May 2015

LEADerShip at a Glance

CHLNet's "Top Ten" Suggested LEADS Readings[1]

Accreditation Canada. (2014). *The 2014 Canadian Health Accreditation Report: Building a stronger health system through leadership*. Accreditation Canada: Ottawa, ON.

Focus: Commitment from leaders to improve quality and safety of health care in Canada: Accreditation Canada data.

This report highlights leadership findings from surveys of Canadian organizations participating in Accreditation Canada's Qmentum program. It is the first such report to provide insight, in light of AC's leadership standards, of the state of health leadership in Canada. Of significant note were the following findings:

- Health care leaders recognize the importance of assessing and improving client flow throughout the organization. They also consider the health status of the communities they serve during the planning and delivery of services, and recognize the importance of effective allocation of financial resources.
- Opportunities for improvement in leadership include ensuring that services are delivered and decisions are made according to organizational values and ethics; the need to consistently conduct exit interviews to improve performance, staffing, and retention; and the need for more effective management and mitigation of risk.
- Patient safety culture results indicate a need for strong support from senior and supervisory leadership.
- Work-life results identified a need for senior management to better communicate organizational goals and act on staff feedback.
- Leading practices were identified in the areas of leadership evaluation, strategic planning, and mentoring.

Implications

The implications are two-fold. Accreditation data provides a window into the quality of leadership as practiced in health organizations in Canada, and has the potential for improving our discourse in that field. Second, such data clarifies some of the strengths and areas for improvement that leaders can explore for their own organization's development.

Link to LEADS and CHLNet's Mission

Accreditation Canada is a rich source of evaluation data that can provide a read on the state of leadership in health organizations in Canada. As such, its broad findings will help shape and improve CHLNet's subsequent research agenda and its knowledge mobilization function.

[1] As recommended by Dr. Graham Dickson (CHLNet Senior Policy Advisor) and Kelly Grimes (CHLNet Executive Director).

Birken, S.A., Lee, S.Y., Weiner, B.J., Chin, M.H., Chiu, M. and Schaefer, C.T. (2015). From Strategy to Action: How Top Managers' Support Increases Middle Managers' Commitment to Innovation Implementation in Health Care Organizations. *Health Care Manage Rev*, 40(2): 159-168.

Focus: How senior leaders maximize commitment of mid-management when championing innovation and change.

Evidence in the leadership literature suggests that top managers' support (or lack of) influences, either positively or negatively, the degree of commitment that middle managers bring to innovation implementation. This study used a mix-methods approach (survey and interviews of 120 middle managers) to try and identify what top managers do that supports middle management commitment to innovation implementation. Results suggest that top managers increase middle managers' commitment by directly conveying to middle managers that innovation implementation is an organizational priority; allocating implementation policies and practices including performance reviews, human resources, training, and funding; and encouraging middle managers to leverage performance reviews and human resources to achieve innovation implementation.

Implications

The study suggests that deliberate, targeted tactics carried out by senior leaders can maximize the potential commitment of mid-managers to effective implementation of change and innovation. While many of the findings are almost "common sense", it then raises the question as to why commitment may be an issue in some organizations when in fact the practices known to be effective are well understood. Why do leaders not do what they know to do to be effective?

Link to LEADS and CHLNet's Mission

Better leadership requires not just an understanding of what is effective, but behaviour consistent with that understanding. The *Leadership and Health System Redesign* project, conducted by CHLNet under the auspices of a PHSI grant over the past four years, identified the very issue of mid-management commitment to innovation as an issue; and identified too that effective communication by senior leaders was a major factor in whether or not they supported the change. This study confirms that finding.

Chapman, A.L.N., Johnson, D., and Kilner, K. (2014). Leadership styles used by senior medical leaders: Patterns, influences and implications for leadership development. *Leadership in Health Services*, 27(4): 283-298.

Focus: An insight into the preferred styles of doctors in leadership roles.

The purpose of this study was to determine the predominant leadership styles used by medical leaders and factors influencing leadership style use. Clinician leadership is important in health care delivery and service development. The use of different leadership styles in different contexts can influence individual and organizational effectiveness. In this instance the six leadership styles proposed by Daniel Goleman, as a consequence of his emotional intelligence work, were explored.

A questionnaire was sent to 224 medical leaders in acute hospital trusts and six in-depth "critical incident" interviews were conducted. Leaders used a range of styles, the predominant styles being democratic, affiliative and authoritative. Although leaders varied in their decision-making authority and

consultative tendency, virtually all leaders showed evidence of active leadership. Organizational culture, context, individual propensity and "style history" emerged during the inductive analysis as important factors in determining use of leadership styles by medical leaders.

Implications
Numerous studies have been done recently that argue for more and better physician leadership if health care reform is to occur. This paper outlines the preferred practices of physician leaders as identified in a UK setting; and shows the value of providing guidance and development to physicians to enhance their ability to use the preferred styles.

Link to LEADS and CHLNet's Mission
The newly named Canadian Society of Physician Leaders (formerly CSPE) and the CMA are important partners in CHLNet. This information may well be of value to them as they support the development of physician leaders across Canada.

Checkland, K. (2014). Leadership in the NHS: Does the Emperor have any clothes? *Journal of Health Services Research & Policy*, 19(4): 1-4.

Focus: The problems with too much of a focus on leadership as opposed to management.

In this paper the author explores the rise of the concept of "leadership" in the English NHS, highlighting the similarity with a previous shift from (bad, old) "administration" to (good, new) "management". She takes a critical look at this discursive shift and highlights some of the overblown claims (her words) made for the value of "clinical leadership". She also argues that, rather than turning all NHS staff into leaders, an effort should perhaps be made to tone down the level of leadership rhetoric and instead emphasize the need for a service full of good followers who will maintain a relentless focus on care, quality and efficiency.

Implications
In our zeal to emphasize the qualities of leadership needed to facilitate effective health reform, it is important to recognize that a basic command of management skills is also required in order for any program or service to be delivered efficiently and effectively.

Link to LEADS and CHLNet's Mission
CHLNet and its partners promote the use of LEADS as a "common language" for leadership to be used across Canada. This study argues that an emphasis on leadership alone, without linking its practice to the skills of effective management, will not necessarily result in productive health reform.

Dickson, G., Mutwiri, B. and Blakely, B. (2015). *The Symbiotic Relationship between Lean and LEADS*. Canadian Health Leadership Network. Ottawa: ON.

Focus: The strong link between Lean and LEADS.

In Saskatchewan, the Ministry of Health (MOH) and individual health authorities (HAs) have endorsed the *Lean management process* to accomplish the twin goals of improving health system effectiveness and efficiency in delivering high quality patient care. In tandem, HAs are using the *LEADS in a Caring*

Environment capabilities framework as a common leadership language to guide leaders in understanding how to implement change effectively. This paper shows how the two processes are both conceptually and practically linked. In other words, management staff will not be successful in introducing and sustaining Lean methodologies without a commensurate behaviour change similar to, and consistent with, the leadership capabilities of the LEADS framework. Based on their experience with both Lean and LEADS, the three authors provide an overview of how the two initiatives are inextricably linked.

Implications
Lean is a popular tool in Canada for generating innovation for continuous improvement of health service delivery. However, its effectiveness is ultimately determined by the ability of formal leaders to adjust their behaviour so as to be in sync with the discipline of Lean. The strong connection between leadership and management style, and Lean, and the relevance of LEADS in terms of appropriate leadership and management behaviours, suggests that it can be used to assist in Lean implementation.

Link to LEADS and CHLNet's Mission
CHLNet endorses LEADS or LEADS-compatible leadership competency (or capability) frameworks as essential for effective leadership of innovation and change. This paper suggests that the long-term sustainability of a popular tool for innovation – Lean – is enhanced if implemented in concert with the leadership frameworks endorsed by CHLNet.

Goodall, A.H., Bastiampillai, T., Nance, M., Roeger, L., and Allison, S. (2015). Expert leadership: Doctors versus managers for the executive leadership of Australian mental health. *Australian & New Zealand Journal of Psychiatry,* 49(5): 409-411.

Focus: Do doctors make better leaders?

This study asks if physician-leaders, with the combination of Can MEDS management and other professional skills, contribute to better performance by health services, including psychiatry. The authors discuss "the theory of expert leadership", a theory that proposes the existence of a first-order requirement – that leaders should have expert knowledge in the core-business of the organizations they are to lead, holding constant management and leadership experience. The theory also holds that expert knowledge is not a proxy for management or leadership skills. The authors propose an argument in support of the theory; but also say that it should be the subject of further scholarly examination.

Implications
The argument, if true, would have significant implications for the choice of executives for leadership positions in Canada: physicians in senior roles would be sought out as preferable candidates.

Link to LEADS and CHLNet's Mission
There is an active debate in many circles in Canada as to whether or not doctors should be preferred to take on senior executive roles. This study contributes to that debate. However, another of its arguments – that leadership and management does not have inherent expertise in its own right – is potentially a dangerous argument to make as it can imply that there is no skill base to the practice of leadership and management.

Gregersen, S., Vincent-Höper, S., and Nienhaus, A. (2015). Health-relevant leadership behaviour: A comparison of leadership constructs. *German Journal of Research in Human Resource Management*, 28(1-2): 117-138.

Focus: The link between leadership constructs and employee health and wellness.

This study examines the statistical analysis of correlative relationships, i.e. between five leadership constructs and indicators of positive and negative employee well-being. The five models of leadership were the consideration model, initiating structure model, transactional leadership, transformational leadership, and leader-member behaviour. The sample consisted of 1,045 health care workers. The researchers conducted relative weight analyses and hierarchical regression analyses in order to identify the best leadership predictor for employee well-being. Their analyses reveal that all leadership constructs had a positive relationship to employee well-being, but that the leader-member exchange best predicts most of the well-being indicators. The other leadership constructs fail to add substantial additional variance.

Implications

The findings advance understanding of how leaders can enhance employee well-being. One major implication is that leader-member exchange construct, like the other constructs, is predicated on the opportunity for the leader and employee to have a reasonable opportunity to have a one-to-one relationship. This condition is not met in many health care settings and therefore the findings suggest that these constructs may have little applicability to some health care settings; or it suggests that a smaller span of control is necessary if employee well-being is to be enhanced.

Link to LEADS and CHLNet's Mission

The *Engage Others* domain of the LEADS framework emphasizes, through the capability of *Contribute to the Creation of Healthy Organizations*, employee well-being is a measure of success. This study supports two notions implicit in that domain of LEADS: that certain kinds of leadership behaviour do enhance employee well-being; and second, that the individual behaviour that does so is unique to each leader-follower relationship; and therefore unique to each leader.

Rosenman, E.D., Shandro, J.R., Ilgen, J.S., Harper, A.L., and Fernandez, R. (2014). Leadership Training in Health Care Action Teams: A Systematic Review. *Academic Medicine*, 89(9): 1295-1306.

Focus: The link between leadership development programs and teams.

This study is a systematic review of key journals and articles describing leadership training interventions targeted at health care action teams, at all levels of training and across all health professions. Health care action (HCA) teams are interdisciplinary teams that often work under complex, dynamic, and time-pressured conditions to accomplish critical patient care tasks.

Fifty-two studies were reviewed. Five (10%) focused primarily on leadership training, whereas the remainder included leadership training as part of a larger teamwork curriculum. Few studies reported using a team leadership model (2; 4%) or a theoretical framework (9; 17%) to support their curricular design. Only 15 studies (29%) specified the leadership behaviours targeted by training. Forty-five studies (87%) reported an assessment component; of those, 31 (69%) provided objective outcome measures including assessment of knowledge or skills (21; 47%), behaviour change (8; 18%), and patient- or

system-level metrics (8; 18%). Determining best practices in leadership training is confounded by variability in leadership definitions, absence of supporting frameworks, and a paucity of robust assessments.

Implications
The implications are two-fold. First, the study informs practices for conduct of, and assessment of, leadership programming, which is of interest to organizations investing in leadership development. Second, it demonstrates that a coherent leadership framework – such as LEADS – underpinning curriculum is a contribution to best practice.

Link to LEADS and CHLNet's Mission
The *endorsement* of the LEADS framework, or a LEADS-compatible framework, by CHLNet members allows for sharing of curricular products and shared evaluation opportunities to determine the value add of leadership programming.

Tholl, B. (2014). Taking a value network from concept to reality: Canadian Health Leadership Network (A case study). *Healthcare Management Forum*, 27(3): 118-122.

Focus: The challenges of creating a viable leadership network (CHLNet).

This article describes, in a step-by-step way, how the value network concept has been put to work to increase leadership capacity through the Canadian Health Leadership Network (CHLNet). The three phases in evolving the network are described: start-up, value creation, and consolidation phases. This is a case study that underscores the fact that networks are best facilitated rather than administered; that trust and reciprocity are the twin pillars for sustaining any network; and that leadership without ownership can be a driving force behind the success of a value network.

Implications
Networks require collaboration between organizations that is tricky to maintain and must rely on their value proposition – and the purpose itself – to retain the loose cohesion required to be successful.

Link to LEADS and CHLNet's Mission
CHLNet is the substance of the article and it provides – from the founding Executive Director's perspective – a historical overview of how it developed to be what it is today, six years after its inception.

West, M., Armit, K., Eckert, R., West, T., and Lee, A. (2014). Leadership and Leadership Development in Health Care: The evidence base. *The Faculty of Medical Leadership and Management with The King's Fund and the Center for Creative Leadership*. 33pp.

Focus: The value proposition for leadership development as construed in NHS UK.

This discussion paper outlines the key challenge facing all NHS organizations: the challenge to nurture cultures that ensure the delivery of continuously improving high quality, safe and compassionate health care. The authors argue that leadership is the most influential factor in shaping organizational culture

and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental. But, they ask, what do we really know about leadership of health services?

The Faculty of Medical Leadership and Management (FMLM), The King's Fund and the Center for Creative Leadership (CCL) sponsored this paper to realize their shared commitment to evidence-based approaches to developing leadership. Together they initiated a review of the evidence by a team including clinicians, managers, psychologists, practitioners and project managers. This document summarizes the evidence emerging from that review.

The summary describes key messages from the review in relation to leadership at different levels of analysis: it includes a description of the leadership task and the most effective leadership behaviours at individual, team, board and national levels. It argues that approach to leader and leadership development is distorted by a preoccupation with individual leader development; and that developing collective leadership for an organization depends crucially on context and is likely to be best done "in place", highlighting the important contribution of organization development and not just leader development. They also argue that leadership of organizations needs to be consistent in terms of leadership styles and behaviours in developing shared leadership across the organization; in practising compassion as a cultural value in all relationships within the organization; and in building cultures where the success of patient care overall is every leader's priority, not just the success of their individual areas of responsibility. It also emphasizes the importance of evidence-based approaches to leadership development in health care and the importance of ensuring a return on the huge investments made.

Implications

The efforts of CHLNet members to promote a national action plan for systematic, collective leadership development across the country are supported by the arguments in this paper. Similarly, the paper has implications for how the LEADS Collaborative and LEADS Collaborative members should be providing programming, and for the CHLNet's Research and Evaluation subcommittee's proposed study on ROI for leadership programming.

Link to LEADS and CHLNet's Mission

CHLNet and its partners are committed to better leadership. Leadership development is key to that commitment. However, leadership development must be conducted in such a manner so as to develop the shared leadership needed to generate culture shifts in support of patient-centred care; and consistent with the caring element of health care service delivery.