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Towards a refined conceptual framework of systems leadership

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Abstract

This paper forms part of an exploratory doctoral research study which aim to explore whether a systems leadership approach is helpful in enhancing patient voice. The focus of this developmental paper is on neglected but important part of systems leadership which is power. The research findings imply that power relations influence the enactment of systems leadership but have been downplayed in the literature linked to systems leadership. This research, therefore, aim to address this gap by conducting an embedded case study of a multistakeholder partnership which aimed to build a collaborative partnership between the health organisations and patients in the region. The data was collected over two years through semi-structured interviews, non-participant observations and documents analysis.

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Introduction and background

The research on collective approaches of leadership is now well-established and wide-ranging and different authors explored and investigated it both theoretically and practically and there are a number of comprehensive reviews in the area of collective and plural leadership (e.g., Ospina et al., 2020; Denis, Langley and Sergi, 2012; Bolden, 2011). Although collective approaches conceptualise leadership as a collaborative and relational processes based on social networks of influence, they often consider power as neutral and usually conflict free (Denis et al., 2012). Therefore, little importance was attached to the role of power and the relationship between power and leadership in the relevant literature (Foldy and Ospina, 2022). While these concepts gained some attentions in recent years, most systems leadership literature (e.g., Senge, Hamilton and Kania, 2015; Dreier, Nabarro and Nelson, 2019) particularly fail to address power and barely touch upon dynamics of power and consequently conflicts and tensions it may cause (Denis et al., 2012). This is series omission in the literature and this research addresses this under-researched aspect and its' consequences on enactment of leadership. This study, therefore, suggests that power has strong impact on systems leadership and can enable or constrain the enactment of systems leadership.

Systems Leadership has been defined by Ghate et al. (2013, p.6) as “ the concerted effort of many people working together at different places in the system and at different levels, rather than of single leaders acting unilaterally”. What distinguishes systems leadership from other social approaches of leadership is that it offers a systemic perspective, founded on principles of systems thinking (Goss, 2015). It is best considered as a mind-set rather than a skill and may well co-exist alongside other leadership approaches, whereby different people contribute to the overall leadership process (Ghate et al., 2013; Goss, 2015). Leadership of this kind must be both shared and distributed and based on a willingness to negotiate and accommodate rather than command and control” (Ham and Murray, 2015, p.22). In fact, systems leadership calls for a fundamental rethinking of the nature and purpose of leadership –from centralised and hierarchical to dispersed and inclusive.

The notion of ‘systems leadership’ is a relatively recent development, driven in particular by practitioners and developers in health and social care (Ham and Murray, 2015; NHS Confederation, 2014) to “enable collaboration between agencies to deliver integrated care” (Ham and Murray, 2015, p.21). It is advocated to be “vital to delivering integrated care, transforming services to address the financial and demographic challenges facing health and social care, and tackling health inequalities” (NHS Confederation, 2014, p.6).

Research methodology

To operationalise my research, I have identified a research site which was a Patient Leadership Initiative (PLI) that aimed to build a collaborative partnership between the health organisations and patients in the region. In doing so, they brought together five of the main health care providers in one of the large cities in the UK, seeking to bring the voice of the community to the centre of the health system in order to influence the way services were designed and delivered.

The main aim of PLI was that both health professionals and patient leaders who participated the initiative co-design and co-facilitate the PLI as it progressed through working in collaboration and bringing in different perspectives. It was aspired that in this way and

through group learning larger aims such as tackling power inequality, promoting patient voice and eventually influencing the health system by being part of the design and delivery of the healthcare will be achieved.

There were also a number of other collaborative initiatives that were founded by the stakeholders involved in PLI and the patient leaders were encouraged to join these initiatives to take a practical role. Four of these initiatives were selected providing that PLs who were members of the PLI were participating in those initiatives. Each of these initiatives developed their own strategy to get engaged with patient leaders in order to include their voices and improve care.

This research, therefore, is an embedded case study which means that the PLI was the overarching case, and the four units were the embedded sub-units. The use of embedded design provided an opportunity for an extensive research as well as providing and enhancing insight into the overarching case (Yin, 2014). This research is conducted in two phases which will now be discussed.

1- Developmental phase (overarching case)

- Time One: A five-day training and development workshops
- Time Two: Attendance at nine bi-monthly forum meetings; connections made to local involvement activities.

2-Practical phase (Sub-units of analysis)

- Joining practical initiatives available at different levels/parts of the health system in order to influence service design and delivery across the health system.

Developmental phase

The overall emphasis of PLI was to foster a spirit of co-production, with members developing their own way forward as much as possible. Data was collected at two points in time during this phase, so it will be discussed under Time One and Time Two as to follow.

1. Time One: patient leaders attended five full-day training sessions over 4 months. Training was delivered by an external facilitator, focusing on building collaborative and communicative capabilities and skills and with the intention of equipping participants with the necessary skills, knowledge and confidence to participate in discussions, bringing the voice of the community into the system and influencing healthcare decision makers.
2. Time Two: Following these training sessions, patient leaders were invited to attend bi-monthly face to face meetings/forums which were intended to provide an opportunity for collaboration, shared collective learning, shared decision making and discussing concerns. This allowed them to reflect on what was going for them and what they learned from it and what they would do next. This also revealed power dynamics, conflicts and tensions that affected collaboration and communication within the group. Time two lasted about a year and half.

Considering the length of the PLI, interview conducted at two points in time. In total, 28 interviews were conducted in this phase. The reason for this was to capture the journey the research participants had been through and to capture shifts in their perceptions, diversity of

the group, power, conflicts, and tensions. As Yin (2014) proposes, collecting data at two or more different points in time helps revealing the changes and shifts occurring over time. Interview focused on both patient leaders' and health professionals' experiences of collaboration, communication, engagement, relationship building and power inequality.

The researcher attended nine workshops and forums in total at Time Two. Observation notes were taken at each of these events to see how collaboration, conflicts and relationships occurred in practice. Observation focused on the practical aspects of participation. What did happen when people collaborate and communicate? What was the nature of relationship between health professionals and patient leaders? What kinds of actions patient leaders were engaged as part of their involvement? (Boeije, 2010). So, the data gathered through observation provided wider and broader perspectives in answering research questions as it helped exploring what happened in the forums, who was involved and when and why things happened. The researcher also received supporting documentation such as meeting agendas and terms of reference to complement interview and observational data.

After being recruited, going through series of training and development workshops and forums, the patient leaders were expected to develop their own capacity to communicate, influence and lead in different collaborative healthcare initiatives ran at different levels of the system including strategic, clinical and operational/non-clinical. This formed practical phase of PLI which I will explore in the next section.

Practical phase

After PLI had been running for some months, patient leaders were encouraged to take a leadership role and to speak on behalf of a range of communities by participating in different available initiatives. In total, five patient leaders became engaged in four different initiatives that formed the four embedded sub-units of this study. These were one clinical, one strategic and two non-clinical sub-units. In total, 24 interviews were conducted in this phase.

The way these units were related to PLI was that they were formed and run by the stakeholders involved in the PLI. The selection of these units of analysis was done in consultation with PLI facilitators/coordinators provided that, first, at least one patient leader was engaged in that unit. Second, it required people to work in a collaborative way. Third, it was relevant to wider current public health policy that aims to engage communities in their own healthcare.

In this study, I have used Braun and Clarke's (2006) thematic analysis framework to analyse my data, because it is well-suited to the rich, qualitative data collected and provides a robust and systematic approach to identifying and refining themes. I identified a number of key themes which are establishing a collaborative relationship, embracing diverse perspectives and shifting power inequalities. The findings reaffirmed the importance of building collaborative relationship and developing a learning mindset highlighted in the initial conceptual framework of systems leadership (Dreier et al., 2019; Senge et al., 2015). However, the role of shifting power was lightly touched in the literature review, and it was identified to be crucial in PLI which had influence over the other two key themes. The conceptual framework was also used as an analytic framework to interpret what research participants were saying about systems leadership, collaboration and power inequality within the PLI.

Preliminary Findings and Discussion

The most overriding aim of systems leadership (as one form of collective leadership) is not to maintain the status quo but working to transform the power relations and disturb the system in order to create alternative models of power within new structures. Thus, this study implies that the realm of power (visible, hidden, and invisible power) required to be identified and challenged (Batliwala, 2011) and an alternative models of power should be coconstructed to make the practice of power visible, democratic, legitimate and accountable, at all levels (Batliwala, 2011). As domination (power over¹) and powerlessness (power under²) are two sides of the same coin, and are interrelated, thus similar attention should be given to powerlessness (power-under) within any change movement (Batliwala, 2011, p.39) such as PLI in this study where most participants experienced powerlessness. Each of these manifestations of power could be challenging to systems leadership. Hence, this study suggests that in order to move towards alternative models of power, there is a need to shift from power over and power under to developing “power with³” and “power within⁴” in systems leadership initiatives including PLI. It is suggested that this might increase the possibilities of people from the margins taking up leadership and practice their voices.

The findings imply that the PLI claimed to be set up based on co-production that did not fit with hierarchical structure and posed some challenges to established norms and power dynamics (Seale, 2016, p.22) already existed in the healthcare system. Co-producing healthcare has become an increasingly popular way of incorporating patient voice into the system by using a combination of service users and providers working in collaboration to design and implement services (Pestoff, 2006) rhetorically. However, it has become challenging when it came to practice within PLI as the focal point of coproduction is that health professionals and patients work in collaboration to design, implement and evaluate services (Pestoff, 2006), being in equal partnership and having equal power (Boyle and Harris, 2013) which did not fully occur in PLI. The findings indicate that there was a gap between what HPs aspired to do and what happened in practice within PLI. This study, therefore, highlights the need for post-heroic leadership to develop “a different mental model of how to exercise power and how to achieve workplace success and effectiveness” (Fletcher, 2004, p.656) in multistakeholder partnerships.

Research Contributions

Systems leadership has been widely adopted in healthcare in the UK as a way of improving patient engagement and patient voice with little attempt to acknowledge underlying hierarchy

¹ Power over derives from direct power and positional / assigned authority, the control (direct or indirect) over the human and other resources within the process, and the way such control can very quickly slip into domination; also control over the use and deployment of resources, decision-making, etc. (Batliwala, 2011, P.38)

² Power under emerges from powerless rage, which unleashes both the destructive power of sabotage and subversion that is often unconsciously deployed by those who have experienced severe oppression or trauma, as well as the constructive power for building movements to confront and overcome injustice. This helps us understand why people who have experienced abuse, oppression and trauma, when they gain power (especially power to and power over), often become abusive, authoritarian, and oppressive themselves. (Batliwala, 2011, P.39)

³ Power with – the effective empowerment and enabling of all those engaged in the transformative process to create solidarity, mutual support systems, safety nets, etc. (Batliwala, 2011, P.38)

⁴ Power within – this is often the source of the sustainability and movements, since this relates to the intrinsic power, but also to the capacity to regenerate oneself and one’s strategies in response to the challenges. (Batliwala, 2011, P.39)

and power inequality. Thus, the study contributes to the literature by providing valuable insights on power inequality as a key aspect of systems leadership and suggest that both theory and practice of systems leadership should be reframed around power inequality. Thus, One of the main contributions of this study is that understanding systems leadership requires understanding the role of power which is also highlighted in Foldy and Ospina's (2022, p.1) recent paper where they argue that "we cannot understand CL [collective leadership] without understanding the ubiquitous, complex, and even contradictory role of power."

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