December 2012

LEADerShip at a Glance

LEADS "Top Ten" Suggested Readings[1]

Broughton, Cynthia. (2012). *Factors Contributing to the Use of 360 Assessment Feedback for Leader Development.* PhD Dissertation. Saybrook Graduate School and Research Center, Australia.

Summary

The purpose of this study was to explore the factors contributing to the use of 360 assessment feedback for leader development in an organizational setting. The 360 assessment, which is also referred to as multi-rater, multi-level, full circle, or multi-source feedback, is a tool commonly utilized in contemporary organizations to evaluate the performance of workers through feedback from coworkers, representing perspectives from a variety of vantage points. The most common application of the 360 assessment is with leaders for development and performance improvement. Effective leadership is a priority and common goal of many organizations today; thus, there is an increased commitment to developing leaders' skills and improving their behaviours. Often, leaders do not utilize the feedback provided through the use of these assessments for a variety of reasons. This exploratory study identified some of the factors that contribute to the successful use of the feedback by leaders for their development.

Focus: Optimal use of 360s for leader development.

Implications

- Certain practices are required for maximum success in using a 360 for leader developmental purposes, especially commitment to the use of a 360 for that purpose.
- Optimal use includes developing a process that addresses the psychological responses to the receipt of feedback and motivation to improve. For example, the process employed to make sense of the 360 report must pay attention to the "initial reaction of the recipient to the feedback," and the importance of a coach/facilitator for "assistance in goal setting".

Link to LEADS and CHLNet's Mission

- CHLNet, as a LEADS Collaborative member, is championing the use of the LEADS 360 for leadership development in Canadian health organizations.
- Optimal use of that tool reflects on the credibility of CHLNet and therefore its members and the partners in the Collaborative itself need to ensure that optimal use.

[1] As recommended by Dr. Graham Dickson (CHLNet Academic Advisor) and Bill Tholl (CHLNet Executive Director).

Centre for Clinical Governance Research (2010). *Network by Network: Transforming Health Care in Australasia; Lessons from "Network to Network 2010: The Inaugural Australasian Clinical Networks Conference"* (March 17-19). Melbourne: Australian Institute of Health Innovation.

Summary

This report discusses the benefits of clinical networks to facilitate health care transformation, the challenges associated with sustaining them, and the approaches that assist in effective management of networks. Topics discussed include: Development of clinical networks in Australasia; developing and maintaining effective networks (e.g. strategic issues, funding, characteristics of effective networks, network leadership); evaluating networks; consumers as partners; and how networks are contributing to improving clinical outcomes.

Focus: Developing and managing effective networks.

Implications

- CHLNet, as a network, is facing many of the challenges discussed in this paper.
- Some of the intelligence re effective networks may be applicable as CHLNet implements its second strategic plan.

Link to LEADS and CHLNet's Mission

- This article was chosen because of its direct relevance to the ongoing evolution and growth of CHLNet as a successful, highly functioning network—and the fact that it highlights the factors and actions that can be deliberately taken to enhance the potential for success.
- It is also a paper that focuses on one of the types of "coalitions" referenced under the LEADS domain of *Develop Coalitions*, and highlights the leadership challenges and skills associated with that domain.

Citaku F., Violato C., Beran T. et al. (2012). Leadership Competencies for Medical Education and Healthcare Professions: Population-based study. *BMJ Open* Vol. 2: 1-11.

Summary

The objective of this article was to identify and empirically investigate the dimensions of leadership in medical education and health care professions. A population-based design with a focus group and a survey were used to identify the perceived competencies for effective leadership in medical education. The focus group, consisting of five experts from three countries (Austria, Germany, and Switzerland), was conducted (all masters of medical education), and the survey was sent to health professionals from medical schools and teaching hospitals in six

countries (Austria, Canada, Germany, Switzerland, the UK and the USA). The participants were educators, physicians, nurses and other health professionals who held academic positions in medical education. A 63-item survey measuring leadership competencies was developed and administered via electronic mail to participants. Exploratory principal component analyses yielded five factors accounting for perceptions of effective leadership: (1) social responsibility; (2) innovation; (3) self-management; (4) task management; and (5) justice orientation. There were significant differences between physicians and other health professionals on some factors.

Focus: Competencies of Leadership in the health professions.

Implications

- Exploratory principal component analyses yielded five dimensions of leadership: (1) social responsibility; (2) innovation; (3) self-management; (4) task management; and (5) justice orientation.
- Social responsibility was rated higher by other health professionals compared with physicians, as was innovation and justice orientation

Link to LEADS and CHLNet's Mission

- This study appears to interpret leadership as the exercise of abilities related to mindset and attention, as opposed to the skills of leadership. In this sense it reinforces the *Lead Self* domain of LEADS, but does not outline skill sets associated with the other domains (even though the ethical component of LEADS that underpins the framework is clearly supported by this study).
- A common framework at a high level (e.g. LEADS) for all professions, might be prioritized differently by different professions. CHLNet members may wish to investigate these different mental models and the impact they have on collaborative endeavours to reform health care.

Dickson, G., Lindstrom, R., Black, C., and Van der Gucht, D. (2012). *Evidence-Informed Change Management in Canadian Healthcare Organizations.* Canadian Health Services Research Foundation: Ottawa (CAN).

Summary

The purpose of this project was to identify a suite of evidence-informed approaches to support change in small and large systems within the Canadian health system. Key issues that leaders and managers face in responding to and initiating change were used to identify evidence-informed approaches. A variety of theories, models, approaches, tools, techniques and instruments exist that decision- makers can effectively use to create change. These approaches need to be deliberately chosen, with attention to stage of change and context, so as to have maximum utility and impact. More attention to change readiness and change capacity prior to

initiating change is suggested. More formal learning regarding change in the four key areas of preparing for change, implementing change, spreading change, and sustaining change would be of benefit to decision-makers. Developers of university credit and non-credit professional development programs are encouraged to make the study of change a prominent feature in their curricula. National and provincial agencies are encouraged to develop a support platform devoted to leadership development in support of change in the Canadian health system (online access to tools and direct access to expertise). While using approaches to change is useful, increased attention to conceptualizing change would likely lead to more effective implementation and results.

Focus: Evidence-informed change models for the Canadian context.

Implications

- Health reform in Canada requires contemporary health leaders to have a skill set to lead and integrate change into their organizations that is evidence-informed.
- There are evidence-informed approaches to change that will assist leaders in being successful; therefore tools, approaches, and programs should be made available to support the learning of those approaches.

Link to LEADS and CHLNet's Mission

- Supports *the LEADS in a Caring Environment* framework's emphasis on the qualities of leadership required to create change in the health sector in Canada.
- Provides an opportunity for CHLNet to take a leadership role in the upcoming NCE knowledge mobilization contest, and to cohere, within its network, the evidence-informed tools, approaches and models that will support leaders in change.

Doll, M., Harper, G., Robles-Schrader, G., Johnson, J., Bangi, A., Velagaleti, S., and The Adolescent Medicine Trials Network for HIV/AIDS Interventions. (2012). Perspectives of Community Partners and Researchers About Factors Impacting Coalition Functioning Over Time. *Journal of Prevention & Intervention in the Community* Vol. 40. No. 2: 87-102.

Summary

This study explored organizational and contextual factors impacting coalition functioning across 15 community–researcher coalitions that were formed to lower rates of HIV among youth. Mixed-methods (qualitative and quantitative) longitudinal data were collected from both community partners and researchers across three time points, and were analyzed to assess factors associated with initial coalition development and functioning. Specific facilitators of coalition functioning over time included developing group trust and cohesion, creating diverse coalition membership, developing a shared vision, and ensuring clarity of coalition purpose and goals. Specific barriers to coalition functioning over time included experiencing a lack of clarity

over member roles and responsibilities, balancing power/resource dynamics between researchers and community partners, balancing coalition building and coalition pace, and experiencing HIV/AIDS-related stigma. Recommendations are offered for how to develop and sustain successful community–researcher coalitions over time in order to address relevant social issues.

Focus: Factors that enhance community partnerships for health purposes—e.g. public health.

Implications

- The importance of deliberately and systematically building the factors that make coalitions successful over time.
- Providing a lens to recognize those pitfalls and factors that are the cause of unsuccessful coalitions in a community, public health context.

Link to LEADS and CHLNet's Mission

- Supports the importance of, and informs the practice of, the *Develop Coalitions* domain of the *LEADS in a Caring Environment* capabilities framework.
- Emphasizes the importance of developing coalition building skills to realize the *Better Leadership, Better Health—Together* vision of CHLNet.

Health Workforce Australia. (2012). *DRAFT Health LEADS Australia—Consultation for an Australian health leadership framework* (27 October). Health Workforce Australia: Melbourne (AUS).

Summary

Health Workforce Australia has been charged with the responsibility of developing a nation-wide leadership development strategy. As the first component of that strategy, they determined the need for a competency framework upon which all leadership programming would be based. A year-long consultative process to determine the contents of that framework was begun in January 2012. In September 2012, after having reviewed competency frameworks from around the world (including the UK and Canadian LEADS model), the decision was made to adapt the Canadian LEADS model to fit the Australian priorities in leadership. This document outlines the rationale for, the principles underpinning, and the contents of the proposed framework. Four of the five domains are very similar to Canada's LEADS; the primary departure that in the Australian framework the D stands for Drives Innovation, while in LEADS Canada it is *Develop Coalitions*. HWA is now in the final stages of consultation with the health communities in Australia to finalize the document.

Focus: National leadership competency frameworks.

Implications

- *LEADS in a Caring Environment* is very reflective of health leadership priorities in developed nations. There is power in the LEADS acronym as a "knowledge mobilization" tool in terms of engaging decision-makers with leadership research.
- Leadership is a high priority in other developed nations; CHLNet's mandate and goal are important.

Link to LEADS and CHLNet's Mission

- This initiative validates the Canadian model to a great extent and shows its quality as both an exemplar internationally, but also as an accurate expression of the qualities of leadership required in the health sectors of developed nations.
- The HWA enterprise—represented by this article—may well spawn a similar entity to CHLNet in Australia, which would both validate CHLNet's aspirations in Canada, but also be a source of further knowledge and opportunities for knowledge transfer and sharing.

Kaplan, R.S. and Norton, D.P. (2008). *The Execution Premium: Linking Strategy to Operations for Competitive Advantage.* Harvard Business School Publishing Corporation. 320 pages.

Kaplan and Norton, co-authors of the path-breaking *Balanced Scorecard* performance measurement system (1992), reflect on best practices for linking strategy and operations. In this self-contained, comprehensive volume, they reaffirm their five basic management principles: *(1) Mobilize change through executive leadership; (2) Translate strategy into operations; (3) Align organization to strategy*; *(4) Motivate to make strategy everyone's job; and (5) Govern to make strategy a continual process*. The authors provide a variety of case studies and helpful templates from both the for-profit and not-for-profit sector to demonstrate the importance of setting clear and compelling vision: one that sets "...ambitious targets for the strategy, including a clear measure of success and a specific time horizon for achievement" (p41). They underscore the importance of accelerating and embedding the needed changes in strategic management systems (i.e. principles 4 and 5) to secure performance improvements for the longer term. They observe that with more frequent changes at the top, the momentum for change is often lost. The book emphasizes the need to "make strategy a continual process", not just an event. They stress the need for strong employee engagement sooner than later and on an ongoing basis in order to become a "Strategy-Focused Organization". They describe and assess the "proliferation" of strategy and operational tools (e.g. SWOT, MBO, TQM) and provide suggested ways and means to make the best use of these tools. They stress the need to focus on just a few, key measureable targets to effectively bridge strategy and management and led by a small, but dedicated group of managers to sustain change.

Focus: Comprehensive treatment of best practices in linking strategy and operations.

Implications

- The importance of strategy as a focus of an executive leader's time, as opposed to an operational focus.
- Effective strategy and execution depends on quality measurable performance measures to guide and course correct toward strategic imperatives.

Link to LEADS and CHLNet

- Provides a methodology re strategy relative to the *Achieve Results* domain of LEADS; and relates it to the increasingly complex, unpredictable environment of change (*Systems Transformation).*
- Member organizations of CHLNet are looking for leadership practices to maximize productivity through efficient methods; this approach emphasizes the importance of acting (execution) in a disciplined way to do so.

Kotter, John. (2012). Accelerate. *Harvard Business Review* (November): 45-58.

Summary

This article reinforces the challenges modern hierarchical health organizations face in their efforts to reform. Although traditional hierarchies and processes—which together form an organization's "operating system"—are optimized for health operations, they can't handle the challenges of mounting complexity and rapid change. The solution is a second operating system, devoted to the design and implementation of strategy that uses an agile, network-like structure and a very different set of processes. The new operating system continually assesses the clinical processes, the health industry itself, and the specific organization that is part of that system and reacts with greater agility, speed and creativity than the existing one. It complements rather than overburdens the hierarchy, thus freeing the latter to do what it is optimized to do. It actually makes service delivery easier to run and accelerates strategic change.

Focus: Strategic leadership of health reform.

Implications

- Reinforces the notion that the pace and rate of change in the health sector requires different models of strategic leadership, models that recognize that speed of change but also the complexity of the system in which health organizations sit.
- Suggests that "seasoned" leaders brought up in traditional systems, and new leaders, should be actively involved in defining what that leadership looks like and how it takes strategic expression in modern health organizations.

Link to LEADS and CHLNet's Mission

- Directly applicable to the understanding of, and operationalization of, the *Systems Transformation* domain of *LEADS in a Caring Environment*.
- Provides a framework or lens for further discussion amongst CHLNet members as to what such strategic innovations might in fact look like in health care.

Mann, D. (2009). The Missing Link: Lean Leadership. *Frontiers of Health Services Management* Vol. 26, No. 1: 15-26.

Summary

People often equate "Lean" with the tools that are used to create efficiencies and standardize processes. However, implementing tools represents at most 20% of the effort in Lean transformations. The other 80% of the effort is expended on changing leaders' practices and behaviours, and ultimately their mindset. Senior management has an essential role in establishing conditions that enable that 80% of the effort to succeed. Their involvement includes establishing governance arrangements that cross divisional boundaries, supporting a thorough, long-term vision of the organization's value-producing processes, and holding everyone accountable for meeting Lean commitments. This is accomplished through regular, direct involvement. When upper management sets the example, durable Lean success and increasingly Lean leadership mindset follow.

Focus: The link between leadership and Lean reform.

Implications

- Lean is a technical solution that demands leadership in order for it to be successful as an intervention and, in particular, for it to be sustained in a culture of continuous improvement.
- How able senior leaders are to change their ability to change behaviour so as to model the input, cross-collaboration and accountability skills required for Lean to be successful, will determine whether or not Lean improves organizational effectiveness.

Link to LEADS and CHLNet's Mission

- Many member organizations of CHLNet are using Lean as a vehicle for health service reform. An equal emphasis on leadership development is necessary for such innovations to succeed.
- Lean is a tool for change that can be used to "champion and orchestrate change"—a LEADS *Systems Transformation* capability. However, the other domains of LEADS are necessary for it to be successful.

Squires, M., Tourangeau, A., Spence Laschinger, H. K., and Doran, D. (2010). The link between leadership and safety outcomes in hospitals. *Journal of Nursing Management* Vol. 18: 914-925.

Summary

The purpose of this study was to test and refine a model examining relationships among leadership, interactional justice, quality of the nursing work environment, safety climate and patient and nurse safety outcomes. The quality of nursing work environments may pose serious threats to patient and nurse safety. Justice is an important element in work environments that support safety initiatives yet little research has been done that looks at how leader interactional justice influences safety outcomes. A cross-sectional survey was conducted with 600 acute care registered nurses (RNs) to test and refine a model linking interactional justice, the quality of nurse leader–nurse relationships, work environment and safety climate with patient and nurse outcomes. In general, the hypothesized model was supported. Resonant leadership and interactional justice influenced the quality of the leader–nurse relationship which in turn affected the quality of the work environment and safety climate. This ultimately was associated with decreased reported medication errors, intentions to leave and emotional exhaustion.

Focus: The link between leadership and safety outcomes in hospitals.

Implications

- Quality relationships based on fairness and empathy play a pivotal role in creating positive safety climates and work environments.
- Nurse managers should advocate for safe work environments, managers must strive to develop high-quality relationships through just leadership practices.

Link to LEADS and CHLNet's Mission

- The study reinforces some of the capabilities of the *Engage Others* domain of the LEADS framework, especially "Contributes to the creation of a healthy organization" capability.
- Better leadership leads to better health outcomes: this study reinforces the fundamental premise of the CHLNet mission.