CHLNet
PROPOSAL

LEADERSHIP BENCHMARKING STUDY

February 2019

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Bench 2: 2019 Health Leadership Benchmarking Study

Purpose

Strong leadership is being identified by many major policy reports as a critical success factor in stimulating innovation and the large-scale change required to improve performance in Canada's complex health system(s). As provinces and territories engage in reform efforts, including a new multi-year Health Accord, building health leadership capacity is an essential piece to modernizing our health workforce to tackle some of Canada's top priorities such as: home care services; mental health services; indigenous health; and health technology to improve access, efficiency and outcomes for patients. Yet as reform initiatives unfold, leaders and the needed capabilities to facilitate innovation and large-scale change have been given limited profile and attention.

Change and innovation in a systems context (macro to micro) requires sophisticated leadership capability. Large-scale change requires levels of systems thinking, strategic thinking, relationship development and self-leadership that supersede the current capacity of many formal leaders (see CHLNet 2014 Benchmarking study and a Canadian Institutes of Health Research study). New models of health leadership are required to generate health workplaces with greater employee/physician engagement that are able and willing to move to a more patient/family-centred approach. A healthy and resilient workforce is key to successful reform efforts and better results.

Background

In 2013/14, CHLNet initiated a benchmarking study looking at the nature and extent of the “leadership gap” across Canada. The study provided a point in time snapshot, confirming there is 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. The study included a streamlined (pre-tested) online survey. The study was funded through a small grant from Health Canada ($5K) and in-kind support from a few CHLNet partners and spearheaded by the late Dr. Glen Roberts (who led an earlier pilot study conducted by the Conference Board of Canada in 2007). Due in large measure to the “good offices” of CHLNet members, the response rate to the 2014 survey was an impressive 58%.

Released and discussed at a special session convened by CHLNet in collaboration with the Canadian Association of Health Services and Health Policy Research (CAHSPR) and the (now defunct) Health Council of Canada (February 2014, Montreal) the original study gained country wide recognition. The intent is to replicate the 2014 study “every 5 years”, relying on a set of tracking questions to begin to track progress over time (e.g. are gaps getting worse/better?), but also allowing for emerging priority areas of concern/interest to be probed more deeply as circumstances changed. This proposal begins that process.

Considerations

Much has changed over the past five years, with many jurisdictions having invested more heavily in leadership development and with our increased understanding about the importance of leadership development to both organizational and system success. Other considerations that merit conducting a five-year follow-up study include:

- LEADS has now been formally adopted in 7/10 provinces and momentum continues to grow across Canada with the establishment of LEADS Canada.
- The National Health Leadership Conference (co-hosted by HealthCareCAN and Canadian College of Health Leaders) has been reinvigorated around key leadership challenges and it now has LEADS fully embedded in the program.
- Several professional bodies either have already formalized leadership development as a core competency (e.g. CANMeds 2015; Physician Leadership Institute) or are in the process of enhancing leadership development efforts for members (e.g. Canadian Nurses Association).
- The Canadian College of Health Leaders is in the early stages of repositioning itself strategically to work toward the professionalization of leadership through a LEADS-based certification process.
- There is increased awareness about other dimensions of the "leadership gap" in Canadian healthcare, with over 80% of the workforce comprised of women and less that 10% of senior leaders being women (i.e. the "gender gap") and with an increased focus on leadership in support of closing the indigenous health gap
- CHLNet's Leadership Development Impact Assessment Toolkit has been pilot tested and will be shared with partners at their next roundtable, with the on-line tool being finalized in early 2019 and made available to network partners as a membership benefit.
- The Health Standards Organization (and Accreditation Canada) is reconvening a Leadership and Governance Expert Panel to explore how wise practices might be more explicitly incorporated into the accreditation process.

It is therefore very timely for CHLNet to initiate, with the support of its network partners, the proposed follow-up study of health leadership capacity across Canada: relying on the successful protocol/process used in 2014 to garner a high response rate (58%); replicating some of the same (tracking) questions; and responding to more contemporary concerns around, for example, indigenous health leadership and gender equity.

Methodology

The purpose of CHLNet's five-year update of the 2014 benchmarking study is to track key leadership metrics over time to allow leadership investments and interventions to be scrutinized in terms of their appropriateness to context. Four core questions framed the 2014 survey:

- Is there a leadership gap in Canada?

- What is the size of the gap?
- How important is the gap? And lastly
- What is being done to close the gap?

The Benchmarking Steering Group will review these research questions and amend as necessary. The 2019 survey should better address where the leadership gaps are. Three sampling frames were used in 2014: CHLNet/Health Action Lobby (HEAL) members, Association of Canadian Academic Health Organizations (ACAHO) Members, and Other (organizations identified in the CHA guide). See appendix A for Executive Summary.

An updated assessment of leadership capacity is required to track progress over time and begin to measure the impact of investments in leadership capacity development. The November 7, 2007 study undertaken by the Conference Board Study on behalf of CHLNet did provide some initial data. However, it was based on a private sector survey and did not garner the response rate or breadth of results required. CHLNet had provided a database of 500 organizations but only 48 completed surveys (i.e. less than 10 per cent response rate). The survey was not pre-tested and, because it was based on a private sector instrument, many of the questions did not reflect the health leadership sector well. It did not, for example, differentiate between continuing professional education and leadership development. Some of these methodological problems surface through a series of one-hour interviews with 12 senior health leaders.

Despite these shortcomings, some interesting data was generated in 2007 that could be used to track trends over the longer period of time such as:

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

Note: The 2014 benchmarking study also included (as an appendix) an update of the inventory of formal leadership development and training programs from 2011. Time and budget does not permit this piece of work to be updated at this time. This original piece of work was made possible by a one-time grant from Health Canada in 2011 ($100,000) and, to ensure academic credibility, was conducted through the Centre for Health Leadership and Research at Royal Roads University. The 2014 inventory update was much smaller in scale and did not map to the LEADS framework. This database of many (but not the universe) of leadership programs now resides on the CHLNet password protected site as a “one stop shopping” opportunity for partners.

It is proposed that this update of the leadership gap, would begin with an online survey developed in February/March and undertaken in April/May 2019.

Focus groups will be held to supplement the data and explore preliminary findings at the Canadian Association for Health Services and Policy Research Conference/CAHSPR (May TBC - Halifax) and National Health Leadership Conference HLC (June 3 -Toronto) breakfast sessions. As well as CHLNet's May 2 Network Partner Roundtable in Ottawa. Other venues that require minimal resources will also be pursued. The final report will go to CHLNet partners at its November 19, 2019 Partner Roundtable.

A Steering Group of funders, academics, and decision makers has been formed to guide the process (see Appendix B Terms of Reference). Specifically, a two-pronged methodology is proposed:

1. ***Quantitative*** – a confidential online survey would be used to seek data, tools and strategies. Only aggregate data would be shared. The survey would be max 10 minutes in length to achieve higher response rates. The sampling frame and master list for coding still need to be determined. The primary survey will include questions that address gender but also indigenous, physician and nurse leaders. We are investigating the possibility of patients and families. Supplementary survey questions may be included for targeted populations such as physicians and nurses. Tracking questions would arise from previous surveys, plus additional questions would assess talent management and the use of LEADS (Appendix C). The survey would not be restricted to CHLNet partners but depend on partner participation. It would have geographic representation and be aimed at the organizational level. It would be pretested with a few health organizations first. Alberta Health Services has already offered to do this. For larger data bases, a stratified random sample may be used.
2. ***Qualitative*** – focus groups with network partners, academics and decision makers will be undertaken to supplement preliminary findings to ensure wise practices in health leadership are included and any new and emerging issues/trends. We will also be exploring in more detail some of the leadership challenges that arise especially around gender and diversity.

Funding Partner Benefits

A partnership model for this endeavour is being used to generate the needed financial and in-kind contributions to carry out the project. To date CHLNet has financial support from the CHLNet Evergreening Fund, Canadian College of Health Leaders (CCHL/LEADS Canada), Canadian Medical Association, Canadian Nurses Association, Canadian Society of Physician Leaders and Health Canada. In kind support is committed from Manitoba's Centre for Healthcare Innovation (CHI team member and potential access to a survey instrument for easier coding), HealthCareCAN (mailing lists), and the University of Ottawa (academic advice).

Funders will receive:

- Cobranding of the organizational survey as a partnership.
- Membership on the steering group, if so desired.

- Ability to broaden the sample size of both the quantitative and qualitative pieces of the survey for their respective member groups.
- Input into both the online survey questions and focus group guide.
- Customized panel of questions under the sponsor's auspices--if so desired--that could be added to the core study (with input from academic advisors to ensure consistency with the survey's objectives).
- Consultation on the draft report.
- Customized summary report, if so desired.
- Priority access to final data and report with recognition.

Deliverables

Final report assessing the leadership gap and importance of health leadership occurring in Canada. It will include highlights on the extent of leadership development and existing programs and tools (see Appendix D for high level project timelines)

Budget

Phase	Activities	Estimated Costs[1]
Phase 1: February 4 to March 15, 2019 Survey Methodology and Development	• Form Benchmarking Study Steering Group and ensure accurate records of meetings • Hire Project Manager • Confirm methodology • Confirm tracking questions • Develop additional questions • Finalize online survey • Determine sampling frame • Create master list for coding • Set up survey monkey or other survey tool with coding • Pretest in three sites	$10,000
Phase 2: March 15 to May 15, 2019 Data Collection and Analysis	• Online survey data collection, analysis and interpretation • Liaison and updates with the Steering Group • Preliminary PowerPoint on findings • Develop focus group guide • Create a communication plan for knowledge dissemination and sharing	$10,000 plus in-kind support from CHI

[1] A more detailed breakdown of costs will occur after determining the sampling frame and survey tool by the Steering Group and Project Manager.

Phase	Activities	Estimated Costs[1]
Phase III: May 16 to June 30, 2019 Focus Groups and Final Report	• CAHSPR Focus Group • NHLC Focus Group • CHLNet Network Partner Roundtable Focus Group • Finalize report: Executive Summary and Full Report • Knowledge Dissemination Strategy	$5,000
TOTAL BUDGET		$25,000

Additional funding from other partners would allow us to secure more academic involvement, widen the sample size (statistically significant), enhance testing of the validity/reliability of the survey instrument, and translate the final report. A separate project will need to be undertaken to update the inventory of leadership development programs.

Appendix A: Executive Summary 2014 CHLNet Benchmarking Study

Preface

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

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

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

Executive Summary

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

Is there a *leadership gap* in Canada?

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

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

What is the *size* of the gap?

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

How *important* is the gap?

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

What is being done?

- *Time for Leadership Development* - 38% of Total Respondents and 56% of ACAHO Members protect time for leadership development.
- *Leadership Development Programs* - 29% of Total Respondents rated their satisfaction with their organization's leadership development programs as satisfied or very satisfied. ACAHO rated higher at 44% satisfaction.
- *Leadership Development Budget* - 30% of Total Respondents rated their satisfaction with their organization's leadership development budgets as satisfied or very satisfied. ACAHO rated higher at 50% satisfaction. The percentage of budget devoted to leadership development has increased since 2007 moving from 1.04% to 1.65% in 2014.
- *Adoption of LEADS or another capability framework* – 47% of Total Respondents have adopted a leadership capabilities framework. The number jumps to 63% for ACAHO Members.
- *Succession Planning* - 39% of Total Respondents and 63% of ACAHO Members have a formal approach to succession planning.
- *Emerging Leaders* - 38% of Total Respondents and 75% of ACAHO Members have formal process to identify emerging leaders.

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

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

What more needs to be *done?*

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

Appendix B: DRAFT Terms of Reference Benchmarking Study Project Steering Group

Purpose

To provide stewardship of a second benchmarking study of health leadership capacity, building on the 2014 study, so as to ensure that it achieves its goals and is conducted in an effective and efficient manner (i.e. high quality and within budget).

Goal of the Project

- To conduct a five-year, follow up to the 2014 CHLNet Benchmarking Study of leadership capacity in the Canadian health system, utilizing tracking questions and insights gleaned from the initial study.
- To supplement the original study by exploring leadership gaps around gender and equity as well as to do a more detailed assessment of resources being deployed in support of professional and leadership development.

Duties and Responsibilities

- Review the results of the 2007 and 2014 CHLNet benchmarking studies and determine tracking questions for a 2019 online survey.
- Refine the survey methodology and determine the sample frame for the survey panel.
- Assess the need for a supplementary series of key informant interviews or a focus group (of convenience), subject to budget considerations.
- Provide input into the draft online survey and oversee the pilot test for modifications.
- Oversee interpretation of findings and final report.
- Ensure that the conduct of the project is in keeping with the caveats of high-quality applied research and knowledge mobilization.
- Provide general oversight, stewardship of, and on-going advice for all aspects of the project including scope, methodology, human resources, deliverables, timelines, funding sources and budget.
- Ensure coordination of, and effective communication processes to engage the partners, funders and other designated stakeholders.
- Elicit and maintain international collaboration and communication.
- Ensure evaluation of the project including a final report of inputs, outputs and outcomes.

Terms of Operation

- Bimonthly meetings via one-hour teleconference; and, as required, at the call of the chair.
- Maintain quality records of meetings.
- Distribute agenda and materials one week ahead of the meeting (responsibility of Chair, along with Executive Director of CHLNet).
- Operate in the spirit of trust and reciprocity.

- Ensure the composition of the group reflects the needs of the project.
- Require a quorum of at least 50% of the members at each meeting in order to make decisions.
- Any member who misses three consecutive meetings will be automatically removed from the working group.
- Provide reports on the steering group activities to the Research and Evaluation Working Group for information purposes.
- Ensure approval of major deliverables and decisions of the steering group through a motion of partners and input from funders.

Timeline

- Preliminary results of Benchmarking II to be shared with Network Partners and the health service and policy research community in May (CAHSPR May 29-30, Halifax) and at CHLNet Breakfast Session at NHLC June 10, Toronto.
- Final report to be shared with CHLNet Partners and released publicly in Fall 2019 (Note: All contributing organizations to be acknowledged on final report).

Composition

- *Chair, Bill Tholl*
- CHLNet Executive Director Kelly Grimes
- CHLNet Senior Research Advisor, Graham Dickson
- LEADS Canada Director, Brenda Lammi
- Network Partner/Funder Representatives:
    - Jonathan Mitchell, HealthCare*CAN*
    - Owen Adams, Canadian Medical Association
    - Johny Van Aerde, Canadian Society of Physician Leaders
    - Pusha Sadi, Manitoba Centre for Healthcare Innovation
    - Mike Villeneuve, Canadian Nurses Association
    - Emerging Health Leaders (TBC)
    - Health Canada (TBC)
    - Patients and Family (TBC)
- Knowledge Experts:
    - Don Philippon, CHLNet
    - Elma Heidemann, CHLNet
    - Ivy Bourgeault, University of Ottawa
    - Karen Lawford, Queens
- Consultant/Project Manager: Jaason Geerts, PhD

Appendix C: Potential Questions

To be added by Jaason shortly.

Appendix D: High Level Timeline