capital and jurisdictional authority to truly influence the 'cloud,' these sub-regional systems may revert to the clock-like monitoring activity and performance metrics. As one senior leader reflected, without this relational foundation, the system cannot move forward:

> Build your relationships. Without that solid level of relationships, you're not going to be able to build on that and go forward."

Elephant 4: Inequality of Capacity for Improvement

The 'heavyweight' infrastructure and QI expertise of Acute Trusts versus the lack of protected 'headspace for improvement' in Primary and Social Care.

The data across our interviews highlights the issue of 'Capacity Inequality' within the health and care system, characterised by an imbalance in Quality Improvement (QI) capability, management infrastructure, and protected time between large acute trusts and their primary, social, and community care partners. This imbalance doesn't just create an inequality of resources, it also fosters a perception that system-level improvement is 'acute-led,' and that improvement-related knowledge is for those with specialist titles and roles. As one senior leader laments:

> So, we've made the job of doing person-centred change an elite sport, and actually the people who you need to do person-centred change are either people needing and using services, or community-based leaders."

The quote above makes a profound point: if we truly want to lead change for improvement across a system, we must ensure the resources are available to build capability throughout the system.

Yet several participants noted that the majority of improvement capability and expertise resides within acute hospitals, presenting a significant barrier for system-level change that needs to be acknowledged and addressed:

> We could have, you know, 20% of an acute hospital's staff base trained, but 0% in primary care. Yet we want them to carry out improvement work to move from acute to community, but we're not putting that investment in... I think that that's a barrier that we need to overcome."

This combined issue of unequal capacity for improvement and supporting infrastructure was particularly prevalent in the Engineering Better Care piloted in the Lancashire and South Cumbria (LSC) region. In this example (which we discuss in depth in section 3) there was recognition from hospital leaders that the fixable spaces for frailty lie outside the hospital. Yet the mechanism for conducting this work was a small funded project which provided a senior programme manager and an administrative assistant to support the programme delivery.

The acute and Mental Health and Community trusts were able to free up improvement leader resource to be able to design and deliver the programme (though this was not equal across the providers). At the outset, it had been envisaged that the general practice input would be funded through the 'protected' GP leadership time at a locality level, but early into the programme the ICB reduced the level of GP capacity available (temporarily as part of a restructure), and subsequently GP input was difficult to maintain.

This highlights a critical compounding effect: it is not just that infrastructure is unequal, but that applications for funding or new funding models for system-level improvement need to ensure under-resourced sectors (including the provision for backfill) are able to access the heavyweight support available.

> So, the ask came from the chief executive of acute hospitals to fix frailty as a system, and we [hospital-based improvement specialists] had to go and mobilise the system. Obviously, the system is everybody, all providers. You then have to ask basically GPs to give up their time to come and attend a number of workshop sessions and potentially do a lot more work so that was really difficult"

Ultimately, the Engineering Better Care experience demonstrated that while significant structural barriers to engagement exist, they are not insurmountable. By recognising the imbalance in capacity and infrastructure, the programme worked diligently to secure GP involvement, ultimately resulting in a measurable decrease in hospital admissions.

A key legacy of this collaboration was a landmark change to the local GP contract, which mandated a standardised approach to frailty screening. This move effectively represents the building of a mechanical gear in a way that supports the 'cloud'. In other words, it institutionalises the left shift by utilising the precision of right shift techniques, transforming an acute-led directive into a community-led clinical solution.

Section 4

The Northern Triangle – Three Approaches to System-Level Change

Why This Work Matters
Of Clocks and Clouds
Intractable Elephants
The Northern Triangle
Leading the Shift
Four Key Lessons

The Northern Triangle: Three Approaches to System Learning

The Northern Triangle was a strategic learning collaboration funded by The Health Foundation and Q Community and led by senior leaders across three distinct and evolving health and care systems in the North of England and Scotland.

In this section we describe and discuss three distinct approaches to supporting system-level change that we reviewed. The three approaches each aligned to different 'levels' of intervention and reflected different 'change beliefs' as outlined below.

- **The pathway level (LSC):**
  Lancashire and South Cumbria piloted the Engineering Better Care (EBC) approach as a structured systems-engineering discipline to improve frailty at the system-level. The core change belief here is that understanding the problem from multiple perspectives across the system precedes action; by using a rigorous 'Understand' phase to map technical dependencies, the goal was to ensure improvement was built on total system clarity and that action followed a structured change approach.

- **The regional level (NENC):**
  North East and North Cumbria ICB developed Boost to facilitate a relational, 'human learning systems' approach. Developed in response to the paradox of high-performing organisations alongside worsening regional health inequalities, the core change belief was that learning is the 'social glue' of the system. By convening communities of practice, they aimed to build the collective capability and trust required to address what matters most to the communities they serve.

- **The national level (Scotland):**
  Healthcare Improvement Scotland designed the Scottish Approach to Change, which is best described as a holistic framework that brings together siloed change methods into a single, practical approach using simple language and a clear focus on inclusivity. It is built on a Quality Management System (QMS) and emphasises enablers of change that integrate a human learning systems approach (similar to Boost) with a structured approach to change. It provides a consistent approach across an entire country.

Each of these three approaches was developed and implemented independently within its respective region, resulting in a coincidental yet clear diversity of change philosophies. The fact that they represent two contrasting philosophies, and one that appears to resolve the tensions of both, is a matter of conceptual happenstance. This convergence is valuable because it was not intentional. It suggests that across different healthcare systems, we saw a simultaneous 'working out' of the same core problem: how to balance the mechanical necessity of the clock with the relational reality of the cloud.

However, we emphasise that our research and report made no attempt to judge the performance of one against the other; instead, we used their independent findings to explore the realities of leading system-level improvement, and to draw practical lessons from the reflections of the leaders involved.

Summary comparison of system-level approaches to improvement

While EBC, Boost, and the Scottish Approach to Change operate as distinct entities with their own mandates and methodological foundations, comparing them side by side highlights the different dimensions of system-level change they address. From programme-led reconfiguration of acute care pathways and the relational convening of a regional community to the national methodology of systemic learning, each approach brings a unique set of capabilities to its specific context. The following table provides an 'at-a-glance' summary of these individual profiles, outlining the intended goals and core philosophies of each.

Table 2: Summary comparison of system-level approaches to improvement: EBC, Boost, and Scottish Approach to Change.

	Engineering Better Care (EBC)	Boost	Scottish Approach to Change
Methodological Focus (The What)	**Systems Engineering:** A goal-oriented five-phase framework (Initiate, Understand, Co-design, Deliver, Sustain)	**System Convening:** A human learning system approach built on four domains (Learn, Connect, Improve, Lead).	**Service Design:** A holistic approach that integrates enablers of change with a layered learning resource and a prescriptive framework for change.
Systemic Capability (The How)	**Redesigning the System:** To address 'wicked' problems by creating clear, structured service pathways that work effectively across boundaries.	**Relational Infrastructure:** Building the 'social glue' and relational trust required to address what matters most to communities.	**Compulsive Curiosity:** Shifting from passive data reporting to investigating root causes with compulsive curiosity.
Strategic Intent (The Why)	**Targeted Resolution:** To ensure the system is 'doing the right thing' through deep inquiry and multi-perspective redesign.	**Collaborative Mobilisation:** To foster a 'system that is best at getting better' through inclusive, multi-agency learning.	**Universal Literacy:** To create a sophisticated learning system that is accessible to everyone.

What follows is a high-level description of each approach, followed by a 'deep-dive' exploration into what can be learned from these approaches to system-level improvement.

Box 4: Engineering Better Care (EBC) –

A framework approach for leading change at the system-level Lancashire and South Cumbria (LSC)

Launched in 2017 through a collaboration between the Royal Academy of Engineering, the Royal College of Physicians, and the Academy of Medical Sciences, and used in Lancashire and South Cumbria from 2022, Engineering Better Care (EBC) represents a shift towards a 'systems-of-systems' approach in healthcare. Developed by Professor John Clarkson and his team at the University of Cambridge, the framework provides a structured methodology for managing complex change. Its application in Lancashire and South Cumbria acts as a significant regional pilot, testing whether systems engineering principles can be effectively applied to the real-world challenges of a complex clinical environment.

This systems-oriented ambition was initially framed by a direct mandate from the Provider Collaborative Board, reflecting the clock-like governance of the acute sector - driven by operational targets and the need for scalable, predictable solutions. Tasked by system leadership with 'fixing frailty' [sic] across the region, the project was created to address the significant pressures frailty placed on hospital 'front doors' and to develop a methodology capable of 'industrialising improvement' at scale. Because it was commissioned by the Provider Collaborative, the programme was initially perceived as 'acute-led,' which created early challenges in engaging wider partners such as GPs and social care.

The EBC methodology is structured around four primary phases: Understand, Co-design, Deliver, and Sustain. During the Lancashire and South Cumbria pilot, however, leaders identified that the initial effort required to get 'ready' for system-level change was so complex that a fifth phase - Initiate - was added to the beginning of the framework. This preparatory phase focuses on identifying the right cross-sector stakeholders and defining clear lines of involvement before technical work begins, driven by the realisation that preparing for system-level improvement is exceptionally difficult and time-consuming compared to a single organisation, requiring a dedicated space to align the 'multiple perspectives' necessary for a true systems approach.

Box 5: The Boost Approach:

A Relational learning system
North East and North East Cumbria (NENC)

Described as a relational learning system, Boost is a key component of the NENC ICB's architecture for building social capital and shared learning across sectoral boundaries. Launched in September 2022, Boost was developed in response to a profound regional paradox: the co-existence of some of the country's highest-performing NHS Trusts alongside its worst health inequalities. Recognising that institutional excellence alone was not improving population health, the ICB adopted a Human Learning Systems (HLS) approach to move away from top-down 'command and control' toward building a socially connected learning community.

Inspired by the relational health models of the Nuka System of Care and the cultural philosophy of Cincinnati Children's Hospital, Boost's mission is to foster a "system that is best at getting better." This is operationalised through a 'network-of-networks' structured around four overlapping pillars: Learn, Connect, Improve, and Lead. Rather than traditional improvement training, Boost focuses on developing "practical fluency" and relational stewardship, shifting the focus of success "from 'green-box' KPIs" to the quality of learning and information flow. By centring on what matters most to communities, Boost empowers partners from the voluntary, community, and social enterprise sector (VCSE), social care, and citizens to drive improvement led directly by those on the ground.

To make this diverse network effective, the ICB serves as a regional convenor, creating an environment where these independent partners can meet and collaborate. Crucially, Boost's digital infrastructure, specifically its public-facing Learning Academy and '.org' domain, serves as the primary enabler for this convening role. By providing a neutral, accessible common ground outside of traditional internal NHS firewalls, it creates a 'front door' for a membership of over 20,000. This membership space enables the ICB to scale peer-to-peer learning and foster the 'social glue' required to connect diverse partners across the region who might otherwise remain siloed.

Box 6: The Scottish Approach to Change -

A Systemic Hybrid - Bridging the Structural and Relational Ends of the Change Spectrum Scotland

The Scottish Approach to Change acts as a national methodology and a 'common language' designed to unify system-level improvement. At its essence, Scottish Approach to Change functions as a hybrid that bridges the structural and relational ends of the change spectrum.

Like EBC, it values 'process rigour' and architectural discipline, with a structured framework for system-level change supported by a comprehensive online resource where users can access technical tools with increased attention to detail as needed for complex redesigns, and to ensure the system is 'doing the right thing.'

Simultaneously, it mirrors the Boost philosophy by grounding itself in a 'People Led' approach, moving care toward the neighbourhood level and fostering a culture of distributed leadership.

The framework is built upon five core enablers: being People Led, having Clear Vision and Purpose, maintaining Process Rigour, fostering Leadership and Culture, and most critically, placing 'Learning' at its heart. Positioned as a strategic superpower, this commitment to learning transcends traditional reporting. By applying a lens of compulsive curiosity, the Scottish Approach to Change moves beyond the 'what' of the metrics to relentlessly pursue the 'why' - transforming raw data into a deep, actionable understanding of the human stories and systems behind the numbers - for example, if a spike in A&E wait times is driven by poverty rather than simply applying an efficiency programme to hit a four-hour target.

By creating a dynamic learning loop, the system moves from 'Planning for Quality' to 'Improving Quality,' ensuring that as teams learn during implementation, they feed that knowledge back into a more nuanced quality plan. Ultimately, this allows the system to move from merely 'efficient' (e.g., doing more with less) to truly 'effective' (understanding complexity and human impact). By utilising plain language instead of specialist jargon, Scottish Approach to Change professes to end the 'elite sport' [sic] of improvement expertise, making improvement a shared capability that is continuously refined through real-world practice.

In detail: Engineering Better Care (EBC): Systems Engineering approach to improve the frailty pathway (Lancashire and South Cumbria, England)

The starting point for adopting Engineering Better Care (EBC) was a direct mandate from the Provider Collaborative Board. The CEOs of the acute trusts made a clear request to adopt a system-wide approach to 'fix frailty,' [sic] driven by intense operational pressure at hospital 'front doors,' where frailty was recognised as a primary contributor to lengthy waiting times in Emergency Departments and high readmission rates.

In response to the hospital leaders' ask to adopt a system-level approach to improving frailty, a hospital team secured funding to design, plan, and coordinate its implementation. Acknowledging the diverse range of improvement methods used by different provider organisations, as well as the limited experience of leading change across multiple providers within a system, prompted a search for a methodology that could be applied collectively.

> So, we all did improvement slightly differently in terms of our default methodology … so that all stems from the same core philosophy, but we didn't have a joined-up language of how we do it. So, the first task was to work out what would be a system-level improvement approach or methodology we could use collectively that we'd all understand, and we could go away and apply that to the 'ask', which was to improve frailty, so that's when engineering better care came about."

The acute hospital taking a leading role in system-level change proved to be something of a double-edged sword. For example, it acted as a crucial catalyst for the improvement endeavour by providing the necessary governance and resources (including process improvement expertise) to address frailty as a complex, cross-boundary problem. This acute-led coordination was underpinned by a shared clinical logic that intervening earlier is better for providers and patients. To illustrate, a hospital chief executive used the metaphor of a 'care escalator' to describe the negative trajectory in which patients end up in the most expensive parts of the care system.

> …if we can intervene earlier from both the health and social care perspective and stop people going up that sort of care escalator, if you like, then, actually, that will reduce costs for everybody in the longer term."

This imagery of a care escalator is powerful. It suggests a mechanical, almost inevitable momentum; once a patient is on the escalator, the system tends to carry them upwards towards acute intervention. The 'escalator' implies a one-way movement in which the patient's condition and the system's costs escalate simultaneously, creating *"the world's worst outcome in the sense that we have patients in the most expensive part of the care system deteriorating. So, it's not only that it's really expensive; it's actually making people actively worse".*

However, the practicalities of expanding improvement efforts beyond the hospital walls requires a different set of skills and expertise, which many highly experienced hospital leaders may not initially be aware of. Even if they are aware, they often lack experience. This transition from facilitating quality improvement within hospitals to orchestrating improvement across a system is described as *"essentially learning a more in-depth way of working."*

One hospital leader reflected on a humbling shift from ‘process improver’ to ‘systems thinker’:

> I feel like I’ve gone from somebody who was unconsciously competent because I’ve done so much improvement work, to being unconsciously incompetent. Because right now, I don’t know what I don’t know about systems engineering and how you design for a whole system… how to shift from process improver to become a systems engineer or a systems thinker, because it’s really different.”

Structural friction and the limits of engagement

The perception of the frailty improvement programme being ‘acute-led’ was reinforced by a significant imbalance in available resources and structural support across the system. This was most evident in the challenge of securing consistent representative involvement from primary care. Despite the acute team’s relational intent, GP participation was severely restricted when the ICB planned a Place-based boundaries restructure and unexpectedly (temporarily) withdrew the allocated funds *“at the eleventh hour.”* This meant the programme went from having a GP representative from each Place in the first learning session, to only GPs who either had continued funding in place for their roles (e.g. a digital lead GP), or were funded by one of the acute trusts.

The original funding application had not sourced financial ‘backfill’ given that locality GP leadership was ostensibly in place. This meant that while acute staff could be released as part of their core roles, GPs faced a direct conflict between participating in system-level change and maintaining their own operational priorities.

Notwithstanding this funding challenge, hospital leaders worked hard to secure GP engagement, believing sufficient representation had been achieved. However, this belief was starkly challenged by the reality of the room on day one. One hospital leader reflected on a humbling mathematical reality check:

> So I thought we’d done really well, if I’m being honest with you, because we had GPs from every patch in the teams. And then I had lunch on day one with [General Practitioner], who said, “There’s a lack of GPs here.” So, I said, “Well, we’ve got a representative, you know, a GP from every area.” And he said, “Yeah, and look around at how many acute hospital people you’ve got and look at the proportion of care that we deliver in primary care compared to the proportion of care that you deliver. You’ve got the balance completely the wrong way around.” And he was right. So that was a key learning point for me about making sure you’ve got the right people in the room to design the event.”

With improvement expertise, financial investment, and political power historically concentrated within the acute sector, the ‘system’ is not a level playing field. Learning from this first iteration of EBC led to the addition of a new ‘Planning for Success’ phase, formally called ‘Initiate’, which precedes the understand phase.

The introduction of this new phase represents the application of important learning, reflecting the reality that system-level improvement is only possible once the ‘relational infrastructure’ has been intentionally built.

Without this groundwork, even the most sophisticated systems-of-systems approach remains vulnerable to the gravity of siloed working.

> Everybody thinks, oh, this is an acute-led piece of work. You know, 'they're dictating what we're doing.' But actually, what we're trying to do is build the capability and bring a methodology to it. But it's seen as a very acute-driven piece of work. So, then you are trying to build that relationship with other wider partners."

Implementing the Engineering Better Care Method

The EBC methodology was initially structured around four primary phases: **Understand, Co-Design, Deliver, Sustain.**

Phase 1: Understand

The Understand phase served as the foundational stage of the Engineering Better Care (EBC) approach during the pilot. Its primary objective was to "deeply investigate the problem landscape" (Senior hospital leader) to ensure that teams do not 'fix the wrong thing'.

In the context of the frailty programme, interviews with senior leaders revealed key elements of the 'understand' phase, including:

- **Understanding the 'system architecture':** examining the "intricacies of how different parts of the system interconnect, the nature of handovers, and the systemic risks associated with those transitions."

- **Understanding stakeholder and user needs:**
  Rather than assuming what is required, this phase involves asking stakeholders (GPs, community care, acute staff, etc.) what they specifically need in their roles to be successful (and then bringing them in to co-design the solutions).

- **Understanding and defining the problem** to **be solved:**
  In the example of frailty, it is not a single disease; every partner (GPs, consultants, commissioners, etc.) has a slightly different view of what the problem is. Getting diverse participants to agree on a problem definition can take time and relies on reconciling differences of opinion to reach a shared perspective and commitment.

- **Identifying knowledge gaps:**
  EBC is supported by a "a thick book with pages and pages and pages of tools and templates and different things that that you don't, you only use when you need". Not all tools associated with EBC were deemed useful (there were too many, and some were considered too complex). The Improvement Canvas for example, was used to 'bounce around ideas" and identify where they lacked knowledge, which then directs further inquiry, such as conducting more stakeholder analysis or 1-to-1 conversations.

The systems challenge: understanding vs. overwhelm

The data shows that the 'understand' phase took around nine months – about three-quarters of the allocated time for the whole programme.

The lengthy phase occurred because frailty is not a single disease; each partner (GPs, consultants, commissioners, etc.) had a slightly different view of the problem. Definitions of frailty and interpretations of the problem varied among professionals and across population demographics. For example, in some communities, high levels of socio-economic deprivation can give rise to factors that trigger the onset of frailty markers at a relatively young age. Further exacerbating the problem, the systems-within-systems approach led teams to think so broadly that it overwhelmed them.

> I think, speaking very honestly, the engineering better care approach started to take us to that place of thinking more broadly, you know, about how we redesign the way bus stops are placed. You know, all this kind of stuff can overwhelm people, and then a lot of people are still back to well, how do we stop readmission rates, or how do we better signpost our patients who are coming for GP consultations... So, I think we got so far down the line [then] we kind of reined it back and said, right, well, what can we work on together now in the short term that's going to make a difference and have an impact. And that was really, you know, let's just increase the identification of frailty and understand the scale of the problem. Because once we understand that and we've got that standardised, we can then start to build on how we support those individuals."

By narrowing the scope back down to these core foundations, the team was able to tip into the co-design phase and deliver tangible outputs before the programme ended. However, because system-level change is non-linear, teams often had to return to the 'Understand' phase even during delivery to ensure that the solutions they were delivering remained aligned with an evolving understanding of the problem.

Phase 2: Co-design

The co-design stage of the EBC framework was intended to be a collaborative space for developing solutions. This phase formally emerged when consensus was reached on the specific problem the group could practically solve within the parameters of the funded programme. In the frailty programme, the transition to co-design occurred after the team had spent approximately nine months in the 'understand' phase, 'wrestling' with definitions and varying professional perspectives. The "tipping point" into co-design only occurred after leaders drew a "line in the sand" to move away from trying to 'fix frailty' entirely and instead focus on four or five pragmatic, cross-cutting themes.

> We all had different definitions of frailty across our system, our providers. So primary care, acute community, and voluntary sector. We weren't using a standard definition of frailty. We all realised that we weren't assessing and grading frailty in the same way that allowed consistency, and we realised that we didn't have joined up IT systems to allow us to see across providers those frailty scores and frailty levels. So we agreed on four or five things we'd work on together, which will form the basis of any frailty work we then do locally. So that then tipped us into the Co-design phase."

Having reached this point, the team were able to relatively quickly agree on the definition for frailty and the use of the Rockwood scale as the clinical frailty score. The aim was to standardise it with a view to developing a single measurement system or dashboard to measure frailty. This standardisation acted as a structural anchor for the programme; it ensured that all providers, wherever they were in the system, were finally looking at the same data set rather than comparing 'apples and pears.' By establishing this shared clinical and technical baseline, the co-design phase moved the work from individual organisational perspectives toward a unified systemic approach.

The representation challenge

Despite tangible outputs, participants offered a blunt self-assessment of the co-design phase, stating, "I don't think we got that [co-design] right in our engineering better care programme." In addition to the under-representation of GPs, participants noted an absence of "expert patients" [sic] or service users "in the room with you... and working in true partnership [which] is really critical." This reflection reinforces the need for the new additional preliminary stage of the EBC approach, to ensure the "right people and partners" are assembled from day one and that co-design is genuinely multi-disciplinary rather than hospital-centric.

Phase 3: Deliver

Participants described the Deliver stage as the phase most closely aligned with traditional improvement theory and practice. Here, the focus shifted from the high-level engineering of the system to the iterative work of process change. Improvement specialists acted as coaches, keeping clinical teams focused on the work. Structured tools, such as driver diagrams, were used to ensure that local actions remained aligned with the broader theory of change.

In essence, this stage relied on a rhythmic, clock-like cadence of bringing teams together regularly to review progress.

> "The delivery phase and all of that is about us as improvers, really coaching the improvement. So everybody's really focused on it because we are bringing them together on a very regular basis to understand what tests of change they're doing, which secondary drivers they might be working on. So it's all aligned to the improvement theory of change that we've got the driver diagram and the delivery bit. For me, that's often where improvement stops and the sustain bit is really critical. So for me, the sustain bit is how do you hardwire it into your systems and processes? How do you get the right system levers and incentives to make sure that the work carries on when the improvement team steps away?"

The participant's description above conveys a level of confidence in the practical side of improvement that characterises the 'deliver' phase of EBC. However, they also raise a significant concern about what comes next, namely what mechanisms and levers can be hardwired to ensure the work continues when the improvement team and the attention to improvement fade away. The participant states that this work is "really critical."

Think tanks and do tanks

Another aspect of the Engineering Better Care pilot was the incorporation of a group of people as part of a 'Think Tank' which was focused on strategy, and a 'Do Tank' which was focused on implementation.

> The idea was the think tank for the strategic minds of the system and the key decision makers that would, you know, make some decisions and then it would filter down... to the doers in the system"

In theory, these ideas make some sense, but in practice, they didn't work out as expected, particularly given that most of the same people worked across both. One senior leader reflected that a perceived lack of a co-produced vision hampered the initiative. Because participants weren't involved in shaping the work from the start, they lacked the intrinsic motivation and commitment to really make it work:

> I think that that's a genuine challenge to navigate, which is why the do tank and the think tank didn't really take off properly because. You were inviting people along to be part of this do tank, but they didn't really know what value they were adding; there were lots of early conversations, and it was very difficult to say what the clear lines of their involvement were. So having a better way of doing that, having a better system vision maybe at the start of it that brings all of those people together before you start to invite them would be useful."

Phase 4: Sustain

The Sustain phase was identified as a critical juncture where improvement efforts frequently falter. A key lesson that surfaced from our participants' reflections was that sustaining new ways of working is not something that can be achieved through continued coaching, but by hardwiring the change into the fabric of the system so that it survives the withdrawal of improvement support, funding, resources, leadership transitions and governance.

The 'sustain' phase: funding gaps, leadership churn, and the ... 'pause'

> The bit that we didn't manage to do... was largely because we didn't get the funding to continue and other things take over, don't they? We ended up with a new ICB executive at that point and the conversations move on. We transitioned the work to our 'action on frailty group'... but then, when we had the transition within the ICB and NHS England, that work was largely paused."

Despite the clarity of the EBC methodology, the frailty programme faced significant challenges in achieving the level of hardwiring required. In short, the transition to the 'Sustain' phase was undermined by a combination of structural and political factors. In particular, funding gaps emerged when the initial grant for programme managers expired amid a period of wider financial challenges, and leadership churn within the new ICB executive led to a shift in strategic priorities.

These external pressures resulted in a loss of momentum. Participants noted that once the formal programme funding ended, there was a lack of mobilisation resources to continue the delivery at a system-level. While the work was handed over to an 'action on frailty group,' the absence of a dedicated improvement advisor meant the relational infrastructure established during the co-design phase began to dissipate.

This was further compounded by a broader transition within the ICB and NHS England, causing the work to be "largely paused" for several months. The 'pause' in the frailty work revealed the vulnerability of a 'Project Clock'; once the external funding and dedicated improvement resource were removed, the mechanical momentum stopped because the change had not yet been hardwired into the system's existing architecture.

However, this learning is now being applied as work is resumed through the National Frailty Collaborative. With renewed interest from senior leadership, the focus has returned to ensuring that the foundations laid during the EBC pilot are not just temporarily adopted but are structurally and financially secured within the system's long-term architecture.

Hardwiring the change

Across our interviews with senior leaders from the Lancashire and South Cumbria region, participants suggested contractual, financial, and governance levers as mechanisms to 'hardwire' change into the system once formal improvement projects conclude.

1. Contractual and commissioning levers

One of the most effective mechanisms for sustainability identified in the region is the use of formal contracts to mandate new clinical behaviours:

- **GP quality contracts:**
  A primary success of the EBC frailty work was building requirements into GP quality contracts to use a specific standardised screening tool, specifically mandating that primary care **"must use and collect Rockwood frailty scores on their patients".**

- **Transactional commissioning:**
  At the ICB level, a 'route one' transactional response, in which providers *"will not get paid unless [they] align to a best practice model,"* was advocated by a senior ICB leader.

- **Commissioning intentions:**
  Another participant described 'hardwiring the learning' from improvement projects directly into annual commissioning and contracting intentions, ensuring change becomes "business as usual." For example, a key outcome of the frailty work was a reduction of people over 65 with mild to moderate frailty going through the emergency pathway by 11%, but as the participant noted the learning from the work was not then carried through to shape commissioning intentions and contracting:

> "What we didn't then do is carry on that learning and continue the contracting around that really good stuff that we did. So now I'm in a position where I can help influence those contracts, working with our strategic commissioning leads to hardwire it in, in terms of contracting and business as usual."

- **End-to-end pathway commissioning:**
  Adopting a different approach to commissioning, where commissioners move away from siloed inputs and instead commission for the entire patient journey. Explaining that providers work in silos because they are funded in silos, system leaders believe that true system-level change (such as the EBC frailty work) is impossible until commissioners stop purchasing individual 'activities' from different providers and start commissioning the entire end-to-end patient journey.

> One thing we talk about [as leaders] is the importance of commissioners working differently. If they commissioned that end-to-end pathway - for example, if they commissioned primary care to do the risk assessments as well as the acute trust, because we've both got a role in that. If they commissioned GP practices or community services to do [the out-of-hospital work] through neighbourhood teams, and they commissioned us to do the turnaround quickly at the front door and said, 'we're not paying you for [individual activity],' then we could focus on the right outcomes. If we got the proportion right and we commissioned right, then we would be able to organise ourselves to deliver the care - because that's what they're commissioning us to do. But they don't do that at the moment."

2. Financial levers and economic models

Several participants emphasised that sustainability is impossible without aligning the financial incentives of different organisations:

- **Pooled and shared budgets:**
  One senior leader spoke of exploring a move toward Section 75 pooled budgets or shared financial frameworks to incentivise "keeping people safe at home" rather than rewarding hospital activity. However, another leader presented a counterview, lamenting the time required to set these up and noting the apparent efficiency of a more decisive 'master-clock' transactional approach.

- **Capitated allocations:**
  Another leader explained they were exploring capitated long-term allocations at a local 'place' level. This would be supported by a pricing framework that encourages shared risk management between partners, moving the system away from transactional, activity-based payments and toward an end-to-end commissioning model. This prospective move toward capitated long-term allocations and shared risk frameworks is an attempt to create a single, synchronised 'system clock' - one that aligns financial incentives with the relational realities of the 'Cloud.'

- **Pump-priming:**
  Where commissioning plans have yet to mature, some acute providers have felt the need to proactively fill the 'void' by investing in the stability of their partners. One hospital leader described a strategy of using hospital resources to "pump-prime" local Primary Care Networks and voluntary sector organisations. While acknowledging that this traditionally falls within the ICB's commissioning remit, the hospital's approach is a pragmatic response to a perceived power vacuum.

  By offering three-to-five-year contracts, the hospital aims to move beyond 'six-month projects' that prevent partners from hiring permanent staff or securing premises. In this instance, the hospital is stepping out of its 'Mechanic' role - fixing only what is within its walls - and acting as a system steward, intentionally strengthening the 'cloud' to prevent the 'master-clock' of the acute sector from being overwhelmed.

Box 7: Relational Interdependence is Central to the Thesis of Systems Thinking

In a world predicated on siloed operations and functional directives, multi-agency inter-professional relationships are vital yet rarely in place or actively sustained. The prevailing lesson from the EBC pilot was that while a technical framework provides the 'what,' relational trust is the prerequisite for any system-level 'how.'

As systems-thinking pioneer Russell Ackoff made clear, continuously improving parts of the system in isolation will 'absolutely not improve' the performance of the whole. Instead, he argues for discontinuous improvement, where creative leaps are required to redesign how those parts interact.

In this context, improving frailty at the hospital front door is akin to removing a symptom - what Ackoff defines as 'defect elimination' - whereas EBC is intended to be the 'creative leap' toward what is actually 'desired' for the frail population. This reflects Ackoff's fundamental distinction between efficiency and effectiveness; he argued that it is "better to do the right thing wrong than the wrong thing right," because "doing the wrong thing right" only makes the system more efficient at failing.

However, the implementation of EBC revealed a significant friction between intent and jurisdiction. While the programme was designed as a whole-system 'right thing,' its origin as an acute-led mandate meant that multi-agency partners often perceived it as 'acute-driven,' creating tension in which hospital leaders were seen to be 'dictating' change across jurisdictions where their authority was not guaranteed.

This aligns with our contention that system-level improvement is a different species of work; it is governed by clock-like performance pressures, yet it must navigate the cloud-like complexity of multi-agency relationships to ensure it is doing the right thing for the whole.

Box 8: What LSC Learned from Implementing Engineering Better Care

One senior leader had given a lot of reflection on their experience with the EBC pilot. They shared four learning points as follows:

1. **Leadership must be clinically led and operationally driven:**
   A primary lesson was that improvement directors should facilitate rather than lead programmes. Specifically, she stated that They noted that EBC was initially viewed as an "improvement programme" rather than a clinical redesign, which was a mistake.

2. **Methodology must match complexity:**
   While the specific methodology (e.g., IHI, Lean, or EBC) matters less than its rigorous application, it must be robust enough to handle the scale and complexity of a whole system. They observed that tools designed for small teams (like the Microsystem Coaching Academy) are insufficient for the multi-partner complexity of an Integrated Care Board (ICB).

3. **Genuine co-design is essential:**
   True partnership and co-design with patients and service users are critical for success. They reflect that the EBC programme did not initially get this right, noting that the design was not informed by lived experience to the extent it should have been.

4. **Hardwire improvement into governance:**
   Improvement must be hardwired into a system's formal governance structures rather than treated as a separate activity. This requires regular reporting of progress and barriers into both the ICB and Provider Collaboration Board to ensure accountability and long-term sustainability.

Beyond these four tactical points, these reflections underscore an enduring tension: the unavoidable nature of the 'clock's' gravitational pull. They highlight the importance of understanding the context – specifically using frameworks like MUSIQ to assess whether conditions for success (such as payment levers, data expertise, and commissioner buy-in) are in place before starting. They also conclude that social capital is vital, as system-level work relies on influencing and persuading partners across organisational boundaries where one does not have direct hierarchical control.

In detail: Boost: An approach to "becoming the best at getting better" (North East and North Cumbria, England)

Boost was established by the NENC ICB as a cornerstone of the system-wide architecture for building social capital and shared learning. While it inherited a decade-long regional legacy of multi-agency convening, noted by one participant as being 'ahead of its time,' the formation of the ICB in 2022 prompted a radical pivot. Recognising the stark paradox of a region having some of the 'best' performing organisations alongside some of the worst health inequalities in England, the ICB leadership realised that purist improvement methods and isolated pockets of best practice were insufficient.

To address this knotty problem, they convened a group of academics and system leaders to move beyond traditional frameworks. This collective inquiry led to a fundamental shift: moving away from the process-heavy models of the past toward a Human Learning Systems approach. Inspired by the cultural ethos of Cincinnati Children's Hospital and the relational depth of the Nuka System of Care, Boost was designed not as a standard improvement office, but as a relational infrastructure capable of fostering a system that is truly 'best at getting better.'

As one participant reflected on this transition:

> "I think how it's evolved is more around the Human Learning Systems approach rather than the purest improvement tools... the focus was more outward around a system offer for learning and improvement, some of which was improvement methodology, some of which was around leadership and working with communities... Really making our staff 'match fit' around this approach and as stewards for the work, if you like."

This concept of being 'match fit' denotes improvement as a collective effort in which each member plays an adaptive, relational role. In the context of Boost, this suggests that improvement is not merely a classroom-based skill set or a set of training modules. Instead, the goal is to develop a workforce with the practical fluency and professional stamina to act as 'stewards' of change. It represents a move from theoretical knowledge to operational readiness, enabling staff to instinctively navigate the messy, relational reality of the system.

This shift toward stewardship and 'practical fluency' required a digital infrastructure that matched the system's boundary-spanning ambitions. To move beyond the silos of institutional firewalls, the ICB invested in a public-facing Learning Academy hosted on a '.org' domain (boost.org.uk). This was a deliberate strategic choice; by opting for a neutral, non-NHS domain, Boost created a common ground accessible to anyone - globally or locally - regardless of whether they hold a standard NHS email address.

As one leader noted, this inclusivity was the foundational intent:

> We wanted to build a community across the system, but it couldn't just rest in the health side of the system. It had to involve all partners - social care, voluntary sector, but also people who live here as well."

With over 20,000 subscribers, the portal serves as the primary engine for this collaborative mobilisation. By removing technical and bureaucratic barriers to entry, it ensures that patient partners, clinicians, local authorities, and the voluntary sector can participate as equal members of a shared learning community. In this sense, the digital platform acts as the "social glue" in practice, providing the neutral space required for lived experience and multi-agency expertise to drive systemic change from the ground up.

The four domains of Boost

As a framework, Boost is structured around four domains:

Learn –
Providing access to training, development and evidence based practice

Connect –
Bringing people together to share insights and build relationships

Lead –
Developing leaders who can convene and influence system change

Improve –
Embedding continuous improvemnt through shared methods and tools

Much of these four domains is delivered via the online hub and learning networks associated with Boost. One ICB leader relays an example of how the boost online learning academy can be used to convene relevant partners, facilitate learning, and incubate relational work across different parts of the system, in this case, to improve palliative and end-of-life care:

> I'm talking to lots of people in the system about palliative and end-of-life care, learning that everybody in different places is going, 'Oh, you know, we really want to bring this together.' So, what the Learning Academy allows us to do is, as long as one person says they'll be the programme lead and they've got a plan on a page of how they want to do it, we can house their learning in one place and help administer it. And so it's not the be-all and end-all, but you know it's, I think it will be a really good resource that we can just grow and grow, and what's great about it is that we can say with palliative and end of life, we can have citizens and paid workers learning alongside each other, so if you're a carer for a loved one or whatever, you can still come on the learning and I think that's quite different to perhaps what's happening in other places."

While the scale of this digital footprint is impressive, leaders were candid about its limits, noting that the platform is not an exhaustive solution but rather an evolving resource. As one senior leader reflected, the reliance on a virtual infrastructure presents a distinct structural tension:

> I think the fact that it's mainly a virtual community is both a strength and a limitation. The limitations come in the online tool. So if you've been around the website, it's very kind of us to pump a lot of stuff out, but we have less opportunity for the connecting and the building. So I think that's a real limitation because it could become just a kind of glorified followership. What I don't know is how many out of the 20,000 are actively engaged, and we probably need to do something to kind of try and understand that a bit more."

This tension highlights a broader strategic vulnerability: Boost currently risks becoming 'a bit of all things to all people.' In an era where ICBs are entering their fourth year of existence and facing 'sweeping reductions in costs and overheads,' the 'broad-brush' nature of relational, open-ended system work is increasingly under threat from a returning pressure to focus strictly on narrow, immediate performance priorities.

The performance paradox: navigating the cloud within the clock

Despite a clear strategic intent to prioritise the relational 'Cloud' as the essential substrate for change, Boost inevitably hits a performance paradox: it must operate within a wider NHS environment still dominated by clock-like performance pressures.

The paradox lies in the friction between these two worlds:

- **The relational value:**
  The success of Boost is found in 'boundary-spanning,' 'social capital,' and the developing 'match fitness' of its 20,000 members.

- **The transactional pressure:**
  However, the formal system often demands that this emergent, cloud-like work justifies its existence through the same transactional, short-term metrics it was designed to transcend.

This paradoxical tension presents itself in the data in several ways, which we explore below.

The difficulty of evidencing impact
One of the primary challenges for Boost is demonstrating a direct, measurable link between its relational activities and core system outcomes. One participant told us of a 'hard sell' and another cited the success of the ambulance handovers work and the significant tangible outcomes of that while also acknowledging "the other stuff might be a bit more nebulous":

> I believe that we make an impact in everything that we do. But how do you evidence that, because it is such a slow burn ... almost the leap of faith isn't it around the behaviour ... That is a hard sell in terms of going 'So what difference is that making to our priority areas of work?'"

Another senior leader noted that the ICB intentionally sought to move toward "measuring learning and the flow of information" as a primary success metric. However, they expressed a deep, enduring tension in trying to satisfy both the national Clock and the local Cloud:

> I think there's something about how you measure [this]... we've said that we want learning to be our key success measure. But at the same time, we're being managed and held to account by a national body that is very transactional and about 'old power'. I'm not sure yet if you can do both—can you deliver on the KPIs set centrally and at the same time deliver 'what matters most' to our communities? I haven't quite found the way to bridge those two things yet."

The senior leader quoted above was unequivocal that Boost and the ICBs' relational approach are having an impact. Another leader, equally invested in maintaining the ICBs' commitment to Boost, notes that its potential has yet to be fully realised:

"The degree of ownership that is felt on it, as I said, by some leaders, in all parts of the system [varies]. Is it something that is part of everybody's language? No, it's not. It's there, and it's more central for some people, but not many. I would say, actually, it's seen as a good kind of resource and tool. But is it really bringing to life the kind of the best of getting better? I think we have a lot more work to do there to get it fully integrated and embedded, so some limitations there".

Measuring the impact of Boost has proved challenging. For example, plans to use Social Network Analysis (SNA) to examine relational outcomes have not yet been realised, and getting participants to report on the tangible impact of training or collaborative work was described by team members as 'really hard,' with many individuals 'disappearing back into their organisations' after an event without providing follow-up reflections and case studies. Moreover, while long-term goals, such as reducing health inequalities, may ultimately benefit from Boost's relational infrastructure, this style of system-based work may take decades to yield measurable results, sitting in direct tension with short-term accountability goals.

Relational approach vs. clock-like pressures

There was a strong belief among many ICB participants in NENC and other regions that the ICB has significant value in taking a convening role. The value of bringing people together from across the system is demonstrated in the example of the ambulance challenge described in Box 9.

The example aptly contrasts the power of the convening approach, when an active choice is made to focus on connecting people for improvement over traditional command and control methods in the face of performance and political pressures (the 'clocks').

Box 9: The Genesis of Boost - From Performance Management to System Convening

The foundations of Boost were forged during the early formation of the North East and North Cumbria (NENC) ICB in 2022. Faced with the immense operational pressure of ambulance handovers, the leadership made a deliberate choice to avoid traditional, top-down clock-like management in favour of relational improvement philosophy.

Reframing the problem:
The Ambulance Challenge
In early 2022, the region faced significant pressure regarding ambulances queuing outside Emergency Departments. Rather than using data to 'performance manage' or shame the worst-performing sites, the ICB CEO adopted an improvement-led approach.

Changing the question:
Instead of asking, "Which of our emergency departments has the worst handovers?", the leadership asked, "Where is the greatest opportunity for improvement?"

Identifying the system Issue:
Recognising that handovers were not a localised process to "fix" but a whole-system issue, the ICB convened partners to explore the root causes together.

Fostering peer support:
Using data to identify 'peers that were doing well', the ICB established a culture of peer support and review, moving away from a punitive culture towards one of shared learning.

Operationalising the ethos: The St. James's Park conference
In September 2022, the ICB convened a system-wide conference. The conference began with a distressing clip of an elderly housebound gentleman to ground the technical work in human reality, ensuring the 'why' of the work remained at the forefront. The event served as a clear signal that improvement would be led by those 'on the ground' doing the work. It was an exercise in bonding - deeply rooted in the 'why' of system-level work - establishing that connecting people and organisations for improvement was not a distraction from delivery, but the very thing that makes delivery possible.

The result: building a system that is 'best at getting better'
These experiences served as a 'proof of concept' for developing a relational focus and infrastructure. By placing social capital and relational work at the centre of its strategy, the ICB's intention was to create a 'community across the system'.

Not everyone agrees that an ICB's role includes convening or improvement. For example, critics view convening as dragging people into meetings without clear outcomes, which may be at odds with the transactional, market-based view of commissioning and, similarly, can create resistance from providers who prefer to focus on their own internal improvement methodologies.

One senior leader acknowledged that this convening role is often under threat from those who prefer a more traditional, transactional model:

> "The question in some circles might be 'Is that your role to do improvement?' ... Why are you spending money on it? That's the provider's job."

However, the ICB's approach was an intentional move away from imposing a specific improvement methodology. Instead, they chose to act as a neutral supporter of existing work:

> "We decided to take that approach because we just thought we'd get so much resistance and actually it would probably set us further back. Some organisations have got really great improvement systems. Why would you get in the way of that? ... Our role will focus around convening the communities of practice and supporting improvement tools."

Boost relies on a relational model, building leadership capability for improvement and convening communities of practice, yet the clock-like pressures of the system undermine this approach by incentivising self-interest. In other words, the broader system is currently 'geared' to reward organisational performance rather than collaboration. Chief executives, for example are held to account for their organisation's financial deficit or quality failures, not for how well they collaborate through platforms like Boost.

> They're not going to lose their jobs because they're not collaborating. They'll lose their jobs because they miss the money, or they have a massive quality failure. So, the whole system is gamed"

Organisational and political vulnerability

Boost's status within the ICB structure makes it vulnerable to shifting political and financial priorities. Given that ICBs have faced three major reorganisations in their first four years and are currently mandated to reduce their headcount by 50%[3]. This environment of 'stretched resources' risks Boost being seen as a 'nice to have' rather than an essential function.

> As a strategic commissioner [Boost] would probably fit in that 'nice to have' box, but, it's not an essential anymore. What's an essential for us is that we train our staff with improvement skills, but I don't think anybody views it as the role of the ICB now to do this sort of system leadership coordination work, which I think is a genuine gap."

Box 10: Case Study - The ADHD Waiting List

In another example, a senior leader recalls the response to ADHD diagnostic waiting lists. The starting point was a classic 'Clock' demand: How do we reduce the waiting list? Rather than jumping to a transactional fix, the leadership's starting point was to reframe the problem.

This meant intentionally 'slowing down' the response to broaden the scope from a single waiting list to the entire state's neurodiversity. This approach required bringing in people with lived experience to shape the solution and using data to look at the desired future state 18 months out, rather than just the immediate backlog. As one leader noted:
"All that stuff just takes longer. But if you're going to do it, that's the way to do it."

There was also some tension regarding where Boost should 'sit' within the ICB. Some expressed concern that moving it into operational or performance portfolios would subject it to a project management or performance approach, rather than being seen as an organic community for learning.

Finally, there was concern that Boost's survival is dependent on specific senior leaders who hold an 'improvement ethos.' If key proponents, such as the current CEO, were to leave, the programme could be subsequently deprioritised or removed from the budget altogether.

Box 11: The System Needs the Cloud to Innovate and Improve but Depends on the Clock to Weather Financial Storms

Ultimately, Boost faces the challenge of maintaining its relational ethos in an environment that often pushes leadership toward operational tasks. To truly embed its mission, Boost must continue serving as a system convenor, preserving space for ongoing inquiry while managing the system's focus on metrics that favour 'ticks' over 'trust.' The real challenge isn't choosing the Cloud over the Clock but balancing them. With ongoing cost cuts and reorganisations, the 'relational' aspect risks being seen as a luxury. The paradox is that the system needs the Cloud to innovate and improve but depends on the Clock to weather financial storms. The next step for Boost is shifting from a broad approach to integrating its relational values into the system's pressing mechanics.

3 At the time of writing, we understand the headcount reduction is now complete and Boost remains central to the ICBs approach to system-level change.

In Detail: The Scottish Approach to Change, a Systemic Hybrid, bridging the structural and relational ends of the change spectrum

The Scottish Approach to Change is a system-level improvement framework developed by Healthcare Improvement Scotland (HIS) to facilitate complex transformational change across integrated health and social care. Building on the aims of the Christie Commission (Scottish Gov, 2011), summarised as 'advocating for collaborative, person-centred, and preventative care' (interview with Senior leader, HIS), the Scottish Approach to Change responds to the implementation challenge highlighted by the more recent Feeley Review (Scottish Gov, 2021).

The foundational goal of the Scottish Approach to Change is to enable this shift to a new 'People-led Paradigm' and to *"create a clear pathway to support everybody to do change well."* This involves several key philosophical changes:

Universal literacy:

The framework explicitly attempts to neutralise 'improvement jargon' to make change accessible to everyone, from admin staff and citizens to strategic commissioners, rather than keeping it as an 'elite sport' for those with specific improvement credentials.

> So, we've made the job of doing person-centred change an elite sport, and actually the people who you need to do person-centred change are either people needing and using services, or community-based leaders."

Effectiveness over efficiency:

A recurring critique from senior leaders was the tendency to adopt improvement approaches that simply make 'the wrong thing efficient.' For example, a system might use process improvement tools to make hospital admissions faster, but if those patients did not require hospitalisation in the first place, the system is merely 'counting beans' rather than addressing the root cause. The Scottish Approach to Change explicitly advocates for a 'new way' (a People-Led paradigm) that shifts the focus toward doing the 'right thing.'

The quote below illustrates why a learning system is central to this shift; it facilitates the social interaction and lived experience necessary to navigate complexity and ensure improvement efforts are directed toward genuine effectiveness rather than just transactional speed:

> I think in order to understand effectiveness and complexity, you need a learning system at the heart because you can't do [system-level change] without it, because you need to understand and you need to talk because there's not a right answer."

Compulsive curiosity:

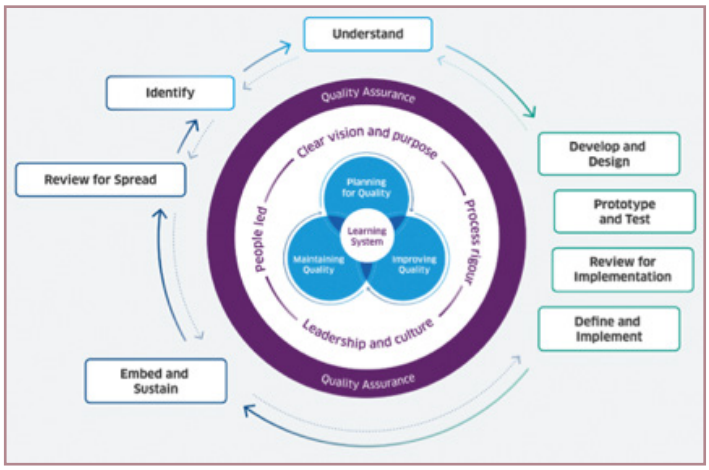
The Scottish Approach to Change enables what one senior leader termed ‘compulsive curiosity’, a refusal to accept a data point at face value. Rather than the transactional response of New Public Management (NPM), which mandates efficiency to hit a target, the Scottish Approach to Change framework uses a learning system to bridge the gap between the clock-like metrics of NPM and the cloud-like social reality:

> With curiosity, you look at a data point and ask: ‘What does that mean? What does it mean for our people?’ The trouble with New Public Management is that it assumes that if a metric is off, you simply mandate an efficiency program until the number changes. It tries to beat people up to be faster. Compulsive curiosity goes deeper. It asks: ‘Why is the number 6 rather than 5?’ It discovers that the people behind that number are from our most deprived areas, and the cause is poverty-driven - they literally cannot afford the bus to the hospital. Instead of trying to force efficiency, we address the root cause. This creates an organic, iterative space held together by the learning system.”

Ultimately, the Scottish Approach to Change aims to move systems away from top-down performance management toward a culture of ‘compulsive curiosity,’ where data is used to understand why things are happening rather than just what is happening.

The Scottish Approach to Change framework

The framework is built upon five key enablers and a central Learning System that links quality planning, improvement, and maintenance.



In developing the Scottish Approach to Change, Healthcare Improvement Scotland began with the evidence base, seeking to understand lessons learned from previous examples of change and improvement about what works and what doesn’t. They also sought to collaborate with health and care professionals across the system to ensure the approach “belongs to the whole system, not to us as an organisation.” Alongside this, Pathfinder sites have been actively testing the approach during the development phase.

The resulting framework comprises eight steps and five enablers, with a central learning system that links quality planning, improvement, and maintenance.

The Scottish Approach to Change and associated resources are comprehensively explained on Healthcare Improvement Scotland’s dedicated webpages[4]. Here we offer a summary of the key elements:

1. The five key enablers

These enablers form the inner ring of the framework and act as the foundational 'bedrock' for effective change:

- **Clear vision and purpose:**
  This 'North Star' defines the desired outcome (vision) and the reason for it (purpose), grounding the work in information from legislation, local needs, and strategic gap analysis.

- **Process rigour:**
  This involves systematically using structured but flexible processes - such as good project management, governance, and commissioning - to enable better decision-making and continuous learning.

- **Leadership and culture:**
  Shifting from command-and-control to 'distributed leadership'. It requires leaders who are compassionate, present, and willing to remove systemic barriers.

- **People-led:**
  This ensures changes meet the actual needs of those served. It includes being trauma-informed, intentionally reducing health inequalities, and embedding human rights into service design. Health inequalities are described as "differences in health outcomes that can be avoided". Addressing inequalities requires intentional effort to understand and respond to the specific needs and barriers of different groups.

- **Learning system:**
  Situated at the absolute centre and described by senior leaders as the superpower of the Scottish Approach to Change, the learning system connects people to share knowledge, assess what is working through data and stories, and turn that knowledge into action (**See Box 12** for further discussion).

2. The Quality Management System (QMS) with learning at the core

The QMS provides a structured approach to managing quality across a system rather than just within an individual organisation:

- **Planning for quality:**
  This involves co-designing services to understand what 'good' actually looks like for the population. It is grounded in legislative requirements, local needs, and a 'strategic gap analysis' that identifies where the status quo falls short of evidence-based best practice.

- **Improving quality:**
  In this phase, teams test change ideas. The learning generated from these tests is used to refine the initial 'Quality Plan' if the original assumptions are found to be wrong or lacking nuance.

- **Maintaining quality:**
  This pillar focuses on ensuring that the standards achieved through improvement are upheld over time. It is supported by an outer ring of Quality Assurance, which provides the necessary standards and oversight within which the system operates.

At the heart of the framework, connecting all three functions of the QMS is a Learning system, ensuring that insights from one area constantly inform the others.

4 To learn more about Scottish Approach to Change and access resources visit: www.healthcareimprovementscotland.scot/improving-care/scottish-approach-to-change/

Box 12: The Learning System as 'Superpower'

"There is no substitute for knowledge...a system cannot understand itself."
- W. Edwards Deming

The Health Foundation (Hardy et al 2022) describes a Learning Health System (LHS) as a virtuous cycle where data, technology, and collaboration ensure that 'data becomes knowledge, and knowledge becomes improvement.' Across the Northern Triangle, we saw three very different ways of making that cycle work:

Learning as the engine (NENC/Boost): Here, learning is the social 'glue.' By building a leadership academy and virtual communities, the North East has focused on a relational infrastructure in which learning together actually drives system-level engagement.

Learning as deep inquiry (LSC/EBC): In Lancashire and South Cumbria, learning is primarily concentrated in the 'Understand' phase of the Engineering Better Care (EBC) framework. Interestingly, many senior leaders we interviewed noted that formal learning often seemed like an 'afterthought', despite lessons from the EBC experience being well understood across various parts of the system. In reality, however, the opposite was true. The significant investment in mapping system boundaries, technical dependencies, and data served as a deep dive into learning itself. Participants effectively 'learnt the system' before attempting to implement changes, establishing guardrails that prevented efforts from focusing on the wrong areas.

Learning as the heart (Scottish Approach to Change): The Scottish Approach to Change explicitly formalises learning by placing the Learning System at the geometric centre of its Quality Management System (QMS), recognising that:
- Planning cannot happen without learning.
- Improving cannot happen without learning.
- Maintaining cannot happen without learning.

It suggests that learning is the 'anchor' that prevents any part of the system from veering off course. For the Scottish Approach to Change, this isn't just a diagram; it creates what one leader described as an "organic, iterative space" where the system can pivot when the data shows the plan isn't working:

"As you're doing 'improving quality', you learn that maybe some of your 'quality plan' is wrong or not nuanced enough... it's that learning that then drives you back from improving quality to planning for quality, and you might think, 'well, I need to look at different measures' to understand if my new thing [is working]."

By focusing on a system that learns about the problem as it evolves, the Scottish Approach to Change provides a 'compass' that allows leaders to pivot and adapt in real time rather than risk becoming wedded to a rigid, outdated plan.

3. The outer improvement cycle

The framework is surrounded by a continuous operational cycle (an extension of the Plan-Do-Study-Act or PDSA cycle) that includes:

1. **Identify and understand (knowledge-building).**
2. **Develop and design** followed by **prototype and test.**
3. **Review for Implementation** and then **define and implement.**
4. **Embed and sustain** followed by **Review for spread.**

4. Quality Assurance

In the Scottish Approach to Change model, the Quality Assurance ring encapsulates the five key enablers and the Quality Management System (QMS). It serves as a protective boundary, ensuring that, as teams engage in 'compulsive curiosity' and testing, they remain within established guidelines, policies, and safety standards.

Systemic, cultural, and practical challenges

As a national framework, the Scottish Approach to Change faces several systemic, cultural, and practical challenges. These challenges, identified through interviews with senior leaders at Healthcare Improvement Scotland and participant observation of a system meeting in Glasgow (February 2026), are summarised below.

1. Terminology and inclusivity tensions
Despite a core goal of making change accessible to everyone, the framework struggles with exclusionary language.

- The term 'Quality Management System' (QMS) is well recognised in healthcare but not always well understood. Further, it is often seen as irrelevant or jargon-heavy by partners in local councils, social care, and the third sector.

- Senior leaders have remarked that 'QMS' sounds like "a piece of kit that you plug in," suggesting a technical fix rather than the deep cultural shift the Scottish Approach to Change intends to facilitate.

- There was concern that calling it the Scottish approach makes it feel like a top-down government directive rather than a community-owned tool for local teams.

2. The erosion of relational infrastructure

A primary challenge for the Scottish Approach to Change is the legacy of a decade of austerity, which senior leaders argue has *"systematically eroded the spaces where change happens."* While senior leaders report that the Scottish system is not formally wedded to New Public Management as the English system is, financial pressures have achieved a similar effect by stripping away the time and capacity for people to think and build relationships.

The result is a system characterised by 'relational inertia.' Without the trust built in shared spaces, professional groups retreat into silos, for example, physiotherapists, nurses, GPs and social workers increasingly fail to give one another the *"benefit of the doubt."* This breakdown in joint thinking leads to clunky interfaces where acute and community services design "shadow structures" [sic].

These shadow structures represent a form of systemic over-engineering where acute providers, unable to rely on, or influence community pathways, build their own internal community-style services to "plug the gap." Conversely, community teams may design entry systems that serve their own internal needs but fail to interface with acute wards, effectively creating two parallel systems that coexist but do not connect. As one leader explained:

> "Money, money, money... we have eroded all of the spaces where people have relationships with each other and where they think together... we get either acute create some form of shadow community service within their structures to try and plug a gap... or community design a system that doesn't interface well with acute and so it's clunky to get people in and out of it and they get stuck."

The Scottish Approach to Change therefore faces the uphill task of not just introducing a new methodology but doing so within the context of a country that needs to actively rebuild the relational infrastructure lost to budget cuts.

3. Structural and cultural barriers: The assurance-improvement paradox

A significant structural barrier for many national system-level change approaches is the historical and cultural tension between assurance (inspections and regulation) and improvement (support and learning). Branding of the national body is both a barrier to trust and a source of strategic credibility and legitimacy, as was the case with England's national improvement framework, NHS IMPACT (cf. Burgess and Downham, 2025).

However, adopting a mindset of compulsive curiosity and using the Scottish Approach to Change, Healthcare Improvement Scotland views this paradox as an opportunity and an asset in connecting the clock-like mechanisms of assurance with the cloud-like approaches to improvement – resulting in a more integrated and effective outcome.

> "Adopting a compulsively curious mindset can take us to a different place that looks at the evidence and genuinely supports leadership. It can be a really enabling and positive thing."

4. Resourcing and sustainability risks

A final challenge for the Scottish Approach to Change is balancing the framework's national ambition with the practical capacity of the core delivery team. With a core team of eight, the implementation task spans a broad landscape of 15 territorial boards, 31 Health and Social Care Partnerships, and various national and third-sector organisations.

To address this, the Scottish Approach to Change is developing a 'self-servicing' strategy designed to decentralise the methodology. This approach focuses on building digital and relational infrastructure that allows local systems to adopt the framework independently, rather than relying on a central change-coaching model. As one leader noted:

> "The idea is that there should be a certain degree of self-servicing available so that people don't need us in person... There are two components: an online resource that provides what you need, and a learning community where people come together to reflect. We're looking at how we get those tipping points - as other [national] bodies embed it, we increase the amount of reach we have."

This shift toward a self-servicing model points to a broader aspiration within the Scottish Approach to Change: the transition from a central expert function to a distributed, system-wide capability. While the current delivery model relies on a small multidisciplinary core, the longer-term goal is to further embed these specialist change roles, such as service designers and strategic planners, directly into local boards. This reflects a strategic move to insulate the framework from central resource fluctuations by making its tools and learning communities a standard part of the national change infrastructure.

Section 5

Leading the Shift

Why This Work Matters
Of Clocks and Clouds
Intractable Elephants
The Northern Triangle
Leading the Shift
Four Key Lessons

The challenge faced

If system-level improvement is a different species of work, it follows that it requires a different kind of leadership.

Leadership that enables individuals to operate effectively within systems characterised by diverse silos, which are not only structural, but represent the complex, political, and professional tensions that form the lived reality of our leaders. These tensions that dis-integrate the system and the perspectives that drive them, are unlikely to be resolved any time soon.

To compound this, leaders face the challenge of operating in systems where purpose, the foundation of effective system leadership, is at best contested and actively in tension between stakeholders, as we found in both the English and Scottish NHS (as discussed in Section 2).

Enabling different work to happen

From a systems thinking perspective, the leadership task is less about directing action and more about creating the conditions in which different, more proactive and integrated work can emerge. As Senge (2006) argues, however capable or committed individuals may be, placing them in the same system conditions will tend to produce the same results. Without changes to those conditions, such as regimes of performance management, financial reporting, commissioning, scrutiny, information systems, and professional boundaries, no amount of strategising or planning will generate materially different work.

Achieving the transformational left shift therefore depends on a fundamental re-calibration of the formal and informal rules of the game that lock in current practice and create the gravitational pull of the clock. Changing those rules is the core challenge for system leaders, and it requires influence in all directions.

Six pillars of leadership for system-level change

With this different species of leadership in mind, one that enables left shift working across a complex and fragmented system, our interview data identified six core pillars of contemporary system leadership:

1 **From hierarchy to stewardship:** System change relies on influence and cooperation that extends beyond the jurisdiction of any single organisation or leader. This requires leaders to act as 'stewards' of the whole rather than just the 'boss' of one institution.	**2** **The power of the 'boundary spanner':** Success depends on individuals who can act in service of system purpose to facilitate conversations. These 'boundary spanners' often have to consciously dilute their institutional status, or seniority, to earn the trust of partners across multiple sectors.	**3** **Managing the discomfort of co-production:** Leading at this level means acknowledging that you do not have all the answers. It requires a level of professional humility and the ability to sit with the 'discomfort' of sharing power with citizens, who often hold the real solutions.
4 **Building relational capital:** Leaders were unequivocal: without solid relationships, you cannot move forward. This is the 'social capital' that bridges fragmentation within clock-like systems of contract and performance management.	**5** **In service of the system:** Leaders require a lens for seeing the underlying system conditions that shape the work, and the ability to address root causes rather than re-apply sticking plasters.	**6** **Amplifying and influencing:** In their quest to enable different, more integrated and left shift work to happen, leaders acknowledge individuals cannot do this alone, it requires coordinated and collective voice and action.

> People get to the top in the NHS, often they are good at running institutions, [but] it's not the same skill that you need to lead across complex systems."

1
From hierarchy to stewardship

System level improvement depends on collaborative working that extends beyond the boundaries of any single organisation. This requires leaders to act as stewards of a health and care systems, rather than heads of single institutions.

Yet traditional hierarchical leadership habits persist. Even the most senior of leaders are tempted to 'act down', defaulting into detailed operational management and, in doing so, diverting attention away from the deeper, systemic causes that need to be addressed.

> A CEO came from another system, they say they used to get called by their ICB chief executive and asked about Mrs. Smith in Ward AB and why they were still in their bed."

A system seeking more control

As we have seen, systems leadership is most needed where jurisdiction is weak and complexity is high, conditions that characterise much of system level change. This lack of effective formal authority is clearly acknowledged in our data and responses to it are increasingly visible in national policy and its local translation.

At the time of writing, in England, ICBs are being steered towards strategic commissioning, with a stronger emphasis on commissioning accountability than on system partnership. In Scotland, there is a move towards sub-national planning and, more operationally, national flow control centres. The tone of guidance, and the consolidation of structures is hardening. This reflects a growing preference for greater jurisdiction, control and scale. In the belief this will lead to more predictable delivery against predefined solutions and targets.

Whether greater jurisdiction over large systems is achievable in the way envisaged and whether it will deliver the more integrated, left shift system that is sought, remains uncertain. There is a real risk that attempts to strengthen accountability by cascading it down to place and multi-neighbourhood level, through consolidated contracting, may instead further fragment the system, rather than integrate it. This risk is heightened by the continued dominance of arguably right shift metrics, such as discharge, length of stay, and reablement, which pull attention rightwards towards short term, acute pressures.

Despite this backdrop, our data indicates that many leaders continue to hold the more complex reality at heart, underscoring the need for more collaborative approaches.

> When things are falling apart, part of the role of leadership is to bring people together to find solutions and not to dictate, and this is when I see commissioning go wrong."

Others recognise the enduring nature of distributed jurisdiction in the context of improving at the system-level, despite ongoing policy and structural shifts. It is suggested that leaders should view their power through a different lens, as an enabler.

> Distributed leadership doesn't mean giving away your power. It means using your power differently, which means using your power to enable. I talk about it's like stepping up and stepping into your power rather than directing your power down."

In systems where no single leader or organisation has effective jurisdiction, stewardship depends on the clear articulation and active protection of shared purpose. Purpose provides the reference point for good decision making and creates the focus for different work to take place in its service. This, in turn, requires leaders who can communicate that purpose with credibility and authenticity.

> We need everybody aligned behind that mission. For that we need good storytellers and good communicators, people who can create a compelling narrative and do it authentically: The best regional leaders do that."

Authenticity and purpose

Authenticity in the pursuit of purpose is quickly recognised by fellow leaders and frontline staff. Equally, they are highly sensitive to blinkered focus on productivity and efficiency targets, where throughput and finance is implicitly prioritised over safety and patient or population outcomes. Such narrow pursuit is a recognised marker of vulnerable systems from a safety perspective (Reason, 1997). We would argue this applies more broadly: at best it breeds disengagement, and at worst, it creates an institutional / system wide pathology in which hazards remain hidden and failures are allowed to recur.

Authentic leadership requires reconnecting with personal purpose, not simply reciting a corporate mission. Why do I do this work? Leading from an authentic place, being open to challenge, willing to show vulnerability, and be genuinely curious, enables leaders to question both their own assumptions and those of others.

In doing so, they become part of the system change itself: shaped by it and shaping it, rather than merely directing it from a distance.

> [You need to understand] who you are as a human being and who you're becoming. I think this is vital to improvement work. I think sometimes we focus too much on the science and we forget about the interior world of people as leaders."

> "[There's] something quite innate about being human, that we don't consider enough. Particularly humans that work in the public for the pursuit of public service, where the motivations are intrinsic. There's something really quite critical about how that shapes how people work into that and work with the system."

Hard edges

In a context where improvement is sometimes caricatured as a world of scented candles and fluffy cushions (cf. Burgess & Downham 2025), it is worth being explicit: stewardship has hard edges. As with all effective improvement, it requires participation, sets clear expectations, and aligns system rules and incentives (Dixon-Woods et al., 2012).

The distinction between the hard edges of stewardship and those commonly experienced elsewhere in the system lies in how they are defined. Stewardship relies on edges grounded in system capability, co-production, and collaboration towards shared goals, rather than arbitrary targets and misaligned incentives that distort behaviour.

Developing a different skillset

Holding to purpose, enabling different work to happen, acting from clear principles, convening to address complex problems, and fostering collective accountability represent a significant shift in leadership focus for large systems and for leaders at every level. Our findings highlight that these six pillars are interdependent: they reinforce and enable one another. Stewardship, for example, cannot succeed in the absence of relational leadership, nor without the time, space, and resources needed to support it.

In some of the systems we studied, the skills of stewardship for system-level change are seen as equally important to more traditional improvement methodologies, resulting in associated changes to system-wide staff development offers.

> [Our system offer] for learning and improvement, is a 50/50 improvement methodology, and leadership for working with communities - really making our staff match fit to be stewards for the work."

In others, the challenge of change of scale, outside of immediate jurisdiction, suggests the same conclusion, that this is a different leadership challenge that requires a different skillset.

> Once you start to disperse, improvement asks outside of the body corporate, it's really difficult to mobilise resources, commitment and an accountability approach that drives the same scale of improvement."

2
The power of the ‘boundary spanner’

As noted earlier in this chapter, the fragmented and siloed nature of our systems show little sign of disappearing. While there have been moves towards more consolidated contracting, particularly in primary care, systems will remain fragmented unless the work itself changes, not just the contracting entity. Even within single providers, fragmentation persists; many organisations remain internally siloed, as many working in hospitals will readily attest.

Boundary spanning organisations:

Our interviewees consistently emphasised the importance of organisations and leaders who can span boundaries, between teams, organisations, agencies, and sectors. At the same time, they noted the increasingly narrow positioning of ICBs as strategic commissioners. This raises a critical question: if it is no longer the ICB’s role to span these boundaries, then who within the system will do so?

> “The vibe of the blueprint for the future of ICBs is for us to retreat into a more technical approach to commissioning, where we use the contracts as the main instrument for delivery, and I think that is far too simplistic.”

Despite acute trusts having resources, both improvement capability and financial, that far exceed those of other parts of the system, interviewees cautioned against assuming they should, or can, lead system level change. Interviewees cited the organisational perspective and specific accountabilities of acute trusts as significant constraints on their ability to act as effective system stewards.

> “[The improvement work will] be seen as a more distributed power across primary care, community cae voluntary sector that we work with and the acute setting – rather than it being convened by the acute trust.

Box 13: Boundary Spanners and Clinical Leadership

While research consistently links clinicians in senior leadership roles with improved outcomes, including higher quality care, lower mortality, and stronger organisational performance, becoming a clinical leader is neither straightforward nor a guarantee of different results. Perhaps telling is the recent move away from clinical leadership as a primary vehicle for reform, with clinical leadership requirements within ICBs reduced in emphasis and roles shifting from core leadership positions towards narrower sectoral or professional representation.

One explanation, particularly pertinent to this report’s focus on leadership more generally, is that when clinical leaders operate within systems where macro level conditions and incentives remain unchanged, they tend to make decisions similar to others. In such contexts, the same assumptions, constraints, and performance pressures continue to shape leadership behaviour, limiting the extent to which individual leaders, clinical or otherwise, an drive systemic change.

The boundary spanning individual:

Boundary spanning depends on relational work to bridge organisational divides. In systems that remain fragmented, relationships and trust become essential for working across the fragmentation. They act as the glue that temporarily holds the system together. Across the regions studied, there was a shared reliance on individuals who span organisational, professional, and sectoral boundaries: building trust, translating across silos and enabling collective sense making of the fractured whole.

Yet these roles can, objectively, also be seen as a sticking plaster solution themselves, they compensate for what is arguably an avoidably complex and fragmented system, rather than addressing the structural conditions that create fragmentation in the first place. Despite their importance in the current context, reliance on boundary spanners is itself a sign of system fragmentation, with progress depending on exceptional individuals rather than routine ways of working.

In a more coherent system, where the system of work is radically simpler (de-fragmented), genuinely integrated and incentives aligned, the need for constant boundary spanning would diminish. Until such fragmentation is designed out, systems will continue to rely disproportionately on a small number of leaders capable of holding multiple perspectives together across organisational boundaries. Our data also highlight an additional vulnerability – the boundary spanning capacity established through time limited programmes often dissipates when funding ends, revealing the limitations of this connective work and its embedding as a lasting system capability.

3
Managing the discomfort of co-production

All three methodologies studied, explored in the previous chapter, prominently feature co-production.

> [Co-production is] about broadening and deepening public services so that they are no longer the preserve of professionals or commissioners, but a shared responsibility, both building and using a multi-faceted network of mutual support."
>
> **Stephens et al 2012**

Peel back the layers of the ambition for a left shift towards true neighbourhood health, and at its core lies the principle of co-ownership of health. This reflects a growing recognition that health and social care can no longer be organised around 'doing to' or 'doing for' people and populations. This principle underpins globally recognised health systems such as the South-Central Foundation's Nuka system of care in Alaska.

Creating fairer, more effective, and more sustainable systems requires a move towards 'doing with', both in enabling individuals and communities to shape their own health, and in how we collectively tackle the system's most complex and intractable challenges. Co-production is a leading enabling methodology for this shared work.

Despite this requirement, interviewees highlighted that, in some cases, systems have become more distant, not less, from the people and communities they serve.

"It's about steps of removal - that's the danger of leadership both at government level and NHS board level, or in any level, is we have become so removed from the people that we serve."

Our data also showed just how far some patients and populations are from even engaging with health and care services proactively. Using the commonly used Patient Activation Measure (PAMS) as an example, some populations are not even at the starting line – requiring caution in the assumptions about the level of responsibility for their own health that some patient populations can take.

[Re Patient Activation Measures] So it's about seeing where people are up to in terms of how engaged they are with their own health and well-being and in NHS England we grade that as zero to five. But a lot of our work with communities has shown us that really people are often at minus five..... When people walk through the door of the NHS, they have at least some level of efficacy, self-actualisation to have even got through the door, right?

In England, the ongoing consolidation of ICBs into fewer, larger organisations means that the geographies they serve are becoming increasingly expansive and far from homogeneous in their needs. While consolidation may offer certain advantages, it also raises important questions about proximity, responsiveness, and local understanding.

Unless Neighbourhoods and Places are given genuine agency and mandate, something that is deceptively difficult in a system more accustomed to top down control and accountability, there is a risk that leadership becomes more distant from the populations served. In some ways, even the simpler model in Scotland, that does not have the purchaser / provider split, still faces the same challenges. With some health boards serving diverse populations across extremely large and challenging geographical areas.

In both cases, this scale may, in turn, weaken the system's ability to respond to local context, support equity, and sustain meaningful dialogue and co-production with communities.

Discomfort

Co-production, relies on the removal of corporate norms, its inherent shifts in power dynamics and the need to surface and address outrage and frustration (Malby 2014) with how things are. This can be a challenging experience.

"And some people are just really uncomfortable, aren't they? Of co-production and acknowledging that they don't have all of the answers."

In a system characterised by perpetual urgency (driven by the clocks of change), co-production inevitably takes time and can be dismissed as inefficient when judged against more traditional, top down approaches.

"Recognising that, well, this is just the start, we're going to have to bring people in with lived experience to help shape this. And you know, all that stuff just takes longer. But if you're going to do it, that's the way to do it."

The view that co-production is more time consuming than traditional quality improvement approaches is misguided. Co-production is not simply a slower route to the same outcomes; it is a different form of work altogether, designed to enable shared ownership, deeper understanding, and transformational change rather than incremental improvement. When judged over the long term, it can in fact save time by avoiding rework, resistance, and missed outcomes.

> “Better to do the ‘right thing wrong’ than the ‘wrong thing right’, because ‘doing the wrong thing right’ only makes the system more efficient at failing.”
>
> **Russell Ackoff**

Co-production is not simply about collaboration across sectors, professions, or organisations; it is inherently about the people who use services, and the communities they belong to. It is a deliberate methodology that goes beyond offering a voice, seeking instead to involve people meaningfully and from a position of equity in problem framing and design. As such, the starting conditions matter.

> [Co-production] couldn’t just rest in the health side of the system, it had to involve all partners, social care, voluntary sector, but also people who live here as well. “

Institutional and corporate norms shape power relations from the very beginning. This can be as subtle as smart suits and lanyards signalling who belongs and who does not, or as substantive as decisions about whether people with lived experience and relevant skills are brought into genuinely influential roles with structural equity.

Box 14: Nominal Value and System-Level Improvement

Meeting the specification but missing the point – the importance of co-production

Nominal value refers to the target value a service should achieve (Taguchi, 1986); the point at which it most effectively meets the needs of the person being helped and, in public services, contributes to wider societal value. Differences in who defines nominal value help distinguish improvement in bounded settings, such as secondary care, from system level improvement. In manufacturing, nominal value is defined and controlled by the producer, with quality judged by proximity to specification. Applying this logic uncritically to health and social care is problematic.

Across health and care services, it is possible to meet contractual specifications, clinical standards, or activity targets while still failing to deliver value as experienced by individuals and communities. When nominal value is assumed rather than explicitly understood, improvement efforts tend to focus on throughput, compliance, and efficiency. Over time, this leads to over treatment, poorly targeted interventions and persistent failure demand.

In secondary care, nominal value remains largely determined by professional and organisational judgement. Even where shared decision making is promoted, technical complexity, standardisation and patients deferring to clinicians often limit the influence of patient preferences on what is delivered (Wennberg, 2002).

By contrast, in system level improvement spanning primary, secondary, community, and/or social care, particularly for people with complex or socially determined needs, nominal value is inherently co-determined. It emerges through relationships, across organisational boundaries, and through meaningful co-production with individuals and communities. This work takes time and cannot be fully specified in advance. Without it, systems risk becoming increasingly efficient at delivering activity that meets a specification, but misses the point.

Co-production is a test of leaders and their capacity to engage with humility and genuine curiosity. Transformational change comes from challenging underlying assumptions, and effective co-production creates the conditions in which those assumptions can be surfaced, questioned, and re-examined. As W. Edwards Deming, John Seddon and others have long argued, systems are the product of ideas and assumptions, each plausible and coherent in the abstract. Unless those assumptions change, the system itself will not.

> You have to be prepared to go into that with a really open mind, especially if you are genuinely focused on what patients want, because what patients want is often not what we think they need".

Relationships with the public, expectations and alignment with left

Across all the systems studied, leaders described a shared ambition to shift left, moving away from a reactive focus on illness towards wellbeing, prevention, and co-ownership of health. However, interviewees were also aware that public expectations, shaped by long standing system priorities, political narratives, and media focus, are often oriented towards rapid access to reactive services, particularly GPs and hospitals.

"We know that the public is very interested in waiting times and those sorts of models. So, in a way, that just keeps reinforcing what we've always done."

This misalignment underscores the scale of the challenge: shifting not only services and systems, but public understanding of what health and care systems are for.

Working more closely with populations, therefore, emerged as central to system level improvement. It is critical not only for delivering strategic commissioning, through a better understanding of need, demand, and population health, but also for the effective realising of the new models of care envisaged in national planning guidance. Yet several interviewees reflected that the starting point is one of distance rather than connection.

4
Building relational capital

> [If I was giving advice to myself 10 years ago] it would be build your relationships…"

In systems typified by fragmentation, relationships play a significant role. At the sharp end of operational management, our data highlighted the value leaders placed on a foundation of good relationships.

> Good relationships mean that everybody's on a system call together, saying, what can we do to help? What do you need? How can we help? It means I can ring the chief executive, or the local authority, and say, I know it's not really your area, but what can you do? And they'll go, right, well, we can do this. We can get communities to do this. You can go to the community services provider and say, could you squeeze any more beds in there? And people respond, and people action, and people do."

Interviewees consistently identified relationships, particularly the trust and shared values they embody, as the glue that enables work to span functional and structural boundaries.

"A good relationship is one that makes a difference for the people that you're trying to serve, right?"

"While not necessary for improvement work, I think that's what good relationships look like on a daily basis, that when people ring you, they trust that you're doing it for the right reasons."

Despite the value placed on relationships and relational work during the interviews, many participants described difficulties in having sufficient resources to create and maintain these connections across systems. In many cases, they noted that a lack of relational working directly impacts the effectiveness of change efforts.

> So you don't have any of those relationships. You don't have people thinking together. There are so many examples of this, particularly if you think about the interface between acute and community care, primary care, secondary care. What we see happen over and over again is either acute organisations create some kind of shadow [duplicate] service within their own structures to try to plug a gap with community, or community services design a system that doesn't interface properly with acute. And then it's clunky to get people in and out of it, and people get stuck. And that's because they haven't thought together, because actually all the meetings people have are separated by acute, or community, or mental health."

The extent to which the capacity for relational working has been diminished was, in some cases, stark, especially given the importance of integrated responses to many complex conditions.

"[We have reached the point where] the only space in your mental health service where social workers meet nurses is in a meeting called delayed discharge planning."

Investing and enabling relational working

Where time and space for relational working are minimal, leaders suggested that systems default to transactional informational exchanges and the bare essentials of operational management. While necessary, this level of interaction is not equivalent to the depth of relationships required to enable transformational change.

To enable relational working that leads to change of form (to trans-form) and be sustainable, our data highlighted the importance of deliberately creating time and space, whether face to face or virtual, where open and frank conversations can take place. Such convening efforts are sometimes derided or undervalued, seen as insufficiently action oriented, overly 'reflective', or emblematic of a softer form of leadership when compared with more visible, directive leadership. Interviewees were well aware of this perception.

We have relationships that allow minimum information flow for safety purposes, but not change."

However, far from being forums for simply 'admiring problems', our data suggest that these convening spaces were central to making progress at system-level. They were actively used to surface, test, and work through some of the most persistent and difficult system challenges, including governance arrangements, capacity constraints and back office support. In this sense, relational leadership work was not an alternative to action, but a necessary for it.

"We've created a space where you can have those open and frank conversations – in a sort of, you know, I wouldn't call it a 'safe space', because that can sound a bit soft and fluffy... but rather a space where it's OK to disagree. That's been really helpful...Where we stumbled a bit was where those conversations didn't happen, where people still held slightly different views, or where we didn't really have the right governance, in place to actually have those conversations and get those issues out on the table. And that's certainly something we've learned."

Investing over time

Developing meaningful and effective relationships takes time, often more than is acknowledged. Our in-depth exploration of the Engineering Better Care approach used by Lancashire and South Cumbria (see Section Four) outlined how long it can take for people to feel comfortable working together. This was particularly evident given the significant inequalities in management infrastructure and capacity across sectors and settings, which further slow the availability of leaders to engage in the development of shared ways of working.

"The 18 months of Engineering Better Care was a real foundation builder, not just in terms of understanding the challenges around frailty and what we need, but also just getting the people to be comfortable working together."

The impact of staff churn

By their very nature, relationships built on trust do not form overnight; they require time and continuity. Interviewees described how this is frequently disrupted when leaders of initiatives are pulled away to other priorities – as discussed earlier in relation to time-bound programme-based boundary spanning roles and the impact of system restructure and organisational rationalisation.

> We struggle to create the conditions [for change]. We can create the conditions, but it's much slower. And then of course, when it's much slower, the chances are that it falls away because people leave. There's a critical person involved in this project. They move on to something else. You know, it slows it down again."

Box 15: Contested Convening – Relational Work in Clock-like Worlds

Our interviews revealed a clear unease around convening. While it was widely seen as essential for system level improvement, interviewees noted that both the term and the practice have increasingly fallen out of favour – particularly within NHS England, and, in practice, also in Scotland following the tightening of budgets and thus capacity that enabled convening to take place.

This discomfort is often attributed to a shift towards harder structural accountabilities, tighter control, and sensitivity to the cost of leadership time spent on activity that does not yield immediate, tangible outputs. However, scepticism was also evident among regional and provider leaders. For organisations not effectively incentivised to prioritise system working, convening was frequently viewed as unproductive:

"Dragging people into a room and attending a lot of meetings that don't add value and don't have any outcomes. It just gets in the way of things."

This tension exposes a clash of our two system logics. From a clock-like perspective, within a resource constrained, inpatient focused system oriented around delivery, standardisation, and measurable outputs, convening appears inefficient. From a cloud-like perspective, convening is not a distraction from the work; it is the work. Effective system leadership requires enabling sense making, alignment, and the shaping the conditions for genuinely different work to happen.

5
In service of the system

> What's good for the system may not necessarily be good for the individual organisation."

In the preliminary section of this chapter, we discussed the systems leadership principle of changing the focus from directing work to enabling different work to happen. Central to this is seeing and simplifying systems, the notion of being able to go beyond reactive sticking plasters, and to address root causes by creating more effective responses to need (doing better things).

> When you look at the system-level stuff, we were really thinking about complex adaptive systems, systems thinking, systems engineering, and that shift from how do you become a process improver to how do you become a systems thinker."

"So we end up investing in a very piecemeal and fragmented way and a whole load of stuff that is targeted on that bit of the problem rather than taking a holistic view of what that population needs".

From sticking plasters to root causes

Our data indicated that across health and care systems under pressure, there was much reactive fire-fighting problem-solving. Often focusing on problems of the moment at single-patient level and involving extremely senior leaders. Diverting their attention away from the collaborative work of addressing root causes.

Other examples described the rushed application of clock-like sticking plasters to what are, in fact, complex problems what require cloud-like appreciation and approach.

> So there was a diktat that came out... saying we need to tackle sickness absence in our workforce, and that we should have one sickness absence policy across the whole system, rather than lots of different policies...So that was the task. I pick it out because it's quite a simple example, really, of treating the symptom, not the cause. Do you know what I mean?"

Even at a highly strategic level, leaders noted that despite stated left shift intentions, relentless attention to reactive priorities, such as delayed discharge, A&E performance and elective waits, absorbs leadership time and capacity. While important in their own right, this focus consistently diverts attention away from the urgent and transformational task of shifting the system left into a more proactive and integrated space.

"[The focus on elective care waits] is sucking the life out of left shift."
Supplementary interview

Moving to re-design

Our interview participants described a number of mindset shifts that they saw as critical to enabling fundamental redesign to address root causes, rather than incremental tweaking of existing models of care. These mindset shifts were identified from the very start of improvement efforts.

Understanding the impact of tight programmatic approaches to transformation

Some described improvement work intended to be transformational, beginning with the implicit assumptions of bounded, programmatic, arguably clock-like, approaches. All of which subtly constrained ambition and approach from the outset.

> We'd been asked by one of the executives to lead it, and it was always seen as an improvement programme rather than a redesign of frailty."

Viewing risk differently

The second mindset shift concerned how risk is understood in change efforts, moving from managing point risk to considering system risk. Interviewees described risk discussions as predominantly acute centric, a framing that reinforces existing system design. When attention is consistently focused on protecting hospital front doors, systems inevitably continue to organise themselves around that priority, reproducing familiar patterns and outcomes.

Broadening perspectives on risk:

> So if we're going to put an idea forward and we're trying to mitigate any risks that the change might have, we need to balance it. At the moment, what we always tend to do is ask, is this going to put more pressure on the hospital? What we actually need to do is balance that risk across the whole system and look at it from each partner's point of view. We always look at things like: is it going to affect the front door? Is it going to slow down discharges? But instead, we need to ask what the social care impact would be, or the impact on community services, or what the OT risk is. And not just risk in terms of numbers, but also the impact on staffing – things like workforce burden as well."

"System-level change takes longer by its very nature. You've got to get everybody together, then you've got to create time in understanding different perspectives..."

Broadening perspectives on risk, and more generally, is recognised as more time-consuming – a necessary evil if there is real intention to get to root causes. Other interviewees voiced the need for leaders to aim beyond point of care risks, to addressing their root causes, which they argue are generally systemic in nature:

"It's no longer good enough just to look at how we make particular point of care risks go away. We have to look at the whole system that creates those point of care risks."

Problem framing

The third mindset shift identified in the data pertains to how problems are framed. Our leaders showed awareness and skill in recognising problem types, and the importance of corresponding approaches to understanding and reframing problems.

> So I think there's something about the clarity of direction as a commissioner on what you want providers to do, that's route one. That lends itself really well to [respiratory for example, where intervention is clear], but not CAMHS for example, that's more complex and requires more of a problem framing approach."

As described in our narrative on the leadership pillar of co-production, how problem framing is done was a common theme in the data. Some interviewees advocated that a highly participatory approach was more effective in the long run.

"My belief is that a participative method (such as world café) will help to surface and address the problem effectively and efficiently [better than banging heads together]."

Moving away from winners and losers

Much of the performance management, regulatory, and commissioning activity in health and care systems is built on the assumption that every part of the system must be optimised. This typically shows up as high capacity utilisation and ambitious, tightly set targets each provider is set and managed against. As discussed earlier in this report, these conditions incentivise organisations, across providers of all types and sectors, to look inward rather than outward. Leaders described the need to move away from this logic, recognising that for the system as a whole to improve, not every part can, or should, be locally optimised.

> "A system must be managed. It will not manage itself. Left to themselves, components become selfish, competitive, independent profit systems, and thus destroy the system."
>
> **(Deming 1993).**

Box 16: Performance Management and the Sub-Optimisation of the Whole

W Edwards Deming, one of the three great quality thinkers of our time, identified the dangers of individual optimisation of components of systems as a key barrier to system improvement. Echoing conclusions later articulated by Russell Ackoff, **Deming argues that local optimisation of parts will result in global loss for the system.**

From a Deming and Ackoff perspective, this is not a failure of individuals or organisations, but a predictable consequence of system design. The conclusion is that some sub optimisation of parts is often necessary for optimisation of the whole; a conclusion that also underpins core Flow theory such as Goldratt's Theory of Constraints. Components must sometimes cede local efficiency, autonomy, or short term gain in service of clearly articulated system purpose.

"It's always this tension, what's good for a system may not necessarily be good for an individual organisation and it's how you navigate all of that."

These insights are particularly salient in large, multi organisational systems, such as health and care, where it is the regimes of performance and finance themselves that incentivise local optimisation. Providers act rationally in pursuit of their own targets and budgets, yet collectively generate system fragmentation, delay, and waste.

The need to develop the leadership skills and capacity for systemic work

The conclusion here is leaders of change within large systems need the skills to create and act upon a systemic view of the work. As also touched on in our narrative on the other pillars, this often starts with co-production to radically shift the perspectives that often re-enforce the status quo. This systemic view of the work will go some way to challenging the very foundations of our models of care, that of the well-established systems and mindsets around performance and contract management.

Set against these leadership requirements, in the English NHS, the organisations seemingly best placed to take a systemic view, Integrated Care Boards, are refocusing on strategic commissioning. Whether this will enable the kind of system leadership required is open to question, not least given the scale of recent headcount reductions and the limits of strategic commissioning as a lever for change some perceive. It also remains unclear whether alternative lead organisations, such as acute trusts or emerging multi neighbourhood providers (MHPs) and integrated health organisations (IHOs), are able or positioned to come together to undertake this work instead.

In the face of this structural uncertainty, the only lasting approach is for leaders to explicitly resist being defined by this technical context. Instead, they must use the relational working spaces they have created to divert collective attention away from micro-detail and towards living with uncertainty, broadening perspectives, and managing and enabling the essential systemic trade-offs required to enable a truly integrated system. The painful reality is that, in this contemporary context, this essential leadership work is in spite of what is seemingly valued or resourced for.

6
Amplifying and influencing

Given the widespread agreement among leaders about what is not working and why, an obvious question arises: why does so much remain unchanged?

Externally imposed conditions of management

One reason is that many of the conditions shaping how work is done are externally imposed. Even large regional systems vary in how much agency they believe they have to work within or challenge them.

More fundamentally however, these conditions, such as commissioning, accountability, financial settlement, management accounting, performance management, and resource allocation are each rational responses to particular stakeholder demands. Viewed through a clock-like lens, each makes sense in isolation. The problem lies in their combined, system wide effect. When layered together, these rational mechanisms interact in ways that produce stalemates, pulling leaders back into clock-like optimisation of parts and frustrating the cloud-like work of system level transformation.

"What you've got is systematic barriers in the way of achieving that and a lot of them sit in the dull stuff. How we do governance, how we do our commissioning, how we look at our data and evidence. So they sit in these dull spaces, which the highly excited motivational people don't like looking at."

The impact of financial management routines and resulting stalemates

In both the core and supplementary interviews for this research, participants identified financial stalemates as one of the most significant barriers to system-level improvement. In some cases, this reflected the previously discussed notion of winners and losers, where improvement in one part of the system resulted in a detrimental change to the financial position of another. This often reduced engagement from organisations that perceived themselves as financially disadvantaged.

Other examples related to the clock-like, time bounded nature of financial settlement negotiations between ICBs and, in particular, acute trusts. These processes are sensitive, given the proportion of system spend accounted for by acute trusts and the level of financial scrutiny and performance management both parties face. Many ICBs seek changes to settlements to release small but strategically significant funding from acute trusts to support transformational left shift strategies. Acute trusts, given the pressures and expectations they operate under, are often reluctant to agree to less funding.

These negotiations operate within externally and centrally determined timeframes, a clock-like context returning to our core metaphor, where failure to reach agreement brings escalation and external scrutiny. An unintended consequence of these hard-edged timescales is that the perceived risks of delay settlement outweigh the risks of muted transformational change.

Efforts to identify and validate new models of care are frequently undermined by deeply entrenched financial management accounting systems within our organisations. With their clock-like focus on technical accuracy and compliance, these systems prioritise control over learning and obscure the true costs of ineffective care. This helps explain why system costs continue to creep upwards, despite relentless and often brutal cost-reduction efforts. As a result, they reinforce the very behaviours and organisational structures that national policy seeks to change. **See Box 3** for examples of systems seeking to overcome these obstacles.

Collective focus and amplification

To reiterate an earlier point, these behaviours are rational responses to the system conditions leaders are operating within and are therefore predictable. Leaders across the system described shared frustration with the resulting stalemate, which cannot be resolved by individual organisations acting alone. While systems approach these negotiations in different ways, this remains a stark example of the impact of clock-like external system conditions. Breaking the pattern requires system leaders to amplify and apply collective voice and focus to influence these system conditions, which requires sustained relational working. Working together to reshape the wider financial and regulatory conditions that sustain it. This is difficult for any single leader, but more achievable when pursued collectively. The enabler for this, as with previous pillars, is the creation and sustained valuing of relational working spaces for system leaders to convene; where agenda is determined by the group rather than externally exposed.

Collective ownership of system risk

Some described their work as shaping systems, emphasising the need to address underlying system conditions. For example by moving towards more collective ownership of financial and performance risk.

> So do we [leaders collectively] have a shared vision about what good care looks like, what good outcomes look like, but also what does a good economic model look like? And I think we're starting to get into that a little bit now with our local authority colleagues. That enables us to look if we can intervene earlier from both the health and social care perspective and stop people going up that care escalator. To reduce costs for everybody in the longer term."

"And I think that's going to come down to resource. About how do we share and pool resource between us? So we've started to get, I think, a bit more clarity now with the Council about section 75 and some of the pooled budgets that have historically just been there forever and nobody's really understood."

Others, as illustrated below, viewed these conditions as largely intractable and noted the understandable risk aversion of many parts of the system. From this perspective, the primary way to break the deadlock was seen to be through the provision of additional funding.

> I think we need to be given the resources to be brave, and this is the trouble. People think around the edges of improvement because people go, we haven't got the money, and we're too scared to make a radical change. We're too scared of taking resources out of A&E."

Building collective ownership of risk is often treated as a structural exercise, for example through the creation of integrated health organisations or multi neighbourhood providers. Yet even within a single organisation, achieving genuinely shared risk requires confronting the same system conditions and clock-like approaches that we have discussed previously, which focus on 'point' optimisation and performance management.

As we noted earlier in this section, ask many who have worked in a large hospital - being part of a single provider is no guarantee of integrated working; organisations can be structurally unified yet operationally fragmented. Collective ownership of risk therefore depends not just on organisational form, but on shifting the underlying clock-like system conditions that continue to pull leaders and teams towards managing parts rather than stewarding the whole.

Section 6

Four Key Lessons

Why This Work Matters
Of Clocks and Clouds
Intractable Elephants
The Northern Triangle
Leading the Shift
Four Key Lessons

Four key lessons:

To wrap up this report, we want to share four key lessons resulting from this research:

1
Recalibrating leadership approaches – working with clocks and clouds

Recognising the interplay between clock and cloud-like system archetypes, and leadership approaches, gives leaders a powerful lens for addressing challenges. It helps explain why certain interventions succeed while others fail, and why tensions between leadership and improvement perspectives so often arise. Rather than judging clock-like or cloud-like working as right or wrong, the leadership challenge is to diagnose the nature of the problem, the system at hand, the dominant leadership ideologies and then respond deliberately. This means applying more directive, clock-like methods where the work and challenge are defined, transactional, and sit within effective jurisdiction, and adopting more relational, cloud-like approaches where complexity, uncertainty, limited effective jurisdiction and interdependence dominate.

2
Focus on optimising the system over the individual provider

Our healthcare systems have developed colossal infrastructure dedicated to the specification, monitoring, performance management, and measurement of individual providers. This architecture is predicated on optimising providers in isolation and reinforcing a sense of winners and losers, something leaders are acutely aware of. It is also a key source of the gravitational pull towards the right shift described in this report. It acts as a (dis)integrating force within large systems and contributes directly to financial stalemates. Until system outcomes are prioritised over individual provider performance, enabling organisations to sub-optimise in service of better overall system outcomes, meaningful system-level change will remain elusive.

3
System-level change ≠ QI at scale

Over the past decade, there has been a substantial and welcome expansion of quality improvement (QI) capability, particularly within acute trusts. While valuable, this has also created inequity when system level change is required, as not all parts of the system start from the same place. More importantly, this report shows that system level improvement is not simply QI conducted at scale. It is a different species of work, requiring different forms of leadership and architecture. This distinction cautions against assuming that scaling QI approaches, largely rooted in clock-like logics, is sufficient for addressing system level, cloud-like challenges and contexts.

4
You cannot micro-manage an elephant

The ancient parable of the blind men and the elephant illustrates how different viewpoints, entirely sensible from individual perspectives, can be fundamentally flawed when applied to the whole at the system-level, with the predictable disagreements that ensue. Whether it is the gravitational pull of acute targets, the uncomfortable truths of social deprivation, the paradox of muddled jurisdiction, or the inequity of improvement capacity, our data suggests that these “intractable elephants” are often misinterpreted as individual provider failures rather than symptoms of the system itself.

While many performance management and scrutiny mechanisms are rational in intent, they often create just an illusion of control – while inadvertently constraining the very systems they are intended to improve. A genuinely transformational step lies in rebalancing the vast effort and infrastructure focused on intensive, granular oversight toward the difficult work of shaping the system conditions. Enabling different, more integrated and left shift work to happen.

This shift is politically and professionally challenging. It runs counter to expectations of neat judgements and rapid, individualised accountability. However, it is precisely this transition, from attempting to fix the parts to being a steward in service of the whole system purpose, that holds the greatest promise for liberating and accelerating meaningful system-level change.

Final reflections and implications for further research:

This report is not an academic exercise setting out what systems leadership should look like. It is a rigorous, inductive analysis of the lived experience of leadership, grounded in what leaders are actually doing as they navigate intense operational and financial pressure. The findings surface a compelling set of emergent insights that illuminate the real and persistent tensions of system-level change in a challenging contemporary context. The metaphors of Clocks, Clouds and Elephants provide a memorable way to frame and revisit these issues, while the Six Pillars of Leadership for System-Level Change offer a lens through which to understand the behaviours and leadership focus required to deliver system-level change.

We did not set out to offer a neat recipe for leading system-level change, nor should we have. Drawing on the example of the Northern Triangle, where improvement leaders from different geographies come together regularly to share their experience of leading system-level change, this report illustrates the value of continuous reflection and collective learning in building system leadership capability over time.

It would be a mistake to assume that the requirement for relational leadership and system stewardship that form the core of leading system-level change is without hard edges, or that it amounts to a world of fluffy cushions and scented candles (cf. Burgess and Downham, 2025). System-level change requires disciplined governance and assurance. At the same time, those governance and assurance arrangements must themselves be open to critique and challenge, to ensure they are fit for purpose and do not inadvertently constrain this work. Without this, relationally led change risks being reduced to yet another tick-box exercise.

As one senior leader observed, the challenge is not how to persuade regions or countries to change, but how to support them and their system leaders to create the conditions for change. This includes protecting time and capacity for improvement, using data to provoke curiosity rather than solely to provide assurance, and resisting the pull back towards provider-by-provider performance management.

Future research should focus on how to lead the intentional reshaping of system conditions to support left shift – a recalibration of clock-like mechanisms, thinking and behaviours. This includes exploring how national and local frameworks can be re-imagined to protect the time, capacity, and governance structures required for relationally led change to take root. Concurrently, longitudinal studies should examine how cross-system learning collaborations, such as the Northern Triangle, and peer-learning networks, generate new thinking, shield leaders from burnout and sustain resilience during prolonged financial crises. Ultimately, the priority for future research is not to invent new ways of restructuring but to discover how to build environments where system stewardship can be more effective despite the pull of clock-like constraints.

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