



# **Shared Action Towards a Canadian Health Leadership Strategy Framework: A Working Paper**

2014

## Preface

CHLNet, a purpose-built coalition of 40 organizations (called Network Partners) has initiated this consultative process on a Canadian Health Leadership Strategy Framework. CHLNet's vision, **Better Leadership, Better Health—Together**, will be achieved only through new and more innovative ways of working together to grow leadership capacity, as outlined in detail in its new strategic plan (see [www.CHLNet.ca](http://www.CHLNet.ca)).

CHLNet created an ad hoc, expert working group to put this working paper together. The working group, chaired by Dr. Gillian Kernaghan (representing Canadian Society of Physician Executives and CEO, St. Josephs Health Care London) guided this effort over the last nine months. Its members include: Carla Anglehart (Health Association NS), Graham Dickson (CHLNet Advisor), Jocelyn Chisamore (Emerging Health Leaders), Emily Gruenwoldt Carkner (Canadian Medical Association), Frank Krupka (University of Manitoba and Winnipeg RHA/Centre for Healthcare Innovation), Suzanne McGurn (Ontario Ministry of Health and Long-Term Care), Paddy Meade (Deputy Minister, Yukon Health), Brenda Rebman (Alberta Health Services), June Webber (Canadian Nurses Association), Bill Tholl (CHLNet), and Kelly Grimes (CHLNet).

The purpose of the working paper is to begin a national dialogue on what concerted action needs to be taken to enhance leadership capacity across Canada and throughout the system, one of CHLNet's four new strategic directions. It is intended to form a foundation for an evidence-informed conversation among Canada's health care leaders. It builds in and upon a four-year, longitudinal series of six case studies spearheaded by CHLNet that examine the crucial role of leadership in health system reform.

## Executive Summary

The Canadian health system is both a source of pride and concern. Demand for services grows due to the twin forces of demography and technology, while we still feel the results of one of the deepest and most long-lasting economic downturns in its history. Canada's health system performance continues to languish when compared internationally. High turnover among senior policy and executive leaders is an ongoing concern as transformational changes are being made across every jurisdiction. Increased scrutiny and public accountability of our leaders are making it difficult to attract and retain talent. Recent research results from a multi-year Canadian study suggests that there is a large and growing leadership gap. As a result, high impact leadership is being identified by most major policy reports as a critical success factor in improving system performance.

This working paper has been developed to address this new policy paradigm; namely, to build and strengthen Canada's health leadership capacity through a collective approach that crosses jurisdictions and disciplines. CHLNet, a purpose-built coalition of 40 organizations (called Network Partners) initiated this consultative process to begin a national dialogue on what actions need to be taken toward reaching a consensus on a *Canadian Health Leadership Strategy Framework*. The paper's intent is to be a foundation for a crucial conversation among Canada's health care leaders.

Evidence is showing that leadership, while certainly a function of time, place and circumstance, has certain common capabilities that are shared among high impact leaders. It is a skill to be acquired and not just an innate gift. Leadership has become an art and science, with new theories (e.g. situational, trait or behavioural) and models of leadership (e.g. shared or distributed) emerging. Leadership is increasingly seen as its own emerging discipline and no longer just viewed as a function of position or authority. Further, leadership is increasingly viewed as a "social good", where everyone benefits from increasing our collective leadership capacity and where a concerted effort is required to effectively grow overall leadership capacity across the country. Given these issues and trends, how do we work together to move forward in achieving this goal?

This working paper is intended to pave the way forward by advancing a strategy framework in support of concerted action. We refer to it as a strategic framework rather than a strategy to acknowledge the decentralized system of health financing and delivery in Canada.

Research and expert opinion shows growing high impact leadership requires a multi-pronged, sustained and collaborative strategy to achieve transformational change. Key elements should be:

1. Creating a collective vision and approach.
2. Establishing a common leadership platform.
3. Gathering more evidence on innovation and leading practices.
4. Enhancing leadership capacity and capabilities.
5. Measuring and evaluating success.

Five years ago, leadership was not on the policy landscape but is now seen as an integral ingredient to achieving a patient-focused and high performing health system. A pan-Canadian, collaborative approach to developing excellence in health leadership is required to achieve *Better Leadership, Better Health—Together*.

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# Shared Action Towards a Canadian Health Leadership Strategy Framework: A Working Paper

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## Introduction

Change is ever constant in the Canadian health system, however the complexity and pace of change is more daunting than ever. The profile of health system leaders is more diverse than ever, with more clinicians taking on senior leadership positions and more “mature” than ever, with a growing majority nearing the normal age of retirement. Demography, as David Foot points out, is destiny. This is true of the population in general and of the profile of health leaders. The 2011 census data shows new population records being reached with seniors now accounting for almost 15 per cent of the population and the proportion of the working-age population aged 45 to 64 reaching 42.4 per cent.<sup>1</sup>

There is growing evidence that senior leadership positions have lost their luster. Specifically, pressures of work-life balance, increased “politicization” of senior leadership positions and increased public scrutiny/accountability are coalescing to make it more difficult to attract and retain high impact leaders. Overall, all of these drivers are contributing to a large and growing leadership gap.

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*Successful innovations are led by people who provide clear vision, champion the change, and create safe environments conducive to supporting an empowered and involved workforce.*

*Council of the Federation, 2012.*

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Given this new reality, how do we work better together, across jurisdictions and disciplines, to enhance and further develop Canada’s health leadership talent pool? The health leadership talent pool includes leaders at all levels of the system from emerging to the senior/executive level.

This working paper has been developed to help in addressing this new policy paradigm... working together to build and strengthen Canada’s health leadership capacity as part of an integrated health human resource strategy. Following a broad range of consultations, including a co-sponsored health leadership forum to be held in Montreal February 14, 2014 and a deliberative dialogue session to be hosted by McMaster University on March 4, 2014, a *policy brief* will be prepared that outlines a pan-Canadian approach and strategy framework for developing and enhancing health leadership capacity across the system. The intent is to bring these findings forward for consideration by the Council of Deputy Ministers of Health.

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<sup>1</sup> Statistics Canada. (2012). *Canadian Population in 2011: Age and Sex*. [www12.statcan.ca/census-recensement/2011/as-sa/98-311-x/98-311-x2011001-eng.cfm](http://www12.statcan.ca/census-recensement/2011/as-sa/98-311-x/98-311-x2011001-eng.cfm)

## Background

### Canadian Health System Performance in Decline

Canada has historically led the world in thinking about health, in measuring health and, until relatively recently, in delivering on health care. However, recent reports from a variety of organizations indicate that Canada has been gradually drifting down the international league tables in terms of health system performance (see: Commonwealth Fund; OECD; European Observatory; Conference Board of Canada).

There is a growing consensus that Canada's 14 separate health systems need to move away from "innovation by accident to innovation by design" and that leadership is the number one enabler of health system innovation. The federal withdrawal from its traditional leadership or "convenor" role is also compounding the challenge of growing leadership capacity, although respective roles and responsibilities in the system are being reframed.<sup>2</sup>

Widespread leadership initiatives are in evidence, with many provinces/territories adopting widely different strategies for improvement such as Saskatchewan's lean approach, Health Links and IDEAS in Ontario or Quebec's population-based improvement. Triple Aim (US Institute for Healthcare Improvement's quality improvement focus of *Better Health, Better Care and Better Value*) is being adapted broadly across Canada. Provinces such as Saskatchewan are making modifications (by adding a fourth piece around *Better Teams*) but the intent is the same, wider spread innovation.

Yet evidence shows that 70 per cent of these improvement initiatives will fail<sup>3</sup>, with poor leadership being a key ingredient in this lack of sustained success. Leaders must be present, adaptive and responsive to each unique situation in creating the "winning conditions" for system redesign, including creating a clear/compelling vision, sustaining a caring and sharing culture for innovation and learning, intentional mentoring, and building trust throughout the system. Yet these fundamentals rarely occur or are sustained in the current environment.

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*Leadership in health is the collective capacity of an individual or group to influence people to work together to achieve a common constructive purpose: the health and wellness of the population we serve.*

*Dickson and Tholl, 2014.*

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<sup>2</sup> Tholl, B. and Bujold, G. (2011). *Functional Federalism and the Future of Medicare in Canada*. HEAL.

<sup>3</sup> Ball, T. (2013). *So, Your Health Link Wants to Succeed: Measures to Overcome Five Learning Disabilities*. <http://quantumtransformationtechnologies.com/category/blog/>

## Call for Strong Leadership

For purposes of this working paper we define leadership as “the capacity of an individual or group to influence people to work together to achieve a constructive purpose.”<sup>4</sup> To reiterate, leadership is increasingly being identified as a critical success factor for system performance. Some reports have identified specific areas, such as primary care reform, where a lack of leadership is particularly evident across Canada.<sup>5</sup> The Royal Commission on the Future of Health Care in Canada flagged the need for “stronger leadership” (2002); the Health Council of Canada recommended more “supportive leadership” (2012); and the Premiers’ report *From Innovation to Action* identified “present leadership” as one of four critical factors for better system performance (2012). The Health Council of Canada’s September 2013 report *Better Health, Better Care, Better Value for All: Refocusing Health Care Reform in Canada* calls for strong leadership as the first of five key enablers of high performing systems.”<sup>6</sup>

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*We view leadership as the foundation for the other key enablers because it supports and provides momentum to move actions towards attaining health system goals.*

*Health Council of Canada, September 2013.*

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The evidence is still building but studies are beginning to show significant returns on investment (ROI) for leadership. Other countries, such as the National Health Service (England) and Australia are stepping up their investments in leadership development. Anecdotally, Canadian health system leaders recognize there is a payoff in investing funds, however it can be difficult to assess the cause and effect of a leadership impact. The private sector has long since embraced traditional metrics such as profit margins dividends or increasing shareholder value. Better measures of effective leadership are needed for the not for profit sector.

For the health sector, measuring leadership impact can be more difficult although alternative assessment measures on the value of leadership investment can be useful such as absenteeism, engagement (physician and staff), or staff motivation. Research suggests that improved physician and staff engagement leads to better patient experience. According to a recent IHI study, “Strong evidence-based literature supports the premise that it is possible to effectively grow emerging leader talent while

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<sup>4</sup> Dickson, G. and Tholl, W. (2014). *Bringing Leadership to Life in Health: LEADS in a Caring Environment*. London: Springer. Available at [www.springer.com/medicine/book/978-1-4471-4874-6](http://www.springer.com/medicine/book/978-1-4471-4874-6).

<sup>5</sup> Aggarwal, M. and Hutchison, B. (2012). *Toward a Primary Care Strategy for Canada*. Canadian Working Group for Primary Healthcare Improvement.

<sup>6</sup> Health Council of Canada. (September 2013). *Better Health, Better Care, Better Value for All: Refocusing Health Care Reform in Canada*.

advancing strategy, increasing employee retention and engagement, and delivering a measurable return on investment.”<sup>7</sup>

In 2009, Avolio, Reichard et al.’s meta-analysis found 200 leadership intervention studies whose overall effect ranged from a “66 per cent probability of achieving a positive outcome versus a 50-50 random effect for treatment participants.”<sup>8</sup> A later 2010 study by Avolio found the expected return on investment (ROI) from leadership development interventions ranged from 200 percent to low negative ROI.<sup>9</sup> Ellehuus shows leading organizations achieve a 37 per cent greater leadership effectiveness or ROI by:<sup>10</sup>

1. Measuring leadership behaviors and outcomes instead of leadership program activities.
2. Looking to tomorrow’s leadership challenge.
3. Coordinating talent management programs across the organization.

In sum, there is a growing recognition of the need to increase high impact leadership capacity across the Canadian health system but lack of consensus on a made-in Canada approach to meeting this need.

## Leadership Issues and Trends

The Canadian health system is still feeling the effects of one of the deepest and most long-lasting economic downturns in Canadian history. The recovery, while steady is slow and uneven. Recent Canadian research results confirm that there have been widespread changes at the senior policy and political level in every jurisdiction across Canada over the past few years. Evidence suggests that this may be due to the increased “politicization” of the health system and an attendant lack of alignment between authorities and accountabilities in the system. With each change in executive or policy leadership comes new policies and priorities, changing the policy context and the alignment of authorities and accountabilities in the system. Morale throughout the system is low. Change fatigue is widespread.

On the positive side, evidence is also showing that, while leadership is certainly a function of time, place and circumstance, there are some common capabilities that are shared among high impact leaders. In the last decade, leadership itself has become a focus of study and many breakthrough theories have been postulated to explain how leadership works such as situational, trait or even behavioral.<sup>11</sup> These theories help build a better understanding of the special knowledge and skills required to become an effective or high impact health leader. New models of leadership such as distributed or shared

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<sup>7</sup> Swensen, S., Pugh, M., McMullan, C., and Kabcenell, A. (2013). *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement.

<sup>8</sup> Avolio, B., Reichard, R., Hannah, S. et al. (2009). A Meta-Analytic Review of Leadership Impact Research: Experimental and Quasi-Experimental Studies. *The Leadership Quarterly*, Vol. 20, No. 5: 764-784.

<sup>9</sup> Avolio, B., Avey, J., and Quisenberry, D. (2010). Estimating Return on Leadership Development Investment. *The Leadership Quarterly*, Vol. 21, No. 4: 633-644.

<sup>10</sup> Ellehuus, C. (2011). Improving Returns on Investment. *Strategic HR Review*, Vol. 10, No. 6.

<sup>11</sup> Avolio, B., Walumbwa, F., and Weber, T. (2009). Leadership: Current Theories, Research, and Future Directions. *Annu Rev Psychol.*, Vol. 60: 421-449.

leadership are emerging as not one person cannot have all the requisite expertise to effect major changes in system as complex as health care. There is also increased understanding of the importance of balancing distributed leadership with designated leadership.<sup>12</sup>

For this report, evidence and leading practice around leadership will be mainly limited to the Canadian, United Kingdom and Australian experience with some select United States examples provided. Emerging leadership issues and trends are discussed in more detail below. Many are derived from the initial findings from a multi-year, path-breaking Canadian research project into the importance of leadership in health system change (PHSI)<sup>13</sup> but also from early editions of the Dickson and Tholl forthcoming volume: *Bringing Leadership in Health to Life: LEADS in a Caring Environment*.<sup>14</sup> The autumn 2013 consultation with CHLNet Network Partners revealed other issues to consider including constantly emerging technology, lack of political support, changes in the economy, and changing demographics. This is by no means a systematic review but rather a brief look into the evidence.

## Emergence as a Discipline

As stated earlier, there is a growing body of evidence underscoring the importance of leadership to organizational and health system performance. There is also evidence to suggest that in a system as complex as health care, that “heroic” leadership models are at best time limited. A more coherent, concerted and distributed approach is required to grow leadership capacity and to support the emergence of the next generation of high impact health leaders. Leadership is no longer seen as tacit knowledge (i.e. difficult to transfer to another person) but rather can be developed through role modelling, mentorship or managing performance. It involves actively nurturing a community of practice of health leaders from all levels (i.e. macro, meso, and micro), with increased attention placed on sphere of influence rather than sphere of control.

Given the pull and push forces in the system, health leaders must embrace what binds them together to achieve the higher goal of enhancing citizen and patient health and wellness. As the evidence base grows, there is an emerging discipline around health leadership and the special demands of leading change in such a decentralized system of planning, financing and delivering health care.

## Being Seen as a Social Good

A basic premise of our health system is that health care is a social good, to be provided on the basis of ability to benefit rather than ability to pay. Leadership in health is likewise increasingly seen as a “social good”. Growing health leadership capacity is everybody’s business. All jurisdictions benefit, directly or indirectly, from increasing our collective leadership capacity. The costs must also be shared. If an organization only looks to the short term, direct benefits of leadership investments, there will be a

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<sup>12</sup> Best, A., Greenhalgh, T., Lewis, S. et al. (2012). Large-System Transformation in Health Care: A Realist Review. *The Milbank Quarterly*, Vol. 90, No. 3: 421-456.

<sup>13</sup> Dickson, G., Tholl, B. et al. (2013). *Draft Leadership and Design Health Insights*. Partnerships in Health System Improvement (PHSI) Project.

<sup>14</sup> Dickson, G. and Tholl, B. (2014). *Bringing Leadership to Life in Health: LEADS in a Caring Environment*. London: Springer. Available at [www.springer.com/medicine/book/978-1-4471-4874-6](http://www.springer.com/medicine/book/978-1-4471-4874-6).

systemic underinvestment in leadership and a growing leadership gap.<sup>15</sup> While the importance of leadership is being recognized, there is still no concerted policy effort across Canada to ensure that leadership receives the policy attention and strategic investments needed to get Canada back into the top tercile of best performing health systems in the world.

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*There is unequivocal evidence in every sector that there is a strong relationship between leadership capability and performance. Good leadership leads to a good organizational climate and good organizational climates lead, via improved staff satisfaction and loyalty, to sustainable, high performing organizations.*

*NHS Leadership Academy, 2013.*

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Senior leaders report that the flattening of hierarchical structures is needed, but has both pros and cons. More collaboration and team-based, distributed leadership is a real positive. The downside is that, in the name of cost cutting and efficiencies, there has been a loss of middle managers with unwieldy and unsustainable spans of control. Indeed, some suggest that a generation of future senior leaders have been lost with the “hollowing out” of the middle management in the system.

One overall conclusion is that, if Canada is to realize the goal of better health through better leadership, current leaders can and must do a better job of mentoring and coaching the next generation of health leaders in Canada to enhance this shared resource.

### **Rise of Distributed or Shared Leadership**

The literature is increasingly reporting on the importance of “distributed leadership” or “shared leadership”. Distributed leadership is where “some of the functions of leadership can be delegated or embedded in other persons or roles in an organization.”<sup>16</sup> Collaborative leadership is replacing top-down, directive or autocratic styles. More decentralized leadership is emerging as the way forward, with sharing of authorities and accountabilities between teams and individuals as leadership occurs at all levels.

Shamir discusses how shared leadership takes time and yet it is rarely taken.<sup>17</sup> There is a significant value of learning with and from each other that results in participating on committees or teams. Distributing leadership across several roles, all with the same vision, is increasingly seen as mission

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<sup>15</sup> Canadian Health Leadership Network. (2007). *A Report on Leadership Development Practices in the Health Sector*. Prepared by the Conference Board of Canada.

<sup>16</sup> English, F.W. (2008). *The Art of Educational Leadership: Balancing Performance and Accountability*. Thousand Oaks, CA: Sage.

<sup>17</sup> Shamir, B. (2011). Leadership Takes Time: Some Implications of (Not) Taking Time Seriously in Leadership Research. *The Leadership Quarterly*, Vol. 22, No. 2: 307-315.

critical to both organizational and system performance.<sup>18</sup> No one person can have all the capabilities or competencies needed to address the complex challenges of an ever-changing series of health leadership challenges. Rather leadership is a shared responsibility to deliver results on behalf of the whole organization.

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*We can no longer expect or afford to see this as a case where the heroic Chief Executives who come in and do wonderful things; health care is too complex for that; we need much more collective leadership.*

*Ham, 2013.*

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## **Continued Rapid Turnover**

Reliable/meaningful metrics of leadership capacity are required throughout the system. One such measure is the average tenure rate in senior policy and executive leadership positions. Senior health leaders no longer are staying in positions for long periods of time. In fact, the tenure of senior government officials has dropped from 4.5 years in the mid-1970s to less than 2 years by 2005.<sup>19</sup> Casual empiricism suggests this decline has continued in recent years although there seems to be more stability at the CEO level. Unplanned or uncoordinated turnover of senior leader changes is having debilitating effects on sustaining innovations in the system. In contrast, high retention rates are being seen at direct care levels, for example the average nurse has 18 years of experience.<sup>20</sup>

On a positive note, a number of regional and provincial efforts to more systematically grow leadership capacity have directly been undertaken (e.g. Ontario's IDEAS initiative, BC Health Quality Council's Quality Academy). Universities across the country are training a new generation of leaders. Nationally, the EXTRA program has produced over 300 highly trained and potentially high impact leaders. There is also a growing acceptance of a common leadership learning platform across the country (i.e. *LEADS in a Caring Environment*). Canada does have a plethora of leadership program offerings but we must harness and leverage both the program activity, the interest and the opportunity to advance the leadership agenda together.

## **A Function of Time, Place and Circumstances**

Change is ever present in the health system, requiring complex adaptive leadership that is patient-centered. Leadership must be responsive to each unique situation by providing the required support for

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<sup>18</sup> Currie, G. and Lockett, A. (2011). Distributing Leadership in Health and Social Care: Concertive, Conjoint or Collective? *International Journal of Management Reviews*, Vol. 13: 286-300.

<sup>19</sup> Tholl, W.G. et al. (2006). Passing the Baton. *Healthcare Management Forum*, Vol. 19, No. 1: 14-40.

<sup>20</sup> Canadian Federation of Nurses Union. (2012). *The Nursing Workforce CFNU Backgrounder*. Available at [http://nursesunions.ca/sites/default/files/2012.backgrounder.nursing\\_workforce.e\\_0.pdf](http://nursesunions.ca/sites/default/files/2012.backgrounder.nursing_workforce.e_0.pdf).

success. There is no “one size fits all” approach to exercising leadership. Instead, leaders in complexity embrace collaboration and diversity, create optimism and build a vision for the future.<sup>21</sup>

Individual leadership is important. Self-awareness, management and improvement must be built in as a foundational element. To do the right thing, at the right time, to get the right result, for patients and people--is challenging even in a stable environment. This is the fundamental difference between good management (doing things right) and good leadership (doing the right things).

Successful leadership is a lifelong pursuit that involves working with others. Forming effective teams requires acceptance that differences in health professional training generates quite different habits, tendencies and mores. Peter Senge called these habits “mental models”<sup>22</sup> and leaders must better understand the effect of these on one’s behaviours and interactions. Our future care leaders will require different competencies than in other generations.<sup>23</sup>

## Acquired Skill

While “all leaders are born”, leadership is not something you are born with it, nor is it a function of your position. Rather it is a skill to be acquired. Leadership education, training and development enhances the quality of leaders and leadership within the various levels of the health system. Historically, leadership development has tended to focus on top down, competency-based leadership development and only for the high performers: nurturing the “heroic leadership syndrome”.

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*Learning leadership differs from learning anything else in two important ways. The first is the tools of the craft. A hockey stick and skates are the tools of hockey...but in leadership, your core attributes, values, beliefs and talents are your tools.*

*Dickson and Tholl, 2014.*

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A new, more distributive view of leadership (at least for the health sector) is emerging, one that believes experiential learning that reflects one’s experiences throughout the spectrum of leadership is key to leadership development and capacity enhancement. Leadership instruments and self-assessment tools such as Myers-Briggs, Firo-B, E-Q-I 2.0, and Campbell Leadership Index can help leaders throughout organizations better understand their innate abilities and personal strengths: “sell your strengths, buy your weaknesses.”

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<sup>21</sup> Zimmerman, B. (2009). *A Complexity Science Primer*. Available at <http://napcrg.org>.

<sup>22</sup> Senge, P. (2002). *The Fifth Discipline*. New York: DoubleDay.

<sup>23</sup> Ford, R. (2009). Complex Leadership Competency in Health Care: Towards Framing a Theory of Practice. *Health Services Management Research*, Vol. 22: 101-114.

## Key Elements of a Strategy Framework

Expanding health leadership capacity, personally, organizationally and systematically, is a challenging task if not undertaken in a planned or orchestrated way. Many are travelling the leadership road but journeying together to achieve a vision is what is required. A multi-pronged, concerted national strategy is required that aims at building and growing individual leadership capacity but also society's collective one. Shared objectives and priorities need to become explicit. Given the evidence gathered to date, key elements for moving the leadership agenda forward as a strategy framework seem to be:

### 1. Create a Collective Vision and Strategy

A clear, compelling and common vision with meaningful and measureable outcomes is essential to tackling any serious system challenge. This includes the challenges of growing health leadership capacity. It involves addressing directly why we need to focus on growing high impact leadership and demonstrating its link to better health, better health care, and better performance. A collective vision is required that considers and engages stakeholders from macro to the micro levels of the health system (i.e. individual, organizational and systemic perspective). A vision must not just describe a better future state but must also set out measurable, meaningful metrics.

In the last few years there has been some conversation on the concept of a charter for improving the quality of patient care. It was discussed, for example, at the fourth annual CEO Forum held in 2010 by Canadian Foundation for Healthcare Improvement (CFHI, previously CHSRF), with the Association of Canadian Academic Healthcare Organizations (ACHAO) and the Canadian Medical Association (CMA) as partners. Conference participants felt that to be meaningful, a charter must consider measures, public reporting, leadership development and support, and skill development. "A charter can only serve to set the course...leaders must drive the transformation in care."<sup>24</sup>

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*To be meaningful, a charter must be part of a package that involves standard measures, public reporting, leadership development and support, skills development and the setting of clear targets.*

*Canadian Foundation for Healthcare Improvement, 2010.*

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More recently, the CMA and Canadian Nurses Association (CNA) have established principles for health system transformation based on IHI's triple AIM that might be useful in establishing this vision.<sup>25</sup> They are:

- Enhance the health care experience (patient-centred and quality).

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<sup>24</sup> Thornhill, J. (2010). Charter on Improving Quality of Patient Care. *Healthcare Quarterly*, Vol. 13, No. 3: 13.

<sup>25</sup> Canadian Medical Association and Canadian Nurses Association. (2011). *Principles to Guide Healthcare Transformation in Canada*. [www.cma.ca/advocacy/hctprinciples](http://www.cma.ca/advocacy/hctprinciples)

- Improve population health (health promotion and illness prevention and equitable access).
- Improve value for money (sustainable and accountable).

Frameworks or strategies can also be helpful in moving health leadership forward as a collective responsibility. Several countries including the United Kingdom and Australia have done this and are beginning to show the benefits of a coalition approach to influence action. For example, the National Health Service (NHS) leadership framework, works on the premise that leadership is most successful “wherever there is a shared responsibility for the success of the organization, services, or care being delivered.”<sup>26</sup> The NHS has consolidated its leadership development efforts to move from an individual investment to a more collective and systematic approach under the NHS Leadership Academy. The Academy’s mission is: broaden and change the range of leadership behaviours people in the health system use; professionalise leadership; and develop leaders who are more innovative. A governing board and a small core team, supplemented by associates and faculty oversee its efforts and operating budget of £31.4 million (2012/2013).<sup>27</sup> Its new leadership model is based on nine dimensions (similar to Canada’s LEADS).

A literature review conducted for the NHS Leadership Academy by the King’s Fund re-examined literature on leadership and leadership development. It proposed a new NHS leadership model, one with three main categories and corresponding elements (with some paraphrasing):<sup>28,29</sup>

**1. Provide and justify a clear sense of purpose and contribution.**

- Focus on needs and experiences of service users
- Interpret the wider environment

**2. Motivate teams and individuals to work effectively.**

- Define clear and challenging goals
- Build team commitment and a positive emotional tone or climate
- Encourage high staff involvement and engagement
- Provide and operate meaningful design for organizations, sub-units and individual jobs, with human resources management systems that provide relevant staff development and reward
- Manage and improve performance with openness to a variety of perspectives on performance including “soft” intelligence
- Listen to staff and respond

**3. Focus on improving system performance.**

- Enact and encourage the practice of service improvement

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<sup>26</sup> National Health Service. (2011). *Leadership Framework*. [www.leadershipacademy.nhs.uk/discover/leadership-framework/](http://www.leadershipacademy.nhs.uk/discover/leadership-framework/).

<sup>27</sup> Parliamentary Business Website: [www.publications.parliament.uk/pa/ld201213/ldhansrd/text/121122w0001.htm](http://www.publications.parliament.uk/pa/ld201213/ldhansrd/text/121122w0001.htm).

<sup>28</sup> NHS Leadership Academy. (2013). *Towards a New Model of Leadership for the NHS*. [www.leadershipacademy.nhs.uk/wp-content/uploads/2013/05/Towards-a-New-Model-of-Leadership-2013.pdf](http://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/05/Towards-a-New-Model-of-Leadership-2013.pdf).

<sup>29</sup> Ham, C., Edwards, N. and Brooke, B. (2013). *Leading Health Care in London*. The King’s Fund.

- Address system problems and pursue innovation
- Model learning of new behaviors

The United States National Center for Healthcare Leadership (NCHL) provides another framework for consideration, although more aimed at the organizational level. The NCHL’s overall goal is to improve health system performance and the health status of the entire country through effective health care management leadership. Its framework contains five principles for change (as outlined in Figure 2):<sup>30</sup>

- Leadership development and organizational business strategy are aligned
- Board is accountable for leadership succession
- Learning is competency-based, inter-professional, and action-oriented
- Key talent management and strategic human resource processes are integrated and aligned
- Leadership development dashboard tracks key measurable outcomes.

**Figure 2: National Centre for Health Leadership Catalyst Framework**



Lastly and probably the best example right now can be found in Australia under the transformational efforts of Health Workforce Australia (HWA), an organization coordinating system reform in that country. HWA’s 2010 framework for action called for a leadership framework that defined the capabilities needed for leaders in all areas of health but clearly states its overall vision of “healthy Australians and a caring, sustainable health system.”<sup>31</sup> Endorsed in June 2013 by the Council of Ministers of Health its new draft document entitled *Health LEADS Australia* sets out a framework for achieving its vision to achieve more healthy Australians: Leads self; Engages others; Achieves outcomes; Drives innovation; and Shapes systems (Figure 3). This modified version of the Canadian LEADS

<sup>30</sup> National Center for Health Leadership. *NCHL Catalyst Framework*. Retrieved from website on October 9, 2013.

<sup>31</sup> HealthWorkfoce Australia. (2011). *National Health Workforce Innovation and Reform Strategy Framework for Action, 2011-2015*.

framework is discussed further below. Australia has made a strategic investment of \$40M to formally recognize the need for health leadership development.<sup>32</sup>

**Figure 3: Health LEADS Australia Framework**



As the recent Australia experience shows, any vision and strategy must include clear, regular, and effective communication channels and engagement strategies. There must be processes to ensure that groups such as patients, physicians, nurses, and other providers have a voice.<sup>33</sup> This means involvement in decision-making to become agents of change. Both horizontal and vertical listening must occur. It is no longer just the formal leaders who have the power and privilege that accompany a senior position in health care. Power has been shifted to those who have the ability to influence others, often through the use of Internet and social media.<sup>34</sup> Leaders must see engagement of these stakeholders as a continuum (more or less engaged), within a context (such as with patients, organizational goals, etc.).

To engage its stakeholders, the NHS (England) has proposed the use of “leadership compacts”. It is a “solid foundation of change management philosophy as a way to engage, build support, and galvanize social movements.”<sup>35</sup> The leadership compact (TLC) intention is designed to support their talent management approach and to show a new approach is intended. Talent management uses a lens of acquire, engage and retain, lead and manage performance, reward, and learn and develop. Physician compacts are also becoming a prevalent way to outline agreed upon commitments.

## 2. Establish a Common Leadership Platform

*LEADS in a Caring Environment* is a “by health, for health” leadership capabilities framework that can provide a useful basic building block for this endeavor. It is one of many frameworks. Based upon five key elements: Lead Self, Engage Others, Achieve Results, Develop Coalitions and System Transformation, LEADS defines the behaviours leaders must master to be successful in this ever-

<sup>32</sup> In conversation with Bill Tholl with HWA, Summer 2013.

<sup>33</sup> Metrics@Work, Grimes, K., and Swettenham J. (2012). *Compass for Transformation: Barriers and Facilitators to Physician Engagement*. Regina Qu’Appelle Health Region/CPNet.

<sup>34</sup> Kellerman, B. (2012). *The End of Leadership*. New York: HarperCollins.

<sup>35</sup> NHS Leadership Academy. (2013). *The Leadership Compact*.

changing health leadership environment. It does this with four measureable and observable capabilities comprising each of the five domains. In essence, the common “what” to do.

In 2006, LEADS was created based on an assessment of a full range of existing leadership models. It took the best of the best and applied these insights to the unique, “caring” health care context in Canada with distributed leadership at its core. LEADS has become Canada’s preferred, common health leadership learning platform to develop new leaders, create change, and grow individual leadership capacity.<sup>36</sup> Through validation both in British Columbia and across Canada, both the face and construct validity have been tested for LEADS.<sup>37</sup> It now provides a common language and focus for health leadership.

Adoption of LEADS has been widespread by pioneering organizations such as CHLNet, Canadian College of Health Leaders, Accreditation Canada, Canadian Medical Association, Alberta Health Services, and numerous health regions and provinces from across Canada. The country of Australia has even adapted it for its own context.

### 3. Gather More Evidence on Innovation and Leading Practices

Over the course of the past decade significant research has been undertaken on health leadership.<sup>38</sup> In particular, CHLNet partnered with Royal Roads University to spearhead a four year study of leadership and its role in health system re-design. The Partnerships in Health Systems Research (PHSI) study is being co-funded by the Canadian Institutes of Health Research and the BC Michael Smith Health Research Foundation. This \$850,000 study features six live case studies from each region of Canada and a unique Participatory Action Research protocol involving both senior decision-makers and health service researchers from across the country. The final cross case analysis report is in the process of being finalized (see [chlnet.ca](http://chlnet.ca) for more details) but some key general insights from the literature were supported, these are:<sup>39</sup>

- Leadership matters to organization and system performance. Canada does not have the desired overall leadership capacity required to lead significant health reform. It exists but does not have the critical mass to transform the system over time.
- Canada is not realizing its full potential because it has not embraced distributed or shared leadership models and collective capacity is being overwhelmed by contravening structural, cultural and political factors.

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<sup>36</sup> Canadian Health Leadership Network. (2014). *Toward a Canadian Health Leadership Strategy: A Working Paper*. [www.chlnet.ca](http://www.chlnet.ca).

<sup>37</sup> Dickson, G., Briscoe, D., Fenwick, S., Romilly, L., and MacLeod, Z. (2007). *The Pan-Canadian Health Leadership Capability Framework Project: A collaborative research initiative to develop a leadership capability framework for healthcare in Canada*. A final report submitted to Canadian Health Services Research Foundation, Ottawa, ON.

<sup>38</sup> Avolio, B., Walumbwa, F., and Weber, T. (2009). Leadership: Current Theories, Research, and Future Directions. *Annu Rev Psychol*, Vol. 60: 421-449.

<sup>39</sup> Dickson, G. and Tholl, B. (December 2013). *Leadership in Health Systems Design Research Project: Partnerships in Health System Improvement Cross-Case Analysis Final Report*.

- Change fatigue is growing among senior leaders and meaningful engagement of clinical leadership is required to sustain reform efforts.
- There are common leadership capabilities needed for reform including emotional intelligence, enlightened self-interest, vision, being a champion for change, team building/teamwork, role model/mentor, and effective two-way communication.
- Continued reliance in some parts of the health system on hierarchical, heroic leadership models. There is a need to strike the right balance between: centralization and decentralization forces; designated and distributed leadership; accountabilities and authorities; organization and system performance; and consensus and engagement strategies.
- Canada's more ad hoc approach to leadership and leadership development continues despite system-wide approaches and funding being seen in United Kingdom and Australia.

Canada's PHSI project demonstrates the ongoing value of a cross-national team of researchers and decision-makers to create a bridge from the research world to the policy world. New and more innovative pathways to effect a stronger national approach to leadership development building on leading local and regional efforts are required.

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*There are two different types of development – horizontal and vertical. A great deal of time has been spent on horizontal development (competencies), but very little time on vertical development (developmental stages). The methods for horizontal and vertical development are very different. Horizontal development can be transmitted (from an expert), but vertical development must be earned (for oneself).*

*Petrie, 2011.*

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In the United States, Petrie in his one-year sabbatical from Harvard University examined leadership trends and concluded that it is “no longer just a leadership challenge (what good leadership looks like), it is a development challenge (the process of how to grow bigger minds).”<sup>40</sup> His research showed four trends:

1. More focus on vertical development (developmental stages) rather than horizontal (competencies).
2. Transfer of greater developmental ownership to the individual rather than others such as a manager or human resources department.
3. Greater focus on collective rather than individual leadership development, i.e. spreading leadership capacity.

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<sup>40</sup> Petrie, N. (December 2011). *Future Trends in Leadership Development: A White Paper*. Centre for Creative Leadership. [www.ccl.org/leadership/pdf/research/futureTrends.pdf](http://www.ccl.org/leadership/pdf/research/futureTrends.pdf)

4. More focus on innovation in leadership development methods, i.e. rapid, new approaches driven by technology and the web.

Evidence-based decision-making is key however research must be translated so sense can be made of the data and applied to everyday health care settings. Good leadership behavior and paths must be modeled from proven leadership practices such as coaching and mentoring. Innovation in leadership practices such as lead physicians/nurse practitioners in Ontario's Family Health Teams and Quebec's Family Medical Groups are key to organizational and system development. New models with citizens and patients as leaders are emerging and patient-centered care can only strengthen health system performance. Leaders must motivate others to explore new models and designs.

#### 4. Enhance Capacity and Capabilities

Enhancing leadership capacity and capabilities requires both collective and individual approaches at the macro, meso and micro levels of the system. Planning and coordination for health leadership is also required as part of a broader health human resources strategy, such as the pan-Canadian framework that garnered support across jurisdictions in 2007.<sup>41</sup> Evidence is mixed on the extent of the leadership gap in Canada, especially among the middle management level.<sup>42</sup> What is being shown is that Canada has not fully embraced a distributed or shared leadership approach, which is seen as key to organizational and system performance.<sup>43</sup> Health care organizations must help build capacity but governments must encourage and promote capacity through funding and other incentives.

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*The tallest (FIR) in the forest is not the tallest just because it grew from the hardest acorn; it is the tallest also because no other trees blocked its sunlight, the soil around it was deep and rich, no rabbit chewed through its bark as a sapling, and no Lumberjack cut it down before it matured.*

*Gladwell, 2008.*

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Historically, leadership education, learning and development has been done at the organization and individual level of the system. It was typically a top down, competency-based and only for the high performers. A more mainstream and expansive view of leadership is emerging, one that believes experiential learning (reflecting on one's experiences) across a full spectrum is key to leadership development. There is a greater focus on shared leadership and rebalancing efforts to place more emphasis on vertical development (not just horizontal). The system must ensure there are moments where emerging leaders can experience leadership opportunities such as through stretch assignments in tandem with mentoring. There must be formal and informal development for physicians, nurses,

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<sup>41</sup> Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources. (2007). A Framework for Collaborative Pan-Canadian Health Human Resources Planning.

<sup>42</sup> Dickson, G. and Tholl, B. (December 2013). *Leadership in Health Systems Design Research Project: Partnerships in Health System Improvement Cross-Case Analysis Final Report.*

<sup>43</sup> Denis, J.-L., Lamothe, L. and Langley, A. (2005). The Dynamics of Collective Leadership and Strategic Change in Pluralistic Organizations. *Academy of Management Journal*, Vol. 44, No. 4: 809-837.

administrators and other health professionals to cultivate and refine their leadership skills; and where possible these opportunities should be done together.

The NHS literature highlights successful leadership development interventions required in an overall strategy.<sup>44</sup> These interventions include: identification of leadership talent; development centres; management and leadership development programs; executive development programs; change management programs; 360 degree feedback; and coaching.

Leadership training programs are being seen at most universities in graduate studies. The Canadian Foundation for Healthcare Improvement (CFHI) runs the Executive Training for health care improvement (EXTRA) program, a 14-month team-based fellowship on better management and use of evidence for quality and performance improvement.<sup>45</sup> EXTRA uses Canadian and international faculty and practice leaders to provide participants with skills and knowledge to become change agents in health care improvement. The Canadian Society of Physician Executives and the Canadian Medical Association's Physician Management Institute undertake leadership training of physicians.

Increased mobility of health personnel across Canada also brings issues around harmonization of training requirements (e.g. concept of a "leadership passport"), agreement on internal trade, etc. Succession planning is required to ensure leadership gaps are filled by the right people at the right time and in the right place. Coaching and mentoring will help with this. Canada needs a better inventory of what is available at the various levels of the health system and across jurisdictions. But in the end, multiple solutions are required to enhance capacity. Leadership development and learning must be a lifelong pursuit as new skills are required constantly.

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*Leaders recognize and manage change, define roles, encourage collaboration, build consensus, provide vision, align goals and activities, and measure performance. Leadership needs to be continual, dynamic and responsive to changing needs.*

*Health Council of Canada, 2013.*

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## **5. Measure and Evaluate Success**

A compelling statement of vision must be supported with key measures of success; these are the book ends of any initiative. What expected results should be achieved and how will the system know when these have been reached? And if results are not met, and evidence validates the need to change, corrective action must be taken. Targets and benchmarks should be derived. A national benchmarking

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<sup>44</sup> National Health Service. (2012). *Leadership Framework and Leadership Development*.

<sup>45</sup> Canadian Foundation for Healthcare Improvement. *EXTRA Program*. Accessed website on September 24, 2013. [www.cfhi-fcass.ca/WhatWeDo/EducationandTraining/EXTRA.aspx#sthash.XTqyxhl4.dpuf](http://www.cfhi-fcass.ca/WhatWeDo/EducationandTraining/EXTRA.aspx#sthash.XTqyxhl4.dpuf)

study is in fact being undertaken by CHLNet with key partners and leading researchers (Graham Dickson, Royal Roads University and Ivy Bourgeault, Ottawa University) to assess the leadership gap.

## Proposed Pan-Canadian Health Leadership Strategy Framework

Based on the evidence gathered to date, a five pillar strategy framework is proposed that reflects this collaborative, comprehensive, incremental, and evidence-based approach (Figure 4). Each pillar represents the elements of a strategy framework and would be applied at a macro, meso and micro levels of the health system with the overall objective of improving health system performance.

**Figure 4: Canadian Health Leadership Strategy Framework**



As mentioned above, the initial PHSI cross case insights are coming soon but in general, the results confirm that leadership is a key enabler for both better organizational and system performance. In particular, the results underscore the work of Best et al. and what they describe as the “five simple rules” of large scale health reforms: (1) blend designated leadership with distributed leadership; (2) establish feedback loops; (3) attend to history; (4) engage physicians; and (5) include patients and families.<sup>46</sup>

<sup>46</sup> Best, A., Greenhalgh, T., Lewis, S. et al. (2012). Large-System Transformation in Health Care: A Realist Review. *The Milbank Quarterly*, Vol. 90, No. 3: 421-456.

For conversation purposes only, the PHSI summary policy insights are presented below in the form of an issue-response matrix for a March 4, 2014 deliberative dialogue. The proposed responses would be at a macro level only. Please see Appendix A for a draft and more detailed description of the matrix.

**Table 1: PHSI Leadership in Service of Health Issues and Options Matrix**

Issue	Response
<b>Current ad hoc approach to health leadership capacity development not sustainable</b>	Develop a pan-Canadian leadership (development) and innovation strategy
<b>Dearth of leader engagement in health reform</b>	Create a Canadian heath leadership charter
<b>Minimal evidence around leadership development and return on investment</b>	Sustain funding for a Canadian health leadership and system redesign research network
<b>Underinvestment in leadership development</b>	Establish a health leadership and innovation fund
<b>Lack of coordinated health leadership strategy framework</b>	Form a Canadian health leadership academy and move toward a common health leadership framework

### Summing Up

A decade ago, leadership was not on the policy landscape. However with declining relative performance, leadership is now seen as an integral ingredient to move to our desired future. Better, stronger, more supportive health leadership is what is required to put Canada back atop the best performing health systems in the world. But it will take collective action that cuts across jurisdictions and disciplines.

There is a growing consensus that a pan-Canadian and collaborative approach to developing excellence in health leadership is required to achieve the desired vision of **Better Leadership, Better Health—Together**. Successful coalitions must: purposefully build partnerships to create results, mobilize knowledge, demonstrate a commitment to customers and service, and navigate socio-political environments. But we must also remember in this leadership journey that individually:

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*You’re a leader for life. We must continue the quest for better understanding of how processes and relationships come together for the complex adaptive leadership that healthcare systems for the 21<sup>st</sup> century will demand. We must all strive to be agents of change or we shall surely be the objects of change!*

*Dickson and Tholl, 2014.*

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## Where to Next

This working paper is intended to be a starting point for an evolutionary approach to ensuring the leadership issues and elements of a strategy framework are fully considered. An electronic consultation occurred over the fall with the 40 CHLNet Network Partners (NP) with 20 respondents. This built on a June 2013 focus group at the National Health Leadership Conference (NHLC). In December 2013, the NP Roundtable included discussion of findings to date and possible action to move forward on a pan-Canadian strategy. The paper's next stop is an invitation only, February 14, 2014 Policy Forum on health leadership in Montreal. It as well will feed into and benefit from a March 4, 2014 McMaster Deliberative Dialogue on fostering leadership in health system change through an issue-response brief arising from the PHSI (Appendix A).

A policy brief from these initiatives will be developed and require approval by NPs at its May 2014 Roundtable meeting. Reporting and additional feedback on proposal action will occur at the June 3, 2014 NHLC CHLNet sponsored breakfast session. The desire is to present at the Committee on Health Workforce (targeted March 2014), with a formal "ask" at the fall Council of Deputy Ministers of Health meeting.

## Bibliography

Aggarwal, M. and Hutchison, B. (2012). *Toward a Primary Care Strategy for Canada*. Canadian Working Group for Primary Healthcare Improvement.

Archer, S. (2013). Leadership Development – Can There Be a Return on Investment. *Development and Learning in Organizations*. Vol. 27, No. 3: 18-21.

Avolio, B., Avey, J., and Quisenberry, D. (2010). Estimating Return on Leadership Development Investment. *The Leadership Quarterly*, Vol. 21, No. 4: 633-644.

Avolio, B., Reichard, R., Hannah, S. et al. (2009). A Meta-Analytic Review of Leadership Impact Research: Experimental and Quasi-Experimental Studies. *The Leadership Quarterly*, Vol. 20, No. 5: 764-784.

Avolio, B., Walumbwa, F., Weber, T. (2009). Leadership: Current Theories, Research, and Future Directions. *Annu Rev Psychol*, Vol. 60: 421-449.

Ball, T. (2013). *So, Your Health Link Wants to Succeed: Measures to Overcome Five Learning Disabilities*. <http://quantumtransformationtechnologies.com/category/blog/>

Best, A., Greenhalgh, T., Lewis, S. et al. (2012). Large-System Transformation in Health Care: A Realist Review. *The Milbank Quarterly*, Vol. 90, No. 3: 421-456.

Canadian Federation of Nurses Union. (2012). *The Nursing Workforce CFNU Backgrounder*. Available at [http://nursesunions.ca/sites/default/files/2012.backgrounder.nursing\\_workforce.e\\_0.pdf](http://nursesunions.ca/sites/default/files/2012.backgrounder.nursing_workforce.e_0.pdf).

Canadian Foundation for Healthcare Improvement. *EXTRA Program*. Accessed website on September 24, 2013. [www.cfhi-fcass.ca/WhatWeDo/EducationandTraining/EXTRA.aspx#sthash.XTqyxhl4.dpuf](http://www.cfhi-fcass.ca/WhatWeDo/EducationandTraining/EXTRA.aspx#sthash.XTqyxhl4.dpuf).

Canadian Health Leadership Network. (2014). *Toward a Canadian Health Leadership Strategy: A Working Paper*. [www.chlnet.ca](http://www.chlnet.ca).

Canadian Health Leadership Network. (2007). *A Report on Leadership Development Practices in the Health Sector*. Prepared by the Conference Board of Canada.

Canadian Medical Association and Canadian Nurses Association. (2011). *Principles to Guide Healthcare Transformation in Canada*. [www.cma.ca/advocacy/hctprinciples](http://www.cma.ca/advocacy/hctprinciples)

Corrigan J. (2013). Distributed Leadership: Rhetoric or Reality. *Journal of Higher Education Policy and Management*, Vol. 35, No. 1: 66-71.

Currie, G. and Lockett, A. (2011). Distributing Leadership in Health and Social Care: Concertive, Conjoint or Collective? *International Journal of Management Reviews*, Vol. 13: 286-300.

Denis, J.-L., Lamothe, L. and Langley, A. (2005). The Dynamics of Collective Leadership and Strategic Change in Pluralistic Organizations. *Academy of Management Journal*, Vol. 44, No. 4: 809-837.

Dickson, G. (2012). *Anchoring Physician Engagement in Vision and Values*. Regina Qu'Appelle Health Region/CPNet.

Dickson, G., Briscoe, D., Fenwick, S., Romilly, L., and MacLeod, Z. (2007). *The Pan-Canadian Health Leadership Capability Framework Project: A collaborative research initiative to develop a leadership capability framework for healthcare in Canada*. A final report submitted to Canadian Health Services Research Foundation, Ottawa, ON.

Dickson, G. and Tholl, B. (2014). *Bringing Leadership to Life in Health: LEADS in a Caring Environment*. London: Springer. Available at [www.springer.com/medicine/book/978-1-4471-4874-6](http://www.springer.com/medicine/book/978-1-4471-4874-6).

Dickson, G. and Tholl, B. (December 2013). *Leadership in Health Systems Design Research Project: Partnerships in Health System Improvement Cross-Case Analysis Final Report*. [www.chlnet.ca](http://www.chlnet.ca).

Dickson, G., Tholl, B. et al. (2013). *Draft Leadership and Design Health Insights*. Partnerships in Health System Improvement (PHSI) Project.

Edmonstone, J. (2011). Developing Leaders and Leadership in Healthcare: A Case for Rebalancing? *Leadership in Health Services*, Vol. 24 No. 1: 9.

Ellehuus, C. (2011). Improving Returns on Investment. *Strategic HR Review*, Vol. 10, No. 6.

English, F.W. (2008). *The Art of Educational Leadership: Balancing Performance and Accountability*. Thousand Oaks, CA: Sage.

Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources. (2007). A Framework for Collaborative Pan-Canadian Health Human Resources Planning.

Ford, R. (2009). Complex Leadership Competency in Health Care: Towards Framing a Theory of Practice. *Health Services Management Research*, Vol. 22: 101-114.

Ham, C. (2013). Reforming the NHS in England: Opportunities and Challenges. *Medio-Legal Journal*, Vol.91, Part 1: 2-17.

Ham, C., Edwards, N. and Brooke, B. (2013). *Leading Health Care in London*. The King's Fund.

Health Council of Canada. (September 2013). *Better Health, Better Care, Better Value for All: Refocusing Health Care Reform in Canada*.

Gladwell, M. (2008). *Outliers: The Story of Success*. Little, Brown and Company.

Grimes, K. (2007). *The Decade of the High-Performing Health Care Workforce: A Talent Management Perspective for Health Human Resources in Canada*. Conference Board of Canada.

HealthWorkforce Australia. (2011). *National Health Workforce Innovation and Reform Strategy Framework for Action, 2011-2015*. [www.hwa.gov.au/publications](http://www.hwa.gov.au/publications)

- Kellerman, B. (2012). *The End of Leadership*. New York: HarperCollins.
- Maddock, S. (2011). Transformational Public Leadership Is Collaborative. *Human Resources Management International Digest*, Vol. 19, No. 7: 40-41.
- Metrics@Work, Grimes, K., and Swettenham, J. (2012). *Compass for Transformation: Barriers and Facilitators to Physician Engagement*. Regina Qu'Appelle Health Region/CPNet.
- National Center for Health Leadership. *NCHL Catalyst Framework*. Retrieved from website on October 9, 2013.
- National Health Service. (2012). *Leadership Framework and Leadership Development*. [www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-LeadershipFramework-OrganisationalToolkit-LeadershipDevelopment.pdf](http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-LeadershipFramework-OrganisationalToolkit-LeadershipDevelopment.pdf)
- National Health Service. (2011). *Leadership Framework*. [www.leadershipacademy.nhs.uk/discover/leadership-framework/](http://www.leadershipacademy.nhs.uk/discover/leadership-framework/).
- NHS Leadership Academy. (2013). *Approaches to Talent Management*. [www.leadershipacademy.nhs.uk/discover/talent-management-approaches/approaches-to-talent-management-now-and-in-the-future/](http://www.leadershipacademy.nhs.uk/discover/talent-management-approaches/approaches-to-talent-management-now-and-in-the-future/)
- NHS Leadership Academy. (2013). *The Leadership Compact*. [www.leadershipacademy.nhs.uk/discover/talent-management-approaches/leadership-compact/](http://www.leadershipacademy.nhs.uk/discover/talent-management-approaches/leadership-compact/)
- NHS Leadership Academy. (2013). *Towards a New Model of Leadership for the NHS*. [www.leadershipacademy.nhs.uk/wp-content/uploads/2013/05/Towards-a-New-Model-of-Leadership-2013.pdf](http://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/05/Towards-a-New-Model-of-Leadership-2013.pdf)
- Parliamentary Business Website: [www.publications.parliament.uk/pa/ld201213/ldhansrd/text/121122w0001.htm](http://www.publications.parliament.uk/pa/ld201213/ldhansrd/text/121122w0001.htm).
- Petrie, N. (December 2011). *Future Trends in Leadership Development: A White Paper*. Centre for Creative Leadership. [www.ccl.org/leadership/pdf/research/futureTrends.pdf](http://www.ccl.org/leadership/pdf/research/futureTrends.pdf)
- Saul, J.E., Best, A., and Noel, K. (January 2014). *Implementing Leadership in Healthcare: Guiding Principles and a New Mindset*. [www.longwoods.com](http://www.longwoods.com)
- Shamir, B. (2011). Leadership Takes Time: Some Implications of (Not) Taking Time Seriously in Leadership Research. *The Leadership Quarterly*, Vol. 22, No. 2: 307-315.
- Senge, P. (2002). *The Fifth Discipline*. New York: DoubleDay.
- Spurgeon, P., Mazalan, P., and Barwell, F. (2011). Medical Engagement: A Crucial Underpinning to Organizational Performance. *Health Serv Manage Res*, Vol. 24, No. 3: 114-120.

- Statistics Canada. (2012). *Canadian Population in 2011: Age and Sex*. [www12.statcan.ca/census-recensement/2011/as-sa/98-311-x/98-311-x2011001-eng.cfm](http://www12.statcan.ca/census-recensement/2011/as-sa/98-311-x/98-311-x2011001-eng.cfm)
- Swensen, S., Pugh, M., McMullan, C., and Kabcenell, A. (2013). *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement. Available at [www.ihl.org](http://www.ihl.org).
- Tholl, B. and Bujold, G. (2011). *Functional Federalism and the Future of Medicare in Canada*. HEAL.
- Tholl, B. and Grimes, K. (2012). *Strengthening Primary Health Care in Alberta through Family Care Clinics: From Concept to Reality*. Alberta Health.
- Tholl, W.G. et al. (2006). Passing the Baton. *Healthcare Management Forum*, Vol. 19, No. 1: 14-40.
- Thornhill, J. (2010). Charter on Improving Quality of Patient Care. *Healthcare Quarterly*, Vol. 13, No. 3: 13.
- Thorpe, R., Gold, J. and Lawler, J. (2011). Locating Distributed Leadership. *International Journal of Management Reviews*, Vol. 13: 239-250.
- Towers Watson. (2012). *Global Workforce Study*. <http://towerswatson.com/assets/pdf/2012-Towers-Watson-Global-Workforce-Study.pdf>
- West, M. and Dawson, J. (2012). *Employee Engagement and NHS Performance*. London: The King's Fund.
- Zimmerman, B. (2009). *A Complexity Science Primer*. Available at <http://napcrg.org>.

## Appendix A: PHSI Leadership in Service of Health Issue-Response Matrix

- 1. Issue: Current ad hoc approach to health leadership capacity development not sustainable.** There is a convergence of evidence and informed opinion that effective leadership is critical to overall organizational and health system performance. Continuing individual efforts in the face of collective challenges will inevitably lead to ongoing system underperformance. Canada has numerous leadership program offerings but we need to harness and leverage the program activity, interest and opportunity to advance the leadership agenda. In the absence of effective, present leadership the forces of fragmentation will continue to overwhelm individual leadership efforts. There is an attendant high level of concern about burnout of current executive and middle level leaders and about where future health leaders will come from. Evidence suggests that where there is a critical mass of shared effort toward a common purpose, there is marked progress. Canada can and must do a better job of working together to leverage innovations in health leadership by creating and sustaining the leadership capacity needed to tackle 21<sup>st</sup> century leadership challenges.

**Response: Develop a pan-Canadian leadership (development) and innovation strategy.** A made-in-Canada, pan-Canadian leadership development strategy is long overdue as an integral part of moving forward with the longstanding commitment to adopt an integrated, needs-based health human resources strategy. The vision of this leadership strategy is to be supportive of a Canadian reform agenda (yet to be clarified) commensurate with the triple aim objectives of *better health, better care and better value*. There is a consensus on the need to do more that dates back to the Federal/Provincial/Territorial consensus reached around the Pan-Canadian Health Human Resources Framework (2007). Canada is capable of doing for our system what Health Workforce Australia is doing for Australia and what the NHS Leadership Academy is doing for the United Kingdom: to support leaders through the complex, ever-changing demands of health leadership for today and tomorrow, through integrated and funded strategies linked to engendering reform. These efforts abroad can help guide efforts here in building a vision for Canada.

- 2. Issue: Dearth of leader engagement in reform.** The evidence is in and it is not good. Early, ongoing and meaningful engagement of the clinical community, especially physicians, and different formal leadership levels (i.e., boards, mid-management, front-line supervisors) in the reform work is generally absent in the system. Engaging all leaders is mission critical to building and sustaining the momentum needed to tackle the difficult challenges ahead. There are exemplars across the country of where physician engagement and leader engagement has been taken far more seriously than elsewhere and where the triple aim objectives are being realized.

**Response: Create a Canadian health leadership charter.** There is need to clarify the respective roles and responsibilities in the system as they are required for reform to happen. The evidence underscores the need to alter accountabilities and authorities in the system to

reflect reform priorities, and how to work together to achieve them. Indeed, it can be argued that the (growing) disjuncture between the two--whereby designated responsibilities are not aligned with change responsibilities-- is the single biggest deterrent to for people stepping up to take on an increased leadership role in system reform. A *Health Leadership Charter* would support "Large Scale Transformation" (LST), by clarifying expectations across leaders from all segments: formal leaders, and informal leaders found in payer, provider and patient communities. Effective reform starts from the premise "nothing about us without us, and "people support what they help create". It would essentially set out the first principles or "simple rules" for LST and for working together to do a better job of creating reform, and in identifying, developing and supporting better leadership. The *Charter* could be built around: blending designated leadership and distributed leadership; establishing goal-oriented feedback loops; aligning leader accountabilities and responsibilities; and meeting expectations of leadership from patients and families. These first principles would play out differently in different contexts.

**3. Issue: Minimal evidence around leadership development and return on investment.**

Recent research gives us a better understanding of the importance of leadership in system reform and some of the factors explaining our underperformance relative to our leadership potential. There is the capacity in the system, but the evidence is lacking on how to create the winning conditions to realize this leadership potential. Leadership efforts tend to be peripatetic and localized, rather than coordinated and aligned at the macro and meso levels of the system. There is an overall lack of data on leadership capacity and the analytical capacity to make sense of the qualitative information that we are just beginning to bring together.

**Response: Sustain funding for a Canadian health leadership and system redesign research network.** The good news is that there appears to be a successful "proof of concept" around the benefits of bringing senior decision-makers and senior health services researchers together to better extend our knowledge of what leadership is required to create health redesign. There is a high level of engagement in undertaking live case studies in health leadership, with an unexpected, high level of disclosure, self-reflection, and self-correction. Knowledge transfer or mobilization remains elusive in some case due to the absence of clearinghouse for new insights. A small permanent health leadership research secretariat, cutting across jurisdictions and operating within an existing or mandate-modified Canadian agency (e.g. CIHI, CHLNet, CHA-ACAHO) should guide efforts.

**4. Issue: Underinvestment in leadership development.** While there is no easily accessible, reliable data on Canada's overall health leadership spend, there is a consensus of opinion that leadership development is not a priority, especially during times of fiscal constraint. Leadership is often seen as discretionary, done in localized pockets, with professional development and travel budgets being among the first to be sacrificed in an effort to direct maximum dollars to the front line. The business case for health leadership development usually flounders because of the inherent challenges of demonstrating return on investment. One of these challenges is

extending our commitment to the fundamental “social good” character of health leadership through greater coordination and investment.

**Response: Establish a health leadership and innovation fund.** A \$50M five-year dedicated health leadership development for health systems redesign fund would be created and be administered by the same arms-length health agency charged with executing on the research agenda. The leadership development agenda would reflect and underscore the need for a concerted approach to talent management, with the creation of regional, provincial and national leadership talent management pools and strategies that respond to the needs of jurisdictions--large and small. It would harness and leverage the leadership program offerings already in place at a local level. The process of development would engage participant leaders in tackling real issues of redesign; and using their collective knowledge to support the reform agenda.

- 5. Issue: Lack of coordinated health leadership framework.** Until relatively recently, there was a lack of consensus on both the importance of leadership (was assumed or taken for granted) and a rigorous, accessible leadership framework. More recently, leadership development programs such as the EXTRA program have helped increase both awareness of the importance of leadership and the credibility of the growing community of practice around health leadership. The collaborative efforts of CHLNet and the Canadian College of Health Leader have also played an important role in setting the table for a “leadership without ownership” philosophy to growing leadership capacity across the country.

**Response: Create a Canadian Health Leadership Academy and move toward a common health leadership framework.** While there is a wide variety of effective ways and means of delivering leadership programs, there is a growing recognition of the need to create a common leadership learning platform or framework to facilitate a common language especially for joint work to create health reform. Other systems (e.g. UK and Australia) have moved to adopt common frameworks, as have high performing organizations (e.g. Cleveland Clinic). Indeed, in the case of Australia a framework developed in Canada has been adapted and adopted country wide. That framework is *LEADS in a Caring Environment*. This framework has a proven track record for helping organizations and individuals realize their potential. LEADS has rapidly spread across Canada, not as an exclusive delivery program but as an appealing common leadership language and platform for assessing or mapping progress. An endorsement of a common framework by senior policy leaders is now needed to help ensure maximum bang for the leadership investment dollar and mitigate the hierarchical, profession-specific, siloed approach of the past. Sustaining the framework and facilitating the development of common, interdisciplinary leadership curriculum would be under the auspices of a Canadian Health Leadership Academy, again working under the auspices of and in conjunction with an existing Canadian health agency and more local efforts.