



Canadian Health Leadership Benchmarking Survey Report: *CHL-Bench*

May 15, 2014

Preface

The Canadian Health Leadership Network (CHLNet) is a purpose-built coalition of 40 organizations (member representatives are referred to as Network Partners). It has initiated a consultative process on a Canadian Health Leadership Action Plan. This Benchmark Study is a key building block in that action plan. CHLNet's vision, **Better Leadership, Better Health—Together**, will be achieved only through gathering data about the need for better leadership, and targeting energy of its Network Partners on new and more innovative ways of working together to grow leadership capacity. The intent is outlined in detail in its new strategic plan (see www.CHLNet.ca).

Over the last eight months CHLNet supported an ad hoc, expert working group to guide this benchmarking study. Its members include: Dr. Owen Adams (Canadian Medical Association), Dr. Ivy Bourgeault (University of Ottawa and Canadian Health Human Resources Network), Dr. Graham Dickson (Royal Roads University and CHLNet Senior Policy Advisor), Ms. Beatrice Keleher Raffoul (Association of Canadian Academic Healthcare Organizations), Dr. David Williams (University of Ottawa), Mr. Bill Tholl (Canadian Healthcare Association and CHLNet), and Ms. Kelly Grimes (CHLNet). We also wish to thank Dr. Glen Roberts (Roberts-Insight) and Metrics@Work for their insights and contributions to the project.

The purpose of this benchmarking study is to track key leadership metrics over time to allow leadership investments and interventions to be evaluated. It leverages a 2007 CHLNet commissioned study by the Conference Board of Canada. CHLNet is very appreciative of the funding and in-kind support provided by: Health Canada, the Canadian Academic Healthcare Organizations (ACAHO), the Canadian Healthcare Association and the Canadian College of Health Leaders.

Executive Summary

The Canadian Health Leadership Network (CHLNet) conducted a nation-wide benchmarking survey that closed on February 2, 2014. It identified key leadership metrics that could be tracked over time, allowing for evaluation of leadership interventions and investments. Established in the fall 2013, a working group comprised of CHLNet network partners and academics guided this effort. Four questions framed the survey: is there a leadership gap in Canada? What is the size of the gap? How important is the gap? And lastly - What is being done to close the gap? Three sample frames were used: CHLNet/Health Action Lobby (HEAL) members, Association of Canadian Academic Health Organizations (ACAHO) Members, and Other (organizations identified in the CHA guide). Results were tabulated for each group and combined (Total Respondents) and are outlined below:

Is there a *leadership gap* in Canada?

- ✚ Yes. However, results are divided. ACAHO Members responded “No” more often than Total Respondents about its future leadership’s capacity when asked “Do you believe your organization has the leadership capacity to respond to future challenges and reforms?” (ACAHO 42.1% vs. Total 32.2%).
- ✚ Approximately, one half of Total Respondents see the gap as being the same as five years ago with fairly equal distribution among those seeing it as larger versus smaller.

What is the *size* of the gap?

- ✚ The majority rated the leadership gap to be small to medium size and see it more as a skill gap than a supply-demand one. More respondents rated the skill gap as medium to large for middle management (52%) than senior management (45%).

How *important* is the gap?

- ✚ Just over half of Total Respondents rated the supply-demand gap as important to very important for both senior managers/executives and middle managers/supervisors groups. This number rises to almost two thirds with respect to a skills gap for both groups. This suggests that respondents view the importance of the gap to be one around capabilities rather than supply-demand.
- ✚ Interestingly for Total Respondents, demonstrating a commitment to customer and service is seen as the most critical leadership capability; but they see developing themselves as the least critical.

What is being done?

- ✚ *Time for Leadership Development* - 38% of Total Respondents and 56% of ACAHO Members protect time for leadership development.

- ✚ *Leadership Development Programs* - 29% of Total Respondents rated their satisfaction with their organization's leadership development programs as satisfied or very satisfied. ACAHO rated higher at 44% satisfaction.
- ✚ *Leadership Development Budget* - 30% of Total Respondents rated their satisfaction with their organization's leadership development budgets as satisfied or very satisfied. ACAHO rated higher at 50% satisfaction. The percentage of budget devoted to leadership development has increased since 2007 moving from 1.04% to 1.65% in 2014.
- ✚ *Adoption of LEADS or another capability framework* – 47% of Total Respondents have adopted a leadership capabilities framework. The number jumps to 63% for ACAHO Members.
- ✚ *Succession Planning* - 39% of Total Respondents and 63% of ACAHO Members have a formal approach to succession planning.
- ✚ *Emerging Leaders* - 38% of Total Respondents and 75% of ACAHO Members have formal process to identify emerging leaders.

These findings corroborate that there is some truth to the perception that there is a leadership gap occurring in Canada--although half of responding health organizations believe it to be the same as five years ago. Concerns seem higher for Canadian Academic Health Science Centres (ACAHO Members) than others in the health care system about the extent of this gap and how strong they see their leaders on critical leadership capabilities (especially around innovation and self-development).

The majority of health care organizations do not seem to be protecting time for leadership development. There is low satisfaction with leadership development budgets and programs. However on the positive side, reports of leadership development budget increases since 2007 seem to have occurred. Academic Health Science Centres seem to see the need to identify emerging leaders and to implement formal succession planning. They report to be more pervasive in adopting a common leadership capability framework such as LEADS. The importance of these leadership issues need increased attention across all health care organizations.

What more needs to be *done*?

Research does show that leadership--especially quality physician leadership--is a key foundational enabler of health system performance and health reform. Large-scale change requires new or enhanced capabilities for our formal leaders around systems thinking, strategic thinking, relationship development, and self-leadership. In sum, these findings strongly suggest the importance of creating a national health leadership action plan that cuts across all levels of the health care system.

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Canadian Health Leadership Benchmarking Survey Report: *CHL-Bench*

Introduction

Major reports raise concerns that the Canadian healthcare system is unsustainable, delivers mid-level performance and does not have the leadership capacity to transform. The Royal Commission on the Future of Health Care in Canada flagged the need for “stronger leadership” (2002); the Health Council of Canada recommended more “supportive leadership” (2012); and the Premiers’ report *From Innovation to Action* identified “present leadership” as one of four critical factors for better system performance (2012). The Health Council of Canada’s September 2013 report *Better Health, Better Care, Better Value for All: Refocusing Health Care Reform in Canada* called for strong leadership as the first of five key enablers of high performing systems.”¹

As a result, leadership is increasingly being identified as a critical success factor in health system performance. Yet there is what many perceive to be a growing and widening leadership gap. This study is aimed at gathering quantitative data to inform that perception: to either validate it, or refute it.

A multitude of factors may explain the perceived gap. Often cited are the complexity and pace of change occurring in the health system, and the aging profile of current leaders.^{2 3} Many experts view leadership no longer as a function of position or authority.^{4 5 6} Recently, proponents of the LEADS Collaborative⁷ extend that notion to characterize health leadership as a ‘social good’ that is being depleted as organizations continue to act independently rather than

Leadership is no longer just a leadership challenge (what good leadership looks like), it is a development challenge (the process of how to grow bigger minds).

—Petrie, 2011

¹Health Council of Canada. (September 2013). *Better Health, Better Care, Better Value for All: Refocusing HealthCare Reform in Canada*.

² Dickson, G., & Tholl, W. (2014). *Bringing Leadership to Life in Health: LEADS in a Caring Environment*. London: Springer.

³ Oblensky O. (2010). Complex Adaptive Leadership.

⁴ Corrigan J. (2013). Distributed Leadership: Rhetoric or Reality. *Journal of Higher Education Policy and Management*, Vol. 35, No. 1: 66-71.


⁵ Denis, J.-L., Lamothe, L. and Langley, A. (2005). The Dynamics of Collective Leadership and Strategic Change in Pluralistic Organizations. *Academy of Management Journal*, Vol. 44, No. 4: 809-837.

⁶ Fitzgerald L, Ferlie E, McGivern G, and Buchanan D.(2013).Distributed Leadership Patterns and Service Improvement: Evidence and Argument from English Healthcare. *The Leadership Quarterly* **24(1)** (February): 227–239.

⁷ The LEADS Collaborative is a coalition of CHLNet, the Canadian College of Health Leaders (CCHL), Royal Roads University and Dr. Graham Dickson established to promote the idea of health leadership as a social good—using the LEADS in a Caring Environment capabilities framework as its foundation.

collectively for our long term best interests.⁸ Leadership is a skill to be acquired and literature is showing the skills needed for leadership are changing with more complex and adaptive thinking required. There is now an emerging discipline of health leadership and leadership development. Health leaders are often seen as an invisible human resource issue with human resource strategies focusing on front line providers. Countries such as the United Kingdom and Australia have adopted system-wide health leadership strategies as part of national reform efforts, and are devoting more resources to leadership development training.

In September 2009 the Canadian Health Leadership Network (CHLNet) formed, supported by 12 founding partners, with a mission of: *Advancing exemplary health leadership in Canada through the efforts of a network of organizations and leaders*. In the last five years, CHLNet's value network has grown to 40 health care organizations from across Canada. CHLNet's primary goal remains to help its network partners enhance leadership capacity across Canada, across the lifecycle of leadership and across the health professions through four value streams: (1) dialogue and engagement; (2) research, knowledge mobilization and evaluation; (3) LEADS framework and tools; and (4) development of a Canadian health leadership strategy.



Leadership is the collective capacity of an individual or group to influence people to work together to achieve a constructive purpose: the health and wellness of the population we service.

—Dickson and Tholl, 2014

Background

In 2013 CHLNet's Network Partners decided that a baseline assessment of leadership capacity and capabilities was required. CHLNet's intention for this benchmarking study (CHL-Bench) was to develop a database of common leadership performance metrics against which to measure/benchmark the impact of leadership investments. The survey would be administered every three to five years to assess where Canada has progressed around leadership development and enhancing capacity. Four broad themes framed this endeavour:

- ✚ The need to clarify the perceived extent of the leadership gap that is occurring in Canada;
- ✚ The importance of health leadership as compared to the CHLNet's 2007 survey *Leadership Development Practices*⁹;

⁸ Dickson, G., & Tholl, W. (2014). *Bringing Leadership to Life in Health: LEADS in a Caring Environment*. London: Springer.

⁹ The Conference Board of Canada. (November 2007). *The Canadian Health Leadership Network Learning and Development Outlook: A Report on the Leadership Development Practices in the Canadian Health Sector*.

- ✚ The desire to contribute to creating an inventory of leadership development and training programs across Canada (formal and informal); and
- ✚ The extent to which leadership/management development and succession planning is occurring within Canadian organizations (with examples collected of policies and programs).

An original Conference Board of Canada survey, conducted in 2007, did not garner the response rate or breadth of results required to establish a validated data base by which to evaluate progress on health leadership in Canada. The rushed timeframe for its creation contributed significantly to the resulting issues. At the time, CHLNet provided a database of 500 organizations but only 48 completed surveys (i.e. less than a 10 % response rate). The survey was not pre tested and many of the questions did not reflect the dynamics of the health leadership sector as well as they might. It did not differentiate between professional and leadership development. Twelve senior leader one hour interviews were conducted to augment results at a work level.

Despite these limitations, interesting data (as of 2007) was generated such as:

- ✚ Health care organizations were committing less to the development of employees than Canadian organizations as a whole i.e. \$632 per employee or 1.04 % of payroll (compared to 1.8 % for other sectors).
- ✚ Health sector employees were even less satisfied with their training, learning and development opportunities than other Canadian employees (44 % health organizations satisfied). These opportunities were often delivered in a more decentralized way.
- ✚ Canadian health care organizations relied more on informal learning on the job (71%).
- ✚ In 73 % of health care organizations, leadership development programs for middle management were external off the shelf (developed and offered externally).
- ✚ Health organizations questioned the effectiveness of their leadership development programs with only 19 % believing in their effectiveness.

These are troubling indicators that required testing in a more fully and robust study. Consequently this study was commissioned to take stock of where the country is in the health leadership journey and where CHLNet needs to go to achieve *Better Leadership, Better Health – Together*.

Myths and Misconceptions

Health leadership has many myths and misconceptions and two common ones are put forward here. The first is that the leadership gap is seen as a knock against current leaders which puts many in a defensive position and unwilling to take action. Instead evidence is showing that the leadership gap is more around capacity and skills mix, not individual performance. The health system is a complex adaptive system that requires new skills as the health system is transformed to improve performance.

The second misconception is that in the past, leadership has often been seen as an elitism concept -- only about executive leaders. But leaders are distributed throughout the system and include emerging

leaders and physician leaders. Leadership development is not just for the elite but all leaders. Human resource and talent management strategies must address a wide pool of leaders and include succession planning.

The four-year, *Leadership in Health Systems Redesign* research study funded through the Canadian Institutes of Health Research (CIHR) and the Michael Smith Foundation for Health Research (MSFHR) grants, explored the leadership dynamics at play in Canadian health reform.¹⁰ These qualitative findings showed that Canada does not have the desired leadership capacity to lead significant health reform and new skills are needed such as systems thinking and relationship development. It showed that quality physician leadership is required for reform to be successful but also found that the increase in politicization of the system combined with increased turnover among senior policy and executive leaders is diminishing overall leadership capacity.

Methodology

Given the results of the previous 2007 survey, a new methodology was initiated. To begin the project a working group was established, comprised of network partners and academic advisors. A survey was constructed that enabled organizations to benchmark their performance over time with their peers. The group designed the survey so it could be administered every three to five years with organizations participating on an ongoing basis. The information collected would enable health organizations to compare and benchmark, with their peers, their leadership efforts over time.

An online, ten to 15 minute survey was administered in early December 2013 (see Appendix A). It gathered information about tools and programs being accessed for leadership development). The survey used a stratified sampling of three groups: CHLNet Network Partners (n=35) and Health Action Lobby Members (HEAL n=40)¹¹; Canadian Academic Healthcare Organizations (ACAHO n=38); and other health organizations taken from the Canadian Healthcare Association Guide (who kindly granted CHLNet access to their Guide as an in-kind contribution).¹² The survey and accompanying emails targeted Chief Executive Officers, Chief Operating Officers or designated Human Resource people.

After significant discussion and research, four research questions framed the survey for the three sample frames:

1. Is there a leadership gap in your organization?
2. How important is the leadership gap?
3. How large is the leadership gap?

¹⁰ Dickson G, Tholl B, Baker R, Blais R et al. (2014). *Partnership in Health Systems Improvement Leadership in Health Systems Redesign: Cross Case Analysis*. Canadian Institutes for Health Research/Michael Smith Foundation for Health Research Study.

¹¹ CHLNet and HEAL categories were combined due to the overlap and uniformity in members/network partners. Members or network partners can include government, national and provincial health associations, patients groups, universities and research organizations.

¹² The CHA guide master list garnered 3,330 names however when only CEO emails are used (rather than general information emails), organizations with no email addresses removed, duplicates removed, and delivery errors removed, the distribution list became 298 (11% of the original sample).

4. What is being done to close the leadership gap?

Following pre testing (n=6), several of the questions that required the respondent to find additional data (such as size of their budget) were removed to shorten the time for completion and simplicity.

Metrics@Work, a provider of organizational measurement administered the survey, which had been developed through the working group with the aid of an external consultant. Both French and English versions were made available. Respondents were assured that information would remain confidential, and that only aggregated data would be shared publicly.

Several questions were tracked from the 2007 to 2014 survey. As well, the 'leadership level' definitions used in 2007 were slightly modified. Recently too the Conference Board of Canada surveyed organizations to compare strategic focus areas across Canada.¹³ From this survey a few additional questions were added. ACAHO members also had additional questions on their leadership development programs and tools being used that

could be added to the CHLNet

Leadership Development

Inventory.¹⁴ Respondents originally

were provided one month to

complete the survey; three

reminder emails were sent. To

accommodate distractions of the

holiday season, the survey closed

February 2, 2014. Metrics@Work

compiled the data in an Excel

format for this report.

Health leaders of the 21st century will need to have the capacity to see the future faster, to manage and mentor talent better and to service growing health needs within increasingly restrained budgets.

—CCHL, LEADS Booklets 2013

Findings

Overall a wealth of information was garnered from this survey. A response rate of 58 % (65/113) was achieved across the two sample frames (ACAHO 50% and CHLNet/HEAL 61%) and 8% (25/298) for the "other health care organizations" category. The findings from the survey are organized according to the four research questions below.

Is there a leadership *gap* in Canada?

- ✚ Yes. But results are divided. ACAHO Members responded "No" more often than Total Respondents with respect to its future leadership's capacity when asked: "Do you believe your organization has the leadership capacity to respond to future challenges and reforms?" (ACAHO 42.1% vs. Total 32.2%).

¹³ The Conference Board of Canada. (2010). *Learning and Development Outlook*.

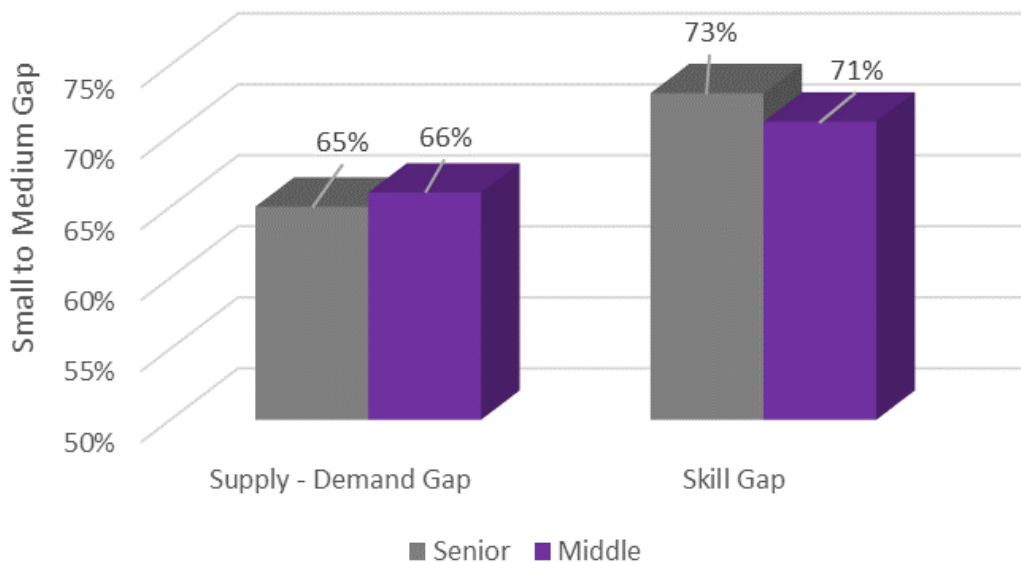
¹⁴ The CHLNet Leadership Development Inventory collects programs from across Canada in one central place. It is a benefit for CHLNet Network Partners only and so can only be accessed on the password protected side of chlnet.ca. It was created with initial funding from Health Canada in 2010.

- ✚ Approximately, one half of Total Respondents see the gap as being the same as five years ago with fairly equal distribution among those seeing it as larger versus smaller.

What is the *size* of the gap?

- ✚ The majority rated the leadership gap to be small to medium size and see it more as a skill gap than a supply-demand one. More respondents rated the skill gap as medium to large for middle management (52%) than senior management (45%).

Figure 1: Size of Leadership Gap

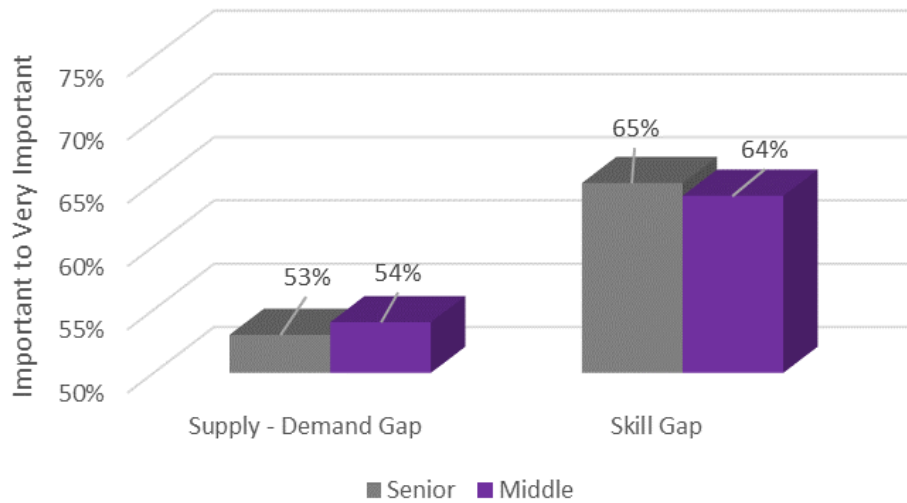


How *important* is the gap?

- ✚ Just over half of Total Respondents rated the supply-demand gap as important to very important for both senior managers/executives and middle managers/supervisors groups.¹⁵ This number rises to almost two thirds for a skills gap for both groups revealing that respondents view the importance of the gap to be one around capabilities rather than supply-demand.

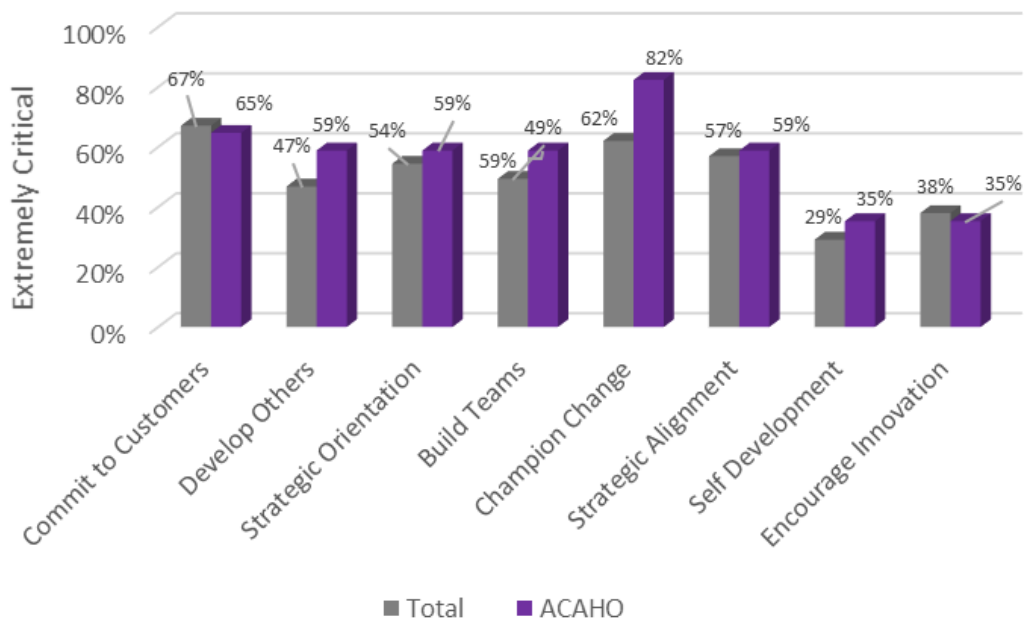
¹⁵ Question five from the survey used a five point Likert Scale for importance.

Figure 2: Importance of Leadership Gap



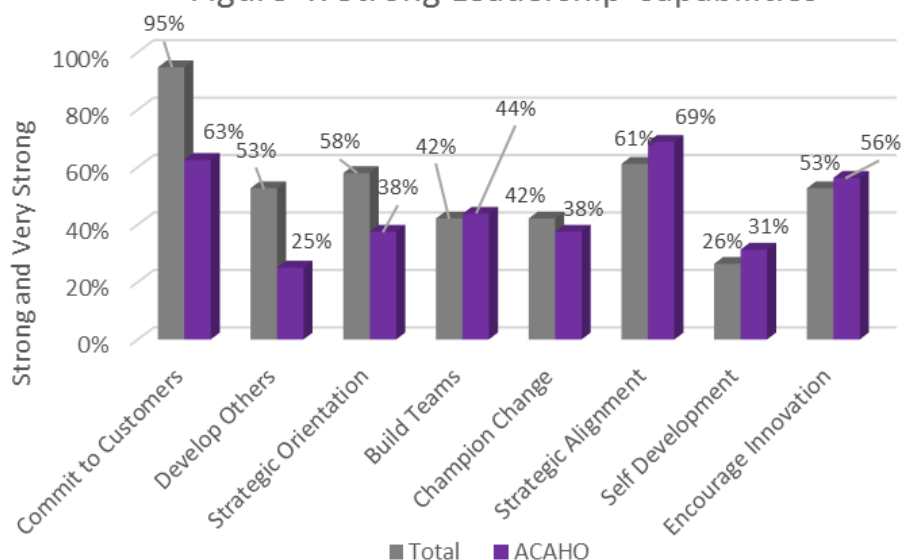
- Interestingly for Total Respondents, demonstrating a commitment to customer and service is seen as the most critical leadership capability but developing themselves and encouraging innovation as least critical. ACAHO Members scored almost all capabilities more critical than the other groups.

Figure 3: Critical Leadership Capabilities



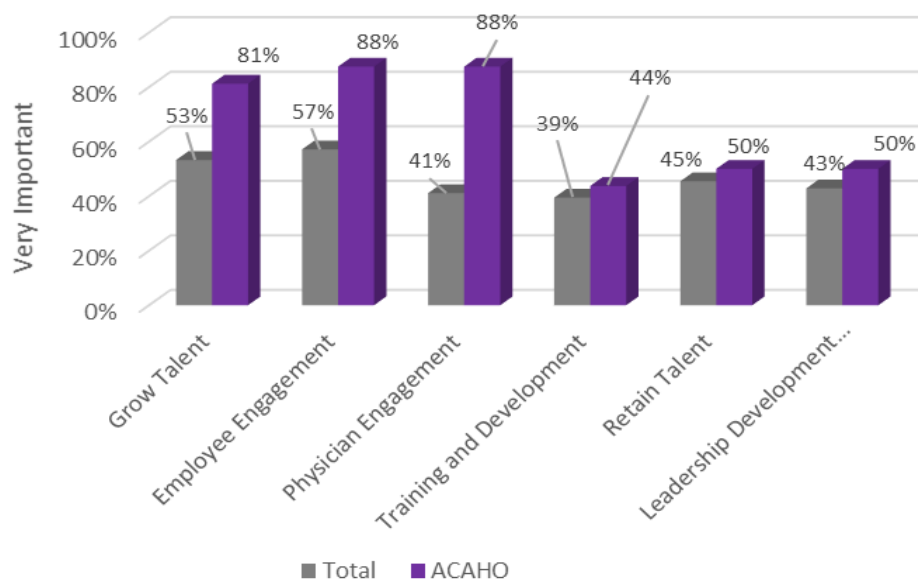
- Other health care organizations tend to score their leaders higher on the critical leadership capabilities than ACAHO or CHLNet/HEAL Members. Developing themselves and encouraging innovation again rates lower, with higher results for demonstrating a commitment to customers and service, and strategically aligning decisions with vision, values and evidence.

Figure 4: Strong Leadership Capabilities



- Around the importance of human resource strategies to the organizations, ACAHO Members rate importance higher consistently than the other groups especially for growing talent internally, and raising both employee and physician engagement. Leadership development and training and development rank lower in terms of importance.

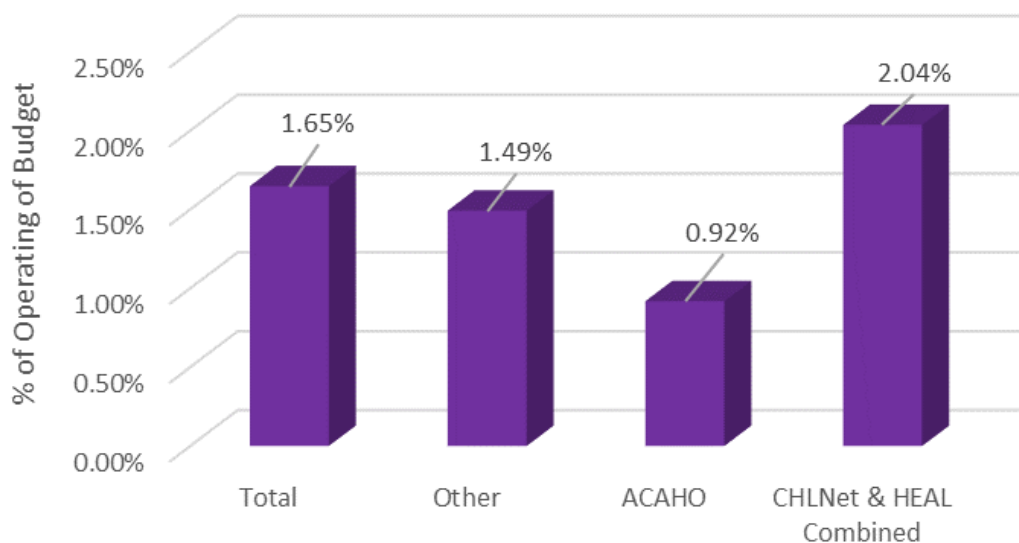
Figure 5: Important HR Strategies



What is being *done*?

- ✚ *Time for Leadership Development* - 38% of Total Respondents and 56% of ACAHO Members protect time for leadership development.
- ✚ *Leadership Development Budget* - 30% of Total Respondents rated their satisfaction with their organization's leadership development budgets as satisfied or very satisfied. ACAHO Members rated higher at 50% satisfaction. The percentage of budget devoted to leadership development has increased since 2007 moving from 1.04% to 1.65% in 2014.¹⁶ This may be due to the framing of the question between the two surveys.¹⁷ This is still lower than the private sector which was 1.8% in 2007.

Figure 6: Training and Learning Spent



- ✚ *Leadership Development Programs* - 29% of Total Respondents rated their satisfaction with their organization's leadership development programs as satisfied or very satisfied. ACAHO Members rated higher at 44% satisfaction. Leadership development programs tend to be more formal¹⁸ for ACAHO Members (61% vs 46% for Total Respondents) than informal although overall fairly balanced. This may be due to the availability of resources in larger health care organizations for LD programs. This is a similar result for Total Respondents between 2007 and 2014.
- ✚ *Leadership Development Delivery* - ACAHO Members are more centralized¹⁹ in their leadership development delivery (58% vs 52% for Total Respondents). Overall delivery seems to have become more centralized since the 2007 survey, moving from 31% to now 52%. Typically health

¹⁶Three outliers were removed that indicated they spent 30 to 50% of their operating budget on training and learning.

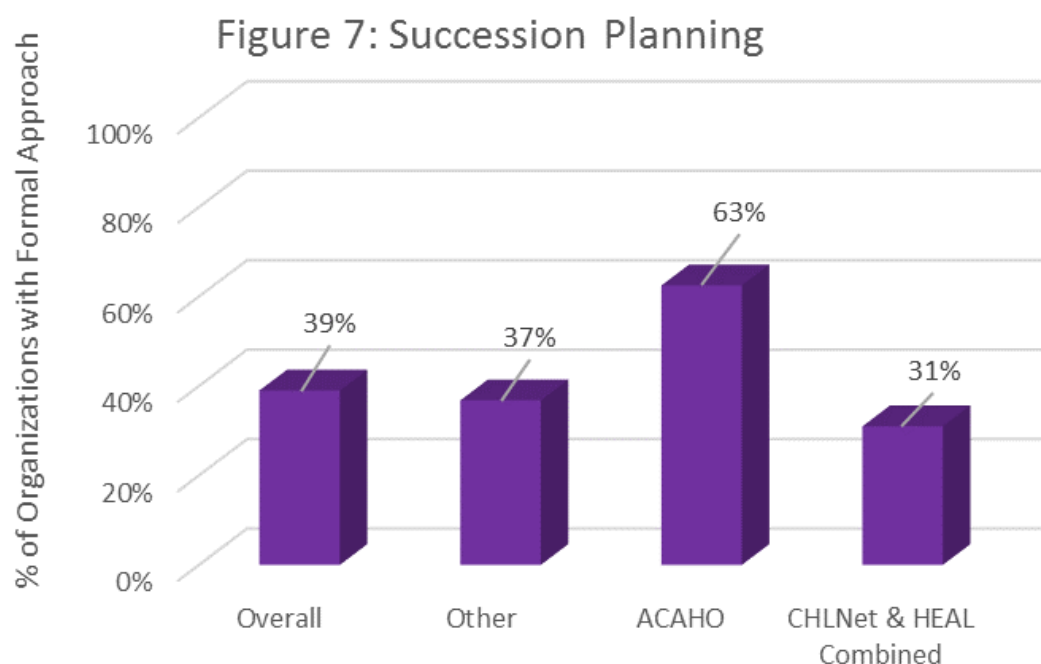
¹⁷ In 2014 only estimates of percentage of budget were requested rather than actual budget numbers to shorten the time to complete the survey.

¹⁸ For the purposes of the survey, the term "formal" is defined as structured training programs or tools. "Informal" refers to mentoring, coaching or ad-hoc programs/tools.

¹⁹ For the purposes of the survey, the term "centralized" is defined as leadership programs delivered centrally by human resource departments. "Decentralized" programs are delivered at the work or front line level.

care organizations use a combination of in-house leadership programs (62%) and external off-the-shelf programs (66%) for leadership development delivery rather than using planned career assignments or executive education programs. This was a similar result to the 2007 survey.

- ✚ *Joint Training* – 94% of ACAHO Members offer joint training across disciplines.²⁰ This compares to 59% for Total Respondents.
- ✚ *Distributed Leadership Model* - In the last five years, organizations have moved to a more distributed model of leadership where leadership is collectively performed or shared between multiple individuals and organizations (greater than 80% in all groups).²¹
- ✚ *Adoption of LEADS or another capability framework* – 47% of Total Respondents have adopted a leadership capabilities framework. The number jumps to 63% for ACAHO Members.
- ✚ *Succession Planning* - 39% of Total Respondents and 63% of ACAHO Members having a formal approach to succession planning.

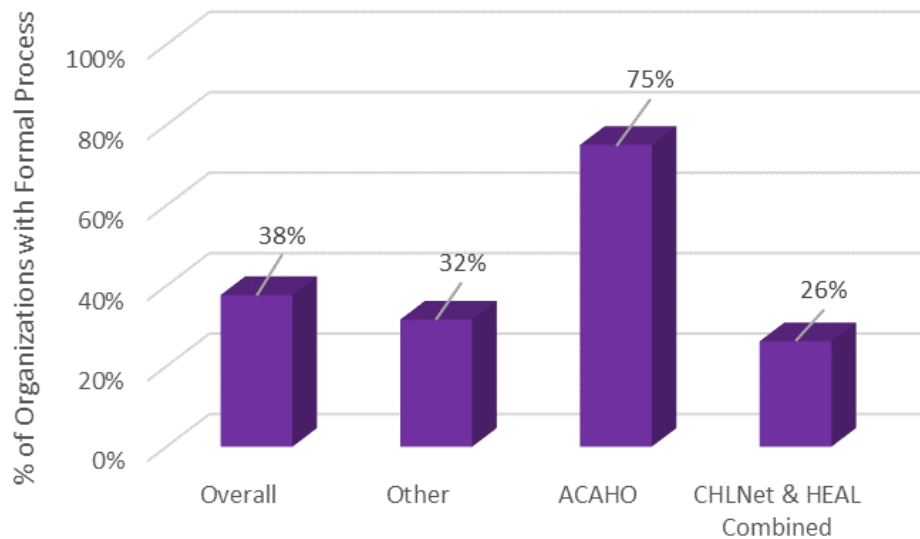


- ✚ *Identifying Emerging Leaders* - 38% of Total Respondents and 75% of ACAHO Members have formal process to identify emerging leaders.

²⁰ Joint training was defined as health providers such as physicians and nurses with administrators.

²¹ For the purposes of this survey, distributed leadership is defined as leadership that is collectively performed or shared between multiple individuals or organizations. Due to the leading nature of how this question was structured, the result may be higher than in expected.

Figure 8: Identify Emerging Leaders



What more needs to be *done*?

These quantitative findings show that there is a leadership gap occurring in Canada. A similar conclusion was made in the 2014 Partnership in Health Systems Improvement Leadership in Health System Redesign qualitative study.²² Expanding health leadership capacity, personally, organizationally and systematically, is a challenging task if not undertaken in a planned or orchestrated way. CHLNet's 40 Network Partners believe a multi-pronged, collaborative approach to a national health leadership strategy is required that aims at building and growing individual leadership capacity but also society's collective one.²³

A shared vision needs to become explicit but linked to policy imperatives such as 'Triple Aim' (better health, better care, and better value) and health system reform efforts. A health leadership capabilities framework such as LEADS can create a common language across provinces and territories. The importance of health leaders as a collective must be recognized with investments made in leadership development and talent management strategies. Additional investments should also be made in funding and coordinating research and knowledge mobilization efforts that focus on health leadership. A national dialogue is warranted so that a pan-Canadian strategy is supported through agreed upon

²² Dickson G, Tholl B, Baker R, Blais R et al. (2014). *Partnership in Health Systems Improvement Leadership in Health Systems Redesign: Cross Case Analysis*. Canadian Institutes for Health Research/Michael Smith Foundation for Health Research Study.

²³ CHLNet's 40 Network partners have created a Canadian Health Leadership Strategy Action Plan that can be found on www.chlnet.ca. It integrates consultations from: a co-sponsored Healthcare Leadership Forum (Canadian Association of Health Services and Policy Research, Canadian Foundation for Health Care Improvement and CHLNet) held in Montreal February 14, 2014; and a Deliberative Dialogue session hosted by McMaster University on March 4, 2014.


leadership metrics to monitor health leadership and its effect on health system performance on an ongoing basis.

Conclusion

These findings corroborate that there is some truth to the perception that there is a leadership gap occurring in Canada--although half of responding health organizations believe it to be the same as five years ago. Concerns seem higher for Canadian Academic Health Science Centres (ACAHO Members) than others in the health care system about the extent of this gap and how strong they see their leaders on critical leadership capabilities (especially around innovation and self-development). The gap is seen to be important and is more of a skills gap rather than a supply-demand for middle and senior managers.

The majority of health care organizations do not seem to be protecting time for leadership development. There is low satisfaction with leadership development budgets and programs. However on the positive side, reports of leadership development budget increases since 2007 seem to have occurred. Academic Health Science Centres seem to see the need to identify emerging leaders and to implement formal succession planning. They report to be more pervasive in adopting a common leadership capability framework such as LEADS. The importance of these leadership issues need increased attention across all health care organizations.

Research does show that leadership--especially quality physician leadership--is a key foundational enabler of health system performance and health reform. Large-scale change requires new or enhanced capabilities for our formal leaders around systems thinking, strategic thinking, relationship development, and self-leadership.²⁴ In sum, these findings strongly suggest the importance of creating a national health leadership action plan that cuts across all levels of the health care system.



We view leadership as the foundation for the other key enablers (of health system transformation) because it supports and provides momentum to move actions towards attaining health system goals.

Health Council of Canada, 2013

²⁴Dickson G, Tholl B, Baker R, Blais R et al. (2014). *Partnership in Health Systems Improvement Leadership in Health Systems Redesign: Cross Case Analysis*. Canadian Institutes for Health Research/Michael Smith Foundation for Health Research Study.

Appendix A: ACAHO Online Survey

HEALTH LEADERS NEED YOUR HELP! Your organization has been carefully selected to participate in this Canada-wide Health Leadership Benchmarking Survey (CHL-Bench). You are one of only 100 healthcare organizations chosen. The hope is that the survey will be administered every three to five years and that your organization will participate on an ongoing basis. The information collected will allow health organizations to compare and benchmark their leadership efforts over time with their peers. Major reports raise concerns that the Canadian healthcare system is unsustainable, delivers mid-level performance and does not have the leadership capacity to transform. The Royal Commission on the Future of Health Care in Canada flagged the need for "stronger leadership"; the Premiers' report From Innovation to Action identified "present leadership" as one of four critical factors for better system performance (2012) and the Health Council of Canada's report Better Health, Better Care, Better Value for All: Refocusing Health Care Reform in Canada (2013) views leadership as "the foundational enabler" for system performance and reform.

This survey has been created to gather your input on whether there is a leadership gap in health care in Canada. We need your input to the following key questions:

Is there a leadership gap in your organization?

Assuming there is one:

1. How important is the leadership gap?
2. How large is the leadership gap?
3. What is being done to close the leadership gap?

Please fill out the survey from the perspective of your organization. There are 3 key sections to this survey:

- I. leadership and priorities;
- II. leadership development capacity; and
- III. organizational information.

The Canadian Health Leadership Network (CHLNet) Research Team and Metrics@Work want to assure you that we will keep your information confidential and will only share aggregate information. CHLNet also commits to providing all respondents with a complimentary copy of the final CHL-Bench report. We appreciate your participation in this very important Pan-Canadian survey on the state of health leadership in Canada. If you have any questions or concerns about your participation in this survey, please contact Metrics@Work at 1-800-726-4082 or send an email to: info@metricsatwork.com

PLEASE NOTE: This survey follows up on the 2007 survey by CHLNet and The Conference Board of Canada (CBoC). Results from 2007 will be compared to this survey as much as possible. The 'leadership level' definitions used are slightly modified from the original 2007 CHLNet/CBoC survey. The Conference Board of Canada recently surveyed organizations to compare strategic focus areas across Canada. The list of options in Q 8 has been generated based on the results from the Conference Board study for comparison purposes.

Marking your responses:

The survey is designed to determine how much you agree with a set of statements about your organization. For each item in the survey, read the statement in the left column (in the example below, the statement is "I am happy with my organization"). If you "agree" with this statement, you would select the bubble under the column "agree".

On each page of the questionnaire there is a section reserved for your suggestions and comments. Comments will be transcribed as written and provided to the Research Team. Please be careful not to identify yourself by your comments.

SECTION 1: LEADERSHIP AND PRIORITIES

This section seeks your views on leadership, if you believe there is a potential leadership gap in your organization, and your organizational human resource priorities.

1. Leadership Capacity

Leadership is the capacity of individual or group to influence people to work together to achieve a constructive purpose (such as the operation of a hospital).

a) Do you believe your organization has the leadership capacity to respond to future challenges and reforms?

- ☐ Yes
- ☐ No

2. Senior Management Leaders & Executives

There are at least two types of Leadership Gaps:

1. Supply - Demand Gap - supply of leaders needed versus number available.
2. Skill Gap - skill set gap of leaders as measured by a set of accepted standards, or expectations.

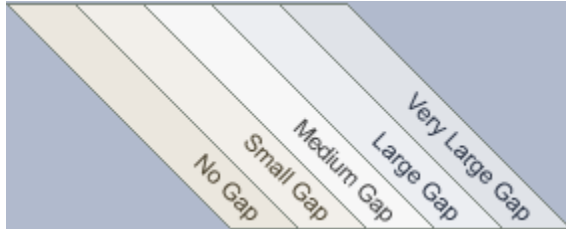
Senior Management Leaders & Executives: Leaders who manage people and/or processes at the senior or executive levels and who plan, develop and implement policies and/or programs at the senior or executive levels and typically sit on the senior leadership team (e.g., Vice-President, Chief Administrative Officer, Chief Executive Officer, Chief Financial Officer, Senior Medical Officer, Chief of Staff, or Senior Nursing Officer).

Please rate the Senior Management Leaders & Executives leadership gap in your organization using the 5 point scale:

- a) Supply - Demand Gap
- b) Skill Gap

c) Other Gap (please specify in the space provided below)

d) Gap Comments: (if you choose not to answer the "Other Gap" or provide specifics, select "submit" and follow the survey instructions to move on to next page)



3. Middle Management and Supervisor Leaders

There are at least two types of Leadership Gaps:

1. Supply - Demand Gap - supply of leaders needed versus number available.
2. Skill Gap - skill set gap of leaders as measured by a set of accepted standards, or expectations.

Middle Management and Supervisor Leaders:

Leaders who manage people and/or processes at the middle management level (e.g., Director or Manager) and leaders who manage people and/or processes at the supervisory or front-line level (e.g., team leader or front line manager).

Please rate the Middle Management and Supervisor leadership gap in your organization using the 5 point scale:

a) Supply - Demand Gap

b) Skill gap

c) Other Gap (please specify in the space provided below)

d) Gap Comments: (if you choose not to answer the "Other Gap" or provide specifics, select "submit" and follow the survey instructions to move on to next page)

Leadership Change:

Senior Management Leaders & Executives

Leaders who manage people and/or processes at the senior or executive levels and who plan, develop and implement policies and/or programs at the senior or executive levels and typically sit on the senior leadership team (e.g., Vice-President, Chief Administrative Officer, Chief Executive Officer, Chief Financial Officer, Senior Medical Officer, Chief of Staff, or Senior Nursing Officer).

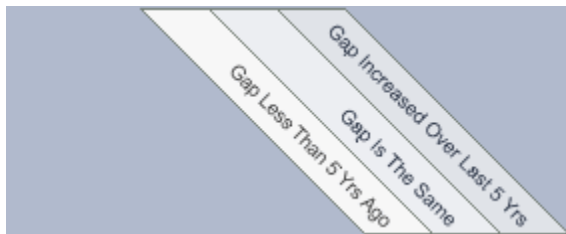
Middle Management and Supervisor Leaders

Leaders who manage people and/or processes at the middle management level (e.g., Director or Manager) and leaders who manage people and/or processes at the supervisory or front-line level (e.g., team leader or front line manager).

4. Leadership Change

Please rate the change over the last 5 years in your leadership gap using the 3 point scale:

- a) Senior Management Leaders & Executives
- b) Middle Management and Supervisor Leaders



Importance of the Current Leadership Gap

Senior Management Leaders & Executives

Leaders who manage people and/or processes at the senior or executive levels and who plan, develop and implement policies and/or programs at the senior or executive levels and typically sit on the senior leadership team (e.g., Vice-President, Chief Administrative Officer, Chief Executive Officer, Chief Financial Officer, Senior Medical Officer, Chief of Staff, or Senior Nursing Officer).

Middle Management and Supervisor Leaders

Leaders who manage people and/or processes at the middle management level (e.g., Director or Manager) and leaders who manage people and/or processes at the supervisory or front-line level (e.g., team leader or front line manager).

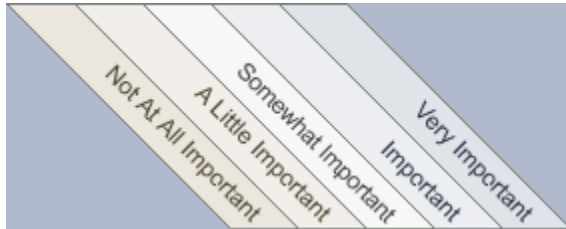
5. Importance of the Current Leadership Gap

Please rate the importance of the current leadership gap in your organization using the following 5 point scale:

- a) Senior Management Leaders & Executives
- b) Middle Management and Supervisor Leaders

Leadership Capabilities

Please Note: For the purposes of the remainder of survey questions, when the term leadership is used it refers to both levels combined.

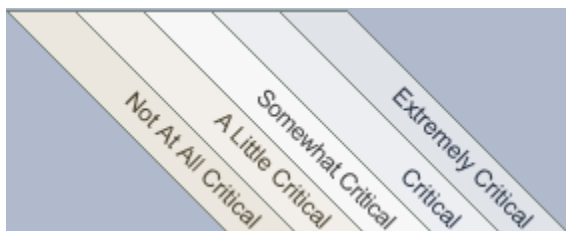


6. Leadership Capabilities

Please Note: For the purposes of the remainder of survey questions, when the term leadership is used it refers to both levels combined unless otherwise noted.

Please rate how critical each of these leadership capabilities are to achieving your organizational goals and objectives using the following 5 point scale:

- a) Demonstrating a commitment to customers and service
- b) Fostering the development of others
- c) Orienting themselves strategically to the future
- d) Building teams
- e) Championing and orchestrating change
- f) Strategically aligning decisions with vision, values and evidence
- g) Developing themselves
- h) Encouraging and supporting innovation
- i) "Other" Leadership Capabilities (please specify in the space provided below)
- j) Leadership Capabilities Comments: (if you choose not to answer the "Other" or provide specifics, select "submit" and follow the survey instructions to move on to next page)



Leadership Capabilities

Please Note: For the purposes of the remainder of survey questions, when the term leadership is used it refers to both levels combined.

7. Strength of Leadership by Capabilities

Please rate how strong the leaders in your organization are for the critical capabilities listed below using the following 5-point scale:

- a) Demonstrating a commitment to customers and service
- b) Fostering the development of others
- c) Orienting themselves strategically to the future
- d) Building teams
- e) Championing and orchestrating change
- f) Strategically aligning decisions with vision, values and evidence
- g) Developing themselves
- h) Encouraging and supporting innovation
- i) "Other" Strength of Leadership by Capabilities (please specify in the space provided below)
- j) Strength of Leadership by Capabilities Comments: (if you choose not to provide "Other" or provide specifics, select "submit" and follow the survey instructions to move on to next page)



Leadership Capabilities

Please Note: For the purposes of the remainder of survey questions, when the term leadership is used it refers to both levels combined.

8. Importance of Human Resource Strategies

Using the 5 point rating, please indicate how important the following human resource strategies are for your organization:

- a) Grow talent internally
- b) Raise employee engagement
- c) Raise physician engagement
- d) Provide employee/physician training and development
- e) Increase efforts to retain critical talent
- f) Improve leadership development programs
- g) "Other" Important Human Resource Strategies (please specify in the space provided below)
- h) Important Human Resource Strategies Comments: (if you choose not to provide "Other" or provide specifics, select "submit" and follow the survey instructions to move on to next page)

9. LEADS

- a) Has your organization adopted LEADS or another leadership capability framework?'
 - ☐ Yes
 - ☐ No
- b) If your organization has not adopted LEADS, what leadership capability framework are you using?

SECTION 2: LEADERSHIP DEVELOPMENT CAPACITY

This section seeks to determine your organization's leadership development capacity.

10. Leadership Development - Programs

- a) Please indicate your level of satisfaction with your organization's leadership development (LD) programs?



11. Leadership Development - Budget

- a) Please indicate your level of satisfaction with your organization's LD budget? '

12. Leadership Development - Dedicated / Protected Time

- a) Do your leaders have dedicated and protected time for leadership development?'

- ☐ Yes
- ☐ No

13. Leadership Development - Delivery

Estimate the percentage (%) of time leadership development (LD) is delivered formally and informally:
(Please ensure that your combined responses for a) & b) add up to 100%)

- a) **Formally** i.e., structured training programs or tools
- b) **Informally** i.e., mentoring, coaching or ad-hoc programs/tools'

14. Leadership Development - Function

Estimate the percentage (%) of time leadership development (LD) is delivered centralized or decentralized:
(Please ensure that your combined responses for a) & b) add up to 100%)

- a) **Centralized:**'
- b) **Decentralized:**'

ACAHO ONLY Questions:

15. Internal Capacity

- a) Do you have the internal capacity to undertake development of your leaders? '
 - ☐ Yes
 - ☐ No
- b) If yes, please specify what in-house leadership learning programs or tools your organization has developed (please include any formal coaching/mentoring programs or succession planning)?
- c) Would you be willing to share these programs with other health organizations?'
 - ☐ Yes
 - ☐ No
- d) If yes, would you be willing to share these programs? Please provide follow up contact details including name, email and phone number in this in the space below:

16. Leadership Learning Programs or Tools

- a) Do you use external consultants, other organizations, or universities to create or deliver leadership learning programs or tools?'
 - ☐ Yes
 - ☐ No

b) If you use external sources, please specify the external consultants, programs, or tools that were most effective to enhance health leadership learning.

17. Joint Training

a) Does your organization offer joint training across disciplines (e.g. physicians and nurses with administrators)?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

18. Emerging Leaders

a) Does your organization have a formal process to identify emerging leaders? '

- ☐ Yes
- ☐ No

19. Distributed Model of Leadership

a) Do you believe in the last five years, that your organization has moved to a more distributed model of leadership (where leadership is collectively performed or shared between multiple individuals or organizations)? '

- ☐ Yes
- ☐ No

20. Succession Planning

a) Does your organization have a formal approach to succession planning?'

- ☐ Yes
- ☐ No

21. How much of your annual operating budget do you estimate is devoted to formal training / learning development (including leadership development)?

a) In percentage (%)'

22. On average, how many leadership positions do you estimate become vacant in your organization annually?

a) Number of vacant positions:

23. What percentage (%) of your vacant leadership positions do you estimate remained unfilled after 120 days of posting?

a) Percentage (%) of positions unfilled after 120 days.