THE LEADERSHIP IMPERATIVE IN PUBLICLY FUNDED UNIVERSAL

HEALTH SYSTEMS

with a particular focus on the development of the

CANADIAN HEALTH LEADERSHIP NETWORK (CHLNet)

Prepared by:

Donald J. Philippon, BA, BEd, MA, PhD, CHE

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CHAPTER 1

CONTEXT, PURPOSE, AND METHODOLOGY

Context

A common theme in health systems around the world is the need to find ways to improve efficiency, effectiveness and quality in their service provision. Faced with technological advances, rising public expectations, demographic and epidemiological changes, these systems are constantly hoping to improve accessibility and quality in their services within the resources available to them.

Over the last three decades concerted efforts have been made to effect improvements under themes such as quality management, patient safety and, productivity improvement. At the heart of all of these efforts is the recognition that we need to effect change. However, health care systems, like individuals, have a built-in tendency to converge around the status quo and any hope at renewal of health care systems means strategies around effecting change become very important. Effecting change in turn becomes very dependent on that rather elusive factor – *leadership*. As noted by Lord Darzi "Making change actually happen takes leadership. It is essential to our expectations of the healthcare professions of tomorrow" (Darzi, 2008).

Even a quick scan of health system change strategies will reveal numerous references to the need for leadership. A recent National Health Service (NHS) Institute for Innovation and Improvement report looking at international systems commented that "Evidence from high performing health systems indicates the need to

invest significantly in leadership-level skills for large-scale change (Bevan, Ham & Plsek, 2008).

Yet, as one follows the experience with these strategies, it usually becomes evident that the focus quickly turns to the outcomes expected from the changes and the *leadership* ingredient is rarely given any concerted focus. So questions like "What were the leadership characteristics that contributed to the success or failure of the "change" are overlooked. Recent literature suggests that concepts of leadership take many forms, including the notion of "complexity leadership where leadership is an emergent phenomenon within complex systems and that models of leadership that were designed for the past century may not fully capture the leadership dynamic of organizations operating in today's knowledge-driven economy" (Dickson, 2009). Much has been written about different leadership perspectives and expectations held by different generations (e.g. Baby boomers, Generation X and Generation Y). Tammy Erickson from Harvard points out fundamental differences in expectations among baby boomers, Generation X and Generation Y (Erickson, 2010).   In Canada there is new interest in leadership from people early on their careers. The recent development of a new organization called Emerging Health Leaders with groups in several parts of Canada illustrates the new interest in creating leadership pathways for younger people.

Health systems are some of the most complex social organizations that exist. Bringing about change becomes a herculean effort as it is characterized by a high degree of compartmentalized professional knowledge, strong traditions in all health care delivery sectors – acute care, long term care, public health, etc. – and often

entangled governance and management processes.   So, it is indeed surprising that despite our recognition of the above, and the complexity of effecting change, that so little attention has been paid to *leadership.*

A focus on *leadership* becomes a particular imperative in publicly funded health systems, in that these systems are accountable to the general public for their use of resources. Health issues are high on the political agenda in all countries with publicly funded universal systems. There is much rhetoric in political campaigns about the commitment to improve quality and access and to do that within reasonable costs. Yet these same systems, paradoxically, have real difficulty in placing a concerted focus on leadership development initiatives. These initiatives are usually placed in the same category as administrative costs, and the popular political message is to commit to reducing these costs so a greater proportion of resources are placed on service delivery. Health care leaders and managers to date have not been successful in making the public understand the critical nature of their work. Without that public understanding, it is not surprising that political leaders are not inclined to support resource allocation to leadership development. Leadership development initiatives, therefore, are vulnerable at times of cost constraint even though one can argue that is when we need leadership development the most.

Part of the challenge in developing leadership capabilities in health systems is related to the many different perspectives on leadership. For some, leadership is a set of personal characteristics – if you hire the right people, then leadership should be self-evident. However, increasingly there is the view that leadership needs to be considered at both the individual and organization level. A person with great

potential to demonstrate leadership will be thwarted in an organization that is not receptive to change. Organizations with people who are open to change will not likely make significant progress unless some individuals can lead. So the need for leadership development strategies at both individual and organizational levels becomes an essential strategy.

Purpose of the Study

This paper intends to review the Leadership development strategies in several countries. The development of the Canadian Health Leadership Network (CHLNet) in Canada will be outlined. The situation in the United Kingdom, with a particular reference to England, Sweden, New Zealand and Australia will also be highlighted. These countries were chosen as comparators for the Canadian experience in that they all share similar values around health care. Each country provides a health system that is universally available to all its citizens and the systems are largely publicly funded.

This paper, undertaken as a Special Project as part of the requirements for the Fellowship in the Canadian College of Health Leaders, has the following objectives:

1. To review and document the evolution of CHLNet with a particular focus on major priorities, strategies, and progress to date.
2. To identify the characteristics of the Leadership development initiatives in England, Sweden, New Zealand and Australia pointing out similarities and differences from the Canadian experience.
3. To put forward recommendations for the future of leadership development in the Canadian health system.

Methodology

The methodologies used for developing this paper included a literature review around specific leadership initiatives and personal contacts with leaders in other countries.

Chapter Two on the Canadian Health Leadership Network is written largely from the personal experience of the author who has served as a national co-chair of the initiative since its inception in 2006. It is recognized that this has both an advantage as no one has been closer to the evolution of the initiative, but it also has a limitation in that events are perceived and interpreted from the eyes of a person that has had a vital stake in the evolution of the initiative.

The selection of other countries also reflects the personal interests of the author in that he has been on study tours in each of these countries and uses those same countries in a graduate comparative health systems course.

CHAPTER 2

CANADIAN HEALTH LEADERSHIP NETWORK (CHLNet)

Introduction

Canada is a federation with its constitution assigning powers to two levels of government: federal and provincial. Provincial governments have the prime responsibility for the planning and delivery of health services with the Federal Government holding some specific responsibilities for certain groups (e.g. Treaty Indians, the Armed Forces, inmates of Federal penitentiaries, and members of the Royal Canadian Mounted Police.) In addition, the Federal Government has an important role in funding through a complex set of arrangements around equalization and tax transfers.

Given the constitutional context, Canada has a very decentralized health system. In effect, what is referred to here and elsewhere as the Canadian Health system is really not one health system, but fourteen health systems (10 provinces, 3 territories, and the Federal system) that are interlocked by common principles that have been put in place by the Federal Government as a condition for receiving Federal financial contributions. Furthermore, all provinces have further delegated most of the responsibilities for health care delivery to sub-provincial boards.

While high priority is placed on health care policy at the Federal and Provincial levels, the decentralized nature of the system means that any improvements or changes in health service delivery need to be implemented at sub-provincial levels.

The introduction of a universal, publicly funded health system for hospital and medical services was completed in the early 1970s (when the last province completed its implementation of universal medical care). This was the result of a series of steps starting with the Province of Saskatchewan in 1947 when it introduced the first universal hospital system. Other provinces followed quickly and in 1958 the Federal Government passed the Hospital Services and Diagnostic Services Act that provided fifty percent reimbursement to the provinces for hospital costs. A similar pattern followed with physician services (medical care) where Saskatchewan introduced universal medical care in 1962. Again other provinces quickly followed and in 1966 the Federal Government passed the Medical Care Act which again provided fifty percent reimbursement – this time for medical costs incurred by the provinces. The two pieces of Federal legislation did far more than provide a formula for federal funding in that they also incorporated the criteria to receive Federal funds, and these criteria have become a set of principles that continue to characterize the Canadian health system today. The five principles were enshrined in the Canada Health Act in 1984: universality, comprehensiveness, accessibility, portability, and public administration.

While the Canadian system is now about forty years old, there have been many changes in funding arrangements, health policy, and health service delivery arrangements over that time – albeit all working within the five principles of the Canada Health Act. After a period of rapid expansion and infrastructure development in the 1970s and early 1980s, many strains became evident: cost pressures, scope of program delivery, timely access, integration, and continuity of care, and human

resources to name a few. Starting in the late 1980s several provincial commissions were established to make recommendations to address these issues, with most of them recommending a form of regionalization to better plan and coordinate service delivery at a sub-provincial level. In that period the Federal government also introduced several changes in the financing by backing away from its fifty percent costs sharing. The 1990s can be characterized as a period of major change in the health system with respect to governance as all provinces except Ontario moved to regional systems. However, by the early 2000s, it became clear that these measures had not gone far enough in changing the health care delivery system.

Through the Federal/Provincial/Territorial discussions, significant focus was placed on the need to increase Federal funding while recognizing that significant reform needed to also occur. The Federal Provincial Accord of 2003 and the 10 Year Plan of 2004 identified key areas for required change and made funding available to help the process along. The need for renewal and major change has been well recognized in the Canadian health system. These areas included primary health care, pharmaceutical policy, waiting list management, aboriginal health, electronic health records, health human resources, home care, patient safety, technology assessment, access to care in the North, prevention, promotion and public health, health innovation, and accountability (Health Canada, 2003) (Health Canada, 2004).

While there has been much attention on the need for change in the Canadian health system, very little focus has been placed at an overall system level on how to create the leadership capacity to drive these changes. It is in this context that the Canadian Health Leadership Network (CHLNet) was born. The origins of CHLNet go

back to the early 2000s with the official launch of the Network in late 2006 when two separate initiatives were merged.

Origins of the Canadian Health Leadership Network

Initiative One: CCHSE Leadership Advisory Committee

The first initiative was led by the Canadian College of Health Service Executives (CCHSE) when it created a Policy and Research Advisory Committee with the main focus being on Leadership Development. The Committee was later known as the Leadership Project Advisory Committee. The CCHSE collaborated with the Academy of Canadian Executive Nurses (ACEN) and the Canadian Society of Physician Executives (CSPE), who also named representatives to this committee. Major-General Lise Mathieu, with the Canadian Armed Forces, initially chaired this group with the chair being assumed later by Dr. Don Philippon, a Professor from the University of Alberta. The CCHSE's Executive Director of Policy and Research, Annette Hewitt, provided the research and administrative support for the committee.

Situational Analysis – In early 2005, a situational analysis identifying needs of the executive and management sector was prepared for the Advisory Committee by Lorna Romilly with funding provided from Human Resources and Skills Development Canada (HRSDC).

The situational report (Romilly, 2005a) noted that the health care system was going to face a major retirement curve. For example, a Quebec study noted seventy-two percent of senior leaders in Quebec would retire within 10 years and that the

average age of managers in that province was over 50. The report noted a changing

context for leaders and managers, including:

- Massive changes in health service structures;
- Elimination of many traditional managerial positions;
- New system-wide and program focussed leadership positions; and
- New competency profiles were emerging.

The report also noted that leadership training and development programs had to

change and that there was not a clear pathway for future leaders. The report identified

several new dimensions of leadership including:

- Systems orientation;
- Performance management;
- Accountability;
- Ethics;
- Change management;
- Managing networks focussed on outcomes;
- Consumer focus; and
- Leading organizational development.

A key message from the report is that there is need to focus on functions rather

than on specific positions or titles. Three categories of future leadership competencies

were identified: *Business acumen* (including: evidence-based decision making,

accountability and risk management, ability to execute and being results oriented, and

having a customer/patient focus); *Personal attributes* (including being: visionary,

values based, an excellent communicator, inspirational, innovative, motivational,

relationship and partnership builder); and *Crossover/Integration* competencies

(including: systems thinking, strategic change management, and lifelong learning.)

National Stakeholders Workshop – The situational analysis was used as background for a National Stakeholder's Workshop that brought together 40 top health care leaders from across Canada in late March 2005 to:

- Review the situational report on human resources issues related to leadership in health care;
- Explore the definition of a health care leader/manager;
- Determine the need, focus and scope for a sector study;
- Establish partnerships and explore mutual interests and roles in co-leading a health human resource sector study of health care leadership and management in Canada;
- Establish an inclusive approach for a steering committee; and
- Provide the basis for a human resource development strategy for health care system leaders.

The top strategic priorities recommended by the participants at the Stakeholders Workshop, subsequently endorsed at the CCHSE Executive Forum in April 2005, were:

- There is an urgent need to undertake a sector study to collect data and information on health leaders and managers.
- There is also an urgent requirement to develop and implement an action plan addressing some of the priority issues while the study is underway in order to provide leadership tools and other resources on an interim basis.
- Consideration should also be given to establishing a Canadian Centre for Health Leadership as a vehicle that could be used to address leadership development and potentially contribute to more effective heath services, as well as increased stability in terms of health human resources.
- Ways must be found in the short and long term to motivate, train and encourage new emerging health leaders/managers.

- The Business Plan must include processes to build commitment and support by communicating the urgency of dealing with the issues with proposed accompanying solutions.
- Strategies to build partnerships with and gain support from governments (national, provincial, regional), health organizations, health care executives, leaders and managers, and educational institutions are an essential part of the process.
- Consideration should also be given to ensuring there is broad representation from diverse groups across the country (Romilly, 2005b; Sector study task force, 2005; Philippon, 2005).

Towards a Sector Study – As noted above, the initial intent was to use the results of the Situational Analysis and the National Stakeholders workshop to develop a final proposal for funding for a major sector study as HRSDC had already funded studies on physicians, nurses and pharmacists (Romilly, 2005a). Work proceeded and a Task Force was created to develop the governance process and framework to undertake the study (Hylton et al., 2005). A second Stakeholder workshop was held in June 2005 to further define the scope of the proposed sector study.

Following the June workshop, further discussions about the sector study took place at the Leadership Project Committee with HRSDC representatives. Through these discussions, it was determined that a tighter definition of who/what should be included in the sector study was needed. This led to awarding a contract to CurryCorp in September 2005 to design and conduct a sub-sector definition exercise using a Decision-Theoretic approach. The cover letter from John Hylton, President of CCHSE, on behalf of the Leadership Advisory Committee, identified the importance of this step as available information on leaders and managers is very limited. He

noted estimates of the number of healthcare leaders and managers in Canada range from 20,000 to 90,000. A general definition, developed through the Stakeholder workshops, was that a healthcare leader/manager is "an individual who creates vision and goals, and mobilizes and manages resources to produce a service, change or product consistent with the vision and goals (Hylton, 2005).

While the definitional research work was underway, the Leadership Advisory Committee was invited to make a presentation to the Health Human Resources Planning Subcommittee on the proposed sector study of health leaders and managers (Hylton et al., 2005; Health Human Resources Planning Subcommittee (HHRPS), 2005). This group consisted of representatives of the Federal, Provincial, and Territorial Governments and as such presented a good opportunity to increase awareness and build support for the concept of a health care leaders and managers' sector study.

The definitional research conducted by Lynn Curry of CurryCorp utilized two rounds of a survey sent out to 79 experts using a list compiled from people who had been invited to March and June stakeholder meetings. Round one responses were received from 35 experts. Using information from the first round, a second round of the survey was used to try to reach consensus on who should be included in the proposed sector study and this resulted in returns from 56 experts. The results of these surveys were then reviewed in a final consultation process with members of the Leadership Advisory Committee. From that a final report was presented in December 2005 (Curry, 2005).

The report identified eight workplace settings that should be included in the Sector study as follows:

- Publicly funded health care delivery systems: acute care, primary care; chronic care, rehabilitation.
- Health promotion, health maintenance organizations.
- Health care services using a non-Western traditional medicine paradigm (but more work was recommended to further define this group).
- Academic institutions (senior positions from each of the health related disciplines).
- Associations, foundations or non-governmental organizations (senior positions only).
- Funding agencies (senior positions only).
- Government sections and agencies responsible for health care (senior positions only).
- Private, not-for-profit health care delivery systems.
- Private for-profit health care delivery systems were identified, but were to be limited to those providing patient care services. (Curry, 2005; Leadership Project Advisory Committee (LPAC), 2005)

The report also identified health care leader and manager role types that should be included in the sector study - a total 16 role types were identified (Curry, 2005).

Proposal Development – Work proceeded on the development of the final sector study proposal. Discussions with HRSDC led to suggesting that a Final Situational Analysis report should be prepared to accompany the proposal. This report would compile and synthesize the information collected in the several reports over the past year. The Association Strategy Group was contracted to carry out this work and a report prepared by Christine Da Prat was completed in late January 2006. The report concluded by outlining the research questions in each of three theme areas (Da Prat,

2006). Following receipt of the report, the Leadership Advisory Committee finalized

its Sector study proposal which was submitted to HRSDC on January 31, 2006. This

proposal outlined the scope and timeline for the study, the governance and model for

the study and presented a project budget request of $1,402,101 for a 30-month study

(LPAC, 2006).

In the period February to April, the status of the Sector Study proposal became

unclear as indications were being given that HRSDC was no longer willing to fund

sector studies in the health area. This left the Leadership Advisory Committee in a

difficult situation as so much effort had gone into developing the proposal.

Seeking Alternatives – Discussions began on seeking alternative sources of

funding and the Canadian Health Services Research Foundation (CHSRF) expressed

some interest in considering certain aspects of the sector study proposal. In May

2006, the Leadership Advisory Committee began to change its focus and the group

was renamed the Health Systems Leadership Advisory Committee. To become more

representative, several categories of membership were identified and invitations were

sent to people to serve on the committee. These included senior executives involved

in health systems leadership, Government representatives, and university researchers

as well as groups already represented on the Committee. The new group began work

with CHSRF to develop a research project around Health Leadership competencies.

Over the next few months, efforts were made to finalize the committee representation

and to formulate a possible research project around health care leadership

competencies. This work proceeded once the new Canadian Health Leadership

Network was formed as will be discussed later.

Initiative Two – National CEO Group

The second initiative evolved from meetings of an informal group referred to as the national CEO Forum. This was an Ottawa based group that involved numerous health related organizations (national associations and professional organizations) who would get together from time to time to discuss matters of common interest. In 2004 several discussions took place around leadership issues and this led to a commitment from Bill Tholl, CEO of the Canadian Medical Association (CMA), to have the CMA provide secretariat services to support a group that would focus on leadership. The group started to meet in early 2005 and Elma Heidemann, the recently retired CEO of the then Canadian Council of Health Services Accreditation (CCHSA), was asked to chair the group. The group consisted of CEOs from the Canadian Medical Association (CMA), the Canadian Nurses Association (CNA), the Canadian College of Health Service Executives (CCHSE), the Association of Academic Health Organizations (ACAHO), the Health Action Lobby (HEAL), and CCHSA.

Stakeholder Meetings – In late 2004, a meeting was held at Royal Roads University (RRU) where Bill Tholl, Graham Dickson and Geoff Rowlands (Healthcare Leaders Association of British Columbia) met to discuss issues and developments pertaining to leadership. This was a key meeting in that several ideas discussed there were then pursued by the new CEO group in Ottawa. After several

meetings in 2005, the CEO group decided to engage other jurisdictions and stakeholders in determining how the leadership agenda might be advanced in Canada.

In May 2006, the group organized a Blue Sky meeting of stakeholders. The session started out with a presentation on the British Columbia Healthcare leadership initiative, by Graham Dickson and Geoff Rowlands. Bill Tholl made a presentation regarding a Canadian Centre for Health Leadership. The participants agreed to create a concept committee for a Canadian centre for health leadership. They also agreed that a larger stakeholder meeting with international representatives should be organized later in the year to help guide the creation of a proposal for a new Centre. Two concepts that emerged at that meeting became key features of succeeding steps towards establishing a leadership capacity focus in Canada. First, the venture was to operate as a "Coalition of the Willing." This was not to be a formal arrangement among the organizations, but rather an informal approach that would be open to others who were interested in pursing the same objective. Second, the concept of "Leadership without ownership" emerged. This was important as each of the organizations had programs and initiatives pertaining to health leadership, and the work of this informal group could not be seen to be the property of any one.

The second and larger stakeholder meeting, referred to as the CHL Networking meeting, was held in November 2006 and included speakers from the UK (John Clark, NHS); USA (Ronald Heifetz, Harvard; /Dennis Redding, Emory University) and Janice Stein, Munk Centre, Toronto. The meeting, co-chaired by Elma Heidemann and Ken Fyke, was an opportunity to review best practises of successful national and international initiatives on leadership and to discuss the key factors around the

creation of a new Canadian Health Leadership Network (E. Heidemann, personal communication, November 12, 2010).

Leadership Issues Exposed – The topic of leadership development was of high interest to members of the CEO group. An article by Tholl, MacLaren, Tchermenska-Greenhill, Adams (2006), reported on a survey of senior leaders that noting that the tenure of senior leaders had declined sharply over the last three decades. Moreover, the authors concluded that the average tenure of senior leaders in the health sector was substantially shorter than that of leaders in the private sector and in other public arenas. For instance, it noted the tenure of Deputy Ministers of Health was now 1.9 years as compared to 11.0 years for "Canada's Best 50" CEOs in the private sector. The article identified several reasons for this trend and set out some broad parameters for a Canadian Centre for Health Leadership which could help better identify, develop, support and celebrate leadership in health and healthcare in Canada.

The context for health care leaders was analyzed in a report by the Emily Gruenwoldt and Glenn Brimacombe (CEO) of the Association of Canadian Academic Healthcare Organizations (ACAHO) from a survey of ACAHO Presidents and CEOs. The report entitled "A View from the Top" provided the views of senior leaders on the changing context of health care with respect to national policy. The changing context and views of senior leaders were identified pertaining to systems performance, wait times and access to care, the Federal role in health care, health research innovation and commercialization, Canada's Academic Health Sciences Centres as a national resource, the Canada Health Act, Public-Private Partnerships and the Health

Council of Canada. Most important was that 86% of the respondents indicated that major reforms were necessary in the healthcare system (Gruenwoldt & Brimacombe, 2006).

Key Developments – On reflection, the CEO group was instrumental in developing some of the key concepts for the formation of CHLNet, including the thinking that evolved from the idea of a "centre" to a "network." As well the concepts of "coalition of the willing" and "leadership without ownership" became guiding principles.

The CEO group also initiated several activities that influenced some of the early foundational work of CHLNet. First, the linkage with Graham Dickson from Royal Roads University and Geoff Rowlands from the Health Care Leaders Association of British Columbia (HCLABC) provided a good starting point to identify priorities for CHLNet. Second, the CEO group initiated discussion with the Conference Board of Canada to explore using one of their established survey instruments to learn more about the health leadership sector in Canada. Finally, in that John Hylton was associated with both initiatives, the CEO group became aware of the work on the proposed sector study by the Leadership Advisory Committee. Furthermore, when the HRSDC funding fell through for a sector study, the CEO group, particularly Bill Tholl and John Hylton, approached CHSRF as a potential funder for some aspects of the work.

Creation of CHLNet

Joining Forces

With the clear recognition that efforts to enhance leadership capacity in Canada were urgent, discussions began later in 2006 around the work arising from two initiatives and whether it would be more productive to merge the two initiatives to form a new entity called the Canadian Health Leadership Network (CHLNet). At a meeting in November 2006, the decision was made to create CHLNet, and the chairs of the two initiatives, Elma Heidemann and Don Philippon, agreed to assume the role of co-chairs for CHLNet.   The initial Steering Committee for CHLNet consisted of the following members:

- Lucille Auffrey, CEO, CNA
- Glenn Brimacombe, CEO, ACAHO
- Chris Carruthers, President, CSPE
- Pamela Fralick, Chair, HEAL
- John Hylton, CEO, CCHSE
- Mary Ellen Jeans, former Chair, ACEN
- Patricia O'Connor, Chair, ACEN
- Geoff Rowlands, Executive Director, (HCLABC)
- Sharon Sholzberg Gray, CEO, Canadian Healthcare Association
- Bill Tholl, CEO, CMA
- Elma Heidemann, Co-Chair
- Don Philippon, Co-Chair

The initial funding for CHLNet came from contributions made by each of the organizations that agreed to serve on the Steering Committee.

Several principles were established to guide the early work of CHLNet. These included:

- CHLNet should be pan-Canadian and align with the Federal/Provincial HHR plan;
- CHLNet should function as a Network of stakeholders embracing the concepts of "Coalition of the Willing" and "Leadership without Ownership";
- CHLNet should represent the lifecycle of leadership from front-line managers to CEOs and Deputy Ministers. It should represent the interests of emerging leaders to senior leaders;
- CHLNet should involve all sectors of health care, including community, acute, public health, long term care and rehabilitation;
- CHLNet should focus on priority areas and practical solutions such as: succession planning, mentorship and leadership development (Heidemann, Philippon & Hylton, 2007).

CHLNet Foundational Work

Early in 2007, CHLNet secured funding for two important projects. First, building on discussion that had occurred in the previous health association CEO group, the Conference Board of Canada agreed to apply its longstanding Learning and Development survey instrument to study the situation at the executive level of healthcare in Canada. Funding to support this project was made available from Health Canada and CHLNet's own resources. The second project receiving early support was the development of Health Leadership Competency Framework. In this case, CHSRF agreed to provide funding to Graham Dickson, Centre for Health Leadership and Research at Royal Roads University (RRU). This was a logical step as Dr. Dickson was already involved in a similar project with Health Care Leaders

Association of British Columbia (HCLABC), that had developed an early version of the "LEADS" framework.

These two early pieces of commissioned work were instrumental in setting a course for CHLNet. While the work was underway, CHLNet convened a Health Leadership Summit in Ottawa on May 22, 2007. Invitations were extended to about 100 health leaders from across Canada. The Summit provided an opportunity to provide an update on the formation of CHLNet and to review the work arising from the two research projects and to provide feedback on next steps (CHLNet, 2007a).

Conference Board Report – The CHLNet Secretariat and Co-chairs worked closely with staff from the Conference Board of Canada (CBoC) to generate a list of senior health leaders across Canada and to modify the existing Learning and Development survey to make it applicable to the health sector.

The CBoC survey was a major learning step for CHLNet in a number of ways. First, there was extreme difficulty in getting a reasonable response rate. While the survey had been sent out electronically to over 500 people, in the end there were only 40 completed responses. Even that took personal telephone calls from the Co-chairs to encourage people to respond.

There appeared to be two reasons for the poor response rate, both which were very instructive to CHLNet. First, was the very limited time available to senior management to engage in these types of activities. There appears to be little time for reflection by senior leaders as they move from one hot issue to the next. Second, and even more revealing, was the fact that most senior leaders could not answer the questions that were being posed on matters such as the resources being directed to

leadership development in their organizations and the effectiveness of current programs.

The CBofC report (Hughes, 2007) generated a number of key findings such as:

- Health sector organizations lag behind other sectors on investment in learning and development for its workforce. The Training, Leadership and Development expenditures represented only 1.2% of human resource expenditures (payroll) in health care versus 1.8% in other sectors. Moreover, the CBoC report noted that Canada overall was falling behind in workforce development, dropping from a rank of 12th in 2001 to 22nd in 2006.
- The proportion of informal learning to formal learning is much higher in the health sector versus other sectors.
- Very few of the current leadership programs in health were regarded as being highly effective.

Because of the low response rate on the survey, CHLNet decided to test these observations with a group of senior leaders in the Health Leadership Summit organized in May 2007. The results of that session are discussed later.

Pan-Canadian Health Leadership Framework – As noted above, Graham Dickson was commissioned to undertake a research project to develop a pan-Canadian Health Leadership Framework. CHLNet established a Steering Committee to oversee this work. CHLNet was mindful that the Graham Dickson had recently been involved in developing the LEADS framework for HCLABC. While CHLNet wanted to build on this work, the direction given to Graham Dickson was to ensure there was a thorough review of concepts across Canada and not just an acceptance of the work done on the LEADS framework, which had a BC focus. Graham Dickson

was asked to create a robust framework that can be applied to many unique contexts within the health care system including, differing provincial structures, different sectors, and remote and aboriginal needs (Dickson, 2007).

The research methodology used by Dr. Dickson included ten focus groups across Canada, interviews with key informants, an analysis of leadership frameworks in other countries, and a review of leadership projects in provinces and national organizations (Dickson, 2007).

The resulting framework (Philippon, 2007) identified three components of exceptional leadership: *Being* (leader's values, beliefs), *Caring* (leader's dedication to caring), and *Doing* (leader behaviours). Within that context, five domains of exceptional leadership were identified: Champions caring, Cultivates self and others, Connects with others, Creates results, and Changes systems. This became known as the 5 C framework. A final testing of the concepts was done as part of the Health Leadership Summit.

May 2007 Health Leadership Summit – The Summit was convened with the following objectives:

- To continue to raise awareness of the current and future health leadership challenges in Canada;
- To update participants on progress and validate findings of the CHLNet work to date;
- To explore issues and options in developing a network of centres of excellence in health leadership;
- To reach consensus on key elements for a framework for CHLNet; and,
- To reach consensus on concrete next steps (Dickson, 2007).

An electronic voting system was set up to gather input on several key matters, including the findings of the CBoC Report and the preliminary findings from Graham Dickson on the development of a leadership framework.

With respect to the CBoC Report, the participants expressed concern about the low response rate, but in general they corroborated the findings in the electronic voting process. Results of the voting on the Pan-Canadian health leadership competency framework indicated that the work was on the right track.

The Summit provided important feedback for the further development of CHLNet, including the following:

- Priority should be given to completion of the competency framework.
- An inventory of existing leadership development programs should be undertaken.
- CHLNet should provide a link to leadership developments in other countries.
- CHLNet should focus leadership issues so that they are aligned with the Federal/Provincial/Territorial Health Human Resource plans.
- CHLNet should provide a focus for key research questions affecting the development of leaders and managers (Dickson, 2007).

CHLNet Value Proposition

Introduction

The foundational projects and the 2007 Health Leadership Summit allowed the CHLNet Steering Committee and Secretariat to develop the value proposition that was adopted with the release of the document: Canada's Premier Health Leadership Development Network: From Concept to Reality in November 2007 (CHLNet, 2007b). A large amount of the credit for the development of this document goes to

Emily Gruenwoldt from the CMA who provided the main Secretariat support for

CHLNet and to Bill Tholl, the then CEO of the CMA, who committed his

organization to providing the Secretariat support and to the co-chairs, Elma

Heidemann and Don Philippon. The key elements of that document (CHLNet, 2007b)

are summarized below.

Mission of CHLNet

The broad purpose of CHLNet is to "identify, develop, support and celebrate

leaders throughout the leadership continuum and transcending all health professions.

More, specifically the goal of CHLNet was to provide organizations and individuals

interested in leadership with access to:

- Applied leadership development tools;
- Collaborative dialogue and networking opportunities; and
- Health leadership development research.

Principles of CHLNet

The following principles were articulated to guide decisions and actions of

CHLNet:

- **Leadership –** Leaders leading successful organizations are critical to the
  ongoing renewal of the health system;
- **Professionalism –** Leaders are competent professionals who exercise
  sound judgement;
- **Excellence –** Leaders strive for excellence based on best practice;
- **Value based** – Leaders lead based on enduring values;
- **Collaboration –** Leaders collaborate;
- **Responsiveness –** Leaders respond to change;

- **Life-long learning** – Leaders learn throughout the leadership life cycle;
- **Succession** – Leaders develop competent successors.

Objectives of CHLNet

The articulated objectives of CHLNet were to:

- Create a community of interest among individuals and organizations seeking to secure competent and capable leaders to meet the demands of the present and future health care system;
- Espouse a culture of knowledge exchange among CHLNet members and other networks or organizations who have undertaken leadership initiatives so that the wisdom and experience of emerging and senior health system leaders might be disseminated;
- Facilitate a greater organizational commitment to leadership development in the health and health care sector along a continuum;
- Encourage coordination of research in the areas of leadership and leadership development;
- Create an environment that recognizes and celebrates the success and achievements of our emerging and senior health system leaders;
- Serve as a forum to position leadership issues within the Pan-Canadian health human resources (HHR) planning process.

CHLNet: Early Priorities

The period 2007 to 2009 were critical years both in building a work plan based on identified priorities and demonstrating the value added role of CHLNet. Three areas of work proceeded around the goal of CHLNet to provide organizations and individuals interested in leadership with access to applied leadership development

tools, collaborative dialogue and networking opportunities and health leadership

development research.

Leadership Development Tools

   Leadership Capabilities Framework – Work on the development of the

Leadership Capabilities Framework became the centrepiece of tool development. The

Pan-Canadian framework, or 5C framework, was disseminated widely through

conferences and workshops to obtain feedback on its efficacy and where

improvements might be needed. The concept of establishing some "pilot" sites to test

out the framework was advanced. Two organizations, Eastern Health Region in

Newfoundland and Labrador and CCHSE, expressed interest in being part of this.

Eastern Health wanted to use the Capabilities framework as part of an internal

leadership development process. CCHSE wanted to explore how the new framework

might be used to establish the standards for the CHE designation. Projects in this

regard are ongoing as of 2011.

   The framework was tested out at the First Nations Health Conference in

Vancouver in January 2008, where Dickson and Philippon conducted a workshop.

The compatibility with work being done on a management competency framework by

First Nations was explored (Philippon & Dickson, 2008a). In April 2008, Dickson

and Philippon presented the framework at a workshop at the "Safer Healthcare Now!"

conference, in Winnipeg. Here the 5C framework was tested out with a group of 43

participants and over ninety percent rated the framework as useful or very useful (Philippon & Dickson, 2008b).

Leadership Awards – Funding provided by Associated Medical Services (AMS) in 2008 also enabled CHLNet to develop a proposal for a Leadership Awards and Fellowship program and to commence work on an inventory of leadership development programs. Consistent with the approach, funding was secured from a Foundation to create the McNaught-Taillon award to recognize the leadership by Don McNaught and Serge Taillon. This award was presented for the first time in September 2008 to Dennis Protti from the University of Victoria for his leadership in Health Informatics.

Collaborative Dialogue and Networking

In September 2008, CHLNet hosted its first Leadership Symposium entitled Leadership in Motion: Changing Systems, Creating Results. The event, held at Montebello Quebec, had Lord Nigel Crisp from the United Kingdom as the keynote speaker. The symposium provided an opportunity for several Canadian healthcare organizations to profile what they were doing, and to engage leaders from across Canada in a dialogue about what works and what doesn't work in creating heath system change. Participants rated the session very highly. However, the costs of this event were covered only because of the generosity of the CMA.   Accordingly, CHLNet has since considered how it can continue with this type of dialogue and networking session on a financially viable basis.

Health Leadership Development Research

The work done on the Leadership Capabilities framework created a strong linkage between CHLNet and the Centre for Health Leadership and Research (CHLR) at Royal Roads University. Graham Dickson, the Director of the Centre, served as the principal investigator on the CHSRF funded leadership capabilities project. In April 2008, in conjunction with CCHSE, CHLNet hosted an inaugural research roundtable in Toronto, with representatives of academic institutions with programs or research related to health leadership development. Graham Dickson presented on the 5C framework and discussion took place on how to align the curricula in existing programs. General support was expressed for using a common framework and the 5C framework was viewed positively   However, academic programs indicated they would need more descriptive, behavioural detail to plan curricula. Support was also expressed for having CHLNet undertake an inventory of health leadership programs in Canada and map those to the 5C framework. The roundtable provided an opportunity to begin the process of creating a leadership research agenda. The group concluded there was little research underway that specifically focused on Leadership (CHLNet, 2008).

Funding was secured in early 2009 from Health Canada to undertake a research project that would both provide an inventory of health leadership programs in Canada and to analyze those programs in terms of the Leadership Capabilities Framework. At about this same time, however, questions began to emerge about the wisdom of continuing with the 5C framework when the LEADS framework was already well

developed and was very similar. Accordingly, CHLNet, CHLR (Graham Dickson) and the Leaders for Life program in British Columbia agreed to explore the idea of amalgamating the two frameworks.

CHLNet: Taking Shape

LEADS in a Caring Environment

The work undertaken by Graham Dickson in consultation with CHLNet and Leaders for Life on comparing the 5C and LEADS framework resulted in a recommendation to merge both frameworks: The frameworks were very similar. This is not surprising as Graham Dickson had done the developmental work on each. It was felt the LEADS framework could serve as the overarching framework with a modification from the 5C framework that included a "Caring" dimension. The resulting framework would be known as *LEADS in a Caring Environment*. The five key capabilities in the framework are:

- Leading Self
- Engaging Others
- Achieving Results
- Developing Coalitions
- Systems Transformation

The two pilot projects underway – Eastern Health and CCHSE – agreed to convert to the *LEADS in a Caring Environment* framework. The new framework was formally adopted by the CHLNet Board at its meeting in September 2009. Shortly

thereafter, the framework was also adopted by CCHSE and the HCLABC. A media

event was organized for early 2010 so the three organizations could demonstrate their

collaboration in adopting a common framework. This proved to be a pivotal step in

that several other organizations across Canada subsequently adopted the framework.

Inventory of Health Leadership Programs

With $100,000 in funding secured from Health Canada in February 2009,

CHLNet engaged the Centre for Health Leadership and Research (CHLR) at RRU to

undertake a research project that would both provide an inventory of leadership

programs and assess those programs against the Leadership Capabilities framework.

The five objectives were to:

- Develop an inventory of leadership development and training activities in
  Canada;
- Identify leadership development/training best practices (later changed to
  leading practices) based on established criteria;
- Compare and contrast the current and ongoing provincial/territorial
  leadership development initiatives with the Pan-Canadian Leadership
  Capabilities Framework (later adjusted LEADS in a Caring Environment
  capabilities framework);
- Identify leadership education/training gaps and challenges;
- Identify future leadership development pilot projects in which leadership
  development gaps could be addressed.

CHLNet established a Research Project Advisory Committee to guide the CHLR

research team. The work was carried out by Graham Dickson and Anita Snell. The

report on objective one was submitted to Health Canada on April 30, 2009 and the entire project was completed in fall 2009.

The research project identified over 108 leadership development programs in Canada that were over five days in length. The programs were assessed against the *LEADS in a Caring Environment* capabilities framework and six leading leadership development program practices identified in the project from canvassing existing leaders and a literature review. These leading practices consisted of:

- the capacity to customize the program to the needs of the learner;

- the use of an effective and appropriate learning platform or blend of platforms in the delivering the program(e.g. classroom, web based);

- the use of workplace learning as part of the program delivery (e.g. action research, job stretch assignments);

- the inclusion of mentoring/coaching into the program;

- the adoption of adult learning design principles (e.g. self-directed learning) in program development; and

- the use of a variety of innovative adult learning practices (e.g. personal learning plans, reflection and critical analysis.) in the program.

Key findings from this research project included:

- The difficulty in identifying workplace leadership programs within health organizations and health authorities and the lack of a mechanism in Canada to share information on these programs;

- The lowest scores on the LEADS criteria were for "LEADS self" and the lowest scores on the Leading Practice criteria were for mentoring/coaching.

- There is a significant gap in the transfer of leadership learning to the workplace and little follow-up with people that have taken leadership programs;
- There appears to be a gap in the field knowledge about the *LEADS in a Caring Environment* capabilities framework;
- There is little empirical evidence on the efficacy of transformational or transactional leadership;
- There may be a gap in the *LEADS in a Caring Environment* framework pertaining to decision-making (Snell, 2010).

The research project identified potential future pilot projects in each of the areas pertaining to the major findings.

Governance of CHLNet

The Steering committee considered what organizational form CHLNet should take on. The matter of creating a stand alone incorporated body was discussed and the idea was bounced off several external people. The majority of the feedback received, recommended against CHLNet becoming another stand alone health organization. In fact, the Saskatchewan CEOs letter of support for CHLNet indicated it would only lend support on the condition that CHLNet did not pursue incorporation.

The concept of Network began to take hold with the idea that the secretariat could be housed at a national organization. Work began on developing a Provisional Agreement among the national associations represented on the Steering Committee, to address how key functions such as housing the secretariat, formation of a transitional board, and funding of CHLNet would be handled. The Provisional

Agreement was signed by all parties in 2009 (CHLNet, 2009a). The term of

Provisional Framework Agreement was from May 1, 2009 to December 31, 2010.

CHLNet has continued to explore the concept of a value added network and to

that end, a session was organized in June 2010 with Verna Allee, co-founder and

CEO of Value Networks LLC.

The Network session with Verna Allee generated a number of key considerations

for the future development of CHLNet, including:

- The importance of thinking of value added roles
- The idea of activating versus building networks
- Identifying the intangible benefits from networking
- Clarifying the unique niche area for CHLNet
- Models for accountability that are horizontal
- Making sure the network is able to adapt to change
- Identifying the core competencies of CHLNet (CHLNet, 2010a).

In December 2010, CHLNet partners supported the concept of moving towards a

network governance model. It was agreed that the existing governance structure

consisting of the transitional or founding board would remain in place until June 30,

2011. A final proposal for a new governance structure will be brought forward for

decision at the June 2011 meeting.

Secretariat Function

When CHLNet was established, the CMA agreed to provide the secretariat

support on the understanding that this arrangement should be reviewed and possibly

moved elsewhere in the future.   The willingness of Bill Tholl to have the CMA host

the secretariat was an instrumental factor in the launch of CHLNet. Bill Tholl not only provided inspiring leadership, but also made available human and other resources from within the CMA to support CHLNet. The role played by Emily Gruenwoldt from the CMA was critical in the first couple of years. The Steering Committee deliberated on many occasions about the most appropriate location for the Secretariat function. Under the Provisional Framework Agreement, the Secretariat would move to CCHSE effective January 1, 2009. CCHSE agreed to house the Secretariat function and provide some administrative support for a three-year period with the arrangement to be reviewed at that time. The actual transfer of the Secretariat function took place in January 2009 as agreed, even though the Framework Agreement was not signed off until later in 2009. CHLNet secured the able assistance of Tracy Murphy to pick up from Emily Gruenwoldt. In October, CHLNet appointed Bill Tholl as its first Executive Director on a part-time basis. This was a very fortunate step given Bill's role in shaping the concept of CHLNet from the outset. In early 2010, Lynda Becker joined the CHLNet office and Tracy Murphy gradually withdrew from CHLNet activities as she took on other consulting assignments.

Founding Board

The Provisional Agreement called for the creation of a Transitional Board for Governance. The transitional board, more commonly referred to as the founding board, was to be comprised of representatives of the organizations that signed the Provisional Framework Agreement (12), three members-at-large and two co-chairs.

The new Board came into place at the May 21, 2009 meeting. At that time, it was agreed that Elma Heidemann and Don Philippon would continue as co-chairs until December 2010.   A process was initiated to find members-at-large and it was agreed that four members should be added versus three as originally approved.

The four new members were appointed and attended their first Board meeting on March 31, 2010. The members-at-large appointed were: Joshua Tepper, Ontario Ministry of Health and Long -Term Care; Lea Bryden, Capital Health, Nova Scotia; Lynn Kirkland, Alberta Health Services; and Ron Robertson from the Odgers Berndston consulting group. The transitional or founding board members were:

- Ray Racette, CCHL
- Rachel Bard, CAN
- Pierre-Emile Cloutier, CMA
- Glenn Brimacombe, ACAHO
- Pamela Fralick, CHA
- Geoff Rowlands, HCLABC
- Wendy Nicklin, AC
- Jill Sanders, (Brian O'Rourke)* CADTH
- Emily Gruenwoldt/ Adrienne Hagen Lyster EHL**
- Gaetin Tardiff, CSPE
- Nan Brooks (Susan VanDeVelde-Coke)* ACEN
- Laurel Taylor (Hugh MacLeod)* CSPI
- Lea Bryden, Member-at-large
- Lynn Kirkland, Member-at-large
- Ron Robertson, Member-at-large
- Joshua Tepper, Member-at-large
- Elma Heidemann, Co-chair
- Don Philippon, Co-chair

 * Names in parentheses represent current members.

** Position shared.

Strategic Plan

In March 2009, the CHLNet Steering committee approved the strategic plan that had been developed over the previous months with the assistance of Marc Valois. The plan reiterated content from the CHLNet Value Proposition as discussed earlier. In addition, the plan identified key result areas for the next three years. The result areas were clustered in two categories: Products and Services; and Strategy and Administration (CHLNet, 2009b).

Products and Services – The strategic plan put forth the following action areas which were seen to be consistent with the three pillars of CHLNet: inventory/tools, research, and dialogue:

- Leadership Development Inventory
- Leadership Development Research Agenda
- Fostering excellence in health leadership
- Leadership program inventory, capabilities framework, awards and fellowship
- "Commons" meeting space
- Safe house for leaders in transition

The strategic plan placed emphasis on the development of a virtual portal to facilitate the above products and services to connect health leaders throughout the lifecycle of leadership (CHLNet, 2009b).

Strategy and Administration – This cluster of action items consisted of:

- Securing stable funding.
- Developing a clear governance model.

- Implementing an effective organizational structure for staff and contractors.
- Fostering connections (partnerships and alliances with stakeholders)
- Broadening CHLNet membership.

In approving the Strategic Plan, the CHLNet Steering Committee felt that the governance and membership areas needed further discussion. The Steering Committee agreed a first step would be to establish a transitional board (discussed above) and to actively recruit new network partners. The target was later set to increase the number of CHLNet partners from 12 to 24 by December 31, 2010.

Financial Plan

In the period between 2007 and 2010, the CHLNet Steering Committee, and later the founding board, often expressed the importance of developing a business plan. Several iterations of a business plan were presented and approved by the Board, but the fast changing context for CHLNet has made this a work-in-progress. A central premise of the business planning is that CHLNet requires a core budget to maintain operations in the vicinity of $100,000 and that specific funding would also be secured for individual projects

Communications and Marketing Plan

In December 2010, the CHLNet Board approved a communications and marketing plan based on work that had been done with the assistance of Kelly Grimes. This plan also contained a work plan for 2010. The overall intent of the plan was to build CHLNet presence in support of its three strategic priorities as follows:

- Value-added products and services – beginning with the development and maintenance of a pan-Canadian Leadership capabilities framework and a pan-Canadian LEADS –sorted inventory of leadership development programs and activities;
- Evidence-informed health leadership development – with an initial focus on bringing together the decision-making and health services research community as a network committed to a pan-Canadian applied research agenda;
- Creation of a "Leadership Commons" – through the creation of opportunities for effective dialogue with the health community (CHLNet, 2009e)

While the Board approved elements from the presented plan, it also recognized that further work was necessary in several areas such as the proposed "Seven Steps to Successful Leadership Program", the marketing to individual champions, and the planning for a "Montebello 2" Leaders dialogue event.

Strategic Linkages

CHLNet has developed two formal strategic linkages with other organizations: Leaders for Life and The Community of Excellence in Health Governance (CHEG).

Leaders for Life – From the outset, CHLNet developed a very close working relationship with the Leaders for Life initiative of the Health Care Leaders Association of British Columbia, and particularly with its Chief Executive, Geoff Rowlands. The seeds of this relationship were planted with the national CEO group in 2004-2005. The development of the Health Leadership framework under the auspices of CHLNet really relied on the expertise of Leaders for Life that had started down this same road several months before.

In November 2009, CHLNet entered into a formal brokering agreement with Leaders for Life to jointly increase the awareness of the *LEADS in a Caring Environment* capabilities framework and the availability of LEADS friendly leadership tools across Canada (CHLNet, 2009c).

CHEG – After several months of discussion on how the two entities could best work together, CHLNet and CHEG signed a memorandum of understanding in June 2010 to work together to strengthen the governance and leadership capabilities of health organizations and to contribute to a better understanding of important health policy issues. (CHLNet, 2010b) In that there is a clear overlap between governance and leadership, both entities want to work collaboratively on activities of joint interest and to be seen working together by their respective constituencies.

Health Leadership Research

Recognizing the undeveloped state of health leadership research and critical need to improve health leadership to effect health system improvement, several people associated with CHLNet began to explore how resources could be secured to bolster this area of research. In June 2009, Bill Tholl and Graham Dickson initiated an application for a "MPD" grant under the Partnership for Health System Improvement (PHSI) program of the Canadian Institute for Health Research (CIHR) was submitted to develop a proposal for developing leadership research capacity (Dickson, 2009). The grant was approved and a formal proposal was developed involving 19 co-applicants from across Canada. CHLNet and the CIHR collaborated on the initiative. The proposal was submitted in November 2009 and the approval was announced in

March 2010. CIHR agreed to provide $350K, the Michael Smith Foundation in

British Columbia agreed to contribute $100K, and another $300K in-kind

contribution was committed from the applicant's. The project entitled "Leadership

and Health System Redesign" intends to develop leadership capacity by bringing two

nascent networks together: decision makers from across Canada under the auspices of

CHLNet and the health research community led by Royal Roads University. Six

nodes of research activity are part of the design: Atlantic, Quebec, Ontario, Prairies,

British Columbia and national. The research project with Dr. Graham Dickson as the

Principal Investigator has 19 applicants representing the decision makers, research

and knowledge mobilization experts. The project has three objectives:

- To develop and conduct applied, qualitative research that will bring researchers and decision makers together to examine a suite of naturally occurring experiments involving leadership in action;
- To build an integrated regional and national knowledge translation and knowledge mobilization strategy that distils the knowledge from the case studies and translates it into practice; and
- To develop a sustainable network of networks that will last well beyond the PHSI funding envelope and timeframe (Dickson, 2009).

The project will utilize an action research approach involving case studies. At the

time of writing the potential case studies are being explored.

Health Leadership Portal

From the outset, CHLNet has seen one of its key roles to make available leadership

resources through a portal. After considering several options, the decision was made

to contract the creation of a new interactive website to a firm called eTraffic as this

firm was also taking on similar projects with the CCHSE and Leaders for Life. With

a modest investment of $15,000, the new website was up and running in May 2010

and was officially launched as part of the National Health Care Leaders Conference

in Winnipeg on June 7, 2010.   The website www.chlnet.ca is available to the public,

but some content is only available to CHLNet members that have a password.

The portal serves a number of purposes. First, it enables CHLNet to fulfill its

network function by linking many organizations. The intent is to provide a window

on leadership developments and links to organizations with resources in specific areas.

Second, it provides a convenient and effective way to make new products, reports,

information and tools available in an easy-to-use format. For instance, for the

Leadership Inventory, it provides not only access to the complete report, but

analytical tools to search for specific aspects.

While the website is in the public domain, much of the contents are only available

to CHLNet partners. There are now questions about how these leadership resources

on the website might be made available to individuals. This matter is under review by

the CHLNet Board.

Partners Networking and Leadership Dialogue

As noted above, following the approval of the Strategic Plan, the CHLNet Board decided to pursue other organizations with the view of increasing the number of CHLNet partners from 12 to 24 by December 2010. Organizations would be requested to provide $5,000 to become a Network Partner with the understanding that there would be an ongoing annual fee in this vicinity. The proposition made to organizations was that becoming a partner would provide:

- Opportunity to shape policies and programs aimed at promoting excellence in health leadership in Canada;
- Opportunity to have input into the future governance structure of CHLNet. (No promise was made for Board membership);
- Preferred access to CHLNet products and services at preferred prices, including access to the: CHLNet web portal, the LEADS – assessed Leadership Development inventory; customized psychometric testing; the on-line LEADS " Diagnostic"; invitation to the annual " Leaders for Leaders" sessions (building on Montebello experience); Quarterly reports; and, online "Leaders for Leaders" webinars (CHLNet, 2009d).

The goal of achieving 24 partners occurred early through the efforts of Bill Tholl, Executive Director, who reported in September 2010 that an additional 13 organizations had either formally joined or have requested a formal invitation to join. These additional 13 organizations were:

- Canadian Blood Services (CBS)
- Canadian Pharmacists Association (CPA)
- Canadian Public Health Association (CPHA)
- Public Health Agency of Canada (PHAC)
- Victorian Order of Nurses (VON)
- Royal College of Physicians and Surgeons of Canada (RCPSC)
- Royal Roads University (RRU)

- BIOTECCanada
- Manitoba Health
- Canadian Institute for Health Information (CIHI)
- Canadian Forces Health Group
- Canadian Health Services Research Foundation (CHSRF)
- Rx and D Canada

In addition, discussions were initiated with several other organizations to become partners and at the time of writing, another five organizations have indicated their intent to become partners.

CHLNet: Ongoing Developmental Issues

Funding Base

To date, the operational funding for CHLNet has been derived from contributions from members plus some small amounts derived from specific research funding, that were intended to offset CHLNet administrative costs and income generated through the partnership with Leaders for Life. The long term sustainability of CHLNet is still in question from a financial standpoint and efforts continue to secure a more stable funding source. The most recent development is a proposal to Health Canada for a multi-year funding contribution agreement that would link CHLNet deliverables to priorities of the Federal Provincial Health Human Resources planning process. The matter has received positive endorsement from provinces further to discussions that

have taken place with the Conference of Deputy Ministers of Health and with its

Advisory Committee on Health Delivery and Human Resources (ACHDHR).

Individual involvement

A key issue is for CHLNet is: How does the network relate to individuals?

CHLNet has been built having health organizations as partners, but many of the

products, services, dialogue sessions and other related developments are of great

interest to individuals in the Canadian health system. In its discussion, several

options and categories have been considered including "Champions" and "Friends".

The term Friends is now being used loosely, but no policy has yet been articulated on

how one would qualify and what benefits would be made available to these

individuals.

CHLNet is very sensitive to the concern that it cannot undermine the membership

base of any of its partners. For that reason, the CHLNet Board has now decided that

it will not be developing an individual membership category. This issue has been

raised by the Canadian College of Health Services Executives and a letter articulating

the CHLNet position was conveyed to the CCHSE Board Chair in October (Philippon,

2010).

Network Governance

The current founding board was put in place with a term ending December 31,

2010 that was subsequently extended to June 30, 2011. Several follow-up options

were discussed at the December 15, 2010 Board meeting which included all the

Network Partners. . As noted above, the Network partners agreed to move to a network model of governance. A final proposal will be brought forward for decision at the June 2011 meeting of the CHLNet founding board and all other Network partner not currently on the CHLNet board. .

Leadership Tools

As the *LEADS in a Caring Environment* gains traction in Canada, there is an increasing interest in applying the framework and the associated tools in the health organizations. The tools have largely been developed by Leaders for Life in consultation with a number of groups including CHLNet and CCHSE. The current thinking is that CHLNet will assume a primary role in making the organizational level tools available across Canada, and that Leaders for Life and CCHSE will focus their efforts on individual tools.

CHAPTER 3

LEADERSHIP DEVELOPMENT IN SELECTED OTHER COUNTRIES:

England, Australia, Sweden and New Zealand

The following section outlines key current leadership development activities in several selected countries. The countries selected are England, Australia, Sweden and New Zealand. These were selected for two reasons: First, these countries all have largely publicly funded universal health systems so they share many of the same values as Canada. Second, the author has personal knowledge of these countries given his graduate course on Comparative Health Systems, which has been offered at several Canadian Universities.

ENGLAND

Introduction

While most references will refer to the United Kingdom, in actual fact there are significant differences in health systems among the UK countries. So the focus here is on England.

Unlike Canada, England has a unitary system of Government where all constitutional responsibility for health rests with the central Government, and in turn this Government has created the National Health Service (NHS). While the NHS exists for all of the UK, there are significant differences in how it operates among England, Scotland, Wales, and Northern Ireland.

NHS Leadership Centre

In England, the NHS has devoted considerable attention to leadership development over the last decade. A pivotal point was the creation of the NHS Leadership Centre around 2001, which subsequently became incorporated into the NHS Institute for Innovation and Improvement in 2005 (John Clark, personal communication, June 12, 2010).

A key initial step by the NHS Centre on Leadership was to commission the Hay Group to develop an overarching framework of leadership qualities. This resulted in the launch of the NHS Leadership Qualities Framework (LQF) in October 2002 by Lord Nigel Crisp, then Chief Executive of NHS and Permanent Secretary of the Department of Health. The LQF, often nicknamed the doughnut, was researched over a two-year period by the Hay Group in consultation with leaders in the NHS. It consists of 15 leadership qualities arranged in three clusters – Personal Qualities, Setting Direction, and Delivering the Service. Each Quality is broken down into a number of levels to identify the characteristics, attitudes and behaviours required for effective leaders.

The NHS LQF is depicted as follows: (NHS Institute, 2010a)

National Health Leadership Council

The emphasis on leadership development in England was given another major boost in 2008, following the release of the Darzi report. The focus on quality resulting from this report elevated the need for major system change. In the words of Lord Darzi, "Making change actually happen takes leadership. It is central to our expectations of the healthcare professions of tomorrow" (Darzi, 2008). According to David Nicholson, NHS Chief Executive, " Spotting and developing confident leaders is a priority for all of us if improving quality is our shared purpose" (NHS Institute, 2010b).

A National Health Leadership Council (NLC) was established both to build leadership capacity, including Talent Management (John Clark, personal communication, June 12, 2010). The NLC was set up "to underpin and champion the priority attached to leadership in the NHS. It aims to ensure that the NHS system supports and fosters effective leadership and to challenge where it does not" (UK Department of Health, 2010). The NLC is chaired by the NHS Chief Executive, David Nicholson.

NHS Institute for Improvement and Innovation

The NHS Institute for Improvement and Innovation has a key role in promoting leadership development. It has been established to transform good ideas into workable solutions for improving the NHS. In essence, it functions as the NHS' own improvement agency (NHS Institute, 2010c). The NHS Institute for Improvement

and Innovation is structured into six areas with one of those being the NHS Institute Leadership. The 2010-2011 Business Plan (NHS Institute, 2010d) for the NHS Institute Leadership states the vision and mission as follows:

Vision: A vibrant centre for health and healthcare improvement which builds energy and enthusiasm for evidence based change in England, and promotes improvement learning from and to the NHS and worldwide.

Mission: To identify and develop inspirational and innovative leaders, representative of all communities with the skills, competencies and commitment to continuously improve the NHS to enable provision of a world class service for patients.

The NHS Institute Leadership has an overall strategy to "identify and provide the limited number of national interventions that add greatest value particularly working to deliver effectively the NLC agenda using quality and productivity as a unifying principle" (NHS Institute, 2010d).

In selecting its interventions for 2010/11, the NHS Institute Leadership has focussed on the five work streams that have been identified by NLC, which are: Emerging Leaders, Clinical Leadership, Inclusion, Board Development, and Top Leaders. The 2010/11 Business Plan for the NHS Institute Leadership outlines how it will support each of the work streams as follow: (NHS Institute, 2010d).

The *NLC Emerging Leader work stream* is being supported by the NHS Institute Leadership through support for graduate training schemes, a Gateway to Leadership program, and an Alumni program.

The *Clinical Leadership work stream* is supported by the NHS Institute Leadership with a heavy emphasis on Medical leadership through the development of the Medical Leadership Competency Framework (MLCF). This Framework was developed jointly by the NHS Institute Leadership in conjunction with the Academy of Medical Royal Colleges. The NHS Institute also supports undergraduate and post-graduate/fellowship curricula, medical engagement strategies, and e-learning materials. For 2010/11, the NHS Institute Leadership is committed to extending the MLCF to other professions and to Developing the Leadership for Quality Certificate.

The *Board Development work stream* is supported by the NHS Institute Leadership through the National executive coaching register, Board development tool, Team coaching, coach supervisor training and the , Leadership Qualities Framework..

The *Inclusion and Top Talent work stream* are supported by The Breaking Through program, Strategies for Success and Regional Coordinators. The goal of the Breaking Through program is to increase diversity in the NHS workforce at director and chief executive level by providing a variety of development opportunities to Black and Minority Ethnic staff. The Top Talent program is Breaking Through's flagship program. Its aim is to identify the most talented Black and Ethnic Minority managers and through a series of developmental activities, help them function at the director level.

The NHS Institute Leadership makes its products available to leadership development programs in the service and academic settings. Some universities utilize the Leadership capabilities framework in their programs and the Institute has been considering some form of accreditation for programs that meet its criteria, including

the competencies. However, this is far from being put in place at this time (Clark, personal communication, January 12, 2011.)

Clinical Leadership

A cornerstone of the current approach in England is to put emphasis on Medical Leadership. An international review undertaken by the Institute for Innovation and Improvement in conjunction with the Academic of Medical Royal Colleges and the University of Birmingham clearly shows the link between engagement of doctors in leadership and quality improvement (Ham & Dickinson, 2008).

A study by McKinsey & Company for the NHS London makes the point that the development of clinical leadership has been hampered by the lack of a clear definition. The authors observe that in clinicians eyes "leadership" is associated with bureaucracy and is often seen as divorced from patient care. They argue that clinical leadership should be "putting clinicians at the heart of shaping and running clinical services, so as to deliver excellent outcomes for patients and populations, not as a one-off task or project, but as a core part of a clinician's professional identity" (McKinsey, 2008).

To advance clinical leadership, the NHS Institute worked jointly with The Academy of Medical Royal Colleges and a wide range of stakeholders to develop the Medical Leadership Competency Framework (MLCF). The MLCF is based on the LQF but presents the capabilities more clearly with a focus on the delivery of services.

The MLCF is depicted as follows:

The MLCF is seen as a pivotal tool to:

- Help design training curricula and developmental programs;

- Highlight individual strengths and development areas through self assessment and structured feedback from colleagues; and

- Help with personal development planning and career progression (NHS Institute, 2010c).

Alongside the development of this framework, there has also been a concerted effort to engage doctors in leadership. Ham and Dickson make the point that much of the variation in quality improvement efforts between organizations both in the UK and internationally, can be explained by the degree of engagement of doctors in the processes (Ham & Dickinson, 2008).   Accordingly, the NHS Institute established a project specifically focussed on enhancing engagement in medical leadership. Work

is now underway to migrate this project into Academy of Medical Royal Colleges (John Clark, personal communication, November 8, 2010).

While the MLCF was developed specifically for physicians, essentially it now has been adopted by other clinical professions. Accordingly, a new Clinical Leaders Competency Framework (CLCF) will now form the minimum requirements for clinical practitioners and non-clinical managers, at what is being called Levels 1 and 2 within the NHS, England. Further work is being planned on the LQF so that additional competencies relating to strategic and political leadership requirements can be built into the CLCF so the framework becomes more relevant to Levels 3 – 5, the latter being CEOs (John Clark, personal communication, November 8, 2010).

Lessons from England

There are five overriding messages from the Leadership work in England that is worthy of reflection in charting the future course for leadership development in Canada.

1. England has taken a very targeted approach to leadership development. While the overall goal is to effect system change, there has been a particular focus on formal managers and clinician leaders.

2. An overriding message is the need to embed leadership development as an integrated part of health system change. The establishment of the Leadership Council chaired by the NHS Chief Executive provides not only a strong health system message about the importance of leadership

development but also presents a means to align the leadership development directly with planned system transformations.

3. A driving focus in the leadership development initiative in England has been the articulation of leadership qualities and competencies, as reflected in the Leadership Qualities Framework and the Medical Leadership Competency Framework. These frameworks have been used to underpin all leadership development activities.

4. Related to the previous point, is the major emphasis England has placed on targeting clinical leadership as critical to health system transformation. For example, and this links back to the embedding point above, a major investment is now being made with General Practitioners(GP) to help them take on the new GP commissioning role.

5. However, another lesson from England is that leadership development continues to be very vulnerable. Despite the world wide recognition of work of the NHS Institute Leadership, the July 2010 White Paper released by the new Cameron Government calls for the dismantling of the Institute by March 2012 as part of an overall plan to reduce 25,000 management positions. There is optimism; however, that activities of the Institute will continue as part of new structures, but the current structural change is detracting from key leadership development activities. (John Clark, personal communication, November 8, 2010; John Clark, personal communication, January 12, 2011).

AUSTRALIA

Introduction

The attention to leadership and leadership development in Australia stands out in stark contrast to the situation in England. Australia, like Canada, is a federation. The recent National Health and Hospitals Reform Commission Report (Australian Hospitals and Health Reform Commission(AHHRC), 2009) has noted that Australia has a fragmented health system with a complex arrangement of funding responsibilities and performance accountabilities between different levels of government. The Commission identifies three reform goals, two of which are particularly relevant to the subject of leadership:

- Redesigning our health system so that it is better positioned to respond to emerging challenges; and
- Creating an agile and self-improving health system for long term sustainability (AHHRC, 2009).

However, what is most interesting is that there is very little recognition in this 300 page report of the importance of leadership to effect change. Recommendation #98 has an element of this when it makes recommendations pertaining to the workforce. A sub-bullet recommends "investing in management and leadership skills development and maintenance for managers and clinicians at all levels of the system. (AHHRC, 2009)

Given that this major reform process did not really address the issue of leadership, it is not surprising to observe that there is no major platform for leadership development on a national scale in Australia. The Australian College of Health

Services Executives has identified this issue, but has not been able to get any major

commitment for action (Australia College, personal communication, November 23,

2009).

In effect, the entire matter of leadership development has essentially been left to

the states and territories. While elements of leadership initiatives can be found in all

seven states and territories, the State of Queensland stands out in this regard.

Leadership Development in Queensland

The emphasis on leadership development in Queensland grew out of a 2005

independent review of Queensland Health that was commissioned because of

concerns about quality and safety (Crethar, 2010). It is to be noted that Queensland

also stands out among other states and territories, in that it has operated a

Government operated Health system for many years. Queensland Health is

responsible for the entire state, which covers a vast geographic area and a state-wide

network of 2,350 delivery sites. Queensland Health delivers a range of services

including hospital inpatient, outpatient and emergency services, community and

mental health services, and aged care services. Not only are there no local

governance authorities, but all health workers are employees of the state, except for

some that work on contract. There are 72,000 staff including medical, nursing, allied

health and managerial.

One of the strategies emanating from the review was the need for leadership

development to drive reform. The following statement in the final report is most

revealing in this regard "the most critical ingredient in achieving the cultural change

required is the changed style and behaviours of leaders…" (Forster, 2005). It was recommended that Queensland executives, managers and supervisors be supported in the development of their leadership capabilities through leadership development programs (Crethar, Phillips, Stafford & Duckett, 2009). The Forster report and the report in the same year from the Public Hospital Commission of Inquiry (Davies Inquiry) were instrumental to the development of the $10 billion *Action Plan: Building a better health service for Queensland* (Queensland Health, 2007a). One of the actions being implemented by Queensland Health through the Healthcare Culture and Leadership Service (HCLS) is a comprehensive suite of leadership development programs. Known as the "Better Workplaces Leadership Development Program, it has been implemented throughout the organization with over 10,000 participants since 2006" (Crethar, 2010).

Better Workplaces Leadership Program

Program Goal – The program aims to effect improvement in the leadership capabilities that will bring about real improvements in both clinical culture and the workplace. A key underlying premise of the program "is that leaders have a significant impact on workplace culture which influences how individuals and teams perform, which in turn has an effect on patient outcomes" (Crethar et al., 2009).

The program is multi-faceted incorporating:

- a range of specific leadership development programs for clinical and non clinical staff;
- specialist leadership development workshops;
- online leadership modules; and

- Executive Coaching and 360 Degree Feedback (Crethar, 2010).

Along side the Leadership program, Queensland Health has an ongoing process to gather opinions from staff. The Better Workplaces Staff Opinion Survey gathers essential information about workplace culture. The program uses the Leadership Qualities Framework from the NHS which was discussed in the previous section. The activities in the program are all based on experiential learning which engages learners in problem solving, critical thinking and self reflection based on context experiences relevant to each of them. The program is offered using several consultants from private Consultancy firms and Australian universities. The HCLS has worked with each of these providers on the design of the specific programs. The effectiveness of external facilitators is closely monitored as well.

Program Evolution – The Better Workplaces Leadership Program has gone through several stages in its development.

Stage I (2006/2007) gave priority to broad organizational leadership development. This involved:

- A two day residential Executive Leadership Development workshop conducted for clinical and non-clinical executives. This was mandatory for the 500 senior executives in Queensland Health. The workshop was developed across the State. A unique feature of this workshop was the drama-based interactive case study "the prophetical" which plays out an evidenced based scenario which is grounded in the lived experiences of

the participants (Haseman, Crethar, Phillips and Stafford, 2009). This approach incorporates drama and other arts-based learning into management and leadership in the attempt to find an alternative to the" logico-rational "approach that has informed traditional practice in management Education (Haseman, et al., 2009). The prophetical was based on real life experiences of senior leaders making it possible for participants to see how the future could be corrected or transformed through their interventions and actions (Crethar, 2010).

- A two-day residential workshop for managers and supervisors which again uses an experiential learning to develop skills in the following areas: individual reflection, the art of listening, processes to lead change, developing results based action plans, developing measurable results, creating a shared vision, creating a climate of hope and possibility, self management and prioritisation, coaching your team, and recognizing your sphere of influence (Crethar et al., 2009).

- A 360 degree feedback instrument was designed based on the NHS Leadership Qualities framework to both provide feedback to individuals on their ratings and to provide a composite report to identify key developmental areas. As of 2009, 535 executives had participated in the process which was administered by the Hay Group. All participants receive a professional debriefing with an experienced executive coach (Crethar, et al., 2009).

- Executive coaching is also made available to participants in a number of the programs usually amounting to 4-8 hours per participant. The purpose is to assist with achievement of personal and career goals (Crethar, 2010).

Stage II (2007/2008) built on the work done in Stage I by providing more customised leadership development to address the specific needs of individuals and team. This included:

- The Executive Leaders program focussed on the top 500 clinical and non-clinical executives was continued, but with focus on the needs of the executive team in each District Health Service. The HCLS works closely with the CEO of each District using data from the 360 degree feedback and staff opinion surveys (Crethar, 2010).

- The Emerging Clinical Leaders program (ECLP) which was developed in recognition of the ageing workforce and the impending retirement curve for clinical leaders. Its aim is to prepare clinicians with skills to move into clinical leadership roles. This is a multi-disciplinary twelve month program providing individual development support and capitalizes on the dynamics and power of the group. Again, this is an experiential learning approach so learning comes from in-context experience and uses residential workshops, on-line facilitated discussion, individual coaching, 360 degree feedback, debriefing workshops and work based action learning including stretch projects and/or job shadowing/rotation (Crethar, 2010).

Stage III (2009/2009) provided a new emphasis on the following:

- A Rural Leadership program was launched recognizing that Queensland covers a vast geographical area and encompasses a number of rural and remote sites these pose a number of unique leadership challenges including limited peer support, politics of small communities, leading teams across distance and managing a "fly in fly out" workforce (Crethar, 2010).

- A Senior Indigenous Health Workers Leadership program was developed to build leadership capacity of Senior Indigenous Health Workers. The program comprises a four-day workshop and explores differences between organizational and indigenous culture. It identifies leadership behaviours required to achieve specific strategic outcomes specific to the indigenous community (Crethar, 2010).

- Specialized workshops were also developed in Personal Leadership development, Energising form Conflict, and Coaching Skills for Leaders (Crethar, 2010).

Stage IV (2009/2010) has provided a more specific focus on Medical Leadership and Executive Succession.

- The Medical Leadership in Action Program recognizes the evidence that exists showing the link between engagement of physicians in leadership and quality improvement (Crethar, 2010). There is recognition that physicians often have difficulty in leadership roles in part because medical training focuses on clinical skills and they have

not been provided with any leadership development. This has created problems when physicians move into leadership positions which now force them to move from an individual clinical focus to a wider organizational focus (Crethar, 2010). The Medical Leadership Action program was developed for senior physicians and like the other Queensland leadership programs it is based on experiential learning. Some key aspects of this program include:

- o "Discovery sessions" at the outset with each individual participant to determine the participant's most pressing leadership challenge.

- o Individual coaching and 360 degree feedback (Crethar, 2010).

• The Executive Succession program is targeted at the senior employees that have a desire to advance their careers to the executive level. Participants are nominated by the District CEO or the Deputy Director General. The program is conducted over a period of eight months and includes a four-day residential workshop, 360 degree feedback, facilitated learning sets (learning communities formed by the participants to support each other) and optional executive relieving opportunities/job shadowing (Crethar, 2010).

Queensland Leadership Program: Impact and Results

Since the commencement of the program in 2006, there have been over 10,000 participants in the program. The overall representation has been about 70% clinicians and 30% non-clinicians. The evaluation results for 2009/2010 indicate approximately 98% of the participants rated the program activities as either good or excellent. In addition, 97 % indicated the experience would benefit their work (Crethar, 2010).

As noted previously, Queensland Health launched a regular opinion survey of staff to assess changes in culture and climate in conjunction with launching the leadership program. Results from these surveys show a continual improvement across most indicators indicating that positive cultural change has occurred across the organization since the implementation of the program (Crethar, 2010).

The Better Workplaces Leadership program was part of several strategies to improve the quality and safety of the Queensland Health system following the 2005 review. Overall these strategies were designed to shift the culture of Queensland health by emphasizing accountability, transparency and participation/engagement (Duckett, 2009). Changes in policy and clinical governance processes were accompanied by The Better Workplaces Leadership program. This program was based on the view that in order to achieve culture change, there needed to be changes in leadership behaviours. The role of the leader was seen to be of major importance to effect changes in the culture. It is noteworthy that the Centre for Healthcare Improvement was given overall responsibility for the leadership initiative and this same organization also had the responsibility for the safety and quality agenda.

The ultimate test for the leadership initiative is whether it has led to health system improvement. Several new monitoring and reporting mechanisms are in place to

review health system performance and there are some indicators of success. Reports indicate progress on reducing "long waits" for elective surgery, a reduction in emergency surgical admissions, and high rates of patient satisfaction with their surgical experience (Queensland Health, 2010; Queensland Office of Economic and Statistical Research, 2009). In 2007 the Workplace Culture and Leadership Centre won the Premier's Award for Excellence in Public Sector management (Queensland Health, 2007b).

Lessons from Australia

There are three key lessons from the Queensland experience with leadership development:

1. Leadership is essential to drive health system reform.

2. Embedding leadership development with health system change, in this case a focus on quality and safety, greatly enhances the ability to achieve real health system changes;

3. Leadership development needs to be viewed as part of the organization culture. Building on work by Schein, Duckett observes" shifting culture is quintessentially what leadership is about, indeed it can be argued that creating and shaping culture is the only important thing leaders do" (Duckett, 2009).

SWEDEN

Introduction

Health care in Sweden is largely the responsibility of the public sector. At the national level, the Ministry of Health and Social Affairs establishes overall policy, objectives and guidelines. The implementation of health policy is largely delegated to County Councils (Institute for Health Improvement (IHI), 2010). So like England, Sweden does have a unitary system of government whereby Constitutional responsibility rests at one level, the National Government. In practice, however, Sweden has a long history of delegating responsibility to local authorities, with County Councils having the major role in the delivery of health services.

While the National Government has continually encouraged improvements in efficiency, quality and effectiveness, the methods to achieve these results have largely been left to the County Councils. Accordingly, leadership development has become an important consideration at the County Council level and Jonkoping County Council stands out in this respect.

Jonkoping County Council serves a population of 330,000 residents with an organization which has 9,000 employees. The County Council is organized in three health care areas where each consists of a hospital with an emergency department and several primary care centers. Public health and dental care are also included in the system (Andersson-Gare & Neuhauser, 2007).

Leadership development in Jonkoping is directly linked to the Quality Improvement initiative which was launched in 2001. The strategies associated with this initiative now have international recognition. As noted by Don Berwick, CEO of

the Institute of Healthcare Improvement, Boston "The lessons of the Jonkoping example deserve careful study by anyone, anywhere who seeks to improve health care as a system" (Andersson-Gare & Neuhauser, 2007).

The Quality Improvement Journey in Jonkoping

The history of Jonkoping Council providing medical services to its population goes back more than one hundred years. However, the development of Quality as a Business Strategy can be traced back to the early 1990s. In 1992, the National Association of Swedish County Councils developed a concerted focus to improve health care services using the banner of "Quality Security". A system of quality assessment similar to the Malcolm Baldridge Award in the United States was introduced – QDL (Quality – Development – Leadership) (Jonkoping County Council (JCC), 2007).

The Learning Culture in Jonkoping

The learning aspect is the soul of the Jonkoping Journey. Over time, the Jonkoping Leadership defined their improvement strategy as based on three principles: Learning is seen as key to improvement; improvement needs to be broad and deep; and improvement must be both bottom-up and top-down. This learning culture has been developed by the leadership threesome in Jonkoping consisting of: Sven Olof Karlsson, the CEO; Goran Henriks, Chief of Learning and Innovation; and Mats Bojestig, MD, Chief Medical Officer. Sven Olof Karlsson served as CEO of the county for 19 years and the three worked together for several years. The CEO has

retired recently and was replaced by Agneta Jansmyr who had a long history with Jonkoping up to 2000, then returned to take this position (Bodenheirmer, Bojestig & Henriks, 2007). Henriks has served as the day-to-day leader of the learning journey. An interesting story about Sven Olof Karlsson is that he was once a Swedish paratrooper and was dropped off in the wilderness to survive on his own – leading to a comment by someone that that may be ideal training for running a health system (Kenny, 2008).

Fundamental to the learning culture of Jonkoping is the philosophy expressed by Henriks (a child psychologist with an MBA) that "sustainable change in health care is to some extent rooted in human emotion. People do not change because they are ordered or coerced – people change because of love of something – a deep emotional involvement" (Kenny, 2008). In comparison to the situation in the United States where financial incentives are very much in vogue as a way to stimulate change, there are very few such incentives in Jonkoping. Again in Henriks own words:

"We don't believe in financial incentives on a personal level… We have very motivated employees. You put fifteen years of your time into learning something, you can't stand to see poor performance. The best incentive for our employees is being the best" (Kenny, 2008, p. 218)

While much change literature talks about the need for a burning platform, Henriks puts forth the view that "The Burning platform is always inside people (Kenny, 2008). He believes motivation comes from knowledge and inspiration, not orders, and he quotes Gandhi in defining leadership as "a group of people going in the same direction by the will and conviction of their own" (Kenny, 2008, p. 218).

The principles of "broad/deep" and "top-down/bottom-up" are integral to the learning culture. In Jonkoping they define "'broad" as improvement that reaches across the system covering all patients, while "deep" signifies that as many people as possible, at every level of the system are engaged in the improvement, thereby increasing the probability that the change will be sustained (Kenny, 2008).

A key learning strategy that has become internationally recognized was Jonkoping's "Esther" project. This was the name given to a project that would help focus on how to improve patient centered care. Esther is a fictional patient – she is a composite to reflect many people to whom Jonkoping provides care everyday. She is an elderly patient, living alone with multiple health issues. In interaction with the health care system, this scenario starts with a call to a home nurse. This leads to her journey through the health system involving ambulance, emergency, diagnostic tests, a consultation and in-patient care. However, the scenario is constructed to reveal the duplication in questioning, delays and waiting at different points of the care cycle. This scenario has become a key learning tool to help staff focus on areas for needed improvement. In effect, the scenario is a way of applying process engineering to health care (Kenny, 2008).

The leadership in Jonkoping has developed a very special relationship with the Institute of Health Care Improvement (IHI) in the United States. The IHI CEO, Don Berwick, has had considerable presence in Jonkoping. Shortly after beginning the development of the Esther Project, Jonkoping joined IHI's "Pursuing Perfection" project 2001. The cultural lessons from the Esther project and concepts from Pursuing Perfection stimulated changes across the health system in Jonkoping (IHI, 2010).

Along with Delft in the Netherlands, Jonkoping became the European reference in the international Pursuing Perfection project (JCC, 2007).

Developing Leadership Capacity in Jonkoping

A key observation about the developments in Jonkoping is that while they have recognized the importance of leadership, the main focus is on developing a learning culture in the organization and inspiring employees at all levels to engage actively in health system improvements. Leadership is seen to be important for all their staff as everyone needs to exercise leadership in some way (Bodenheimer, Bojestig & Goran, 2007). There are several features and strategies that have made this approach very effective in Jonkoping. These include the senior leadership team, the commitment to dialogue and the establishment of Qulturum and Futurum.

Jonkoping Leadership Team – In reviewing the Jonkoping experience, Maura Davies, a CEO in Canada, has commented that "to a large degree, Jonkoping's success is a result of inspired, persistent, transformational leadership by CEO Sven-Olof Karlsson and other senior leaders whom he selected to lead this remarkable organization" (Davies, 2008, p.148). In analyzing his leadership style, Davies notes the important role Sven-Olof Karlsson had in modeling the way by his personal attendance at IHI Forums, his willingness to learn from others, his openness to new ideas that challenged the status quo. She also notes his decision to strategically invest in learning and the establishment of Qulturum as a building block for Jonkoping's quality improvement (Davies, 2008). Another key factor in his success, according to

Davies, is that Karlsson's lengthy stable leadership allowed him to build strategic partnerships with other key organizations to build learning and research capacity.

Karlsson's commitment to develop a system to foster improvement led him to make a few key strategic changes to his leadership team. In 1997, he created a new position for Henriks, who became the chief of learning and innovation. In 2006, he appointed Bojestig as chief medical officer and planning director to ensure that transformation was by leadership and focussed on clinical results (Baker et al., 2008).

Developing Dialogue on Change – Looking over the history of Jonkoping, it becomes evident that the culture of improvement is rooted in many processes to encourage dialogue and reflection on current practices. Starting in 1994, a new instrument, Development of Dialogue, was developed as a means for all hospital departments and primary care centres to describe their activities and improvements. Also groups were formed around the needs of patients with each group led by a senior physician. Using the "Developing Dialogue Instrument", a flow chart was developed for each patient-group to identify difficulties and delays in the flow of activities for patients. This instrument continues to this day (JCC, 2007). The concepts of the "Development of Dialogue" and the Esther project were both very critical in the diffusion of a quality improvement mindset as more than 4,000 employees were involved in these projects early on and from that more complex planning and improvement approaches were introduced: Plan-Do-Study-Act (PDSA), the Balanced Scorecard, Break Through Series method, Brent James methods on clinical improvements, and Mark Murray's work on access (JCC, 2007). The impact of these

processes was remarkable. For example, the Esther project led to major reduction in waiting times for appointments, hospital stays decreased and a major reduction in hospital admissions occurred (Kenny, 2008).

From the very beginning of its quality journey, the senior leadership team fostered a culture that was continually on the lookout for better ideas from elsewhere. The close linkage with IHI and participation in the IHI international forums has been very beneficial in this respect. The "strategic harvesting" of ideas from international sources has been an important feature of improvement in Jonkoping (Baker et al., 2008).

By the late 1990s, Jonkoping had made significant investments in developing improvement capabilities and while improvements had been made, there were still gaps and a lack of connection between the teams of people working on projects and how these contributed to overall system improvement. In part, this led to a new initiative called Big Group Healthcare. This was a meeting of all executive, clinical and quality leaders and managers from across the system over five days during the year. At these meetings, leaders and managers gather in "circles of learning and open dialogue" to report on their progress, to discuss what is and what is not working, to learn how the system is performing as a whole, and to participate in "co-designing" the overall plan for the health system (Baker et. al., 2008).

Establishment of Qulturum – The engine to foster learning and effect improvement is the Qulturum leaning centre. This is housed in a stand-alone facility

located on the central campus of Jonkoping's healthcare facilities. Qulturum which means "meeting place for quality and culture" serves as a "centralized quality house."

Henriks, who heads up Qulturum, also refers to Qulturum as an "institute for language" that links staff from various disciplines because their own languages are so different (e.g. clinical, financial). Qulturum is funded by 0.03% of Jonkoping's annual budget and a partnership with the Swedish Pharmacy Association. The physical structure is very impressive and enables both large group and small group learning venues supported by technology when necessary (Baker et al., 2008).

Qulturum is an innovation learning centre and its sole mission is to support the improvement of health care services. It has no clinical or administrative responsibilities for delivering health services. The 15 to 20 staff members focus their full attention on improvement activities (Baker et al., 2008).

Qulturum has an explicit strategy for recruitment and staff development. Personnel are carefully selected from the county's front-line champions. Training and developmental learning is provided in a wide-range of areas including: front-line team facilitation; project management; leadership capabilities; improvement methods; data collection; process mapping; patient safety related methods; and, general improvement methods (Baker et al., 2008).

The central role played by Qulturum in the Jonkoping Quality Journey is key to understanding how this organization has developed the capability for system improvement. Since 2000, Qulturum has served as the Jonkoping County Council's institution for quality improvement and development providing in-house training of staff from across the organization. Unlike many other health systems that have tried

to focus on practical improvement methods, rather than ones based on theory, Qulturum bridges this divide. The key principles for training and support provided by Qulturum are that these activities must align with the County Council's strategic aims and action must be grounded in improvement theory. Qulturum provides support for system-wide improvements and unit-based projects both at the outset of projects and on an ongoing basis as changes are being made to care processes (Baker et al, 2008). Integrated into the learning sessions are theories of Senge, Juran, Deming and others as well as tools such as the rapid-cycle methods, and The Clinical Value Compass. As of 2007, over 4,000 of the 9,000 staff in Jonkoping had received this theory-based and action-oriented training (Baker et al., 2008).

Another key role played by Qulturum is in the harvesting of ideas from elsewhere. Henriks, the head of Qulturum states **"**We have a rule of not bringing in consultants to solve our problems. We are of the mindset of see one, do one, teach 500." (Baker et al., 2008). So the approach is to build internal capacity by using external expertise to train their own coaches and trainers rather than to use consultants at the front lines. This has also allowed Jonkoping senior leaders to take the approach that no new resources are available for improvements except for specific capital projects. Programs and staff have access to improvement support from Qulturum staff and they fund changes through process improvement (Baker et al., 2008).

Another related initiative has been the establishment of Futurum (started in 2004) to provide students during their basic professional training with high quality clinical training. Futurum is also responsible for clinical research performed by County
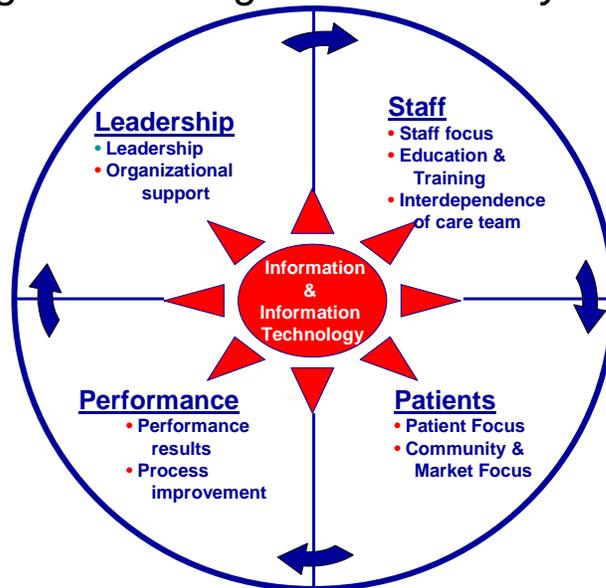
Council staff and a new research field on quality improvement has been developed (JCC, 2007).

Specific Leadership Development Strategies

From the above account of the quality Journey at Jonkoping and the approaches to developing leadership capacity to effect change, it is clear the emphasis on creating a learning organization and engaging all staff in making quality improvements. The philosophy that everyone is a leader is paramount.

However, in discussions with Goran Henriks it is also evident that leadership development for senior managers is seen as a vital component. The diagram below on High Performing Microsystems illustrates that leadership is important at all levels and in all processes (NHS Institute, 2009).

High Performing Clinical Microsystems

Leadership
- Leadership
- Organizational support

Staff
- Staff focus
- Education & Training
- Interdependence of care team

Information & Information Technology

Performance
- Performance results
- Process improvement

Patients
- Patient Focus
- Community & Market Focus

So while there is a broad strategy to develop leadership skills in all staff, there is also a recognition that senior managers need to lead by example. These people are not only administrative leaders, but process leaders, and as such they need to constantly develop skills and behaviours to be effective. Through Qulturum, specific leadership development is provided for all Chiefs of Wards, Chiefs of Departments, Chief Executive officers, and process leaders. (There are six CEO-type positions in Jonkoping County Council with the County Council CEO having overall responsibility – three for hospitals, one for primary care, one for diagnostic services, and the County Council CEO). The program is provided on an ongoing basis and involves 10 to 15 days over the year. This development involves learning on the Balanced Scorecard system, Quality Development as well as work in the more traditional areas of finance, human resources and administrative systems. There are also three days for self development. In addition each person must be involved in Quality Improvement work (G. Henriks, personal communication, November 10, 2010).

From their own learning about quality in health care, Goran Henriks and Olaf Karlsson became convinced that top leaders also needed more academic background to be effective leaders in quality improvement. This has led to the development of a Master's program now offered by the Jonkoping Academy that is associated with four institutions of higher learning, including the Jonkoping University that grants the degree. This is a two-year program offered in English and has an enrolment of about 70 students with about 40% being Jonkoping County Council staff. This program requires each participant to be involved in a real world quality improvement project.

Again the emphasis here is on developing people who can lead process change (G.

Henriks, Personal Communication, November 10, 2010).

Impact of Quality Strategy in Jonkoping

The impressive results in Jonkoping are now being recognized internationally.

Berwick has observed that Jonkoping had achieved an overall approach to quality that

is "perhaps unparalleled internationally" (Andersson-Gare & Neuhauser, 2007, p.2).

Jonkoping County leads Sweden in many performance measures. On an index of 11

indicators comparing all County Councils, Jonkoping has repeatedly had the highest

scores in Sweden (Bodenheimer, Bojestig & Henriks, 2007).

The key conclusion to be drawn is that the learning culture created and nurtured in

Jonkoping has yielded very positive results. While the importance of leadership is

well recognized, the approach to leadership development is part of their overall

quality improvement process which attempts to engage all staff in a continuous drive

for improvement. It is also evident that success breeds success. A sense of pride has

developed and even though Jonkoping has been at the top of the list in terms of

performance for several years, there is no sign of complacency setting in. Rather there

is an ongoing goal of continuous improvement.

Lessons from Sweden

There are three key learnings from Sweden:

1. Leadership development has the greatest chance of effecting health system

    improvement if it is integrated with the culture of the organization;

2. A focus on all staff as having the potential to demonstrate leadership in their own work is critical to achieving a culture of quality improvement; and

3. A sustained focus on quality improvement within a stable organizational setting can create a sense of pride among staff, to continually effect health system improvements with the resulting quest for continuous improvement becoming part of their identity.

Introduction

Like England and Sweden, New Zealand has a unitary system of government meaning constitutional responsibility is held by the central government. Historically, responsibility for the delivery of health services has been largely delegated to local authorities, but the nature of that delegation has changed significantly over the years. The present system of District Health Boards (DHBs) has been in place since 2001 following the passage of the New Zealand Health and Disability Act in 2000. Twenty one DHBs were created initially. In May 2010, two DHBs on the South Island amalgamated resulting in the current 20 DHBs (New Zealand Ministry of Health, 2010)

DHBs have a broad range of responsibilities for publicly funded health and disability services. The Ministry of Health provides direction and guidance through a number of policy documents on how goals and objectives are to be achieved. The Ministry also sets out accountability requirements and works with DHBs to make sure the requirements are understood and met (New Zealand Ministry of Health, 2010). The broad range of responsibilities of DHBs requires the exercise of leadership on several fronts as can be inferred from some of the following objectives:

- To improve, promote and protect the health of communities;
- To promote integration of health services, especially primary and secondary services;
- To reduce health disparities by improving health outcome disparities between various population groups.

Following the election of a new government in November 2008, a Ministerial

Review Group (MRG) was established to provide recommendations on how to

improve system performance, the system's capacity to deliver into the future and how

to move resources to support front-line care. The MRG articulated a number of

threats to the sustainability of the existing health system and made recommendations

on how to address these issues. The report raised serious concern about the

sustainability of the existing system given that costs were rising at a rate far greater

than the increase in GDP. Among the many recommendations, the MRG calls for

new models of care with the patient rather than institutions at the centre of service,

stronger clinical and management partnerships, improving hospital productivity,

reducing the cost of "back office" services and redirecting resources to front line care

delivery (New Zealand Ministerial Review Group, 2009).

The MRG's recommendations can be broadly placed in two categories. First,

recommendations aimed at changes in culture and processes, including greater

clinical leadership and engagement, and integration of services. Second, those

recommending changes in structure that are aimed at reducing waste and bureaucracy,

improving safety and quality and enhancing clinical and financial viability (New

Zealand Ministerial Review Group, 2009).

The recommendations put forth by the MRG have led to significant developments

at both the national and DHB level which have elevated the need for health system

leadership and leadership development. At the national level, a new agency called

Health Workforce New Zealand (HWNZ) has begun to focus on leadership

development. While there is overall framework for leadership level for the DHBs, two of the largest DHBs have taken major steps to improve leadership capability.

HWNZ – Leadership Development

HWNZ was set up in 2009 to lead and co-ordinate the planning and development of the country's health and disability workforce. The agency supports DHBs and other healthcare employers to realize the full potential of their workforce. The agency is overseen by an independent board. The work of the agency is in three areas: investment relationships and purchasing; innovations; and, intelligence and planning. The innovations mandate includes development of potential in the workforce (Marinelli-Poole & McGilvray, 2010).

Work is underway to develop a new national institute of health leadership. In June 2010, HWNZ brought together 200 senior representatives from across the health sector to focus on the future of clinical leadership. The intention is to have the new institute draw on existing initiatives to establish programs for clinical, managerial and executive leaders at all levels. The hope is to have the new institute operational by the end of 2010 (Marinelli-Poole & McGilvray, 2010). In the meantime, to maintain momentum for leadership activity, HWNZ is considering proposals for funding from a number of organizations. A panel will be convened drawing from expertise from DHBs, universities and international partners to review the proposals (Health Workforce New Zealand, 2010).

Leadership Development in Counties Manukau

The Counties Manukau District Health Board (CMDHB) is one of the existing 20 DHBs and is one the three in the greater Auckland area. CMDHB is the third largest DHB in New Zealand, with a population of 470,000 residents. It has an ethnically diverse population with 60% being Maori, Asian, or Pacific peoples.

Like other DHBs, CMDHB provides a wide range of services to its residents, but in addition provides niche specialist tertiary services on a national level. Its main hospital, Middlemore Hospital, is one of the largest teaching hospitals in New Zealand. CMDHB is also known to have the largest birthing unit and busiest emergency care service in Australia and New Zealand (Marinelli-Poole & McGilvray, 2010).

Recognizing the many challenges and the need for health system improvement as outlined in the MRG report and from work within the CMDHB, a new leadership initiative has been put in place. CMDHB, in partnership with the University of Auckland Business School's New Zealand Leadership Institute (NZLI), has developed an innovative program aimed at clinical leaders to achieve leading edge clinical quality (Marinelli-Poole & McGilvray, 2010). NZLI, also known as Excelerator, is a national leadership development and research institute that was developed through strong partnerships with both University and private sector organizations. Excelerator is committed to lifting the quality of leadership in New Zealand across all sectors (New Zealand Leadership Institute, 2010).

CMDHB and NZLI have developed The Leading Excellence in Health Care program based on research done within CMDHB that revealed key themes around

clinical identity and the clinician/manager partnership that is critical to achieve improved outcomes for patients. The program places much focus on moving from thinking as clinician/manager to thinking as a leader. It also emphasizes leadership as a collective endeavour and the need to create engaging conditions for leadership. Importance is attached to both developing a leadership mindset as well as a leadership skill set. The program is designed to help participants: build a strong sense of inquiry: to seek multiple perspectives; and, to look at underlying assumptions and factors around presented problems. The intent is to develop leadership that not only strengthens the individual's actions, but also pays equal attention to the leadership of others around them. Identity (personal, professional and collective), partnership and complexity are key drivers of the program. Central to the development process is the distinctive pathway for clinicians into leadership (Marinelli-Poole & McGilvray, 2010).

The leadership program was launched in 2009 with 100 participants in four groups of 25 including a mix of clinicians, managers and primary care providers. The program had three residential sessions. Learning is supported though face-to-face workshops, on-line learning, readings, peer conversations, leadership experiments and reflective practices. The initial phase of the program delivered by NZLI removed participants from their day to day working environment so they could apply themselves to a learning mindset and a series of leadership activities.

A mid-program evaluation conducted in early 2010 revealed unanimous enthusiasm for leadership development in general and strong support for the program from both participants and non-participating senior executives alike. The evaluation

indicated benefits already accruing to the organization including more networking

and relationships that brought changes in attitudes and improved relationships

between primary and secondary providers (Marinelli-Poole & McGilvray, 2010).

Some key learnings from the evaluation included:

> People felt valued because they had been accepted into the program.
> Few people were emotionally prepared for the depth of personal learning they
> were called to do but the benefits with respect to self awareness and
> confidence were highly valued.
> The program challenged the "patch advocacy" by widening people's
> perceptions of issues.
> Creating new networks and relationships reduced impediments to change. For
> instance, hospital clinicians felt a lot less threatened by the Government policy
> of devolution from hospital-run services to the community.
> Entrenched attitudes between primary health and secondary care participants
> that were evident at the beginning of the program mellowed over the learning
> period creating new opportunities for relationships and dialogue.

The next iteration of the leadership program is now under development for 2011-

2012 and the intent is to intensify leadership development by integrating it within day

to day action in the organization. Conceptual learning will continue to form part of

the program, but more attention will be given to bringing leadership to life within

context. This new phase will be supported by the creation of the new centre for

health services innovations within CMDHB, with its Maori name of Ko Awatea. The

centre has been formed through a new partnership among CMDHB, the University of

Auckland, Manukau Institute of Technology, and the Auckland University of

Technology. Ko Awatea is scheduled to open in early 2011 and will primarily focus

on:

- developing leaders of the future, especially clinicians
- creating a workforce that reflects the ethnicity of the community
- improving clinical care and new models of care
- linking healthcare research and best practice to foster continuous quality improvement.

CMDHB sees leadership development as fundamental to addressing its challenges and achieving its far reaching goals. Among its challenges are a major population increase, a high incidence of long term conditions related to socio-economic deprivation and the current ratios of health professionals to patients that are below national averages. Based on the projected growth in service demand, CMDHB will need to double its workforce over the next 15-20 years. The priority being placed on leadership development will be supported by Ko Awatea with respect to workforce development, education and learning, research and innovation and quality improvement. The intent is to strengthen the leadership development program by greater engagement in "real work". A strategy to ensure connection to real work, is to have leadership development program participants engage in action projects within their own organizational units The planned first year of the revised program will blend the work of relational and adaptive leadership (complexity leadership), quality improvement tools and systems skills development using material from the Oxford Centre for Health Transformation. The intent of the second year will be to build capacity into CMDHB to deliver this program with NZLI moving more to an affiliated partnership. The hope is to develop a program that can be delivered to a national and potentially international audience. These developments have received a strong endorsement from HWNZ (Marinelli-Poole & McGilvray, 2010).

Leadership Development in Canterbury

The Canterbury District Health Board (CDHB), located on the South Island, is the second largest DHB in New Zealand serving a population of 500,000 or 12 % of the population of New Zealand. Like Counties Manakau, Canterbury's population is growing and aging. Total population is expected to grow by 15% by 2012 and the percentage of people over 65 is projected to increase from 13 to 18 % in that same time period with an even more rapid increase in the 85+ group. CDHB provides both a wide range of services for its residents and several specialty services are offered on a national basis. CDHB is the largest employer on the South Island with approximately 9,500 employees across 14 hospital and numerous community sites (Marinelli-Poole & McGilvray, 2010).

CDHB has recognized that past efforts to bring about major system change have often had poor success with the result being increased pressure on scarce resources. The recent Global Financial crisis has heightened interest in the need to effect major change and to do that there is now a strong conviction that they must have leaders who can inspire and champion change (Marinelli-Poole & McGilvray, 2010).

At the heart of the new approach to develop transformational change is work being done on the Leadership Capability Framework. Past efforts to use frameworks from vendors and industry bodies have had only limited success often because of inconsistency among the frameworks and often inflexibility in trying among the different perspectives. Accordingly, CDHB has initiated a new process to improve

leadership while raising both performance and the readiness/capacity for change (Marinelli-Poole & McGilvray, 2010).

Clinical leadership is seen as vital to effect transformation and this is being viewed as far more than creating new hierarchical structures or putting clinicians in charge. There is a recognized need to empower clinical leaders to initiate and promote positive change and to make available the best tools from other industries. This is being pursued with a philosophy to encourage a greater sense of partnership across primary, secondary, community, and non-government organizations in the delivery of services. There is also a changing dynamic between managers and clinicians (of all professions) to develop more shared responsibility for both clinical and financial outcomes (Marinelli-Poole & McGilvray, 2010).

CDHB has put in place a number of key initiatives to support leadership development and these include:

- **2020 –** a shared vision process across the whole system involving clinicians and managers;
- **Improving the patient journey –** a focussed program around the patient experience which places high value on the patients' time, and therefore seeks to minimize wasted time;
- **Canterbury Initiative** – a process that brings together clinical leaders and managers from hospital and primary care so they can redesign care processes together;
- **Xcelr8 –** a leadership and management training program where key clinical leaders and managers train together to identify opportunities for improvement using LEAN principles. This encourages inter-disciplinary collaboration and engagement and all this work ties back to the patient journey (Marinelli-Poole & McGilvray, 2010).

CDHB has developed a major focus on quality and safety which is led from the top of the organization with an articulated strategic plan. The formal leadership structure ensures inclusion of clinical expertise at all points of decision makers – as active participants as opposed to advisors. This reinforces the importance of engaging clinical leaders and creates opportunities to develop their leadership skills (Marinelli-Poole & McGilvray, 2010).

Much work is still to be done in developing the training programs for the health professional in a leadership role. In this respect, CDHB is working with other partners across the South Island (several other DHBs are included here) in the development of a Leadership Capabilities Framework. The framework has been developed in the context of the workforce using principles of transformational leadership. CDHB's emphasis on clinical leadership has in part been drawn from the work done by McKinsey & Company for the NHS (Marinelli-Poole & McGilvray, 2010). The work done by McKinsey and Co. defines "clinical leadership" as follows:

> It is putting the clinicians at the heart of shaping and running clinical services, so as to deliver excellent outcomes for patients and populations, not as a one-off task or project, but as a core part of the clinicians' professional identity (Mckinsey, 2008. p.3).

The CDHB Leadership Capabilities Framework has nine dimensions, with seven levels in each, applicable to all individuals in the health workforce as follows:

1. Display self knowledge
2. Establish the change imperative
3. Build relationships and mobilize support
4. Think and act strategically

5. Communicate a vision and sense of purpose

6. Empower others to act

7. Stimulate innovation and create immediate wins

8. Consolidate and continuously improve on strategic change

9. Foster a positive culture.

The seven levels within each of the dimensions progressively deal with development from an individual level (level one) to ultimately a governance/board level (level seven). Several benefits of the framework have been identified, including providing a tool to identify and promote talent, alignment with international portable qualifications, consistency with principles and values of CDHB, creation of a standard level of competence, and the promotion of innovation (Marinelli-Poole & McGilvray, 2010).

Overall, application of the CDHB Leadership Capabilities Framework provides a levelled approach across clinical and non-clinical staff, thereby allowing the identification of talent and the management of information on the capabilities of the workforce. In that the framework is really an underpinning platform, it has relevance to all staff development activity, including recruitment, performance review, talent potential and succession planning (Marinelli-Poole & McGilvray, 2010). Work continues on curriculum development to support the framework, further alignment with other DHBs, and developing longitudinal research to assess the frameworks impact in terms of leadership capacity for system wide change (Marinelli-Poole & McGilvray, 2010).

Similarities within differing approaches

There are clearly some common features between the leadership development approaches being taken by the two DHBs reviewed here: These include a focus on quality improvement; changing the dynamics between clinicians and managers; integration of primary and secondary care; the move to multidisciplinary teams; and, a focus on clinical leadership. However, it is evident that the leadership development is really a means to an end, with the end being improved system performance and patient outcomes. So the way to achieve this end is being approached somewhat differently in both DHBs with the new HWNZ monitoring the situations closely. CMDHB has designed a series of interventions across management and leadership levels from front line to executive coaching emphasizing "leadership as a practice approach." CDHB has tied its initiatives much more to HR practices around the use of the Leadership Capability Framework. Both DHBs are attracting interest from other DHBs. The CMDHB is working with other DHBs on the North Island and CDHB is working with other DHBs on the South Island (Marinelli-Poole & McGilvray, 2010).

Lessons from New Zealand

There are four prominent learnings from New Zealand:

1. Leadership development needs to be linked directly with health system improvement in such a way that leadership development program participants and the organizaitonal units they come from, can see the immediate relevance of leadership initiatives in their day to day work;

2. A focus on leadership development for clinical leaders is critical to success in achieving health system changes and this means new relationships between the clinicians and their non-clinical manager colleagues and a stronger commitment to interprofessional models;

3. Having an agreed upon Leadership Capabilities framework can provide a cohesive focus on leadership development across differing professional groups; and

4. Building on experiences of health districts can serve to create a platform to create a national approach to health leadership development. At the time of writing, the new New Zealand Institute of Health Leadership is being implemented by the new Health Workforce New Zealand agency. The intent is that this new Institute will create four training hubs to manage leadership development consistent with the direction to have DHBs collaborate and plan regionally (B. Wraight, personal communication, January 17, 2011).

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The premise of this paper is that there is a particular imperative in universal publicly funded health systems to develop increased capacity to effect health system change. These systems reflect societal and corresponding political convictions that health care should be there to support all citizens based on their health needs. However, the continual growth in resource requirements by these systems comes at the expense of other social and political priorities. Sustaining the commitment to universal health systems is very dependent on demonstrating that these systems are operating effectively and efficiently and that they have the capacity to continually make system improvements. Sustainability of these systems cannot be achieved by complacency around the status quo. In that these systems are dependent on taxpayer support and political support, the sustainability of these systems is directly related to the capacity to increase productivity, to reduce duplication and waste, and to maximize patient outcomes. The positive note is that reduction of waste and duplication are key targets for quality improvement programs as well. Without increasing the capacity to generate system change, there is a significant danger that political will may be lost to maintain a universal publicly funded system. To some that scenario may seem unlikely as there is widespread research to demonstrate that publicly funded systems operate more effectively than private systems. However, that

argument may be inadequate to maintain political support because the higher cost of a private system to society as whole still means less funding commitment by Government and the taxpayer. So to a sick taxpayer, it makes sense to pay more taxes to maintain the public system, but for the majority of people, who are not in immediate need of the health services, they may want to take their chances on paying less in taxes now, hoping their future health bill cost will not be a problem for them. So the argument being made here is that there is a particular imperative for universal publicly funded systems to create the capacity for system renewal and change.

The second premise of this paper is that creating the capacity for system renewal and change is really a question of leadership capacity. So if the desire is to move the current system to a new state and to keep ongoing improvement alive, much greater attention needs to be given to leadership development than in the past. In effect, leadership development is a means to an end and not the end in itself. The end point is a highly productive and effective health system. Furthermore, in health care, low quality in service and patient outcomes do not generate savings as they simply create another round of demands on the system.

So the question that stimulated this study was how we can increase leadership capacity in Canada. The author's personal involvement with the development of the Canadian Heath Leadership Network (CHLNet) over the past five years has certainly heightened this interest. While CHLNet seems to be gaining some traction in Canada, many questions remain on how to develop effective leadership development strategies and what role can CHLNet serve in that respect. The decision was made to look at leadership development strategies in other universal publicly funded health systems to

learn what might inform future leadership development in Canada. One might question why only look at universal publicly funded systems, and the rationale for that was twofold. First, these systems all share similar values and, in particular, they cannot increase quality and productivity by sacrificing access. Second, publicly funded systems all have difficulty in generating political/taxpayer support to invest in matters that are not seen to be directly related to the provision of health services. So if lessons are going to be applicable to the Canadian situation, then these systems might serve as a good starting point for comparison.

In reviewing the leadership development situation in England, Australia, Sweden and New Zealand, five major themes emerge that should be of value to leadership development in Canada, including the further development of CHLNet. These five themes are:

- The link between leadership development and organizational culture;
- The need to embed leadership development within health system operations;
- The effective use of leadership capability frameworks in leadership development programs;
- The importance of clinical leadership; and
- The value of organizational stability and continuity in building and sustaining leadership capacity

The Link between Leadership Development and Organizational Culture

In that the ultimate goal of leadership development is to increase capacity for health system change to effect improved performance, the real challenge is to nurture and change the culture of health organizations. This requires some fundamental thinking about who really is the target of leadership development. In this respect, there appears to be a continuum of views and approaches. At one extreme, there is the view that leadership development is for all staff, and developing leadership skills is critical for everyone in the organization regardless of their formal role or responsibilities. The premise of this view is that everyone needs to be on the constant lookout for how to carry out their functions more efficiently and effectively. This view really underpins the importance of change at the micro-system level starting at points of interaction between providers and patients and then working the implications through at other levels. What is called for is the development of a learning organization where all staff members see the search for improvement and better outcomes as part of their professional identity. The other extreme is to view leadership development as being of particular significance for managers and senior leaders as they must drive change and renewal. This approach tends to lead to selecting particular people seen to have potential and investing in their leadership development. The extrapolation of this view is that these selected people in turn will lead and enable developments in the organization, to engage all staff to effect a change in organizational culture. In reality, all leadership initiatives reviewed represented a combination of these views although the amount of emphasis on each view varied.

Jonkoping stands out as subscribing to the philosophy that everyone is a leader and the goal is to develop the leadership skills of all staff so they can all be process and outcome improvement leaders. The approaches in England and New Zealand tend to lean to the other extreme where targeting is occurring with managers and potential managers to develop leadership skills. Yet, when one considers the excellent performance in Jonkoping, serious thought needs to be given to the advantage of creating a learning organization as opposed to investing in a few people.

Embedding Leadership Development in Systems Operations

While the goal of all leadership development programs is to increase capacity to effect health system change that will increase productivity and improve patient outcomes, the linkage between leadership development and health system change varies greatly. Again there are shades of gray here, but it appears that Jonkoping, the NHS in England, and to a certain extent the Canterbury District Board in New Zealand, have embedded leadership development as part of health system change initiatives. Of particular note is that all countries reviewed have embedded leadership development within quality improvement initiatives. Moreover, the quality improvement initiatives are closely intertwined with the ongoing health system operations. This approach increases the sustainability of leadership development, as it is less likely to be seen as an administrative add-on cost.

Leadership Capabilities Framework

There are clear differences among the countries studied in the importance attached to Leadership competency frameworks. The NHS in England has placed emphasis on this, as has the Canterbury District Board in New Zealand. In contrast there is virtually no discussion of this in Jonkoping, Sweden, the Counties Manakau Board in New Zealand and only minimal reference to this in Queensland Health, Australia. Also interesting is that the organizations using this approach are quite passionate about it, while those not using it seem quite indifferent to the concept. Yet, when you begin to drill down in the capability frameworks themselves and select particular behaviours, the organizations not using a framework will generally say they are covering those things. So the question that emerges is whether the leadership frameworks are simply a way to capture general concepts that would be covered in any case, or do they in fact focus the leadership development activity. But more important is that leadership capabilities need to become real as part of leadership development activities that are linked to real priorities for change in the health care organizations.

Clinical Leadership

A strong and consistent message from the experience in each of the other countries studied is that clinicians need to be directly involved in leadership if health system change is going to occur. This is a major emphasis in England, Jonkoping County in Sweden, Queensland in Australia and in New Zealand. The biggest learning to achieve is to have clinicians see leadership and change as a fundamental

part of their professional identity. This requires a concerted focus as clinicians are educated in a discipline with a patient, not health system, perspective.

Leadership and Organizational Stability

Another lesson emerging, which at first glance appears contradictory, is that organizational stability may be a pre-condition for real system change. The pattern in Canada, as in many other countries and certainly with the NHS in England, is that political will to accomplish health system renewal is usually translated into action by initiating massive organizational restructuring. However, here the lessons from Jonkoping are instructive. First, at an organizational structure level there appears to have been very little change over the past two decades, and in fact, the senior leadership team has had a very long tenure. Second, the focus in the organization is on micro-systems – the points at which the health professionals provide services to patients. The stability in organizational form and in the senior leadership team has led to sustained initiatives in the area of patient processes and quality improvement. The results in Jonkoping are excellent as has been noted in this report.

On reflection, the conclusion can be reached that the political level and senior health system managers in Canada resort to organizational structural approaches as it is the only thing they have direct control over. So, legislation can be changed, delegation of responsibilities can be altered, and the associated organizational structure can be modified relatively easily. However, the question that arises is whether or not this is really only a distraction from the real change that is necessary. By having leaders and managers deal with the aftermath and implications of structural

change, energy and resources get pulled away from the micro-systems that need nurturing to effect process improvement.

RECOMMENDATIONS

One of the objectives of this project is to make recommendations from lessons learned from other countries to help shape the future development of CHLNet. The following recommendations are put forward based on the conclusions noted above.

1. While the developmental work on CHLNet has recognized the importance of distributed leadership and that everyone is a leader in some ways, there is much work to be done to make CHLNet products and services available to support the learning needed within health organizations to support health system change.

   To move in this direction, it is recommended that CHLNet seek opportunities to work directly with health care organizations to both assess the efficacy of tools developed to date and to inform future product development. As a network and resource portal, CHLNet should engage with other program delivery partners (management consulting firms, academic programs, etc.) in working with the health organizations. From this experience within health care organizations, CHLNet could begin to activate the development of curricula, resource materials and other tools to assist organizations in developing their staff to effect system change.

2. Related to the above is a key message that needs to be further developed, conveyed and advocated by CHLNet - that leadership development must be embedded at all levels within health care organizations. The lessons from other countries reviewed point to the potential of embedding leadership development within quality improvement initiatives. While considerable efforts are underway in each province on quality improvement, both within the health delivery organizations themselves and at the provincial level with Quality Councils, there may be significant opportunities to integrate leadership development within these initiatives. This will require making the case that leadership development is critical to increasing the capacity for health system change and that resource commitment in this area will yield health system improvements. CHLNet needs to convey this message at the Federal/Provincial/Territorial level, provincial level quality councils and directly with health care delivery organizations. The recommendation made in #1 above will serve to reinforce the message if the evidence can be generated that these investments really do enable health system change. So careful documentation and accumulation of evidence on the extent of system change should be a top priority for working with health organizations.

3. The development of a Leadership capabilities framework has been a very positive step in the evolution of CHLNet to date and the commitment to refresh and update the framework over time should be a major priority of

CHLNet working with its partners. However, the experience in other countries suggests that how the framework is put to practical use within health care organizations is even more important. Because CHLNet is a network and not directly connected to the operation of the health system, there is a danger that the framework may be regarded as too academic or distant.

The only way to mitigate the above concern is to work closely with health care organizations in applying the framework in different contexts and for different purposes. For instance, evidence on how it might support recruitment, retention, and performance measurement, succession planning and quality improvement will be critical to sustaining the current high level of interest in the framework.

CHLNet should not become complacent on this and assume that the framework's apparent currency and resonance with health system leaders will continue. Bridging the framework to the workplace setting will require significant energy and commitment.

4. While CHLNet has worked with clinician organizations from the very beginning (CMA, CNA, ACEN, CSPE), the importance attached to clinical leadership in the experience of other countries points to the need for much more work in this area.

A related and equally important message is that interprofessional approaches are critical for health system improvement. Since the professional clinical organizations have a primary focus on one discipline, there is a unique role

here for CHLNet to serve a new brokering and enabling role. This role could

include taking on a role to help develop curricula with related resources and

promoting approaches to foster interprofessional clinical leadership

development. In that the CMA's current Physician Managers program is

already reaching out to other disciplines to some extent, early discussions with

the CMA would be timely to help determine how to best develop an approach

that involves all the clinical health professions.

5. As the only Canada wide organization with a sole focus on health leadership,

   CHLNet should place increased emphasis on advocacy to heighten the

   understanding between health system performance and leadership

   development. This role needs to develop carefully and must be evidenced

   based. The current PHSI project provides an excellent starting point to begin

   to gather the evidence, but a sustained commitment to leadership development

   will only be possible if evidence is gathered on an ongoing basis. This

   evidence needs to be used both to effect changes in the leadership

   development approaches themselves, as well as for the purpose of making the

   case for the linkage between investment in leadership development and health

   system performance.

   An equally important role for CHLNet is to advocate for the pre-conditions

   that will make leadership development effective. This goes well beyond

   simply arguing for more resources to support leadership development. In

   addition, CHLNet should address system wide issues that impact leadership

development such as exposing the negative implications of constant structural

change. Such a role will need to be carried out both diplomatically and with a

good use of evidence as in some respects it will run counter to the pervasive

practice of many politicians and senior leaders in government and health

authorities.

APPENDIX A: List of Acronyms Used

AC   Accreditation Canada

ACAHO   Association of Canadian Academic Healthcare Organizations

ACEN   Academy of Canadian Executive Nurses

AMS   Associated Medical Services

CADTH   Canadian Academy for Drugs and Technologies in Health

CBoC   Conference Board of Canada

CCHL   Canadian College of Health Leaders (formerly Canadian College of Health Services Executives.)

CCHSA   Canadian College of Health Services Accreditation (now Accreditation Canada.)

CCHSE   Canadian College of Health Services Executives (name was changed effective October 31, 2010 to Canadian College of Health Leaders.)

CHLNet   Canadian Health Leadership Network

CHLR   Centre for Health Leadership and Research

CHSRF   Canadian Health Services Research Foundation

CSPE   Canadian Society of Physician Executives

CMA   Canadian Medical Association

CNA   Canadian Nurses Association

CHSRF   Canadian Health Services Research Foundation

CPSI   Canadian Patient Safety Institute

EHL   Emerging Health Leaders

HCLABC	Health Care Leaders' Association of British Columbia
HEAL	Health Action Lobby
HRSDC	Federal Government's Human Resources and Skills Development Canada Department (HRSDC)
HWNZ	Health Workforce of New Zealand
NHS	National Health Services
PHSI	Partnerships for Health System Improvement
RRU	Royal Roads University

List of References