



Changing Health Organizations with the **LEADS Leadership Framework**

Report of the 2014-2016 **LEADS Impact Study**



*Fenwick
Leadership
Explorations*



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Key Messages

The LEADS in a Caring Environment health leadership capabilities framework (LEADS) was developed in British Columbia in 2006 to address the needs of healthcare in the context of health organization renewal (Dickson, Briscoe, Fenwick, MacLeod, & Romilly, 2007; Dickson, 2008). The *2014-2016 LEADS Impact Study* reviewed the processes of and gathered feedback from five health organizations that were early adopters of LEADS and found a range of applications and outcomes for individuals, organizations, and systems.

At the individual level, LEADS

- provides a framework that legitimizes individuals' efforts to act to address challenges that they identify as priorities (i.e., it is empowering and enabling);
- provides a common language that facilitates multidisciplinary collaboration across a wide range of practice areas (i.e., facilitates efficiency and effectiveness);
- offers a framework that teams can use to work together to address specific tasks and strategic goals on a flexible ad hoc basis (i.e., supplements accountability);
- increases communication effectiveness, including the ability to have difficult yet productive conversations (i.e., provides a way to address friction); and
- enables professional development and succession planning (i.e., motivates and engages individuals).

Regarding health organization functioning, LEADS

- builds trust by encouraging reflection and collaboration, rather than competitiveness and inflexible controls;
- assists managers in engaging and guiding their teams by suggesting development opportunities, and stimulating the development of tools to assist teams to work together;
- supports succession planning by providing opportunities for individuals to self-select as potential future leaders through talent development opportunities; and
- provides standards to stimulate positive feedback systems to enable system change.

Relating to health systems achievement, LEADS

- provides a flexible framework that transcends accountability structures to achieve change;
- fosters innovation by providing a framework that individuals can use to link their own ideas to actions that are in alignment with strategic objectives;
- helps achieve strategic health priorities by encouraging individuals to link tasks to priorities through reflection, personal professional planning, performance assessments, and reporting; and
- provides a language for senior leaders to connect with all staff by focusing on the processes of innovating and addressing communication challenges.

Executive Summary

Health systems face constant change, including responding to new technologies, shifting standards of care, and increasing demands for more sophisticated care. In addition, complex public health issues must be addressed, such as mental health, the well-being of Indigenous peoples, substance use challenges, and aging populations (Naylor et al., 2003; Romanow, 2002; Truth and Reconciliation Commission of Canada, 2015). The interaction of public policy with health administration creates another area of complexity. These challenges are occurring in the context of an aging workforce and continued challenges in staff recruitment and retention, especially in rural and northern regions. These complex problems cannot be resolved with simple solutions; they demand sophisticated, responsive health systems.

The 2014-2016 LEADS Impact Study is the first systematic investigation of how the LEADS framework has been implemented by health organizations in Canada. The LEADS framework was developed in 2006 in the Province of British Columbia (Dickson, 2008; Dickson et al., 2007). Although its use has spread throughout Canada and beyond, information about its implementation and effectiveness is still largely held among practitioners. This study, therefore, set out to answer five strategic research questions:

- Why are you using the LEADS framework?
- How are you using the LEADS framework?
- What is helping or hindering the use of the LEADS framework?
- What difference does your use of the LEADS framework make?
- How do you know that your use of the LEADS framework is making a difference?

The research utilized an embedded case study approach (Yin, 2014). This approach maintained the integrity and coherence of each case, while also studying the same phenomena, in this case leadership development and LEADS, across all the cases. The embedded case study approach made sense for studying leadership development because of the small pool of key informants, such as senior leaders and talent management staff, in each health organization.

Five health organizations participated as cases, representing diverse sizes, functions, geographic jurisdictions, and approaches to implementation. Four of these organizations had at least four years of experience implementing LEADS, and one, Island Health, had been involved in the initial study when LEADS was developed in 2006.

Exploratory interviews and focus groups were conducted with 76 people, from informal leaders to board members (Appendix 3). The interviewees and focus group participants represented diverse areas of practice, including key professions, administration, and talent management. Individuals were asked about how they used LEADS, how it had been adopted by their institution, and what difference it was making to them, to their workplace, and to health systems. Participants were asked what evidence they

could provide to demonstrate impact or effectiveness. The results showed how the linked, progressive system outlined in the LEADS framework works.

Changing the Way Health Organizations Function

All the health organizations involved in this study had experienced a radical reorganization or changes in strategic vision prior to adopting the LEADS framework. In British Columbia, where LEADS was developed, 52 health regions were amalgamated into five regional health authorities in 2001 (Ministry of Health Planning, Government of British Columbia, 2002). Alberta Health Services (AHS) was launched in April, 2009, out of several regional health organizations (Alberta Health Services, 2009; Donaldson, 2010). Health PEI was created in 2010, moving health administration and policy out of government and amalgamating brick-and-mortar institutions with the regional health organizations (HPEI-Int). The Canadian Agency for Drugs and Technologies in Health (CADTH) underwent a customer service review in 2009 (CADTH-Int). Saskatchewan, the first province in Canada to amalgamate healthcare organizations in 1993, completed reorganization in 2001, but continued to search for improvements, eventually through the Lean Six Sigma program as well as LEADS (Canadian Plains Research Center, 2006; Government of Saskatchewan, 2013; Mutwiri, Witt, Denysek, Halferdahl, & McLeod, 2016). As these cases demonstrate, the implementation of leadership frameworks, while not solely responsible for resolving strategic dilemmas, became a means to change the way the organizations worked.

Each organization in this study was an early LEADS adopter, and each organization took unique approaches to implementing LEADS. However, they each consulted with external partners to map their existing talent development assets, and then proceeded to more specific programmatic offerings that developed leadership domains and capabilities identified in the framework. The results showed that LEADS is highly adaptable and suited to use in diverse contexts, helping to create a common language for a systems-thinking approach. Seven key findings are highlighted in the following sections.

1. Implementation: A Flexible, Responsive Framework

Initially, each organization in this study (except for Island Health, which developed its approach in parallel to the development of LEADS) began its implementation with general introductory sessions on LEADS. As the implementation progressed, existing and new programs were mapped to LEADS domains and capabilities and a variety of educational programs (including private market and existing in-house courses) were used to create a LEADS-based leadership development program. Workshops focused on specific LEADS capabilities, such as developing personal awareness of oneself or building interpersonal communications or management skills. External consultants who were familiar with LEADS often introduced LEADS; however, as these projects progressed, organizations developed internal capacity to offer LEADS-based programs. Over time, cohort-based or group modules were developed that brought people together for face-to-face courses, supplemented by applied team projects. These cohort-based offerings provided momentum for change. The face-to-face delivery of these programs also created enduring connections that facilitated ongoing cross-organization collaboration. An incidental outcome was that individuals who had participated could easily integrate into new work units that used LEADS. As the program offerings grew, talent management staff continued to explore how to deliver programs

efficiently and effectively. For example, AHS experimented with online elective programs and CADTH moved to an applied leadership model in which teams of leaders used LEADS to solve problems. This co-planning model provided ongoing introduction for new staff. All organizations included in this study continue to evolve and explore how to continue to develop leaders using LEADS.

2. Engaging through LEADS

Participants in the study reported that they liked LEADS, and talent management staff noted a high demand for the programmatic offerings that they developed. New managers found the information extremely helpful for learning how to engage with their responsibilities. Participants in the study who were already passionate and knowledgeable about leadership found that taking part in this study renewed their interest in, and the value of, LEADS. The organizational training investments made participants feel valued by their senior leaders. Participants found that because LEADS was easy to use (i.e., intuitive), they felt motivated to use it. Because of these outcomes, LEADS became a conduit for engagement and motivation and helped to “change the culture” by providing a way to conduct work.

3. Empowerment and Accountability

Accountability and empowerment might seem to be opposites; however, participants described ways in which the use of LEADS in performance review systems supported both. LEADS domains or capabilities enabled them to identify key strategic goals on which to work. Managers could support staff using a common language. In some organizations, performance reviews were supported with LEADS 360° assessment feedback and regular performance review systems that linked individual goals, unit tasks, and strategic directions.

4. Developing Outcome-Focused Team Structures

The LEADS framework enables leaders to interact with individuals from multiple disciplines across a range of work environments as well as with community leaders and members. Study participants repeatedly described ways in which they referred to the framework to identify problems and think through solutions. Further, LEADS legitimized individuals’ efforts to involve others to help resolve issues. This positive approach to problem solving enabled leaders to implement actions that were beyond the traditional means of command-and-control hierarchies and permitted the growth of flexible yet accountable, action-oriented structures. LEADS enabled leaders to leverage diverse skills across teams and empowered more junior managers and those with cross-disciplinary portfolios to work together. Leaders accomplished this through the common language of LEADS, which enables facilitation and communication when identifying and working through challenges.

5. Activating a Complex System

LEADS provided a means for individuals to engage each other, to resolve difficulties, and to employ creative problem solving while maintaining accountability for reliable, responsive health services. By facilitating communication, learning LEADS capabilities appeared to ease interaction between individuals and generate more effective collaboration. In addition, once leaders became familiar with

LEADS, they could transition from unit to unit, or between organizations, and easily integrate into their new teams. Individuals working with external partners found that they used the same language, which helped in establishing and accomplishing goals. Work units in different departments could communicate effectively despite their various views and contexts, including disciplinary differences. Thus, LEADS enabled leaders to work more effectively within the complexities of the organization without changing the structure.

6. Sustaining Customer, Client, and Patient Outcomes

As public agencies, health organizations are challenged to meet and sustain overall health service goals. The ability to meet policy and strategic priorities was most apparent in Saskatoon and Sunrise Health Regions, where the Lean Six Sigma program made goals part of the accountability structure. However, across the case study organizations, participants spoke about the way LEADS helped them meet the complex health needs of the population and small communities. Goal achievement was most successful when organizational structures helped link individual actions to unit goals, unit activities to organizational missions, and organizational missions to policy directions. Even during reorganization or other types of disruption, the LEADS leadership framework was effective in supporting outcomes that aligned with organizations' mission and vision statements. Some of the helpful structures included regular performance reviews, 360° assessments that were explicitly tied to outcomes, regular leadership team meetings, LEADS champions in the organization, board backing and engagement with leadership development and strategic visions, and human resources practices that targeted and explicitly promoted leadership development as part of a strong organization.

7. Self-Evaluating Progress

One of the challenges of deploying leadership development is the lack of a linear relationship between learning and behavioural change. Several participants who had taken leadership development training earlier, such as through the Master of Arts in Leadership program at Royal Roads University, said that they had gained fresh insights or developed a deeper understanding in a second course or a later project when they were applying leadership principles. Regular reflection through professional development planning processes, one-on-one meetings with managers, coaching sessions, or discussions after performance review processes provided valuable opportunities to reflect on professional development.

These seven key findings summarize the way LEADS supports organizations' mission and vision statements, helps individuals in planning and achieving work tasks and responsibilities effectively, and allows organizations to align and coordinate collaboration while not disrupting accountability structures.

Reflections on the LEADS Framework

This systematic study of the LEADS framework documents a range of effects, illustrating that the framework can help to achieve a cultural shift. This study also indicates that adopting LEADS is not a one-time event. Each of the five organizations conducted ongoing systematic work to review implementation approaches, maintain interest, and evolve organizational capacity to utilize LEADS. The

study also found that, although talent management staff led the program implementation, organizational champions helped to boost momentum and maintain a credible program. In addition, for broad and effective utilization, executive leaders had to demonstrate how strategic goals were linked to leadership approaches. Participants expressed a need for more research into how to make programs more effective and a need to investigate how to make what is being accomplished more transparent. What was disconfirmed was that the LEADS framework itself needed upgrading. In fact, LEADS was compared favourably with many other systems that participants described as more limited or rigid than LEADS.

Introduction

The LEADS in a Caring Environment health leadership capabilities framework (LEADS) was developed in British Columbia (BC) in 2006 as the first step in a three-year provincially funded leadership development project called *leadersforlife* that was led by the Health Care Leaders Association of BC (2006–2009). Following 2009, the Canadian College of Health Leaders (CCHL), Canadian Health Leaders Network (CHLNet), Royal Roads University and Dr. Graham Dickson championed the framework across Canada; their common purpose evolved into the establishment of the LEADS Collaborative in 2012. The use of LEADS has spread to provincial health organizations in Alberta, Manitoba, Saskatchewan, Nova Scotia, and Prince Edward Island (PEI), as well as to health regions and organizations in Canada. LEADS has also drawn international attention, including in Australia (Health Workforce Australia, 2013) and New Zealand (McHardy & McCarthy, 2015).

The development of LEADS was inspired by the need for a Canadian approach to leadership in health at a time of increasing complexity of need, service, and interaction between health organizations and the contexts of health (Dickson, 2008). Dickson et al.'s (2014) cross-case analysis of five case studies found that the challenges facing healthcare continue to require “adaptive leadership”, which enables “people [in an organization] to tackle tough challenges and thrive” (Heifetz, 1994; Heifetz, Grashow & Linsky, 2009, p. 14). The study also found that Canada’s fragmented healthcare system requires coordination and knowledge translation beyond what currently exists. Dickson et al. (2014) stated that the LEADS framework was one potential avenue for accomplishing this change. There is a strong consensus among those who use LEADS that it works. However, how LEADS impacts leadership and how, in turn, leadership can impact the changing conditions of healthcare needs further research (Leadership for Health System Redesign Planning Committee, 2015; Lavis, Moat, & Rizvi, 2014).

LEADS has been available for almost ten years. This study systematically examined how LEADS was implemented in five very different health organizations, the effects of implementation, and ways to enhance the use of the framework. This report describes the original impetus for the development of LEADS as a Canadian leadership framework designed to respond to specific Canadian contextual conditions and needs. It then describes the adoption of LEADS in each of the five health organization case studies and then presents the main findings. Finally, the impacts of LEADS as described by the study participants are outlined. The report ends with five key lessons. The methodology and sampling methods are described in more detail in Appendix 1.

Throughout the report, participant codes have been used when citing material from the interviews and focus group sessions (see Table 1). These codes have been used to protect participant anonymity.

TABLE 1. PARTICIPANT CODES FOR STAFF OF THE FIVE CASE STUDY ORGANIZATIONS

Participant Code	Description
AHS-INT	Alberta Health Services Interviewee
AHS-FG	Alberta Health Services Focus Group Participant
CADTH-INT	Canadian Agency for Drugs and Technologies in Health Interviewee
CADTH-FG	Canadian Agency for Drugs and Technologies Focus Group Participant
HPEI-INT	Health PEI Interviewee
HPEI-INT	Health PEI Focus Group Participant
IH-INT	Island Health Interviewee
IH-FG	Island Health Focus Group Participant
SHR/SHI-INT	Saskatoon Health Region/ Sunrise Health Region Interviewee
SHR/SHI-FG	Saskatoon Health Region/ Sunrise Health Region Focus Group Participant

I. Background: The Development of LEADS

The Need for Health Leadership in Canada

Health systems are challenged by the complexity of health issues “in which we cannot control all the multiple cause-and-effect and feed-back relations at work” (Van Dormael, Kegels, & Marchal, 2005, p. 3). Health systems are increasingly recognized as complex adaptive systems, in alignment with a holistic approach to health and World Health Organization principles (Alliance for Health Policy and Systems Research, 2004; van Olmen et al., 2010; World Health Organization, 1978). However, moving from a hierarchical to a systems approach requires leadership development and a change in how leadership functions (Snowdon & Cohen, 2011).

Not enough is known about the implementation or outcomes of leadership development in health systems (Snowdon & Cohen, 2011). More specifically, although some jurisdictions have been working to shift the culture of healthcare administration toward systems thinking by instituting appropriate leadership development approaches informed by LEADS, more documentation is needed on the impacts of leadership development approaches on the performance of health systems (Snowdon & Cohen, 2011). Proponents of complex adaptive systems suggest that leadership can impact the achievement of strategic priorities if it is “shared, distributed, collective, relational, dynamic, emergent and adaptive” (Uhl-Bien & Marion, 2009, as cited in Popp, Milward, MacKean, Casebeer, & Lindstrom, 2014, p. 43). Leadership research could provide opportunities for researchers to contribute to systems transformation by providing information for results-oriented development (Alliance for Health Policy and Systems Research, 2004). The results of this research will contribute to the movement from 20th-century command-and-control organizational approaches to organic systems thinking, which is flexible, adaptive, and responsive.

It is hoped that the findings of this study will inform future applications of LEADS, facilitate a better understanding of the contexts and challenges of leadership development using the LEADS framework, and provide insight into the challenges of shifting to a systems-thinking approach. At the applied level, the findings may inform improvements to ways of implementing LEADS by individuals, teams, and organizations. This research also builds an understanding of LEADS as well as its value as a leadership framework. Better understanding of the context of leadership development and deployment will lead to improvements in the LEADS 360° assessment tools and support the ongoing development of client-centred LEADS offerings by LEADS Canada. This project also provides a more detailed theoretical understanding of the kind of organizational network challenges that exist for healthcare leaders. The study outcomes indicate the need to find a way to more systematically document the impacts of LEADS on leadership development and on organizational and health outcomes. The results are relevant beyond health systems, demonstrating potential in other organizational domains in the public and private sectors.

The Evolution of the LEADS in a Caring Environment Framework

The development of the LEADS framework occurred in a context of organizational change in BC (Dickson, 2008). In 2002, the Province of BC created a new ministry to address four specific challenges to the provincial healthcare system: (a) an ever-growing demand for services; (b) a lack of resources focused on high-quality patient care outcomes; (c) lack of long-term illness prevention planning and wellness strategies; and (d) decreasing affordability of healthcare for British Columbians (Ministry of Health Planning of BC, 2002). The new ministry identified fragmentation and a system oriented toward acute care and physician care among the barriers to moving forward (Ministry of Health Planning of BC, 2002). Although these orientations had been logical in the 1960s, when Canada's healthcare system was designed, the provincial government identified current challenges as requiring a system-centric approach.

To develop such an approach, BC's 52 health authorities were consolidated into five regional authorities and one pan-provincial authority, the Provincial Health Services Authority, which operates 10 specialized agencies and services and cross-provincial services such as mental health policies, forensic psychiatric services and supports, rural emergency services, and other population-specific services and agencies including health research (Ministry of Health Planning of BC, 2002, p. 21). In addition, in 2013, the First Nations Health Authority was established to support and address the health needs of BC's urban and rural Indigenous population. In 2001, the BC Ministry of Health Planning was charged with developing a 10-year plan to renew BC's healthcare personnel plan. While leadership was not specifically mentioned in the ministry's charter document, the events set in motion in 2001 by the reorganization of healthcare authorities soon created the need and the opportunity to think more carefully about healthcare leadership in BC.

After the BC reorganization into health authorities, the Health Care Leaders' Association of BC (HCLABC), a member organization of healthcare leaders from across BC, began to search for ways to explore, learn from, or share leadership development programs. The CEO of HCLABC, Geoff Rowlands, and Dr. Graham Dickson, hosted a symposium at the Centre for Health Leadership and Research in the winter of 2004 at Royal Roads University. The intent of the symposium was to...

...define the concept of strategic leadership for healthcare reform: what it looked like, whether it was needed in the current health environment, why it was important, and what, if anything, could be done to improve efforts in British Columbia to develop strategic leadership. (Dickson, 2008, p. 8)

The message from the 73 healthcare leaders and graduate students who attended the symposium, many of whom held healthcare leadership positions, was "a strong consensus... that the kind of leadership needed to guide the Canadian health system into the future was both qualitatively and quantitatively different from the leadership currently in practice" (Dickson, 2008, p. 8). Furthermore, symposium attendees noted an absence of leadership literature that referenced the Canadian healthcare sector. Leadership material used in Canada either referenced private-sector models used within the United States (US) or, like the work by Goffee and Jones (cited in Dickson, 2008, p. 6), applied

to executive leadership in the United Kingdom (UK). The lack of literature specific to the Canadian context opened questions about how well the UK and US models fit, first, for the public health mandate of health systems in Canada, and, second, in relation to the match or potential differences between the executive and leadership structures in the UK (Dickson, 2008).

A year after the symposium, in 2006, the Province of BC granted funding to the HCLABC for a project to “define a set of qualities of leadership and management that could become the foundation of a provincial leadership capacity enhancement initiative” (Dickson, 2008, p. 7). The project, steered by the *leadersforlife* project, as they came to be known, was to raise the quality and quantity (depth and breadth of experience and knowledge) of health leadership for the health systems in BC (Dickson, 2008). In 2006, research began with interviews of leaders and leadership development practitioners from the BC health authorities. Next, a comprehensive review of leadership literature was conducted in which key leadership behaviours were compared with existing competency and leadership models in healthcare, public and private sectors, nationally, internationally and from within the health regions within BC. The interview data and literature review findings were combined to articulate the optimal characteristics for healthcare leadership in BC. These characteristics were then validated through a symposium comprised of representatives of all BC health regions (the BC Medical Association, at the time) and selected academics who were experts in competency frameworks met to discuss and approve/disapprove the proposed framework. The result was the approval of the LEADS Health Leadership Capabilities Framework, or LEADS framework, as it is often called, which has five domains, and four capabilities for each domain (see Table 2).

In 2007, the Canadian Health Services Research Foundation¹ (CHSRF) commissioned a study into the potential format of a pan-Canadian health leadership framework, the Pan-Canadian 5 C’s framework (Dickson et al., 2007). Following this, consensus was developed with the members partners of the Canadian Health Leadership Network (CHLNet) through a commissioned feasibility study of merging the Pan-Canadian 5 C’s framework and BC’s LEADS. In 2009, the LEADS framework was expanded to include recognition of the unique nature of the healthcare ‘caring’ environment with the emphasis on caring having been contributed by the CHSRF study and the full title of the LEADS framework added the phrase “in a Caring Environment” (G. Dickson, personal communication, May 3, 2017).

¹ The Canadian Health Services Research Foundation is now known as the Canadian Foundation for Healthcare Improvement (www.cfhi-fcass.ca).

TABLE 2. LEADS LEADERSHIP FRAMEWORK DOMAINS AND CAPABILITIES

Domain	Capabilities
L Lead Self	Self-motivated leaders: <ul style="list-style-type: none"> • <i>Are self-aware</i> • <i>Manage themselves</i> • <i>Develop themselves</i> • <i>Demonstrate character</i>
E Engage Others	Engaging leaders: <ul style="list-style-type: none"> • <i>Foster development of others</i> • <i>Contribute to the creation of healthy organizations</i> • <i>Communicate effectively</i> • <i>Build teams</i>
A Achieve Results	Goal-oriented leaders: <ul style="list-style-type: none"> • <i>Set direction</i> • <i>Strategically align decisions with vision, values and evidence</i> • <i>Take action to implement decisions</i> • <i>Assess and evaluate</i>
D Develop Coalitions	Collaborative leaders: <ul style="list-style-type: none"> • <i>Purposefully build partnerships and networks to create results</i> • <i>Demonstrate a commitment to customers and service</i> • <i>Mobilize knowledge</i> • <i>Navigate social-political environments</i>
S Systems Transformation	Successful leaders: <ul style="list-style-type: none"> • <i>Demonstrate systems/critical thinking</i> • <i>Encourage and support innovation</i> • <i>Orient themselves strategically to the future</i> • <i>Champion and orchestrate change</i>

Note. From *LEADS in a Caring Environment Framework*, by the Canadian College of Health Leaders, 2016, Ottawa, Canada: Author. Copyright 2016 by the Canadian College of Health Leaders. Reprinted with permission.² Retrieved August 3, 2016 from <http://leadscanada.net/site/framework>

Between adoption of LEADS by the Health Care Leaders Association of British Columbia (HCLABC) at its annual meeting in the fall of 2006 and the end of funding in 2009, *leadersforlife* collaborated with all BC health authorities in the BC Health Authority Learning Design Action Research Team. This group guided the use of LEADS in province-wide leadership development programs. Several LEADS-based education programs were designed in partnership with post-secondary institutions and piloted with middle, senior, and executive leaders. In 2007, *leadersforlife* developed four 360° assessments that, along with executive coaching, were integral parts of the education pilot projects. Throughout this time, health authority leadership development staff continued to explore ways to adapt existing leadership development programs to LEADS or to develop new program offerings based on LEADS.

In 2009, the funding for *leadersforlife* ended however it continued to function through 2011. In the same year, the BC Health Leadership Development Collaborative (BCHLDC), now known as the BC Health Leadership Development and Engagement Collaborative or BCHLDEC, was formed to continue to advance a shared approach to leadership development in the province. In the ensuing years, the BCHLDC designed three new province-wide programs, known as the LINX modules: Core, Experience, and Transforming. The shared structure for leadership development in BC ensures some efficiencies and consistencies across leadership, talent, and management development programs.

Initially, the primary work of championing LEADS across Canada was spearheaded by the Canadian Health Leadership Network (CHLNet), *leadersforlife* and Graham Dickson. In 2010, the Canadian College of Health Leaders (CCHL) endorsed the framework and joined the movement to champion its' uptake across Canada. The LEADS Collaborative — a partnership of CCHL, Royal Roads University, CHLNet and Graham Dickson — was created to continue to steward the distribution and uptake of LEADS across Canada in 2013. With their respective networks and roles within the LEADS Collaborative, each member organization has strengthened the uptake of LEADS. The mission of the LEADS Collaborative is to develop, support and sustain LEADS-based leadership capacity for health system transformation. The LEADS Collaborative partners are also committed to the continued evolution of the LEADS framework.

In 2011, the HCLABC approached CCHL to become more formally involved with LEADS and, in July 2012, HCLABC transferred its legal interest and intellectual property rights in the LEADS framework and the *leadersforlife* program to the CCHL. The CCHL created LEADS Canada upon assuming the responsibility to operationalize the distribution and uptake of LEADS nationally. LEADS Canada, through certification and licensing of LEADS facilitators and coaches, coordinates the provision of LEADS-based leadership development programs, and creates partnerships with organizations to help customize programs to

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ensure a successful cultural shift and thorough embedding of the framework. CCHL has also made LEADS the foundation of its longstanding Certified Health Executive program (CHE). Figure 1 presents a timeline of the evolution of LEADS.

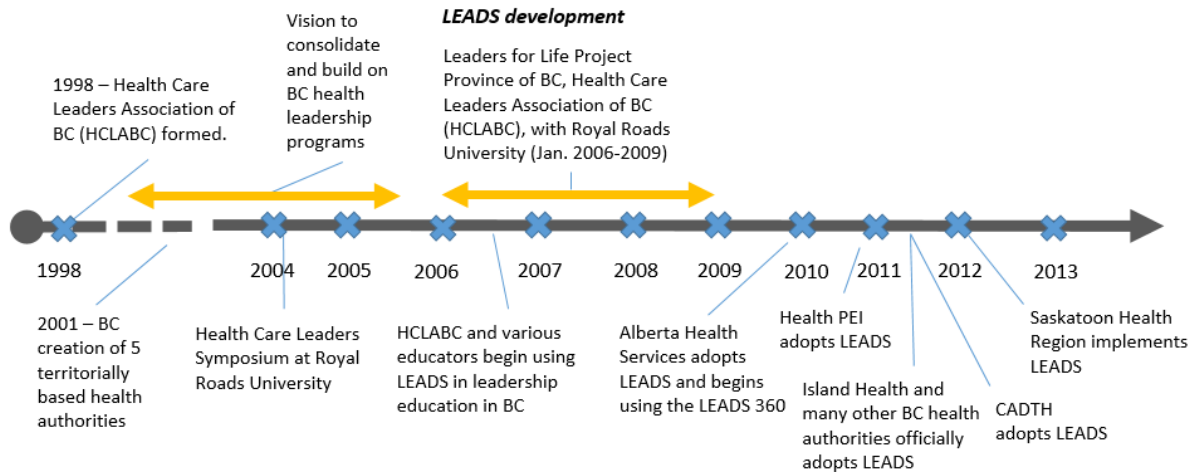


Figure 1: Timeline of LEADS Evolution

Note. BC = British Columbia; CADTH = Canadian Agency for Drugs and Technologies in Health; CCHL = Canadian College of Health Leaders; CHE = Certified Health Executive; HCLABC = Health Care Leaders Association of BC; PEI = Prince Edward Island.

LEADS was indirectly studied through Dickson et al.'s (2014) nationally funded Leadership and Health System Redesign (LHSR) project, which focused on leadership in Canadian health organizations. The LHSR project included six jurisdictions across Canada, and although not specifically focused on LEADS, four of the six case study reports reflected on the use of LEADS. Dickson et al.'s (2014) findings demonstrated that traditional models of leadership still need to be challenged. The evidence from the LHSR project supported open and flexible collective leadership models³ that approach leadership with a shared or distributed model (Dickson et al., 2014). In addition, the LHSR researchers found that healthcare contexts continue to be extremely complex and that change is overwhelming leadership (Dickson et al., 2014). The authors strongly recommended a whole-systems approach and the need for a central body to address national challenges in leadership.

³ Collective leadership capacity “requires alignment of thinking and action among formal leaders that challenges traditional conventional notions of autonomy, accountability, and collaboration that they currently bring to their role” (Dickson et al., 2014, p. ii). Collective leadership capacity also “refers to the overall capacity to lead as exhibited by all formal and informal leaders in the system. This term is not to be confused with the construct of distributed leadership, shared leadership, or collaborative leadership, terms with unique definitions within the literature” (Dickson et al., 2014, p. ii, footnote).

The historical development of LEADS provides the background for this study. In the period between 2009, the official end of the LEADS development project in BC, and 2012, when the CCHL officially assumed responsibility for LEADS, four of the organizations that participated in this study adopted and implemented LEADS. Island Health (then known as the Vancouver Island Health Authority) had been involved in the original development. These five organizations offer an important continuum with which to review the evolution of LEADS in practice.

The LEADS Impact Study and Research Questions

This study explored how LEADS was adopted and used by five Canadian healthcare organizations, as well as its impact. The research was designed as an exploratory qualitative study, since this was a new topic. The goal was to interview decision makers, talent management teams, and participants in leadership development programs who used LEADS. To start, in 2014, a pilot study was conducted with key stakeholders who were very familiar with LEADS to check the scope and relevance of the research focus and interview questions. The pilot participants included current and retired consultants, advisors, educators, and health organization staff. The purpose was to affirm and/or recommend revisions to the research focus, the five strategic questions, and the interview questions.

The interviews affirmed the importance of the research focus and the need to generate grounded, systematic documentation about the adoption and implementation of LEADS. Pilot participants affirmed the five strategic questions, with slight modifications, and these were:

- Why are you using the LEADS framework?
- How are you using the LEADS framework?
- What is helping or hindering the use of the LEADS framework?
- What difference does your use of the LEADS framework make?
- How do you know that your use of the LEADS framework is making a difference?

The first two strategic questions were designed to explore how LEADS was adopted and implemented. This study moves beyond practitioner knowledge about tools, tips, approaches, and programs to provide a documented baseline for future studies as well as for improvement to current practices.

The last three strategic questions aim to document ways that the effectiveness and impact of the LEADS framework are being valued. Although it is beyond the scope of this study to document actual results of measurement or assessment, this report provides information on how participants know LEADS is making a difference and, therefore, how they are rationalizing expenditure. The wording of the questions was deliberately broad to leave room for qualitative and quantitative methods of valuation and assessment.

Organizations across Canada that had been using LEADS for a few years were invited to participate as case study organizations. The pilot study participants, the research team, and members of the sponsor

organizations generated the list of invitees. The final selection criteria are described in Appendix 1. The organizations that participated varied in time of adoption, size (scale), range of geographic distribution, service focus, talent program characteristics and approaches, and other dimensions such as use of consultants and in-house staff. The relative size of each organization is indicated in Table 3, along with information on population served according to each organization’s own figures. CADTH provides services across Canada to health organizations, so its distribution is national, but its client base comprises other health organizations.

TABLE 3. STAFF OF THE FIVE CASE STUDY ORGANIZATIONS AND POPULATION SERVED ON OR AROUND 2015

Organization	Staff (approximate)	Population Served
Island Health	18,000 ⁴	765,000 ⁵
Health PEI	4,098 ⁶	145,800 ⁷
Saskatoon Health Region	14,768 ⁸	350,000 ⁹
Sunrise Health Region	2,945 ¹⁰	59,551
Alberta Health Services	104,900 ¹¹	4,108,300 ¹²
CADTH	185 ¹³	National

⁴ Island Health staff numbers are compiled from three sources (Island Health, 2013; Vancouver Island Health Authority, 2015; Wikipedia, 2017).

⁵ Island Health population served from Wikipedia, cross checked against the 2015 Annual Service Plan Report which gives the 2015 number as 760,000 (Vancouver Island Health Authority, 2015; Wikipedia, 2017).

⁶ Health PEI staff numbers are from the Health PEI web page “About Us” (Health PEI, 2017), and as presented on their website.

⁷ The 2014 provincial population for Prince Edward Island is from Statistics Canada (Statistics Canada, 2016).

⁸ Saskatoon Health Region staff figures are from 2014-15 Annual Report (Saskatoon Health Region, 2014). Note that the report states that physicians are included: “1,013 physicians and 13,755 registered nurses other healthcare service and support workers and managers” (2014, p. 7).

⁹ Saskatoon Health Region population served is from the “About us” page (Saskatoon Health Region, 2017).

¹⁰ Sunrise Health Region staff and population are from the 2014-15 Annual Report (Sunrise Health Region, 2015, p. 22).

¹¹ The Alberta staff numbers are from the Alberta Health Services Health Plan and Business Plan (2014-2017) (AHS, 2014).

¹² Alberta provincial population figures from Statistics Canada (Statistics Canada, 2016).

¹³ CADTH staff and service information was provided by the site liaison for this study.

II. The LEADS Impact Study: Five Health Organizations

Innovating the Way: Five Case Studies

The organizations in this study were considered early adopters of the LEADS framework (see Table 4), as they created their approaches in the early days of the use of the framework, when there was minimal consulting and product support to facilitate adoption and use. Due to the diversity in healthcare systems, each of these organizations provided unique insight into how and why an institution might choose to implement the LEADS framework and the ways in which the evolution of implementation may occur.

TABLE 4. YEAR OF LEADS ADOPTION OF THE FIVE CASE STUDY ORGANIZATIONS

Case Study Organization	Year of Adoption
Island Health (BC)	~2010*
Alberta Health Services	2010 (Jan)
Health PEI	2011
CADTH	2011 (Oct)
Saskatoon Health Region (with Sunrise Health Region participating)	2011–2012

Note. *Island Health (BC) participated in the development of LEADS from 2006 to 2009 and adopted the framework in approximately 2010 as a partner in the BC Health Leadership Development Collaborative. CADTH = Canadian Agency for Drugs and Technologies in Health; PEI = Prince Edward Island.

Health PEI: Adopting LEADS in a Context of Change

Although adoption of the LEADS framework was unique to each organization, all five undertook these initiatives in the context of changing needs and, in many cases, shifting organizational structures. At Health PEI, various movements converged to spur change, including a review of succession planning, the establishment of a single provincial health authority, and the introduction of a collaborative care model.

Across government proper and other organizations, when you look[ed] at the leadership group, one [issue was] an aging demographic. Can we look at succession planning? . . . [and the question was], . . . What sort of professional development do we want to be doing with this group? LEADS was seen as a good framework, a good guide to help us with that. But yes, it was happening sort of at the same time. (HPEI-INT)

This participant's recollection fits with others' understanding of what was generally going on in healthcare at the time, both within Canada and in Health PEI specifically (HPEI-INT). Shauna Fenwick, lead sponsor of this project who was also involved in the original development of LEADS, recalled the following:

At the time of the original study the main drivers were the change from bricks-and-mortar health organizations to integrated health systems, and the need for new leadership abilities to lead large, multi-institutional, multi-geographic and multi-purpose organizations [as well as] the demographic challenge of looming retirements of leaders and the unattractiveness of management careers for many healthcare employees. (S. Fenwick, personal communication, 2015)

Prior to 2005, an integrated regionalized health services structure had been in place within PEI. In 2005, health services were amalgamated under a centralized governmental department model. In July of 2010, a single provincial health authority, Health PEI, was established as an independent Crown corporation, assuming the operational services of the government's health department (i.e., the Department of Health and Wellness). A board was created and leadership was united across all the facilities and areas of practice. This process introduced organizational challenges at the most senior levels. "It was interesting to be involved right from the first, because it was quite a challenge. . . . At the beginning [there] was a lot of homework" (HPEI-INT).

Today, Health PEI fulfils provincial healthcare mandates on behalf of the Government of PEI. Health PEI provides a full range of health services, including mental health, long-term, and palliative care. Community health is also within the jurisdiction of Health PEI, as are programs for substance use and other public health issues. In terms of the case studies presented within this report, Health PEI, though considerably smaller, is like Alberta Health Services in being provincial and comprehensive.

When Health PEI was being established, its senior leaders were also considering the adoption of the LEADS framework. Coincidentally, several healthcare leaders within PEI completed a graduate degree in health leadership at Royal Roads University, at the same time as Health PEI was adopting LEADS, in 2010–2011. They completed an applied research project in the program, using LEADS as a framework for analysis and formed a community of practice, which continues to help individuals to support Health PEI.

As the LEADS framework was being adopted, a new clinical information system and a simultaneous shift to a collaborative model of nursing care was introduced. One participant observed:

We had gone through significant changes with the introduction of a clinical information system, which had a huge impact, and lots of unrest within the system, and then there was a huge change in practice with a collaborative model of care. You really had to pull out every opportunity you had to demonstrate leadership within the system. . . . It was a 15 out of 10; that's what level you had to be at. (HPEI-INT)

Health PEI exemplifies the kind of change or churn that was common across Canada now, as local and regional entities amalgamated into larger regional or provincial authorities. The example of Health PEI demonstrates that research exploring the effectiveness of the LEADS framework requires an understanding that it is not only implemented to help with change, but also introduced within a complex context of change.

CADTH: Changing the Culture

Canadian Agency for Drugs and Technologies in Health (CADTH) is an independent, not-for-profit organization responsible for providing objective evidence to help healthcare leaders make informed decisions about the optimal use of drugs and medical devices in the Canadian healthcare system. CADTH is unique in providing an example of nationally distributed service that grapples with interactions across many jurisdictions. Acceptance of CADTH's evidence across the country is critical to its mission and, like other distributed health organizations in Canada, CADTH must respond to and coordinate with many other health organizations. Quality, relevance, timeliness, and impact are essential to successful deliverables for CADTH. Customer service is a priority, including engagement and collaboration with customers and diverse stakeholders. At the time of the study, CADTH comprised approximately 185 employees.

The exploration of leadership at CADTH occurred in the context of change, a common theme among the other organizations in this study. In 2009, CADTH embarked upon an organization-wide change initiative to adopt a new customer-service focus. This change was intended to ensure relevance across CADTH's products and service offerings and realize the vision of a new President and CEO.

In September 2011, two years after initiating a new leadership program, CADTH began its LEADS implementation with an introductory session for the full leadership team. After this, CADTH initiated classroom-based workshops focused on the LEADS domains, such as "Lead Self" or "Engage Others". In these day-long workshops, participants explored their own strengths, learned communication skills, applied tools such as the ladder of inference (Argyris, 1990), explored strengths-based leadership, and practised listening skills.

CADTH also offers LEADS development that can be applied in regular management team meetings. In 2015–2016, CADTH evolved the domain workshops into what is now known as the applied leadership model, which includes focused use of the framework within the decision-making structure. CADTH continues to annually offer half-day introduction to LEADS workshops for new staff. This has been helpful in orienting new staff to CADTH's culture, and ensures that everyone at CADTH is well versed in the LEADS language and concepts.

Senior leaders at CADTH are required to meet formal LEADS-based leadership performance objectives, with on-the-job learning and ongoing manager support being a big part of the program. Participants can also access related development supports including coaching, 360° reviews, mentorship, formal leadership classroom learning, and online leadership tools.

Island Health: Sustaining Leadership Development

Island Health is one of five regionally based health authorities in the western province of BC. These authorities were created in 2001 out of 52 smaller organizations, hospital boards, and independent health organizations (Government of British Columbia, 2002). Island Health is responsible for the population on Vancouver Island and many smaller islands, as well the rugged central coast of Mainland BC. The total population served is approximately 765,000 people, of which more than 50% live in cities and towns on the sheltered and agriculturally rich southeastern section of Vancouver Island. Three completely distinct First Nations cultural-linguistic groups live in this region, including the Nuu-chah-nulth on the west coast of Vancouver Island, the Kwakwaka'wakw on the north side of Vancouver Island and the central coast of the Mainland, and the Coast Salish on the south and eastern side of Vancouver Island (Vancouver Island Health Authority, n.d.). According to the 2006 census, a total of 40,550 urban and non-urban people identified as Aboriginal within the Island Health Authority's area (Vancouver Island Health Authority, n.d.). Two non-territorial provincial health authorities also operate in the Island Health region: The First Nations Health Authority, which has responsibility for Indigenous health, and the Provincial Health Services Authority. During the time of this study (2015–2016), Island Health underwent reorganization, changing its centralized structure to one with four regional headquarters. In addition, a new CEO took the helm in 2013, just prior to the start of this study.

As described in the Background section of this report, Island Health¹⁴ and the other BC health authorities collaborated with the *leadersforlife* project and the development of the LEADS framework. This included participation in the original research leading to development of the framework and in pilot educational projects based on LEADS from 2007 through 2009. Concurrently, BC health authorities continued to offer locally developed and successful leadership development programs. In Island Health this was the Leading in a Learning Organization (LILO) program. From approximately 2009, leadership development consultants from Island Health also participated in the formation of the province-wide BC Health Leadership Development Collaborative (BCHLDC). Collaborative members came from all six regional health authorities in the province, with a vision to “advocate for leaders and leadership practice, improve access to leadership development opportunities, attract and retain the best leaders” (Accreditation Canada, 2013).

In addition to the offerings by Island Health, many individuals in the region and across Canada also had their first exposure to LEADS during the Royal Roads University health leadership graduate program, when Dr. Graham Dickson of the University's Centre for Health Leadership, who was the academic partner and lead, the LEADS framework, taught in the program. As a result of this learning, be it through the health authority or at Royal Roads, Island Health staff began to implement the LEADS framework in their workplaces.

¹⁴ From the time of the creation of the BC Health authorities until 2013, Island Health was known as the Vancouver Island Health Authority (VIHA).

The BCHLDC was funded to “develop and establish a long-term talent management strategy and approach to the development and sustainment of healthcare leaders within the province of British Columbia” (Roberts, 2014). LINX suite of programs was developed and tailored to different levels of leadership and is currently available across all health authorities in BC.

At the time of this study, Island Health offered the three LINX leadership development programs in face-to-face and online formats. The first is Core LINX for new managers and leaders. The second is Experience LINX, available to anyone who has attended Core LINX or an equivalent program and been in a management/leadership role for 2 years. Third is Transforming LINX, which is available to senior leaders who are expected to achieve an executive position within a couple of years. While the LINX programs offer development topics relevant to the various leadership levels, they also build on and complement each other. Focus group participants who had taken LILO when they were new managers at Island Health compared their experience to Core LINX and noticed that it incorporated management training (such as budget and labour relations) as well as leadership development. These programs, much like programs in the other organizations, used a mix of proprietary programs, coaching or co-coaching, practise projects, and skills development. One participant described Core LINX as follows:

[The first thing] we learned about [was] LEADS, basically. We [did] a self-assessment MBTI [Myers-Briggs Type Indicator] then leadership and principle-centred leadership [and] really quick stuff about leadership, emotional intelligence. They incorporate Coaching Out of the Box as well, [and] you do that 3-day session in your triads, learning how to be a coach. Healthy workplace, developing people, teamwork, cross-functional team collaboration, how to run a meeting, setting direction. Then some really brief stuff on the fundamentals of system transformation and change. So it feels like more hard skills; I mean they're all learning skills, but it was more concrete theory. (IH-FG)

The participation of Island Health as one of the cases provided an example of a well-structured leadership development program that had been running in some format (pre- and post-LEADS) for more than 15 years. This experience with leadership development provided the ability to reflect on what it takes to sustain LEADS and how LEADS works for the organization and for individuals.

Alberta Health Services: Developing Collaborative Leadership at Scale

Alberta Health Services (AHS) was the largest of the health organizations in this study, both in territorial coverage for direct service and in terms of staffing. With over 108,000 employees, and more than 8,000 individuals in leadership positions, AHS provided an example of the challenges of large-scale LEADS implementation. AHS was created in 2010 out of 12 former regional health authorities in Alberta. Many of these had their own leadership frameworks, and, as in BC, senior leaders undertook a review to create efficiencies. As a participant in talent management services reflected,

[LEADS] was adopted as a result of the former 12 health authorities that were brought together under [the] banner of Alberta Health Services. At the time, there was no consistent set of leadership competencies across the then 12 disparate health authorities. . . . There was a

decision made by the executive of the day that we would consolidate under LEADS, and it was adopted at that time. . . . It was also based on the fact that LEADS was also being adopted nationally by many other health authorities. (AHS-INT)

As with other organizations, the fact that LEADS was already being used in Canada made it a credible option. However, there was a team that systematically reviewed all the leadership frameworks in use in Alberta and examined other models that were available at that time. One participant recalled that this process took almost a year (AHS-FG). Ultimately, senior leadership elected to implement the LEADS framework. The best programs and practices were then mapped to LEADS and external consultants were brought in to provide orientation and introduction to the framework itself.

One AHS participant recalled attending a forum in November 2010 that aimed to certify internal and external leadership consultants in the use of LEADS. Unfortunately, the convenors of the forum were unable to complete their intention to certify. The 2010 forum helps to date the adoption of LEADS at AHS.

[There was a meeting in] BC to be certified in LEADS—hosted by Graham Dickson, Bill Tholl, and Geoff Rowland. It was 2 or 3 days in length, where they introduced the framework to folks from across Canada and certified us in the use of framework. And that was right around the time that AHS had adopted LEADS. (AHS-INT)

At the time of this study, AHS provided LEADS-based programs in multiple ways. It offered an executive education program open to directors and senior leaders, which was delivered by the University of Alberta and University of Calgary. Several in-house certificate programs were also available to management level personnel. Both the in-house and university-led Executive Education Program had practise components, in which participants design and accomplish projects, working in small teams to solve organizational challenges.

Also at the time of this study, changes were being introduced to both the in-house and university-led programs. Both had been offered on a face-to-face, cohort-based model, but the in-house certificate programs were in the process of being transitioned to blended learning programs, and the executive model was restructuring its residency model.

The five 3-day residencies of the Executive Education program were developed into three week-long residencies to reduce the number of times senior leaders were pulled away from their primary work. This restructure also shortened the overall length of the program from eight to six months.

For the in-house programs, the size of the province meant that it was difficult and expensive to bring people together for face-to-face learning. The cohort model trialled through the pilot demonstrated it was also difficult to operationalize cohorts across the breadth of the province, particularly in rural areas. These challenges were resolved by providing registrants with online learning options for in-house certificate programs. In addition, participants could enrol in individual courses, register for a whole certificate series, or opt into the certificate later, depending on their learning goals. Certificate

registrants participate individually (rather than in a cohort) until they complete all required courses, when they then register for the project and work with a team to demonstrate their learning by collaborating on a project and resolving an operational challenge. In addition to these open registration programs and courses, leaders could also request focused sessions for their own work units, and thus bring leadership development to a whole unit.

As a case, the scale of AHS presented the opportunity to see how a larger organization with considerable resources could approach leadership development. This case also revealed the unique challenges of integrating across a health organization that spans hundreds of worksites and provides services to a large population.

Saskatoon and Sunrise Health Regions: Focusing on Results

Saskatchewan was the first province in Canada to begin the process of amalgamating health entities into regions. The process originated in 1993 with the passing of the Health Districts Act, which created 32 regional districts out of some 400 hospital boards and institutions. The regional focus “was intended to create an integrated and responsive system, responsible for a wide range of health services, including mental health, community, long-term care, residential and acute care services, health promotion, and public health” (Kouri, 2006, para. 2). After a decade of successful implementation, the province faced a decline in federal revenue transfers and, in 2001, consolidated the 32 districts into 13 regions (Fyke, 2001).

In 2009, after a provincial commission on patient safety, Commissioner Dagnone (2009) reported on what was needed to enhance patient safety and care. Through conducting focus groups and interviews with providers and patients, Commissioner Dagnone found:

Change is a constant phenomenon to which the health system is not immune. . . . [The minister] initiated this unique review in order to improve both the patient experience and the efficiency and effectiveness of the health system. This report and its recommendations represent the start of a change journey. What is required now is resolve, leadership, commitment, and courage on the part of all. (p. iii)

Meanwhile, in 2010 or early 2011, as one of the study participants recalled, Qu'Appelle Health Region invited Dr. Graham Dickson and the Executive Director of CHLNet, Bill Tholl, to present an overview of the LEADS framework:

I attended that event, and what I heard really excited me because it resonated from a deep level in terms of what I understand to be transformational change model. I was excited that it had a focus on health. I was then [in a leadership position], and had been really looking for an enduring model of leadership, and one that spoke to healthcare, not business. (SHR/SHI-INT)

At the time, the Saskatchewan Leadership Program, as it was termed, was using a competency-based framework and an accompanying 360° performance assessment. The personal connections made at that workshop resulted in Saskatoon Health Region (SHR) deciding to explore LEADS.

After that event I came back to Saskatoon Health Region and connected with [the senior leadership], and asked if we would pursue this further and what the implications would be. [They] were pretty supportive, and we connected with Graham Dickson. We decided to have [our] team of organizational development consultants trained. (SHR/SHI-INT)

This participant believed that they were among the first in Canada to take part in, as their facilitators labelled it, a train-the-trainer model (SHR/SHI-INT). In SHR, newly trained consultants then began to offer LEADS-based programming in January of 2012. SHR made program seats available to participants in other Saskatchewan health regions on a reimbursement basis. As a result, in this study, the call for participants was extended to Sunrise Health Region (with its operational approval) to draw on the experiences of those who had participated in the SHR leadership development sessions.

The launch of leadership development offerings in SHR evolved alongside other changes in the province. Five years after the 2009 Dagnone Commission report, the province adopted the Lean Six Sigma approach to quality improvement. While being recognized for SHR's leadership in healthcare at the annual National Health Leaders Conference, its CEO, Maura Davies, asserted that Commissioner Dagnone's report had galvanized change:

The status quo was no longer working when it came to healthcare quality. Healthcare leaders saw [the commissioner's report] as a call to action. "All too often, healthcare reviews are commissioned and then put on the shelf and forgotten," says Saskatoon Health Region president and CEO Maura Davies. "Our review was the catalyst for system-wide change." (Foubert, 2014, para. 1)

SHR adopted the Lean Six Sigma program to address the need to improve patient care quality and change how the healthcare system worked (Mutwiri, Witt, Denysek, Halferdahl, & McLeod, 2016). A committee, including CEOs of some health regions such as Sunrise and SHR, reviewed a range of international approaches. As Davies (cited in Foubert, 2014) reported, they established three components of goals under Lean Six Sigma:

One: *A strategic planning process where everyone in the system thinks and acts like one—also known as Hoshin Kanri (a Japanese phrase, Hoshin Kanri is the system by which goals are determined, plans to achieve those goals are established, and measures created to ensure progress towards those goals).*

Two: *Developing infrastructure to support and coordinate continuous improvement across work units and settings.*

Three: *Building the capability among leaders and the entire healthcare workforce to do daily continuous improvement. (Pick One Approach section, para. 4–9)*

As a participant in this study said, the search for improvement has become a major driving force in the SHR and Sunrise Health Region:

We know that change is inevitable, and to keep doing [what we have been doing] isn't sustainable; therefore, it is necessary for organizational change. Just to change to make sustainable I would say is the bare minimum, and we should continually be seeking to change to improve to provide the best patient care experience possible and be a high-performing organization. (SHR/SHI-INT)

In discussing the differences between LEADS and Lean, the study participants from the SHR and Sunrise Health Region suggested that LEADS provides the “how” while Lean provides the “what.” The systems work together in that, first, Lean supports a methodology of regularly setting short-term, achievable, and measurable goals. Teams work toward these goals using the Lean continuous improvement or *Hoshin Kanri* process, and at the end of the timeline, the achievements are assessed, and either corrected or a new goal is selected. LEADS, meanwhile, is utilized to support team processes such as reflecting on contributions to goals and the *Hoshin Kanri*, or to support the “achieve results” portion of LEADS, with a specific aim of systems transformation.

The Saskatoon case offered an example of how LEADS and Lean could be used in a coordinated fashion, as well as provided an opportunity to see how the Saskatchewan Health Leaders program works as a distributed interregional shared model of health leadership development. The range of products, tools, and programs are offered to participants who come to Saskatoon and return to their regions for implementation. No special selection process is used; as with the other cases in this study, potential participants express an interest in or are nominated by their managers or directors to participate, no matter their region, and if there is room and there is funding, they obtain a seat. However, the hub and spoke, or provider–client, relationship stands in contrast to the range of in-house programming offered within AHS to its own employees and to the LINX programs available within Island Health, which are also used by other health authorities in BC.

Summary

Each of the five participant organizations faced major reorganization, realignment, or renewal of vision. Three health authorities (Island Health, AHS, and Health PEI) had new CEOs during the two years of this study. In addition, for AHS, this timeframe involved a series of rapid turnovers in senior leadership. All five organizations, including CADTH, were at various stages of aligning their foci toward outcomes. The business of healthcare was under revision due to public scrutiny. As one participant said, “You have to be operating at 150%” (HPEI-INT). Stress placed on individual staff was enormous, yet a change agenda must be achieved. This review of the implementation of LEADS occurred within the context of an urgent need for reform, and under the conditions of imposed transformation driven by political decisions and budget cuts.

The decision to adopt LEADS in these jurisdictions was referenced to several events. First, individuals appeared to play a significant role. In all the cases except for Island Health, a key individual or individuals became aware of LEADS, often through connection with the developers of LEADS, including Dr. Graham Dickson. Once key decision makers became aware of LEADS, it was then scrutinized before being adopted. Typically, there was then a corporate review, which examined options for models of leadership programs and surveyed assets already in place. Adopting LEADS was often seen as a wise move because it was specifically developed for healthcare institutions and was being used by other organizations. For these organizations, compatibility was as important a consideration in LEADS adoption, because it enabled the highly complex and intertwined healthcare systems to work together.

Program development often started by mapping existing offerings to, or against, LEADS and triaging or supplementing pre-existing programs. At Island Health, for example, this involved both the review of existing programs across health authorities when LEADS was being developed and retrofitting the pre-existing LILO program. Four of the organizations developed and implemented a continuous cohort-based program of implementation, as described in Section III. LEADS Implementation: Good Habits, Innovative Practices, and Challenges. All the cases in this study also embarked on regular review and renewal of their programs.

In summary, the five participating cases provided diversity of size, geography, innovation, purpose, and service. Since healthcare is governed provincially in Canada, each of the cases also reflected unique provincial needs and influences, yet provided information relating to consistent issues across Canada.

Section III describes the ways in which programs have been implemented.

III. LEADS Implementation: Good Habits, Innovative Practices, and Challenges

The first two research questions of this study focused on ways in which LEADS is being adopted and implemented by organizations. As mentioned earlier in the report, there is much practitioner knowledge about tools, tips, approaches, and programs; however, this living knowledge is held by practitioners, and has not been systematically documented. Currently, both sponsors, the CCHL and Fenwick Leadership Explorations, and others provide supports and resources within the Canadian context to assist with LEADS implementation, but more information is needed on how to improve the adoption and implementation of LEADS and leadership development.

This section focuses on key strengths and challenges in implementation of LEADS in and across the five case study organizations. This section begins by mapping some of the key points of implementation practices as reported on and observed by the study participants across the organizations. The focus is on strengths and innovations within the various organizations rather than on any tool or program.

Introducing LEADS

As early adopters, all the organizations, except Island Health, followed similar steps. The process for each organization began with internal discussion and consultations, typically at the executive level, but often with input from knowledgeable individuals or teams from talent management and development. At AHS, for example, after amalgamation of the regional authorities, a year was spent surveying what programs existed and comparing assets of different models. At Health PEI, this process began with an exploration led by the CEO and some individuals in strategic operations and talent management. One participant recalled how fortuitous the timing was:

We were discussing a void, or need, for a leadership framework in terms of professional development and all the various HR [human resources] functions and so on. So I started to do [some] research, and came upon Dr. Dickson's work, the LEADS framework, and it just fit like a glove! Initially, [I thought,] 'I can't believe that this work's already been done, and is out there and has been researched.' I continued to research, dig a little bit further, share a bit with our leadership group. (HPEI-INT)

For these early adopters, the combination of discovery, sharing goals, and verifying with others in healthcare was an important part of identifying whether LEADS would be a good fit and work for the organization. Initial consultations also often initiated a process of assessing the talent programs and assets of the organization to decide on the most effective way forward. The steps were:

- Assess the value of LEADS for the organization;
- Assess the process required for implementation, including
 - cost and resource valuation,
 - comparison of current talent management programs with additions needed to shift to LEADS, and
 - appraisal of and search for resources, internal and external;
- Secure external experts or consultants to assist with the above steps and implementation;
- Develop introductory options; and
- Execute initial offerings.

The process to discuss, explore and validate the right path required conversations among the senior leaders with leadership and approvals from the most senior levels. External experts were often consulted in this process. At both CADTH and Health PEI, Dr. Graham Dickson and some of the other original developers of LEADS, including Shauna Fenwick were called in. At the time, the CCHL was in the process of becoming the national holder of the LEADS intellectual property rights. Currently, organizations can obtain centralized information from LEADS Canada at the CCHL with whom the original developers continue to be involved, in addition to certified consultants. Participants recalled the external experts' involvement in developing approaches for their specific organizations as very informative and important for confirming their decision to adopt LEADS. Part of this arose from the availability of informed consultants, such as Dr. Dickson, Bill Tholl, and Shauna Fenwick. A participant with Health PEI recalled that Dickson and Tholl came down to meet with the leadership group, after which Health PEI adopted the framework (HPEI-INT). Having access to informed and experienced experts was critical to enabling an organization to make the decision to commit direction, resources, and strategic outcomes to LEADS implementation.

The initial exploration of whether to adopt LEADS led directly to questions of how to generate and implement LEADS offerings. At CADTH and Health PEI, after the decision to adopt LEADS had been made, Dr. Graham Dickson was engaged, and they tailored a program to meet the needs of CADTH. Similarly, at Health PEI, this process resulted in the introduction of LEADS and its domains in face-to-face sessions with a cohort model. This approach provided a comprehensive overview of what LEADS entailed.

I don't think we could have done it a different way. I think you need[ed] to have education [and] information first. Combining informal and formal leaders was [also] really useful. We continue to do [that] for new people coming into the organization, and periodically we'll just do "LEADS 101."¹⁵ (CADTH-INT)

¹⁵ Some participants referred to comprehensive LEADS introduction workshops as LEADS 101.

This participant noted that, at CADTH, all staff were invited to the early general information sessions (CADTH-INT). At Health PEI, these general introductory sessions occurred in what it called its Management Forum, and, as one participant recalled, this introduction led her to personally embrace LEADS and start a journey of leading others in leadership development.

It was really fantastic, because we . . . met with Management Forum, which was every manager in the building. So we were introduced to the concept of leadership, and talked about it. Shauna [Fenwick] and Bill [Tholl] were down to kick that off and do an education piece on [the LEADS 360°]. So that was my initial involvement. (HPEI-INT)

The experiences at Health PEI and CADTH demonstrated how the initial offerings were targeted toward introducing LEADS to as many people as possible through single, unified sessions. In contrast, the process at AHS was more ad hoc because they were merging regions and concurrently reviewing and deciding on what leadership model to adopt. The programs evolved out of the resources at hand and the need to act on several fronts at once.

When AHS came together from the multiple seven or eight former health entities and we merged into one organization . . . it was about bringing together content from the various historical entities and creating workshops [as we went]. . . . We had [a lot of] individual courses. Some of them had clear, direct lines of sight to LEADS, and a specific domain, specific competencies.¹⁶ [We used] some courses and workshops [that] had been developed by external parties, and we were able to make those connections, but really it was just one-off courses. Leaders were starting to ask, “Okay, I can see how I can take a course, and maybe it can help me in my development, but to what end—why am I taking these individual courses?” There was no sort of holistic approach, and so we began to develop in-house certificate programs. Two years ago we did the first pilot; last year we did pilot two, and this year (2016) we are launching organization-wide with these new certificate programs. (AHS-INT)

The need to keep talent programs going while bridging to the new LEADS framework resulted in the evolution of the *in-house certificate program* (AHS-INT) for emerging and middle-level managers. The approaches at CADTH and Health PEI, in contrast, engaged the whole leadership team, confirming senior support, while at AHS the multi-front rollout meant the pathway was not as clearly articulated. However, all the approaches were designed to include everyone in leadership (or at CADTH, everyone including staff) to establish LEADS as the program of choice. The inclusion of all stakeholders seemed to be foundational to the goal, which was to change the organizational culture.

After introductory programs, the next steps in leadership development related to practice; as such, the overview sessions were followed by programmatic offerings. These included, with some variation between organizations, the introduction of the LEADS 360° assessment tool, LEADS-based program

¹⁶ The speaker was familiar with competency-based frameworks: LEADS refers to capabilities.

offerings, which were typically delivered on a cohort basis, and integration of the LEADS framework into practice, including via management meetings.

Starting with the LEADS 360° Assessment Tool

At Health PEI, the introductory sessions were followed by the adoption and implementation of the LEADS 360° assessment tool.

We [began] work to integrate it [LEADS] into our role descriptions for our executive directors. One of the larger initiatives was we took on the 360° LEADS feedback. And did that with our senior management group, and I understand that's filtered down, or is filtering down throughout the organization. (HPEI-INT)

We all did our LEADS 360°. I think the first year our CEO did, and our higher-level executives, and executive leadership team, and then it came down to the directors, and then it came down to the managers and the associate directors. (HPEI-INT)

One of the reasons that Health PEI provided an interesting case example for this study is that it started with a comprehensive introduction, including with its board. Involving the board represented a pathway to adoption that emphasized board leadership and a holistic approach. Health PEI then moved to include introductions to LEADS more generally.

The approach taken at Health PEI, to include everyone and start with board leadership, may have worked particularly well in the context of the relatively small population of the province, in which organizational members often know each other personally. However, at Health PEI, the next step was to align the job descriptions with performance development planning. One participant explained that a senior manager had worked to amend job descriptions to ensure performance reviews and role descriptions consistently aligned with the LEADS 360° assessment (HPEI-INT). AHS also engaged with the LEADS 360°, which it continues to use for senior leaders in development programs. The executive program, for example, starts with a pre-program LEADS 360° assessment and is followed on completion by a post-program 360° approximately six months later. Starting with the LEADS 360° enables the language and behaviours to be linked immediately, which is something both organizations had been particularly interested in.

When looking at different paths that could be taken to adoption and implementation, starting with the LEADS 360° is one choice. For AHS, the decision to use the LEADS 360° was made in the context of having a legacy of leadership programs. AHS was able to use the LEADS 360° to create a bridge from programs that were not referenced to LEADS to new programs that were built with a LEADS foundation. The LEADS 360° assessment also helped to ground program attendees in the personal leadership practices of the AHS.

At Health PEI, starting with the LEADS 360° at the executive level seemed to make sense from a governance alignment perspective and from the perspective of championing LEADS. The LEADS 360°

helped both organizations anchor their introduction to and adoption of LEADS clearly and strongly by using the assessment framework to communicate their adoption of LEADS. In contrast, the cohort-based introductions took a different path.

Development of Cohort-Based Programs

Following adoption, four of the organizations grew their programs by developing regular cohort-based offerings grounded in LEADS. While participants described many reasons for developing cohort-based programs, the most compelling was tied to resources, in that economies of scale could be achieved by running one program or course and bringing people together. However, more importantly, this approach was linked to the desire to create organizational change by generating momentum through group cohesion. While each set of programs were unique, the following description from SHR/Sunrise describes the way it engaged people through cohort-based participation:

It's an eight-month program, and [I believe] we have 11 actual classroom days spread across the 8 months. But before the group even meets in person in [the] classroom for the launch of the program, we have everybody do a LEADS 360° assessment. When we have the launch of the program it includes them receiving their 360° and a LEADS coach debriefing, then starting to develop a learning plan, which we ask them to co-create with their sponsor. [Their sponsor] is usually their manager or director of [their] program. And we have them start journaling as well.
(SHR/SHI-INT)

All the organizations included in this study used cohort- or team-based learning; however, AHS and Island Health provided two contrasting forms of cohort-based programs, which are examined here. Island Health offered cohort-based leadership development with the 10-month LILO program in the late 1990s. LILO includes distance, face-to-face, and project-based learning. The LINX programs, which took its place, includes the 14-month Core LINX program, which has online and face-to-face components, and the 6-month Experience LINX program, which is like the former LILO. The evolution of programs, as one talent management staff member at AHS noted, reflect organizational needs and capacities plus leadership development goals, and not just staff need.

Ideally we'd do a needs assessment on the organization and find out what they need, and then develop content to develop the certificate programs based upon the learner needs [but] we didn't have that luxury; we had the ability to take all of the existing courses that we had developed, and [map] how each of them spoke to LEADS, and then look at how we [could] package these into various certificates for the various levels of leaders in the organization. So we looked at it in terms of where a leader is in their role. So in our initial pilot, we had an emerging leader certificate, so those that were interested in leadership, we had two certificates for entering leaders, so those that were sort of newer to leadership, we had sort of a foundational entering leaders course and then an experienced entering leaders certificate program, and then we had one for quote unquote experienced leaders, so an experienced leaders foundational certificate program, and then an experienced leaders advanced program. So we had five different certificate programs that we piloted in that first year, and they were all a combination

of face-to-face courses [and] our e-learning modules that are available that we have partnered with Harvard ManageMentor, an external vendor, for our e-learning. We did online discussions as well, so we had some supplementary learning, and then [practise] work that the participants were doing.

We did one pilot of each program—we have five zones in AHS, so we piloted one cohort—it was a cohort model—one in each zone. One zone did a cohort of 30 people [in] the emerging leaders program; another zone did the entering leaders foundations; another zone did entering leaders advanced. It was the same 30, roughly 30 people who did the whole program as a cohort. It went over 9 months, and [that was] the programs from beginning to end.

Also, at the end, [they] did a wrap-up project based upon LEADS [in which] we tied the entire program, all of their learning, back to the various domains, [and] various capabilities in the framework. We had them do a group project at the end, where they were assigned a domain. They had to report back on the domain and how the learning over the course of their certificate program, and the group as a cohort, helped their development in the specific domain, and then how it helped drive organizational objectives as well. So that was the initial pilot that we ran.

Very well received, huge positive response to it, and that was Phase 1. Phase 2 was—it evolved into a bit of a different look and feel, and we’ve moved on to Phase 3 as well, now, with is the board organization-wide launch of the certificates, which is coming up in the beginning of February. We’re going to announce to the organization the new programs. (AHS-INT)

The AHS pilot programs required an extensive commitment from the participants; however, as was evident at the executive program graduation in January 2016, participants felt strongly bonded by the end. Participants also felt that the way LEADS evolved for them was very powerful, and in spite of the different program formats, when they put the whole picture together, they felt empowered and were able to use the framework effectively. The following story, although it is long, explains how those who took part in the program developed a solid understanding of LEADS over successive courses.

It didn’t become clear until, actually, halfway through the Executive Ed [education] course—[and] I realized that, “Oh yeah, we’re using LEADS in this course, and the PMI [Physician Management Institute]¹⁷ courses are all about LEADS as well!” It seemed to me a bit like a [hanging] mobile. At first there were just these courses [that] I would take—the PMI self-awareness course because my department offered it. And then I really liked it, so when I saw another one on engaging others, I thought, “Oh, I enjoyed that PMI course; I’ll take another.” And it was sort of like these things that were loosely connected. I got to realize that they’re a good use of my time and money. . . . When I had taken several of them [then] I realized how they were connected, and then you’ve got the little chart with Lead Self, Engage Others, Achieve

¹⁷ The Physician Management Institute, operated by the Canadian Medical Association, provides professional development to physicians.

Results. . . Each course sort of has an indication of which LEADS category it fits in. Then as I took the Exec Ed program, . . . somebody actually pointed out to me the whole sort of pyramid and the way the arrows go, and the terms along the sides, [and then] I understood how the five pillars relate to one another. So it wasn't just a list, but there's a Lead Self, and then Achieve Results, and all along that axis is personal processes—I have this in front of me. (AHS-INT)

AHS intentionally designed this educational process. At all the organizations, an important component of the process was mapping the programs to the LEADS domains and ensuring that participants had a systematic exposure to all the domains and capabilities. This example from Island Health explains how, as at AHS, it mapped this across programs:

[Our] leadership development programs—we've been working on provincially—so our Core program for new managers [and] leaders uses all of the domains and subdomains as the framework. All of the modules come directly from the LEADS capabilities, and we've ensured that there's development in each. When we get to the mid-level program [Experience LINX], bearing in mind that it was developed before LEADS, so it wasn't built with LEADS in mind, we have mapped it, and it focuses on Lead Self, Systems Transformation, and Engages Others. The program for very senior leaders [Transforming LINX], [who] will be moving into executive roles quickly, is a focus on Lead Self, Develop Coalitions, and Systems Transformation. (IH-INT)

The LEADS framework was flexible enough that capabilities and domains could be explored in many ways, and organizations could tailor their programs to systematically repeat the domains with different approaches and intents. However, throughout the various products and formats, the LEADS framework became more powerful to participants as they grew to understand it more.

Developing Internal and External Resources

Organizations initially hired external experts to advise them on developing LEADS-based courses and programs. However, they also simultaneously initiated the development of their own trainers or consultants, both to be informed about how to develop LEADS-based programs and to develop some of the programs. At SHR, for example, the initiative to adopt LEADS resulted in a decision to start by obtaining certified training for its own internal talent consultants. After SHR had the capacity, Sunrise Health Region then began its own internal development:

We had an opportunity. . . Saskatoon made an [appeal] to the province, . . . [for] the other health regions . . . to provide [them] with some capacity. So would health regions be prepared to train-the-trainers [to] assist with the program? Then you can use them in your own region. We jumped at that! So. . . our commitment is [that] we will help in September with the program . . . but then we've built capacity with three trainers in our own region. (SHR/SHI-INT)

The mix of external consultants, purchased programs and resources, and internal consultants seemed to provide the right amount of flexibility and investment. SHR/Sunrise started with an external consultant who offered a two-day workshop on emotional intelligence and a full-day workshop on coaching using

Coaching Out of the Box (i.e., the 5-5-5 program). However, by certifying its own internal consultants, it could segue into in-house programs and supports.

Some of our in-house consultants partnered together to deliver that training, since we're also coach-trainers. So typically the first—we've had 4 days of in-person—we call it Launch Week—is them getting their 360° [assessments], the learning plan, a lot of Lead Self and Engage Others with an 'in' to the content of the learning sessions. (SHR/SHI-INT)

Each organization developed resources in a way that made sense within that specific context. CADTH, invited two coaches who had been affiliated with the organization to participate in its in-house LEADS development programs. As a small organization, it was able to leverage its external resources by bringing its affiliates along in the organizational development. At Island Health, its membership in the BCHLDC helped usher in LEADS, and eventually led the organization to transition from its own in-house LILO program into the three-level LINX program. Island Health could utilize an external consultant who was very familiar with LEADS and the organization to help it develop more targeted offerings.

While all the organizations gradually developed internal expertise, they also continued to utilize external consultants, whether it was for specialized services such as consulting or for designing programs. They also used specific proprietary programs that matched LEADS capabilities, like the popular Coaching Out of the Box (5-5-5) program. In summary, these five organizations did not apply one single solution, but instead utilized a strategic mix of resources that included smart development of internal assets along with judicious use of longstanding relationships with expert, informed external consultants and pre-packaged learning programs.

Bringing LEADS to Life

Planning and development led to engagement, and most, if not all, of the cohort-based programs required a practise project as part of the completion. At SHR/Sunrise, as was the case at Island Health and AHS, participants were sponsored by their work units to enter the program with practical projects that fit into work unit goals. The projects were guided and mentored and were presented as a final capstone to complete their development. One participant described the process in this way:

What we also tie in to the program is the action learning, where we have them identify an organizational project in which they can apply the learnings from each of the different modules over the eight months into something that's actually part of their job, that they can do and integrate [with the learning]. [It's] not just something else on top of their full-time job, but it's meaningful and relevant to what they're doing, and their sponsor can also support that. (SHR/SHI-INT)

The practise projects often involved co-mentoring or partnering with other cohort members. This built a bond, which was evident in the informal conversations in the focus groups, which often started with participant updates on their various projects. In response to focus group questions, participants often spoke about the value of the projects and how they leveraged the supports that had been put in place.

At AHS, participants used a triad co-coaching model, for example. However, from the senior sponsor or talent management perspective, the challenge was not to lose the momentum:

The challenge is in bringing it to life in your organization and making it meaningful, and not just a poster on a wall, not just competencies that you're evaluated against once a year, or during a performance appraisal. . . . What I say to folks is, "When you come out of that, don't allow the momentum, the inertia in the organization to pull you back into the way it's always been."
(AHS-INT)

The process of engagement thus had a trajectory, starting with initial introductions and offerings, then moving to cohort-based learning and development, and then into applied projects. Practical projects were thus instructive for participants while also being part of a plan of change. As a result, it was also important to engage enough people to encourage organizational change by instigating momentum. This appeared to be more challenging in the larger organizations, despite their greater resources.

This is the fourth cohort, so there's been [about] 150 or so leaders in the organization that have gone through that. And so that's a lot of people that now have an appreciation for the [LEADS] framework. They've been evaluated against it pre- and post-program, they've worked on those competencies throughout the program, they've got some real intensive leadership development, they've worked on real projects where they need to use those skills in addition to their technical skills as they go through it and come out. What my concern is . . . even though there's been 150, 160 leaders, that's 150 or 160 of about 3,000. So when I talk about that critical mass, it's still just a drop in the bucket. (AHS-INT)

The challenge for AHS was in bringing diverse people together. The regional distances mattered, as they affected time and costs to attend. There were also barriers when some participants returned to work units in which LEADS was not yet a common practice. However, another option for AHS, because it had more than 100 people in its leadership and talent development team, was that it could offer tailored programs to various institutions and work units. Senior managers could choose to bring LEADS to their workplaces for an immersion experience. One executive-level participant described how he did this to support a group of new managers.

The other thing that we did was we made sure that everybody had access to some kind of developmental opportunity. Whether it [was] available through MyLearningLink [electronic learning portal] [or], when we did our restructuring. We ended up with [over 10] managers who were brand-new out-of-scope for the very first time in their careers. We actually developed about an eight-month curriculum specifically for them. And it was based on the LEADS framework too. We did it with HR [human resources] and talent development [because] there wasn't a lot of clarity on what the differences are [that] you're looking [at] between a unit manager and a program manager, a program manager and a director, and a director and executive director. So, writing those position descriptions with that really clear language in it, and differentiating between the types of competencies in each one of the domains . . . gives people a little bit more purpose in terms of how they organize their own development. So if

they're aspiring to be a director next, then they can assess themselves and look at the types of competencies that they need for that. (AHS-FG)

As this participant described, a la carte options were available to help individual work units adopt and implement LEADS. Thus, although AHS is faced with the challenge of achieving change in a large organization, it has developed the ability to be flexible and allow senior leaders to focus on their own units and teams. This provides a picture of success that is not universal throughout an organization, but provides intensive areas of change in pockets. Leveraging cohort-driven change to impact work units was also evident in the other cases. In contrast, at CADTH, the whole organization operated as a unit of change, with the opportunity/challenge boundary being at the interface with those not in management positions.

Individuals who participated in these cohort-based programs experienced the change and realized work unit outcomes. As an AHS executive program participant remarked, taking his whole team through the program made a difference, not only to the way they worked, but also to their personal development and focus (AHS-FG). Moreover, the ability to create a common language helped sustain this collective effect:

We did a cohort type of set of 10 courses, all based around LEADS, for all our front-line managers and some of our supervisors, and what I'm finding is we really have now a common set of language [skills] that we can talk about. We can not only challenge each other, but [also] help each other in areas that we may be working to develop ourselves in. (AHS-FG)

The cohort-based models not only engaged individuals, but also provided the opportunity to network across an organization, to consolidate the language being used (often referred to as LEADS language), and to create alignment and energy within teams. There is an individual learning component, which will be described in the following section, but also a cross-organizational aspect that helped to build solidarity around change.

Challenges to Targeting Audiences for Leadership Development

One of the interesting issues that emerged was who was targeted for program involvement and why. In general, organizations aimed to involve managers, directors, executive-level leaders and, in some cases, informal or emerging leaders. Part of the plan for who was included was about changing leadership culture, while part of the goal seemed to be to change whole units by transforming the leadership style of those in formal leadership positions. To accomplish this change, organizations specifically targeted these groups with different levels and types of supports and programs, as previously noted. This helped people learn from each other and, while developing trust, engage in difficult and real problems.

We all commented when we were done that we had the same cohort all the way through. I found that the initial course that you took was very much—it was very similar to any of the courses that you took with any program; everybody sat and watched and listened, spoke when they had to, and that was it. And by the third or fourth, you'd learned who people were, you'd

learned to trust them, and. . . we were having open, honest dialogue, not just sitting nicely. (AHS-FG)

Despite the plans, however, the targeted groups were not always reached and the leaders at the “right” level were not always available. Individuals who were eligible were not always able to attend all the sessions, even if they were introductory information sessions. In addition, a CADTH participant commented, individuals who came to the organization after the programs started, or who advanced into more senior positions during the first year of LEADS introduction, sometimes missed key parts of a comprehensive introduction to LEADS (CADTH-INT). Another challenge of participation was, to run efficiently, programs needed to be full. As a result, although programs were targeted to levels, they occasionally included people at various levels. The gaps and mixing created a challenge for organizations that were attempting to create organizational change and support a new way of working together; although this mixing seemed to be appreciated by participants, who had the opportunity to mingle with people in widely divergent areas of practice and spheres of influence.

In the opposing scenario, some people who were really interested in taking the programming could not attend because cohorts were full. The value some people felt in being invested in was balanced by the frustration others experienced when they had no option to attend yet really wanted to learn.

Well, you apply and you need to have support from your manager, and the organization then does a triage of who all wants to go and priority goes to those people who are in official leadership positions. So my journey has been to pick up that lovely binder that goes through the whole LEADS structure. [I] have been doing that on my own but relating it to the work and experiences that I'm currently having. It's also helping me articulate my PRDP [Performance Recognition and Development Program]—it has been just a different venue. (IH-FG)

The work to balance resources and opportunities led organizations to evolve virtual or online courses and programs. The expense of bringing senior leaders together, away from their jobs, was considerable, and not always possible in terms of time commitments and responsibilities. Virtual and asynchronous programs partially resolved these challenges, and these included seminars and lectures by consultants as well as courses and programs available as self-study or in cohort models online. However, the benefits of the face-to-face cohorts were evident as people connected during the focus groups. Other advantages to face-to-face programs were that participants:

- meet others and gained contacts that lasted afterwards;
- felt appreciated and found mentors;
- developed trust; and
- gained insight and appreciation of widely disparate areas of practice, including administrative areas such as information technology, facilities management, and personnel services.

Both AHS and CADTH evolved toward more virtual offerings. Some participants indicated the move to virtual offerings was positive, but some expressed regret over the loss of the face-to-face programs. Over time the strengths of the different formats may become more apparent; however, it was clear that engaging target audiences was a key component of making talent development work and was not as simple as it seemed.

Embedding LEADS in Organizational Practices

In addition to introductory sessions and workshops and adopting or preparing to use the LEADS 360° assessment tool, organizations moved to embed the use of LEADS in management practices. Using LEADS in management or leadership meetings was most clearly discussed in Health PEI and CADTH, where these meetings were structured with space for LEADS reflections. At CADTH, being small and centrally controlled, the whole leadership team met regularly (approximately every 6 weeks) and dedicated 1 hour of a 3-hour meeting to reflection on strategic priorities using LEADS. This collective reflection time helped accomplish three things: (a) introduce LEADS to newer members of the leadership team, (b) focus application and action on strategic priorities using collective wisdom, and (c) offer opportunities for continued practice and evolving understanding of how to use LEADS. This practice—more, it seemed, than the introductory LEADS workshops or the 360° assessments—helped link strategic direction with implementation of LEADS to inculcate the language of LEADS and thereby change the culture while also providing time for reflection, which is a difficult resource to come by. As previously noted, at Health PEI, the leadership reflected on LEADS regularly through the Management Forum meeting:

Management Forum is when every manager in the building gets together once a month to review what's happening in the organization, so the leadership component [has] always. . . been a critical component of that. We are always striving to be better leaders, and help others be better leaders at the end of the day. (HPEI-INT)

Although this description speaks to the benefit of this reflective practice, it should also be cautioned that, according to various participants, such review and reflection might not have been a consistent practice in all the areas and institutions.

Performance reviews were another type of practice in which LEADS language became part of the learning and habit of LEADS. When the performance reviews were practised as they should be, the use of LEADS was very helpful. However, in some cases, the timely completion of performance review was aspirational rather than a practice. For example, in one focus group, participants discussed the amount of organizational change and said that they did not have enough time to regularly consult and reflect. The following comments were in relation to their professional development planning:

Participant A: Instead of using the PDRP [Performance Recognition and Development Program] to develop your plan and meet your objectives as you go through the year, over the last couple of years [we] tend to be in this pattern of good intentions, and then we get to this point and we start going, "Oh, yeah, gee, let's reflect and see how we met those goals that we set out in our

planning meetings, and cross our fingers that we're on track." It's not the best way to go about it.

Participant B: I would agree with that. We talk about that quite a lot, because it's really just a quick recap of what you did this last year, and I don't know how valuable the conversations are with employees [when] that is happening, in terms of their growth and development.

Participant A: And I think what we miss when we do it this way is resetting our direction in a timely fashion. Because we're missing these opportunities to say, "Okay, three months ago we had this conversation, this was the direction we're going," and have we checked in to say, "Oh wait, we're changing course a little bit, and we're good, and everybody's still on track." Sometimes we end up closer to the end of the year and we realize that some individuals haven't been on track, and we've lost that capacity, and their potential, and it's not good for the organization, it's not good for the employee either. . . . I think we're getting better, but just marginally. (IH-FG)

As these two managers shared, the opportunity to tie development and reflection into strategic goals of the organization was often missed. Although the investment was present, the practice was not institutionally supported due to workload and time pressures.

Another challenge faced by organizations as they were implementing leadership development was how to surface doubts. Leadership meetings were one forum in which people could explore the cautiousness they felt. For example, one interviewee spoke to the way practitioners in the team were having trouble accepting change in practice. They did not buy in to the new leadership approach. During a session in which some resistance was evident, one resister laid out how they would do things differently, given the chance. Ironically, the path that was outlined was exactly what would be proposed if one were to use LEADS, and after some discussion, the group realized that this was a direction they wanted to go. This type of experience speaks to the difficulty of introducing "new" ways of doing things: the issue of spreading the same message throughout an organization and the challenge of having people who are busy and under pressure understand what is being proposed and how it would be practised. As such, it is beneficial to be able to have small-group discussions in which there is the opportunity to share information among leaders who are peers.

Summary

The first research question asked, "Why are you adopting LEADS?" in the exploration of how organizations adopted LEADS, the need for strategic change became evident. The goals, however, were not always clearly articulated. The more time went on and the more change in senior leadership, the less clear the reasons. This seemed to provide the opportunity for a gap to open between organizational change and leadership development. Individuals carried on in their own work units, but felt less supported and were less able to connect their own work with work conducted elsewhere in the organization. At the same time, each of these organizations faced the pressure of an increasingly demanding healthcare context. As a result, the pressures were great while the need to achieve results

was also great. The leaders who were part of the decision to adopt LEADS made their choices within this context, however, and the way LEADS was adopted and implemented was shown to be a careful, step-wise process meant to support organizational change. In the next section, some of the supports that helped achieve successful implementation are discussed.

Structuring Supports for Successful Implementation

The goal of leadership development is to impact day-to-day practice and enhance performance. Building processes that allow for leadership learning into organizational routine is, therefore, part of changing the future. Some organizations implemented practices that provided systems that were very effective for people to use. The professional development and performance review practices were also important opportunities for learning and change that were already structured into organizational processes. Other approaches were, as theory did suggest, very influential, such as corporate championship. Finally, evolving the program provided another opportunity for change, one that also involved talent management in being part of the change. Collectively, these four areas of practice changed the organization as well as the individual, creating a new way of being and inculcating a systems-thinking leadership environment.

Regular One-on-One Management Meetings

One of the most important resources, which participants mentioned repeatedly, was the need for consistent time to reflect. Interviewees reflected on the tight timelines and pace of work as challenges. As LEADS is expected to be part of goal setting, this leadership approach requires reflection on what is working and what else needs to be done. Time for reflection helps to reinforce both goals and consistency of leadership practices.

Participants noted one of the most important moments for reflection occurred in one-on-one meetings between managers and direct reports. All interviewees reported their organizations aspire to holding regular review meetings between managers and staff. CADTH had developed a stable systematic review practice. Various interviewees said that this is a consistent practice at CADTH prior to adoption of LEADS and had remained in place. This stability of practice likely assisted with smoother adoption of LEADS. CADTH participants indicated these one-on-one meetings provide a venue for directors to work with managers to align individual goals with desired strategic outcomes, to help resolve barriers and difficult situations, and to review and support LEADS-related leadership practices. The LEADS framework was used to identify how to address challenges in these sessions; as such, these sessions supported a problem-solving function as well as pointing to domains that might provide avenues to address the challenges. A CADTH interviewee said that this practice was really implemented, not just given lip service, which seemed to be consistent with the way other interviewees referred to the regular meetings (CADTH-INT).

Utilizing Coaching Relationships

All participating organizations provided coaching to staff, with more availability to professional external coaches at the most senior levels. Participants noted co-coaching was an important supplement to professional coaching, and it was taught throughout all the programs, with internal coaching consultants also available to offer support, frequently on an as-needed basis and occasionally as part of a formal offering. During the LEADS programs, new managers might be assigned a limited number of individual coaching sessions. Participants noted these sessions provided important opportunities for individual reflection on personal skills and aspirations and were very important for absorbing and acting on feedback received through reflection, including feedback received through processes such as the LEADS 360° assessment. The various organizations had different capacities, depending on their scales. For example, through the LEADS adoption, CADTH maintained relationships with two coaches, one for executives and another for managers. Importantly, both coaches were invited to participate in introductory LEADS workshops, so although CADTH did not have internal consultants, it was able to develop its resources to align with LEADS. Several interviewees spoke to the benefits of this approach, indicating that because of this involvement the coaches knew the LEADS language that the organizational members were using. This made it easy to use LEADS within the coaching relationship and to apply LEADS to practice. This simple action of bringing the coaches along appears to have helped CADTH support a successful implementation of leadership development.

Professional Development Planning

One of the ways in which organizations adopted and implemented LEADS was through individual take-up in professional development planning (PDP). In some cases, such as with Island Health, the organization formally structured the PDP process through utilizing an online system.

The LEADS-based leadership development was part of an opportunity for individual professional development, while using the LEADS framework could also provide insight into next steps a person might like to take. For example, if a person identified a strength or weakness to address or develop further in, the individual might then target the next professional development opportunity to focus on that area of development. LEADS appeared to provide a very effective framework for personal development planning.

Although talent management personnel worked hard to provide opportunities, participants perceived the PDP process as one of the more ad hoc and sometimes frustrating experiences. To begin, the PDP process was not necessarily linked to LEADS, or, as in the following example from Island Health, could not always be linked to opportunities for further study.

I do my own learning plan, it is part of my professional responsibility as a nurse to do that, and as well as my just ongoing lifelong learning. But I don't think anyone—and I was in contact with [human resources], there was a mentorship program being offered, and I offered to be a mentor, and I asked her, 'Can I sign up for Transforming LINX?' I felt, a couple years [after my training], that I needed to reconnect with people who are having this conversation about leadership. [I was

told] that's really for director level, so I wasn't able to have that course, and I asked, 'Well, what else do you have for people like me?' She suggested a master's in leadership, [but] I did that— what else is there?' There isn't really anything in that middle. And I guess that's one of the gaps I would see, at least in Island Health, between Experience LINX and Transforming LINX, that there's this Transforming LINX for directors and above, our executive, but what I see is—and this may be because of my [area of] work—it's that [the] transformational change is happening closer to the frontline than at the executive level, but it's just maybe a different sort of perspective. So maybe there's some opportunity to have some bridge between the two. (IH-INT)

This participant highlighted several dilemmas (IH-INT). First, there is more demand for programs than can be provided, and this was true across all the organizations. Participants felt lucky to be able to get into programs and, in one organization, a manager worried that by not being able to get people into programs, she might be creating tensions rather than cohesion in her team, because some people had opportunities and others did not. Second, there is a desire for follow-up or refresher material, even informally, illustrated by this participant's offer to join a mentoring program to mentor others. Not having such resourcing and support can result in missed opportunities to harness the energy or interest of employees and to build on the momentum of their earlier involvement. This dilemma was present across the organizations but seemed most effectively addressed through Health PEI's community of practice and CADTH's applied leadership model. The community of practice was not widely available within Health PEI, but it could be deliberately duplicated. CADTH's applied leadership model had various assets, described above, but also seemed to fit in with learning theory that suggests that on-the-job learning is one of the strongest ways to make in-the-classroom educational experiences stick. This approach also seems consistent with both the co-coaching triad type groups and the availability of mentors and coaches, which were frequently informal connections and occasionally formal paid coaches, particularly for the executive level.

A third dilemma highlighted above is both an advantage and a disadvantage, in that there is a gap between the levels of program.

I did express interest in actually taking the course. However, it was more earmarked towards having the management staff take it. I don't have [any] direct reports, but a seat became available unexpectedly. In an effort to not lose out of that opportunity they asked me if I would like to take the program. That's actually how I ended up being part of it. (SHR/SHI-FG)

CADTH, however, perhaps because of its smaller scale, blended participation across the levels. Across all the organizations, however, participants really appreciated mingling with a diversity of people. In the focus groups, people from widely disparate areas of practice, regions, divisions, , scope of practice, ages, and disciplines really appreciated the insight and connections. There was a great deal of respect paid to others, which clearly arose from their connections through program experiences. Thus, while there are good budgetary reasons for spending more on executive-level development than on informal leader development, from the point of view of transformational leadership or distributed leadership theory, mixing levels may be just as beneficial for the organization.

A fourth point raised by the participant's experience is that many individuals who are highly motivated do take graduate degrees out of their own interest (IH-INT). In Health PEI, a group of Royal Roads University graduates co-created the community of practice and still talk to each other about ways to enhance leadership development in Health PEI. They do this after hours. At Island Health, two participants who had taken a master's degree also put in their own time after hours to develop a process of reflection and planning necessary to leadership practices. In AHS and SHR, the knowledge and experience of individuals who had participated in LEADS development inspired leaders to advocate for the adoption of LEADS, because it made sense to them. The value to all these organizations from these individual efforts is enormous, yet it did not seem that any organization provided PDP funding, scholarships, or any incentive for, or recognition of, post-graduate study. Compared to the cost of hiring consultants, the benefit of having in-house leaders who are experts themselves and motivated to make change for their organizations is enormous.

The interest around obtaining training was high among participants, and organizations are working hard to harness this high level of interest and motivation among these leaders. There are, of course, others who are not interested, and one participant alluded to those who attend the sessions but then leave the organization, perhaps intentionally taking advantage of the high-quality offerings to further their own advantage externally.

There [are] some managers and leaders who have really adopted it, and are bringing it to the forefront. I would guess that people who sign up for the focus groups are those, but there [are] definitely some people within my cohort who were requested to be there, and had to be there. I'm not sure how well it was received, or even then adopted, and then what does the rollout look like to their surrounding team? (AHS-FG)

However, even if this is the case, it is equally true that many participants pursued opportunities on their own, such as through a master's degree in leadership studies or the CCHL Certified Health Executive designation. Although training was not always applied within the organization, or directly to the benefit of those organizations, the availability of recruits with LEADS knowledge was an asset as individuals switched between organizations. As noted below, a senior leader suggested it would be beneficial if LEADS was also incorporated into recruiting (AHS-INT).

It [using LEADS in recruitment] is something that we should, certainly could do and would aspire to do, but through the recruitment process we could do some evaluation towards these competencies. And the fact that people in other health authorities across the country have also been exposed to this, and in theory are working towards this framework as well, provides some consistency. (AHS-INT)

This was demonstrated within this study, as one participant had switched between two of the case study organizations during this research. Several individuals fit this profile in this study, some at very senior levels and some at new manager levels.

Performance Reviews

Although the LEADS 360° assessment was not part of the focus of this study, the discussion of performance reviews arose frequently as participants reflected on how they used LEADS and how it was implemented. As a talent management specialist described it, the performance review is a key component of talent programs:

We support leaders with informal supports like coaching and mentoring, [the] 360°, and the performance planning and review, succession planning, all of those wonderful current management pieces [as well as] the leadership capability. A fundamental component to all of those [is] that we're clear with our leaders what we expect from them in terms of capability and behaviour, and we provide them with opportunities for feedback, and growth and development. (IH-INT)

As this participant and others described it, performance reviews are one of the critical processes through which organizational change is enacted (IH-INT).

Participants talked about setting their own personal goals in the review process, and also about reviewing how their jobs and roles were affected by strategic goals and changes. The following discussion reflects some of the difficulties.

The way that it's incorporated into the performance appraisal in terms of the use of the LEADS framework, it's very prescribed and it's hard, there's not a lot of latitude for qualitative feedback. And so they've used the framework, and it looks very nice, but the meat of the performance appraisal is still in the back, where the conversation occurs about what your successes and your achievements have been for the year, what your personal performance goals are for the upcoming year, what your supervisor has seen as areas of growth opportunities and areas of strength. Maybe in the design, because you have that sort of structured framework that you're responding to at the start, maybe it encourages the thought process along the framework that guides the completion of the second half. (AHS-FG)

Interviewer: What about, for example, looking at Lead Self? How do you gauge—you said that you set your own goals and then assess them on a quarterly basis. Do you do anything like that?

Participant B: No.

Participant C: And that's self-driven for me, it's not because anybody has asked me to do it.

Interviewer: Well, it sounds like that's a practice that developed in the corporate environment that you were in before, too, so this is something that you bring as a customary habit. Do you want to add anything?

Participant A: I was trying to just get a sense of our people strategy, and I don't know, it doesn't actually look like—has it officially been [implemented?] Because I can't find the strategy right

now, it says, 'Deliver on the people strategy April 2016 to March 2019.' Just wondering if we [will] have more prominence of LEADS in that, but I can't tell at this point. (AHS-FG)

There is a tension between a structured performance review process and one that is effective for the people involved. In this conversation, it appears that the format they are using does not support the kind of conversation Participant C likes to have or finds useful, even if it is practised regularly and fits the accountability structure for the organization (AHS-FG). Participant A was not so sure how the review processes were supposed to be used, and attempted to locate the new “people strategy” as the dialogue continued to see if the processes provided explicit guidance (AHS-FG). Not surprisingly, the more distance people had from the senior levels, the less familiar they were with performance review practices and how to use them, and the less control they had of their work situations.

However, if the practice of completing corporate performance reviews was sometimes imperfect, it did provide opportunities that people leveraged in interesting ways. For example, a physician talked about how she was working with a voluntary performance review system to support physician leadership:

Adoption or implementation of LEADS has been kind of an interesting process in my own area. I don't have a large staff; arguably I have no staff. I have a whole series of wonderful colleagues that are at various stages of their career or life path. So we try to develop these [capabilities] within ourselves, within our various role or capacities. So what we've tried to do with LEADS on a more formal basis is performance evaluations, or periodic reviews, as something that's beneficial, and core in our hiring processes. [We] have really actively tried to demonstrate these [because] often physicians are the spokespeople, are often chairs, are often called upon to set the tone of various collaborative meetings. (AHS-FG)

Champions and Leaders of Leadership Development

Leadership and organizational change theory has long described the importance of champions in change processes. Throughout the interviews, but especially in the senior leadership and talent management teams, participants contextualized the adoption of LEADS within change agendas and leadership.

As a small organization with direct access to their CEO, CADTH provides a great example of how a strong champion makes a difference. The CEO at CADTH led the charge to respond to the need for change in 2009, and as part of setting a new corporate direction, also has made his views on leadership clear. As a champion of this change, he has invested effort to model and maintain leadership messaging. He consistently posts communiqués reflecting on his leadership, his learning, and information relevant to the organization. These efforts were reflected by participants who said, “People really believe him” (CADTH-INT) and, “He walks the talk” (CADTH-INT). He achieves consistent integration of his messaging with the strategic alignment of the organization through these actions. He has high credibility and support among leaders in the organization because of his efforts. This asset is not to be underestimated.

Board leadership was also important. Health PEI participants were clear that their board used LEADS. Although at CADTH participants reported their board members “have their own leadership model”

(CADTH-INT), the CADTH board had, in fact, rearranged its structure to be less hierarchical, removed an executive decision-making inner circle, developed a board charter and evaluation process, and required all board members to actively participate in decision making. Thus, at the most senior level, CADTH has also implemented leadership development, demonstrating implicit support and providing consistency with the CEO's actions. The appreciation of Health PEI participants for their board leadership suggests that any opportunity to be transparent helped to support people to connect their own work to the strategic vision of the organization.

The example of CADTH is most clear because of the smaller size of the organization, but the participating organizations all had, at some point, clear direction from leadership on the adoption of LEADS. Participants reflected that this clarity of vision could be challenged by the rotation of leaders. Although participants in the organizations that had new CEOs (Island Health, Alberta Health Services and Health PEI) knew that the organization still championed LEADS or leadership development, individual participants were not always clear if the senior leaders drove this initiative. In the absence of this certainty, individuals committed to leadership forged ahead. They still made change within their own spheres of practice, but they felt less bold about reaching beyond their work units, and they reflected some uncertainty about whether their efforts would have ripple effects beyond their direct reports (IH-INT; HPEI-INT). While this uncertainty was not widespread, its existence speaks to the importance of regular direct communication from leaders to their reports at all levels of an organization.

Evolving Leadership Development Programs

As leadership programs were implemented, the organizations met with several challenges. Some of those arose from the changes within organizations, such as reorganization imposed externally or internally or changes in leadership. Other challenges arose from the need to contain costs or to focus on changing health needs and treatment options, or changing resources such as staff levels. Across the organizations, within all three study participant groups (executive, talent management, and frontline leader), interviewees and focus group respondents talked about the impacts of shifting agendas, both internally and externally. Talent management had to remain in accord with and responsive to these changes.

There was a tension between engaging individuals and achieving a threshold of enough people to change the culture within the organization, as discussed above. Evolutions included the following types of program changes:

- movement toward more online and virtual offerings;
- development of embedded leadership practices (e.g., applied leadership program at CADTH);
- partnering with provincial academic institutions to provide health-related leadership education in professional programs or through master's degrees (Health PEI; AHS);
- development of in-house tools (e.g., Behavioural Dictionary at AHS);
- development of communities of practice (e.g., Health PEI);

- development of the capacity for staff members to take one course at a time or to engage in self-study, and then to package these together toward a certificate program (asynchronous rather than cohort model);
- development of in-house resources;
- experimentation with and piloting of various purchased proprietary programs;
- expansion of the use of the LEADS 360° assessment tool;
- institution of structured mentoring and co-coaching models (e.g., a peer-mentoring program);
- Further education of talent management specialists (often pursued by individuals without institutional support); and
- alignment with new strategic direction.

This list exemplifies the multiple purposes of talent management programs: to serve the organization's strategic objectives, to support and value individual staff to do their work as best as possible, to support succession planning by preparing future leaders, and to enhance functioning of current practices and tasks in the organization. In addition, the evolutions also represent work that talent management consultants engage in, reviewing and monitoring advances in their own fields of expertise and adjusting learning and development as new theories and practices emerge.

Picturing the Evolution

The evolution of programs at CADTH provided one example of the way programs were piloted, adjusted, expanded, and diversified. After approximately two years of the overview workshops and other intensive offerings, in the fall of 2014 a decision was made to evolve to what is called applied leadership development (see Figure 3: Program Evolution at CADTH).

Back in 2011, that's when we did the one day per letter [domain]. I think as time has evolved it's a more condensed version. So, for new management or new staff it could be two half days or a full day... and then that refresher every 6 weeks at a leadership team meeting. (CADTH-INT)

As this participant described, starting in the winter of 2014–2015, CADTH began incorporating LEADS-based reflections into its team meetings (CADTH-INT). One hour of each 3-hour leadership meeting is devoted to professional development, and these meetings occur approximately every 6 weeks. During the meetings, the LEADS framework is explicitly used to review business issues and strategic priorities and to develop action plans. Team members learn from each other as they share knowledge and ways of applying leadership principles and practices.

In addition to the applied leadership model, CADTH continues to offer programs and courses, including tailored virtual offerings with external consultants. A new limited entry cohort model brings 10 participants through a structured program. The cohort model introduces conditions, as participants

must be sponsored and must have an objective related to their work performance. The intention of this combined approach is to provide further opportunity for coordinating leadership evolution with strategic outcomes while also supporting a deepening of knowledge and practice.

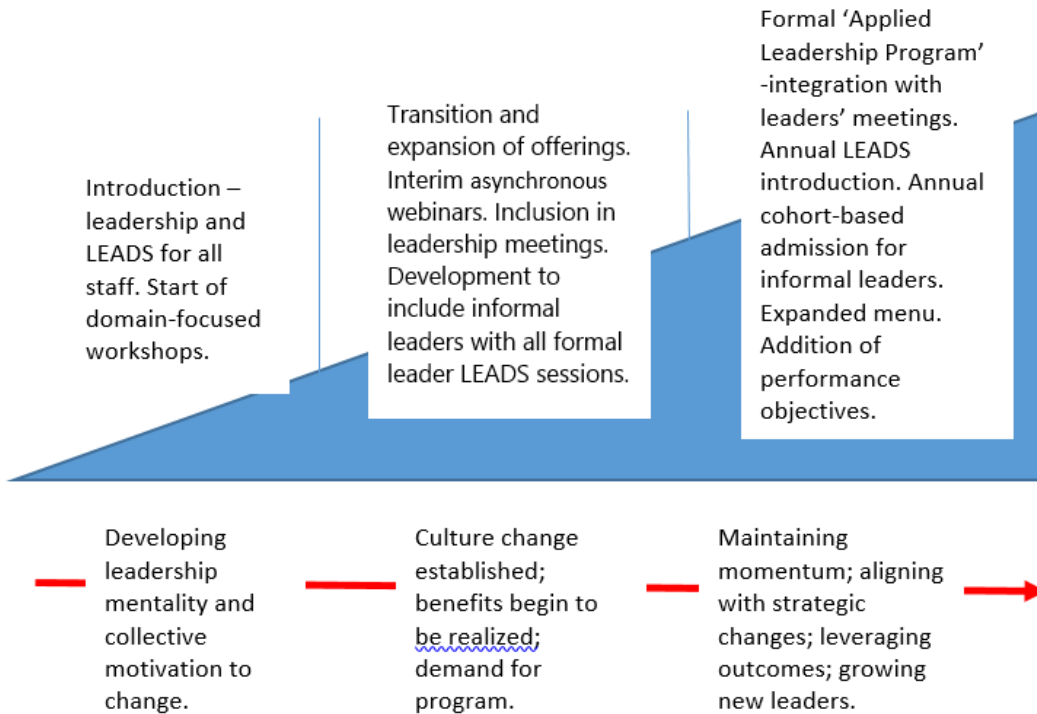


Figure 2. Program Evolution at CADTH

The development of the applied leadership approach fit well with two organizational changes at CADTH, which came out of a period of rapid growth. The first was the development of a new department (termed directorates in CADTH) focused on health technologies.

The evolution of programs at CADTH, as elsewhere, requires both a widespread, organizational effect and increasing depth for individuals. This was often achieved or aimed for through the more intensive cohort programs, which were linked to organizational outcomes through practice projects. Individuals practiced these links through the development of their organizational projects and through consistent engagement. Meeting both organizational expectations and individual development goals was part of the complex work of talent management consultants and leaders.

Continuity of Participant Experiences

The evolution of programs, while beneficial and necessary, also provided continuity challenges. One challenge was in connecting people who had been through the program with those who were being brought along as new leaders. Even though individuals were having different experiences, integration and coherence needed to be maintained. In the following quote, one participant described the evolution to include new staff, with the aim of bringing the whole organization along in the culture change:

Some of the framing and what do we do for new staff. We do look to replenish. . . maybe that's not the right word. But, the informal leaders. . . so they come in and do a two-year stint. They receive that initial training and the ongoing session and then we look to bring in a new cohort. In that way you could see in a few years everybody at CADTH would be an informal leader or part of management in terms of being exposed to LEADS. (CADTH-INT)

The overview provides the plan, but staff members were also aware of the evolution of programs and compared notes to see how their experiences were similar and different. The following conversation, in a different organization, Island Health, is in response to the interviewer's question about whether people still understood that what they were referencing was LEADS, even though the programs had evolved. They start by talking about the screening process.

Participant A: When people go to register for these programs, one of the questions they ask you is "Have you taken LILO?" And if they have, then there's some conversation around the fact that Experience LINX is essentially what LILO used to be, and if they're an experienced leader, then Core LINX may or may not apply.

Participant B: So, we're probably right in the middle of some people not having that LILO connection, and others maybe not being exposed yet to LINX, so. . . I would expect that LILO will start to fade as it ages out. (IH-FG)

These participants confirmed that although the programs were different, there was continuity and people still understood each other's experiences (IH-FG). This conversation highlighted the way in which employees map and track the relationship between the leadership development programs and their own understanding of organizational development agendas and strategic priorities. Their reflections indicated how employees work to assess how their skills and development can be useful in their work with colleagues, especially if they need to explain how they are approaching issues from a leadership perspective. Having a common referent, such as LEADS, made their leadership development more effective and meaningful for them.

Summary

Asking how LEADS was implemented revealed how organizations developed leadership programs. LEADS was a part of these program evolutions, and the framework appeared to be flexible enough to support changes through time. LEADS also appeared to be flexible enough to accommodate a variety of foci, from the emphasis on the LEADS 360° assessments in Health PEI to the well-established programs offered through Island Health. LEADS provided a framework, not only to guide individual thought, understanding, and practices of leadership, but also for talent management to map programs and practices. It also, due to its non-prescriptive nature, seemed to allow organizations to efficiently bridge between former offerings and new LEADS-based programs. One essential asset for these early adopters was a knowledgeable and well-informed expert who could help organizations tailor their implementation to a new LEADS-informed structure. Another key asset was senior leaders who clearly championed the use of LEADS. Talent management consultants also had to be knowledgeable and nimble, thinking about multiple audiences at once and including strategic goals in their program planning. At the same time, it was the participants who made the programs come alive. The next section reviews interviewees' responses to questions about whether LEADS made a difference to them and their work.

IV. Effects and Impacts

One of the important questions about LEADS, or any leadership development program, is whether the framework makes a difference to healthcare outcomes or organizational functioning and how can this effect be identified or discerned. As the first systematic exploration of how or whether LEADS makes a difference, this study broadly explored what the relevant answers might be. Key stakeholders who participated in a 2014 pilot test of the strategic research questions and interview questions indicated the need to clarify whether this study was inquiring about LEADS (the framework) or LEADS (the implementation). To some extent, the two are inseparable, but to start, this study described individual experiences with LEADS and how people put LEADS into practice. Second, this inquiry examined the effects on interactions in the work environment, which, in the experiences of participants, were reflected in team dynamics and other intra and inter-organizational interactions. Third, this study looked at the systemic effects on the organization itself. The summary of this section reflects on the organizational implications of using LEADS.

To be sure that people were referring to LEADS and not to leadership development experiences in general, participants were probed to be specific about how or in what way the experiences they were discussing linked to LEADS. It was important to understand whether their experiences were a result of the many well-developed proprietary programs that were used, the excellence of facilitators, or other institutional factors. However, participants clearly linked LEADS to the effects. For example, people often gained important insights or skills through educational workshops using tools such as StrengthsFinder (Rath, 2007), Myers Briggs (The Myers-Briggs Foundation, 2016), or other programs. However, if one of these educational experiences led them to insight into effective communication tools or approaches, they would then link the importance of this to a LEADS domain, such as Engage Others, as well as the capabilities defined within the domain. LEADS worked to thematically organize and link programs which, while valuable, could be an assemblage rather than a systematic collection.

Engaging Individuals

Participants spoke of powerful personal and professional impacts from using LEADS, for example, gaining insights about themselves, being able to communicate with others more effectively, and getting work done because they could balance their own style with others' skills and assets. This study captured this individual-level impact of using LEADS with the title "Engaging" because when individuals were engaged, LEADS worked for the organization. However, what participants also said was that Lead Self was foundational to using the other domains, so engaging with LEADS seemed to start with engagement at the individual level through the capabilities of Lead Self. As described below, it seemed that some individuals resisted using LEADS, and if they did resist, then LEADS could not work for the organization, despite excellent development programs. However, as LEADS was intuitive to use, the threshold for engagement was low—LEADS was easy to use if it was seen as useful.

Knowing Oneself as the Foundation to Action

As previously noted, engaging with LEADS seemed to start with the domain Lead Self. Many participants spoke to the value, personally and professionally, of knowing themselves better. They enjoyed this aspect of personal and professional development, but they also valued it because it provided insights into their own characteristics, strengths, and communication styles, which led to understanding their own interactions and preferences.

I just eat this stuff up. That journaling that you're talking about, I can't even get started how amazing that was. [Although] I feel like it was an onerous task sometimes—daily trying to make time or find time to journal—but some of the things that came out of that definitely allowed me to put names to the person I am, and it's allowed me to really be clear to myself. That was really epic. (IH-FG)

This participant, and many others, appreciated the insights that came from knowing herself better (IH-FG). This was important for personal relationships at home, which must be interpreted as stress reducing and, therefore, helpful in the workplace: wellness is an important complement to a more functional workplace. However, in addition to being personally rewarding, knowing oneself helped individuals to be more effective at work. Some participants spoke about being better able to get tasks done by knowing how to identify and call on supports that complemented their own skills and characteristics. One participant described how, starting with knowing herself, she then used this knowledge to bridge into managing others and planning projects that aligned with new strategic initiatives:

I take the approach—what do I personally need to develop if this is a project that is going to require a new approach or new skill development on my part—what might that be [for me]? What could it be for our [work unit]? So within our group we have a clear understanding of—we've done the Myers Briggs. We've also done StrengthsFinder [and] we have a sense within our team [of] the skill set that we have. We work to complement each other. This isn't really formal, but we try to do this. Of course our staff are always rotating, so that makes it challenging. [But] then I look at what the plan is. What might exist from [a] learning perspective? What do we need that isn't out there that we can then pull in that is specific to our team, our broader team, or within our own [work unit]? So we use it [LEADS] to help guide all of that. (IH-INT)

Self-knowledge was foundational to communicating with others, planning days more effectively, and managing styles of interaction, including motivating others and working in teams more efficiently. The difficulty was that insight into oneself often led to insight into other people's challenging characteristics. With the awareness that all individuals face challenges and have blind spots, team members could work to achieve what was required. In other words, self-awareness often led to understanding, or comprehension of others' motivations, and as a result, compassion. Through knowing themselves better, people could and did see the opportunity to take it upon themselves to resolve communications or work-related challenges. Self-awareness, therefore, enabled people to take on the kind of

responsibility (response-ability) that is important for good workplace interactions and accountability to the organization.

When participants were asked which domain they used more, or whether one was more important than another, they often said that Lead Self was foundational, but that they were all linked.

I'd go with L [the Lead Self domain] and S [the Systems Transformation domain]. So, the Leading Self—meaning we're one of the larger [organizations] needing to have a good understanding of strengths, weaknesses, gaps, all of that. And then the S, so recognizing that you are part of something larger, and by thinking of the S I think the E [Engage Others domain], the A [Achieve Results domain], and the D [Develop Coalitions domain] kind of come along with that. So thinking, if we've got to do this for the organization, what do we need to do? We need to achieve results. How do we do that? By engaging others and developing the coalition. I would choose those [as the] book ends. (CADTH-INT)

Knowing oneself enabled people to focus on their own barriers, to better understand others' reactions to themselves, and, as described above, to identify areas that they wanted to improve on when communicating with others.

As previously discussed, participants applied their insights to PDP, which made LEADS not just something that was applied, but also something that multiplied after training and development. For example, the following conversation started with a reflection on how people could use the way LEADS was embedded into performance appraisals to link who they were to their achievements and their future professional development.

Participant A: Having it [LEADS] embedded in the performance appraisal is—it ties it all in, it pulls it all together. It's not just "that framework" on the sidelines. It's really meaningful, and it's part of your annual performance, with your staff and yourself. You have to go back to it and look at it and see, "Well, what have I done in these domains? What have I achieved?"

Participant B: And it has a common language. (AHS-FG)

Moving from self-awareness to other engagement and then to forward planning for development demonstrates how LEADS begins to be part of a multi-dimensional implementation. It also demonstrates how self-reflection can result in LEADS being applied in diverse processes. Participants linked self-reflection to annual planning, and, as they did so, it brought reflection on personal characteristics into the realm of organizational effectiveness. Self-assessment tools, like the LEADS 360°, provided a strong organizational structure for continually looking back and looking forward. While development in the domain of Lead Self and self-awareness provided a way for individuals to make choices and to be in control of their own professional goals and actions, it was also foundational to their engagement with organizational tasks and agendas.

Getting Engaged through LEADS

Beyond self-awareness, participants reflected on how leadership development opened a door, or gave them permission to become more engaged in their work and their responsibilities. Participants said they could identify challenges more easily and start working to resolve problems more quickly. They felt better about their contributions and were more effective. Informal leaders (people with responsibilities but no reporting staff) and new managers reflected that they felt valued by the organization when they were invited or nominated to take part in the program. When the organization invested in them, they invested in the organization. From the organizational side, this engagement might be viewed as enhanced accountability, but from the individual side, people felt empowered to act on what they saw as their responsibilities without asking permission for specific tasks.

One of the interesting observations of many interviewees across all the organizations was that they referred to LEADS to explain what they did and why they did it. At CADTH, two participants described how referring to the domains of Engage Others and Develop Coalitions enabled them to explain why they needed to reach across departments (CADTH-INT). LEADS gave them a language that others understood, and legitimized their tasks. Having a common language also enabled leaders to reach out to people in other units, and those individuals understood that they were being contacted because they needed to work together to solve a challenge or achieve a goal (CADTH-FG; IH-FG). LEADS appears to liberate people from the confines of structure, while still maintaining the accountabilities organized through structure. The result was an ability to tap interdisciplinary skills and cross-departmental knowledge through recognized LEADS-informed meetings and work groups.

Standing Back: Waiting to Engage

When looking at the effect of LEADS on individuals, it is important to acknowledge that not everyone engaged. Across the organizations, participants gave examples of colleagues who did not buy in to the process. In addition, sometimes participants expressed frustration because they were not able to obtain development opportunities—they could not participate in everything they wanted to. Some participants also felt isolated; they had participated in leadership development but they did not work in environments in which others had participated or understood, or they felt that corporate leadership was weak, or even that their own managers or directors did not understand their leadership efforts. One clinical director, who participated on the condition of complete anonymity, expressed great frustration with the LEADS 360° process and indicated he thought it was “a waste of time” (participant code omitted to protect identity of participant). The lack of opportunity to apply LEADS, or lack of engagement, demonstrated that barriers at the individual level could block LEADS implementation.

Negative reactions were sometimes tied to methods of program rollout, but they also sometimes seemed to arise out of the responsibilities people felt toward their professional standards and practice. Participants reported this as reluctance among colleagues; future research is needed to shed light on those who had reservations or concerns about LEADS implementation to determine why they were hesitant. Participants also often described these reluctant individuals as carrying out important line duties. It makes sense that highly specialized and educated professional staff, who are very valuable and

necessary in healthcare, are entrusted to use their judgement to decide what health services are needed or what care their patients need. Ironically, physician leaders who participated in the study reported that once colleagues understood that LEADS enabled them to exercise their leadership the way they saw fit, the reaction could be very positive. In addition to physicians, participants described reluctance among work units, regions, institutions, or professions, including, pharmacology, radiology, governance, human resources, laboratory technicians, and scientific-technical staff. No profession was immune to the need to be sold on LEADS, and LEADS could not be rolled out with enforced compliance because it is an opt-in program. However, this meant that one of the challenges for those who did find LEADS and leadership development useful was the need to support those who were using LEADS and worked in parallel areas, departments, or regions. The Develop Coalitions domain was helpful in guiding work, but using it as a lens points to the tasks of bringing together autonomous units in healthcare.

Researchers and leaders recognize the challenge of introducing leadership within professions. For example, the Canadian Medical Association, which represents physicians, offers leadership development in its continuing education offerings (i.e., the Physician Management Institute). Various universities also now offer some, albeit limited, education about leadership and organizational management within nursing and medical training, although participants, including talent management and development staff, wished there was more. Talent management participants from most of the organizations were working with local academic institutions to offer more leadership development and health systems education. Some participants at CADTH, for example, noted that they did not have management training prior to stepping from informal to formal leadership positions.

Another challenge to embrace LEADS might arise out of the relative stability of departments and staff, and the ability of some people to stay in positions for lengthy periods of time. While there is considerable turnover and vacancy in some areas of practice or regions, in others there is long-term stability. This means that initiatives may be perceived as “new” for very long periods of time. Participants referred, in some cases, to limited opportunities for advancement and, therefore, limited incentive to change one’s way of working or to take on leadership challenges. This challenge appeared to be addressed by offering leadership opportunities broadly so that many people could participate. However, it is important to note that the stability, which can be an asset, can also be a barrier to change.

It’s Intuitive: Enabling Individual Action

The fourth area of individual effect was in the use of LEADS. As was evident throughout the interviews, individuals felt that they owned the framework—they could pick and choose what they were focusing on and why. Participants often said, “It’s intuitive,” or “It’s nothing special,” by which they meant that using LEADS did not have to be complicated. For example, one executive, who confessed he did not really remember the details of the framework, said that he still used LEADS as an organizing rubric to keep him on track as he plans and coordinates a new community-based initiative across a wide array of departments. Using LEADS to plan, in this way, means that it can work like a rubric to focus or coordinate a person’s reflections on whether all the necessary parts of an action are in play (reflection, engagement, action, engaging internal and external stakeholders, and achieving systemic change). Using LEADS as a rubric to organize experiences was one way that LEADS was useful even though, or perhaps

because, the framework was “nothing special” (AHS-INT). This “nothing special” comment referred to the fact that LEADS is easy to use, and does not have special proprietary techniques: this was often mentioned as a huge asset.

When participants referred to the framework being easy to use, they also captured a range of other benefits. Participants who had limited time to focus on using the framework could still recall general lessons or skills and benefit from them. In addition, they could begin to use the framework, benefiting from insights in programs and workshops, yet also suddenly understand something much later and become interested in and able to use lessons learned earlier in new ways. The ways that LEADS could still be useful even when it was used in limited ways spoke to its suitability across a variety of contexts and conditions.

However, those who were interested, which was typical across the study, used LEADS more systematically, setting aside time to apply specific tools and aspects of the framework to review their own strategic objectives, strategize overcoming barriers or addressing workplace challenges, work with colleagues in study groups, or plan future professional development. Thus, in asking the research question, “What difference does LEADS make,” one answer is that it enables individuals, no matter their level of understanding or context, to be more effective. LEADS likely has more impact when people utilize it more systematically, but being easy to use means that it is still effective when people only apply it schematically or, for contextual or resource reasons, lack the opportunity to use it in detail.

Summary

In asking what difference LEADS makes, the stories that participants told spoke to a variety of ways that LEADS was useful. These included self-reflection and self-understanding, which participants appreciated on a personal and professional level. Many said this was the foundation of LEADS and leadership development. Second, LEADS helped people engage with others. This aspect of impact affirms one of the hypotheses behind the proposal for the study, which was that health organizations and systems constitute a complex adaptive environment. LEADS enabled people to reach beyond the scope of their individual positions and roles to engage others in strategic tasks as well as in the work of serving patients better. This was empowering to individuals. At the same time, LEADS did not overcome disciplinary or professional allegiance to serving the needs of patients. People needed to be convinced that what they were doing was for the good of patients and the system. Witnessing reluctance in others led participants to see that their own challenge and opportunity was to learn to engage others for the betterment of all. The assumption of responsibility in this area, and the impetus to action, speaks to the interconnected, self-adjusting, and semi-autonomous nature of Canadian healthcare systems. Finally, LEADS is easy to use. This means it has a low threshold of effectiveness, although it is likely more effective the more it is applied, especially in when it is used in more nuanced ways.

The four areas of individual impact also suggest metrics that could be used to gauge the effects of adopting LEADS. First, if self-development is foundational, then simple pre- and post-program surveys of self-awareness or interpersonal skills may effectively gauge learning. This approach could also work to assess the growth in interpersonal communication. Surveys of successful resolution of difficult

conversations might also be an indicator of self-awareness growth. Third, if allegiance to professional practice is very important and caused people to hesitate or be reluctant to adopt LEADS, then the degree of perception of lack of fit between leadership and professional responsibilities could be an indication of where gaps may need to be addressed in order to have a full rollout. Finally, if LEADS is intuitive to use, random samples of the extent to which all of LEADS is being utilized might indicate the scope individuals have to practise leadership, and this may provide feedback on supports that may be needed for broader use, especially during change and transition.

Engaging and Enhancing Teams

When asked what difference LEADS might be making, the second area of impact that arose was teamwork. This may have reflected the scope of practice of many people who were interviewed, who were at various levels of management. However, almost all the participants frequently referred to interdisciplinary or cross-departmental work and to ways in which they worked with others in teams. As managers and directors, this work was focused on supporting and guiding individuals within their teams, but also connected those people to the organizational goals so that they could respond to and leverage cross-unit energies and make the whole system function. As one manager said, “Where trying to implement something like LEADS, it is sometimes challenging for people to see their own role and how they bring it to fruition on a whole system” (CADTH-INT). This participant’s statement demonstrated an important principle of implementing a leadership framework like LEADS, which is that it requires collaboration beyond one’s positional role, and this not only applies to managers themselves but also to their team members (CADTH-INT).

Some of the codes around support for managing that were generated from the statements across all the interviews and focus groups are listed in Table 5: LEADS Supported Management Functions. These codes indicate the different characteristics of teamwork, starting with codes that speak to creating or building a team mindset. The codes in the first column (Building a Team Mindset) (see Table 5 LEADS-Supported Management Functions) describe how participants felt they had more skills for working interpersonally as a team. When staff were more prepared, this supported managers in helping to create stronger teams. The activities under “b. Lifting Up” describe the work managers felt more prepared to do, with guidance developed through reflecting and strategizing using LEADS, to address challenges of team engagement. The second set of codes, under “2. Support for Managing” (see Table 5), describe the work that was apparent as managers motivated individuals to address and support strategic goals. Orienting the team toward achieving goals also includes supporting individual diversity. The third area (see “3. Creating Aligned Teams” in Table 5), describes building teams to create the kind of alignment that brings team members together with organizational goals. Finally, LEADS also helps managers connect those teams to the whole organization (see Column 4 “Connecting Across the Organization” in Table 5). It was very apparent from what managers in the study discussed that much of their work was in linking teamwork to strategic goals, not only motivating or guiding their teams to do the work they do well, but also informing and helping their teams to meet broader organizational goals. In the sections that follow, each of these areas of work are described in turn, painting a picture of how LEADS supports managers not only to execute organizational mandates, but also to support teams to develop actions.

TABLE 5. LEADS-SUPPORTED MANAGEMENT FUNCTIONS

1. Building Team Mindset		2. Support for Managing		3. Creating Aligned Teams	4. Connecting across the Organization
<p><u>a. Learning to be a “team”</u></p> <ul style="list-style-type: none"> • Integrating with the team • Supporting team members • Sharing in the team • Bringing everyone on to the same page • Integrating teams • Supporting learning to work as a team 	<p><u>b. Lifting up</u></p> <ul style="list-style-type: none"> • Combatting individualist view • Moving away from unit focus • Addressing lack of collaboration • Extending tasks with LEADS • Addressing barriers to implementing LEADS 	<p><u>a. Task-focus shift</u></p> <ul style="list-style-type: none"> • Working – head down (making room for new) • Focusing team on strategic objectives • Evolution of mindset • Collaborative decision process • Thinking differently • Distributing goals • Being part of the puzzle 	<p><u>b. Aligning and supporting diverse individuals</u></p> <ul style="list-style-type: none"> • Aligning teams • Supporting different styles • Mixing managers and staff (aligning aim) • Interdisciplinary environment (working together) • Supporting diversity in teams • Including “everyone” cross team • Cross-team collaboration 	<p><u>a. Building</u></p> <ul style="list-style-type: none"> • Needing to build a team • Developing useful new teams • Fitting into new team • Creating enjoyable work environment • Daily interactions • Working in pods • Developing working groups 	<p><u>a. Role shift</u></p> <ul style="list-style-type: none"> • Role as a collaborator <p><u>b. Finding team</u></p> <ul style="list-style-type: none"> • Coming to the table • Identifying politics challenges • Questioning • Challenging

Note. LEADS = LEADS in a Caring Environment health leadership capability framework.

Building a Team Mindset

One of the benefits of using LEADS, as identified in Table 5, was to move beyond an individual task focus to a whole-system focus. Participants described feeling more engaged and being able to take responsibility for engagement. This was true for participants as individuals and in their role as managers, as they worked to engage their teams. When using LEADS, managers needed to cultivate a team mindset within their teams, which was one way LEADS helped to create team support. As one participant stated, it is sometimes hard for people to see their own role (CADTH-INT). This participant went on to refer to the interconnectedness of all individuals (CADTH-INT). She spoke to the “push” required to bring LEADS into the workplace, and the need for managers to think about how to orient their team to a holistic model of thinking. At the same time, the LEADS-informed development that people were engaged in provided a pathway to learn about operating in teams. As people talked about their experiences of building on the LEADS-related learning in self-reflection, communication skills, addressing difficult conversations, and navigating sociopolitical environments, they linked these skills to working more effectively in teams. Ideally, the push from managers toward more of a team mindset and the ability of individuals to work more effectively together converged. Managers commented on the importance of messaging and experiences being consistent: “In order to transform our system, it takes time. . . . It’s an evolution of mindset for many people who have been individualized. Especially when some groups are more challenged the more individualized their work is” (CADTH-INT).

The change in mindset and skills gave people permission to really live the values of collaboration. As this participant said, the shift also involves organizational values and finding a way to link development with strategic direction, personal decisions, and personnel hiring.

So understanding. . . clearly understanding the values of the organization. In turn, that helped staff to . . . I think, ultimately, be happier at work. If your own personal values do not align with the values of an organization, there will be conflict. If the values of the organization are really clear and the expectation of your employer is really clear in terms of how those values are to be used and how they’re brought to life, with freedom, in hiring good people who will in turn contribute in how those values are brought to life. There’s better alignment of direction strategically from a systems perspective as well as happier staff. That’s my understanding of when LEADS really came to be. (IH-INT)

Making values transparent and being aligned with those values was part of taking in and accepting strategic alignment, and this is what helped to build a team orientation.

A lot of it is on building collaboration, or a lot of the challenges we were facing were collaborative challenges, and working with a team, and working with interdisciplinary healthcare members, from radiologists to frontline technicians to administration, and helping everybody to come to the table with respect for diversity [of professions], so we could all think faster and learn—to try to foster a learning organization as well. (CADTH-INT)

This participant saw the challenge of working across diverse contexts based on past and current cross-organizational experiences (CADTH-INT). Speaking of experiences, participants often saw challenges in learning to work beyond one's own unit. Through the development process, LEADS emphasizes the value of working together toward a better healthcare system. This mindset change, that all people are interconnected, helped to emphasize the importance of the shift from task to team.

The movement to a team orientation would seem to be basic for a health system, yet participants remarked on this repeatedly, as the codes in Table 5 illustrate; as such, shifting to a team orientation seemed foundational to a change in the way organizations worked. This shift toward a team mindset was not just within teams, but also in connecting teams to the agendas of the organization. Using LEADS, or implementing LEADS through leadership development programs, appeared to support the evolution of a different kind of structure, which then supported a change agenda.

Support for Management

Having LEADS and the structure of leadership available helped managers coordinate their teams in several ways. The institutional processes that accompanied leadership development partly aided in the facilitation of this process. In the following excerpt, a manager/director participant spoke to how she used the institutional processes and LEADS to do forward planning.

What I would do at the beginning of the fiscal year if I knew this was going to happen: I would sit down and look at the LEADS framework and say, "Okay, this is going to take at least the full fiscal year. It's probably going to take a year-and-a-half. What do I need to focus on in terms of my own skill development as well as be aware of in order to best support a project like this?"
(IH-INT)

The way this participant spoke about using LEADS revealed how she could use it to help navigate the coordination of her team with the organization's goals and the unit's work responsibilities. It speaks to the dual role of a manager to both support and guide the team members and to orient the whole team to organizational priorities and constraints (such as budget reductions or changes). The framework helped this speaker balance strengths, identify gaps, and think about where development opportunities would help the team move forward. It also helped her think about how to manage staff rotation and fluctuation, a constant issue in health units in which the work of serving health needs is prioritized over the individual worker.

In addition to being able to use LEADS for planning and guidance, leadership development opportunities provided an avenue for managing a challenging task, which is to provide opportunities for staff, thereby engaging them in change. At CADTH, for example, leadership development opportunities created a balance to the lack of opportunity for advancement due to the small size of the organization and the stability of its staff. For managers and directors, leadership development, therefore, helped them to offer something to their staff that was interesting and helped the team to grow.

Dependent on the type of training, we have much of it, some would say too much of it, on . . . our e-learning platform. We can access a lot of training in that manner. We also have lots of classroom-based courses that you can sign up for, think of them as a public course, and they're held in different parts of the province throughout the year. And then we would also offer, me as a leader, if I wanted to run my team, my leadership team, though a session on crucial conversations or something like that, I can ask for that service from my HR [human resources] people, and the right resources will be brought to bear to provide that assistance to my team. So more of a contract sort of training. So those would be typically the three formal ways to get training. (AHS-INT)

The challenge with these opportunities was that there were limited available spots, and individuals had to be nominated. For example, a participant noted that “either you put forward your interest, and then the nominations would be picked out of [those] people. . . Or sometimes you get tapped on the shoulder” (AHS-FG). This selection process was more ad hoc than managers, talent development specialists, or potential participants would have liked because some people could not get into courses. Moreover, managers were not always able to fill the seats in programs, so sometimes individuals were “tapped” who did not seem enthused. However, in general, those study participants who participated in leadership development appreciated the opportunities and felt valued by the organization.

In addition to supporting managers and management tasks, LEADS enabled people to step into roles as collaborators and networkers to bring teams together. For example, a participant whose unit touched all areas of the organization said that having LEADS in the organization enabled him to think about how others would receive his communication. LEADS also provided a common language, which meant that he didn't have to explain why it mattered that he was there, talking to them; they understood the value of networks (CADTH-INT). The language of LEADS provided a systems perspective that contextualized this participant's engagement within the work of the whole organization without challenging the structure of position, title, or accountabilities. This enabled this individual to transcend job title and department area to get his job done. This theme, of being able to move from job descriptions into collaborative roles as leaders or participants, was particularly useful to people in more abstract or service positions, and it made their work more effective and efficient. As such, in addition to helping people in formal management roles, the LEADS framework enabled informal leaders to function as work unit or project heads and interact with managers.

As well as supporting management functions, introducing new and potential managers to LEADS enabled them to get to know more senior managers in a learning environment, which helped them integrate into the environment and develop helpful networks. A new manager said:

Meeting in such a big group with the informal leaders, we got to really connect with people across departments, and talk to people, in discussion groups that you normally don't see day-to-day. So that was good. On top of becoming more aware of things like coalitions, and systems transformation, and a lot of the material, you're meeting with people [and managers] that you

normally don't interact with face-to-face as often as you should. That was really helpful, really interesting, very refreshing too. (CADTH-FG)

The integration of LEADS in CADTH meetings helped this participant link her former tasks to her new responsibilities in guiding others, and more importantly, connecting the work of guiding to strategic priorities. This work was reinforced by the framework itself, which provided multiple ways to think about her new tasks, but she also received support through engagement in group meetings, which were LEADS focused and which mixed new and senior management. This mixing helped her see into the organization and how it worked, as well as to step into her responsibility to guide implementation of strategic directions. This *leading by pulling* rather than managing by directive allowed her to engage and learn at a pace that she could absorb.

Some participants expressed caution regarding the implementation of leadership development. A theme across the interviews was that participants perceived that leadership programs were restricted and that it was difficult to get into programs. Directors, however, expressed frustration when it seemed that they could not choose which individuals received leadership development, especially if they wanted to support team dynamics to develop in a more structured way. Talent management personnel, however, argued that the systems were logical and open, and although there were limited spaces, there was a great deal of control. While the logistics of selecting people was driven by resourcing issues as well as efforts to select those who were interested and had potential to be cultivated as future leaders, it was easy to see how, from a management perspective, the inability to control who in the team had opportunities could create difficulties in managing teams. In addition, if only one or some individuals have development opportunities, some level of team education might be needed to support the person returning with their LEADS training, as well as to help shift the culture to one of systems thinking.

Aligning the Team

One of the barriers to implementing change that participants identified was the hectic, task-focused nature of health organizations. However, they also noted that the capabilities within the LEADS Develop Coalitions domain specifically identified ways that helped people shift their mindset from working as individuals to collaborating as a group.

This mindset shift was needed to see how one's own tasks fit within work of others. This was particularly important for activities requiring cross-departmental coordination and for working toward the greater goals of serving the public, achieving strategic organizational objectives, addressing population healthcare needs, or even broader agendas, such as World Health Organization priorities (WHO, 2014) or the Truth and Reconciliation Commission of Canada (2015) agendas. Meeting these bigger goals started with team efforts.

I think one of the key areas that comes to my mind right now, at least for First Nations, . . . [is there are] always pressing actions that come in last minute that we need to respond to. . . . One of the recent ones is the United Nations or the UNDRIP [United Nations Declaration on the Rights

of Indigenous Peoples],¹⁸ [or the] Truth and Reconciliation Commission that came out across Canada. So . . . [the government has] asked . . . [us] to respond to a couple of the key recommendations and identify what actions we'd take over the next 2 to 3 years. Those are issues that have come forward from the United Nations and of course internally, nationally, within Canada, those bodies [are] demanding or generating a demand for . . . [us] to do a systems transformation in terms of how they address First Nations health. So that's what systems transformation kind of means to me in the work that I do. I think that we have to encourage . . . [our organization] to respond, to items, [or] issues or things . . . [that are] happening in main stream that are requiring action—be providing innovative responses—thinking outside the box of what our usual response is when an issue comes up. So there are of course always very standardized approaches depending on whether or not it's an environment crisis or a health crisis or if it's just to improve, which is what the UNDRIP . . . [is] asking to truly recognize the indigenous rights to healthcare for First Nations. So I think that we really have to try and help orientate . . . [us] to really think strategically about how they're going to address that because these are not going away. Every 10 to 15 years new recommendations come out from the United Nations, and they get stronger, and First Nations are getting more in a position now where they can't be ignored anymore. (AHS-FG)

The incredibly complex but important work that this participant is doing involves translating broad directives around urgent health issues¹⁹ to her specific work alongside other teams and external partners. The translation of broad and important agendas into practice across diverse work units was similar for many others who were in director-level positions; they were working with broad ranges of practice to coordinate pharmaceutical, public health, research development, personnel, and other strategies to fulfil important missions. This participant went on to point out that this work requires innovative thinking. The adoption and implementation of LEADS helped give the organization a framework that elevated the work of teams to the organization's mission and health priorities that were more broadly expressed.

Connecting Across the Organization

One of the effects of participation in leadership development, especially through the cohort models, was that participants were introduced to people across their organizations at different levels. The personal acquaintanceship, which was valuable in a networking sense, enriched people's learning about the organization as learned about challenges other people faced and what education and experiential assets

¹⁸ See the *United Nations Declaration on the Rights of Indigenous Peoples* by the United Nations, 2008. Retrieved April 5, 2017 from http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

¹⁹ Compared to the general population, which the United Nations Development Program rates among the top in the world in quality of life, Indigenous people in Canada rate in life expectancy, health, and educational achievement more closely to South Korea or the Czech Republic (Cooke, Mitrou, Lawrence, Guimond, & Beavon, 2007).

they brought to their areas of practice. Connecting vertically was especially valued, sometimes for career advancement but also for the opportunity to learn from more senior leaders in the organization.

The power of connecting vertically was matched by the power of connecting across diverse areas of practice. This was amply demonstrated in the focus groups, where people mixed from areas as diverse as public health, facilities management, clinical leadership, information systems management, long-term care, nursing, pharmacy, and many other diverse disciplines and areas of practice. It was very clear in one group that a facilities manager was held in good esteem; in addition, during the group, some participants decided to remain in touch to discuss a proposed project. While many cohort-based personnel development initiatives might provide the same opportunity for networking, LEADS explicitly supports this cross-disciplinary team building, giving it official sanction by naming it. As a result, participants could joke with each other using LEADS terms, but they also understand exactly how their activities fit within a purposeful plan to build the organization's effectiveness.

In addition, connecting across organizations could have very practical structural benefits. LEADS supported a team orientation that promoted informal, ad hoc, cross-departmental, and extra-disciplinary input. This new way of operating created flexibility in and through the hierarchical structure of health organizations. For example, one participant described former strategic planning meetings:

Each group would bring PowerPoint slides and they would talk at us for an hour and a half at a time, telling us what is happening. They were not looking for feedback. They were not looking for questions. They did not like questions. They were not looking for anything from us. They were telling us, "This is what's happening." And they would tell us, "This report is being completed, this is what's going on, this is next step, this is next step." (CADTH-INT)

The previous way of presenting relied on a model of competence and achievement, but, as this participant pointed out, it is not a way that admits mistakes, invites contribution or collaboration, or utilizes the insights of diverse members of the organization. The participant went on to describe the new approach:

There's currently a research project that we're working on regarding [a new action]. I'm with the [name of team]. There's a communications and branding department, [and] all of us have had to work together to get the common message [along] with the executive [and my colleague here] to move this project forward. It would not have been able to—we've been on tight timelines, and it's been a lot of work, and I can honestly say that I don't think we would be where we are with that project if we weren't able to leverage and build coalitions within our own organization. (CADTH-INT)

This new approach does not create new structures, nor does it change accountabilities—it changes the way goals are achieved and who is involved.

Summary

Individual participants appreciated LEADS because of the insight they gained into themselves and the ways in which they could work with others. LEADS could also be a contributor to team effectiveness in several ways. First, it helped people think in teams by aligning people's values with the proposed development. Second, it helped managers do the job of motivating and encouraging individuals, as well as connecting their team's work to that of the organization. Third, it assisted leaders in thinking innovatively about how to connect big agendas and important health challenges to their projects and interdepartmental or inter-organizational work. Finally, through communications enhancements, LEADS helped connect both formal work units and ad hoc projects and agendas with each other. In these ways, adopting the leadership framework of LEADS appeared to strengthen and connect a team-based structure that was interdisciplinary, accommodating of diversity, and supportive to management. It also helped achieve innovation, a topic that is expanded on further in the next section.

Changing the System

In each of the organizations in this study, there was a path of change that resulted in a different way of functioning. Beyond impacts for individuals and teams, there were indications of changes in processes and structures that suggest organizational impacts of adopting LEADS:

- demand for leadership programs;
- successful internal recruitment (succession planning);
- adoption of leadership inquiry into recruitment processes;
- development of internal leadership experts;
- cultivation of external resources;
- inclusion of regular performance reviews using LEADS;
- support for opportunities for emerging leaders;
- support for healthier workplace practices (better communication and improved interpersonal relationships at home and at work);
- engagement in successful cross-departmental or interdisciplinary projects;
- addressing complex health challenges (including innovating new approaches);
- engagement in interdisciplinary networks; and
- engagement across diverse health organizations.

As reviewed in earlier sections, the list above, while not exhaustive of all the changes that occurred, captures the evolution of effects that start with individual change. Individual changes have team-level effects, and teams begin to operate differently. The changes in human resource and talent program development impact one another, and begin to alter other processes in the organization. Finally, those larger, more abstract concepts, such as culture change, begin to be evidenced in the way challenges or new projects are approached. Thus, several systemic changes appear to be set in motion through the adoption of LEADS. The LEADS framework was relevant, as well, at all these levels of operation, from the individual to the team to the organizational and systemic.

Talent Program Changes

All the organizations included in this study had some indications of changes to talent management processes, which indicated growth and alteration of health organizations. All organizations, for example, cultivated and used external resources, such as consultants and proprietary programs, as part of a high-quality and informative development program. All organizations also developed internal experts in LEADS and leadership development, although some (e.g., SHR) were more deliberate in cultivating consultants, whereas others (e.g., AHS) developed internal resources and focused on communities of practice (e.g., Health PEI). These organizations had cultivated relationships with external consultants and proprietary program providers, as well as amplifying and supplementing their own offerings. Some organizations were also in the process of cultivating relationships with external educational institutions or professional practice organizations to include leadership and leadership development activities using LEADS or a similar approach. The extension of these activities to external organizations suggests that LEADS is changing the health provider environment across Canada. All the organizations in this study embarked on a deliberate investment and cultivation intended to change their organization, and each achieved a change in its own program offerings and the way these functioned within the organization.

Succession Planning

While talent management includes succession planning, this deserves its own focus as part of an important facet for organizations. The Canadian workforce is aging, along with the general population of Canada, and there is a need for a greater diversity of long-term supports. Addressing succession planning is important for professional organizations as well as health organizations.

The study found evidence that the participant organizations were beginning to meet their succession planning goals. At CADTH, for example, as a smaller organization with a stable workforce, managers noted that new employees are challenged to find opportunities. At the same time, senior leaders are concerned about impending retirements. The loss of one person can be disruptive in a small organization. However, management and informal leader participants from CADTH were really pleased with the opportunities for growth that the leadership program had opened. Three individuals from CADTH who were either new to management or who were informal leaders participated, and all of them were pleased with the opportunities they had been given. At Island Health, individuals who found their way into the Core LINX program described it as a well-organized system of education and support for their new duties. Participating helped them meet others that they could call on. The appreciation

expressed in the study appeared to speak to transitions between the groups of individuals presented in Table 6.

The list of spheres of influence can be seen to move from narrow to broader scopes of practice, although it is not always the case that those at the lower levels do not have broad reach. This is somewhat dependent on the type of position it is; for example, staff working in the disciplines of substance use, public health, maternal care, or nutrition may have a broad scope of interaction with the public and external agencies. However, what can be seen is that leadership development provides means for engaging beyond one’s formal role, and for connecting a person more strategically internally.

The results of these processes made internal candidates more visible to senior leaders and gave these individuals the opportunity to practise their skills. For example, one senior manager at CADTH, remarking on a new leader, was pleasantly surprised that this person was ready for and interested in more responsibility (CADTH-INT). The person could volunteer for a project due to openings provided through the leadership development. The opportunity to develop a succession pathway at CADTH and other organizations points to succession planning as an instance of evidence of success.

Table 6. Leadership Development Benefits at Different Management Levels

Management Level	Leadership Development Benefits
Non-Leaders to Informal or New Leaders	Opportunities to learn about leadership; opportunities to mingle with leaders; insight into organizational dynamics and priorities.
New Leaders	Opportunities to learn about managing/management tasks; support for managing teams; support for strategic planning.
Managers	More depth in leading teams, strategic planning, supporting team members, and connecting with discipline-specific priorities and agendas.
Clinical Leaders	Opportunities to work with colleagues to improve the focus of their practice and to link with other aspects of their organization for a more coordinated approach; opportunities to reduce the number of errors that arise from systemic dynamics; opportunities to inform new leaders/clinicians; opportunity for structured input into organizational agendas.
New Directors and Directors	Opportunities to connect with strategic initiatives; encourages interdisciplinary work; cultivate intra- and extra-organizational coalitions; opportunities to interact with industry/external partners to create change.

Management Level	Leadership Development Benefits
Executive, CEO, and Board	Opportunities to align the organization and liaise with government and other external agents and priorities; opportunities to work with external partners in healthcare to change the healthcare system in Canada; opportunities to have input into social determinants issues (this may occur at the advanced director level as well).

As previously discussed, PDP and the LEADS 360° processes assisted in linking actions to strategic objectives and health priorities. In addition, the institutionalization of these processes assisted in altering the structure of how the organizations functioned, enabling these linkages. The extent to which these processes worked was also an indication of how organizational structures changed to reflect the implementation of LEADS.

Culture Change

Culture change is difficult to measure, and even to define. When participants spoke about changes, they referred to different ways of working, to running meetings differently, to having a different pathway for planning their work, and to different forms of communication from senior leaders (such as blogs and personal reflections). They also referred to different expectations, and to being enabled to reach out to others to engage in new ways on work issues that they identified.

One question that arose when examining these actions, and more generally when studying a systems approach such as LEADS uses, is how leadership operates in conjunction with the administrative and bureaucratic hierarchies of healthcare and all corporate organizations. Participants described several key features that enabled them to transcend old ways of working to become more effective and to achieve their aims, such as enabling managers to motivate and support teams differently, allowing individuals to work more effectively across sectors and disciplines, and enabling individuals to legitimize activities that went beyond the scope of their position to engage others in their tasks. Many of these activities fit within the Develop Coalitions domain descriptors of LEADS.

This is the heart of what I think LEADS does. It's changing the culture, it will help to change the culture, through the strategies that we have [and] through the values that we use. One of our values is courage, . . . [the]courage to do the right thing. To empower staff to do the right thing you can't go through five layers of management to get to a decision to find out if somebody can do the right thing. It takes courage. (IH-INT)

This participant, who also has a master's degree in leadership, is comfortable with the term culture change and sees a different way of working (IH-INT). In responding to a question about what participants thought of in terms of systems transformation, this participant's response looked at the connection to the future.

Systems transformation: a lot of the role that I'm currently in is looking to the future. When I look to the future I think there's a near future, a 'mid' future, and a future that's way out there. It's a direction, more than a place that you get to, and the direction is always changing. So being okay to evolve as healthcare changes, over the years, I think it's very difficult to say in 10 years we're going to be "here." Because we're not sure what the journey is going to take us on those 10 years. I've learned to live in a place of fog—that we build the bridge as we create it. That was very difficult for me, because I like to know exactly where I'm going and how I'm going to get there. Tell me where it is, and I'll know when I'm done. That's just not the way of healthcare. So being okay a little bit with the ambiguity of creating the way along the journey and [that] sometimes we don't get it right the first time. Sometimes we have to of course correct. I'm okay with that too. (IH-FG)

As this participant said, this systems way of working does not provide the definitive answer (IH-FG). However, there is a next step, one that is part of a course-correcting journey. Who does the course correcting is interesting—it involves this participant as well as others.

In this next conversation, managers who worked directly with frontline staff were discussing how to make LEADS work for their staff and how they could help their staff in their clinical practices.

Participant A: I think there's a next step. . . in terms of "okay, we have this, now how do we build it as meaningful for our staff?" Because I couldn't necessarily take it to all my staff in the framework and say, "Okay, we're going to apply this now," like they did in the course [with me]. So how do I take that and make it meaningful for my staff?

Interviewer: You mean you couldn't take it to your staff because you don't have enough time to be an educator, and they're not enrolled?

Participant A: Partly time, but partly with their clinical focus, and maybe I'm making an assumption about their readiness to adopt something like that, but I look at that and I might—I think of myself when I first started practicing as a physio. I wouldn't necessarily have picked that up, as how does this fit with my clinical practice? As a manager I can, easily, but how is—as my interaction with this patient, what does this mean to me?

Participant B: I agree. And I think that if we were to take it to the frontline staff, it would have to be framed just a little bit differently, which you could easily do and make it really work well for them. But I find that whenever I would bring something like this into any of our meetings, or [others interject agreement] they just glaze over, and it's like talking stats or budget. I would like to see it massaged a little bit so that it was applicable to the frontline staff that where they could look at—

Participant A: Maybe in language of building communities of practice, or maybe in language of a patient outcome versus Achieve Results, it needs to be taken into the clinically relevant language, right?

Participant C: I'm thinking for the in-scope performance appraisals, as well, as an organization, they don't talk about LEADS, in a sense, but they do have it in one of the sections—the Lead Self portion of it. So that is a small portion of the in-scope performance appraisal as well, although I think we could probably do a better job as an organization on the frontline managers, in supporting our staff to also embrace the framework. (AHS-FG)

The work of managers is evident in this exchange as they think about the framework, their own learning, and how to bring it to their own staff and make it relevant. This discussion of the work of translating LEADS demonstrated the way personal professional development changed how the organization worked. It provided these managers with the capacity to change the way healthcare was executed, which is another aspect of systems change.

I think there's a gap [in] that transformative change is really, I think, at the point of care. And that in order to—we didn't talk about culture of an organization, though we've talked a lot about it, we didn't actually say, 'It's about organizational culture, and changing that organizational culture.' It's really—culture eats strategy for breakfast. (IH-INT)

Summary

Evidence of change due to adoption of LEADS can be accompanied by very obvious structural change, such as shifts within human resource and talent management programs and ways of operating (including forms and mandated review processes), but organizational change was also more subtle and overlapped with systems change. There were some indicators of changes in the ways of working, and some which were longer term, such as success in succession planning. However, these organizations showed adaptations since adoption, including development of internal and external resources. The answer to the question of whether LEADS makes a difference is yes, but it makes a difference at the individual level in ways that are more standardized across the organizations, while it changes the team and network environment in ways that are unique for each organization. The changes at the organizational level are uniquely suited to the context of each organization, and its scale, constraints, inputs, and choice of evolution. The next section discusses the organizational processes that provide ways to answer the question, “How do you know that your use of the LEADS leadership framework is making a difference?”

V. The Difference LEADS Makes: Impacts

The last question in the study explored what kind of evidence of impacts participants could point to, and what kind of documentation their institutions used, including whether any were using metrics. Some participants, who are leaders, felt doubtful that this was the right approach, as measurement of outcome assumes a linear relationship between education and action. In fact, no organization had metrics—no secret measurement device was found. However, the interviewer prompted with probes, such as, “If someone asked you if it was worth it, would you say yes, and if so, why are you convinced?” In response, participants indicated that they were convinced that LEADS was beneficial and provided three types of evidence:

- anecdotal evidence (qualitative, including stories, experiences, aspirations, and participation experiences in networks and events);
- process changes (organizational alterations); and
- outcomes (as indicated in reports, performance reviews, general health services reports, presentations, and publications).

These types of evidence are discussed in within this section in relation to meeting strategic needs and innovation in leadership development programs.

Outcomes: Meeting Strategic Needs

One of the difficult questions to respond to in this inquiry was whether the promise of systems transformation, or other intended changes (succession planning, culture change), was achieved, and furthermore how the participant could tell if it had been. The answer is difficult to assess for a variety of reasons, particularly because leadership development is not a skill training that leads to an identifiable behaviour. Rather, the LEADS framework outlines a set of capabilities that people may adopt. In addition, the methodology of this study was interviews and focus groups with individuals, not an organizational-level outcomes review. Nevertheless, as indicated in the previous sections, participants described many instances in which they connected with strategic objectives, how teams were mobilized to achieve objectives, and how organizations changed to support leadership objectives.

Linking Evidence from Individual Performance to Strategic Direction

Participants spoke about LEADS as addressing the “how” of work rather than the “what.” By this, participants meant that LEADS enabled their work toward meeting strategic objectives. If the general strategic goals are set very broadly, as they are at CADTH, it is up to the units to meet specific service requests, and the units control how they do the work. This approach is empowering, but it requires self-direction. However, participants were also able to specifically identify how they used LEADS to think through how to improve their accomplishments, to explore challenges, and to consider ways of addressing those challenges. At CADTH, participants also pointed to institutional practices that helped

this thinking through of “how,” such as the regular meetings with managers to review work objectives, as well as regular performance reviews in which they could reflect on their achievements in relation to strategic directives. Similarly, one participant reflected on how she used regular goal setting to help with performance outcomes, but then used LEADS to reflect on exactly how to proceed:

When I worked in private practice, we were always driven by profit margin. You always had to identify your goals. We would go back to them quarterly. [So] I go back to my personal performance goals quarterly, and I like the framework, because I can look at what my goals [were] over that 3- or 4-month period. It’s very motivating to be able to look at something and feel like you made some progress in an area. I actually have the [LEADS table] laminated and posted above my desk, because it’s detailed enough that it gives you prompts as to ideas of what might be a good goal, or how to move that further forward. (AHS-FG)

Although this participant referred to her previous experience to explain the way she developed a habit of goal setting, she described many practices that linked the use of LEADS to her outcomes (AHS-FG). As others did across the organizations, this participant created a visual rubric, posting the framework in her work area. However, she also described a regular, scheduled habit of reflecting on the link between her areas of accountability, her day-to-day work, and her professional development using LEADS. This combination of institutional support and practice provides experiential evidence of the way LEADS is linked to outcomes.

Collecting Evidence through Institutional Processes

Systems that could be used for collecting and reporting on the outcomes of using LEADS are already part of regular institutional reporting practices, but the link to LEADS was not generally made explicit. Some of the institutional processes include individual performance assessments, which show the link to work-unit outcomes, while others include annual reports and types of regular reports such as planning documents. Each of these processes offers unique opportunities to reflect on LEADS-related outcomes.

1. **Performance assessments:** Every person who went through leadership development in a cohort model, and many others, completed either the LEADS 360° assessments or another, often in-house, evaluation. When performed regularly (as they are intended to be used), ahead of the work cycle, these assessments serve as a record of goals versus achievements. While there are confidentiality issues in using the information in the assessments, they also represent opportunities (points) for data collection. If a voluntary or supplemental form was filled out occasionally (e.g., sampled on a random basis), important features of individual-level and team-level functioning and engagement could be captured. This could include qualitative data, such as stories of addressing difficult challenges, overcoming or enhancing communications issues, or connecting unit-level work with strategic goals. This supplemental form could also include some quantifiable data, such as instances of using LEADS to create plans, develop teams, or address communications or engagement issues.

2. **Annual reports:** Annual reports, which every department is required to contribute to or generate, could, but do not seem to, explicitly capture LEADS or leadership-related inputs to successful strategic initiatives. Relating to this lack of LEADS reporting, an executive-level participant spoke about the utility of these reports for strategic planning purposes:

*There's specific reporting required on a frequent basis. What comes back to the executive team is. . . a dashboard of where we are with our targets and priorities and those sorts of things. So, we've tried to institute various tools to allow that accountability to be throughout the organization. One thing I like to do is, on a quarterly basis. . . sit down for a day off-site to talk about a number of things. We always talk about what are our priorities for the next 3 months in accordance with all of these other documentations: have we slipped somewhere; do we need to focus more on this particular area; have we already succeeded; and can add something else in? Has something changed in our environment that we need to focus something more on?
(CADTH-INT)*

3. **Reporting:** In the large and diverse organizations and professions that interact in the health system, there are many regular reporting activities that feed into planning processes and provide an opportunity for capturing and generating awareness of how LEADS is being used. Including leadership information all the time would be onerous, but making the processes of planning more transparent would support a broader dissemination of how leadership approaches, and LEADS in particular, are being used.

In SHR/Sunrise, where the adoption of Lean Six Sigma has altered the way of recording and tracking accountabilities and actions, the links between leadership and outcomes may be more explicit because short-term work unit goals are regularly recorded. It may be that the Lean approach provides a model for reshaping reporting in ways that make the connection to leadership development more transparent and illustrate success.

The evidence of outcomes can be captured at the individual level through experiential reports, reports of work-unit accomplishments, and reflection on individual achievements around planning, communication, and engagement. The evidence can also be captured at the institutional level by leveraging the many types of reports that are regularly issued. This may require developing administrative staff members' leadership development awareness and asking the administrative side to contribute to leadership development by reflecting on impacts. However, the information can be captured, it must be understood as non-numerical data. The outputs could include published stories, reflections, celebrations of achievement, or presentations, including asynchronous visual presentations.

Innovation in Leadership Development Programs

Talent management process indicators provide evidence of organizational change. The way that the organizations in this study developed leadership programs, and the way that LEADS worked with or within those changes, indicates a systemic change rather than a mechanistic “addition” of leadership development. As a result, the leadership development programs themselves, while producing metrics of enrolment and engagement, generated evidence of a variety of organizational effects. For example, new approaches and resources were developed and trialled continuously. These resources, and the learning of participants and internal leadership consultants, embedded LEADS and leadership approaches as a practice of the organization. The evidence is in processes, and how organizations changed because of the infrastructure developed for LEADS. As a result, organizational changes in the following areas could capture part of the impact of LEADS:

- change management and leadership meetings, which included
 - reflective practices,
 - development of leadership skills (i.e., practise),
 - presentations on leadership issues (either skills or objectives), and
 - reframing of objectives into LEADS-like language;
- use of LEADS language as a shortcut to communications;
- use the LEADS 360° or other related assessments;
- reflection on leadership practices through
 - executive, CEO, and/or board members blogs, communiqués, or stories about leadership practices, and
 - clear examples of leadership development practices using LEADS;
- celebrating success through graduation ceremonies and certificates of completion for leadership graduates (i.e., evidence of success);
- shift to outcome focus through
 - emphasizing achievement,
 - altering human resources and professional planning processes to reflect LEADS principles and values; and
 - reporting out and up on ways of achieving strategic objectives.

Three types of evidence are in play: anecdotal, process-related, and outcome-related. CADTH, for example, as a smaller organization, provided a concise example of the adoption and implementation of a leadership development program. While the story of the development of leadership programs, like the one at CADTH, might seem obvious within talent management departments, this study revealed considerable diversity of understanding among participants who were not in talent management about the story of development within their own organizations. Lack of knowledge about the reasons behind adopting LEADS limited participants’ understanding of how their organization was using LEADS. Many participants could not pinpoint when LEADS was adopted, were not exactly sure why, and did not know how other units were taking up LEADS. Generating an integrated, coherent story would help buttress the perception of success, communicate culture change, and educate others on next steps. In addition,

making the leadership programs development more transparent and linking the program development to the use of LEADS would also assist people in understanding how approaches might change, when to send signals about processes of implementation that were not working, and help inform those who are not involved in leadership development about their potential roles in organizational change.

The Quest for Feedback and Metrics

Feedback is an important part of program improvement and accountability, and participants from all the organizations expressed great interest in feedback they could receive that would help them adjust implementation. However, interviewees across all the organizations noted that there were no readily available metrics. As a result, participants were interested in learning from what other organizations were doing in terms of measurement, and the quest itself is informative.

That's where we struggle, because [the talent manager] and I talked. . . [with the consultant] about this in the beginning. "How do we measure this?" [Our organization] has had and continues to have low turnover. I can't use that as a measure. But again, how do you use metrics? Could this be helping keep our attrition low? By having all employees more self-aware and engaging others? How do I measure, by doing this training, and investment, that it is helping? (CADTH-INT)

There is an acknowledged tension between the search for metrics and the fact that human development and leadership education programs are not necessarily conducive to measurement (Fenwick & Hagge, 2015). Nevertheless, in the search for feedback, talent management specialists explored various approaches, which sometimes included a search for metrics. One organization conducted a culture survey, but even though participants in programs found it valuable, the organizational leaders acknowledged that it is difficult to capture such issues. However, surveys may be able to capture some more behavioural aspects of the kinds of outcomes described above, such as instances of successful communication or cross-disciplinary or work-unit collaboration, examples of innovations, changes in abilities to address agendas, including complex health needs, and improved well-being. Some LEADS characteristics, such as instances of usage of LEADS terms, might also be captured by content analysis of open-ended comments. However, recording the ways in which LEADS terminology is used would have to be strongly linked to behavioural change to be a meaningful indicator.

In the sections below, some approaches to metrics are discussed. Prior to this, it is important to note that consideration of any measurements must be set against the investment in talent management staff, directors, and other resources—the denominator in the equation. Although it is extremely difficult to compare across the organizations, given the different structures, scales, and services of talent management departments, none of the departments appeared to represent more than 0.5% of talent development and management services when compared to the total employee pool. Two organizations appeared to have a 1:200 ratio of talent management staff (at a senior level) to their employee base. More importantly, participants from two organizations reported their organizations had only one person in this position, not a department, and leadership development was only a part of the individual's responsibilities. However, in those organizations, leadership development was shared through a variety

of organizational structures, including an array of internal and informal supports that developed over time. Any approach to metrics of outcomes would need to consider the inputs and assets, and the evolution of supports, programs, and products over time, before the issue of value is even approached. However, there are still some metrics that are available, specifically enrolment and process measures.

Enrolment and Process Measures

Demand for programs was an important indicator of success, and organizations could and did use uptake as a marker. Enthusiasm for LEADS (anecdotal evidence) was evident throughout these programs, although it is not surprising that a study on the value of LEADS would attract individuals who had something positive to say. Nevertheless, if demand is one indicator, then reduced demand, or absence of demand from certain quarters, would be an indicator that something is not working or the programs are not meeting needs or expectations. This quantitative indicator could be used as leverage to identify or explore instances of absence of demand through a qualitative approach. Conversely, if lack of demand were investigated, it could be compared against reasons behind strong demand, including waitlists. The critical issue to explore behind demand or lack of demand could relate to the indications of value expressed throughout this study, including the following:

- opportunity for advancement;
- opportunity to network broadly and, therefore, to have more resources to draw on to accomplish one's own work-unit objectives and responsibilities;
- satisfaction with self-reflection in professional and personal relationships;
- ability to innovate;
- flexibility to accomplish one's tasks;
- a rubric for reflection and strategizing team resources and objectives for future agendas; and
- ability to link broad and complex health needs to one's own work-unit goals and agendas.

Other indicators of demand could include waitlists and demand for programs (i.e., evidence of interest); uptake of voluntary leadership opportunities (i.e., evidence of succession development); incorporation into regular practices, such as one-on-one management meetings (i.e., evidence of uptake and traction); and development of internal modelling (behavioural) or resources (i.e., evidence of buy-in and efficiency development).

Communicating through Stories of Success

Stories of success provide another type of evidence, one which is often referred to in leadership development materials. Again, using CADTH as an example, participants from this organization shared at least two stories beyond the individual level. The first included formal unit and directorate reports, which provide evidence of having met goals and achieved objectives. One interviewee indicated that this approach provided an avenue for reflection: “Wow! We did a lot this year!” The responsibility for communicating these stories is placed with an internal knowledge mobilization team, so it is embedded in organizational responsibilities, an effective practice that supports leadership development. The second avenue for capturing stories at CADTH includes regular communiqués from the CEO and other stories that intentionally share success and focus on leadership. Many organizations have some variation of this practice, although the information is not always from the CEO. Personal communiqués and blogs reinforce leadership practices, demonstrate how LEADS can be used, and provide backing to corporate messaging of personal buy in. Evidence of senior leadership support was very important, as participants at CADTH pointed to their CEO and said, “He walks the talk” (CADTH-INT). This type of practice could be expanded to other levels in the organization so that leadership processes become part of the historic record and are made relevant to many areas of practice. If stories were also captured from new leaders, for example, this would enable senior managers and directors to understand what is happening at the level of informal leaders. To manage this, it may be possible to ask units to focus on or relate an example. Ideally, this would be done in a cost-efficient manner, perhaps captured in an annual “looking back/looking forward” type of session or similar format in which the work of thinking and capturing is done all at once, with refining and standardizing of the stories being handled at a later point in time.

The challenge with collecting stories and communiqués is that they are not often considered to be “evidence.” To buttress story as evidence, the whole sector needs to focus on ways that information is connected to action, and how stories work to transform the way people operate. This is not completely foreign in healthcare: Qualitative evidence and analysis are used to communicate clinical information and case histories and case studies are often used by practitioners. This could be systematically studied to explore the barriers to understanding stories and communiqués as evidence in healthcare reform.

Evolutions in Theory and Practice

Another potential source of feedback on the value of leadership development is theoretical information about evolutions in practices of talent development. Talent management participants in this study reported considerable sharing amongst colleagues within their discipline, which indicates a strong interest in more knowledge. However, this study showed that some information is general to leadership development and some of it is specific to LEADS.

The following information is relevant to leadership development program implementation:

- resource investment (including availability of assets);
- speed (and ease) of implementation;
- time to change (how soon effects can be expected at individual, team, and organizational levels);
- possibilities for future growth;
- individual satisfaction;
- flexibility of framework;
- senior leadership support (executive, CEO, and board);
- access to development programs; and
- integration with performance review and performance assessment processes.

The following information specifically relates to LEADS:

- satisfaction with ease of adoption of LEADS;
- general and specific costs (appear to be lower or dramatically lower but also less specifically targeted than some proprietary programs and, therefore, harder to evaluate);
- ability to be used at all levels and in a variety of types of contexts;
- behaviourally specific (seemed to be not as present as some would like);
- integration or choice of whether to commence with LEADS 360° assessment;
- outcomes such as “change in culture”;
- congruence with other health leadership initiatives; and
- capacity for supporting innovation, particularly in response to complex health needs.

Summary

The search for metrics and feedback demonstrates a wide range of evidence, but also that there is more evidence than is systematically captured or reflected on. This reveals a lack of transparency rather than a lack of effect. Several institutional processes already capture information, and with small modifications could systematically aggregate that information and package it in a variety of ways. Perhaps the biggest barrier is the type of evidence that is being sought. More research may be required to explore and shift the way evidence is used and presented.

Understanding general trends in leadership development requires constantly searching for and reviewing new knowledge about leadership theory development and implementation. The search for knowledge may be most comprehensively accomplished by national bodies that review and survey leadership programs regularly, such as the federal government or a national organization. In addition, the need to stay current suggests that some talent management investment should be dedicated to continued learning in the field of leadership development to help foster organization’s specific programs.

VI. Summary

The critical question at the end of the study is whether, or to what extent, implementing or using LEADS helps to address the important strategic priorities in healthcare. Health organizations are constantly striving to meet the health needs of Canadians, including addressing very broad prevention or population health issues. One participant referred to how staff worked hard (HPEI-INT), echoing something that was referred to commonly, which is that one of the primary tensions with leadership is the workload and dedication to the values of healthcare and pride in doing a job well. The domains of LEADS were explicitly utilized to explain and link tasks to goals, demonstrating that LEADS is effective and that it does have outcomes related to patients' health. The findings strongly indicated that, in many ways, using LEADS enabled individuals to work in more focused ways to achieve important goals, such as, meeting organizational objectives, linking strategic objectives to individual tasks, and coordinating teams.

The data revealed challenges to meeting needs beyond the control of organizations and that any leadership development approach needs to be able to address. These include shifts in external funding or priorities, changing population needs, advances in healthcare standards, processes, or supports, including pharmaceutical and technological supports, and the increasing complexity of care. Organizations need to stay nimble to respond to priorities that can shift as the public, or publicly elected representatives, identify priorities, which can be very specific, such as reducing wait times for procedures.

Limitations and Strengths

This study was exploratory, both in its questions and in the purpose of its method. The five cases chosen for the case study adopted LEADS at different moments in time, which means that they evolved their programs relatively independently. They provide insight into early LEADS implementations. However, there are currently more resources and more is known about using LEADS now that the CCHL has adopted LEADS in its Certified Health Executive program, products, consultant development programs, and LEADS 360° assessment.

This study included a small sample size from each participating organization, which provided a window that emphasized qualitative data and allowed investigation of what was salient from participants' perspectives. This was critical for exploring material for which there were no systematic antecedents on what was important. At the same time, this study was not an organizational review of any one of the participating organizations. It was valuable and important to have the study liaisons' inputs to ensure that the depiction of adoption and implementation was correct. However, a comprehensive investigation of the kind of evidence indicated through this study (performance planning, feedback from performance reviews, work-unit reviews, leadership development programs, and the workings of specific forms and electronic processes, among other processes) would give a more complete picture of each organization and more in-depth information about what works.

The overall sample size of 76 participants provided a very robust variety of qualitative information, which included perspectives of people at all levels, including board members and the executive, directors, management, and informal leaders. Nevertheless, the voices of those who had not participated in leadership development were absent, as were the voices of those who were not attracted by the invitation to speak to what works. As with all strengths-based studies, this study leaves out important voices of those who did not find that LEADS worked for them. Given this study's findings, it would be important to test where the findings of application or development do not work, and to do further qualitative exploration of places in which LEADS or leadership development may be failing. Some interviewees were also concerned about the need to engage frontline staff who are not in leadership positions with understanding how the entire organization was attempting to realign itself and change its way of working. This study cannot speak to this concern.

Participants in this study represented spheres of practice and scopes of jurisdiction that were quite diverse, including regional services (covering sets of facilities), provincial services, diverse professions, administrative leadership, hospital (facility and associated services) leadership, core administration and executive leadership, and external relations positions. The diversity of types of positions and practice responsibilities indicates that LEADS can work across positions, between positions, in different configurations of responsibilities, and within and between different departments and organizations. LEADS worked across these diverse areas with virtually no adjustment, except slightly different emphasis on interpretation and application at different levels.

The approach taken for the investigation, which relied on a single researcher who was not familiar with the organizations, the LEADS framework, or the sponsors prior to the study to conduct the investigation, assisted with ensuring that there was minimal external bias. However, a drawback is the more limited insight into what was known. Some of the information presented in this report may, therefore, repeat what is already known, so that even if systematic documentation is achieved, some of the findings may be less important. This external validity, then, is a result of stronger internal validity. However, the sequestering of the research also means that the interests of the sponsors were held at arm's length, and this assists in assuring that the findings are a truer reflection of the strengths and limitations of LEADS adoption and implementation.

Overall, the approach of using five case studies and sampling across the cases provided a robust framework for assessing how LEADS worked.

Reflections on LEADS

One of the purposes of the study was to explore whether LEADS was still working, ten years after development. As has been described, many individuals spoke to how well LEADS worked, how easy it was to use, and the advantages of not having a complex model with special terminology. Some participants in this study said that, although they could not remember the details of LEADS, they were still able to effectively use it. Others said the model was intuitive, was easy to use, and made sense. People also liked the way the five domains fit together. People frequently said that Lead Self domain was foundational.

Participants did express some misgivings about the framework regarding their ability to use all the domains. Sometimes interviewees felt they did not have enough time to reflect, given their busy jobs. Some participants did their work with LEADS after hours, and this was particularly so for the talent management consultants, who knew the model intimately, believed in it, and supported its use. Sometimes participants felt that the domain of Systems Transformation was out of their reach. Although during the interviews, explorations of the reasons behind this belief often led to a realization that thinking about systems often depended on what one thought of as a system—whether this was one’s own area of practice, the organization, the organizations one interacted with, or the needs of the population. Most participants could speak to some type of system that was being interacted with successfully, excepting the one anonymous participant, cited above, who did not find it useful.

Some participants from Island Health and AHS indicated gaps within the LEADS framework. At AHS, for example, some talent management team members felt that the open architecture of LEADS did not provide enough guidance. They developed what is called the Behavioural Dictionary, which provides more specific guidance around application at various levels in the organization. Few AHS participants referred to the dictionary by that name, but some participants referred to being able to check what they could be doing. This suggests that for some organizations and individuals, it may help to provide specific examples of enacting the capabilities, alongside what seemed to be competencies for leaders at various levels. When discussing tools and applications, participants were asked what challenges LEADS presented, and in response one participant stated,

Well, for example, we built a patch for LEADS in that we built a behavioural dictionary. The behavioural dictionary is more robust than the sentinel behaviours that are part of LEADS. We share our behavioural dictionary across the organization, so people can say, “If I’m measuring [someone] against Engage Others, and the [LEADS] capability ‘build effective teams,’ what does that look like?” So I can pick that up and use it.

[Other frameworks] talk about what it looks like when it’s not a developed capability yet, when it’s an overused capability, when a leader is in the sweet spot with that capability, how that capability balances with other capabilities, and how to leverage particular types of learning, and where to find that learning, to help a person enhance that capability. . . . It’s not all in a centralized package yet, and we’re building that ourselves, slowly but surely. Whereas if we picked up an alternate, as I say, more robust, framework, we wouldn’t have to do that. (AHS-INT)

Although LEADS was deliberately developed without the specific guides that some competency frameworks use, it was apparent that some organizations, such as AHS, find more specificity useful. There were also some very limited indications that applications of the Systems Transformation domain or the capabilities under the Develop Coalitions domain could be made more transparent. It was evident that there are many more proprietary programs and supports for the Lead Self and Engage Others domains than for the Systems Transformation and Develop Coalitions domains. A few individuals also spoke to the value of including management training alongside leadership development. At Island Health, for example, the Core LINX program provided management skills training, including budget and

project management, labour relations management, and other skills associated with management. Although LEADS does not purport to be a management guidance tool, leadership development programs may consider whether they should systematically complement or include management training, especially for new leaders.

In summary, the findings point to an enduring strength and flexibility 10 years after development of the LEADS framework. There were no indications that aspects of the domains or capabilities needed adjustment, as indicated by participants who noted that it was intuitive. The framework was shown to have tremendous flexibility and utility across organizations that varied widely in scale, scope, context and reach of services, types of clients, and approaches to talent development. The results may be summarized in five key lessons for implementing leadership development and using LEADS: (a) support individuals, (b) ensure opportunities for continuous learning, (c) develop internal and external resources, (d) continue to monitor progress and adjust the program, and (e) share results and celebrate success.

VII. Key Lessons

The study results show that the LEADS leadership framework is effective in diverse organizations of varying scales with different formats of implementation. The study demonstrated there was no one best way to implement LEADS. Rather, each of participating organizations developed an approach that worked for them in response to their contexts, resources, and strategic aims. The secret to the continued usefulness of LEADS was in ongoing implementation innovation, focused attention on what was working, as well as in the sustained engagement by individuals. LEADS continues to work for these five health organizations, despite the ongoing change in each organization. The results, therefore, show that LEADS can continue to work over time, both as a program and as a practice. The participants in this study also demonstrated how using LEADS enables them to link their actions to strategic direction, although the clearer the strategic direction was, the more strongly their actions could be linked.

Participants also reported some challenges. These relate to resourcing programs, accepting new employees into talent management development programs, supporting staff to continue to use LEADS, and ensuring opportunities for continuous learning. Also, as indicated earlier in the report and widely discussed in leadership literature, corporate champions appeared to make a significant difference to the ability of individuals to link their own actions to strategic directions. In organizations in which the strategic direction was unclear or in which change was constant, LEADS practices seemed less reflective of corporate vision and more reflective of individual practice areas. The five key areas of recommendations are as follows: support individuals, provide opportunities for continued learning, develop resources, monitor progress, and document and communicate success.

1. Support Individuals

As talent development consultants know, changing the way people practice requires practise. The well-known assertion is that 10% of learning is in formal training, 20% is in specific practise assignments, and the remaining occurs on the job in day-to-day implementation (Lombardo & Eichinger, 2004). Many participants affirmed this idea when they described how they gained insights into applying LEADS much later, even years after they took LEADS training, especially by practising on the job.

Some of it's the diversity of areas that people work in. Sometimes it's because people are very individual, so what they take from anything is individual. And then, also because it's not linear. People might be doing the 360s, but their "aha" moment might not come for 8 years. (AHS-INT)

One of the most important, foundational, resources for individuals was time. People needed some time, at regular intervals, when they could reflect on their own practice, goals, dilemmas in the workplace, or strategic issues to plan. Some people did this after work, but some did not have the time.

One of the barriers to focusing on leadership is time, the time pressures associated with life, as well as with work. Sometimes we focus on the task instead of the accomplishments or the needs or the impact of the work that we do. Spending time in a more structured way through one-on-one meetings, through mentors, through leadership team meetings, divisional meetings and

[with] coaches is a way [that] we've been successfully trying to deal with some of those time challenges. (CADTH-INT)

As this executive member described, finding cost-efficient ways to generate time for reflection and implementation is challenging, but it can be accomplished with systematic, multi-dimensional approaches. From the perspective of people further down in the organizational hierarchy, the opportunity to practise is more ad hoc, as this focus group excerpt demonstrated:

In some of our big team meetings, we did talk: "Well, this is something that was really interesting that came out of it," but not more than maybe like 10 minutes [just] a little bit of team sharing. But I think people were a lot more aware of tools you could use in a team, like discussion groups or flip charts. (CADTH-INT)

Another focus group participant elaborated:

Yes, especially for problem solving, and setting tasks and goals at the beginning of a project: I think the tools were quite valuable. To a lot of people they were new, so they understood how to use them better, and were able to utilize them. (CADTH-INT)

As these informal leaders noted, the group conversations led to ideas, awareness of and practise with new tools, and, in the group, confirmation that what a person was thinking about made sense. The type of group or opportunity did not seem as important as the systematic opportunities to reflect and practise in a group or team setting. Individuals who worked alone, and felt without support (only a few in the study), were unable to leverage their work and to align that work with organizational and strategic objectives. They expressed more ambivalence about the organization, even if they felt good about the work they were doing.

Participants specifically referred to the following elements of support: mentors and co-mentoring, coaches; communities of practice colleagues who had been through training with them and formed networks; refresher courses; and strategic messaging (for encouragement, sanctioning of action, as well as reflection).

One of the hardest endeavours to accomplish in a bureaucracy is to enable individuals to contribute their talents toward innovation and problem solving. One of the effects of supporting individuals was that they felt empowered to act on issues that they identified or ideas they had. The LEADS framework gave individuals a sense of personal power by providing multiple points of action that they could choose from, as needed, if they wished. The flip side of permission to act was a sense of personal responsibility. This strengthened a sense of accountability without putting rigid performance targets in place that required monitoring.

Individuals harnessed this sense of action by putting role-related goals into their performance reviews, identifying LEADS pathways to achieving those goals, and then reporting back out at their next team leadership, individual mentoring, or performance review meeting.

Recommendations to support individuals are:

- Develop structures that provide opportunity for individuals to reflect, preferably with others, on challenges they see or opportunities they want to work on, and to plan actions.
- Provide reporting opportunities with others so that plans can be problem solved and successes can be celebrated.
- Develop a way to articulate specific, achievable, and defined actions related to strategic goals.

Performance reviews could be an opportunity for support if they provided the occasion for a manager to discuss personal and strategic goals with the individual being reviewed. In many cases, participants were very positive about their reviews and looked forward to them. However, this only arose in the cases (i.e., organizations) in which performance reviews were conducted regularly.

Many interviewees in the study also participated in LEADS 360° performance reviews, and many spoke very positively about using these assessments. However, one participant²⁰ strongly objected to LEADS based on an experience with the 360° assessments. This participant referred to LEADS as “a waste of time” and it seems that this person was subject to anonymous abuse through the 360° process.

Recommendations to conduct assessments and reviews are:

- Use 360° assessments regularly to provide comprehensive insight and encourage self-awareness.
- Provide substantive training on how to provide and receive constructive and helpful feedback.
- Follow up with reflection as noted above.
- Conduct all performance reviews regularly and use lack of ability to do so as an indication of resourcing needs or time to review.

2. Provide Opportunities for Continued Learning

The initial steps of introducing LEADS were exciting for organizations and participants. Those who had just finished programs were eager to continue. However, those who had been through programs some time ago, or who had taken leadership training as a graduate degree outside of the program, often spoke to the need to have some way to renew those skills. Some participants expressed feeling alienated or underappreciated when they were isolated in a large organization (participants couched this carefully, but this was evident in the lack of connection with leadership and the lack of support or recognition they received). Renewing LEADS skillsets was less of an issue in those organizations which

²⁰ Participant code withheld to preserve anonymity.

offered single courses or online options outside of cohort programs, but as some participants reported, individual courses could be full and it could be hard to access them, as there does not seem to be systems of prioritization. Participants experienced success with communities of practice, although this was limited to a few individuals at Health PEI and the Applied Leadership Program at CADTH. These offered a way to implement continued learning on the job, consistent with the recommendations to implement practise opportunities.

Recommendations to provide opportunities for continued learning are as follows:

- Plan ways for graduates to re-enter refresher courses or practise, perhaps with applied projects. Bring cohorts back together periodically for reconnection, refresher courses, or encouragement.
- Structure opportunities for ongoing collaborative work that explicitly uses LEADS and provide in-house resources to support new learning.
- Develop mentors and coaches as triads or teams who can mentor others in LEADS or co-mentor through debriefing. Ensure that these groups are interdisciplinary, matching the composition of the original training cohorts.
- Invite individuals to be involved in documenting outcomes by sharing stories such as internal project results or quality improvement projects. Ensure that the LEADS process is explicit and provide resources to help presenters maintain this accuracy and clarity.

3. Develop Resources

All the participating organizations evolved their programs over time. To balance this, one key question of the study liaisons was whether there were good practices elsewhere that they could learn from. All the organizations started their LEADS implementation in the following way:

- Surveying or mapping their talent development offerings to the LEADS framework and deciding on what to keep, what to develop, and what to acquire externally.
- Conducting introductory sessions.
- Securing external consultants who knew LEADS; some of the organizations, like SHR, have moved to a train-the-trainer model.

CCHL offers an organized roster of consultants, and their approach is to partner with organizations to create an implementation and uptake plan that is tailored to the needs of the organization. As the organizations are unique in their needs, in response to the question about how to implement, participants indicated there is no one way to implement LEADS, or likely, any leadership program. The response, rather than standardization, has been remarkable innovation for each of these organizations. The following list presents some of these innovations:

- Health PEI developed a community of practice.
- CADTH developed the “applied leadership model”, incorporating leadership practice into meetings and action.

- Island Health updated the performance review program and developed and updated the talent management offerings (Core LINX, Experience LINX, and Transforming LINX).
- AHS developed the Behavioural Dictionary and evolved from cohort models to online and face-to-face delivery. This organization also adopted suites of programs.
- SHR and Sunrise Health developed a train-the-trainer model, experimenting with program offerings, and using Lean Six Sigma.

In addition to questions about ways to implement, as was evident from these cases, the way in which these programs evolved had an impact on the way that the organizations operated; as a result, LEADS became part of the organization, not just a program offering. As changes become embedded, for example, in reflection opportunities in meetings or performance reviews, the use of LEADS in performance reviews, or using 360° assessments, the people who are involved become mentors and guides. There are two types of resources: those that are external to programs and personnel who are internal to the organization.

The external resources are as follows:

- External consultants, such as those listed by the CCHL.
- Programs that may be purchased to help support the evolution of capabilities.
- The networks in healthcare in which executive leaders, professionals, and others can exchange ideas (this includes through professional associations).
- Post-secondary institutions, which may partner to offer training courses that include leadership development to upcoming professionals or workshops to current employees.
- The 360° assessments and other products directly offered by the CCHL.
- Discipline-specific professional development.
- Pan-Canadian health leadership organizations, such as the CCHL, Accreditation Canada, CHLNet, and other boards and bodies.

Over time, the participating organizations developed internal experts and more standardized practices, and, as these resources became routine, they also become more diffuse.

Recommendations to develop resources are as follows:

- Anticipate that approaches to using LEADS will evolve, and costs will change as well.
- Develop connections with external consultants and include them in the evolution of your program.
- Plan on developing in-house advisors or experts, whether they are in formal talent management or embedded in leadership positions. Some suggestions from the cases include the following:

- Support communities of practice—this engages the skills of the most highly motivated individuals in an organization and serves as a font of innovation.
- Support some individuals to obtain graduate degrees in leadership studies, as this develops an invaluable inside resource.
- Support executive development through the CCHL Certified Health Executive program.
- Invest periodically in updating in-house program, and communicate how the “old” program relates to the “new” one to enable people to easily map their path through the in-house program.
- Support conference attendance (such as the annual CCHL/HealthCareCAN National Health Leaders Conference).
- Develop partnerships, perhaps in conjunction with local universities, to bring practitioners and students together for days of sharing in-house symposia to emphasize the relevance of leadership development in healthcare, to help explore complex problems, and to demonstrate how LEADS is used.

A footnote to the recommendation to develop resources is that one of the questions raised in the pilot report was whether LEADS itself (the framework) needed revision. This question was carried forward into the study, and the answers indicated a great deal of thoughtful reflection on the tensions between management preparation and leadership development. Participants in one of the Island Health focus groups could contrast the new LINX program, which had systematic management training in the Core LINX (first level), versus the previous LILO program, which had offered management in individual ad hoc units, followed or paralleled by the leadership program. These participants spoke to the need to get grounded in basic labour relations management, budget management, and so on, and appreciated the way that this training was systematically provided, although they debated whether it should come before the leadership or after. One person thought after, so that those in the nursing positions could begin with leadership self-reflection (Lead Self in the LEADS framework) in preparation for advancement and entry into management (IH-FG). This type of reflection was raised regularly and suggests that one additional recommendation for organizations might be to ensure that management training and development is systematically available, but that it is also marked as management development, as there seemed to be some confusion amongst participants.

What is clear is that leadership must cultivate resources strategically. When LEADS is first introduced, the organization tends to rely on external consultants; for these organizations, it then shifted to a mix of standardized offerings driven by internally knowledgeable people and the judicious use of external consultants. This evolved to capture a more diffuse group of participants.

4. Monitor Progress

As Fenwick and Hagge (2015) described, evaluating leadership is difficult because leadership development is itself a developmental endeavour. Leadership is both personal and systemic—it is context dependent and not prone to linear evaluations. Given that, as previously described, there are multiple ways of finding evidence for the difference LEADS leadership development may be making. In

the context of healthcare environment, in which evaluation is considered through metrics, there is a challenge to reporting in ways that are understood to be rigorous. Nevertheless, all but one of the participants in this study were personally convinced, through their own experience that LEADS worked and was worthwhile.

As described above, participants pointed to three types of outcomes when seeking to provide evidence that LEADS was effective. The first was personal impact on themselves, their capacity to act and do their jobs, and their ability to plan for either personal professional improvement or future actions. The second types of outcomes were the organizational indicators of the way the organization itself was changing (i.e., culture change). Third, were the differences in outcomes for the unit or organization, ranging from connections to strategic goals to perceived efficiencies?

All participants reported that LEADS had made a difference to them in their work in the following ways:

- changing the language;
- shifting the culture, the way things worked;
- making it clearer to them how they wanted to continue to develop professionally and personally;
- facilitating individual roles, ease of accomplishing one's own work;
- simplifying interdepartmental interactions and customer service; and
- improving customer service.

The weakest reported responses to the research questions were regarding the reporting mechanisms and systematic celebrations. Participants were asked, "How do you know it is working?" In response, participants had many answers, and from their responses the recommendations were developed to focus around three types of evidence: individual accomplishments, organizational development, and links to strategic priorities.

Individual Accomplishments

While departmental accomplishments are presumably shared in reporting mechanisms, these were often hidden from view until aggregated into annual organizational reports. This is too abstract to be individually informative. Starting with performance reviews, accomplishments, small and large, could be reported. The performance reporting and coaching arenas provide the most obvious opportunities to capture stories. However, these activities were not performed regularly in all organizations. When they were, they provided a very important moment of reflection and consolidation of input so that next steps could be planned. It may be that some formats for reporting and reviewing are too onerous or cumbersome. It is a truism in the cellular service and broadband fields of communication that countries with little infrastructure are at an advantage to take on new technology because they have nothing to lose: they are nimble as a result. This study shows that brief anecdotes are very helpful, and that sharing at an interpersonal level provides learning opportunities. Therefore, if possible, it could be helpful to

utilize the performance review and coaching process to deliver stories for sharing, but it may also be better to simply create a new structure (such as team meetings) to gather this anecdotal evidence.

Organizational Development

As discussed earlier in the report, rather than looking at accomplishments, there is considerable evidence about the way that programs change and these could be documented in the following ways:

- Uptake and utilization figures for talent management programs, which are popular and in demand. These statistics are likely available in annual reports, but the link to LEADS needs to be made more clearly and could be supplemented by personal reflections from graduates.
- Adopting LEADS gradually percolates into several other organizational areas. The first step in these organizations often seemed to be performance reviews. Following this, there is a desire to change recruitment screening to reflect LEADS values and orientations, and then to change succession planning, then to provide development opportunities. These and other aspects of human resource and talent management practices should be documented as part of the culture change.
- Through LEADS, people align their professional development opportunities, strategically planning their own future development. The pattern of professional development could be another indicator of how LEADS is working.
- Succession planning—internal applicants are often identified through the nomination into leadership development.

Links to Strategic Priorities

While strategic priorities are reported on at the aggregate level, an individual's work toward these priorities is not. However, individuals translate organizational priorities into their own specific work areas, and they achieve processual or objective goals. These small gains are evidence of work towards strategic priorities. The SHR method of capturing work toward the Lean *Hoshin Kanri* goals may be the most explicit format for recording these small goals, since individuals set their own performance targets and systematically report in. However, this process also needs to be examined more closely since the more limited participation in SHR leaves a gap in understanding how or whether this is working at the practice level. The Island Health quality improvement research expansion may also be able to capture small unit or team accomplishments. Although, if these initiatives are to produce evidence of the use of LEADS, they must be made more explicit. In Island Health, this would likely be identified with the programs (i.e., Core, Experience, or Transforming LINX).

Recommendations to link strategic priorities are as follows:

- Provide opportunities to celebrate the use of LEADS in relation to individual accomplishments through stories, anecdotes, personal achievements, or reflection.

- Report on the evolution of structural change.
- Make the link between LEADS and strategic priorities action more transparent at a local or unit or department level.
- Celebrate these accomplishments by highlighting them at an organizational level.
- Provide communiqués from the most senior levels that recognize leadership qualities and processes.
- Incorporate and celebrate program graduation.
- Count the evolution of human resource, talent management processes, and offerings as evidence of culture change.
- Document the evolution of internal resources, the development of programs, innovation and testing of offerings, and goals as part of making the process more transparent.
- Specifically reach out to those who are not trusting, who are ‘standing back’ to see if leadership development will work, by discussing and addressing gaps. Gaps that were identified in this project include the following:
 - Offer more support for understanding how to participate in and receive feedback on 360° assessments.
 - Make pathways or next steps in leadership development clear and accessible to graduates.
 - Work on incorporating leadership and systems understanding into discipline-specific training including through outreach (post-graduate and other education).
 - Address the need for management training and development.
 - Share innovations outside of one’s own organization and province.
- Identify the development of in-house resources, including communities of practice, trainers, links with graduate programs, development of specific tools (such as the AHS Behavioural Dictionary, or maps of existing leadership offerings to upcoming opportunities in development).

5. Document and Communicate Success

One of the barriers to changing the culture within an organization is in communicating what is happening. Many participants in this study, who presumably took part because they had interest in LEADS and leadership development, nevertheless had very limited perspectives on how other parts of the organization were doing, or even what the overall leadership development plan was. Participants also often could not tell if LEADS was changing strategic accomplishments elsewhere in their own organizations. Most participants, except for those who were involved in national organizations, also did not know what was happening outside of their province. Nevertheless, participants from all the organizations provided examples of communication practices, from instructions and guidance embedded in performance review documents, to strategic plans that were publicly posted, to guidance on specific disciplinary practices. What was missing was either transparent communication about the connection between this guidance and LEADS, and/or a comprehensive reflection on how the organization was doing, couched in LEADS terms or phrased in ways that linked leadership to

organizational, unit, or individual accomplishment. Given that people were inspired to make healthcare better, providing feedback on success was a powerful motivator. Those who took part in the focus group sessions provided strong examples of the interest and appreciation participants had for each other and the support they had available to others who were working hard in leadership positions.

Recommendations to document and communicate success are as follows:

- Communicate success and progress
 - on an organizational level;
 - on a unit level (institution, department, operating unit, or region); and
 - reflecting individual innovation and achievement as examples.
- Celebrate and tell stories in multiple formats (e.g., in workshops, at meetings, in blog posts, in formal reports, or in awards).
- Develop corporate champions and charge them with communicating success and personal reflections that relate to the whole organization, both as an example of practice and as illustrations of the ways in which LEADS can be linked to strategic outcomes.
- Encourage and provide avenues for telling small anecdotes or stories of individual achievement at staff meetings, through PDP processes, or by expressing appreciation. These stories could focus on personal reflection, appreciations, or providing examples of the ways that LEADS can be used. Most of these organizations are large enough to supply a continuous learning resource by providing stories.

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Appendix One: Sampling and Analytic Approach

Case Study Method

The approach followed here was a qualitative case study. This approach was chosen for three reasons. First, no systematic studies of LEADS implementation have been done to date, since the leadership framework was developed in 2006. There was one overall exploratory research question:

- How is the LEADS leadership framework adopted and implemented in Canadian health organizations?

The second reason for choosing an exploratory case study approach was that, as described below, health organizations in Canada tend to be singular and not of a type. For example, each province has a specific set of policies and jurisdictional issues governing health organizations. As a result, it is difficult to compare cross-provincially without considering the variation in administrative and political contexts. Also arising out of this context of provincial jurisdiction, each type of health system is structured distinctly, some with regional authorities, some with provincial organizations, and some with local or regional historic health boards and non-profit organizations and/or private partners (such as long-term care facilities). Thus, while health needs may have commonalities across the country, health organizations are diverse.

The third reason for choosing an exploratory case study approach was that the LEADS framework was developed relatively recently (2006), and all the cases in this study are early adopters of LEADS. Therefore, there is no typical evolution or standardized approach. Additionally, in 2011-2012, the ownership of LEADS passed from a provincial organization, the Health Care Leaders' Association of British Columbia, to a national organization, the Canadian College of Health Leaders. The change in ownership resulted in unique approaches to adoption, based on the time of adoption and available supporting resources. For these reasons, an exploratory case study was deemed the best approach.

After developing the exploratory research objectives, the following strategic research questions guided the inquiry:

- Why are you using the LEADS leadership framework?
- How are you using the LEADS leadership framework?
- What is helping or hindering the use of the LEADS leadership framework?
- What difference does your use of the LEADS framework make?
- How do you know that your use of the LEADS leadership framework is making a difference?

Generalizability

Case studies are understood not to be generalizable. However, Flyvbjerg (2006) suggested that case studies are theoretically generalizable. That is, the pragmatic lessons and insights that are gained from case study may be applied by the audience to instances that they are familiar with. This is facilitated by providing as much information as possible about the cases so that the reader can contextualize the findings.

Case Study Analytic Goals

The research team selected five Canadian healthcare organizations with a range of characteristics that were early adopters of LEADS. The inquiry aimed to describe how each organization implemented leadership development using LEADS. However, describing how LEADS was used does not explain what issues leadership development aimed to address, or what the challenges and barriers were. To answer these questions, one must understand the goal of leadership development. The data analysis revealed that all of these organizations were working to achieve strategic goals through leadership development. Each case of leadership development in healthcare systems in Canada, was a case of achieving change through LEADS implementation.

Case Study Sample Characteristics

The selected cases represented a range of characteristics, including the following:

1. Diversity east to west, representing various provinces—from British Columbia (BC) to Prince Edward Island (PEI).
2. Different scales and types of operations, from the Canadian Agency for Drugs and Technologies in Health (CADTH), with 184 employees, to Alberta Health Services (AHS), with over 108,000 employees.
3. Diversity in service, with CADTH standing out as not providing direct healthcare delivery, while the two provincial organizations (i.e., AHS and Health PEI) have responsibility for most healthcare in each of their provinces, from public health to long-term care and diverse other types of responsibilities.
4. Diversity in model of LEADS uptake, with Saskatoon Health Region (SHR) standing out as using the Lean Six Sigma program in conjunction with LEADS.
5. Diversity in resourcing, with SHR standing out as a provider of talent management and development services for other regions.
6. Geographic scope of service, with regional, provincial, and national scope. Two organizations (i.e., Island Health and SHR) represent regions, two represent provinces (i.e., AHS and Health PEI), and one (i.e., CADTH) represents a nationally distributed service. SHR also supplies talent development services, or “seats,” to other health regions, and as a result some participants came from Sunrise Health Region, a partner recipient.

The cases that were included in the study were among those recommended by pilot study participants and the research team, who were all familiar with LEADS. Although the research team sought an organization in Ontario, both organizations approached declined to participate. In keeping with the purposive sample,

- organizations that were not using LEADS were excluded;
- organizations that were not early adopters were excluded, as the study sponsors wanted organizations that had been using LEADS for a while;
- no more than one organization per province was included, except for Saskatchewan, where a talent services client and provider relationship existed between two health organizations; and
- Francophone organizations were excluded, as LEADS was not available in French and the study did not have a transcription budget or translation capability to conduct the study in two languages.

Strengths-Based Approach

As part of the exploratory nature of the study, a strengths-based approach was adopted to review and understand what successful implementation looked like. Each individual organization was a successful case of implementation. Analysis focused on what was working to understand “how” and “why” LEADS might make a difference. Interviews and focus groups were chosen to gather a range of perspectives on these questions.

Sampling Rationale

In keeping with the strengths-based approach and exploratory nature of the study, the sampling process was purposive. A purposive (sometimes called purposeful) sample aims for the best informants on a topic, rather than a representative set.

A purposeful sampling is sometimes contrasted with representative sampling. A typical survey method seeks a sample that represents a population, and the sample represents a typical set of the population. Determining and ensuring that the sample is truly typical is a significant concern in survey research because the sample is considered representative of the population.

A representative sample was not appropriate in this study because every organization is different, and many individuals’ roles and work areas are also unique. The findings about leadership implementation cannot be representative. However, the research team, the study sponsor, Canadian healthcare organizations, and other stakeholders can learn from these individuals and, hopefully, apply the lessons to new cases of leadership implementation.



Figure 3. Key Stakeholder Sample Groups

The sampling plan involved asking a relatively small set of three types of key informants in each organization about their experiences (see Figure 4: Sampling Plan). The first type of informant included decision makers with responsibility for and/or knowledge of why the organization adopted LEADS, and they were asked what sustained their belief that LEADS was working. The plan was to seek sufficient informants, which might be one or two individuals from each organization.

The second set of key informants included talent development specialists and decision makers. This group involved relatively few individuals (up to a maximum of five people in any of the organizations surveyed). The key informants were people who could speak to the implementation plan and reflect on challenges. They knew LEADS as a framework best, both from reviewing it and planning programs around it, and as part of a suite of personnel development aims. The plan was to interview two to three people in this category.

The third type of informants included people who participated in development programs and used LEADS in their work. The plan was to interview a minimum of five informants from each organization to develop an idea of how or whether LEADS ‘worked’—that is, whether it was useful and how it was applied. This was extremely important to know, related to the original intention, which was to explore and document how LEADS was being used, given that the framework has not been systematically studied since it was developed. The sampling plan is summarized in Table 7: Sampling Plan.

In summary, the sampling strategy was designed to consult with informants who were knowledgeable about the subject (program participants, decision makers, talent development specialists, and those with specialized knowledge).

In the interviews and focus groups, participants were prompted for their experiences and for how they knew that implementation worked (i.e., what their knowledge base was). Participants were explicitly asked if they were familiar with other leadership frameworks or approaches, how many

years they had been with the organization and in what capacities, how much or little they were involved in leadership development, and how they personally used LEADS. They were also asked what differences they had seen because of their own, their unit's, or organization's use of LEADS, and how they would answer the following question: "If you were challenged about its (LEADS) effectiveness, what would you say?" (See Appendix 2: Interview and Focus Group Questions.) The interviews reflected each participant's unique perspective, while probes were used to build on themes that were emerging from previous interviews within and across all the organizations.

TABLE 7. SAMPLING PLAN

Sample size	Role and relevance to leadership development
1 to 2 (interviews)	Decision makers responsible for approving adoption of leadership frameworks (LEADS).
2 to 3 (interviews)	Talent development specialists and leaders – those responsible for developing programs.
Up to 15 per site in focus groups or individual interviews	Participants who have participated in leadership development activities, including informal leaders, managers, directors, and senior and executive directors and up, as relevant.
Total: 5 –15 per case 25 – 75 total	One case, AHS, argued for a larger sample given the size of their organization.

Note. AHS = Alberta Health Services; LEADS = LEADS in a Caring Environment health leadership capability framework.

Interview responses provided the opportunity to check consistency of information about leadership development and LEADS across all the cases. The information about the cases was checked with the case study liaisons to ensure accuracy.

Comparing Cases

The leadership development approaches in the five cases were explored to gain insights about the adoption and implementation processes utilized and their strengths. This provided five varying cases. This type of approach, in which the same phenomenon is studied in different cases, is not a comparative case because the researcher is not comparing one organization against another. Yin (2014) called this an embedded case approach.

As described by Yin (2014), an embedded multiple-case study approach is one in which several similar entities (cases) are investigated for the same type of information, and the results are

compared or blended across the cases. This approach is advantageous when the cases serve as very specific contexts but have small samples or there are many diverse instances that can shed light on a similar phenomenon. In an embedded case study approach, the phenomenon of interest is within, or embedded in, each case, but it is the same type of focus in each case. In this leadership research, the embedded multiple-case study approach helped address a sampling challenge, which is that there were few key informants in each instance (case) of leadership program development.

In summary, the research was designed to be exploratory, build on strengths of practice, leverage diverse individual perspectives, and speak to a variety of health organizations and their contexts. The research design could not aim for comprehensive coverage, but as Flyvbjerg (2006) suggests, the audience will be able to interpret the principles and apply them to their own situations. The next steps are to more systematically index the results and test them in a survey.

Interpreting the Validity of the Results

The small sample size of some types of key informants propelled the research team to use the multi-case embedded case study approach to be able to secure an adequate number of informants to gather data, for example, on the decision to adopt LEADS. The internal validity of this study relies on the sufficiency of the sample size across all the cases. However, the research team believes that the systematic links between research question, inquiry method, sampling plan and execution, and analytic process provide a robust platform for creating conclusions. The case study method was suited to the exploratory nature of the questions.

The external validity, or correspondence with reality, was confirmed through the case selection and by opening the recruitment process through the talent development departments. The cases were either recommended by pilot participants who were knowledgeable about LEADS and healthcare in Canada, or by the study team, who had been involved with LEADS for many years. The research team approached seven potential partners that all met the desired characteristics for diversity (discussed above).

The issue of bias is always raised in qualitative studies because the analyst interprets the results. In this study, all interviewees were asked the same questions, but probes were exploratory and followed the line of questioning or issues that had been raised during analysis. All interviews and focus groups were recorded and then transcribed by a professional transcriber. When necessary, the audio was proofed by the study lead and then all transcripts were returned to participants to verify accuracy and to check for any confidentiality issues. Participants were guaranteed anonymity per the ethics review process and approvals. The approved transcripts were then coded in the Atlas.ti (2012) software. The coding process was generated out of line-by-line coding. A total of 1,085 codes were then aggregated into families, or groups, and these were then further grouped into 19 super-families representing linked themes. The redundancy of coding that occurs during this grouping process is one way of smoothing out idiosyncrasies in the original line-by-line codes. The super-families were then applied to the cases to see if they conceptually fit, and the final report was generated out of this grouping process.

The site reports provided a different approach to analysis, and allowed comparison of the two approaches. Each site report focused on the history of adoption and implementation, and on the strengths and challenges the organization faced. Site liaisons read and assessed the reality of the facts as represented. The themes that appeared in these narratives could be compared to the themes developed by the cross-case analysis. This helped to ensure that the themes were not so specific as to be only true in one case and balanced small sample size in any one organization. In addition, the research team, whose participants are all very familiar with LEADS, provided guidance on case selection, helped formulate the questions, ensured that the principal investigator captured key issues in leadership in health, and provided essential background information on the development of LEADS. The research team also reviewed preliminary results, as they were being developed but, for confidentiality reasons, did not have access to the data or participate in coding.

In sum, the research design, the double layers of analysis, the participant verification of transcripts, as well as the site report confirmation process ensured that the final results met criteria of internal and external validity for case study research.

Appendix Two: Interview and Focus Group Questions

Interview and Focus Group Questions

1. What is your role in your organization and how you are involved in adopting or implementing LEADS?
2. Can you tell me about the ways your organization is implementing LEADS?
3. Can you describe how you use LEADS in your work?
 - a. Thinking of the 5 domains, which of these are the most relevant to your work?
 - i. Lead Self
 - ii. Engage Others
 - iii. Achieve Results
 - iv. Develop Coalitions
 - v. Systems Transformation
 - b. Could you provide some examples of how you use these capabilities or of how they are used in your organization?
4. We are interested in why LEADS is being adopted. Are you aware of what led your organization to adopt LEADS?
5. What difference does your use of LEADS make to you, your work, or your organizational context?
6. How do you know that LEADS is making a difference? Is your organization tracking impacts? How so?
7. Is there anything else you think is important to know about the difference that LEADS makes?

Appendix Three: Sampling Results

The sampling plan aimed to gain the participation of key decision makers who were responsible for adopting LEADS, of talent management staff and consultants who were responsible for developing programs, and a range of leaders who had participated in programs. The research team recognized that each individual case, given the small number of people in any position, might not yield a sufficient sample. Therefore, the sampling within cases was designed to provide some insight into each program; however, the hope was that across cases there would be sufficient numbers. This latter goal was achieved so that the concepts could be explored in full. The numbers also protected the anonymity of people in singular positions.

TABLE 8. STUDY PARTICIPANTS BY POSITION TYPE (JULY 2015 – FEB. 2016)

Case	Exec. Director and above (including CEO and board)	Directors (including Medical/ Clinical or Practice leaders)	Managers (including Talent Management)	Informal and Line staff	External	Total
Island Health*	0	10	5	0	0	15
CADTH	3	3	1	2	0	9
Health PEI	4	5	5	1	1	16
SHR/Sunrise	2	1	3	1	0	7
AHS	8	12	7	2	0	29
Total	17	31	21	6	1	76

Note. *For Island Health, participants are listed according to both title and whether they took Experience LINX (for Directors or more experienced leaders) or Core LINX. Those who took LILO are included with the Experience LINX.



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