

Title: The role of systems leadership in facilitating healthcare transformation

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Abstract

This is an exploratory research study that forms part of a larger doctoral research, aiming to investigate the implementation of systems leadership within English healthcare through focussing on a patient leadership intervention in a large UK city. The focus of this developmental paper is on exploring whether adopting systems leadership approach can facilitate the transformation the healthcare has been experiencing. This research, therefore, aimed to address this gap by conducting an embedded case study of a multistakeholder partnership which aimed to build a collaborative partnership between the healthcare organisations and patients in the region. The data has been collected over two years through semi-structured interviews, non-participant observations and documents analysis.

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Introduction

The study of leadership has significantly developed over the last century and various leadership theories have emerged, such as trait, style, contingency, and situational approaches (e.g., Stogdill, 1948; McGregor, 1960; Fiedler, 1964), follower-orientated leadership approaches (e.g., Dansereau et al., 1975; Graen and Cashman, 1975) and transformational leadership (e.g., Burns, 1978, Bass, 1985). While such heroic perspectives have increased our understanding of leadership and inspired much research, they have also provided opportunities for some leaders to misuse their powers and restrict others from participating in leadership activities (Bolden, 2011; Denis et al., 2012; Yammarino et al., 2012). These heroic approaches, thus, were criticised for promoting and espousing ‘Great Man’ theories (Edwards, 2015) and made a way for emergence of collective approaches of leadership which call for re-evaluation of how power, responsibility and leadership are distributed (Spillane, Halverson and Diamond, 2004; Gronn, 2000; Edwards, 2011). A paradigm shift has occurred within the field and many scholars now view leadership as a property of the collective. Systems leadership has also been advocated to be appropriate for public sector organisations as charisma, wisdom and intelligence of individual leaders are no longer considered sufficient to enable public sector organisations to respond effectively to the complex challenges they have been facing (Flinn and Mowles, 2014; Stacey, 2011; Snowden and Boone, 2007). Systems leadership is classified under collective leadership (Ospina et al., 2020; Ham and Murray, 2015) which occurs at systemic level and goes beyond organisational boundaries and engages different stakeholders (The Institute for Systemic Leadership, 2017).

Leadership in healthcare

The English healthcare has been going through various transformations to ensure high quality care and compassion is in place while meeting financial deficiencies (West, 2021; West, Bailey and Williams, 2020; West et al., 2014). Change is an ambiguous and interactive process and leadership has been recognised to be central to any change programme specifically in healthcare in recent years (Fitzgerald et al., 2013). The topic of leadership in health care has always been of interest to policy makers as well as academics (Degeling et al., 2006; Kirkpatrick et al., 2009) and many attempts have been made to apply collective approaches of leadership across health system, with a view to enhancing the organisational performance and to deliver better and safer care (West, 2021; Martin et al., 2015; West et al., 2014).

The healthcare is confronting complex issues including changing demographic pressures, increasing public demands and budget cuts (Hickmann et al., 2022; The Lancet, 2021; West et al., 2014) alongside rebuilding public confidence after several scandals occurred at healthcare premises (West et al., 2014). The challenges the healthcare has been facing are complex and systemic that cannot be resolved by any individuals or individual organisations working alone and require a collective approach to harness skills and capacity from across the system to address them (Sharp et al., 2022). The important question is that how health care system can respond effectively to these wicked issues and unmet needs. Adopting a collective and systemic approach has been advocated to be central in addressing these issues more effectively (West, 2021; Curtis et al., 2021; West et al., 2014) as traditional leadership theories offer linear solutions which has some limitations to address these issues (Curtis et al., 2021).

While experiencing complex and intractable issues is not new within healthcare, they have been brought into greater focus in recent years as organisations struggle to resolve persistent

challenges such as budget cuts and increasing public expectations, as argued by Bolden et al. (2023):

“Combined with significant constraints around funding, a growing scale and complexity of demand and calls for greater inclusion and citizen involvement, the challenges of traditional leadership frameworks to respond to complexity have been widely voiced” (Bolden et al., 2023, p.338).

Although this has been the case for a long time, but what has made it particularly significant is that policy has moved towards devolution and integration of health and social care budgets by which policymakers have attempted to bring closer together the planning, commissioning and delivery of health and social care to reduce unnecessary fragmentation within and across services, and support people to live more healthy and independent lives (Ham and Murray, 2015; Edwards, 2019; Edwards, 2021; Dayan, Oung and Reed, 2022). Therefore, the NHS has gone through different reforms in addressing these and moving from market-based principals and competition to more local-based principals to help the NHS progress has been identified to be essential (Dayan et al., 2022; Edwards, 2021).

The NHS Five Year Forward View plan was the initial step to move towards an integrated care model to address the NHS main aim which was providing “high quality care for all, now and for future generations” (NHS England, 2014). The Five Year Forward View set out a clear direction for the NHS on what a better future should be – showing why change was needed and what it will look like. Integrated care models were encouraged within this framework which required new partnerships with local communities and local authorities through working systemically and collaboratively.

Although the focus of Five Year Forward View was on moving towards prevention and integration, however, the legacy of The Health and Social Care Act 2012 was identified as one of the biggest barriers to the implementation of Five Year Forward View which fragmented commissioning functions and reinforced the role of competition within the system (Darzi, 2018). According to Darzi (2018, p.6), “it is increasingly clear that if we want our health and care system to be fit for the future, then further reform must be embraced.” Building on the policy platform laid in the NHS Five Year Forward View, the NHS long term plan has been developed in 2019 to consolidate the idea of the need to integrate care to meet the needs of a changing population (NHS, 2019).

Lessening the emphasis on competition and bringing local authorities and the NHS closer together (The Lancet, 2021; Edwards, 2021), integrated care systems (ICSs) has become legally established through The Health and Care Act 2022 and replaced the Clinical Commissioning Groups (CCGs) (NHS England, 2023; Dayan et al., 2022). ICSs are the latest policy reform in line to promote and establish an integrated care service delivery and provision (NHS England, 2023; Dayan et al., 2022). ICSs are identified as the biggest legislative restructure the NHS experienced so far, aiming to end the healthcare market-based and competition principals through working in partnerships (Edwards, 2021). Each integrated care system has two statutory elements, an integrated care partnership (ICP) and integrated care board (ICB) (NHS England, 2023). However, the legislative framework is only part of the story and how people behave and relate to each other is another part of the story which seem to play a key role too (Edwards, 2021). The ICSs are new and there is little empirical evidence of their effectiveness, however, implementing ICSs does not seem to be an easy task and, therefore, there will be no surprise it brings some complex potential conflicts of interest in practice that need to be addressed (Edwards, 2021).

Such integrative and adaptive approaches to change and leadership have been widely advocated across the health system and a wider recognition of the limitations of previous approaches of leadership is in place (Sharp et al., 2022). Systems leadership has been identified to be vital in delivering integrated care and making sure that leaders are working together effectively both nationally and locally across the health system at every level (Jerofke-Owen et al., 2023). In the field of healthcare, according to the NHS Confederation (2014):

“systems leadership is about local leaders from across the health and care system sharing a cohesive approach to working together to improve the whole local health and care system. It is 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).

In the words of Ham and Murray (2015, p.22), systems leadership “must be both shared and distributed and based on a willingness to negotiate and accommodate rather than command and control.” However, NHS is probably more hierarchical than any other sector in the UK and hierarchy and status difference are evident amongst health professionals (West, 2021; Edmondson et al., 2016) which could hinder implementing systems leadership. Within this hierarchical environment, leaders “can use their privileged positions to acquire more power and limit others’ access to it” which is referred to as ‘personalised power’ (West, 2021, p.154). Conversely, systems leadership “involves seeking to share power and resources so that leadership is deployed most effectively in delivering health and social care services – what is called socialised power” (ibid). This suggests that alternative modes of power should be co-constructed to make the practice of power more visible, democratic, legitimate, shared and accountable at all levels (Batliwala, 2011).

Although systems leadership is being advocated as an approach to transform public sector organisations whereby multiple stakeholders need to collaborate and cooperate across groups and system (Ghate, Lewis and Welbourn, 2013), “how this can be achieved in the face of differing and/or potentially competing priorities and agendas remains unclear” in policy and practice (Bolden et al., 2023, p.339). The question now is that whether implementing systems leadership could facilitate moving towards an integrative care system and could eventually enable transforming healthcare or it is just another major reorganisation the healthcare is going through. This paper aims to address this gap.

One of the challenges arises is that there is a risk that systems leadership becomes a holder for all the romantic notions we have about leadership – a belief that it is the solution that we have been striving for all the time. There is a danger in assuming that the only way to resolve intractable problems is with systems leadership that if only we had systems leadership, we would not be in this situation; if only we had it twenty years ago, we would not have these problems now. This indicates how difficult systems leadership is to both start and maintain.

Research methodology

This study is an exploratory longitudinal embedded case study (Yin, 2018; Tight, 2017) that aimed to investigate the implementation of systems leadership within English healthcare through focussing on a patient leadership intervention in a large UK city. The overarching case was a ‘Patient Leadership Initiative’ (PLI) that aimed to build a collaborative partnership between the healthcare organisations and the patients in the region. I chose PLI as, first, it required people to work and lead across organisational boundaries collaboratively and systemically (systems leadership) which was aligned with the national policy, demanding to

work in collaboration and integration. Second, it aimed to address a system-wide issue; patient voice marginalised rather than being at the centre of the health system. There were also four interconnected initiatives that formed embedded case studies. The use of embedded case study design provided an opportunity for extensive research as well as providing and enhancing insight into the overarching case (Yin, 2018).

The empirical part of this study has been conducted in two phases:

1-Developmental phase: This phase linked to overarching case and at this phase data was collected at two points in time 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. In total, 28 interviews were conducted in this phase. As Yin (2014) proposes, collecting data at two or more different points in time helps revealing the changes and shifts occurring over time.

2-Practical phase: This phase linked to sub-case studies and at this phase data was collected from four interconnected case studies to examine the similarities and differences. In total, 24 interviews were conducted at this phase.

I applied a multi-methods approach including semi-structured interview, observation and document analysis (Steccolini, 2023). In order to complement interview data, I observed nine meetings and observational notes were taken at each of these events to see how collaboration, conflicts and relationships occurred in practice (Thomas, 2021). I also received supporting documentations such as meeting agendas and terms of reference to complement interview and observational data (ibid).

In order to analyse my data, I have applied thematic analysis framework proposed by Braun and Clarke (2006) because it was well-suited to the rich, qualitative data I collected and provided a robust and systematic approach to identifying and refining my themes. A thematic analysis approach was also in line with my epistemological and ontological stances of interpretivism, and social construction of reality. Braun and Clarke (2006) suggest six steps that are required to be taken to analyse qualitative data: 1) data familiarising, 2) generating codes, 3) searching for potential themes, 4) reviewing and revising themes, 5) finalising and naming main themes, and 6) presenting research findings. Adopting this framework was not a “linear process of simply moving from one phase to the next, [but rather it was a] more *recursive* process, where movement [was] back and forth as needed throughout the phases” (Braun and Clarke, 2006, p.86). I have, therefore, moved back and forth through these six steps in an iterative flexible way, throughout my data analysis.

Main findings and discussion

The findings of this study identify three key aspects of systems leadership including ‘establishing a collaborative relationship’, ‘embracing diverse perspectives’ and ‘shifting power inequalities’. The first two are in line with the literature linked to systems leadership specifically what Senge et al. (2015) and Dreier et al. (2019) attributed to systems leadership in their papers that formed the conceptual framework of this research. However, the role of power has been downplayed in most systems leadership literature specifically the ones that contributed to this research conceptual framework. Within this research, there was a strong consensus throughout the interviews, observations, and documents analysis that the role of power was a key determinant of systems leadership which affected the other two determinants of developing collaborative relationships and embracing diverse perspectives.

Although 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), it has become challenging when it came to practice as the focal point of coproduction is that health professionals and patients work in collaboration to design, implement and evaluate services (ibid), being in equal partnership and having equal power (Boyle and Harris, 2013) which did not fully occurred in practice. The findings imply this approach 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.

The most overriding aim of systems 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 power dynamic needed to be identified and challenged (Batliwala, 2011) and an alternative models of power should be co-constructed. 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 such initiatives. It is suggested that this might increase the possibilities of people from the margins taking up leadership and practice their voices.

Despite the potential benefits of systems leadership in facilitating healthcare transformation, the findings identified some barriers that inhibited systems leadership implementation to enhance patient voice and bring it to the centre of the health system. NHS hierarchical structure, its long-lasting cultural norms and entrenched bureaucratic barriers were among the most challenging barriers. These coupled with the complex layers of policymaking and intervention, could present formidable obstacles to the effective implementation of a systems leadership approach. Future research should strive to explore these issues in greater depth and offer practical strategies for overcoming institutional barriers to change.

Developing the paper prior to presentation at the conference

I aim to develop the discussion section and research contributions prior to my presentation at the conference.

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)

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