



Report of CHLNet Steering Group

Benchmarking Health Leadership in Canada:

March 2026



Canadian Health Leadership Network
Le Réseau canadien pour le leadership en santé



Benchmarking Health Leadership in Canada: 2025

HEADLINE FINDINGS

Commissioned by the Canadian Health Leadership Network (CHLNet) and its 40+ network partners, this study offers an updated snapshot of how health leadership bench strength is perceived across Canada. Results show consistent patterns of where leadership is strong, where pressure is increasing, and where focused action could make a meaningful difference. Here are the top findings from the 2025 survey:

1. Leadership capability is not keeping pace with rising system complexity

The system's complexity has grown faster than leaders' capabilities, creating a widening gap

- Fewer than four in ten respondents view leaders as highly capable
- Systems thinking and innovation remain the lowest-rated leadership capabilities
- Key development needs include innovation, change leadership, collaboration, and creating healthy organizational cultures - capabilities often affected by operational pressure

2. Mid-level and emerging leadership pipelines are under sustained pressure

These levels are the backbone of operational leadership; strain here threatens leadership continuity and organizational culture

- 40–50% report moderate or large leadership supply gaps at these levels
- Succession planning remains inconsistent, particularly for mid-level and emerging leaders
- Burnout, workload, recruitment challenges, and stress continue to erode leadership pipelines

3. Leadership development is occurring, but it is not well aligned or consistently supported

While organizations offer development, impact requires time, investment, and evaluation

- 92% of respondent organizations offer formal development, but only 33% evaluate its impact
- Only 26% provide protected time for development

4. Leadership gaps are affecting organizational performance – and the impact is increasing

Leadership gaps are increasingly constraining strategy execution, morale, and day-to-day operations

- Over 60% report that leadership gaps have a significant impact on organizational performance (including strategic misalignment, reduced trust, burnout, and operational inefficiencies)
- More than half (57%) report that this impact has increased over the past five years

5. Engagement and psychological safety remain inconsistent across the system

Both are essential for retaining staff, supporting innovation, and preparing future leaders

- Fewer than half of responding organizations treat engagement as a high priority
- About half report that their organization supports psychological safety, while roughly 30% report that it does not

6. Diversity is increasing among emerging leaders, but not at senior decision-making levels

This limits the impact of diversity on senior-level leadership and governance

- Respondents report that representation improves at emerging leadership levels but does not advance into senior and executive leadership roles.



Call to Action

Leadership development has not kept pace with the complexity and pressure facing Canada's health system. What's needed is coordinated, system-level investment in leadership development -- pan-Canadian in direction and shared priorities, evidence-informed in design, and accountable for impact in practice. Without this shift, leadership capacity will continue to lag behind system demands.

At the same time, health leaders do not need to wait to act. There are actions, one can take now to strengthen leadership capacity within their scope of influence:

- *Protect time for leadership work.* Explicitly carve out and defend time for leaders - especially mid-level and emerging leaders - to step out of constant operational mode and focus on change, people leadership, and system improvement.
- *Strengthen leadership pathways.* Identify high-potential leaders and connect development opportunities to real roles, stretch assignments, mentorship, and succession plans.
- *Focus development on evidence informed capabilities.* Prioritize skills that are consistently weakest across the system – systems thinking, change leadership, cross-organizational collaboration, and culture-building – and align learning to real operational challenges.
- *Use engagement and psychological safety as leadership indicators.* Treat team engagement, trust, and safety as signals of leadership effectiveness, and discuss them regularly in leadership forums and performance conversations.
- *Measure what changes.* Move beyond participation to practical measures of impact - such as changes in leadership behaviours, team outcomes, retention, or readiness for next-level roles.
- *Advance diversity through pathways and decisions.* Ensure that diverse leaders are not only developed but also visible in succession planning, sponsorship, and decision-making opportunities at senior levels.



Preface

Created in the fall of 2009 with 12 founding partners, the Canadian Health Leadership Network (CHLNet) is a not-for-profit, purpose-built coalition of 40+ organizations (called Network Partners) who gather to build health leadership capacity and capabilities across Canada. Its purpose is:

“By working together, better incorporate evidence and systems thinking into the practice of 21st century health leadership to improve health system performance and advance transformation.”

Members cut across jurisdictions, policymakers, academics, health associations, regional health authorities, and health disciplines. Through its [strategic plan](#) and shorter-term four [2025-2026 Courses of Action](#), CHLNet conducts its work in building health leadership via four value streams: *Support Leaders Through Dialogue & Engagement; Build and Apply Health Leadership Research, Evidence, and Knowledge; Accelerate 21st Century Care Leadership Practices; and Champion Strategic Leadership Excellence*. Evidence-informed tools and toolkits are free to network partners.

In 2014, the Canadian Health Leadership Network (CHLNet) embarked on its first benchmarking study (*CHL-Bench*), looking at the nature and extent of the health leadership gap across Canada. That study, a point-in-time snapshot, confirmed there were both a skills gap and an overall “supply-demand” gap, that concerns varied across different health settings, and that Canada was not taking leadership development seriously enough.

Repeated five years later, *Bench II* tracked progress from *CHL-Bench* to measure progress over time, to identify emerging health leadership challenges, and help inform CHLNet’s strategic planning process. Its purpose was to help our network partners, individually and collectively, better understand the importance of building leadership capacity and evidence-informed leadership practices for health leaders today and in the future.

The network’s intent is to replicate this study “every 5 years”¹, relying on a set of tracking questions to begin to track progress over time (e.g., are gaps getting better or worse?), but also allowing for emerging priority areas of concern and interest to be probed more deeply as circumstances change. This report outlines the 2025 findings from our third benchmarking study of Canadian health leadership.

¹ Ongoing or just in time data collection is preferable however in Canada there is no centralized health workforce data on health leaders and leadership.



Acknowledgments

CHLNet’s third benchmarking study is an initiative conducted in collaboration with the Canadian College of Health Leaders (CCHL), Canadian Medical Association (CMA), Canadian Nurses Association (CNA), Canadian Society of Physician Leaders (CSPL), Emerging Health Leaders (EHL), Healthcare Excellence Canada (HEC), HealthCareCAN (HCC), Good Samaritan Society (GSS), LEADS Global, Royal Roads University (RRU), Saint Mary’s University, University of Ottawa, and University of Manitoba/Shared Health Manitoba. Without their generosity of both financial and in-kind contributions (from translation, project management, and communications to facilitation), we would not have been able to undertake this update of the pan-Canadian health leadership study.

The *Bench III* Study Steering Group provided the vision and stewardship of this five-year follow-up survey. Thanks so much to these individuals (listed below) for their practical guidance and invaluable insights. An extra acknowledgement to Stephanie and Cher, who kept us on track and focused with their desire to build a coalition of the willing for pan-Canadian health leadership. We are grateful to have been awarded a [Mitacs Accelerate Grant](#) with Dr. Kevin Kelloway as supervisor for PhD candidate, Isaiah Hipel. Isaiah, you have a great future ahead of you, especially with the enviable combination of expert data analysis and eloquent report writing. Thank you all!!

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Executive Summary

Healthcare in Canada remains one of the nation's most complex undertakings - an interconnected system spanning jurisdictions, professions, and care settings. Since CHLNet's last benchmarking study in 2019, health systems have experienced profound disruption, including the COVID-19 pandemic, workforce shortages, geopolitical unrest across the globe, escalating climate-related disruptions, and accelerating reform. Against this backdrop, *Bench III* (2025) asks a central question: Do we have the leadership capacity and capability required to meet today's challenges and tomorrow's demands?

The Canadian Health Leadership Network (CHLNet)—a value network of partners dedicated to "Better Leadership, Better Health — Together"—initiated *Bench III* to answer this question. Building on the 2014 *CHL-Bench* and 2019 *Bench II* surveys, *Bench III* continues CHLNet's commitment to tracking perceptions of leadership capacity and capability across Canada's health sector. The 2025 survey replicated key measures from prior cycles while expanding the scope to include escalating issues such as equity, diversity, and inclusion (EDI), psychological health, and evolving organizational priorities for engagement and succession.

152 respondents participated in the 2025 survey, representing organizations (n = 48), nurses (n = 42), physicians (n = 24), and other health professionals (n = 38) across Canada. Because of small and uneven subgroup sizes for nurses, physicians, and other health respondents, this report limits formal cross-cycle observations to the Organization group. Findings for nurses, physicians, and other professionals are presented descriptively to highlight current perceptions.

In addition to the survey findings, a brief focused dialogue with CHLNet partners was conducted in December 2025 to help contextualize emerging themes. Insights from this consultation are included in an Addendum to the report and reinforce several system-level challenges described in the *Bench III* findings, particularly those involving leadership frameworks, succession planning, and persistent capability gaps in systems thinking and innovation.

High-Level Findings (2025)

Overall Leadership Capability Perceptions

Across all respondents, perceptions of leaders' capabilities remain generally positive but with notable concerns. Nearly half (48.7%) rated leaders as somewhat capable, with 34.7% describing them as very capable. Smaller proportions reported leaders as not very capable (13.8%) or not at all capable (2.6%). Fewer than four in ten respondents view their leaders as "highly capable."

Specific Capability Strengths and Gaps

When rating leaders across the LEADS framework capabilities, clear patterns emerged:

Relative Strengths:

- Integrity, resilience, and commitment to values
- People-centeredness and commitment to patient/customer service



- Supporting the development of others

Persistent Gaps:

- Systems thinking and critical thinking (lowest-rated capabilities)
- Innovation and change leadership
- Building partnerships and networks across organizations
- Creating healthy organizational cultures and psychological safety

Leadership Capacity: Supply of Leaders

Supply gaps vary by level:

- Executive and senior leaders: Most respondents (65-70%) reported only small or no gaps
- Mid-level leaders: Approximately 40-45% reported moderate to large gaps
- Direct care/emerging leaders: Approximately 45-50% reported moderate to large gaps

Contributing factors include retirements, limited interest in leadership roles due to workload and stress, insufficient succession planning, and recruitment challenges.

Impact of Leadership Gaps

Over 60% of respondents reported that leadership gaps have a significant or very large impact on organizational performance. More than half (57%) indicated the impact has grown larger over the past five years.

Reported impacts include:

- Strategic misalignment and implementation challenges
- Lower morale and diminished trust
- Increased burnout, turnover, and retention difficulties
- Operational delays and resource allocation challenges
- Limited innovation and quality improvement capacity

Leadership Development and Support

Among organizational respondents:

- 92% offer formal leadership development, but only 33% evaluate its impact
- Only 26% provide protected time for development
- 68% invest less than 1% of operating budget in leadership development
- 62% use a leadership capability framework with LEADS remaining the most common

Succession Planning

- 54-57% have succession plans for executive and senior leaders
- 46% or fewer have plans for mid-level and emerging leaders
- Planning is often episodic and vacancy-driven rather than strategic and continuous

Engagement and Organizational Culture

- Fewer than half of organizational respondents rated staff, nurse, or physician engagement as a high priority
- Approximately 50% described their organization as supportive of psychological safety, while 30% described it as unsupportive



- 31% of all respondents reported their organization as "not very engaged"

Diversity and Inclusion in Leadership

Representation of Indigenous peoples and racial/ethnic minorities was rated as limited, particularly at senior and executive levels:

- 50% of respondents rated executive leaders as "not at all" or "not very" reflective of Indigenous perspectives
- 50% rated executive leaders as "not at all" or "not very" reflective of racial/ethnic minority perspectives
- Representation improves progressively from executive to emerging leader levels, suggesting diversity is seen in emerging leaders but not advancing to senior positions

Key Message Across All Findings

While leadership development infrastructure exists in many organizations and frameworks like [LEADS](#) provide shared language, several systemic challenges are evident in 2025: capability gaps in innovation and systems thinking, uneven succession planning, limited evaluation of development impact, under-prioritization of engagement, and slow progress on senior-level diversity representation.

Interpretation and Implications

Taken together, the 2025 findings highlight both areas of strength and areas requiring attention. While important elements of leadership infrastructure are in place, the results suggest that incremental adjustments to existing approaches may be insufficient to address the complexity and scale of current leadership challenges. More deliberate, system-level strategies will be required to meaningfully strengthen leadership capacity and capability across the health sector.

Implications for Action

These findings point to several priority areas for CHLNet partners:

- 1. Strengthen Leadership Pathways Through Strategic Succession Planning:** Shift from episodic, vacancy-driven approaches to continuous talent management supported by active succession maps, multiple leadership pathways, integrated diversity goals, and targeted development for identified successors.
- 2. Move Beyond Providing Leadership Development To Evaluating Its Impact:** Embed rigorous evaluation that assesses behavioral change and organizational outcomes, ensure protected time for application, provide coaching and stretch assignments, and leverage frameworks like LEADS for alignment and common language.
- 3. Make Innovation and Systems Thinking Core Development Priorities:** Build organizational cultures that support experimentation, create leadership pathways that include innovation-focused roles and system-level exposure, integrate systems thinking into core curricula, and balance operational demands with strategic work.



4. Elevate Engagement and Retention as Strategic Leadership Priorities: Treat engagement as a leadership accountability, invest in transparent communication and inclusion of frontline voices (especially from individuals with one or more structurally excluded identities), support equity-based psychologically safe environments, and recognize engagement's direct impact on workforce stability and future leadership pathways.

5. Embed Equity, Diversity, and Inclusion into Leadership Systems: Ensure diverse representation in talent pools and succession plans, foster inclusive leadership behaviors and cultural competency, create fair pathways to development opportunities, evaluate programs for equity of participation, and move from performative commitments to substantive action.

6. Establish a Standing Panel for True Longitudinal Tracking: Create a formal panel of organizations committed to participating in each five-year cycle to enable defensible trend analysis, provide reliable sample stability, support qualitative follow-up, and strengthen evidence-based cases for leadership investment.



Background and context

Leadership is a cornerstone of high-performing health systems. Over the past two decades, evidence has consistently shown that effective leadership contributes to better organizational performance, improved patient outcomes, and a more engaged and resilient workforce (Arnold, 2017; Barling et al., 1996; Boamah et al., 2018; Kelloway et al., 2012; Kelloway & Barling, 2010; Nielsen et al., 2008; Upadhyay Soumya et al., 2022). In the Canadian context, where healthcare governance spans 14 jurisdictions and sectors, the capacity and capability of leaders play a particularly critical role in ensuring that complex reforms translate into tangible improvements in care delivery and population health.

The Canadian Health Leadership Network (CHLNet) emerged in 2009/2010 as a *value network*—a collaborative coalition of partners who share knowledge and resources to collectively strengthen leadership across the health system. Guided by the vision of “Better Leadership, Better Health—Together,” CHLNet’s mission has been to build and sustain a collective leadership capacity for health system transformation. A pillar of this mission is the ongoing benchmarking of leadership across Canada. By tracking how leadership is perceived, developed, and supported, CHLNet provides its partners and policymakers with evidence to inform investment, development, and policy decisions.

Currently, CHLNet’s focus is [Championing Strategic Leadership Excellence](#) around four themes:

1. Leadership practices for the 21st century to transform health systems.
2. Anti-racism and social justice to achieve effective, diverse, and inclusive leadership.
3. Learning systems that support workforce wellness.
4. Climate-conscious leadership practices for resilient and sustainable health systems.

These four themes have coalesced into the *Canadian Learning Collaborative for Health Leadership*, being led by scholars in these priorities.

Evolution of the Benchmarking Initiative

CHLNet’s first benchmarking initiative (*Bench I*, 2014) established an understanding of leadership capacity and capability within Canadian health organizations. The study revealed variation across sectors and pointed to organizational challenges in talent management, development, resourcing, and succession planning. Five years later, *Bench II* (2019) revisited these themes, identifying some progress, such as, the increasing adoption of the LEADS in a Caring Environment framework. However, the study also found persistent weaknesses in innovation, engagement, and evaluation of leadership development.

The *Bench III* study continues this work, capturing data in the wake of an extraordinary period in healthcare history. Between the last survey and this one, Canada’s health system has endured the COVID-19 pandemic, ongoing workforce shortages, and escalating public expectations for accountability and inclusion. These pressures have magnified the need for adaptive, compassionate, and system-oriented leadership. *Bench III* thus provides a reflection on how leadership has evolved under crisis conditions.



Conceptual Framework: Capacity and Capability

CHLNet’s benchmarking model is built on two interrelated dimensions: leadership capacity and leadership capability.

- **Leadership capacity** refers to the supply side of leadership: the number, distribution, and preparedness of individuals available to lead at various levels. It captures organizational processes such as succession planning, leadership development investment, and time and resources dedicated to leadership growth. In short, capacity answers the question, “Do we have enough leaders to meet current and future needs?”
- **Leadership capability**, on the other hand, reflects the quality and effectiveness of those leaders: their skills, behaviours, and ability to navigate complexities. Capability encompasses competencies such as self-awareness, systems thinking, collaboration, innovation, and the ability to engage and empower others. Capability answers the question, “Are our leaders equipped to lead well?”

The distinction between capacity and capability has guided all three benchmarking cycles. Taken together, these dimensions provide an overall picture of the leadership landscape, from the presence of development systems to the lived expression of leadership in daily practice.

Emerging Priorities in the 2025 Context

While the capacity–capability framework remains the backbone of CHLNet’s benchmarking model, the 2025 survey expanded to reflect the contemporary realities of leadership. Three contextual shifts are particularly important:

1. **Post-pandemic transformation:** The pandemic exposed and amplified pre-existing issues in healthcare leadership, particularly around communication, agility, and workforce well-being. Leaders were required to make rapid decisions in ambiguous contexts, often without established playbooks.

Leadership Implications: The post-pandemic environment now demands that leaders demonstrate advanced capabilities in crisis management, transparent communication under uncertainty, rapid adaptation to changing conditions, and attention to staff psychological health and trauma-informed approaches. Leaders must also navigate heightened public scrutiny and maintain trust during prolonged system stress. These expectations now extend beyond traditional operational management, requiring advanced capabilities in crisis leadership, communication under uncertainty, and trauma-informed workforce support.

2. **Health human resources crisis:** Across Canada, shortages of nurses, physicians, and interprofessional professionals have heightened the strategic importance of leadership in workforce planning, engagement, and retention. *Bench III* examines whether



leadership priorities have adapted accordingly. Specifically, whether engagement and succession have moved higher on organizational agendas.

Leadership Implications: Leaders are now expected to play active roles in talent management, succession planning, and creating work environments that support retention—functions that were previously considered primarily within the domain of human resources. Effective leadership in this context requires understanding workforce data and trends, building psychologically safe and engaging cultures, advocating for workload management and staffing resources, and balancing short-term operational demands with long-term workforce sustainability.

3. **Antiracism and Social Justice:** Since 2019, the national and international conversation about inclusion and systemic bias has deepened. Health organizations increasingly recognize that leadership diversity and inclusive cultures are not only moral imperatives but also essential for innovation and performance. *Bench III* incorporates new items assessing perceived progress on representation and inclusivity within leadership structures.

Leadership Implications: Leaders are now expected to demonstrate cultural competency, recognize and address experiences of harm among structurally marginalized groups, actively advance representation and inclusion in hiring and succession decisions, and create conditions where diverse perspectives are genuinely valued and integrated into decision-making. This requires capabilities in recognizing bias (including one's own), fostering psychological safety for staff with marginalized identities, and moving beyond performative commitments to substantive organizational change. *Bench III* incorporates items assessing perceived progress on representation and inclusivity within leadership structures to understand the gap between organizational commitments and lived experience.

Together, these contextual forces redefine what “good leadership” means in 2025. They also influence how capacity and capability are developed and assessed. For example, whereas early CHLNet surveys focused primarily on formal learning program availability and frameworks, current approaches examine the conditions that enable leadership to flourish such as dedicated time and ongoing evaluation of the impact of leadership development programs.

Purpose of the 2025 Benchmarking Study

Bench III was guided by three overarching research questions:

1. What are the perceived leadership gaps in Canadian health care organizations?
2. How are the issues related to these gaps shared or different across groups in the health systems, and how do those groups perceive the importance of leadership development, organizational development, and succession planning as ways to close those gaps?
3. What are the 21st-century care leadership practices required today and into the future?



Therefore, the purpose of *Bench III* is threefold:

1. Identify and assess leadership gaps in Canadian healthcare organizations, including gaps in skills, diversity, and succession planning.
2. Identify strengths, gaps, and priority areas for action to inform evidence-based strategies that strengthen leadership capacity, support workforce sustainability, and enhance organizational effectiveness across Canada's health sector.
3. Provide actionable recommendations to the Canadian Health Leadership Network (CHLNet) and its partners to improve leadership development, succession planning, and workforce engagement.

By focusing trend analyses on the Organization group, this report ensures robust comparability with prior years while presenting descriptive overviews of nurses, physicians, and other health professionals' perspectives for a more holistic understanding of the system. In doing so, it continues CHLNet's commitment to transparency, collaboration, and evidence-informed improvement.

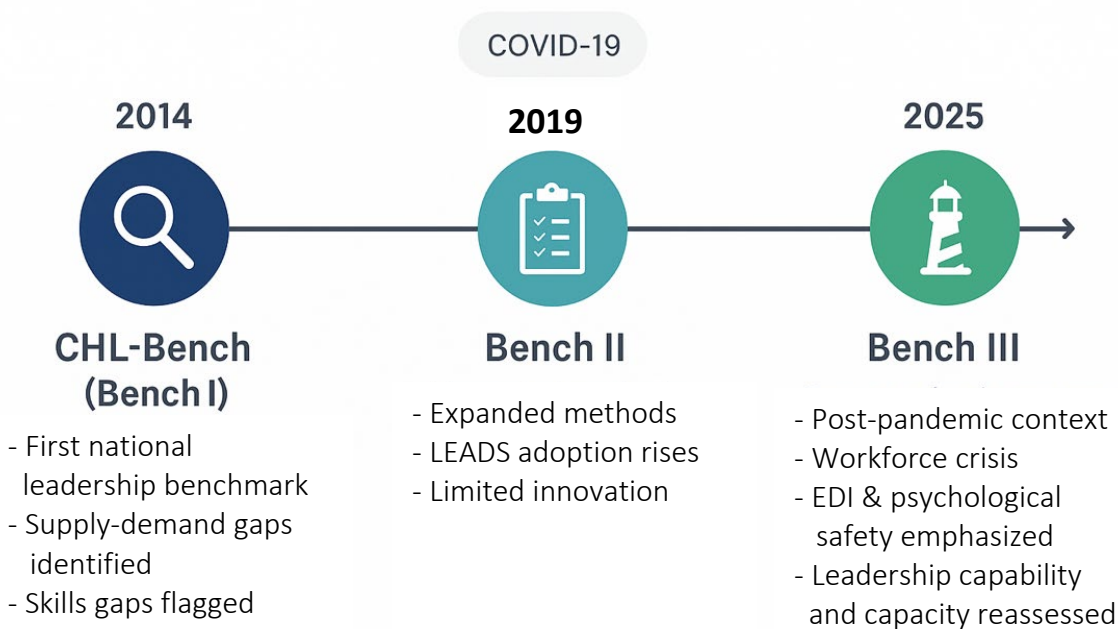


Figure 1: *Timeline of CHLNet Benchmarking (2014–2025)*

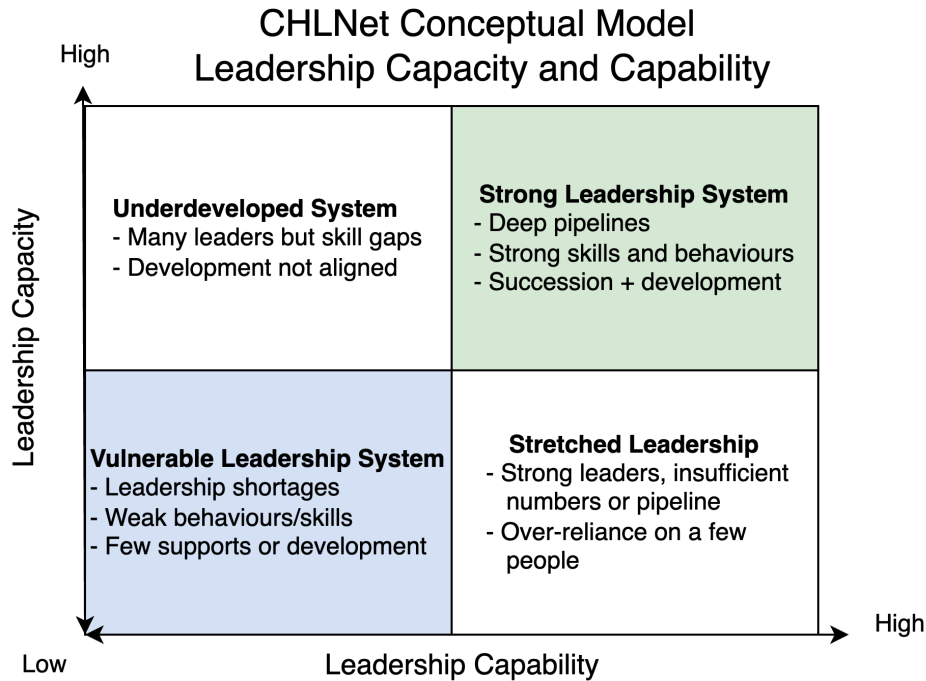


Figure 2: CHLNet Conceptual Model: Leadership Capacity and Capability

Participants

A total of 152 respondents completed the 2025 survey.

Participants self-identified into one of four broad groups:

| Group | Description | Sample Size (2025) |
|----------------------------|--|--------------------|
| Organization Group | Leaders or staff responding on behalf of a health organization (executives, managers, human resource, organization design, quality, or system-level roles) | 48 |
| Nurses | Registered nurses and nurse leaders | 42 |
| Physicians | Physicians, medical leaders, or department heads | 24 |
| Other Health Professionals | Interprofessional health, administrative, or academic respondents not captured above | 38 |

Participants who completed the organization surveys represented a diverse range of different types of healthcare organizations across many provinces. The most common organization was



long-term care (25%), followed by provincial/territorial wide health care organization (15.9%). Ontario had the highest number of participants (37.8%) followed by Alberta (22.2%) and British Columbia (15.6%). There were no responses from Prince Edward Island, Newfoundland, New Brunswick, Yukon, the Northwest Territories, and Nunavut.

Limitations

Several limitations should be considered when interpreting these findings:

1. Open recruitment: Because the survey relied on voluntary participation through open recruitment from partner networks, results cannot be generalized to all Canadian healthcare leaders, nor could the response rates be captured.
2. Uneven group sizes: Small sample sizes for Nurses, Physicians, and Other participants limit between-group and trend analyses.
3. Self-report data: Perceptions may not fully reflect objective leadership performance or organizational outcomes.
4. Instrument consistency: Although wording was harmonized with the 2019 Bench II, minor edits and added items introduce some measurement variation.
5. Cross-sectional design: The 2025 survey provides a snapshot in time and cannot establish causation.
6. Non-comparable samples across Bench cycles: The composition of organizational respondents in 2025 differs substantially from prior cycles. For example, the 2025 sample includes a higher proportion of long-term care organizations (25%) relative to previous cycles and excludes several provincial or territorial respondents. Because the 2025 sample of organizations cannot be confirmed as equivalent to those in *Bench I* (2014) or *Bench II* (2019), findings between Bench cycles should not be compared to previous cycles. They reflect patterns observed within each respective sample rather than verified trends in the same population of organizations over time. Results from previous Bench cycles will be reported alongside the *Bench III* report.
7. Absence of matched or longitudinal data: No mechanism exists to confirm that individual organizations participated in more than one Bench cycle. This means that apparent changes between cycles may reflect differences in who responded rather than genuine changes within the same organizations over time. Accordingly, all cross-cycle observations in this report should be read as descriptive comparisons of independent samples, not as evidence of trends.

Despite these limitations, the study offers a meaningful cross-sectional picture of how health system participants in 2025 perceive leadership capacity and capability across Canada. It also continues the only recurring national health-leadership benchmarking initiative available and, with appropriate interpretive caution, allows for descriptive comparison with patterns observed in earlier cycles.

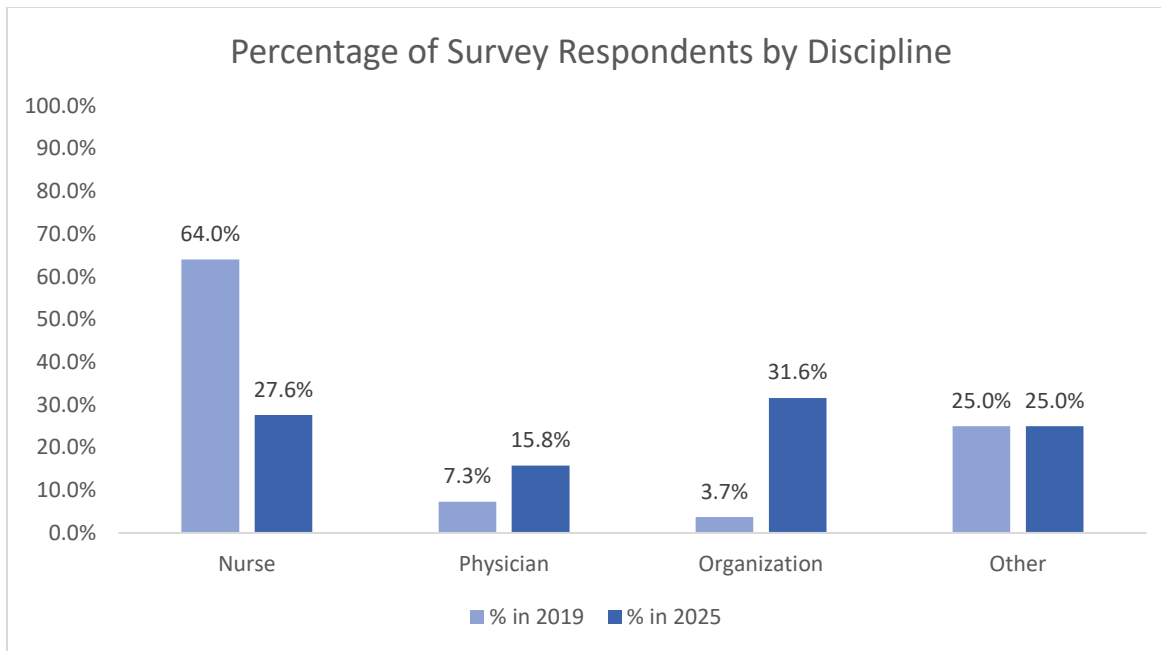


Figure 3: Respondent Composition by Discipline (2025)

| Discipline | Number of Respondents | |
|--------------|-----------------------|------|
| | 2019 | 2025 |
| Nurse | 715 | 42 |
| Physician | 82 | 24 |
| Organization | 41 | 48 |
| Other | 280 | 38 |

Table 1: Total number of survey respondents participating in CHLNet leadership benchmarking studies from 2019 to 2025. Bench II saw a substantial increase due to expanded sampling; Bench III reflects the post-pandemic landscape and continued partner engagement.



Results: Key Insights and Perspectives

Because of the inability to make direct comparisons of groups over time, results for nurses, physicians, organizations (leaders on behalf of an organization), and other health professionals are presented as cross-sectional snapshots only and should not be interpreted as trends or compared to 2019.

Leadership capability

Leadership capability refers to the extent to which leaders demonstrate the skills and behaviours required for effective leadership. This section summarizes:

1. overall capability ratings
2. capability ratings by LEADS domain
3. strengths
4. areas for further development

Overall Capability Ratings

The following overall capability ratings represent all respondents combined. Because the four professional groups differ in size and context, these aggregated results should be interpreted only as a broad system-level snapshot.

Across all respondents in 2025 (i.e., combining organizations, nurses, physicians, and other professionals), perceptions of leadership capability are generally positive but not strong. When asked how capable leaders in their organization are overall, 48.7% indicated that leaders are somewhat capable, and 34.7% said leaders are very capable, while 13.8% rated their leaders as not very capable and 2.6% as not at all capable.

These results suggest that most participants view leadership as at least moderately effective; however, fewer than four in ten perceive their leaders as highly capable. While foundational leadership capacity appears to be present in many organizations, the findings indicate there is meaningful room to strengthen consistency, depth, and excellence in leadership capability across the system.

Respondents were asked whether the gap between current and required leadership capabilities is larger, smaller, or unchanged compared to five years ago. As shown in Figure 4, responses varied across leadership levels, but several consistent patterns emerged.

Across all levels, the most frequently selected response category was “the same”, indicating that many respondents perceive the size of capability gaps as largely unchanged over the past five years. However, a substantial proportion reported that gaps have become “a little larger”, particularly for mid-level leaders and direct care/emerging leaders, where these increases were reported more often than for executive or senior leaders.



Reports of gaps becoming “much larger” were less frequent overall but were present across all levels. Conversely, relatively few respondents indicated that gaps had become “a little smaller” or “much smaller,” suggesting limited perceived improvement over time.

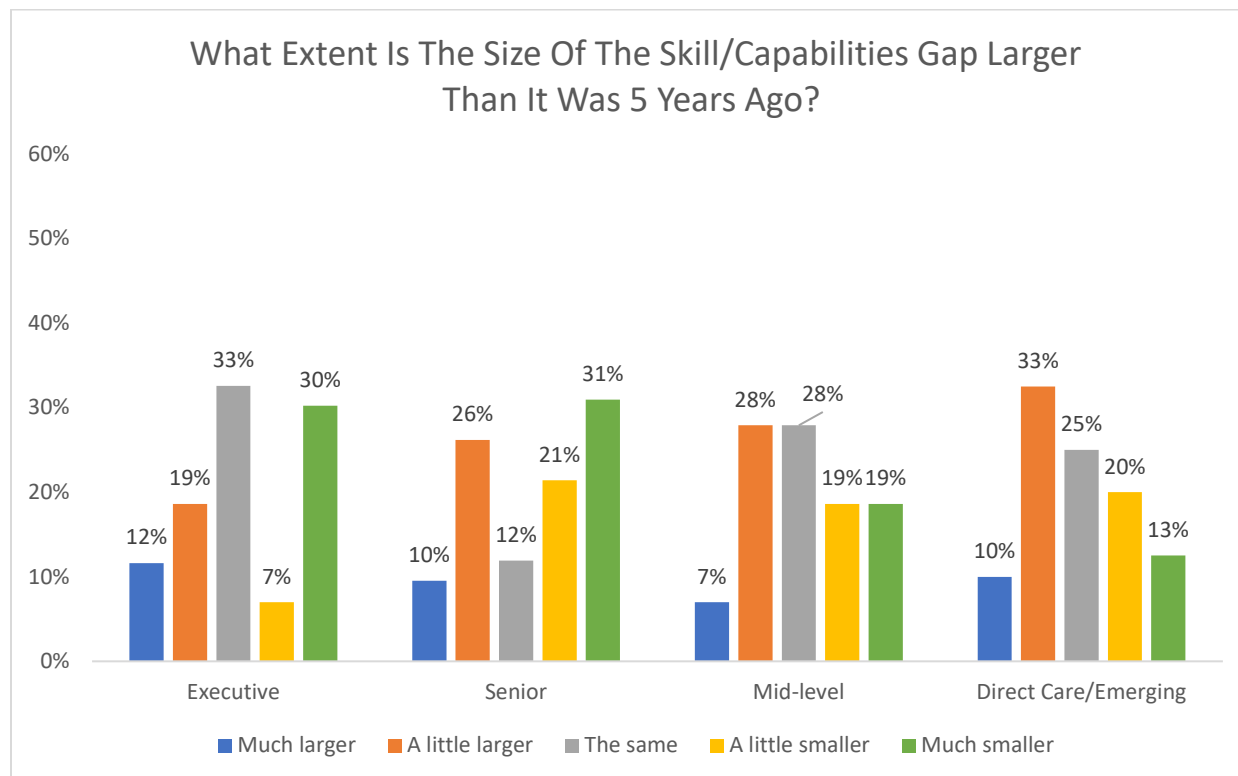


Figure 4. Change in Perceived Leadership Skill/Capability Gaps Compared to Five Years Ago

LEADS Capability Ratings

To provide a more detailed assessment of leadership capability, respondents rated the extent to which leaders in their organization demonstrate specific behaviours aligned with the LEADS in a Caring Environment Framework. The survey included items from each of the five LEADS domains—Lead Self, Engage Others, Achieve Results, Develop Coalitions, and Systems Transformation. Respondents used a four-point scale ranging from *Not at all capable* to *Exceptionally Capable*.

Across all respondent groups, the distribution of ratings showed a consistent pattern. Behaviours associated with leading self, achieving results, and developing coalitions tended to receive higher ratings, while those associated with system transformation and engaging others were rated lower.



Lead Self

Leaders were most frequently rated as capable in modelling honesty, integrity, resilience, and confidence. Ratings for leaders' self-awareness were slightly lower but still generally positive across groups.

Engage Others

Respondents indicated that leaders support the development of others more often than they contribute to the creation of a healthy organizational culture. Although many leaders were viewed as supportive in fostering the development of others, fewer respondents reported leaders contributing to the creation of a healthy organizational culture.

Achieve Results

In this domain, leaders received higher ratings for setting direction, with slightly lower ratings for strategic alignment of decisions with organizational vision, values, and evidence. While most respondents indicated that leaders provide overall direction, fewer felt that this direction was consistently translated into day-to-day decision-making.

Develop Coalitions

Commitment to customers and service (people-centred care) was rated positively, while capability in building partnerships and networks received more variable ratings. Responses indicate that leaders are generally oriented toward service quality, though cross-organizational collaboration may be less consistently developed.

Systems Transformation

Across all domains, the lowest ratings were observed for capabilities related to encouraging innovation, supporting new technologies, and demonstrating systems or critical thinking. Fewer respondents rated leaders as highly capable in these areas compared with other capability domains.

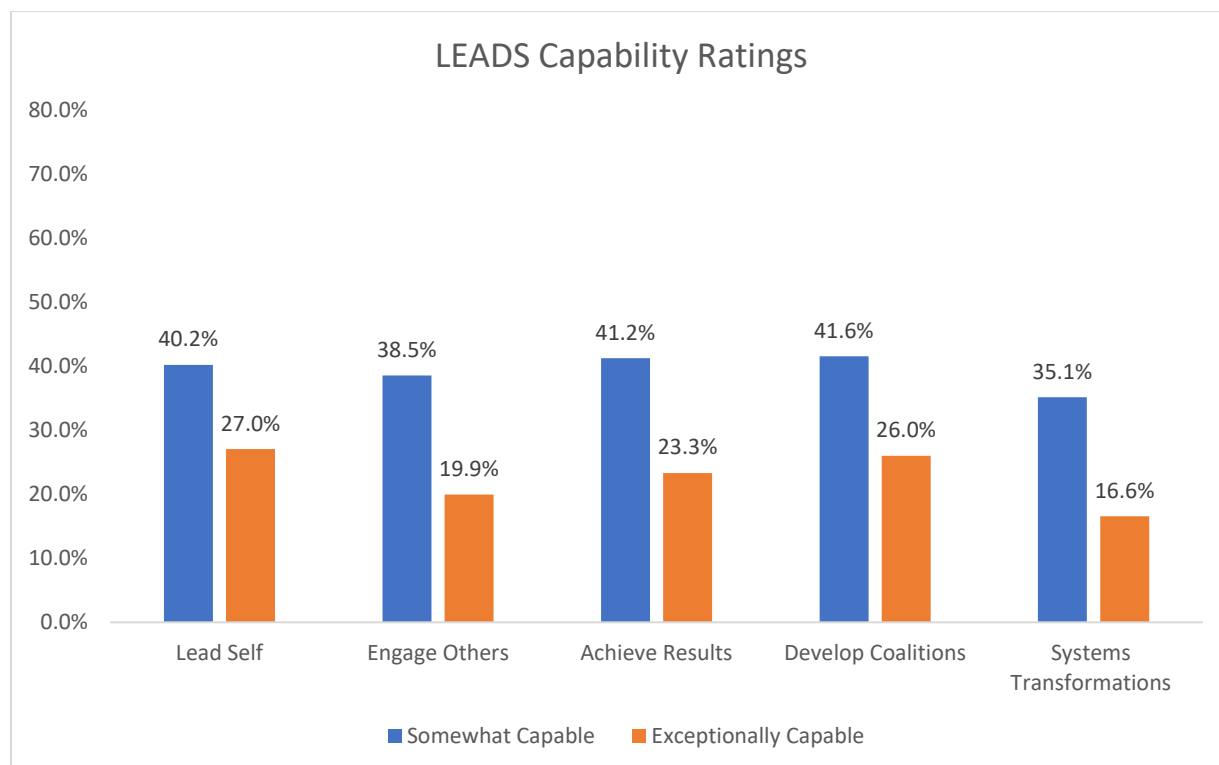


Figure 5. Percentage of respondents rating leaders as “Very” or “Exceptionally” capable across LEADS capabilities.

This profile is generally consistent across organizational, physician, nurse, and other respondent groups, though the exact proportions differ.

Areas for Strengthening Across LEADS Domains

While several leadership capability strengths were identified, respondents also highlighted important areas for improvement. These vulnerabilities, consistent with themes from the *Bench //* report, cluster primarily within two interconnected LEADS domains: Engage Others and Systems Transformation.

Across all respondents, responses expressed concerns about leaders’ abilities to:

- Foster meaningful partnerships and networks within and across organizations, especially under increasingly complex system demands.
- Support and champion innovation, including new technologies and new models of care.
- Demonstrate systems and critical thinking at the pace required for current challenges.
- Provide consistent coaching and feedback, particularly for emerging leaders and mid-level leaders.
- Strategically align decisions with evidence, values, and long-term vision, especially under short-term operational pressures.



These findings suggest that while many leaders are skilled in interpersonal, value-based capabilities, fewer consistently demonstrate the higher-order competencies needed for system-level leadership, innovation readiness, and long-term transformation.

These survey patterns were echoed in the December 2025 focused dialogue with CHLNet partners, where participants reaffirmed that leaders continue to struggle with systems thinking, innovation, and navigating cross-organizational complexity. Participants described operational pressures as “crowding out” time for strategic work, creating a cycle where innovation is aspirational rather than embedded in leadership practice.

Leadership Capacity (All Respondents)

Leadership capacity refers to whether organizations have enough leaders, supported by the right systems, to meet current and future needs. Unlike capability, which focuses on leader behaviour, capacity reflects structural and organizational conditions.

This section includes:

- leadership supply (Do we have enough leaders?)
- future readiness (Are pathways strong?)
- diversity representation
- availability and evaluation of leadership development
- psychological safety and engagement
- organizational priorities

Supply of Leaders (Number Needed vs. Number Available)

Respondents evaluated whether their organizations have enough competent leaders at four levels: executive, senior, mid-level, and direct care/emerging.

Across the respondents:

- Supply gaps were smallest at executive and senior levels.
- Supply gaps were largest at mid-level and direct care/emerging levels, reflecting pathway challenges and turnover pressures.

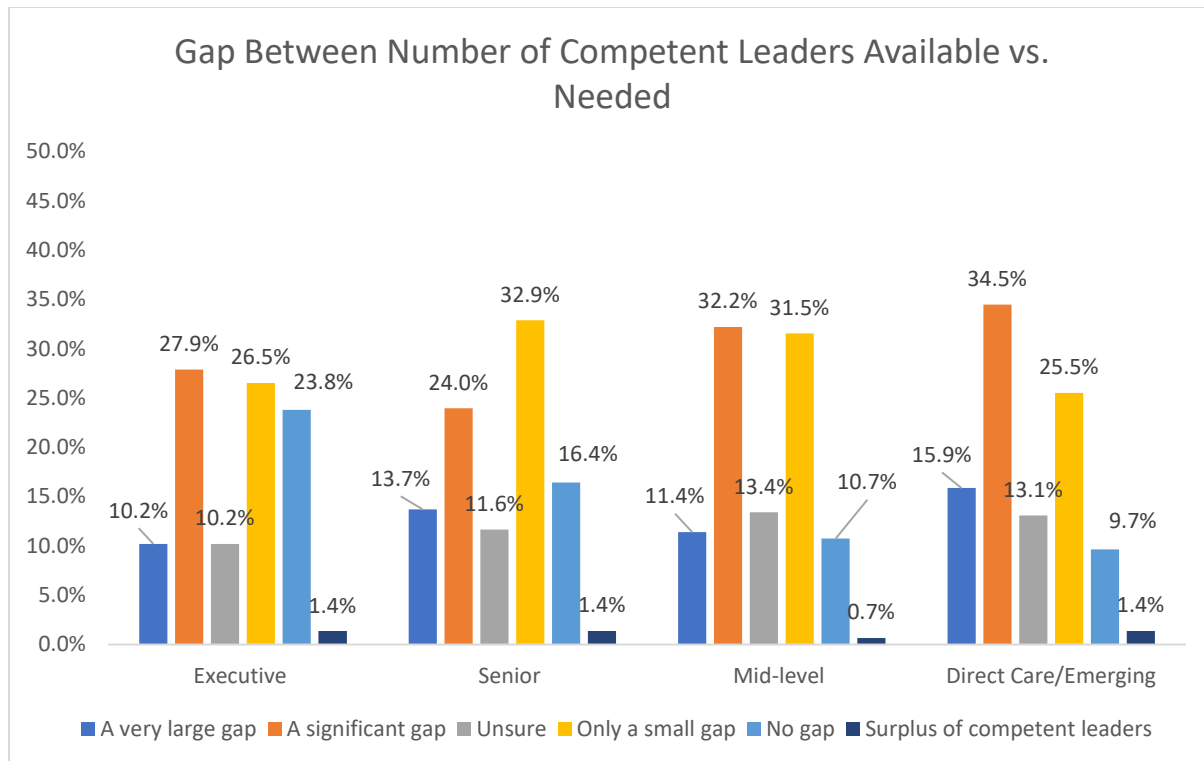


Figure 6. Extent to which participants think that there is a gap between the number of competent current leaders in your organization and the number needed to achieve organizational goals and anticipate/meet future challenges and reforms (2025).

Change in Supply Gaps Over Five Years

Respondents noted whether supply gaps were larger, smaller, or unchanged compared to five years ago.

Patterns included:

- many reporting similar gaps to five years ago
- a sizeable portion reporting worsening gaps, particularly for mid-level and emerging leaders
- fewer reporting improvement

Factors mentioned in comments included retirements, recruitment difficulty, workload increases, and limited interest in leadership roles.

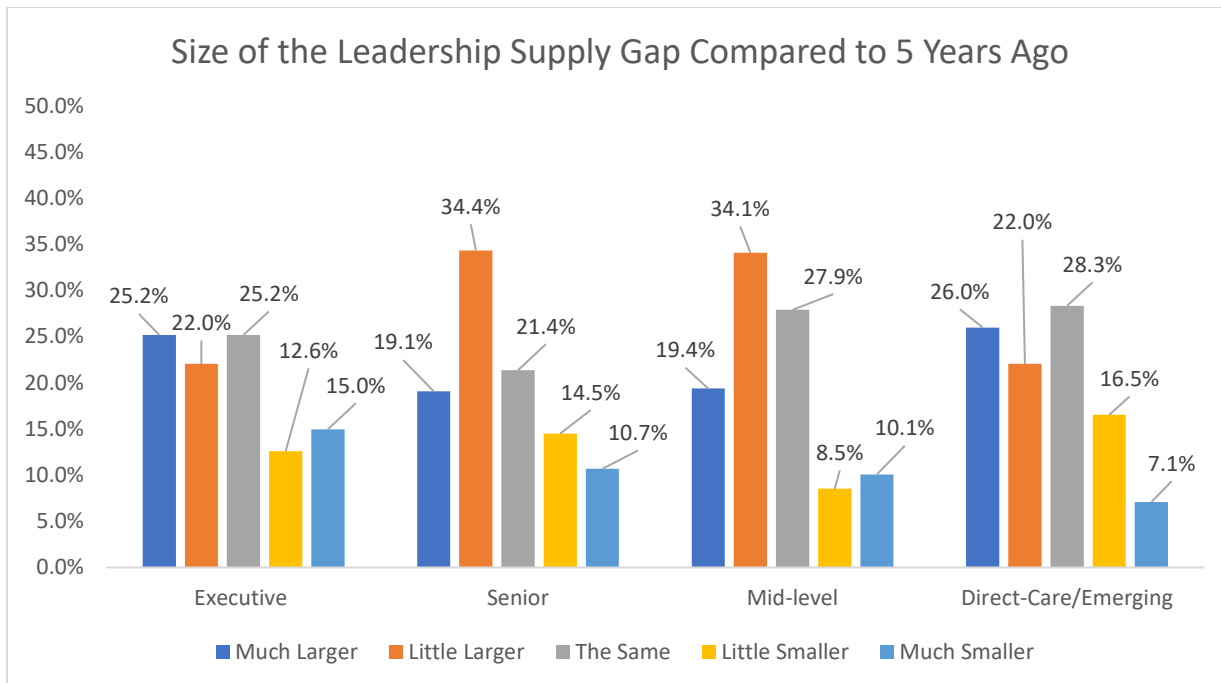


Figure 7. Respondents’ evaluation of the size of the leadership supply gap due to skills and capabilities compared to five years ago.

Diversity of Representation

Across respondent groups, perceptions of diversity and representation within leadership structures varied by leadership level. While respondents indicated progress in some areas (particularly at mid-level and emerging leader tiers), senior and executive leadership roles were more often viewed as lacking representation of diverse identities and lived experiences. Figure 8 shows the perceptions of diversity representation of respondents across leadership levels.

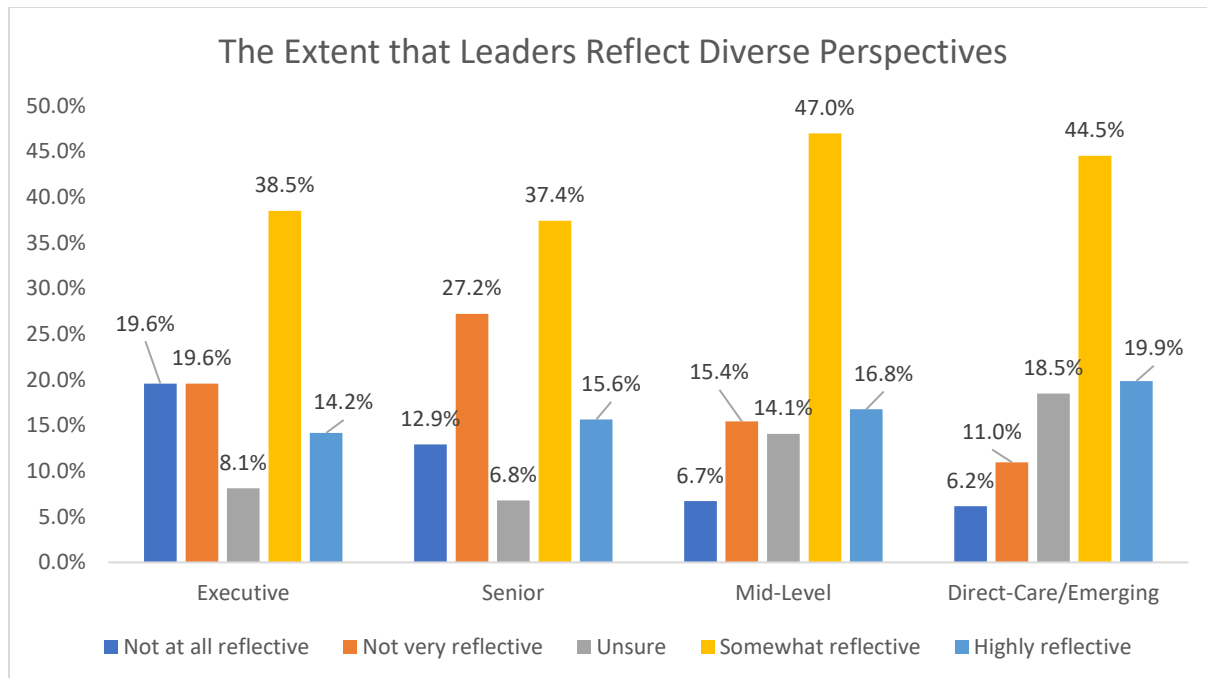


Figure 8. Respondents’ evaluations of the extent to which leaders reflect a diverse range of perspectives.

Qualitative responses further emphasized that representation alone is only one dimension of inclusive leadership. Respondents described concerns related to cultural competency, psychological safety, and leaders’ abilities to recognize and address experiences of harm among marginalized groups. Many highlighted the importance of including lived experience, particularly racialized, Indigenous, 2SLGBTQIA+, and disabled staff, within formal leadership roles. Respondents’ perceptions of the size of diversity representation across leadership levels is represented in Figure 9.

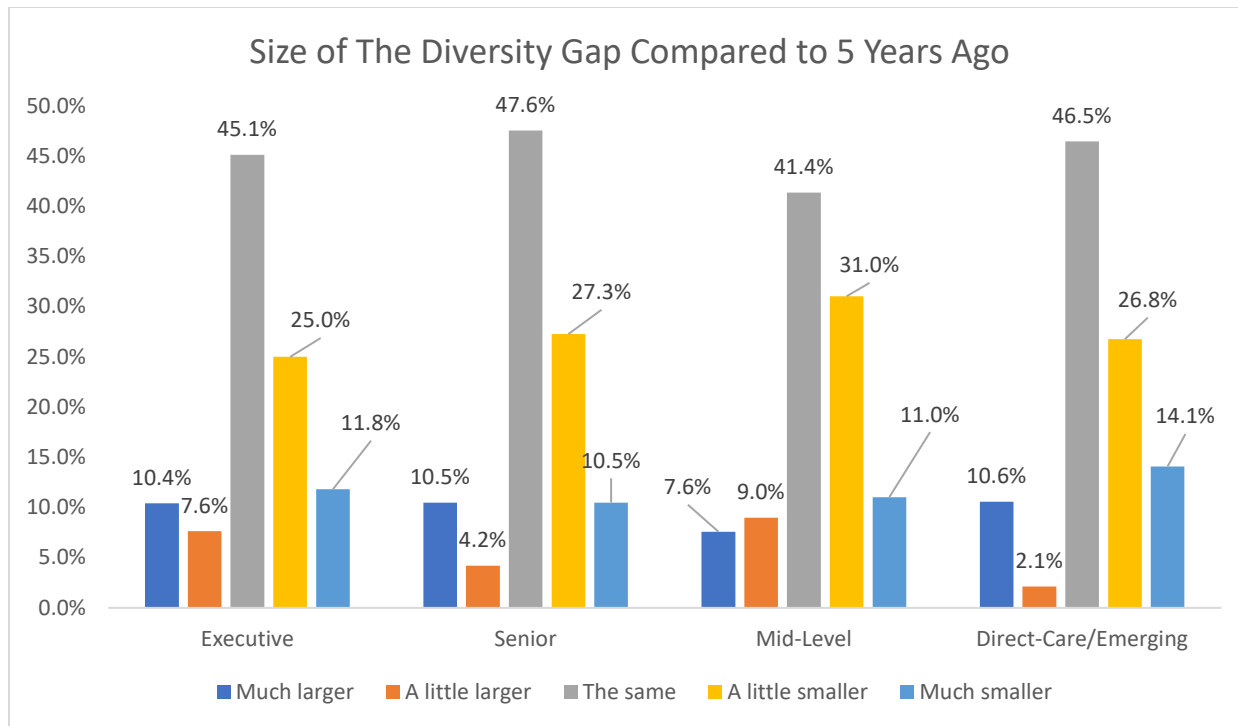


Figure 9. Respondents' evaluation of the size of the diversity gap in leadership compared to five years ago.

Indigenous Representation

Respondents were asked to what extent leaders reflect the diverse perspectives and lived experiences of Indigenous Peoples, including First Nations, Inuit, and Métis. Perceptions varied across leadership levels, but several consistent patterns emerged.

Executive Leaders

For executive leaders, just under one-third (29.9%) of respondents reported that this level is not at all reflective of Indigenous perspectives, the highest proportion across leadership tiers. An additional 20.4% rated executives as not very reflective. Combined, this represents more than half of respondents indicating limited Indigenous representation at the executive level. Only 13.6% perceived executive leaders as highly reflective, while 23.1% selected somewhat reflective and 12.9% were unsure.

Senior Leaders

A similar pattern emerged for senior leaders. Approximately 27.4% rated this group as not at all reflective, with 23.3% selecting not very reflective. About 25.3% viewed senior leaders as somewhat reflective, and 9.6% perceived them as highly reflective. Unsure responses accounted for 14.4%.



Mid-Level Leaders

Perceptions of mid-level leaders were somewhat more favourable, though still mixed. While 22.3% rated this level as not at all reflective and 22.3% as not very reflective, a larger proportion (27.7%) selected somewhat reflective. Only 6.8% rated mid-level leaders as highly reflective, and 20.9% were unsure, indicating more uncertainty about Indigenous representation at this level compared to executive or senior leadership.

Direct Care / Emerging Leaders

Direct care and emerging leaders received the most positive ratings overall, though perceptions remained diverse. 18.8% rated this level as not at all reflective, and 22.2% as not very reflective. The largest proportion (29.9%) selected somewhat reflective. Only 4.2% rated leaders at this level as highly reflective, and 25.0% were unsure—the highest uncertainty across all leadership tiers.

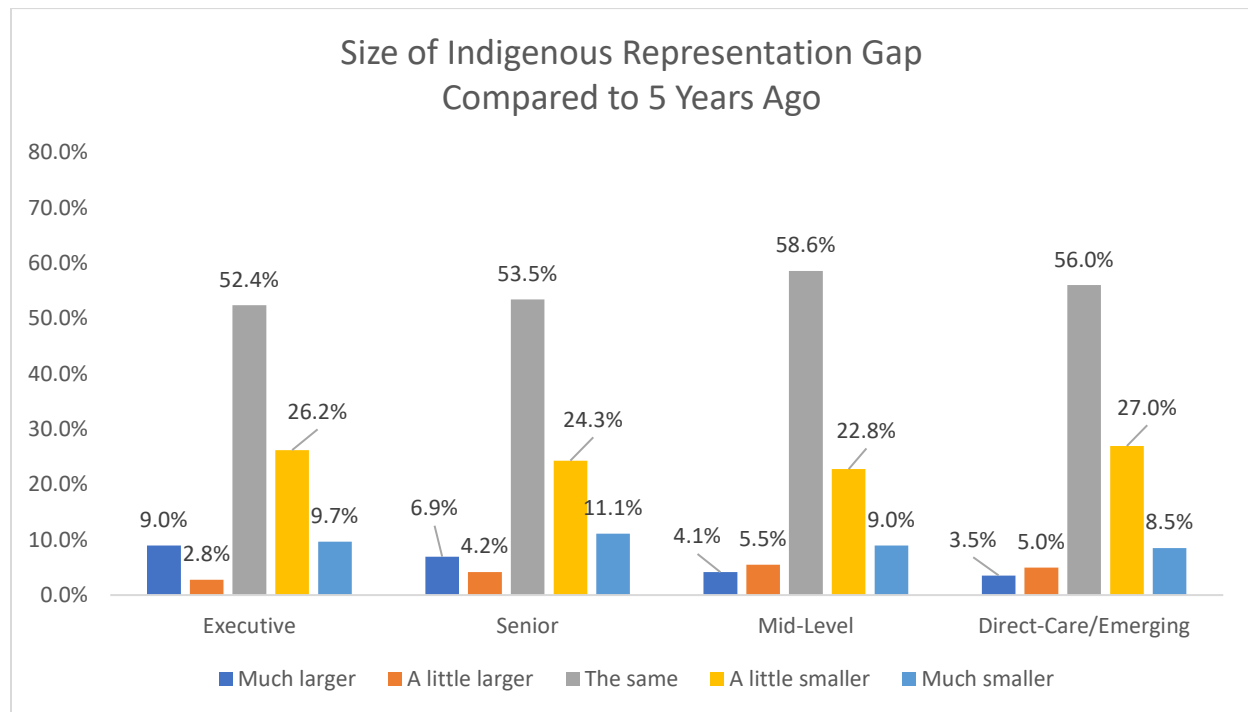


Figure 10. Respondents' evaluation of the size of the Indigenous representation gap in leadership compared to five years ago.

Changes in Racial/Ethnic Representation

Respondents were asked to what extent leaders at four levels (executive, senior, mid-level, and direct care/emerging) reflect the diverse perspectives and lived experiences of racial and ethnic minority groups.



Across all four leadership levels, responses followed a similar pattern. At each level, the most common category selected was “Somewhat reflective,” followed by “Not very reflective.”

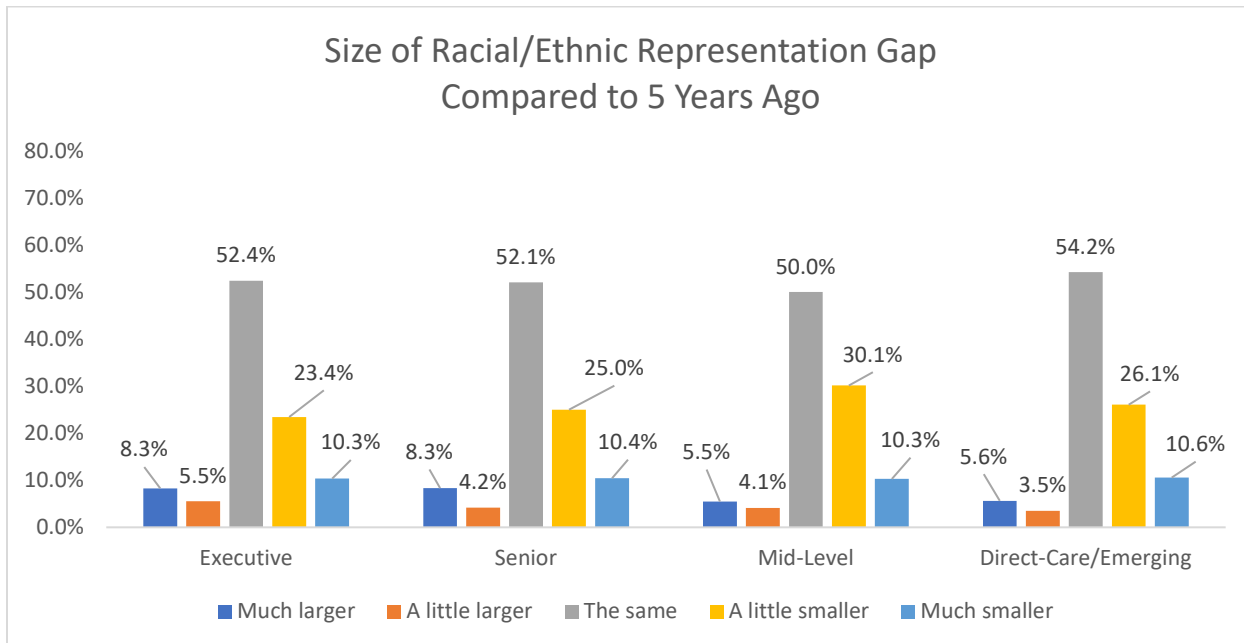


Figure 11. Respondents’ evaluation of the size of the Racial/Ethnic representation gap in leadership compared to five years ago.

Executive Leaders

For executive leaders, 29.5% of respondents indicated that this level is somewhat reflective of racial/ethnic minority perspectives. Nearly half of respondents rated executive leaders as not at all (24.7%) or not very reflective (25.3%). Only 13.0% rated executives as highly reflective. About 7.5% were unsure.

Senior Leaders

Perceptions of senior leaders were similar. Approximately 35.2% indicated that this level is somewhat reflective, while 17.9% rated it as not at all reflective and 26.9% as not very reflective. A small number (13.1%) considered senior leaders to be highly reflective. The proportion who were unsure (6.9%) was comparable to that of executive leaders.

Mid-Level Leaders

Mid-level leaders received slightly more favourable ratings. Nearly half (46.9%) were rated as somewhat reflective, the highest proportion across all four levels. Fewer respondents rated this level as not at all (9.5%) or not very reflective (18.4%), while 11.6% rated them as highly reflective. About 13.6% were unsure.



Direct Care/Emerging Leaders

For direct care/emerging leaders, 42.7% of respondents selected somewhat reflective, and 16.1% selected highly reflective. Smaller proportions rated this level as not at all (7.0%) or not very reflective (16.8%). Unsure responses were higher here (17.5%) than at other levels.

Other Leadership Gaps

In addition to the structured capacity questions, respondents were invited to indicate whether they had identified any other leadership capacity gaps within their organization and, if so, to describe these gaps. Approximately one-third of respondents (34.9%) reported additional gaps. The accompanying open-ended comments highlighted a diverse set of capacity challenges. These responses can be grouped into several broad themes.

1. Experience and Preparedness of Leaders

Many respondents raised concerns about leaders' depth of experience. Comments referenced:

- very junior leaders in positions of significant responsibility
- limited exposure to leadership competencies
- insufficient mentoring and coaching
- leaders promoted due to tenure or expediency rather than capability
- lack of preparedness to manage system-level complexity

Several respondents described situations where leaders were appointed without foundational leadership skills, leading to downstream challenges with decision-making, engagement, and performance management.

2. Ability to Navigate Complexity and Systems Change

Several responses highlighted gaps in leaders' ability to operate effectively within complex and rapidly changing health-system environments. Reported challenges included:

- limited systems thinking and strategic planning capability
- difficulty prioritizing among competing demands
- limited capacity for transformational change
- lack of agility, adaptability, or resilience
- limited understanding of social determinants of health and broader system drivers

Some noted that leaders remained focused on tactical or protective responses rather than long-term system improvement.



3. Communication, Collaboration, and Relationship Management

Respondents also highlighted gaps in communication and relationship-building, particularly between leadership levels. Examples included:

- disconnects between senior leaders and middle managers
- perceived lack of transparency or collaboration
- inconsistency in aligning decisions with frontline or patient perspectives
- unmet expectations around communication during uncertainty

A few respondents noted a perceived division or “rift” between leadership tiers, affecting alignment and trust.

4. Equity, Diversity, Inclusion, and Anti-Racism Capacity

Several comments pointed to gaps related to EDI and anti-racism capability, including:

- limited understanding of harm experienced by racialized or Indigenous staff
- insufficient accountability mechanisms for addressing bias or discrimination
- under-recognition of leadership potential among racialized employees
- need for improved anti-racism training, policies, and leadership pathways
- gaps in representation, particularly across senior and executive roles

Some respondents emphasized the importance of applying equity and sustainability lenses and incorporating lived experience into leadership roles.

5. Workload, Span of Control, and Resource Constraints

Respondents described structural capacity challenges that influence leaders’ ability to perform effectively, such as:

- large inequities in span of control
- increasing workload intensity
- resource gaps affecting frontline teams
- difficulty managing rising acuity and operational pressure

These issues were often linked to burnout, turnover, and limited time for leadership development.

6. Talent Management, Succession, and Leadership Pathways

Several responses pointed to gaps in succession planning and talent development, including:

- concerns about future bench strength
- challenges recruiting or retaining leaders



- limited exposure to career development opportunities
- a shrinking pipeline of individuals interested in leadership roles

Some noted that the pandemic accelerated retirements and contributed to shortages of skilled leaders.

7. Organizational Culture and Psychological Safety

Several comments described challenges related to culture, including:

- maintaining a healthy environment under stress
- inconsistent accountability
- limited relational or “people-focused” leadership skills
- difficulty creating psychological safety
- challenges leading through uncertainty

These concerns were often linked to burnout and workforce instability.

8. Other System-Level Considerations

A small number of responses highlighted broader system-level issues, such as:

- the impact of political appointments into senior leadership roles
- disconnects between policy-oriented executives and operational leaders
- gaps in climate-health readiness and misinformation response
- limited technical or AI proficiency in some leadership roles

These comments reflect the evolving expectations of leaders as the health system becomes more complex.

Impact of Gaps on Organizations

Respondents were asked to assess the extent to which leadership gaps negatively affect organizational performance. Among those who answered this question, most reported that leadership gaps have at least some impact on performance. Approximately one-third (31.7%) indicated that the gaps have a very large impact, and a similar proportion (30.7%) reported a significant impact. Smaller proportions described the impact as only a small impact (15.8%) or no impact (5.9%). A small number of respondents (2.0%) indicated that their organization does not have leadership gaps. About 13.9% were unsure.

Respondents were also asked whether the impact of leadership gaps has changed compared to five years ago. Among those who provided a rating, the most common response was that the impact is “the same” (23.7%). However, over half of respondents perceived an increase in impact, with 30.1% reporting that the impact is “much larger” and 26.9% reporting it is “a little



larger.” Smaller proportions indicated that the impact is “a little smaller” (12.9%) or “much smaller” (4.3%). A small number selected “N/A.”

Summary of Open-Ended Responses on Organizational Impact

Respondents were invited to describe how leadership gaps affect organizational performance. The comments reflected a wide range of impacts and experiences. Several key themes emerged:

1. Strategic Alignment and Decision-Making

Many respondents described challenges related to maintaining alignment between organizational strategy and day-to-day operations. Reported impacts included:

- confusion or inconsistency in strategic direction
- limited follow-through on plans
- delays in decision-making
- reduced clarity about priorities
- difficulty implementing change across levels

Some respondents noted gaps in the ability to manage complex organizational transformations.

2. Culture, Morale, and Psychological Safety

A substantial number of comments referenced impacts on organizational culture, including:

- lower morale
- diminished trust in leadership
- frustration among frontline staff
- feelings of disengagement or lack of accountability
- challenges maintaining a healthy environment under pressure

Several respondents linked leadership gaps to reduced psychological safety and less supportive work environments.

3. Workforce Outcomes: Burnout, Retention, and Recruitment

Respondents frequently associated leadership gaps with workforce pressures, including:

- higher burnout
- challenges retaining frontline and mid-level staff
- difficulties attracting talent
- increased turnover, including among senior leaders
- loss of experienced leaders without sufficient backfill or succession planning



Some comments highlighted the strain caused by mismatches between leadership expectations and available resources.

4. Operational Performance and Service Delivery

Many comments described direct operational impacts, such as:

- delays in care or service delivery
- less efficient processes
- challenges with resource allocation
- inconsistent practices across units
- increased operational burden on teams

A small number cited specific consequences such as emergency department closures, understaffing, and preventable adverse events.

5. Impact on Innovation, Improvement, and Adaptation

Respondents noted that leadership gaps can limit organizational adaptability, including:

- reduced innovation capacity
- difficulty implementing new technologies
- incomplete follow-through on quality improvement initiatives
- limited progress on system-level challenges

Some indicated that leaders have remained in “crisis mode,” limiting long-term planning and innovation efforts.

6. EDI, Representation, and Lived Experience

Several comments highlighted the impact of insufficient diversity or lack of EDI-related competencies among leaders, noting:

- inequitable treatment of racialized or Indigenous staff
- performative rather than substantive action on EDI issues
- limited representation of marginalized groups in leadership
- fewer opportunities for staff with lived experience to shape decisions

Some respondents noted negative impacts on staff engagement, belonging, and organizational fairness.

7. System-Level and Structural Factors

A smaller number of respondents described broader system-level impacts, including:



- effects of political or policy shifts on leadership stability
- lack of integrated thinking across sectors
- tension between executive decisions and frontline realities
- perceived disconnects between senior leaders and complex clinical environments

These comments often linked leadership gaps to reduced capacity to navigate system pressures or anticipate long-term risks.

HR & Organizational Development Priorities

This section examines respondents' perceptions of their organization's priorities related to workplace culture, engagement, performance feedback, talent management, and psychological safety. These insights reflect system-level patterns across all respondent groups (Organization, Nurse, Physician, Other), as the survey items were not all identical across professions.

Workplace Culture & Organizational Priorities

Across all respondents, organizations appear to place moderate (not strong) priority on core HR and organizational development (OD) functions. Most items cluster within the "somewhat a priority" range, suggesting that organizations are aware of these needs but may not be investing in them consistently.

Employee Engagement

Approximately 60% of respondents rated increasing employee engagement as at least "somewhat of a priority." However, 27.9% viewed it as a low priority or not a priority at all, and 10% were unsure. These mixed results may reflect inconsistent engagement strategies across organizations or variable visibility of engagement initiatives.

Physician Engagement

Priority levels were slightly lower for physician engagement, with 48.8% rating it as at least "somewhat a priority." More than one-third identified low or no priority. High uncertainty (13.8%) suggests that many respondents, especially those outside physician groups, may lack visibility into physician engagement planning.

Performance Feedback

A similar pattern emerged around performance feedback:

- 52.2% reported it was "somewhat" or "high" priority,
- while 32.5% viewed it as low or no priority,
- and 16% were unsure.



This indicates inconsistent performance management practices, which aligns with other findings related to leadership capability gaps in coaching and accountability.

Talent Management & Succession Planning

Development of a talent management strategy and succession plan was rated as at least “somewhat of a priority” by 37.4% of respondents. However, nearly 45% felt it was a low priority or not a priority at all. This limited prioritization echoes the 2019 finding that succession planning is an underdeveloped area in many health organizations.

Retention of Critical Talent

Retention was viewed slightly more favourably, with 38% identifying it as at least “somewhat a priority.” Still, over 33% reported it was a low or no priority. Open-text comments emphasized persistent retention challenges, burnout, and a lack of meaningful retention strategies.

Development Opportunities for Physicians

Just under 39% perceived that providing physicians with leadership development opportunities was a priority, while roughly 41% rated it as low or no priority. The level of uncertainty (18%) indicates that many respondents may not be aware of development opportunities for medical staff.

Interpretation

Overall, the results suggest moderate prioritization but low strategic clarity in HR and OD functions. Priority levels do not consistently align with the leadership capability and succession planning gaps described elsewhere in the report. A substantial minority of respondents remain unsure about their organization’s priorities, signalling limited communication, transparency, or visibility of HR strategies across levels.

Psychological Safety

Respondents rated the extent to which their organization promotes a psychologically safe culture supportive of innovation and change. Across all four leadership levels, responses followed a similar pattern:

- Executive leaders: ~47% supportive, ~32% unsupportive
- Senior leaders: ~48% supportive, ~28% unsupportive
- Mid-level leaders: ~50% supportive, ~30% unsupportive
- Direct care / emerging leaders: ~50% supportive, ~28% unsupportive

Approximately one-quarter selected “neither supportive nor unsupportive” across levels.



Interpretation

Across all leadership tiers, psychological safety appears mixed, with about half describing their environment as supportive and roughly one-third describing it as unsupportive. However, the persistence of 30%+ unsupportive ratings suggests that psychological safety is uneven and not yet embedded system wide. The pattern mirrors concerns raised in open-text responses about trust, transparency, and communication within leadership structures.

Engagement & Well-Being

When asked about overall engagement levels:

- 44–46% rated their organization as “somewhat engaged” or “highly engaged.”
- 30.6% reported the organization is “not very engaged.”
- 17.7% reported neutral engagement (“neither engaged nor not engaged”).

Interpretation

Engagement appears modest but fragile, with nearly one-third describing their organization as not engaged. Combined with the earlier findings on employee engagement being only a moderate priority, this suggests a misalignment between organizational goals and lived experience. Participants in the December 2025 focused dialogue reinforced this picture, describing engagement as “fragile and highly sensitive” to communication gaps, inconsistent accountability, and change fatigue. They noted that trust—particularly among frontline staff—had eroded in many settings, and that organizational leaders were struggling to rebuild it under continued system pressure.

Leadership Development Systems

This section examines the availability, quality, and evaluation of leadership development across the participating organizations, integrating questions on incentives, disincentives, development activities, protected time, and budget allocation.

Leadership Pathways: Incentives & Disincentives

Incentives to Pursue Leadership Roles

Top-selected incentives for pursuing a leadership position across all respondents included:

- “I could have a positive impact on the team/organization” (up to 25%)
- Being offered leadership training/support (5–16% depending on version)
- Positive previous leadership experience (up to 18%)
- Increased remuneration (3–17% depending on question version)



Overall, response rates were low (due to the multi-select format and high missingness), but the narrative is clear: purpose, impact, and support matter more than financial incentives.

Disincentives to Pursue or Advance in Leadership

Top-ranked deterrents for taking a leadership position included:

- Added stress and longer hours (19%)
- Increased administrative burden (6–10%)
- Cultural barriers (e.g., “not conducive to change”) (7–11%)
- Negative past leadership experiences
- Pay decreases for certain professions (notably physicians)

Open-text comments reinforced systemic challenges: burnout, organizational instability, lack of psychological safety, perceived age discrimination, and insufficient support for leaders.

Interpretation

The incentive/disincentive patterns show leadership pathways constrained not by lack of interest, but by workload, culture, and perceived risk. Leadership roles are seen as high-effort, high-stress, and not reliably supported by organizational systems.

Participation in Leadership Development

Among respondents:

- 62% had participated in several formal programs.
- 21% had participated in one program.
- 17% had never participated.

Satisfaction With Leadership Development

Respondents expressed moderate satisfaction with existing offerings:

- Selection of programs: ~48% satisfied, ~39% dissatisfied
- Effectiveness of programs: ~45% satisfied, ~35% dissatisfied

The proportion of respondents selecting “unsure” (12–18%) suggests that many may not be closely connected to program evaluation processes.

Interpretation

Satisfaction levels indicate room for improvement in both the variety and perceived quality of offerings. The gap between participation and satisfaction suggests that leadership development is available but not always strategically aligned or high impact.



Protected Time for Development

Only 26% of respondents reported having protected time for leadership development, while 74% said they do not.

Interpretation

Protected time appears to be a significant system bottleneck. Without structural time allocation, even high-quality programs fail to translate into meaningful capability development. This structural barrier was a recurring theme in the focused dialogue, where participants emphasized that leadership development is often present in name but insufficiently resourced and difficult to apply in high-pressure environments. The disconnect between development offerings and organizational infrastructure was described as one of the most persistent impediments to genuine capability growth.

Formal and Informal Development Activities

Formal Development (provided by organization)

Top offerings included:

- Internal structured programs (18%)
- Interactive workshops (14.5%)
- Online leadership courses (12.5%)
- 360-degree feedback processes (12.5%)
- Conferences (12.5%)

Formal external programs, coaching, simulations, and degree programs were less common.

Informal Development

Common offerings included:

- Mentoring (17.8%)
- Ongoing goal setting/feedback (17.1%)
- Webinars (15.1%)
- Stretch assignments (7.2%)
- Communities of practice (8.6%)

Interpretation

The landscape is characterized by light, low-cost, informal learning supplemented by selective access to formal offerings. This structure favours already-established leaders and disadvantages emerging or aspiring leaders.



Evaluation of Leadership Development

Only 32.6% of organizations measure the impact of their leadership development programs, a decrease from 45% in 2019. Evaluation methods were mostly limited to participant surveys (Kirkpatrick Level 1 or 2). Very few organizations assess behavioural change or organizational outcomes.

Interpretation

Evaluation systems remain underdeveloped and often disconnected from talent management or strategic planning. This limits the ability to demonstrate ROI or justify increased investment.

Investment in Leadership Development

Among respondents able to estimate their organization's budget allocation:

- 68% reported investing less than 1% of their operating budget in leadership development.
- Only ~2% indicated investments above 2%.

Analysis of the open-text comments suggests a growing concern about stagnant or declining investment despite post-pandemic workforce demands.

Succession Planning & Talent Systems

Only 44–57% of respondents reported having a formal succession plan across leadership levels. Mid-level and direct-care leaders were the least likely to have structured succession processes.

Among those with succession plans:

- Gender and Indigenous identity were the most considered dimensions.
- Visible minority status was considered less frequently.
- Open-text comments revealed tension between competency-based selection and diversity-based selection approaches.

Interpretation

Succession planning is limited and inconsistently applied. Organizations struggle to balance diversity, skills, and readiness, potentially contributing to perceived leadership pathway instability. This finding was reinforced in the December 2025 focused dialogue, where participants described a pattern of leaders entering roles with limited preparation, insufficient mentorship, and inconsistent expectations—what several referred to as a “missing middle” in experienced mid-level leadership. Participants underscored that addressing pathway fragility



requires long-term, system-level succession strategies rather than episodic or vacancy-driven approaches.

Comparative Organizational Results – Bench I, II and III

The *Bench III* findings offer an opportunity to situate current organizational leadership capacity and capability within the broader context of CHLNet's ongoing benchmarking initiative. This section presents findings from *Bench I* (2014), *Bench II* (2019), and *Bench III* as parallel snapshots of the leadership landscape at three distinct points in time. Important note on interpretation: because the organizational samples across the three cycles cannot be confirmed as comparable—particularly given differences in organizational type, geographic representation, and the absence of matched longitudinal data—this section does not attempt to draw conclusions about change over time. Instead, it presents the three sets of findings side-by-side. These observations are descriptive rather than inferential.

Overall Leadership Capability

Bench I (2014): Organizational respondents reported that while many leaders demonstrated foundational interpersonal strengths, capability gaps were evident in systems thinking, innovation, strategic change leadership, and cross-sector collaboration. These were described as areas where leaders struggled to meet emerging system demands.

Bench II (2019): Organizational respondents identified similar patterns, with the same domains noted as persistent weaknesses. Leaders were generally perceived as moderately capable, but ratings remained lowest in areas requiring advanced cognitive, strategic, and system-level skills.

Bench III (2025): Organizational respondents again report that leaders are generally perceived as "somewhat" or "highly" capable, with ratings remaining lowest in areas requiring advanced cognitive, strategic, and system-level skills—especially innovation and system transformation.

Perceived Leadership Capability Gaps

Gaps in Skills and Competencies

Bench I (2014): Capability gaps were documented in strategic skills needed to navigate complexity, the ability to foster cross-sector collaboration, and competence in driving innovation and system transformation.

Bench II (2019): Respondents reported substantial capability gaps at the mid-level and among emerging leaders, with smaller gaps at senior and executive levels. These deficits were noted as limiting leaders' abilities to support adaptation, engagement, and system change.

Bench III (2025): Respondents report substantial capability gaps at the mid-level and among emerging leaders, with smaller gaps at senior and executive levels. These deficits are noted as limiting leaders' abilities to support adaptation, engagement, and system change.



Perceived Changes in Gap Size (Five-Year Retrospective Questions)

Bench II (2019): When asked whether leadership capability gaps were larger or smaller than five years prior, the most common response was that gaps were about the same. A meaningful minority reported that gaps had become larger, while a comparable minority noted that gaps had become smaller.

Bench III (2025): When asked whether leadership capability gaps were larger or smaller than five years prior, the most common response was that gaps were about the same. A meaningful minority reported that gaps have become larger, while a comparable minority noted that gaps have become smaller.

Leadership Supply: Number of Competent Leaders

Bench I (2014): Significant concern was documented regarding leadership supply, with findings noting insufficient numbers of competent leaders and a lack of depth in leadership pathways.

Bench II (2019): Organizational respondents assessed the number of competent leaders at various levels. At most leadership levels, the most common response was reported only a small gap or no gap in the number of competent leaders, though a minority reported significant or very large gaps. Supply gaps were noted as particularly concerning at mid-level and emerging leadership positions.

Bench III (2025): At all leadership levels, the most common response was reported only a small gap or no gap in the number of competent leaders. A minority reported significant or very large gaps. Supply gaps remain most pronounced at mid-level and emerging leadership positions.

Perceived Changes in Supply Gap Size (Five-Year Retrospective Questions)

Bench II (2019): When asked whether the supply gap had grown or shrunk over the prior five years, the most frequent response was that the gap remained about the same. Roughly equal proportions indicated that gaps had become either larger or smaller.

Bench III (2025): When asked whether the supply gap had grown or shrunk over the prior five years, the most frequent response was that the gap remained about the same. Roughly equal proportions indicated that gaps have become either larger or smaller.

Impact of Capability and Supply Gaps on Organizational Performance

Bench I (2014): Capability and supply gaps were noted as undermining organizations' abilities to carry out change initiatives, support staff, and adapt to system pressures.



Bench II (2019): Organizational Leadership gaps are widely viewed as materially affecting organizational performance, particularly in areas of change management, staff morale, and strategic alignment. Approximately 40%–46% of respondents reported a very large or significant impact, while around 25%–35% perceived a small impact.

Bench III (2025): Across leadership levels, approximately 40%–46% of respondents reported a very large or significant impact from leadership gaps. Around 25%–35% perceived a small impact, and a small proportion indicated no impact. Leadership gaps are viewed as meaningful constraints on organizational performance, particularly in areas such as change management, strategic alignment, staff engagement, and quality improvement.

Perceived Changes in Impact Over Five Years (Five-Year Retrospective Questions)

Bench II (2019): When asked whether the impact of leadership gaps was larger or smaller than five years prior, organizational respondents most reported that the impact was about the same as five years earlier. Similar proportions indicated that the impact had become larger or smaller.

Bench III (2025): Organizational respondents most reported that the impact of leadership gaps is about the same as five years ago. Similar proportions indicated that the impact is larger or smaller.

Succession Planning

Bench I (2014): Formal succession planning was rare, and many organizations lacked structured pathways for leadership continuity.

Bench II (2019): Succession planning had become somewhat more common, particularly for senior and executive roles, though attention to mid-level and emerging leader succession remained limited.

Bench III (2025): 54–57% of organizations report succession planning at the executive and senior levels. Far fewer organizations have plans for mid-level or emerging leaders. Succession practices remain uneven, with the least attention paid to the leadership levels where turnover and instability are reported as highest.

Leadership Development Systems

Availability and Evaluation

Bench I (2014): While many organizations offered leadership development activities, few evaluated their impact. Most learning occurred through informal, unstructured mechanisms.

Bench II (2019): Availability of leadership development was high. However, evaluation practices remained limited, and protected time for development was insufficient. Informal learning



continued to dominate. Approximately 45% of organizations reported evaluating leadership development impact.

Bench III (2025): Availability of leadership development is high in the 2025 sample, with 92.1% of organizations offering formal development opportunities. However, evaluation practices remain limited: only 32.6% of organizations report measuring the impact of their leadership development programs. Protected time for development was reported by 26% of respondents in the 2025 sample. Informal learning dominates the development landscape.

Use of Leadership Frameworks

Bench I (2014): Use of standardized leadership frameworks was limited.

Bench II (2019): Over 80% of organizational respondents reported employing a leadership capability framework. The majority of those using frameworks relied on LEADS in a Caring Environment.

Bench III (2025): 61.7% of organizational respondents report employing a leadership capability framework. Of those using a framework, the majority continue to rely on LEADS in a Caring Environment (51.1% of the total 2025 organizational sample reported using LEADS).

Implications for the Future

The 2025 findings depict a health system that values leadership and has invested in foundational development structures. Yet integration, succession readiness, innovation capability, and engagement remain uneven. At the same time, the results highlight meaningful gaps in innovation, systems thinking, engagement, and succession readiness. Although many organizations report having leadership development structures and capability frameworks in place, the translation of these structures into consistently integrated and high-impact leadership systems is uneven.

These results must be understood within the broader realities facing the health sector in 2025. Workforce shortages sustained operational pressures, rapid decision-making under uncertainty, and heightened attention to psychological health and equity have reshaped leadership expectations. Leaders are now required to operate with greater agility, systems awareness, and cultural competence than ever before, often within constrained environments.

Against this backdrop, the 2025 findings point to six major implications for CHLNet partners and the broader Canadian health system.

1. Establish a Panel of Participating Organizations to Enable True Longitudinal Tracking

A persistent methodological challenge across all three Bench cycles has been the inability to confirm whether the same organizations participated from one wave to the next. Without a



stable, matched sample, observed differences between cycles reflect changes in who responded as much as changes in the leadership landscape itself, which limits the strength of conclusions that can be drawn over time.

To address this, CHLNet should consider establishing a formal panel of organizations committed to participating in each successive benchmarking cycle. Panel members would agree at the outset to complete the survey every five years, creating a true longitudinal dataset that tracks change within the same organizations over time rather than across shifting samples. This would allow for more defensible trend analysis, enable meaningful comparisons across cycles, and produce the kind of cumulative, organization-level evidence that is currently out of reach.

A standing panel would offer two additional benefits. First, it would provide a reliable foundation of participation, helping to ensure adequate sample sizes in future waves and reducing the variability that results from open, network-wide recruitment alone. Second, organizational panel members could serve as anchors for qualitative follow-up — for example, being invited to focused dialogues or case-based conversations that connect their survey responses to lived organizational experience.

CHLNet would need to consider how to structure panel membership in a way that is inclusive and representative across jurisdictions, sectors, and organization types — and how to complement the panel with open recruitment to capture emerging voices and newer network partners. Incentives for sustained participation, such as customized benchmarking feedback or peer-comparison reports, could also support long-term commitment.

This investment in methodological infrastructure would strengthen not only future Bench reports but CHLNet's broader capacity to make the case — with longitudinal evidence — for sustained investment in health leadership development across Canada.

2. Strengthen Leadership Pathways Through Integrated, Future-Focused Succession Planning

Succession planning is widespread but uneven. Many organizations do not have formal structures for identifying talent, preparing emerging leaders, or managing transitions—issues also highlighted as early as *Bench I*. This leaves organizations vulnerable in a context where retirements, turnover, and labour mobility remain high.

Bench III underscores the need to shift from episodic or vacancy-driven approaches to continuous, system-level planning. Organizations benefit from:

- Maintaining active, updated succession maps for senior and mid-level roles
- Supporting multiple pathways into leadership, including clinical and non-traditional routes
- Integrating diversity goals into succession planning
- Ensuring development plans accompany successor identification



CHLNet can continue to support this work by promoting evidence-informed frameworks and shared resources across jurisdictions.

3. Move Beyond “Providing Leadership Development” Toward Evaluating Impact

Leadership development is widely available. Yet many respondents, particularly nurses and frontline professionals, report insufficient protected time, uneven access, and a lack of evaluation.

Bench III suggests that while offerings of leadership development have not declined, their impact is inconsistent. Many organizations still rely on attendance-based metrics rather than assessing behaviour change, team dynamics, or organizational outcomes.

To strengthen leadership development systems, CHLNet partners can:

- Embed impact evaluation frameworks (e.g., learning transfer, behavioural indicators)
- Ensure protected time across roles and professions
- Provide coaching and applied-learning opportunities
- Leverage frameworks like LEADS to align development with organizational strategy

By prioritizing evaluation, organizations can shift leadership development from a programmatic activity to a strategic investment.

4. Make Innovation and Systems Thinking a Core Development Priority

Bench III highlighted that systems/critical thinking, and innovation are the lowest-rated capabilities across the health system. These gaps are particularly concerning given the rising system complexity and the need for integrated care models.

Respondents across all groups consistently noted that leaders demonstrate strong relational and values-based competencies but struggle to:

- Navigate complex system dynamics
- Advance digital and technological innovation
- Support staff through change
- Champion new models of care

Addressing these gaps requires more than training. Organizations would benefit from:

- Cultures that support experimentation
- Leadership pathways that include stretch assignments and innovation-focused roles
- Systems thinking frameworks integrated into curriculum
- Deliberate support for balancing operational demands with strategic innovation



CHLNet and partners may wish to explore system-level supports that build innovation capability across organizations.

5. Elevate Engagement and Retention as Strategic Leadership Priorities

Engagement, especially among nurses and physicians, is under-prioritized. Low engagement directly contributes to turnover, absenteeism, reduced well-being, and lower quality of care.

Bench III results reinforce that leadership and engagement are inseparable. Leaders strongly influence whether staff feel supported, valued, and included.

To strengthen engagement, organizations can:

- Treat engagement as a leadership accountability
- Invest in regular and transparent communication
- Include frontline and clinical voices in planning and evaluation
- Support psychologically safe work environments

For many organizations, engagement is not an additional task; it is central to leadership effectiveness.

6. Embed Equity, Diversity, and Inclusion into Leadership Systems

Bench III findings show that while organizations are increasingly attentive to EDI, respondents continue to report significant representation gaps, particularly at the executive and senior levels.

Leadership pathways benefit from deliberate attention to EDI, including:

- Ensuring diverse representation in leadership pools and succession plans
- Encouraging inclusive leadership behaviours across all levels
- Creating fair, transparent pathways for access to development
- Evaluating leadership development opportunities for equity of participation

CHLNet's work in this area positions the network to continue supporting organizations in embedding EDI principles into leadership systems.



Summary of Opportunities Ahead

Overall, the 2025 findings suggest that Canadian healthcare is supported by a strong foundation of committed leaders. At the same time, system-level leadership development remains a work in progress. Persistent challenges in innovation, engagement, and succession readiness indicate that existing approaches may not yet be sufficient to meet the complexity and pace of today's health system demands. Contemporary pressures have heightened the urgency of strengthening these areas to ensure sustainable and future-ready leadership capacity.

Opportunities for CHLNet and partners include:

- Strengthening system-wide leadership pathways
- Elevating leadership development from programmatic to strategic
- Building cultures that value innovation and systems thinking
- Embedding engagement and EDI into leadership accountability
- Continuing to standardize leadership language and expectations through frameworks like LEADS

The next section draws together these themes to outline where CHLNet partners may choose to focus their collaborative efforts moving forward.

Conclusion: Where to From Here?

The 2025 CHLNet *Bench III* results provide a comprehensive, evidence-based snapshot of health leadership capacity and capability in Canada. The findings reflect a system that clearly values leadership and has invested in foundational development structures. At the same time, they highlight areas where stronger integration, coordination, and strategic focus are required.

Overall, leadership capability ratings are generally positive, with most respondents describing leaders as somewhat or highly capable. However, meaningful gaps remain across leadership levels, particularly in systems and critical thinking, innovation, and navigating emerging challenges. These areas are increasingly central to effective leadership in a complex and rapidly evolving health environment.

Leadership pathways also present areas for attention. Succession planning is more prevalent at executive and senior levels than at mid-level and emerging-leader tiers, where turnover pressures and workforce instability are often most acute. Strengthening leadership continuity will require more deliberate, system-level approaches to talent identification, preparation, and transition planning.

Leadership development opportunities are widely available across organizations. Yet the conditions that support meaningful impact—protected time, structured application, coaching, and systematic evaluation—remain inconsistent. Without these enabling structures, development risks remaining programmatic rather than transformative.



Workplace culture indicators suggest moderate prioritization of engagement, psychological safety, and talent management, but lived experiences appear uneven. Engagement remains fragile in many settings, particularly among frontline professionals, underscoring the critical role of leadership in fostering trust, communication, and inclusion.

Findings related to equity, diversity, and inclusion indicate that representation gaps remain across leadership levels, especially in senior roles. Building more inclusive leadership pathways will require sustained, intentional efforts to align succession planning, development opportunities, and accountability mechanisms with equity goals.

Taken together, the 2025 findings point to a health system with a strong foundation of committed leaders — but one that must evolve its leadership systems to meet rising expectations and sustained system pressure. Strengthening innovation capability, embedding systems thinking, investing in sustainable leadership pathways, and integrating engagement and equity into core leadership accountability will be central to future progress.

Ongoing benchmarking will remain an important tool for informing evidence-based action, supporting collaboration across jurisdictions, and ensuring that leadership development keeps pace with the demands facing Canada’s health system. As complexity increases and public expectations rise, the need for adaptive, inclusive, and future-ready leadership is both clear and pressing.



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Appendix A. Addendum: Insights from CHLNet Focused Dialogue (December 2025)

These insights are referenced in the Executive Summary and provide qualitative context that reinforces many of the system-level themes surfaced in the survey data.

To supplement the survey findings, CHLNet held a brief national-focused dialogue with health system leaders on December 3, 2025. The discussion provided additional context behind the persistent leadership capacity and capability gaps identified in *Bench III*. Three breakout sessions explored: (1) the declining use of leadership frameworks, (2) uneven succession planning, and (3) persistent leader capability gaps. The following questions were asked:

- Use of leadership frameworks is low. Only 61.7% report employing a capability framework compared to over 80% in 2019. The majority of those using leadership capability frameworks continue to rely on LEADS. Why do you think framework use is low? Does a common framework help or hinder the building of health leadership capabilities in an organization?
- Succession planning is widespread but uneven. 54% of organizations maintain a formal approach for senior leaders, while attention to mid-level succession remains less consistent (46%). Why are organizations not doing more strategic succession planning beyond executive levels? How can the network foster the need to strengthen the leadership pathways through integrated and future-focused succession planning?
- Leader capabilities continue to show the same relative strengths and weaknesses observed five years ago. The most frequently cited strengths are integrity, resilience, and people-centeredness, while the lowest-rated areas remain systems/critical thinking and innovation. Why do you think that is? How might the network and its partners cultivate cultures that build innovation and systems thinking capabilities further?

While time-limited, the discussions provided valuable contextual explanations for *Bench III* patterns and highlighted system-level barriers that survey data alone cannot fully capture. The following summarizes key themes raised by participants.

1. System-Level Complexity and Leadership Overload

Participants emphasized that leaders at all levels, particularly mid-level leaders, are operating in environments of intensified complexity, rapid change, and heightened scrutiny. Consistent with *Bench III* survey findings, members of the focused dialogue described leaders as “overwhelmed” and “stretched thin,” noting that workload and pace increasingly limit the ability to practice strategic leadership, engage teams, or invest in capability development.

2. Challenges in Talent Pathways and Leadership Readiness

Echoing *Bench III* survey data, participants described significant variation in leadership readiness. They noted a pattern of leaders entering roles with limited preparation, insufficient



mentorship, and inconsistent expectations. Several pointed to a “missing middle,” referring to a thinning layer of experienced mid-level leaders critical for organizational stability.

3. Culture, Engagement, and Trust as Central Leadership Challenges

Participants highlighted a widespread erosion of trust and psychological safety, particularly among frontline staff. They noted that engagement remains fragile and highly sensitive to communication gaps, inconsistent accountability, and change fatigue.

4. Persistent Gaps in Systems Thinking and Innovation Capability

Participants of the focused dialogue reaffirmed that leaders continue to struggle with systems thinking, innovation, and navigating cross-organizational complexity. These themes precisely mirror the lowest-rated LEADS domains in the survey and the long-standing capability gaps first documented in *Bench I*.

Participants suggested that operational pressures often crowd out time for strategic work, creating a cycle where innovation remains aspirational rather than embedded.

5. Equity, Diversity, and Inclusion: Progress but Slow System Change

Participants reported growing organizational attention to EDI but reiterated concerns about limited representation at senior levels, insufficient lived-experience leadership, and uneven cultural safety. These qualitative insights support the *Bench III* findings that representation gaps remain a defining feature of Canada’s leadership landscape.

6. Leadership Development: Availability Without Integration

Consistent with survey findings, participants emphasized the disconnect between leadership development offerings and organizational infrastructure. They described development as present but insufficiently resourced, inconsistently evaluated, and difficult to apply in high-pressure environments.

Overall Interpretation

The focused dialogue findings strengthen the central message of *Bench III*: Canada’s leadership challenges are structural, persistent, and deeply connected to system complexity, workforce pressures, and uneven organizational supports. The perspectives shared reinforce that addressing these issues will require coordinated, long-term strategies—especially in strengthening pathways, embedding innovation, and integrating EDI.



Appendix B. Methodology

Study Overview

The 2025 CHLNet Benchmarking Study (*Bench III*) was designed to provide a follow-up assessment of leadership capacity and capability across the Canadian health system, building on the methodology established in the 2019 *Bench II* survey. The goal was to ensure that results could be compared across the two time points while also capturing emerging leadership challenges that have arisen in the post-pandemic context.

Survey Administration

Data were collected through an online Qualtrics survey that was open from September 25 to October 16, 2025. The survey link was disseminated through CHLNet's national network of partners, including health authorities, professional associations, and academic organizations. Consistent with prior cycles, participation was voluntary and based on an open invitation.

Instrument Design

The *Bench III* instrument replicated nearly all items from the 2019 *Bench II* survey to preserve longitudinal comparability. Only minor wording adjustments were made to clarify terminology and ensure contemporary relevance (for example, updating examples of leadership frameworks or adding references to post-COVID contexts).

The questionnaire retained the two-pillar conceptual structure used in *Bench II*:

1. Leadership Capacity – items assessing organizational infrastructure, succession planning, investment in leadership development, and time and budget allocations.
2. Leadership Capability – items assessing perceived leader behaviours and competencies (e.g., communication, systems thinking, innovation, collaboration, and integrity).

In addition, *Bench III* introduced several new or refined items addressing equity, diversity, and inclusion (EDI), leadership evaluation practices, and organizational engagement priorities. These additions reflect CHLNet's evolving strategic focus while maintaining alignment with earlier measures.

Inclusion and Exclusion Criteria

To ensure data quality, records were screened for completeness. Any response that did not answer at least 50 percent of the survey items was excluded from analysis. Duplicate entries and test records were also removed. No imputation procedures were applied; all analyses were based on valid (non-missing) responses per item.

Data Analysis

Data were exported from Qualtrics into SPSS for cleaning and aggregation. As in the 2019 *Bench II* report, analyses focused on frequency distributions and percentages for each item. Because the survey was open and unsampled, no weighting or inferential statistical testing was applied.

For comparability with *Bench II*, results are presented at two levels:



1. Organization-level comparison (2019 vs 2025): matched indicators are displayed side-by-side to illustrate directional changes in leadership capacity, capability, and development practices.
2. Cross-sectional 2025 snapshots: descriptive summaries for the Nurse, Physician, and Other Health Professional groups, highlighting current perceptions without implying statistical change from previous years.

Ethical Considerations

Because this project was undertaken for internal benchmarking and improvement purposes within CHLNet and its partners, formal research ethics review was not required. Participation was anonymous, and no identifying information was collected. Completion of the survey implied informed consent.



Appendix C. Definitions used for Leadership and Leadership Positions in Surveys (December 2025)

Executive Leaders

Executive leaders hold the highest-level leadership positions with overall accountability for organizational performance, strategic direction and external relationships. Job titles may include CEO, President, Chief Operating Officer, Executive Director, and Dean.

Senior Leaders

Senior leaders are part of the top management team, responsible for major departments or portfolios. They translate organizational strategy into operational plans and report to executive leaders. Job titles may include Vice President, Associate Dean, and Vice-Dean.

Mid-Level Leaders

Mid-level leaders manage specific programs, units or service areas. They are responsible for day-to-day operational leadership, including staffing, quality of care, budgeting and implementing department initiatives. Job titles may include Clinical Manager, Program Manager/Director, Project Lead or Regional Coordinator.

Direct Care or Emerging Leaders

Direct Care Leader or Emerging Leaders supervise direct staff and are responsible for front line service delivery. Emerging leaders are often early in their career leadership and may be developing formal leadership roles. Job titles may include Project Coordinator, Team Lead, or Supervisor.

Leadership

The collective capacity of an individual or group to influence people to work together to achieve a common constructive purpose: the health and wellness of the population we serve (Dickson & Tholl, Bringing Leadership to Life in Health: LEADS in a Caring Environment, 2020).

LEADS in a Caring Environment framework

Defines health leadership through five domains: Lead Self, Engage Others, Achieve Results, Develop Coalitions and Systems Transformation.