



Benchmarking Health Leadership in Canada: 2020

Report of CHLNet Steering Group

April 15, 2020



Benchmarking

Health Leadership in Canada:

2020

Preface

Founded in 2009, Canadian Health Leadership Network (CHLNet) is a value network of 42 partners, which extends coast to coast in Canada. We believe that transformation of our health systems can only be accomplished through a commitment to Better Leadership, Better Health—Together. Our work is centred around *three value streams*: connecting people through dialogue and engagement; advancing health leadership research, knowledge and evaluation; and accelerating leadership practices and capabilities. In 2013/14, CHLNet did a benchmarking study, CHL-Bench, looking at the nature and extent of the leadership gap in healthcare 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.

Five years later in January 2019 under the auspices of our Research and Evaluation Working Group, an expert steering group comprising decision makers and academics was struck to provide stewardship of a second benchmarking effort. Called Bench II, it tracked progress from CHL-Bench to measure progress over time, to identify emerging health leadership challenges and help inform CHLNet’s strategic planning process. It is intended to help our network partners, individually and collectively, better understand the importance of building leadership capacity and competencies for leaders today and in the future.

Acknowledgments

CHLNet is a small value network and without the generosity of our contributors to this project, it would not have come to fruition. Great appreciation to our group's Chair Bill Tholl, O.C. whose vision and devotion to health leadership kickstarted both of CHLNet's CHL-Bench and Bench II studies. Many thanks to the steering group members who gave freely both of their time and wisdom: Dr. Owen Adams (Canadian Medical Association), Dr. Ivy Bourgeault (University of Ottawa), Dr. Graham Dickson (CHLNet Research Advisor), Emily Follwell (HealthCareCAN), Kelly Grimes (CHLNet Executive Director), Elma Heidemann (CHLNet Emeritus), Brenda Lammi (LEADS Canada/Canadian College of Health Leaders), Dr. Karen Lawford (Queen's University), Jonathan Mitchell (HealthCareCAN), Ola Norrie (Manitoba Centre for Healthcare Innovation), Dr. Don Philippon (CHLNet Emeritus and University of Alberta), Pusha Sadi (Manitoba Centre for Healthcare Innovation), Dr. Johny Van Aerde (Canadian Society of Physician Leaders), and Mike Villeneuve (Canadian Nurses Association). Extra acknowledgement to Pusha and Ola for their excellent work in setting up and extrapolating the data from the online surveys; and also to Jane Coutts, the queen of editing.

Thanks to the principal investigator and author of the technical report, Dr. Jaason Geerts (LEADS Canada and the Cass Business School, City, University of London). There are rich data to be gleaned from Jaason's detailed report (available soon at chl.net.ca/tools-resources/research), and we hope it serves as a foundation for other health leadership research efforts. And lastly we acknowledge the organizations who believed in this work and in turn generously contributed financially or in-kind to it: Manitoba's George and Fay Yee Centre for Healthcare Innovation, Health Canada, Canadian Health Leadership Network, Canadian College of Health Leaders, Canadian Medical Association, Canadian Nurses Association, Canadian Society of Physician Leaders, and HealthCareCAN.

Kelly Grimes

Executive Director, CHLNet

April 2020



Bench II Main Messages

- Strong leadership is essential for preparing healthcare for the future — but we must face the fact there are serious shortcomings of leadership in Canadian healthcare, including a lack of diversity among leaders that doesn't reflect Canadian society, too little succession planning and limited leadership development opportunities.
- CHLNet's 2014 and 2019 surveys of healthcare leadership show some progress was made over the past five years. More organizations are seen to have sufficient leadership capacity to accomplish goals and meet challenges and many more are providing some sort of leadership training and introducing succession planning. Today's leaders model honesty and integrity, contribute to healthy organizational culture and are committed to person-centred care.
- However, Canadian healthcare organizations were poorly rated on their ability to close gaps in leadership and its required skills. Human resources, organizational development and leadership training consistently lack attention from leaders, and frontline workers feel their leaders don't prioritize keeping them engaged.
- Solutions include:
 - promoting succession planning and leadership development programs;
 - doing more to involve, listen to and value frontline workers to keep them engaged;
 - consciously working to be more innovative and to adapt new technology.

Table of Contents

- Executive Summary..... 1
- Context..... 4
- Approach 6
 - Research Questions 6
 - Data Collection..... 7
 - Data Analysis..... 8
 - Research Steps..... 9
 - Limitations 9
- Results: Key Insights and Perspectives..... 10
- Implications for the Future 19
- Challenges 19
- Opportunities 21
- Conclusion: Where to From Here? 24



Executive Summary

Healthcare in Canada is an immense undertaking, divided among multiple jurisdictions, with providers and resources often stretched to the limit by the effort of meeting the needs of more than 37 million people. We can be proud of the commitment and brilliance of the people who work in the system — but we cannot afford to ignore the fact there are some serious shortcomings of leadership in Canadian healthcare.

The Canadian Health Leadership Network (CHLNet) is a value network of 42 partners, founded in 2009 to promote better leadership as the key to transforming health systems. In 2014, CHLNet did a benchmarking study, *CHL-Bench*, asking senior executives from health organizations about the nature and extent of the leadership gap in healthcare across Canada. That study found gaps in leadership skills and gaps between the number of competent leaders there are and the number needed (the supply-demand gap). It was clear Canada was not taking leadership development seriously enough.

Five years later, it was time to follow up CHL-Bench in a second Canada-wide survey, Bench II. This time, we did two separate surveys. Survey A went to a group of senior executives similar to those we surveyed in 2014. Survey B went to a new cohort made up of additional administrators, physicians and nurses. We wanted to learn whether people at different levels of healthcare organizations had different views on whether Canada had made progress in addressing the supply-demand and skills gaps identified in the 2014 survey. We sent out over 5,000 online surveys and received almost 2,000 responses (for an overall 31% response rate).¹ More data were gathered during three focus groups. Participants in them helped with interpreting results and flagging some of the limitations of the study, including its qualitative nature and the fact that it's difficult to establish any trends or patterns from two point-in-time surveys.

Two overarching questions guided the study:

1. Are there perceived leadership gaps in Canadian health care organizations?
2. Are issues related to those gaps shared across different 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?

¹Limitations of this study: This is a qualitative study using pooled data informed by three focus groups. While response rates were high, results are subject to interpretation. Further analysis and study are planned. It should be noted that this study was completed before COVID-19 and interpretation of results reflects this.

The results showed the two survey groups were frequently at odds in their perceptions of the state of leadership in Canadian health care. Time and again, senior executives were more positive than those closer to the front lines about how well healthcare leaders are doing and how effectively organizations are preparing future leaders. Here are some highlights from the report of what's working and what's not, followed by ideas on what should be done to help health organizations across the country build the leadership they need.

Progress, 2014-2019

More organizations in 2019 than 2014 were perceived to have adequate leadership capacity to achieve organizational outcomes and meet future challenges and reforms (65% versus 55%).

Almost all organizations (93%) are providing leadership development training (internal or external) compared with just 62% in 2014. The most common approaches are ad hoc programs or tools, such as webinars, and ongoing goal setting and feedback (23% each).

There has been little increase in diversity in formal leadership roles, but acceptance and efforts to increase diversity have improved since 2014.

Most survey respondents (86%) report using capability frameworks, a two-fold increase since 2014 (47%). Of organizations that report using a capability framework, four out of five use the LEADS in a Caring Environment framework.

There has been a noticeable increase since 2014 in the number of organizations with a formal approach to succession planning, which includes efforts to identify more diverse candidates.

Respondents said healthcare leaders' strengths included modelling honesty, integrity, resilience, and confidence (56% said leaders in their organization did that exceptionally well), contributing to a healthy organizational culture (50%); and demonstrating a commitment to customers and service (people-centred care) (50%).

Leaders were weakest at demonstrating systems/critical thinking (21%), self-awareness (25%) and encouraging and supporting innovation, including new technology (23%).

The two groups of respondents disagreed on how effective organizations were being in attempting to close gaps in leadership and skills. Almost half the respondents said human resources and organizational development practices were either low priority or not priorities at all. Three-quarters of respondents said engaging staff ranked low or not a priority at where they worked; even more said retaining talent and succession planning were not high priority.

Based on the results of Bench II and the lessons we've learned from comparing it to CHL-Bench, we see five areas senior leaders and individual professionals must work on together to improve healthcare leadership in Canada. They are:

Promote succession planning

Turnover is expected to be considerable among health leaders over the next five years, which is an opportunity to close the leadership gap through development programs and succession planning

Undertake evidence-based professional leadership development

More than 50% of respondents who perceive themselves as leaders have had no leadership training. New evidence-based approaches and openness to nurturing leadership at all levels will ensure better leaders in the future.

Improve engagement of health professionals

The survey gave very low scores for efforts to engage providers (fewer than 20% prioritize greater physician engagement and only 10% do for nurses). Low clinician engagement is linked to decreased retention and increased absenteeism, clinical errors and burnout.

Develop capabilities for 21st century care

Systems thinking and innovation are essential skills for leaders, but this study shows supporting innovation was the lowest-rated capability among health leaders, just as it was in the 2014 study.

Invest in leadership development

Our respondents reported low satisfaction with leadership development. Many don't participate at all and half said they were dissatisfied with the programs they were offered. Leadership development budgets were reported to have declined since the 2014 study and Survey B respondents said there was also less time allowed for it. Both should be increased.



Benchmarking Health Leadership in Canada 2020

Context

A 2007 Conference Board of Canada survey of representatives of 500 prospective CHLNet partner organizations revealed that Canadian healthcare organizations were concerned about whether Canada had the leadership capacity to address the 21st century challenges of increasingly complex health systems. This was a major factor in deciding to proceed with the formal *creation of CHLNet* in 2009. Five years later, in response to requests by network partners, CHLNet launched its first benchmarking study CHL-Bench. The study was administered directly by CHLNet in collaboration with decision makers and academics including Dr. Graham Dickson (Royal Roads University) and Dr. Ivy Bourgeault (University of Ottawa). Its purpose was to determine whether perceptions of leadership gaps could be identified in Canadian healthcare organizations, along with the perceived importance of any identified gaps and what was being done to address them. In May 2014, CHLNet published the *Canadian Health Leadership Benchmarking Survey Report*. The data for it came from an online survey that was completed by senior executives (or their designates) on behalf of their organizations. The response rate was 58%.

Respondents identified two large and growing gaps. The first was an overall supply-demand gap — a shortfall in leadership capacity respondents said was likely to grow due to, among other factors, the aging of senior and mid-level health leaders. The second was a skills gap, defined as whether health leaders had the capabilities or competencies to deal effectively with the complexities of a 21st century healthcare system. It was agreed it would be important to monitor progress over time.

Over the past five years, many initiatives to address these gaps have been undertaken by CHLNet and its network partners including the development of a series of toolkits on health leadership: *Measuring the Impact of Leadership Development*, *Empowering Women Leaders* and *Wise Practices*. The Canadian College of Health Leaders now has a thriving LEADS Canada portfolio of programs to provide facilitated training leadership development training. The Canadian Society of Physician Leaders has the Canadian Certified Physician Executive program. CHA Learning, the professional development division of HealthCareCAN, has partnered with several leading health organizations to deliver a diverse suite of online leadership development programs. More attention is being paid to leadership through university-based programs and more research has been conducted into leadership and leadership development in the health sector.²

In January 2019, CHLNet decided it was time to gauge progress with a second benchmarking study to be conducted in a disciplined way with dedicated resources. A volunteer steering group along with a principal investigator (PI) stewarded the project, called Bench II. CHLNet leaders and the project's steering group felt that a more robust and extensive investigation was required to explore the gaps longitudinally as well as understand the reasons for them and how to address them. They chose a mixed-methods approach, involving an expanded group of individual respondents and three focus groups.

This study builds on the results of CHL-Bench conducted in 2014. The primary purpose of Bench II is to assess progress (or perceptions of it) in filling the supply-demand and skills gaps identified in the 2014 survey. Gaps were defined in this study as “a divide between current leaders and what or who is needed to achieve organizational goals and anticipate/meet future challenges and reforms. These include capabilities, supply/demand, and diversity representation gaps”³. After five years it is important to determine whether the programs and initiatives of CHLNet and its network partners are having a positive impact in closing the supply-demand and skills gaps identified back in 2014. A related objective was to identify whether new gaps have emerged since 2014 or gaps identified then are perceived to have changed in nature and their relative impact on organizational performance.

The results of this study will provide important insights for CHLNet's next strategic planning cycle and we hope will help network partners in their efforts to build health leadership capacity and capabilities. This

² Dickson, G. and Tholl, B (2020). *Bringing Leadership in Health to Life: LEADS in a Caring Environment. Second Edition*. Springer.

³ For each of the questions, respondents were asked to rate the size or absence of the gap on the following six-point Likert scale: 1 – A very large gap, 2 – A large gap, 3 – A medium gap, 4 – A small gap, 5 – No gap, 6 – Unsure. They were also asked to comment on whether they thought, for each gap they identified, it was larger or smaller than it was five years ago, measured on a five-point Likert scale.

report describes the approach of this second benchmarking study, its results and their implications for future action by CHLNet and partners. A more detailed technical report containing additional rich data can be found shortly at www.chlnet.ca.

Approach

Bench II builds off the results of CHLNet's first benchmarking study CHL-Bench. It is a qualitative, longitudinal comparative study.

Research Questions

The following questions guided the study.

1. Are there perceived leadership gaps in Canadian health care organizations?

1.1 Does it appear that the nature and size of the gaps have changed since the 2014 benchmarking study?

1.2 If there are leadership gaps, what is their nature? That is, do the gaps pertain to skills, capabilities, or competence of positional leaders, an insufficient number of competent leaders, an unrepresentative distribution of leaders in terms of diversity, or all three?

2. Are issues related to these same gaps shared across different groups in the health systems, and how do they perceive the importance of leadership development, organizational development, and succession planning as ways to close those gaps?

2.1 What is the perceived impact of these gaps on performance at the organizational level?

2.2 What perceived priority is given to a selection of common human resources, organizational development, and leadership development practices?

2.3 How effective are efforts to close the leadership gaps through development opportunities perceived to be?

2.4 What more could be done to close the gaps and how?

Data Collection

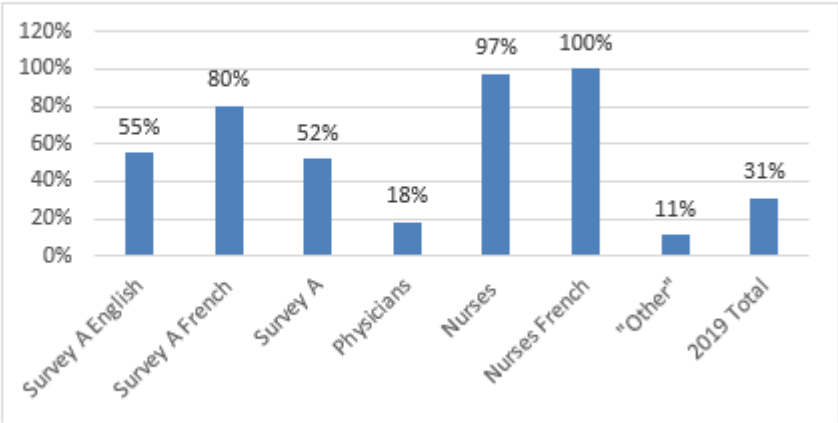
We used a structured survey tool and focus groups to gather data. The survey tool was built on the 2014 CHL-Bench version but expanded significantly to allow for better exploration of the nature of leadership gaps in healthcare and how to overcome them. The focus groups were used to validate (or not) survey findings.

There were two surveys. Survey A was a subset of questions that replicated key questions from CHL-Bench to enable comparison; it was sent to a sample of respondents similar to the group sampled in 2014. Survey B was constructed to explore in-group differences (i.e., between senior leaders and mid-managers and professionals such as nurses and physicians) in perceptions of leadership gaps. These groups were not surveyed in the original 2014 study. Both surveys were significantly expanded to probe issues including gender and diversity, Indigenous health leadership and common practices and priorities in human resources, organizational development and leadership development.

The draft surveys were tested with members of the Benchmark Steering Group. Over 5,000 surveys were sent out by CHLNet and its research partner organizations (Figure 1), with over 1,900 respondents giving a 52% response rate for Survey A and 31% response rate overall. These return rates provide a high level of confidence in the key findings and results.

Figure 1

2019 response rates



A third pot of data was gathered from three focus groups — a break out session at semi-annual meeting of CHLNet Network Partners (Ottawa, May 2, 2019), a breakfast session at the annual meeting of the Canadian Association of Health Services and Policy Research (Halifax, May 29, 2019) and a breakfast session held in conjunction with the National Health Leadership Conference (Toronto June 19, 2019). These focus groups helped the research team in interpreting and/or validating the analysis of the results and flagging some of the limitations of the study, including its qualitative nature and the fact it's difficult to establish any trends or patterns from two point-in-time surveys.

Data Analysis

The PI for the study, along with key representatives from the Centre for Healthcare Innovation at the University of Manitoba, conducted the data analysis. The Steering Committee for the project provided advice and guidance to the process.

Survey A, which contained questions to compare gap perspectives between 2014-2019, were analyzed separately to determine whether the gaps identified in 2014 had changed—either positively or negatively—or were similar. The differences between 2014 and 2019 were identified and commented upon. Differences were categorized as insignificant, significant or important according to the percentage differences in key gap areas. Results of this comparison are provided in the first section of the findings.

The data from Survey B were analyzed on a question-by-question basis to determine differences or similarities between groups on their perceptions of those gaps. The preliminary results were tallied (based on Likert Scale responses) and more than 450 write-in comments on additional leadership gaps were reviewed using key words and phrases analysis to identify broad areas of concern. Further questions aimed at understanding efforts to address key issues such as leadership development, engagement and succession planning were analyzed to determine organizational commitment to those practices. Qualitative comments from respondents about improving leadership development were analyzed using a key word search to identify themes permeating the raw data.

Focus group results were also themed according to key concepts that emerged, and those findings compared to the results of surveys A and B to lend additional credibility.

Research Steps

The principle investigator and research team used an iterative, four-step process to do the study. The steering committee was involved at each step through bimonthly teleconferences, providing feedback on progress and making suggestions on how research processes might be improved to strengthen the study.

Step 1: The PI and research team worked with the steering group to identify key tracking questions from the in 2014 survey that would allow reasonable assessment of progress over time on the two key leadership gaps: supply-demand and skills. Based on an assessment of new or emerging leadership issues and concerns coming out of the literature and network partner roundtables, the steering group provided input into Survey B.

Step 2: The PI and research team asked the steering group to identify a reasonably comparable sample of health care organizations to respond to the original tracking questions (Survey A). The organizations that made up the sample included all 40+ CHLNet partners and the members of HealthCareCAN (i.e. hospitals, regional health authorities and academic health science centres).

Step 3: The PI and research team worked with the Canadian Society of Physician Leaders, the Canadian Nurses Association and the Canadian College of Health Leaders to identify a reasonable sample of individual physicians, nurses and other healthcare leaders at various levels of authority. Survey B was administered by those organizations, which helped ensure impressive survey response rates.

Step 4: CHLNet convened the focus groups described earlier in the methodology.

Limitations

In 2014 the survey sample was restricted to CEOs and other senior organizational representatives. This generated a strong sample to base results on. However, in 2019, if the survey had been distributed according to the same guidelines, the results would have been skewed because the number of health organizations was markedly smaller after a five-year trend to larger regions. Saskatchewan, Manitoba and Nova Scotia, for example, all went from multiple regions to one per province over that time. As a result, there were many fewer CEOs to respond to Survey A, and they were further removed from the front line.

Survey B helped mitigate this problem by allowing administrators and healthcare providers to answer similar questions as the CEOs, so data could be added, where appropriate, to Survey A data. Survey B let us assess whether the perceptions of the CEOs and COOs who responded to Survey A were shared at lower levels of the organization. It also allowed us to gather additional data for understanding leadership

development dynamics in organizations. That extra information revealed significant discrepancies in perception between the two groups of respondents, most clearly around the skills gap. Comparisons, therefore, between Survey A respondents and the related group in CHL-Bench were tempered by this limitation.

Results: Key Insights and Perspectives

Overall, Bench II shows mixed results on whether the supply-demand and skills gaps identified in 2014 have improved and also highlights new and demanding challenges around culture and diversity. We learned progress is a matter of perspective: Survey A (senior executives) have a much more sanguine and even optimistic view of progress than the individual physicians, nurses and other health professionals who took Survey B. This difference exists across a number of the key underlying indicators of progress over the past five years as well as emerging areas of concern: diversity and inclusiveness, commitment to supporting professional training and development and succession planning.

These and other insights are described in more detail below, organized by the two main research questions.

1. Are there perceived leadership gaps in Canadian healthcare organizations?

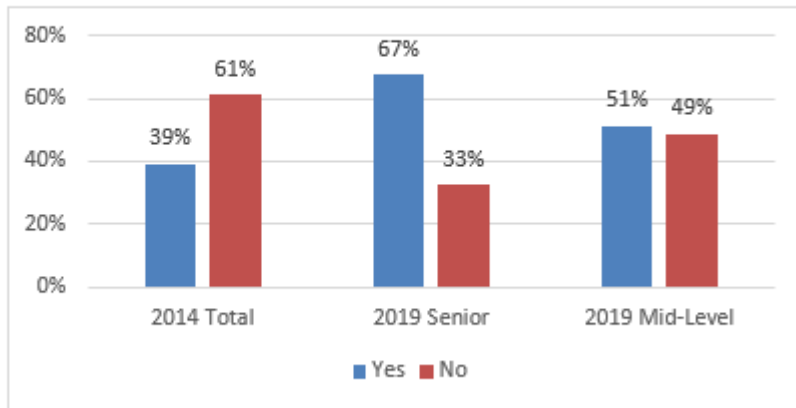
Bench II shows mixed responses to this question; some important progress has been made on two key gap challenges identified in 2014, growing leadership capacity to close the supply-demand gap and closing the skills gap.

Progress

From a progress perspective, more organizations in 2019 than 2014 were perceived to have adequate leadership capacity to achieve organizational outcomes and anticipate and meet future challenges and reforms (65% versus 55%). While progress is relatively modest, we can take comfort that we are headed in the right direction in terms of this overarching leadership development goal. Where we have made real progress, it appears, is in increased formal programs and initiatives in support of succession planning (Figure 2) — including efforts to identify more diverse candidates — which is reported to be almost twice as common in 2019 (66%) as it was in 2014 (39%). That is more than a 70% increase over the past five years.

Figure 2

Succession planning (2014 and 2019)

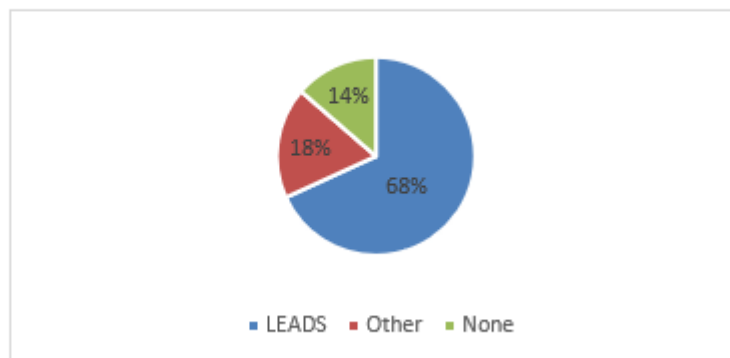


In terms of progress on other fronts, almost all the respondents (93%) reported their organizations are providing formal leadership development (internal or external) compared with just 62% in 2014. This represents a 50% increase over five years. Most of the programs are interdisciplinary and the portion has doubled since 2014.

Another positive result is that most survey respondents (86%) report using capability frameworks, a two-fold increase since 2014 (47%). Of organizations that report using a capability framework, four out of five use the LEADS in a Caring Environment framework — affirming CHLNet’s early goal to encourage use of a common framework to create a shared leadership vocabulary (Figure).

Figure 3

2019 leadership capability framework adoption



Respondents also report increased availability of shared leadership tools that can prepare the workforce to guide and support their organizations effectively. The most common leadership development activities are ad hoc programs or tools, such as webinars, and ongoing goal setting and feedback (23% each). Lectures and online courses were seldom mentioned by respondents, which suggests there's a shift away from more traditional teaching approaches.

A fifth positive finding was around diversity and inclusiveness (i.e. gender, Indigenous identity and visible minorities). There has been little increase in diversity in formal leadership roles, but there is a reported increase in acceptance and efforts to increase diversity since 2014.

Lastly on the positive side, there has been a noticeable increase since 2014 in the number of organizations with a formal approach to succession planning, which includes efforts to prioritize identifying more diverse candidates.

Leadership gaps

There were areas of concern around the supply-demand gap and the skills gap. For example, in 2014 nearly a third of respondents indicated there were large or very large gaps in both the number of competent senior and mid-level leaders in their organizations and the number needed, and also between those leaders' capabilities or skills and what they needed to have (Figure 3 and 4). In 2019, still half of respondents suggested their organizations don't have all the leadership capacity needed to achieve strategic outcomes and anticipate and meet future challenges and opportunities. Similarly, very few respondents reported no leadership capacity gap and only a third asserted their organizations are "highly capable." The 2019 results suggest these gaps are expanding and have a significant negative effect on organizational outcomes and system efficiencies.

Figure 3

Comparing 2014 data to 2019: supply-demand/need gap

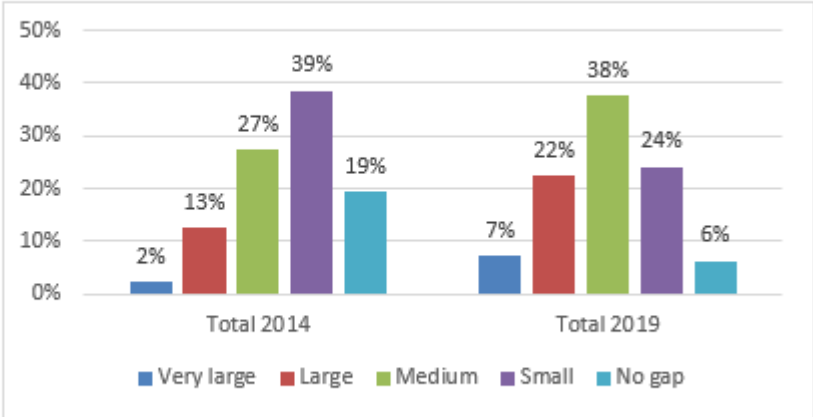
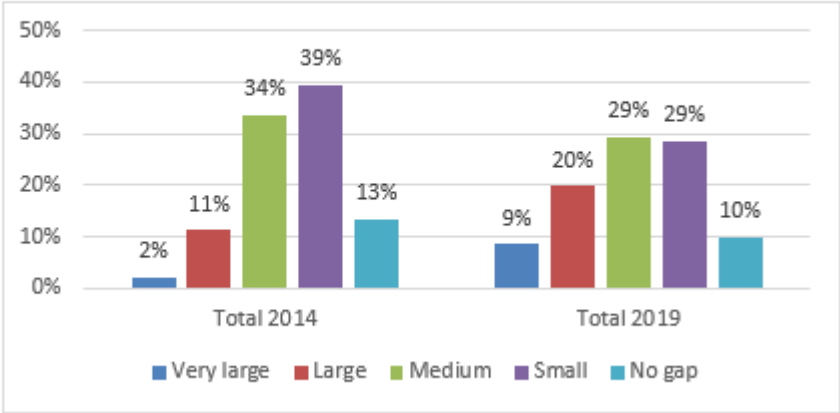


Figure 4

Comparing 2014 data to 2019: skills/capabilities gap



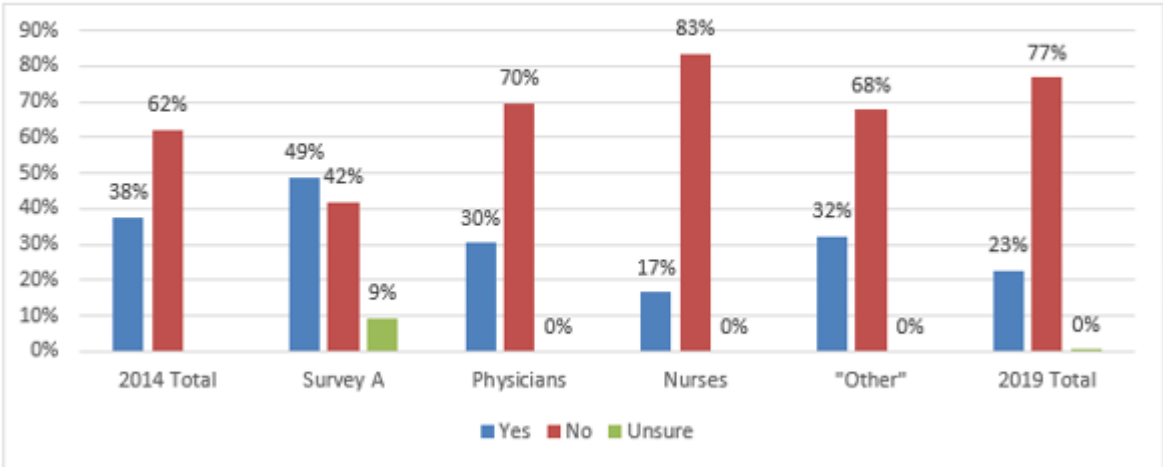
There is also a growing gap between the need and the capacity for innovation in healthcare, which is not taking advantage of rapidly advancing technology, including artificial intelligence. The ability to innovate and lead change is essential in a time of volatility, uncertainty, complexity and ambiguity (the “VUCA world”) and in complex adaptive systems. The 2019 study revealed that encouraging and supporting innovation was the lowest-rated capability among healthcare leaders, which is reminiscent of the 2014 results. Innovation is often closely linked to organizational culture — the most common reason participants

in leadership development programs gave for failing to experiment and apply what they've learned is a workplace culture that is adverse to change⁴. Only a quarter of respondents in this study reported their organizational culture is highly supportive of change and innovation. The 2019 respondents also reported the lowest-rated priority was retaining critical talent, which had declined 47% since the 2014 study.

Finally, the average overall percentage of the annual budget allocated to leadership development seems to have decreased in the period between 2014 and 2019 and there has been a considerable decline in reported protected time for leadership development (Figure 5).

Figure 5

Protected time for leadership development (2014 and 2019)



Overall, and what is perhaps most concerning, is that the leadership gaps are perceived to be getting larger, and their impact on organizational performance worse. Comparisons of the data from both the 2014 and 2019 benchmarking studies confirm this finding. More details follow in the next section.

2. Are issues related to these same gaps shared across different groups in the health system, and how do they perceive the importance of leadership development, organizational development, and succession

⁴ Geerts, J. M. (2019). *Emerging Leaders Program (ELP) and Advanced Emerging Leaders Program (AELP). Independent Review and Report* (p. 98). Yale University School of Management; Geerts, J. M. (2018). *Optimal leadership development for professionals* [Unpublished doctoral thesis]. University of Cambridge; Gilpin-Jackson, Y., & Bushe, G. R. (2007). Leadership development training transfer: A case study of post-training determinants. *Journal of Management Development*, 26(10), 980–1004; Rowland, D. (2016). Why leadership development isn't developing leaders. *Harvard Business Review*, 1–5.

planning as ways to close those gaps?

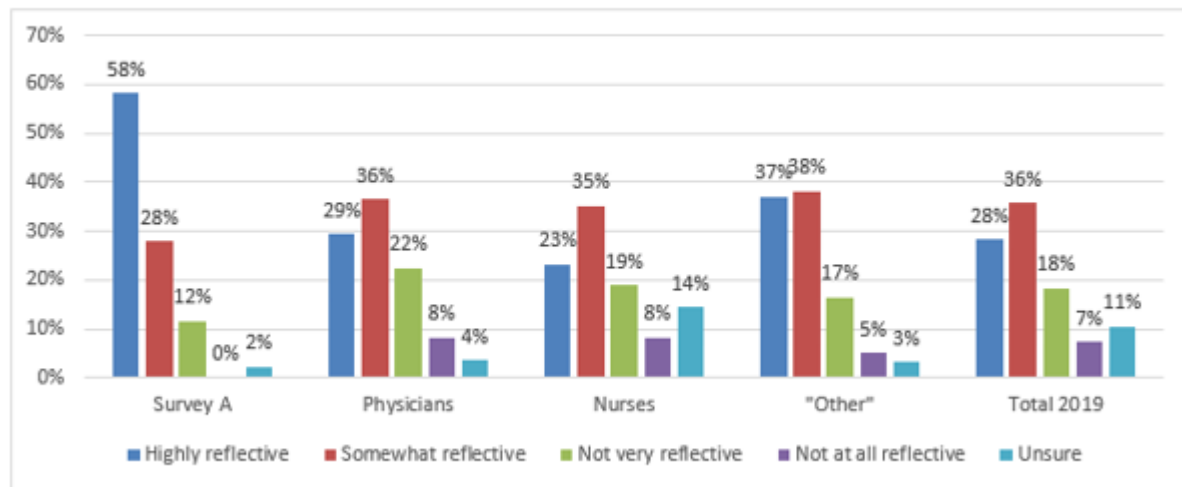
We asked about organizational development, leadership development and succession planning in both Survey A and Survey B to investigate the causes of leadership gaps and what can be done to fix them. Response are discussed below.

Diversity and Inclusion

On the positive side, on the issues of diversity and inclusiveness, over half of senior executives and more than a third of all respondents recognized the importance of greater diversity among leaders, but 58% of Survey B’s individual respondents reported diversity among leaders had not increased over the past five years (Figure 6).

Figure 6

Ratings of diversity of perspectives - gender: senior/executive



There is significant work yet to be done to increase representation of Indigenous perspectives, which were the lowest-rated among gender and visible minorities, with more than half of respondents indicating Indigenous perspectives were not very or not at all reflected in their organizations⁵. Physician respondents were least likely (2%) to say Indigenous perspectives were “highly reflective” among senior leaders compared to 10% for total respondents.

⁵ See Figures 13 and 14 in technical report

Health Leadership Capabilities

In 2019, in order to get more specific information on where the gaps in skills are, we asked how well positional leaders demonstrate specific leadership capabilities. Results showed leaders did best at these capabilities:

- Modelling honesty, integrity, resilience, and confidence (56% rated leaders in their organization as demonstrating it “exceptionally well”);
- Contributing to the creation of a healthy organizational culture (50%); and
- Demonstrating a commitment to customers and service (people-centred care) (50%).

The three lowest-rated capabilities of leaders were:

- Demonstrating systems/critical thinking (21%);
- Self-awareness (25%); and
- Encouraging and supporting innovation, including the use of new technology (23%), which was also the lowest rated as measured by the number of “not very capable” ratings (15%).

In addition, respondents were invited to describe “gaps between the leadership desired and the leadership required” and submitted 450 responses. A preliminary search of keywords and phrases revealed numerous deficiencies:

- A lack of management experience (n=51 mentions), suggesting leadership development and management training need to go hand-in-hand. Similarly, a lack of knowledge of healthcare was identified by many respondents (n=37)
- A lack of leadership diversity in terms of gender, visible minorities and Indigenous peoples was flagged by many (n=24)
- Senior, mid-leaders and administrators do not show as much appreciation for, or understanding of, clinical experience as respondents would like (n=14)
- A lack of effective communication both vertically and horizontally (n=31)

Respondents said these and other gaps are having a large or very large impact on organizational outcomes and have gotten worse since 2014, as have their adverse effects.

Human Resources, Organizational Development and Leadership Development Practices and Priorities

The 2019 survey and focus groups also sought to identify human resources (HR), organizational development (OD) and leadership development practices and priorities that could contribute to closing the gaps and building capacity in organizational leadership.

Responses suggested the recommended priorities don't resonate with organizational thinking:

- Almost half of respondents indicated that most of the key HR/OD practices were either a low organizational priority or not a priority at all.
- The highest-rated priority was increasing employee or staff engagement, although only 27% of respondents reported their organizations consider it high priority, and more than half of nurses and physicians indicated increasing engagement was a low organizational priority or not a priority at all.
- Four human resources and organizational development practices were rated low priority or not priorities at all by a majority of respondents: increasing nurse engagement (56%) and increasing physician engagement, retaining critical talent and developing a talent management or succession plan strategy (52% each)⁶.
- Retaining critical talent and developing a talent management and succession planning strategy were considered high priorities by just 15% of respondents each.

Nearly half of respondents indicated they were not very satisfied or not at all satisfied with the selection and effectiveness of the leadership development options provided by their organizations. This should be qualified, however, by the fact half of respondents had never participated in leadership development. Another finding that may need to be qualified is the low rating for retaining critical talent, which was down 47% since the 2014 study. Survey A's organizational representatives gave HR/OD priorities much more favourable appraisals than the individual respondents of Survey B. On a positive note, two-thirds of respondents in both surveys A and B reported their organizations had a formal approach to succession planning for senior leaders and half said there was one for mid-level leaders.

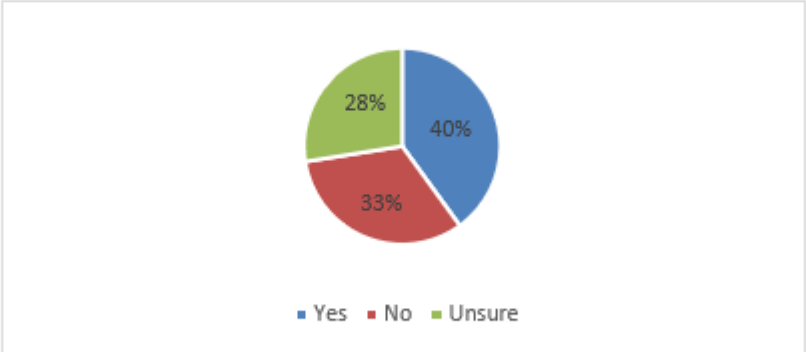
⁶ See Figures 40 and 41 in Technical Report.

There are other differences in perception between the participants in the two surveys. The individual professionals who took Survey B indicated the amount of protected time for leadership development had declined 39% since 2014. That contradicted the perception of CEOs and COOs in Survey A, who felt time and funding had increased for leadership development since 2014.

Both groups agree, however, that experiential forms of leadership development, such as action learning projects and simulations, as well as 360-degree assessments, coaching and mentoring are rarely provided. Finally, fewer than half the respondents reported leadership development programs are evaluated and only one reported having a robust evaluation framework (Figure 7).

Figure 7

Leadership development evaluation



As we've mentioned, about half of respondents said they had never participated in a leadership development program, which is surprising given nearly 80% of respondents are currently in leadership roles. Respondents said the most effective leadership development activities were ongoing goal setting (20%), mentoring, and stretch assignments (16% each). Organizational respondents were significantly more favorable in their assessments than individual respondents.

Implications for the Future

These findings contain a wealth of knowledge for CHLNet and its network partners as we map out strategic directions for the next five years. The challenges and opportunities we need to consider are outlined here:

Challenges

The findings suggest four overarching areas health systems need to focus on to build leadership capacity:

- The anticipated acceleration in turnover among senior and mid-level leaders that will exacerbate the supply/demand gap;
- The disparity between how senior leaders and individual professionals see the leadership gap in their organizations;
- The fact the skills gap is not being closed quickly enough (indicated by low scores on staff engagement, leadership capabilities and low support for innovation); and
- The persistent failure to prepare for the future, for example through leadership development programs or succession planning.

Turnover

Two-thirds of respondents anticipated considerable turnover among senior and mid-level leaders in the next five years, which will present a challenge filling those positions with effective leaders and an opportunity to increase diversity in leadership roles.

Vertical Gap

The study suggests there's a disconnect between what CEOs and COOs think and the perspective of the individual respondents. The senior staff respondents who took Survey A offered consistently and significantly more favourable assessments of leadership in healthcare than individual (Survey B) respondents. This is similar to other health leadership studies such as the CIHR funded Leadership and Health System Redesign study, where groups experiencing leadership are less complimentary of their organization's practices than the senior leaders. Overcoming the vertical gap between what top leaders think about leadership in the organization and what people lower down perceive will be vital to collective success and organization performance in the future.

There were notable trends in what nurses thought. For example, nurse respondents were most likely to report large gaps in leadership supply vs. demand and gaps in senior leaders' ability to meet needs. They were also more likely to say those gaps are having a very large negative impact, and that there has been a

large increase in the impact of the leadership gaps. Nurses were least likely to say their organizational cultures are “highly supportive” and most likely to describe their organizations as not at all supportive.

Skills Gap

Respondents gave low ratings to the level of leadership capabilities found in their organizations and a majority said the lack of leadership skills in their organization had a negative impact on productivity. In particular, nearly half of individual respondents negatively assessed engagement levels of staff at their organizations, labelling them as neither engaged nor not engaged, not very, or not-at-all engaged (compared to only 11% of CEOs and COOs who said the same). Only 13% of all respondents said staff at their organizations are highly engaged (again a strong contrast to organizational responders, more than half of whom rated engagement high). Ratings of nurse engagement were the lowest of all groups — and combined with the common sentiment that key human resources and organizational development practices are low priorities, suggest nurses feel under-appreciated and under-prioritized by their organizations⁷.

The second piece of evidence that the skills gap is real is that only a quarter of respondents rated their organizational culture as being “highly supportive” of innovation and three quarters of nurses indicated that they were disinclined to take on a leadership position because they feel their organizational culture is not conducive to change. This makes it unsurprising that encouraging and supporting innovation was the lowest-rated capability among leaders.

Persistent Gaps in Capabilities

Bench II reminds us there are perceived leadership gaps in Canadian health organizations that have persisted over time⁸. In 2019, for example, despite years of emphasis on building a people-centred healthcare system, only half of respondents said their leaders demonstrated people-centred care exceptionally well. There were also unexpected low scores for encouraging and supporting innovation, systems/critical thinking, and developing others, which are key capabilities for managing in a world of volatility, uncertainty, complexity and ambiguity (VUCA) and for leading complex adaptive systems. Encouragement and support for innovation is perceived to be low and organizational cultures are thought to be unsupportive of change.

⁷ Refer to Figures 69 and 70 in the technical report

⁸ It is important to state that the presentation of these data and recommendations are intended to be dispassionate and without inference regarding the individuals currently working and leading in healthcare organizations.

Ratings for self-awareness among leaders were also low, with only a quarter of respondents suggesting their leaders demonstrate it exceptionally well. That matters because self-awareness is closely linked to effective leadership, and leaders who lack self-awareness have been shown to have deleterious effects on organizations⁹. Another area that badly needs improvement is the lack of diversity among senior and mid-level leaders. Visible minorities, diverse gender and Indigenous identities are reported to be significantly under-represented. In addition to the obvious social justice reason to actively eliminate this situation, there is reliable evidence that in some cases diverse teams and organizations outperform homogenous ones.

Opportunities

What can we learn from this extensive probe into the perceptions of organizational leaders and the individual health professionals who work for them? We see five important opportunities to close the supply/demand and skills gaps, that will help build more capable leaders for decades. They are:

Promote succession planning

In the next five years, it's anticipated there will be moderate to large turnover among leaders, which is an opportunity to be intentional about whom to prioritize for leadership development and promotion with formal talent management and succession planning. Survey data show having a formal approach to succession planning for senior leaders has increased since 2014 (although only a quarter of respondents rated their organizational culture as being highly supportive of change and innovation).

The people who should be prioritized for succession planning programs and promotion include those with proven leadership success, clinical expertise and strong leadership capabilities. However, it's equally important to focus on diverse candidates and emerging leaders (positional and non-positional) across the organization. At the same time, while succession planning and leadership development are key strategies for closing leadership gaps, it should be understood the days of top-down management are over. Instead, formal and informal leaders at all levels should work to improve engagement by recognizing everyone in the organization as both leaders and team members in developing innovations and supporting organizational priorities.

⁹ Caulkin, S. (2015, December 6). Have we created an unachievable myth of leadership? Financial Times. <https://www.ft.com/content/07ed132e-8fa3-11e5-8be4-3506bf20cc2b>; Kellerman, B. (2018). Professionalizing leadership. Oxford University Press; Pfeffer, J. (2016). Getting beyond the BS of leadership literature. McKinsey Quarterly, 1–7.

Undertake evidence-based professional leadership development

It is concerning that more than 50% of respondents to the survey who perceive themselves as leaders have had no leadership training and we hope succession planning will make a difference in that result. However, distributed leadership, where anyone can step forward as a leader (including frontline workers, family members and citizens) is also fundamentally important for the future of Canadian healthcare. Closing the health leadership gap requires that we optimize the talent and energy of all those people. That requires an evidence-informed approach to leadership development that could be adapted for unique contexts and made available to people seeking development opportunities.

To support creation of leadership development programs, CHLNet has commissioned a research study of wise practices for evidence-informed, experience-based and innovative approaches to designing, delivering and evaluating leadership development programs. These resources will form part of a toolkit for creating and refining leadership development programs to help close the gaps highlighted in this report, as well as improving diversity representation, engagement, innovation and leadership system wide. We're hoping this toolkit ensures organizations won't need to reinvent the wheel for their unique contexts. It's helpful that most organizations use the LEADS capability framework with its common leadership language, which should make it easier to share development practices and tools.

Engage health professionals

There is reliable evidence from the literature of the effect that good nurse and physician leaders can have on people and organization health.¹⁰ It's encouraging that respondents reported their main incentive to take on a leadership role was having a positive impact, rather than to earn more money. The second most attractive incentive for nurses was being provided with the requisite development to succeed as a leader. For both physicians and nurses, a fear of increased stress and longer hours were the top disincentives to moving into leadership.

However, our study points to a failure to engage physicians, nurses and other healthcare professionals. Many healthcare professionals indicated their organizations under-appreciate and under-prioritize their staff. Individual respondents' ratings of human resources and organizational development priorities showed organizations considered nearly everyone a low organizational priority or not a priority at all — while it's

¹⁰ Geerts, J. M., Goodall, A. H., & Agius, S. (2020). Evidence-based leadership development for physicians: A systematic literature review. *Social Science & Medicine*, 246, 1–17. <https://doi.org/10.1016/j.socscimed.2019.112709>.

clear to us engaging and developing effective clinical leaders is a key strategy for closing the leadership gaps this study identifies.

Equally troubling are the low scores organizations got for the priority they give to increasing physician and nurse engagement (fewer than 20% prioritize greater physician engagement and only 10% do for nurses). Those ratings are lower than they were in 2014, which is troubling because low clinician engagement is linked to decreased retention and increased absenteeism, clinical errors and burnout — which is on the rise among healthcare professionals¹¹ to the point it has been described as an epidemic¹².

Develop capabilities for 21st century care

Systems thinking and innovation are key health leadership capabilities but this study shows encouraging and supporting innovation was the lowest-rated capability among health leaders, just as they were in the 2014 study. It is deeply worrisome that no progress has been made in taking advantage of the enormous strides being made in technology and artificial intelligence. Successful innovation is often intimately linked to organizational culture and the most common reason that participants in leadership development programs give for not experimenting or applying what they've learned is that their workplace culture is averse to change. Only a quarter of respondents in this study reported that their organizational culture is highly supportive of change and innovation.

Invest in leadership development

There is research evidence showing leadership development can improve a variety of outcomes and we believe it should be ramped up significantly across healthcare. Our respondents, however, reported low satisfaction with leadership development. Many don't participate at all and despite the fact the number of organizations providing some form of development has increased since 2014, half of 2019 respondents said they were dissatisfied with the selection and effectiveness of the programs they were offered. They also reported that many of the approaches to developing leaders that are most strongly supported by research

¹¹Aronsson, G., Theorell, T., Grape, T., Hammarstrom, A., Hogstedt, C., Marteinsdottir, I., Skoog, I., Traskman-Bendz, L., & Hall, C. (2017). A systematic review including meta-analysis of work environment and burnout symptoms. *Bmc Public Health*, 17, 264. <https://doi.org/10.1186/s12889-017-4153-7>.

¹²Noseworthy, J. (2019). The future of care—Preserving the patient-physician relationship. *New England Journal of Medicine*, 381(23), 2265–2269. <https://doi.org/10.1056/NEJMSr1912662>; Canadian Medical Association. CMA National physician survey. Ottawa, CA: CMA. 2018. <https://www.cma.ca/sites/default/files/2018-11/nph-survey-e.pdf>; Canadian Society of Physician Leaders. *Accepting Our Responsibility: A blueprint for physician leadership in transforming Canada's health care system*. 2017 <https://physicianleaders.ca/assets/whitepapercsp110032.pdf>; Snell, A., Dickson, G., Wirtzfeld, D., & Van Aerde, J. (2016). In their own words: Canadian physician leadership. *Leadership in Health Services*. 29(3):264-81.

— such as action learning projects, simulations, 360 assessments, coaching and mentoring — are seldom offered.

Participants also said they lack the time to successfully apply their development lessons to the workplace, putting the onus on busy professionals to make time without offering organizational support to do so won't likely change that. So we're concerned by reports both the average percentage of annual budgets allocated to leadership development seem to have decreased and that time protected for leadership development has declined. Both should be significantly enhanced to levels comparable to other jurisdictions (such as NHS England or the corporate sector).

Conclusion: Where to From Here?

Overall, the 2019 results of Bench II suggest we have made progress over the past five years and provide reason to be optimistic about the future. We understand the gaps better than before and know the strategies and tactics that will reduce them. More than 80% of respondents use a leadership framework and more than two-thirds of respondents have succession planning (formal and informal) in place. But Bench II also provides many insights into some major challenges CHLNet and its partners face. It is clear we must do more to mentor and sponsor emerging leaders, to level the playing field in terms of gender, visible minorities and Indigenous peoples and to encourage, support and adapt innovation.

CHLNet commits to building the results of Bench II into our new strategic plan and to working with our 42 network partners to develop a concrete action plan — emphasizing diversity and innovation — that will prepare the leaders Canada's increasingly complex health system will need for 2040 and beyond. Two of our first steps will be to reach out to Indigenous health leaders to further analyze the identified leadership gaps; and to further develop a *Wise Practices Toolkit*¹³ for leadership development. This strategy will also involve incorporating shared resources developed by partners such as the *Empowering Women Leaders Toolkit*¹⁴ and *Measuring the Impact of Leadership Development Toolkit*.¹⁵ The time is now to make the needed course corrections to ensure that there is a cohort of health leaders who are well prepared to guide and support their organizations now and for future decades.

¹³ Underdevelopment by the Wise Practices Steering Group to be available by Fall 2020.

¹⁴ Completed and available June 2020 on the LEADS Community for Practice.

¹⁵ A free member benefit for CHLNet partners on the password protected side of CHLNet's website. Otherwise may be accessed for a fee through LEADS Canada <https://leadscanada.net/site/LDItoolkit>.