# Building Momentum and Diffusion of LEADS across Canada

**A Brief History**

Prepared as background for Chapter 11 of the second edition of the LEADS book edited by Graham Dickson and Bill Tholl, and as reference document commemorating the 10th Anniversary of CHLNet

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# Author Note

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## *Introduction*

Within a span of a decade the LEADS in a Caring Environment leadership framework (LEADS) was developed and widely adopted across the health system in Canada. This has been a very atypical development given the highly decentralized nature of the Canadian system. In fact, to refer to it as a "system" stretches the definition as in reality there are 14 health systems across the country: 10 provinces, 3 territories and a federal government system for specific population groups.

The emergence of leadership as a major priority for the health system in Canada began to receive concerted attention around 2005. During the previous decade, several Royal and provincial commission reports pointed to the need for major reforms in the health system. In the discussion of the various dimensions of reform there was frequent mention that leadership would be critical. Yet to that point very little attention had been given to identifying leadership capabilities that were need for health leaders and managers. This lack of focus on leadership was greatly compounded by the decentralized nature of the Canadian health system. While the "system" is held together with underlying principles in legislation and financial levers exercised by federal Government, there are substantial differences among the jurisdictions. In this context Canada has not done well with the uptake of successful innovations as spreading ideas and practices from one jurisdiction to another is often hindered by the tendency to home-grow solutions (1).

## *Creation of CHLNet*

The early roots for the creation of a health leadership network and the development of a leadership competency framework can be traced back to work done in British Columbia by the Health Care Leaders Association of BC (HCLABC) in conjunction with Royal Roads University (RRU). A Health Leadership Symposium held at RRU in fall 2004 sparked interest in developing a contemporary health leadership competency framework. HCLABC under the leadership of Geoff Rowlands put forth a Health Leadership Capacity Strategy with funding providing by the Health Leadership Council of BC, an organization consisting of the Deputy Minister and Health Authority CEOs (10).

Elevating health leadership to a priority across Canada was a complex process that required coalition building and networking. The "developing coalitions" domain in LEADS was lived out in the formation of the Canadian Health Leadership Network (CHLNet). Two forces converged in the early 2000s to create a platform to build support and momentum for health leadership. First in 2004, a group consisting of the CEOs of several national health associations based in Ottawa began to discuss how they could enhance leadership capacity in the Canadian health system (4). The initiative was spearheaded by Bill Tholl, then CEO (General Secretary) of the Canadian Medical Association. The group engaged the recently retired CEO of Accreditation Canada (then called the Canadian Council on Health Services Accreditation), Elma Heidemann, to support the group. Representatives of this group participated in the health leadership symposium in fall 2004 at RRU, noted above.

Second, the Canadian College of Health Leaders (CCHL) (then called the Canadian College of Health Service Executives), recognized it had to enhance its role in leadership. In the first 30 plus years of its existence, the College's priority was on credentialing health service managers focusing largely on skills

and abilities needed to function as a successful manager at an institutional level. In 2004, the College created a Leadership Advisory Committee including a wide range of organizations including the Canadian Society of Physician Leaders and the Academy of Canadian Executive Nurses. Don Philippon was a member of that Committee (1). The then CEO of the Canadian College of Health Leaders (CCHL) was a member of the CEO group noted above group and within a few months serious questions were raised as to why there were two groups.

The decision to merge both groups and form CHLNet was a critical coalition building step. The process started in 2006 with a Steering committee structure with the network being formalized in 2009 (5). The merger was facilitated by having two founding co-chairs – Elma Heidemann and Don Philippon, key players in the two merged initiatives. Each brought valuable coalition building experience. Elma was well informed about health care players at the national level, had extensive knowledge of the health care organizations across Canada from her former CEO role with the accreditation council and had network contacts with health system leaders. Don had served in senior leadership positions in two western province both at the policy and operational levels, including having been a Deputy Minister, had experience working on the federal-provincial scene, and had academic interests in health system performance and leadership. CHLNet was well positioned from the outset with a critical coalition partners as 12 major national organizations were founding members. Within a few months the organization secured sufficient resources to hire a part-time executive director, a role Bill Tholl assumed as the founding Executive Director. This was another critical coalition building enabler given Bill's background on the national scene with the CMA and other national associations and his deep roots with the federal Government. At the outset, the six objectives for CHLNet were to:

1. Create a community of interest focused on enhancing health leadership;
2. Espouse a culture of knowledge exchange on leadership initiatives;
3. Facilitate greater organizational commitment to leadership development;
4. Encourage the coordination of research in the areas of leadership;
5. Create an environment that recognizes and celebrates health leaders; and
6. Serve as a forum to position leadership within pan-Canadian health human resources planning processes.

## *Foundational initiatives for CHLNet*

Work done by the groups prior to merger laid the foundation for CHLNet. The CCHL's Leadership Advisory Committee had commissioned a situational analysis and scoping work as the basis for a National Consultation forum that followed to determine the size of the health leadership domain in Canada (6). A follow-up piece of work on a theoretic modelling exercise (7) and another on human resource issues and information gaps pertaining to health care leaders and managers (8) was completed (2006). These analyses provided the basis for a proposal to Human Resources and Skill Development Canada in 2006 (9) to undertake a major sector study which never did materialize. However, the data gathering, and related discussions provided important background for CHLNet to better understand both the scope and challenges with health leadership in Canada. The CEO group had made some critical linkages with the Centre for Health Leadership and Research at the University of Victoria (then led by Dr. Graham Dickson) and the Health Care Leaders Association of BC. The symposium in fall 2004 at RRU noted above had converged on the idea of developing a contemporary leadership framework.

From the outset the work of CHLNet was guided by two key principles: the network was to be a coalition of the willing meaning there was no compulsion to join and the approach for all the work would be leadership without ownership which meant a sharing all results with network partners. These principles quickly generated interest among several organizations and the membership of the network grew. In the initial period the Canadian Medical Association (CMA) served as the host organization for the Network, a relationship that had been forged by Bill Tholl. Later this function was assumed by CCHL where it resides to this day.

The initial discussions at CHLNet exposed the frustrations around leadership development in Canada. While every new health initiative stressed importance of leadership, there was no concerted approach as to what leadership development should look like for the Canadian health system. The situational analysis noted above estimated the number of persons in leadership roles to be in excess of 90,000 but there were no common definitions of roles/titles and organizations tended to rely on one short course often at costly US universities to provide leadership development. A recurring observation was that leadership was given lots of lip service and had become almost a throw away word. Conviction developed around the CHLNet table that a more concerted focus was needed. This would include a definition of leadership domains as focus for leadership development. Fortunately for CHLNet, work in BC had proceeded to the development of the initial LEADS framework. CHLNet began to examine how it could build a leadership framework that would be accepted nationally. Given the nature of the Canadian federated system, it was obvious that simply to adopt a framework developed in BC would not work. So CHLNet secured funding support from a national research granting agency to conduct workshops across Canada using work done in BC as one source of input. The result was the creation of the "5 C" Framework which mirrored many aspects of the LEADS framework. In the period 2006-2009 the two frameworks co-existed but increasingly the wisdom of that was being questioned. So CHLNet contracted Dr Graham Dickson to look at how the two frameworks could be merged (Dickson 2007).

Several key developments between 2007 and 2009 set the stage to propel the LEADS framework as the preferred health leadership framework in Canada. First, the CHLNet Leadership Summit in May 2007, that included leaders from across the country, provided guidance to Dr Dickson on the need to create a framework that resonates with all jurisdictions in Canada. Second in fall 2007 the Canadian Health Services Research Foundation agreed to provide funding to help develop and validate the leadership framework. Third, in September 2008 the CHLNet Leadership in Motion conference, again with leaders from across Canada, made a strong case that health system change was intrinsically tied to leadership. Finally, the formal adoption of the new LEADS in a Caring Environment framework in September 2009 by both CHLNet and CCHL gave the new framework legitimacy across Canada (1).

In 2009, the importance of leadership in health system renewal was given a major boost with the Leadership and Health System Redesign project. The four-year project was overseen by a network of senior decision-makers and health researchers and was funded by the Canadian Institutes for Health Research (CIHR) through its Partnership in Health System Improvement (PHSI) program and the Michael Smith Foundation for Health Research (MSFHR) in BC. Six case studies explored leadership dynamics at play across Canada in redesigning the health system to help develop leadership capacity in the Canadian health system through applied research and knowledge translation. The project was stewarded by a network comprised of senior decision-makers (under the auspices of CHLNet representing over 40

health organizations) and representatives of the health leadership research community from nine universities across Canada (with Royal Roads University [RRU] as institution of record).

Building momentum around a focused interest on leadership was a major early accomplishment of CHLNet. Sustaining that momentum has been the more recent challenge. With a very minimal core administrative budget, Kelly Grimes who succeeded Bill Tholl as Executive Director working with an engaged Secretariat drawn from the membership has developed a very action oriented and inclusive agenda that involves many people from across Canada.

Almost ten years later, the 12 founding organizations have expanded to over 40 network partners. The vision for CHLNet remains the same: *Better Leadership, Better Health – Together*. Members now cut across jurisdictions, policymakers, academics, health associations, regional health authorities, patients and health disciplines. To be a part of this value network, prospective partners agree to embrace LEADS or LEADS-compatible framework as a leadership platform for their own organization and promote the framework within their respective spheres of influence.

CHLNet's work continues around three value streams: *Connecting People through Dialogue and Engagement; Advancing Health Leadership Research, Knowledge and Evaluation; and Accelerating Leadership Practices and Capabilities*. The value streams and many deliverables in the work plan use LEADS (or LEADS compatible framework) as a foundation. CHLNet initiatives now evolve through a series of working groups, comprised of decision makers and academics, which oversee specific projects to enhance leadership capacity in the context of current and future health reform.

Over the past decade, CHLNet has raised awareness through a collective voice about the critical importance of quality leadership to health system performance; stimulated the application of the best evidence, research and knowledge to leadership development and to the practice of leadership; and supported LEADS as the dominant health leadership framework across Canada.

## *Formation of LEADS Canada and the LEADS Collaborative*

The adoption of LEADS was made easier by two characteristics of the framework. First, while the research that underpins the framework drew from many different and well-known models, the resulting LEADS framework with its five domains was seen as both intuitive and simple to comprehend. It was never put forward as introducing new concepts but rather as a distillation of the best in the literature and packaged in a simple and coherent format. Second, a basic distinction was made early in the background research between "capabilities" and "competencies" and the LEADS framework is a capabilities framework. The basic distinction is that LEADS does not provide a precise set of competencies but rather critical domains and capabilities for leadership from which more specific competencies can be built.

Between 2009 and 2014 several organizations across Canada began to use LEADS including: Alberta Health Services; Hamilton Health Sciences Centre, St Michael's hospital, the Association of Community Health Centres, Community Care Access Centres and the Muskoka Local Health Integration Unit in Ontario; Manitoba Health; Prince Edward Island health authority; Regina and Saskatoon health authorities in Saskatchewan; Capital Health in Nova Scotia; Eastern Health in Newfoundland & Labrador; and the Canadian Agency for Drugs and Technology in Health, the Canadian Institute

for Health Information, the College of Family Physicians, the Canadian Medical Association for its Physician Leadership program, and HealthCare*CAN* at the national level.

The rapid uptake and widespread interest that was quickly developing meant the LEADS framework had to migrate to a more formalized model. Yet guided by the early principles of CHLNet – coalition of the willing and leadership without ownership – meant attention had to be given to an appropriate model for achieving this. There was a genuine concern that having the framework become a propriety offering of one organization would undermine the continued organic spread of the framework. Three interrelated issues arose: intellectual property (IP); governance of the framework including ever greening and building tools; and need for a formal organization to market and provide LEADS related services. Given the multiplicity of people and organization with a stake in LEADS this became a major challenge. However, despite the natural tensions that develop in situations of this kind, solutions were found that provide the platform for LEADS at the present time.

First, the LEADS Collaborative was formed to bring together the four parties that were instrumental in getting LEADS developed: CCHL, CHLNet, Dr. Graham Dickson and Royal Roads University. This structure has now evolved into the present LEADS Collaborative Steering Group, comprised of CHLNet, CCHL and Dr. Graham Dickson with two sub-committees focusing on leadership evergreening and business development. Second, CCHL acquired IP rights from the Health Care Leaders Association in BC and from Royal Roads University. This created an issue regarding recognitions for the work done by Dr. Graham Dickson. CCHL took an enlightened view and worked out an agreement to share IP with Dr. Dickson. Third, CCHL created a "subsidiary" called LEADS Canada to market LEADS, develop tools, control licensing and deliver LEADS related educational and developmental services. Working within a non-profit, sole-source model, LEADS Canada's approach to leadership development has been to partner with health organizations to co-create LEADS-based leadership development programs. The intention of the LEADS Canada programming is to build internal capacity and LEADS sustainability within health organizations for both individual leadership development and promoting a positive cultural change.

## *LEADS Canada: Mission and Programming*

CCHL made an initial investment to centralize the LEADS framework to a national organization and support existing contracts when LEADS moved from its' original home in BC. This started as an additional portfolio for an existing full-time position at CCHL. However, supporting and distributing of LEADS-based services quickly took on a life of its' own. LEADS Canada was formed with Brenda Lammi as its head and this organization has since evolved from a 1.8-person operation with 13 facilitators to an eight-member administration team with 30 certified LEADS Canada facilitators, 112 Organizational LEADS Facilitators and over 60 certified LEADS Executive Coaches. The growth of LEADS Canada is attributable not only to its' approach to partnering with client organizations, but also through the inspirational sharing of time and knowledge by Dr. Graham Dickson and other leading experts to guide decisions and provide input on direction and networking.

The mandate of LEADS Canada is to work within three strategic priorities: (1) knowledge generation and exchange; (2) provision of leadership development services and programs; and (3) the development of tools and assessments. Within the three strategic priorities lies the common themes of best practices supported by evidence and a client-centred lens with the purpose of capacity building within organizations. The foundational LEADS-based services offered through LEADS Canada have been determined by the co-creation process with many health organizations from across Canada.

In addition to providing direct services, LEADS Canada provides the licensing of LEADS and the certification of individuals to build capacity for the sustainability of LEADS. The purpose of the licensing and certification is to ensure integrity of the application and integration of LEADS.

## *Putting LEADS to Work: The Extent of LEADS Diffusion in Canada*

The diffusion of LEADS across Canada is extensive. The uptake has been very organic in that there have no central directives from government to utilize LEADS. A recent tally indicates over 100 organizations are using LEADS across Canada. In many ways this greatly understates the level of utilization as in several cases LEADS has been adopted by the provincial heath authority, so they are using it in many sub organizations and units. In addition, many people in the health system reference and utilize the framework in a variety of ways without accessing any specialized services from LEADS Canada.

LEADS Canada has created and supported a moderated Community for Practice for individual leaders, certified LEADS facilitators and coaches, and client organization representatives. The idea behind the Community for Practice is to promote the sharing of dialogue, resources and creative solutions faced by those developing and applying their skills, integrating the framework within their organization, and/or creating innovative ways to build skills in others. The Community for Practice is a pan-Canadian network of leaders (regardless of title) speaking the same leadership language, who are motivated to contribute to health system transformation. This Community for Practice was designed using best-practices for online communities and includes a moderator who is both a LEADS Canada facilitator and coach, regularly scheduled events (distribution of readings), ad hoc events (moderator led Q&A opportunities), targeted webinars, and an in-person event.

The annual in-person event is the LEADS Exchange Day held on the third day of the National Health Leaders Conference. It is a well-attended event with participants from across the country representing those interested in using LEADS, to the early adopters looking to share and/or be inspired by others. LEADS is not only widely used in Canada but the framework is has proven to be very robust so it lends itself to a wide variety of applications, including serving as the backbone for leadership development in organizations; supporting performance assessment with its 360 tool; framing the assessment of the impact of leadership initiatives (LDI toolkit), and guiding recruitment and succession planning.

## *Conclusion*

A recent review, that will be covered in the upcoming book on LEADS edited by Dickson and Tholl, concludes that the Canadian experience in developing a national approach to leadership development is different from approaches in Australia, the United Kingdom and New Zealand**.** The backbone of the Canadian approach has been the use of a national leadership framework, “LEADS in a Caring Environment.” The LEADS journey in Canada was inspired by the need to improve the performance of the Canadian health system. Health care leaders themselves took the initiative to better define capabilities needed for effective leadership. A symbiotic relationship between the Canadian Health Leadership Network with its health organization membership footprint, and the Canadian College of Health Leaders that credentials individual leaders has been fundamental in this journey. LEADS Canada, a part of CCHL, is advised on an ongoing basis by a collaborative involving CHLNet, CCHL, and Dr. Graham Dickson, the principal researcher behind the LEADS framework. The LEADS framework is now well diffused across the country with uses in all provinces and at the national level.

Early assessments indicate that it is making a difference, particularly in elevating the confidence of leaders to tackle major changes to improve the performance of the system to achieve better health outcomes.

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