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Atlantic (Newfoundland) Node Case Study Final Report

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Exploring implementation of a Leadership Framework in Relation to Core Drivers of Management and Employee Engagement – an Atlantic Case Study

The nature of health care and the systems that are organized to deliver that care are quite complex because of the number of individuals, institutions, and organizations involved in the delivery of health care (Swanwick & McKimm, 2011). Manager and employee engagement is emerging as an important variable that influences the optimal operation of health organizations (West & Dawson, 2012), however the main challenge is how to create the environment needed to promote that engagement (Squazzo, 2011). Creating that environment is crucial because of the importance of engagement to the safe and effective delivery of health services and particularly to patient safety; one of the main concerns of health organizations (Canadian Patient Safety Institute, 2010; Institute of Medicine, 2004). Evidence is increasing that strongly suggests that low levels of engagement have a negative impact on patient safety (Charles, McKee, & McCann, 2011; Simpson, 2009a). Engagement has other positive effects in that work engagement is also thought to increase the health and well-being of employees who are engaged and thus contributes to healthy workplaces (Mauno, Kinnunen, & Ruokolainen, 2006) and higher quality work environment (McAlearney & Robbins, 2013).

Despite the growing importance of engagement in the health care sector for patient safety, healthy workplaces, and better work environments, levels of engagement in many sectors including health care are decreasing (Aon Hewitt, 2011)[1], thus it is increasingly an area of organizational concern as well as research interest and importance (West & Dawson, 2012). One of the key questions for research is what influences engagement? Levels of engagement are known to vary greatly from organization to organization and a number of contextual factors have

[1] Many organizations including the health care sector use the survey from Aon Hewitt, however results were not reported by sector.

been identified that affect engagement, for example, the nature of work and resources available to do that work (Mauno et al., 2006). Leadership is also thought to be one of the key enabling factors for improved engagement (Kerfoot, 2007; Vincent-Höper, Muser, & Janneck, 2012; Simpson 2009b), yet many of the conditions under which this happens and how it occurs are not well understood (Bakker, 2011; Tims, Bakker, & Xanthopoulou, 2011). Thus the focus of this case study is how the implementation of a leadership framework can be used to foster management and employee engagement in a large health care organization.

Background of Initiative: Engagement and the Leadership Strategy

As part of the strategic directions of Eastern Health, developing increased capacity in leadership is seen as important. As a consequence a Leadership Strategy was developed and while it was not developed specifically for engagement, engaging employees was one of the key areas to address.

Management and Employee Engagement

Eastern Health, as with many other health care organizations, is very concerned about current engagement levels and is actively seeking to improve the engagement of all employees to address current and future goals and challenges. Eastern Health conducted a management engagement survey in 2007 and an all employee engagement survey in 2009 and 2012 through *Aon Hewitt Associates Best Employer Survey*. Results indicated low engagement levels as compared to other health organizations[2]. In 2007, 37% of managers were engaged compared to 32% in 2009. In 2012 engagement of people managers increased to 37% overall, with a slight decrease for the director group. The 2007 management survey identified the top three drivers for

[2] The percentages are taken from the Employee Engagement Scorecard Reports supplied by Aon Hewitt. The scorecard gives percentage for Eastern Health compared with other health care organizations.

formal leaders to be: Tools and Resources, Managing Performance, and Career Opportunities. In 2008 action planning groups were created to develop plans to address the major issues.

The 2009 survey further indicated that 25% of employees were engaged and the top five major drivers of engagement in Eastern Health employees were: Managing Performance; Senior Leadership, Recognition, Human Resource (People) Practices, and Organizational Reputation. Effective leadership was a core theme throughout the five drivers. Eastern Health repeated this survey in 2012 with a finding of 26% overall engagement. The drivers remained relatively stable with tools and resources replacing people practices in the top five.

The Leadership Strategy and Framework

Effective leadership and management/employee engagement are both strategic and operational imperatives for the organization, the Board of Trustees, Executive Team, managers, and staff. Both leadership and engagement were clearly articulated in the 2008-11 Operational Plan, Leadership Strategy, and People Plan. The 2011-14 planning cycle included a continuation of organizational commitment to improving engagement and advancing leadership through simultaneous implementation of leadership and employee engagement strategies.

In December 2010, Eastern Health formally launched its Leadership Framework incorporating the LEADS in a Caring Environment Framework, along with an internally developed management accountabilities. A multi-faceted implementation plan was developed as a key component of the organization's Leadership Strategy (2008-11) to ensure integration of the Leadership framework with core management processes including: recruitment, onboarding, development, performance management and tools and supports (e.g. Manager's Toolkit, decision-support). Recent efforts have focussed on introducing LEADS to all formal leaders via a series of two day "Leading in a Caring Environment" workshops and leveraging the

capabilities for further leadership talent development (e.g. succession planning, leadership progression, and enhanced developmental programming). An Employee Engagement Action Plan was released March 2011, outlining what employees felt about recognition, performance management, HR policies and practices, organizational reputation, and senior leadership in the organization, improvements made and action plans in each of these areas for 2011-12.

Brief Overview of the Literature on Leadership and Engagement

There are a number of definitions of engagement, however the most frequently used one, also known as work engagement, has been defined as " a positive, fulfilling work-related state of mind that is characterized by vigour, dedication, and absorption" (Schaufeli, Bakker, & Salanova, 2006, p. 702). Vigour define as the energy and resilience applied to work including when working under challenging conditions, dedication is the strong involvement in work and the significance that a person attaches to work, and absorption is the engrossment and concentration in work (Bakker & Oerlemans, 2010). It has also been defined by various other authors as the sense of purpose the employee brings to meet the goals of the organization or the positive connection to the organization (Mone, Eisinger, Guggenheim, Price, & Stine, 2011). Engagement is thought to be the opposite of burnout (González-Romá, Schaufeli, Bakker, & Lloret, 2006) but others would disagree with that categorization.

Factors that Increase Engagement

A number of factors are thought to increase engagement or are described as drivers of, or antecedents to, work engagement (Aon Hewitt, 2011; Mauno et al., 2007). In the Aon Hewitt model of employee engagement there are six (6) interrelated drivers for engagement and each driver has a number of factors that are measured on the survey they have designed to measure employment. These drivers (factors) are: (1) Quality of life (physical work environment and

work-life balance); (2) Work (work activities, sense of accomplishment, resources, and processes); (3) People (senior leadership, managers, colleagues, valuing people, and customers; (4) Opportunities (career opportunities and training and development); (5) Total rewards (pay, benefits, and recognition); and (6) Company practices (policies and practices, performance management, brand alignment, company reputation, and diversity) (Aon Hewitt, 2011, p. 7). The importance of these drivers to organizational engagement varies by country, but in North America for the past three years, the top drivers have been career opportunities, managing performance, organization reputation, brand alignment, and reputation. Other research has suggested leadership is one of the factors that can improve engagement in managers and employees (Salanova, Lorente, Chambel, & Martínez, 2011).

Leadership and Engagement

A literature search was conducted with the search terms "leadership" and "engagement" through the various health bibliographic databases, e.g., PubMed and CINAHL. There is a moderately large and a growing literature in this specific area. Much of the literature is on reports of initiatives to increase engagement that may or may not be directly evidence-based (Kerfoot, 2007; Squazzo, 2011). The overview for this brief review was limited to research articles that addressed leadership and engagement, and in particular research that examined leadership in health care organizations or included employees in health care organizations as participants in the research. It was felt that this review strategy would provide a clearer understanding of what we know about leadership in health care and how that might affect employee engagement within that particular sector.

Much of the research on engagement in health care has been conducted with nurses (Gokenback & Drenkard, 2011; Laschinger, 2006; Wong, Laschinger, & Cummings, 2010) or physicians (Hornung, Glaser, Rousseau, Angerer, & Weigel, 2011; Parand et al., 2010), because their engagement is so critical to a quality patient environment. At least one study was located on midwives working within an institutional setting (Feeney, 2013). West and Dawson (2012) as part of their background work on engagement for the National Health System (NHS) in Great Britain reported on a study that included the various sectors and main occupational groups with NHS and found that engagement varied widely among those groups.

Research on leadership and engagement in health care. There is growing evidence of the importance of the role of managers in nursing units and how they contribute to engagement. Nurse-management relations influenced the level of engagement for nurses working in the psychiatric setting at least for the sub-scale of engagement identified as dedication, while it had no effect on vigour or absorption (van Bogaert, Clarke, Willems, & Mondelaers, 2013). They used the engagement subscales from the Utrecht Work Engagement Scale (UWES) developed by Schaufeli et al. (2006). In the van Bogaert et al. study nurses who felt they were regularly consulted on problems and procedures by their managers had higher levels of dedication to their work. In that same study vigour was influenced by nurse-physician relationships at work and of the variables measured no significant relationships were found for absorption. Other researchers too have noted the importance of the supervisor or manager to engagement. For midwives working in a hospital setting the main predictor of a high level of engagement was support at the organization level and in particular at the supervisor and co-worker level (Feeney, 2013). The author suggested that when this support was felt the midwife was more likely to be motivated and thus engaged.

Research on leadership and engagement in other organizations. The literature on leadership and engagement within health care was limited and a second review was performed that included other types of workplaces in order to draw upon additional evidence of the importance of leadership to engagement. The research included a variety of workplaces and occupations. One area of focus was on the type or style of leadership and the relationship of this leadership to engagement. In a variety of small companies, Papalexandris and Galanaki (2008) found that style, whether it was entrepreneurial or professional, was not so important as the leader having a vision and being a good manager and mentor. Other researchers have focused on transformational leadership because this is a leadership style that is thought to encourage engagement. In a study by Tims et al. (2011) the researchers examined the daily effects of transformational leadership and found that it worked to increase daily engagement of employees by enhancing the personal resources of these employees. As well, Tukey, Bakker, and Dollard (2012) studied empowering leaders and the effect these leaders have on work engagement. Their findings supported the positive effects this could have and the importance of empowerment as a way to motivate workers. In particular empowering leadership had the effect of helping workers to assume more autonomy and thus assume greater responsibilities while at the same time having a positive effect on team work; thus showing individual and organizational effects.

The importance of leadership and type of leadership is a factor, but ought not to be the sole focus on engagement, because there are other influential conditions that leaders might be aware of and employ. Cross, Gray, Gerbasi, and Assimakopoulos, (2012) found informal networks in organizations could be used to increase engagement, however whether the interactions were negative or positive was key. Negative interactions or negative or bad experiences worked against engagement and exerted a stronger influence than positive

interactions (Cross et al., 2012). These informal networks are often not known to formal leaders and therefore are an overlooked asset.

Summary and Conclusion

There are a number of criticisms in the literature on the study of engagement. One of the criticisms is that most of the conceptualizations of engagement are at the individual motivational level, however as Tukey et al. (2012) indicate engagement is "embedded within a broader organizational context (p. 22). Most of the research located on leadership and engagement has been cross-sectional and quantitative employing one of the engagement/work engagement scales and correlating the scores with some measurement of an aspect of engagement and/or leadership. One of the most commonly used measure of work engagement is the Utrecht Work Engagement Scale (UWES) developed by Schaufeli et al. (2006) that reports findings related to three sub-scales: vigour, dedication, and absorption. The most frequently theoretical model used is Job Demands - Resources Model as predictors or antecedents to employee engagement (Bakker, 2011). This model focuses on both work and personal resources and takes into consideration such characteristics as a supportive work environment, as well as, the person's sense of self and resilience. Few studies have taken a qualitative approach examining the process of how leadership influences manager and/or employee engagement. This case study is designed to address that gap in the research.

Research Purpose and Questions

This case study is part of a larger national research project *"Partnerships for Health Systems Improvement"* (PHSI) that focuses on leadership in health care in Canada. It is comprised of six (6) case studies; five (5) regional studies representing various regions of the country and one (1) national case study. These case studies were designed to examine some of

the examples of leadership initiatives that are currently in place to support increased leadership capacity in health care throughout Canada. All case studies used a common set of questions, developed within the PHSI project, that were adapted to the particular phenomenon being studied within each case study (see Appendix A). Integration of all the case study findings will provide evidence on how effective leadership is in addressing some of the critical challenges in health care and what needs to be addressed in terms of leadership in health care in the future.

Overall Goal of the PHSI Research

The overall goal of the PHSI research project was to use applied research and knowledge translation strategies to develop leadership capacity by addressing the following research questions:

1. What is the current state of health leadership capacity in Canada? What is working or not working, in terms of supporting health system transformation, and what contextual factors influence effective leadership action?
2. What are the gaps between current practices, the evidentiary base in the literature and the expectations for leadership outlined in the emerging health leadership capacity/competency frameworks (e.g., LEADS), and how might a set of national standards for leadership be structured?
3. How can knowledge of effective leadership be translated and mobilized by the network into programs, tools, and techniques to develop a culture of effective leadership in Canada, and enhance the development of quality health leaders?

Goal of the Regional Case Study

In this particular case study on research into the implementation of a leadership framework in relation to core drivers of management and employee engagement our goal was to address the following questions:

1. How is the implementation of a leadership framework seen to be related to the strategy of increasing engagement in Eastern Health?
2. What are the gaps between current practices, i.e., Leadership Framework, and expectations for leadership within Eastern Health?
3. Based on the findings from the case study research what needs to occur to further enhance leadership capacity?

Research Methods

In keeping with the overall design of the PHSI project the research was guided by the principles of case study research (Yin, 2009) and a participatory action approach (PAR) (Greenwood, 1999). The research was divided into two main phases or cycles for data collection: 1) A situational analysis of the context of engagement and the need to institute a leadership strategy to enhance engagement in Eastern Health and 2) A second PAR phase that examined the institution of the leadership framework and how that has influenced engagement.

The Case Study

The main strengths of the case study are that they are used when the research is designed to address "how" or "why" questions and the events or phenomena being studied are not controlled in any way by researchers because they are contemporary and real life events that are occurring outside of the research (Yin, 2009). The how or why questions we were examining were how and why the implementation of the Leadership Framework related to increasing engagement within

the organization. As described in the background a leadership framework was developed to describe and enhance the type of leadership that was required within Eastern Health. The Leadership Framework integrated *LEADS in a Caring Environment Capabilities Framework (LEADS)*. LEADS Framework is a distributed leadership framework and consists of five (5) capabilities and four (4) sub-domains in each of the capabilities or main domains (see Table 1) (Dickson, 2010). LEADS, as a core component of the Eastern Health leadership framework, is introduced to directors and managers through an interactive workshop format in a two-day format. The purpose of the workshop is to:

- Increase knowledge of Eastern Health's Leadership Framework with a specific focus on the LEADS capabilities;
- Use the Leadership Framework as a tool for professional growth and development; and
- Increase Eastern Health's capacity to achieve results and manage change through the enhancement of leadership skills (Eastern Health, Participant Workshop, n.d.).

Table 1

LEADS in a Caring Environment Health Leadership Capabilities Framework [3]

Capabilities or Domains	Sub-domains of the Capabilities
1. Lead Self	1. Are self-awareness 2. Manage themselves 3. Develop themselves 4. Demonstrate character
2. Engage Others	1. Foster development of others 2. Contribute to the creation of healthy organizations 3. Communicate effectively 4. Build teams
3. Achieve Results	1. Set direction 2. Strategically align decisions with vision, values, and evidence 3. Take actions to implement decisions 4. Assess and evaluate
4. Develop Coalitions	1. Purposefully build partnerships and networks to create results 2. demonstrate a commitment to customers and service 3. Mobilize knowledge 4. Navigate socio-political environments
5. Systems Transformation	1. Demonstrate systems/critical thinking 2. Encourage and support innovation 3. Orient themselves strategically to the future 5. Champion and orchestrate change

Unit of Analysis. In the design of a case study it is important to identify the unit of analysis (Yin, 2009). The unit of analysis is what is being studied or how a case is defined. In this case study the unit of analysis was a process; the implementation of a leadership framework for directors and managers within the context of increasing engagement among management and

[3] Capability and sub-categories taken from Dickson (2010) printed in Leads in a Caring Environment pamphlet (leads.cchl-ccls.ca)

employees at Eastern Health. The importance of identifying a case is that it assists to identify appropriate data sources and data collection methods to be used.

Participatory Action Research (PAR)

This case study was an action research project working with formal leaders in Eastern Health who were engaged in strategies to improve and enhance management engagement and further develop their leadership abilities. Action research mainly consists of a "communicative process" in which the researcher engages on whatever communicative levels needed to answer the research questions (van Beinum, 1999). The PAR cycle consisted of the academic researcher together with two research partners (institutional researchers) in Eastern Health taking part in such events as the launch of the management framework, attending and participating in a workshop for Eastern Health leaders, and attending management meetings to explain the PAR cycle. The institutional researchers were active participants in the development and implementation of the leadership framework. In addition key stakeholders and participants in the leadership development workshops were important to understanding the implementation and progress of developing leadership strategies in the organization. The other main communicative processes for data generation was a series of focus group discussions with managers, directors and LEADS faculty within Eastern Health.

Data Collection

***Data for Phase I: The situational analysis*.** Data for this phase of the case study consisted of two data collection methods; individual interviews (n=3) and one focus group (n=5). First, we identified and interviewed key stakeholders to understand some of the background factors that led to initiating the Leadership Framework. Key stakeholders consisted of individuals from senior management, and Human Resource (HR) Strategists involved in leadership and

engagement. The purpose of these interviews was to understand the contextual factors that led to particular actions in the leadership strategy. All interviews were semi-structured with an open-ended question that allowed interviewees to contribute additional information. The main questions explored were a set of questions developed on the national level that were then adapted and used to explore our particular phenomenon, i.e., leadership and engagement (see Appendix A). The individual interviews were approximately one hour duration and were tape-recorded and transcribed verbatim. The focus group lasted approximately two hours and was recorded and transcribed verbatim.

We reviewed selected documentary sources that captured some of the organizational and environmental contextual factors that have had an impact on management engagement. The intent in the use of these documents was to complement the interviews with key stakeholders and consisted of such sources as government and Eastern Health documents, minutes of meetings, and any records or outputs from part of the action plan. These documentary sources are listed in Appendix B. We reviewed some of the actions of the leadership/management accountabilities implementation plan that have taken place with the HR strategist/personnel who had key involvement in the plan in order to review the action, progress, and main lessons learned.

***Data for Phase II: Implementation of the Leadership Framework*.** This phase consisted of conducting focus groups with four groups of managers who have been involved with or exposed to it in some capacity and would potentially hold different perspectives of leadership and engagement. The focus group discussions consisted of new managers who had attended management orientation within the past 12 months (n = 6), a group of directors (n = 10) who had taken part in one of the LEADS workshop, *Leading in a Caring Environment* (LEADS)

workshop faculty (n =7), and a group of managers who had attended one of the LEADS workshops (n = 15). In total 38 participants took part in this part of data collection.

Data collection for the individual interviews was held in the academic researcher's office or the participant's office, depending on which setting was most convenient and comfortable for the participant and afforded privacy. All focus groups were held in a boardroom at the corporate offices of Eastern Health. This was a setting familiar to the participants as they often hold meeting in this venue so location would be familiar. The boardroom also afforded the participants relative freedom from interruptions from work. At the focus groups a senior research assistant from the university assisted the academic researcher with data collection. The research assistant person also transcribed all interviews and focus groups and assisted with data analysis.

Data Analysis

Data analysis for Phase I and Phase II were similar. All interviews, individual and focus groups, were recorded and transcribed verbatim. The transcribed data were imported into and analyzed using the qualitative analysis software (NVivo10). Content analysis was used to identify common themes and patterns in response to the questions posed. The researchers came together on various occasions to discuss the data and data analysis. Data analysis was enhanced by the contributions of the researchers from the institution, who were able in many instances to clearly identify the context around what the focus group participants were reporting. This helped to ensure a more accurate interpretation of the data than would have occurred without their participation.

Ethical Considerations

A proposal for the study was submitted to the Health Research Ethics Authority (HREA) and ethical approval for the research was granted. Ethical considerations were in keeping with the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans 2 (TCPS2)* and as approved by HREA. Following HREA approval the proposal was approved by the Research Proposals Approval Committee (RPAC) within Eastern Health. At any event the academic researcher attended she always introduced herself, explained the purpose of her presence and the nature of the research. If others attending the event had questions these were answered. Attendance at these events was not considered as part of data collection rather they were to help the researcher understand the context of the research. This was made clear to other attendees.

All participants who took part in the Phase I or Phase II individual interviews or focus groups signed an informed consent. Prior to data collection each potential participant was sent a letter describing the purpose of the study and their involvement in the research, a copy of the informed consent, and a list of questions that would be used to guide the interview or focus group discussion. Participation was voluntary in that potential participants were invited by one of the researchers through a letter or email asking if they were willing to take part in the study. If the person was interested she or he either contacted the academic researcher to set up a convenient time and place for the interview or responded to the email to attend a focus group session. Prior to any data collection the academic researcher reviewed the consent form with participants, answered any questions, and witnessed the signature of participants. All participants were informed of the voluntary nature of the participation in research, that she or he could withdraw at any time without any repercussions, i.e., no effects on their position within the organization.

All participants were assured confidentiality. No names will be used in any of the findings. Positions are only used when they are illustrative of an area of responsibility and not used in place of a name of an individual. When transcripts of interviews or focus group discussion were completed any identifying information was removed. Lists of participants and their contact is kept separate from interview and focus group discussions. All lists of participants and transcripts are on a password protected computer in a password protected file. These data files will be maintained by the academic researcher for at least five (5) years following publication from the data.

Findings from Phase I: Situational Analysis

Meaning of Engagement

Engagement has a number of meanings, not only as reported in the literature, but in how it is conceptualized and demonstrated (see Table 2). The first questions we explored within the individual interviews and the focus group discussion were "*What is your understanding of engagement?*" and "*How do you demonstrate engagement in your work?*" These explorations were important to better understand the meaning of engagement within the organization, how it was or could be operationalized or put in place, and what were some of the necessary conditions for engagement to occur. All the participants considered engagement at the organizational level as the goal or ideal and the aim of the work on engagement within the organization or what they were attempting to achieve, although there was one participant who did acknowledge that engagement could be present and demonstrated at a lower level because "you could be engaged just in a group of three" and was not always about being engaged at the organizational level.

Engagement as connectedness. One of the meanings of engagement was that of connectedness. It was how connected the person felt to the organization and particularly to the people within the organization. The connectedness was a factor that enabled a person to work with others and want to help others. It was a form of caring. Similarly, engagement was described as a feeling of belonging, being a part of something important, and because of the connection you feel you are able to contribute through your work. The contribution through does go beyond what is expected of a particular position in the organization. If you are just doing your job in a perfunctory manner that is not engagement. Engagement as connectedness was an internalized feeling in that you feel "you work for a great organization" and that you want to belong and to contribute, but moreover you wish to remain with the organization. Engagement affects outcomes because you leave the organization a better place because of these contributions. In turn you find a sense of meaningfulness in your work, you enjoy your work, and get satisfaction from what you do. Engagement is the enabling factor that helps to care about what you do and for the people that you work with in the organization.

Engagement as commitment. Engagement was also described as how you approach your work; with commitment. This feeling of commitment gives the person engaged energy, and for some a passion, for what they do. It allows the person to put forward their best efforts on behalf of the organization and do what is right for the organization and people within the organization. It helps to create connections with people, with work, and with the overall organization, and provides an understanding of how all these are connected. Any communication about the organization is positive because of the feeling of pride about the organization. Engagement is the motivating factor for you to do your work and contribute to that work in a meaningful way.

Table 2

Meaning of Engagement

Meaning	Function
1. Connectedness	Enabling
To organization	For working with others
To people	For wanting to help others
Feeling of belonging	For contributing to work
Part of something important	For going beyond expectations
Internalized feeling	For retaining employees
	For how you speak about the organization
Outcome oriented	
Leave organization a better place	Improving organization
	Find meaning in work
	Enjoying work
	Getting satisfaction from work
2. Commitment	Motivating
How you approach work	Giving your best effort
Energy felt at work	Doing what is right
Passion for work	Caring about what you do and people you work with

Demonstrating Engagement

Participants agreed that engagement had a behavioural component and gave a number of examples. Overall it was by working to create a "culture of engagement" and this could be accomplished by their daily interactions in which they showed their commitment and support to the directions of the organization, i.e., vision, values, and strategic plan. Another means was in interactions with others demonstrating that they cared about "work and outcomes of work, about the organization, and people in the organization". It was important to speak positively about work and to be constructive in whatever they did.

Engagement could also be demonstrated through a positive attitude. This positive attitude conveyed to others that you were engaged, you loved your work, and you wanted to make a difference. It was going beyond what was expected and seeking out opportunities to do so. It was also about making sure you followed through with any commitments at work. Engagement with others was shown by working with others to achieve common goals. The demonstration of engagement was consistent with how the various participants viewed engagement.

Conditions for Engagement

For engagement to occur participants agreed that there were some important conditions needed (see Table 3). One of the most important conditions was an environment in the organization that supports engagement and if this is not present to the degree required, that environment must be created. While there are formal means of creating a supportive environment, e.g., making certain organizational values explicit, these values have to be "lived" values and demonstrated in day to day interactions. The environment must be one in which an employee can feel valued for what she or he contributes to work. It is a caring environment because it is difficult to care in an environment that does not care about the people in it. There has to be reinforcement of engagement when it occurs; either formally through programs or awards or informally when a person is told that what she or he did was important.

Table 3

Conditions for Engagement

Condition	Dimensions
1. Supportive environment	Showing caring in actions Make employees feel valued
2. Understand meaning of engagement	At the individual level At the organizational level How demonstrated at each level
3. Authenticity	Not too academic, have more natural Focus on positive aspects
4. Must be practiced	Role model to others Live values of the organization in interactions
5. Reinforcement needed	Formally (awards) Informally (verbal)

Another condition for engagement was an understanding of what the term means and how it can be practiced. Even though there is a sense of a "natural attitude" about engagement it is more complex than that, particularly when you make a distinction between individual engagement and collective engagement; the latter is more organization focused and part of the initiatives put in place to increase engagement. However, individual engagement is a necessary prerequisite to collective engagement. There was also some concern expressed about the idea of a collective engagement (organizational level) and a concern that there was so much focus on it that at times it felt "a little inauthentic and too academic when it should feel more natural".

Leadership Capabilities Required for Engagement

In our exploration of engagement and in the context of implementing a leadership framework one of the questions posed was *What leadership capabilities are required to successfully achieve engagement?* All participants believed that the leader needed her or himself to feel a sense of engagement and the energy that came from this feeling. It is difficult to engage others if you are not actively engaged yourself or if you do not believe in what you are doing. Many of the capabilities mentioned were those thought to contribute to effectiveness as a leader. A necessary prerequisite though was the leader needed to be perceived as having the power and being in a position to act.

Knowledge. Possessing various forms of knowledge was also an important capability. First, was self-knowledge or being self-aware of your own strengths, challenges, and leadership styles. It was a knowledge of who they are and how they influence others. Second, was a knowledge of what was expected in your role. It was knowing what your goal was and how you were going to achieve that goal. Third, was a knowledge of people and their behaviour and how people respond in different contexts and how to motivate and engage others. Fourth, it was knowledge of the organization, how it operated, what were the mission, values, and strategic initiatives of the organization because these needed to guide any actions as a leader. Fifth, it was a knowledge of leadership and how one leads in different contexts.

Communication. To be a good leader it was thought essential that the person had the ability to communicate very well because so much depends on good, clear communication. The communication was described as a two-way process because it was important to get information out but it was equally important to listen and to hear what others were saying. Equally important was the ability to communicate a sense of caring about the organization and about others. These

characteristics were critical to working with others and getting desired outcomes such as, contributions to the health system and engaging others. These also assisted in coalition building both internal and external to the organization. A related capability required by a leader is strong interpersonal skills that will enable the person to develop good relationships. These skills are required in order to foster a sense of community and belonging.

Flexibility and vision. Leaders are required to be open and flexible to new ideas, feedback, and changing a course of action if required. This requires a great degree of flexibility coupled with the ability to respond to people, needs, and situations and the ability to accept change. Leaders are seen as visionary and having vision or at least a vision of how things could be done differently. One participant summed up the capabilities as a good leader needs "emotional intelligence", which involves many of the characteristics mentioned above.

Leadership Capabilities Present to Create Readiness to Implement the Framework

A number of the characteristics that participants suggested were required to foster engagement were ones that were present and helped to implement the Leadership Framework. However, a necessary precondition was that the leaders working on the framework had a personal commitment to seeing the implementation through and in terms of engagement to think about the findings from the survey on engagement and what deliberate actions were needed to address these. They also required a vision of an engaged organization and that to achieve this goal it was necessary to come together. This vision encompassed the ability to see the "bigger picture", which was more than just addressing the survey results.

The leadership capabilities also required a sensitivity to the diversity and differences within the organization and a recognition that the organization was a collection of entities and cultures or subcultures resulting from a fairly recent merger to form a larger health authority and

that management practices varied among the different institutions that formed the larger entity. There was a necessity to consider and to be sensitive to this context. This had implications for the approach adopted starting with bringing together key players for discussion on leadership and on how to move forward.

Other approaches that assisted were being able to think in a transformative way, going back to the values of the organization to guide actions, looking for barriers that needed to be removed or challenges to be addressed, and being a voice for what you believe is correct, which subsumed the ability to say "no" if it was not the best way to move forward. Since achieving the desired results would not happen if working alone, the leaders fostered conditions for partnerships to happen and built partnerships, thus building relationships.

Contexts and Influences at Various Levels for Leadership Development

Next in our interviews and focus group we explored what they saw as some of the contexts and influences on leadership at the national, provincial, and organizational level. Participants had not been involved at the national level and since none of our participants were working or involved in decision-making at the provincial level, this might be a limitation of the case study.

National level influences. Leadership in health care is a national focus and has been for some time (Dickson, 2007). Funding of the main PHSI study would suggest importance of this focus. Participants talked about this national focus and concern about leadership. They were also aware of some of the national initiatives, e.g., Canadian Health Leadership Network as well as other initiatives that would require a focus on leadership, e.g., Primary Health Care Initiative. Another influence they were aware of was that the LEADS Framework was being widely adopted nationally.

In some provinces national surveys on engagement are either mandated or becoming more of a business requirement. The results of these surveys are compared widely. Similarly the reorganization and regionalization of health authorities into larger organizations seem to be a national phenomenon and therefore with any reorganization it is important to examine and realign leadership. Participants were uncertain if leadership issues associated with regionalization had been discussed nationally by ministers of health. There also has been a focus nationally on patient safety with the creation of the Canadian Patient Safety Institute (CPSI). Health care is seen increasingly as a very risk adverse industry, so again leadership might arise in that context. The final influence is the need of all health organizations to achieve national accreditation and through this to do benchmarking and examine performance indicators. Leadership is one of the national standards that is assessed in the accreditation process.

Provincial level influences. The decision to create regional health authorities (RHAs)[4] was at the provincial level and these were in part cost-cutting measures but also in keeping with national trends in health care reform. The merger of smaller health boards to form the larger RHA meant that leadership had to be realigned to fit the new structure. The merger of the health boards was a very public process and was much discussed and debated in the public arena. Under the government, health would be seen as a public service so there would be some focus on engagement and quality of work life in keeping with provincial health and safety acts, but the overriding concern might be how the public view the functioning of health services and the sense of the public losing confidence in the RHA because of recent adverse events in the news. Thus interest in public safety and concern have been highlighted by adverse events in health care and formal inquires set up by the government into practices and what went wrong. In any inquiry

[4] The Regional Health Authorities Act of Newfoundland and Labrador 2008 and amended 2011 defined the boundaries of the four (4) health authorities for the province making Eastern Health the largest health care authority in the province.

leaders and leadership are very much part of the investigation and the recommendations from the inquiries did recommend a role for leadership to ensure that mechanisms were put in place to safeguard patients in the health system.

Local level (RHA) influences. From its inception the RHA recognized the need to build a common culture with an engagement strategy and there was a strong commitment toward this goal and to the leadership that must be put in place to accomplish it. There was also an awareness and respect for the different institutions and boards that came together to form the RHA and a recognition of the diversity of individuals and practices coming from all the components of the RHA. Since the inception of the RHA, leadership has been a focus; what it should look like and how to develop it. Eastern Health undertook internal and external research to help build leadership capacity and examined what was happening on the national scene to inform its efforts and in particular The Canadian Health Leadership Network (CHLNet). New positions such as HR Strategist were put in place, strategic plans developed, and a commitment to the goal of having a leadership framework aligned with national health leadership capabilities (i.e., LEADS).

Key Leaders and Contributions

A number of individuals were identified as key leaders in the process of implementing the Leadership Framework and fostering engagement. This ranged from support at the CEO level in endorsing and supporting efforts around leadership to the formal and informal leaders assigned responsibilities to put informed processes in place for engagement. At the VP level individuals were instrumental in bringing together key participants and providing input in the process. With support from the organization, HR strategists took on the initiative of introducing the leadership framework at different levels. A Leadership Committee was formed that was representative of

the different sectors and management groups of the RHA, that volunteered to act as an advisory group. Directors and professional practice groups or representatives were also active in the process as were some of the front line managers who wished to take action in light of the results of an engagement survey. The contributions of some of the strategies put in place to encourage leadership and/or engagement were mentioned as well. In particular the LEADS framework and the FISH! Philosophy© were frequently referenced as effective means of teaching and learning about leadership and engagement.

Impetus for Emphasis on Engagement

As part of the situational analysis and in order to better understand the push or the drive for change we asked participants the following question: *Where did the need/evidence for focusing on engagement come from?* The impetus was not seen as coming from a single source or event but more a combination of factors all indicating that a change in the direction taken was needed. Part of the push was the creation of the new RHA that resulted from the coming together of differing sectors with differing cultures and the need for more coherence and standardization within the RHA. Another impetus was the formal inquiries that were taking place because of adverse events that had happened in the RHA and how Eastern Health was being talked about and portrayed in the public media. The employee engagement results were also an impetus for change because of the low levels of engagement found. The literature on leadership and engagement was mentioned as contributing factor, but as one participant observed: *About evidence-I'm not sure we're completely there yet – that people are looking for the evidence of why should I bother. What difference does it make?"*

Conditions for Change: Facilitators and Challenges

With any organizational change there are always conditions that help facilitate that change process as well as challenges or sometimes even barriers to the introduction of that change process. There were certain factors in both of these categories that those implementing the leadership framework faced.

Facilitators. One of the main facilitators was the creation of Eastern Health as a new RHA and because it was a new organization there was a need to create a structure for leadership. This meant the creation of new documents and plans to help create that leadership structure and the chance for input into how that structure should be. The creation of the Eastern Health also meant there was a need to create a sense of community that encompassed all within the organization. This helped to create an environment that supports employees to feel valued and supported and that their contributions can make a difference. A second facilitator was within the organization there was a recognition that engagement was central to the organization and the survey results on engagement was evidence that some action was needed in this direction. The recognition of the importance of engagement to the organization also meant that in order to effect engagement, structures had to be put in place to create the conditions for it to occur. The creation of positions of HR strategists and the development of the leadership framework were facilitators as were the planned events that brought people together within the organization. Another facilitator was support within the organization, i.e., at the level of the CEO and the VP (HR) for the framework and the hard work of all directly involved.

Challenges. Just as there were a number of facilitators for the process of change being introduced there were a number of challenges or factors that impeded or slowed down the work on leadership and engagement. These challenges or threats were seen as both external and

internal to the organization. In terms of external threats or challenges both the government and the public were seen as key players. The government was seen to be taking a greater role in the running of the RHA and this was seen as taking away to some extent the autonomy of the institution. The bureaucracy and hierarchy that characterizes governments meant that any change could be slow or that the focus within the organization could be diverted elsewhere. For example, while public inquires were being set up by government and conducted the focus was on these inquiries and the issues that these brought forward. Public opinion, or at least the negative opinions being expressed in the media, were also seen as challenges. It was difficult to not internalize the blame being apportioned by the public or to feel pride in the organization when the reputation of the organization was perceived so negatively. It also helped to create a sense of a culture of blame and a fear of reprisal if things go wrong.

A number of internal threats were identified by participants. Just as the creation of the new RHA was seen as a facilitator because of the opportunity it afforded for the new leadership structure, it was seen as a huge challenge because of the differences that existed between the sectors that came together to form the new RHA. Different cultures coming together with their own values and ways of operating coupled with loyalty to the previous sector is always challenging and takes time to overcome. The size of the organization was believed to be almost a barrier because it was so large, spread out geographically, and required a certain bureaucracy and hierarchy to run efficiently especially from a financial perspective. It was somewhat difficult to get the resources, e.g., time, finances, and people to move the leadership agenda forward.

Other internal threats perceived were differences in focus or at least what seemed to be competing ones within the organizations. One was that the financial situation, which often surfaces, seems to divert a focus to budget and budgeting reports. There also seemed to be a

focus on problems and not solutions within the organization and leadership and engagement required a solution focus. Within the category of internal threats was a focus on the organization per se and not an understanding of the centrality of keeping a focus on people. Leadership and engagement requires a focus on people and relationships among people in the organization. It also requires that the leaders know and buy into the values of the organization. In addition there was diversity in thinking about what developments were required and the focus seemed to be on management and not leadership. This seemed to result in not always feeling there was active sponsorship for leadership at the executive level. There also appeared to be some uncertainty in the organization on what was the purpose of the Leadership Framework, i.e., was it meant for managers or for more widespread usage.

Another category of challenges was related to change. Some of this change was in personnel, particularly at the executive level, which often results in a change process being slowed down. With any change in personnel, particularly at that level, it is necessary to familiarize those new to the organization with the work in progress so that there is the support required at that level to move forward. Change had also occurred at the director and manager level. Change could be a challenge in other ways because there will always be some scepticism when something new is introduced and this slows down what you are trying to accomplish. Some individuals are resistant or reluctant to change and want to stay with the comfort of how they have done something in the past. It is not always that people resist change but some might not know how to do things differently, so they need help with that part of change. It was challenging moving engagement beyond HR, the department asked by the executive to be in charge with the operational processes and planning of the leadership framework because other issues in the organization always seemed to need more immediate attention. However, as one participant

observed the context is never stable as there always is the threat or occurrence of some event such as "a strike, major storm, or pandemic; something is always happening".

Reflections on Leadership and Engagement

As the participants reflected on the development of the Leadership Framework there were a number of important lessons learned about what was important for a leader in making change and what activities were successful. First, was the importance of people to the process and the need to recognize their importance. Building effective relationships and involving others was cited as critical as well. Since engagement requires engaging people there has to be a readiness on the part of the individual as well as a personal commitment to change, in order for any strategy to be effective. For those actively promoting engagement it was important to know how influence is exerted, e.g., the importance of the front line manager and the impact that person can have on staff or for other the visibility of senior management. Good communication was seen as critical as was the acknowledgement of the need for open dialogue. The open dialogue fosters talking with people and helping them see their role or part in the change process. Trusting people with information fosters the type of dialogue needed.

A second important lesson was the importance of having a well thought out plan, however, it was emphasized that there is a need to move beyond the development of a tool or plan because action is required. Having a plan means there is a conscious effort to look at leadership. In moving forward with the plan though it is critical to bring others on board and let them know what is happening around leadership development. Very important too was an effort to have engagement valued at all levels and be adaptable to all the change that was occurring. The last two suggestions by the participants were to keep the mandate of patient care and good patient

outcomes as the goal and have the courage to move forwards despite what seems to be a challenge or even opposition.

Activities to increase engagement. Having a participatory process especially early in the development and ensuring formal leaders are brought together for discussion and input were identified as activities that were very helpful. These activities encourage relationships and signals inclusiveness which are both seen as precursors to engagement. As well a participatory process signals openness to learning and a willingness to engage people on a broad basis. The participatory process can be extended to include employees other than managers and higher level leadership.

Other activities that were believed to be important to success were the creation of a department with staff that were given the responsibility and accountability for developing and implementing the leadership framework. This not only signalled the importance of development of leadership within the organization, but equally important afforded individuals with time to develop and institute policies and promotion of these policies that would move the agenda forward. Key stakeholders created an employee engagement action plan that was designed to address the following issues; recognition, performance management, senior leadership, HR policy and practice, and organizational reputation. An action plan created for 2011-12 had specific activities that were identified for each of these priorities and a report came back to staff one year later that communicated progress on this plan. An employee promise was developed and circulated.

A leadership framework to guide change has to be promoted and specific means of promoting it were instituted. During orientation all new managers are introduced to the framework. The framework is also used on a continuing basis in that it is integrated into all that

is done on leadership, i.e., performance management. As well there are on-going two-day workshops "Leading in a Caring Environment" that are offered to managers and directors in the organization. These workshops are interactive and help participants to learn how to put the LEADS capabilities into actions. There are a number of reflective exercises embedded into the workshop that enable participants to think about the capabilities in action.

Findings from Phase II: Implementation of the Framework

Meaning of Engagement

For the focus groups in Phase II we used the same set of questions based on those established nationally for the PHSI project as we posed in our interviews and focus groups to understand our situational analysis. We began with the questions "*What is your understanding of engagement?*" and "*How do you demonstrate engagement in your work?*" There were some similarities in the responses from this group to the responses of those in the first group in Phase I, but also a few differences. One difference was when the directors and managers talked about engagement it was more nuanced and expanded. While most could give a definition or meaning to engagement, for a few engagement was hard to describe; you know what it is, however it is difficult to articulate, but you definitely can identify what it is not.

Understanding of Engagement. In our exploration of what engagement meant participants identified some important aspects of engagement to keep in mind (see Table 4). First, engagement is not just an abstract concept, but something concrete in the form of an action or how an action is performed. There is a behavioural component to engagement; it is not just intent. It must be demonstrated. Second, engagement is not just a one way process. It was described as a "two-way street" in that for employees at all levels to be engaged, they must feel valued and validated within the organization and by their immediate supervisor. Third,

engagement is not "all or nothing". One can be engaged at certain levels and not at others. It is possible to be engaged within a particular program or department or even a smaller institution within the organization and not engaged in the organization as a whole or the engagement could be just related to the person's profession. Engagement also varies by time as one participant said "it ebbs and flows". Even the most engaged employee might have a bad day or period where some level of disengagement might even be protective of the individual. However, for others, engagement can override negative aspects or difficulties associated with their work, in that it enables you to put these aside and move forward. All seemed to agree that total disengagement was problematic to the organization and there were employees who seemed totally disengaged. A participant also made the distinction between active and passive disengagement in that those that engage in active disengagement try to find an opportunity to undermine what the organization is trying to accomplish. Fourth, engagement does not just happen spontaneously nor by "osmosis", but mechanisms need to be put in place to make it happen, reinforce it, and reward it. That reward can be intrinsic through the satisfaction an employee feels as a result of her or his accomplishments or extrinsic through a formal recognition. Formal recognition programs were thought to be helpful in motivating others as well as reinforcing engagement at the individual level or group level. Fifth and final point, engagement is infectious and when present and felt, you "want to pick up the sign and carry on". All of the participants saw leadership as a vehicle by which engagement could be created and reinforced. In fact leadership was essential to creating an environment in which engagement could occur.

Table 4

Important Aspects of Engagement

1. Not just an abstract concept	Has a demonstrated behavioural component
2. Not just a one-way process	Need to value and feel valued
3. Not usually all or nothing	Occurs at different levels (e.g., organization, department or program, unit, or profession) Personal level of engagement varies by time and situation
4. Does not just happen	Needs to be reinforced and rewarded (intrinsic and extrinsic Must be role-modeled
5. Is infectious	Makes others pay attention Motivates others

Descriptions of Engagement

There were a number of ways that engagement was described. Descriptions of engagement could be categorized into three main groupings: (1) as commitment, (2) as connectedness, and (3) other meanings of engagement (see Table 5).

Engagement as commitment. The most frequently used description of engagement was that it was a commitment and for some participants this was at the organizational level, while for most of the others the commitment was to the particular work they did or to a program and the success of that program. It could also be at all levels, such as "commitment to each other and the commitment to our role and the corporate commitment and the corporate responsibility to our clients, our patients, and our residents is what engagement is all about because that's why we're here". A few qualified the commitment as being to excellence in whatever they did. Commitment means to be bound emotionally or intellectually to something and other related terms used by

participants were loyalty, enthusiasm, passion, or motivation. Meyer and Allen (1997) distinguished between affective and normative commitment. The former reflects attachment and involvement in the organization, while the latter duty and responsibility. Both types of commitment were present in our data.

Engagement as connectedness. The second most frequently used description was that of connectedness or relationship to the organization, part of the organization, or to people within the organization. To be engaged meant that individuals felt part of the organization or at least part of a team or program within the organization. Some felt engagement had to be "more than just my department, connecting with other departments, sharing information, sharing ideas and creating the excitement that comes from that", while for others a narrower focus was sufficient, such as a connectedness to a particular group like their co-workers. Others described the connectedness as a sense of feeling like a community. Engagement was a sense of belonging, connection with others, and could be as part of the mission of the organization. This connectedness gave individuals a sense of ownership and control over what they did in their work. The connectedness had an emotional component in that it encompassed caring about others and this could be extended to the organization and others within the organization.

Other meanings of engagement. There were other understandings of engagement expressed. It could be internalized and expressed as part of the formal definition adopted by the organization "stay, say, and strive" or as one person described as a "buy-in". Other understandings of engagement were more outcomes of engagement and expressed as a form of consciousness "of what you are doing and the people that it affects" or the ownership or control that employees want over what they do. For others engagement was an enabler that when it was

hard to come to work, it was something that allowed you to remain positive and do your work. It was that "positive energy" that helped through difficult times.

Table 5

Definitions of Engagement

Definitions	Descriptions
1. Commitment	Loyalty, enthusiasm, passion, and motivation
2. Connectedness	Relationships, sense of community, feeling part of something
3. Other	Institutionalized "Stay, say, and strive", as an outcome, as an enabler, or positive energy

Demonstrating engagement. Participants agreed that engagement had a behavioural component and gave a number of examples of how they were able to not only demonstrate but foster engagement at work. A frequently cited example was that of being a role model or leading by example that encompassed coming to work with a positive attitude, conveying you wanted to be at work and be involved, enjoyed what you were doing, or striving to do your best. Commitment to whatever role the leader held and appreciation of others' roles in the organization were other means of showing engagement. Others demonstrated engagement through how they interacted or communicated with employees. They made sure they talked with employees and listened to them and their concerns. They offered to share knowledge and experience or assist in any way. It was not only what they did but how they did it; in that "tone, demeanour, and approach to people mattered". It was important to have conversations with employees as a means of connection, but this needed to encompass "really listening to the concerns and issues they're having".

For others engagement was demonstrated by being inclusive, for example, including all in a decision that would affect them by asking for their input of ideas or opinions. Likewise in resolving problems or conflict; making sure all who were involved could assist with problem-solving and contribute to any solutions. These leaders wanted to ensure that any new solutions were largely determined by the employees. Depending on the nature of the problem and the individual employee's situation some mangers stressed you needed to deal with employees individually and in groups.

Necessary Conditions for Engagement

There are a number of conditions or characteristics that directors and managers believed need to be present for employees to be engaged. Some of these conditions were at the corporate level, some at the managerial level, and others at the individual level (see Table 6). Conditions at corporate level and managerial level, while different in scope, often overlapped. At the corporate level there is a requirement of a demonstrated commitment and responsibility to clients so that all within the organization has the ability to feel proud of what the organization is about and what it is doing. At the corporate and managerial levels and in order to foster engagement, a true appreciation of everyone was required, what they bring to the organization, and the constraints under which they are required to work. This can be extended to showing respect for others and their particular roles. Visibility of leaders is important to foster employee engagement because employees need to feel that leaders are present and engaged. They felt they need to know who the leaders are starting with the Board of Trustees and down the line.

Table 6

Necessary Conditions Engagement at Different Levels

Levels		
Corporate	Managerial	Individual
Demonstrated commitment and responsibility to patients or clients	Understanding of the various roles of employees in programs and departments	Ability to find joy in work
True appreciation of the work of all in the organization	True appreciation of the work of people in the department or program	Feel valued
Visibility to all in the organization	Visibility and interaction with employees in the department or program	Have a sense of belonging
	Be present in an authentic way	

Individual level conditions were the ability to find joy in your work and enjoy what you are doing, and being there because you want to be and wanting to do the best within the scope of what is expected in your position. These conditions are often considered in examining job satisfaction. There also needs to be a sense of belonging to the organization and that you are not excluded in any way. There is the sense of being valued as an employee and for what you bring to the organization. A number stressed the individual level conditions and these believed that when these feelings were present they were engaged. The conditions identified at the corporate or managerial levels were enablers that fostered these feelings.

Challenges to Engagement

There are a number of factors that focus group participants believed challenged or even seemed to work against engagement for both managers and employees. These could be divided into structural and individual or personal challenges.

Structural challenges. One of the main structural challenge that was frequently mentioned was the size and complexity of the organization and the many departments and programs that are contained within the organization. This is further complicated by the relatively large geographical area covered by the organization and especially for employees in rural areas the separation from the core that is both spatial and emotional. One can feel a sense of connectedness or commitment to the local site, but not to the organization as a whole. The size and complexity of the organization contributed to having a bureaucratic structure of governance with many restrictions in place and thus working in such an environment seemed to worked against engagement.

Another structural challenge for engagement at the organizational level that was identified was that there seemed to be "silos" constructed between departments and professions so that you may feel engaged within your department or profession, but not to the organization as a whole. This was seen to be an obstacle that needed to have further consideration. Efforts to increase interdepartmental or interprofessional collaboration was not yet felt to be at a desired level to overcome this challenge. In addition sometimes the nature of your work reinforced this perceived obstacle in that you worked solely in a particular unit or department and the busy nature of the work did not always contribute to seeing the bigger picture of the organization.

The creation of Eastern Health out of many different formerly autonomous or semi-autonomous institutions/organizations geographically scattered was seen as a challenge to

engagement to the organization as a whole. These "legacy" organizations as they are described have particular cultures and ways of operating that are being brought inline with Eastern Health and it takes time to even know the new organization. There is still a rural urban split in the organization. The challenge is "how do I feel connected to this huge organization because it is huge. Again but if I'm living in a small rural community, I work in this particular hospital. This is my community. This is my hospital". The need for a sense of belonging, one of the individual level conditions for engagement, is well illustrated in that example.

Perception of how engaged or disengaged employees were was also seen as a challenge. Participants admitted to having concern over the survey results, but felt that the results did not necessarily measure such a complex construct as engagement, and more importantly led to a self-fulfilling prophecy as one manager explained "I think it's almost a theme or culture that staff are disengaged or we're here [Eastern Health] and morale is low and those types of things and I think when you talk to different groups, it's not the fact". A lack of focus on engagement and the importance of engagement that was thought to occur when other events, whether it be budgetary concerns or public inquiries, seemed to be the main focus within the organization. Given how these events are played out in the public media and the need to address these issues with the public, it is not surprising these events would seem front and center for the organization. With so many issues facing the organization, some wondered if engagement "fell through the cracks" and at the higher level "we forgot what the important anchors were to keep people engaged".

Trust or lack of trust at an organizational level was also seen as a challenge. This could be not trusting the system to perform well or deliver because of past experience or not trusting managers at a particular level "people won't be engaged with somebody they don't trust." Some of the lack of trust was attributed to not seeing follow through on various initiatives that had

been promoted within the organization. This issue of trust was compounded when "there is uncertainty in the organization whether it's around layoffs or access to annual leave. Those things hinder people from being engaged". In addition to trust, participants felt that they needed to know they had the support of their leader or the person they reported to most directly.

The part uncertainty played was mentioned by several participants and one large factor contributing to the uncertainty at the time of the data collection for this research was the possibility of lay-offs for those at the managerial level. This uncertainty made some rethink the whole concept of engagement and talk more about self-preservation. Others admitted that their level and feelings of engagement made the uncertainty a more difficult situation and resulted in them feeling torn between loyalty to the organization versus worrying about their own future. It was described as a major distraction and as was pointed out "there's a link between disengagement and distraction. I think people are distracted right now because the layoff issue is a concern for management, it's just as well to say it". They also discussed how this event was illustrative of what needed to happen when similar situations occur. They needed to have good clear communication on the situation and if that was not possible because of constraints on senior management then at least they needed to hear that.

Another challenge to engagement identified was a somewhat pervasive feeling of negativity. This negativity could be on the part of managers and staff, who tended to see the problem side of an issue rather than the opportunity the problem could present. Additionally the negativity could be in how communication was delivered and especially how it was received. There was too much on the communication side of hearing what was done wrong. When this was external communication the effect it could have was far reaching "you got to be careful [about] the negative messages or how the organization was portrayed in the media". Some of the

negative media portrayal made some staff want to distance themselves from the organization and certainly did not contribute to a sense of pride of belonging to the organization. It seems as if the media only want negative stories "We've submitted positive stories and I don't think they [media] want them either".

Individual challenges. A few of the factors that were identified were at the individual level and these were seen as somewhat more challenging to address. They knew that some staff did not see themselves as part of the larger organization and self-identified with their previous institution and wanted to maintain that status. They had other staff who did not want to be engaged, rather "They wanted to come in. They want to do their jobs. I heard this when I spoke to my staff. 'And when I leave I just want to leave'. That's how they view things".

Part of reason for the lack of engagement on the part of some of the staff, but not all, was attributed to generational differences. Generational differences were seen as challenges at the individual level "the whole generational gap that we have, the whole generational differences. We have a young generation that communicate technologically and yet we haven't got WI-FI in our staff lounge or we haven't got the ability to communicate that way and operate that way". As one participant observed this was the first time so many different generations were present in the workplace and there were real differences that if not addressed they could even pose a barrier to leadership and engagement.

Promoting Engagement

Given the variety of challenges on a structural or organization level and at the individual level participants believed a number of strategies needed to be actively employed in order to promote or foster engagement. Some of the strategies were at a formal level and others informal and others cut across both levels. At the formal level they discussed the importance of

recognition programs. Examples of these include the CEO Awards of Excellence, allied health and nursing awards; most of which have a special leadership recognition. Another formal means to promote engagement was not so much targeted towards recognition but more directly at visibility. An example of the latter was the "Walk the Talk" program; a program specifically designed so that patient and employee safety is reinforced. It is designed for those at the Vice President (VP) and director-level to authentically engage with staff at the program level. Another example of encouraging engagement was to change particular processes so that they were more inclusive.

Informally the managers felt that they could employ a number of strategies that would promote engagement. These included being supportive of staff who were demonstrating engagement, being encouraging to staff in their efforts, or being present to staff. One of mangers suggested a way of having a positive impact on engagement was to encourage creativity at work, however she did admit that in order for this to be successful work needed to be done at higher levels to increase accountability of staff.

Strategies that could be employed formally or informally were first, living the values of the organization (respect, connectedness, integrity, fairness, and excellence) whether it is interacting with individuals on a daily basis or in formal meetings. A second strategy in this category was "bringing that [reminder] back to why we are actually here and it's bout the resident, the patient, or the client". Some managers admitted that this was an easier strategy in some programs than others because some programs or departments were not directly involved in patient care, but that the connection had to be made. A strategy that one manager suggested that could help was to ask of all decisions "what impact is this decision having on that patient in the

bed or that decision that the doctor has to make for that patient?" As managers they saw that they had a role to play in involving others in decision-making in order to get the buy-in" needed.

Leadership Capabilities

Capabilities are qualities, abilities or features that can be used or developed or the potential one has as a result of these qualities or abilities. Within the context of our exploration of leadership capabilities they "describe individual abilities required in the unpredictable, complex, and dynamic context in which leadership is required" (Dickson, 2007, p.1). Because our particular interest was in how these capabilities fostered engagement in others, the question we asked our focus group participants to focus on and discuss was "*What leadership abilities or characteristics have helped in achieving the implementation of the leadership framework*"? While the participants made the point that a manager is not necessarily a leader nor possess leadership qualities, they did believe that managers needed to have certain leadership abilities and qualities. They did feel managers were in leadership roles and if the organization wanted to positively effect engagement the managers required certain leadership characteristics. They did recognize too that there were informal leaders within the organization and felt some of these needed to be nurtured and mentored to move into more formal leadership roles. They did not see mentoring occurring at the rate it ought to happen given the aging of many of those in leadership positions. They also acknowledged there were different styles of leadership and not all styles are a good situational or personal fit. Having diversity in styles was important and knowing what style fit the situation and not to be "boxed in by a particular leadership style".

Communication. One of the qualities or characteristics that they saw in leaders and they felt contributed to implementing the leadership framework was first, effective communication. To be effective the communication had to be two-way in that the leader needed the ability to

inform those under her/his leadership, but to listen and in particular to hear. The communication needed to be truthful and honest, as did the leader, because the employees had to believe in the authenticity of what the leader said and did. The communication needed to be open because "managers are the most trusted source of information for our employees and if we do not have timely and respectful communication to our group then it kind of falls apart". Openness was a feature that transcended communication because it was required for ideas and for change; to be open-minded was important. It also applied in the context of admitting as a leader you made a mistake or were wrong.

Knowledge. Knowledge or being knowledgeable was mentioned by a number of participants. This knowledge pertained to having a good working knowledge of the organization and what it was about, solid knowledge about your own portfolio and if applicable the roles and people under your responsibility, and knowledge of issues you are dealing with because "you can't lead if you do not know." One of the challenges for new leaders was making sure that they had the necessary knowledge and knowledge of what was their span of control. Knowledge of self was important as was having the ability to learn from others. Leadership also subsumed certain types of knowledge, i.e., what leadership is, styles of leadership, and how to lead within different contexts.

Follow through. A third quality mentioned by a number of participants was "follow through" on the part of the leader "If you promise to do something or look into something you absolutely need to follow through as a leader". This ability to follow through was tied to the leader's credibility and to be a leader you had to be credible. Follow through was also tied in with effectiveness as a leader and could be used to determine if one was a good leader or not. To be able to follow through the leader had to be a good decision maker and to support those decisions.

Visibility. Another capability was that of visibility, leaders need to be seen, although perhaps more important was that "leadership needs to be visible". There were a number of ways that this leadership could be visible, such as in communications to employees, i.e., in documents, and in planning activities. A visibility of leadership was that plans were carried through in specific actions and outcomes and not just on paper. The visibility is not just to be seen but it serves a broader purpose. Employees need to know who their leaders are and that they are accessible and have an interest in employees and issues concerning the employees. An authentic presence is required.

Inclusiveness. Inclusiveness and the ability to include others in work activities was seen as another important capability. This was a means of getting others involved in solving problems related to their work. There was a broader function for inclusiveness in that it helped promote the idea that everyone is responsible for their work. It also promoted teamwork because if "you have an engaged leader you're going to have an engaged team and you're going to have a better product than doing it all on your own". Related to inclusiveness and an important means of encouraging inclusiveness was good relationship building abilities as well as the ability to work in teams.

Vision. Vision was identified as an important capability of leaders. It is the ability to see the bigger picture in what you and others are doing. As well it is about a vision for change and how to achieve that change. It is keeping in mind the vision that the ultimate goal of why the organization exists is "for the patient". To help with achieving this vision means "a leader anywhere in the organization is thinking outside of the policy and outside of what I've got to do today . . but thinking about the connection with other people and the continuum of a process."

Role model and mentor. The leader is a role model and a mentor to others and leaders need to understand and use these capabilities well. They need to role model the important characteristics identified by the participants. One participant spoke to the importance of his and how it was done "To me when I lead, I help facilitate, I help move people. I don't lead people, I help them move themselves". It is leading by example, being positive, prioritizing, and enthusiastic. Some mentioned the importance of internalizing the first part of the LEADS framework "leading self". Being a mentor to others and encouraging their development as well as identifying and encouraging emerging leaders was seen as important to the present leaders.

Other capabilities. Other capabilities mentioned were consistency, flexibility, being empowering, empathetic, understanding diversity, caring, having autonomy, and being available. For a number of these abilities or characteristics participants spoke about a balance. First there needed to be consistency in what leaders did and this was balanced by being flexible in approach when that was possible. Consistency also needed to be balanced by fairness to all involved. Having autonomy is balanced by taking responsibility and that responsibility extends to "decisions good or bad". Empowerment and delegation are a balance in that the former makes the latter not seem so top down and instils a sense of responsibility.

Leadership and Engagement

The next question explored was on the question of leadership and engagement: *Who are the key leaders and what do they need to do to achieve optimal engagement on the part of managers and employees?* There were wide ranging discussions on this topic and a number of divergent views. Some saw leadership in a hierarchical way with leadership starting from the top or the CEO or mainly residing there. Next were the VPs, directors, and for some then frontline

managers. The reason that they believed upper levels were key was that many of the initiatives were executive decisions by the very nature of the initiative and had to be made at a higher level.

In the discussion of what these individuals needed to do, visibility was seen as very important because if staff do not see the presence of senior leadership the message is that they're not being heard or their view is not important. Being heard and being valued by the organization was believed to encourage engagement. Inaction or lack of visible action worked against engagement, but the communication of the status of an action was seen as critical as well. The identification of key leader varied by institution in that in the major acute care facility, they "needed the CEO to be front and center", while for geographically diverse institutions directors or managers were seen as important for visibility.

Others saw leadership in a more situational manner with different leaders having different functions when it came to promoting engagement and for these the leader ought to be appropriate to the situation as explained "things that have to be made at a VP level because they're really systemic, there are things that need to be made at the director level, and things that have to be made at a manager level". In terms of what was required to be effective most agreed that getting others involved in leadership activities was important.

Many identified the frontline manager as a key leader in terms of engagement because of her or his more direct impact on the staff. The frontline manager was not only the person who was the conduit or "in between", between frontline staff and senior management and executive, but critical to enabling work in units and reinforcing what is happening in the direction of the organization. A few moved the notion of a key leader up to the director level and felt that because the managers were so busy it did not allow for the responsibility for leadership to be at

that level. Managers were seen to be one of the positions with the most job demands and accompanying responsibilities.

For others key leadership was more diffuse. Some saw key leaders at every level because everyone in the organization is a "stakeholder". Others saw leadership at the team level and what these individuals accomplished together was important and illustrative of leadership. They did stress the importance of evaluating these teams in some way to ensure they were operating in a proactive manner. Finally a leader could be situational; when someone shows leadership skills in a particular situation.

How leaders encouraged engagement. Leaders encouraged or fostered engagement in a number of ways both formally and informally when they promoted leadership. Formally, leadership was fostered through workshops, e.g., LEADS workshop and having reminders of the Leadership Framework in the form of notepads and mousepads. These were good reminders of the framework because they helped keep in mind the capabilities and the language of the capabilities and this helped to make it a normal language and a way of thinking about leadership. Performance evaluation, although not strictly speaking a strategy for engagement, could be used to that purpose or to at least get a feel for how the person being evaluated felt about her or his work.

However, the formal mechanisms are not sufficient and respondents identified a number of ways they encouraged engagement. Some of these mechanisms were ensuring staff involvement, having them come forward with issues and work on these issues. They also tried to have staff become involved in issues outside their immediate work area so they could feel part of a larger group. Encouragement of individuals and activities was another strategy as well as "helping them to grow their own portfolios, to help them with their resumes, simple things like that would really give them a sense of oh yeah, I'm really important".

Communication was identified as a means of encouraging engagement; how you communicate and what you communicate matters if you are trying to have a positive effect. One aspect of communication that was stressed was that it needed to be timely and consistent. Even though there are more than 13,000 employees in the organization they needed to get the same formal communication at that the same time and current technologies make this possible. To this end a good communications department was essential as was a clear and formal communication plan. The importance of a communication plan was attributed to language "language is so important and comments you make can be interpreted many ways, so you need to be sensitive to that".

Another strategy that was important was to foster leadership at every level in the organization. Some participants had already seen how effective this could be "I know it's amazing when you can identify people and start to mentor them or engage them in activities that give them a challenge and they can rise to that challenge and it doesn't matter what level they are in the organization." There was a recognition that leadership development was key at the managerial level and this was balanced with what to do at the level of front-line workers. If it is at that level where disengagement is problematic then it has to be addressed there, because this is an area of the most interface with the public through interactions with patients.

Activities to Increase Engagement

Although participants had felt that a great deal had been accomplished in terms of leadership and engagement, they still felt there was work left to be done. We used the opportunity of the focus groups to have participants assist us with the final research question: *How can knowledge of effective leadership be translated and mobilized by the network into programs, tools, and techniques to develop a culture of effective leadership in Canada, and*

enhance the development of quality health leaders? We did this by particularizing the question to their situation and asking: *What learning activities do leaders need to ensure sustainability of the initiative of increased engagement?*

In the longer term respondents talked about creating a culture of engagement and identified that all had a role to play in this. While there was some discussion about how this could occur there was general agreement that the environment was key. One suggestion was to keep talking about engagement "but I think if we create a culture in talking about it [engagement], discussing it and doing things at least we're putting money where our mouth is kind of thing. The organization will look at it, that we're trying to engage people in some form or fashion and to modify it where needed." While this participant recognized the challenges in doing this, it at least kept any momentum towards increasing engagement going.

Focusing on pride in the organization was also seen as a strategy for leaders to embrace and promote and this would also help to create the culture of engagement. Participants gave examples of a number of successes such as awards received by employees, especially national awards, and strategic initiatives they had achieved. There needed to be more emphasis on success and less on failures and errors, however, the latter needed to be addressed and used as a learning opportunity.

Another activity that was seen as important for increasing engagement was research. One participant used the example of the challenges that were being seen with integration of the various institutions/sectors and the effect this had on engagement within the organization. This proposed research could lead to identify specific strategies that would help create more discussion around the impact of integration and what needs to be done to strengthen engagement. Challenges can then be addressed in a constructive manner because it is not enough to attribute

challenges to factors without knowing how to address them: "Size of the organization, it's a challenge, right, the connectedness and the communication [also challenges] but it's not impossible and sometimes I wonder if that's not the default position, is because 'oh we're so large and it's not possible'. But it is indeed possible."

There also has to be ways to be proactive on some of the changes that were happening and one of these was bringing on new and younger employees for leadership. Consideration of generational differences was a key in that development and having a knowledge of these generational differences, expectations of the diverse groups, what leadership styles were important:

> This is the first time ever we've looked at four generations of individuals in the workplace. You have baby boomers, generation X, generation Y and all a mixture in a workplace together. So I mean you really have to be diverse. You look at generation X and baby boomers as well they didn't have a manager and things like that. They stayed in workplaces. They didn't move to any other workplaces. So it's kind of different so the whole culture is different. It needs to be sustainable to maintain it in a framework. I think you really got to be diverse.

Reflections on Leadership and Engagement

The managers and directors had made a number of important observations about the implementation of the leadership framework and effects they felt it had on engagement. In particular they talked about what they had learned and were applying. In this discussion the two examples they used were the FISH! Philosophy© and the LEADS in a Caring Environment Framework. The FISH! Philosophy© reinforced such characteristics as having a positive attitude about work, having a sense of fun and enjoyment even though health care was "serious" you

could still be happy and smile more, and above all have a readiness for whatever may come your way. The FISH! Philosophy© was felt to align well with and reinforce the LEADS Framework.

The LEADS in a Caring Environment Framework was mentioned as having a positive effect and in particular participants frequently referenced the capabilities, even if not always directly referenced to the LEADS Framework. Each of the five capabilities are addressed below together with some examples identified by participants.

Lead Self. Many discussed this capability as possessing self-knowledge and knowing what type of a leader one is and what influences their leadership style. Taking responsibility was important and this extended to responsibility for self development. Characteristics of self-motivated leaders, as suggested in the LEADS framework, were also what these individuals felt they brought to their situations, especially those of honesty and integrity. A participant summed up the importance of this capability: "I think the first part of our LEADS framework in terms of leading self is a big piece of that [being a leader] and kind of, you know, having that constant reflection about where you sit as a leader and how your values align with the values of the organization and those kinds of things." Other specific references were:

- Makes you see you own strengths, what you can bring to something (Are self-aware);
- Lead by example, by looking after yourself (Manage themselves);
- Important to look after your own professional development (Develop themselves); and
- Always be honest, employees appreciate that (Demonstrate character).

Engage Others. The second capability seemed to be the most frequently mentioned capability in terms of strategies that participants employed and that might be attributed to the fact

that it might seem to have the most resonance with our research. They recognized the importance of both team work and being inclusive if they were to increase engagement. Bringing departmental members together to work on common issues and valuing their input in these interactions was important. Showing caring in how you approach and interact with others was mentioned as a critical element. Other instances were:

- Helping newer staff with putting together their resumes (Foster development of others)
- Have those involved with the issue give input (Contribute to the creation of healthy organizations)
- Communication is a two-way process and it is important to listen to others (Communicate effectively)
- People who engage, engage others in return (Build Teams)

Achieve Results. Much of the discussion was around being goal oriented. They could see the importance of linking the goal to all their activities and talked about the goal of seeing how every activity was ultimately linked to good patient care. This extended beyond those in direct care services as the manager of one such department observed: "We really have seen engagement in staff very much about around LEADS [framework], being the ones that make the decisions and helping to improve the processes on their floor and taking some you know, ownership about the care of their patients and making sure they're getting their patients in on time". Other specific examples were:

- Need to decide what the goal is and follow that (Set direction)
- Have to show how actions related to the vision and goals of the organization (Strategically align decisions with vision, values, and evidence)

- If you make a decision then follow through with action; cannot be just in a plan (Take action to implement decisions)
- To sustain learning from framework must decide on outcomes and measure these (Assess and evaluate)

Develop Coalitions. This was another capability where participants could give a number of good examples of how the capability was carried out in practice. Some were in terms of going outside their own department or program to create broader connections. They saw the purpose of the connections as important vehicles to improve services to clients in that all had a role to play in that goal. Others recognized how leaders for geographically dispersed programs needed to pay attention to all the employees in the program despite the spatial challenge facing them and to use the necessary technology to do so. This meant being aware of some of the challenges those in outlying areas may feel and trying to overcome those challenges. Other instances were:

- Need to involve more than own program or service (Purposefully build partnerships and networks to create results)
- All need to keep in mind the ultimate goal-the patient (Demonstrate a commitment to customers and services)
- It's a lot learning from each other and I think that's important[because] there are really good examples happening. (Mobilize knowledge)
- Sometimes have to realize that directives come from outside the organization (Navigate socio-political environments)

Systems Transformation. The last LEADS capability that of "Systems Transformation" was referred to in the discussion by some participants more than others. It was present to the degree that many in the directors and managers groups were future oriented. There was a concern

about succession planning for leaders and what part they could play in that role. There were others through that were more oriented to the present or had a narrower focus and it is difficult to say how much the timing of the research was a factor. A major concern for at least the manager group was an impending lay-off announcement for that group. They had to admit it was a preoccupation and the uncertainty over what was going to happen and was a "distraction" and distraction works against engagement. Other examples of systems transformation as a capability were:

- Always have to keep in mind the bigger picture when making changes (Demonstrate systems/critical thinking)
- One key thing to sustain engagement is to be open to change and new ideas and different ideas (Encourage and support innovation)
- I'm not interested in sustaining what we have now. I'm interested in creating and then sustaining (Orient themselves strategically to the future)
- We have to look at new ways of doing things (Champion and orchestrate change)

Overall, LEADS was evaluated positively and was making a difference to leadership and how individuals thought about and practiced leadership. That is not to say there were not challenges as a participant said "there are many aspects of LEADS of course, that's very important. But we just find it very difficult to be able to do that all the time". Some felt it would be timely for an evaluation of LEADS, look specifically at a team in which the leader has used the framework and "look at their work and assess what they do and kind of see what they should do and maybe where they should focus their attention". They did feel the current research was helpful in examining the area of leadership and engagement. One of the main gaps identified was that front-line staff were not getting the advantage of learning about leadership and if everyone

in the organization was expected to exhibit a degree of leadership then somehow this needed to be addressed.

Discussion and Implications for Practice

The present case study was designed to first, explore how an implementation of a leadership framework was related to the goal of increasing engagement in Eastern Health, second, to identify what we see as gaps between current practices and expectations for leadership, and third, based on our findings to look at recommendations that need to occur to further enhance leadership capacity to continue to increase engagement at all levels.

Effective leadership is an important initiative on the part of Eastern Health and the importance of this is well represented in the documents of the organization. In the Leadership Strategy (2008-11) (Updated March 23, 2009) there was an acknowledgement of the importance, but equally acknowledged the challenges, and the need for a comprehensive plan that would address the leadership needs. Also acknowledged was that in order to engage employees, effective leadership is a critical factor and that there are a wide variety of levels of leadership: executive, director, manager, clinical/team/leader, physician leader, and all employees and that the developmental needs of these various levels differ yet nevertheless overlap.

Both leadership and engagement were seen as very complex constructs especially within an organization as complex, large, and covering such a wide geographical area as our discussions on engagement illustrated. The geographical diversity was a real challenge for some of the directors and even for many of the managers if their responsibilities covered departments that spanned what was seen as the geographical divide or referred to as the "urban-rural split". Complexity and size or the organization were more challenging for others as they discussed how the Leadership Framework might help in the their work.

Through the exploration of leadership capabilities and what was required to achieve the change desired around engagement of management and employees, there was definitely some diversity of opinion. Part of the reason could be in how leadership was understood to be structured within the organization. The Leadership Framework based on LEADS is very much a distributed leadership model, but not all saw that as the actual leadership model that was in place. To some leadership was still quite hierarchical and top-down and that made the capabilities in the systems transformation part of LEADS more challenging because greater autonomy was required to use these capabilities. Those who did believe there was a distributed leadership in the organization felt leadership preparation had to be more widespread and include front-line staff: "That's where our services are being delivered so it's not entirely useful for just the managers to have heard and seen that bit [LEADS Framework] but not translated to frontline people".

The status of engagement and how to address this issue was an area where there was also a great deal of discussion. For some the survey findings were not congruent with their personal observations about either management or engagement and did not see what was represented by the survey results. Others felt that if they had some responsibility to improve engagement they required more information and feedback about their particular department and what was important to that department. The nature of the disengagement would help to indicate what leadership capabilities might be needed or best employed. This group felt that the exercise of developing action plans at a department or program level for engagement would help.

Leadership development was seen as a continuous process and some of our participants were new in their leadership positions and had only a brief exposure to the Leadership Framework through their orientation and not yet had the opportunity to take part in the workshop designed for leaders in Eastern Health and these individuals did admit that in order to understand

and employ the capabilities under "develop coalitions" and "systems transformation" they had other development needs. These developmental needs related to having a good working understanding or the organization and the roles of various positions of key people in the organization. They had to have a better knowledge and understanding of the socio-political context in which they were working. This context is quite complex and changing and takes time to more fully understand much less use that understanding.

Implications for Practice

From the research and analysis of the findings we were able to identify some leadership areas that could be strengthened. These are presented under communication, attention to diversity, and creating a culture of diversity. These are all areas where leadership has play an important part to play.

Communication. In all interactions with participants communication came up most frequently as an important capability for leaders to address. In particular participants wanted the communication to be honest, open, timely and accessible to all at the same time and felt this could be enabled by technology. The timeliness was important because they felt silence had detrimental effects. Communication then operates on rumours and this spreads the wrong messages. There was an acknowledgement that for some matters there has to be a lag in decision-making because the final decision may lie outside the organization, but updates on the status could still be communicated. It is acceptable to say "I do not know yet" and why. The stress engendered by a communication lag on an important issue affecting people at any level can be detrimental to feelings of engagement.

The communication also needed to be well-crafted so as not to get the wrong messages out. The other aspect of the communication was that it needed to be positive. Too much negativity

still prevailed and there was a real need to break that cycle. Good communication is not just at the leader's level but can be promoted at all levels of the organization and in particular to front-line staff and their interactions with co-workers and patients/clients/residents. That communication needed to be appropriate and professional. Interactions with patients is not a time to talk to other staff about personal or social issues "patients can hear". There was also a need for communication to be two-way for leaders to listen to the concerns of employees on any issue, seek their input and to listen. Finally in terms of leadership and engagement through communication there was a need to keep the message of engagement in the forefront. They could talk about and use the language of LEADS in daily practice but more importantly to link actions to LEADS language.

Attention to diversity. Large health care organizations are complex and diverse and sometimes it is the perceived or real differences from this diversity that can be a challenge for leaders and particularly leadership. Three areas of diversity were identified. The first was geographical differences. Geography shapes identities in terms of a sense of place and space, so the challenge is how do leaders see and use these as positive forces. The challenge is how to identify and address these issues and determine which are particular to place and which ones relate to the organization as a whole. Are there particular strategies leadership strategies that will assist with this diversity? It does take time to shift identities from a small regional board and institution to a larger one.

The second area of diversity was generational differences and how these affect engagement and the type of leadership required. Some participants wondered if the younger generation had a better work-life balance than older generations and that we might need to think of engagement in different ways that we have previously. There was also a sense that many of these may not

readily see career opportunities within the organization, so how do we mentor younger generations and recognize their contributions. There is also limited choice of younger people who wish to remain in the region to be employed in health care outside Eastern Health so in the absence of choice how can it still be made an attractive option.

Create a culture of engagement. The larger project for leaders and leadership is to create a culture of engagement. The participants saw that some of this work had begun and needed to continue. Addressing the two gaps that were identified above could help with this project. The participants did see that a multipronged approach was needed and that all employees in the organization had a part to play. While they recognized that the Leadership strategy and Leadership Framework were important tools, a limitation they identified were that they were aimed at the management level and above. It is unrealistic to think that every employee in the organization can attend and participate in the workshop designed for the leaders, but how to extend the reach of that framework to front-line employees. The LEADS framework is described as designed for "all levels of the health system" (LEADS in a Caring Environment –leads.cchl.ca) so the challenge is how to get it to all levels.

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Appendix A: Study Questions

Core study questions	Node sub-questions	Initial situational analysis	PAR cycle 1 (repeat for cycles 2 and 3)	
What is your understanding of engagement? What leadership capabilities do leaders need in order to initiate and implement engagement?	How do you demonstrate engagement in your work? What leadership capabilities are required to facilitate and achieve successful health system change with respect to the initiative of increased engagement?	What leadership capabilities were responsible for creating the current state of readiness with respect to the initiative of increased engagement?	What leadership capabilities are contributing to achieving the goals of increased engagement?	What leadership capabilities will be required to accomplish the goals of the next phase of the initiative of increased engagement?
How does leadership at different contextual levels of the health system affect engagement?	What leadership actions and by whom, appear to align effort(s) at all levels of the system (local, provincial, national) to initiate and implement change in the initiative of increased engagement?	What leadership actions, by whom, at all levels of the system, contributed to the current state of the initiative of increased engagement?	What leadership actions, by whom, are required to align efforts at all levels of the system to initiate and implement change in the next phase of the initiative of increased engagement?	What leadership actions, by whom, will be required to sustain efforts at all levels of the system to implement change in the next phase of the initiative of increased engagement?
Who was effective in exercising leadership in support of engagement, and what roles did they play, and what did they do?	Who were the key leaders in the initiative, and what responsibilities were required of them, to create effective change in the initiative of increased engagement?	Who were the key leaders, and what responsibilities did they perform, in order to create the current state of the initiative of increased engagement?	Who are the key leaders, and what roles are required to create change in the next phase of the initiative of increased engagement?	Who will be the key leaders, and what roles will they required to take in order to sustain change through the next phase of the initiative of increased engagement?

Where did the impetus for change come from, internal vs external? Bottom up vs top down?	Where did the change imperative start for the initiative of increased engagement?	Where did the evidence for change come that helped to shape the initiative of increased engagement?	Where is the sustained leadership coming from to execute the initiative of increased engagement?	Where will the longer term leadership come from to sustain the initiative of increased engagement?
What external and internal factors influenced leadership across and between levels of the health system in order to achieve sustained, meaningful engagement?	What contextual factors, internal and external, both impede and facilitate leadership of sustained, meaningful change in the initiative of increased engagement?	What contextual factors, internal and external, impeded or facilitated leaders' abilities to achieve the current state in the initiative of increased engagement?	What contextual factors, internal and external, are impeding or facilitating leadership of sustained, meaningful change in executing the initial phase of the initiative of increased engagement?	What contextual factors, internal and external, may impede or facilitate leadership sustained and meaningful change in the next phase of the initiative of increased engagement?
What learning opportunities will maximize the potential of leaders in the Canadian health system to sustain long term health system transformation?	What leadership lessons from past practices are important for leaders of change to learn?	What learning activities do leaders identify as having been effective in the initiative of increased engagement?	What learning activities are leaders participating in as part of the initiative of increased engagement?	What learning activities do leaders need to ensure sustainability of the initiative of increased engagement?

Appendix B: Documentary Sources Accessed

The following is a list of documentary sources accessed for understanding contextual factors of the leadership and engagement.

Eastern Health (n.d.) *Our developing leadership promise . . .* (Pamphlet)

Eastern Health (n.d.) *Together we can: Our employee promise . . .* (Pamphlet)

Eastern Health (n.d.) *Leading in a Caring Environment: A workbook for Eastern Health Leaders*. Participant workbook.

Eastern Health (n.d.) *The LEADS story* (Pamphlet)

Eastern Health (March 2009). Leadership framework: Management accountabiities.

Eastern Health (2012) *Together we can: Annual performance Report 2011-2012.* Retrieved from *www.easternhealth.ca/publicreports.aspx*

Eastern Health (March 2011 *Employee engagement action plan.*

Eastern health (2011). Together we can: Strategic Plan 2011-2014. Retrieved from http://www.easternhealth.ca/publicreports.aspx

Eastern health (2011). Mapping our success: *Annual performance Report 2010-2011.* Retrieved from http://issuu.com/easternhealth/docs/annual_performance_report_2010-2011?e=7060942/4992799

Leaders for life (n.d.) *Leadership self-assessment for mid-level leaders.* (Assessment Survey)

http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-for-engagement-improvement-nhs-final