CHLNet Proposal and Workplan

HEALTH LEADERSHIP WISE PRACTICES GUIDE AND TOOLKIT

August 2019

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CHLNet Wise Practices Guide and Toolkit

Purpose

Leadership development (LD) programs are delivered within the organization; an individual/team gets excited to apply new capabilities but then are stymied when they return to the workplace by policies, mindsets, and culture, i.e. systemic things that don't allow change to occur. **There is a need to gather research on what successful leadership development practices and tools are (evidenced based, experiential, and emerging) but also what conditions were in place to facilitate this and overcome barriers.** A central repository (i.e. toolkit or guide) will be created to house this data electronically for sharing.

Background

- CHLNet's Road Map to Action developed as part of its 2016 Health Leadership Action Plan identified a five-point plan including: a collective vision; common leadership language; evidence on innovation and leading practices; enhanced capacity and capabilities; and measure/evaluate. This project continues our effort to build evidence on leading practices.
- Change and innovation in a systems context requires sophisticated leadership capability.
- Delivering a collective leadership strategy is highly desirable as leadership development focused on individual leaders and teams often fail to produce desired impact at the collective level. "Leaders in formal roles must create the conditions in which responsibility, power, authority and decision-making is distributed within and throughout an organisation rather than at the top of a hierarchy. They must redefine their leadership role to focus on empowering collective leadership amongst all staff and embrace their responsibility for ensuring that these staff are valued, supported and engaged in fulfilling the organisation's mission, vision and strategy." (The King's Fund, *Delivering a Collective Leadership Strategy for Health Care*, 2018.)
- Distributed leadership is a complex concept to define. Using sensemaking tools to change behaviour (www.distributedleadership.com.au) such as LEADS, ASER (Action Self-Enabling Resource), and/or 6E Conceptual Framework can help in the design and delivery stages (Kirsty Marles, CHLNet/LEADS Canada webinar, 2018).
- Studies suggest using the term "collective leadership" to bridge the gap between distributed leadership and shared leadership and prevent cognitive complexity (S. Goksoy, *Analysis of the Relationship between Shared Leadership and Distributed Leadership*, 2016).
- More recently, significant amounts of funding and energy have been put into documenting and promoting certain techniques and approaches for leadership development within organizations. There is a need to look at the best practices perhaps grouped in terms of broad directions, design factors and micro learning strategies (G. Dickson, 2018).
- Need to determine what successful leadership development practices look like in action, i.e. strategically building momentum; creating a living vision; and nurturing collaboration and initiative (H. MacLeod, 2018).
- Cultural change required: BC noted system level actions such as code of conduct, leadership commitments, sustained succession planning, effective performance management and 360 reviews, mentoring/coaching, and create innovation zone (BC Ministry of Health, *Culture Change*, 2018).

- Winning conditions to approach change might include:
    - Choose a model cell for experimentation, learning and modeling (IHI, *4 Steps to Sustaining Improvement in Health Care*, 2016);
    - Assess collective leadership readiness and gaps;
    - Realign talent management and financial approaches with collective leadership practices. (The King's Fund/CCL, *Delivering Collective Leadership*, 2018); and
    - Evaluate the leadership strategy – be explicit on the return on investment in leadership development through measurable LD objectives (CHLNet LDI Toolkit, 2018).

Considerations

- CHLNet and its 43 network partners gather provincial leaders to stimulate and grow health leadership capacity and capabilities in their respective jurisdictions in the context of current and future reform activities and challenges. The Health Leadership Exchange and Acceleration Working Group oversees this effort.
- Early in the project, CHLNet's ROI Steering Group identified the need for a companion document or guide for health leadership development in Canada. It became apparent that organizations had access to a plethora of tools to begin their journey to develop leaders but little knowledge about which were evidence informed and what approaches/practices could maximize impact. A guide would be welcomed to accompany the now live, Leadership Development Impact Assessment Toolkit which is free for all CHLNet partners as a member benefit. Programs that are not designed for results will not get them. This project is to identify the design principles that the literature suggests are needed for maximum success.
- Annually, LEADS Exchange Day tools are shared among interested OD/HR individuals. These have been housed on LEADS Canada's Community for Practice and are accessible to all. This endeavour would build on this endeavour and gather evidence informed literature and tools further.
- CHLNet's Research and Evaluation Working Group, through grants and projects such as Empowering Women Leaders, are furthering the building of this evidence.
- The 2019 Benchmarking Study being collected this summer/fall may provide data and insights into further considerations and capabilities to address the health leadership gap across Canada.
- Graham Dickson and Bill Tholl are in the midst of writing a new book on LEADS and its use.
- CFHI's EXTRA: Executive Training Program is a team-based fellowship in quality improvement (QI) and leadership open to participants from across Canada. The 14-month bilingual improvement fellowship will see participating teams acquire skills and knowledge to help them design, implement and evaluate major quality improvement projects. This includes building leadership capabilities.

It is therefore very timely for CHLNet to initiate, with the support of its network partners, a guide and toolkit on *Wise Practices for Health Leadership and Leadership Development in Canada*. The term "wise practices" is used to ensure that both evidence and experience-based practices are considered. Our desire is to turn evidence into knowledge into action. Evolving and emerging innovations and tools (such as mentoring up) will also be included. Once we have landed on a set of practices, a set of tools will be needed to complement. Context must consider in a thoughtful approach for implementation (i.e. if it's a multisite organization, interdisciplinary approach, etc.). Our intention is for a repository of tools, practices and advice to result; becoming a living resource over time.

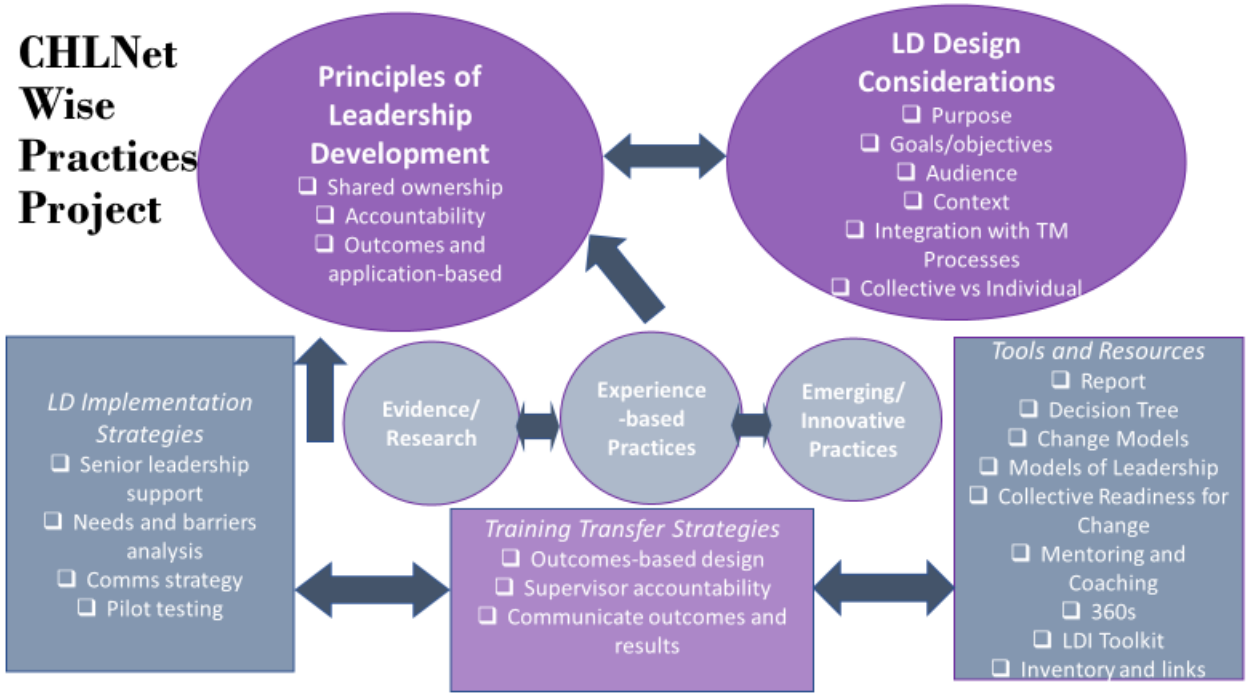
Methodology

The *Wise Practices for Health Leadership and Leadership Development Steering Group* began to gather in May 2019 to further ponder the scope, methodology and other funders for this project and amend as necessary. Two highly skilled and knowledgeable co-chairs are now in place (Dr. Gillian Kernaghan and Maria Judd). The terms of reference (Appendix A) were approved by network partners in November 2018 however were modified by the Steering Group at its first meeting. Membership includes a mixture of CHLNet partners/funders and knowledge experts. It will report regularly to CHLNet's *Health Leadership Exchange and Acceleration Working Group* (HLEA) and *Secretariat*.

A needs assessment will guide this effort. It is proposed that a few key thought leaders (core secretariat) will be assigned to review and discuss evidence and determine where potential gaps might be. CHLNet, through support of a Mitacs grant, has begun to collect some of this data. Additional meta reviews will be sought and compiled including thesis work by Jaason Geerts at Cambridge University on this topic. Key informant interviews will supplement findings based on established selection criteria. Some wise practices might include measurable objectives, action learning, coaching/mentoring, 360s, etc.

A gap analysis will highlight what is missing around practices (i.e. measurable objectives) and tools (i.e. critical thinking and system tools, see Appendix B and C for samples) and determine the classification of the toolkit (i.e. buckets of practices/tools and when to use, contexts, situations). Figure 1 is the Draft Conceptual Framework. The final project scope will be determined by the Steering Group and approved by CHLNet's network partners. Following completion, the continuous updating of this work will become the purview of CHLNet's other working groups i.e. Research & Evaluation and Health Leadership Exchange and Acceleration.

Figure 1: Draft Conceptual Framework



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 CHLNet's Evergreening Fund, Canadian Foundation for Healthcare Improvement (CFHI), and Canadian Centre on Substance Use and Addiction (CCSA). The Canadian College of Health Leaders (CCHL/LEADS Canada) has agreed to in-kind contribution of research and writing services for the literature review (5 to 10 days). Additional financial and in-kind support is required and will continue to be sought from CHLNet partners, HLEA Working Group, and Steering Group Members.

Funders will receive:

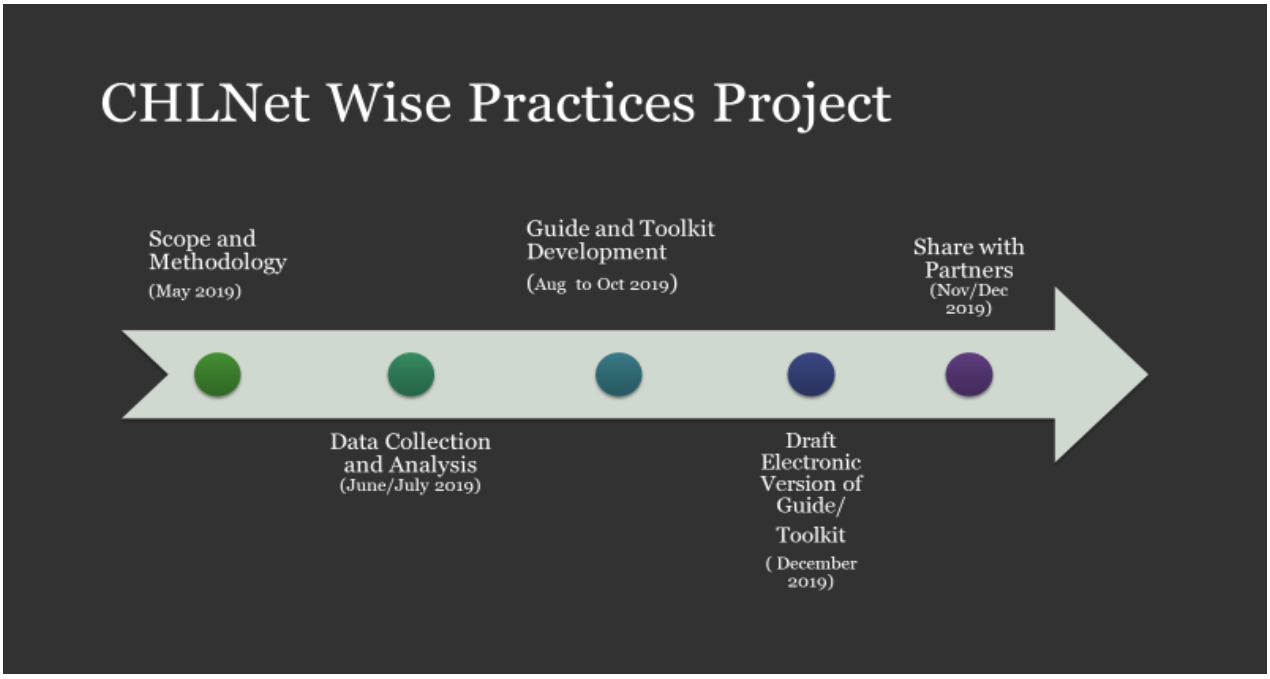
- Cobranding of the guide and toolkit as a partnership;
- Membership on the steering group, if so desired;
- Ability to input into all stages of product development including final review and approval;
- Organization acknowledgement in knowledge dissemination strategies and outputs; and
- Use of guide and toolkit within the funders own program of work i.e. CFHI's EXTRA Program.

Deliverables

An electronic guide and/or toolkit that contains evidence informed Wise Practices for Health Leadership and Leadership Development in Canada. The guide and toolkit will be a free member benefit for all CHLNet partners.

Timelines

Timelines are outlined below.



Budget and Workplan

Outlined below are the three phases with associated activities and costs.

Phase	Workplan Activities	Estimated Costs[1]
Phase 1: May 3 to July 30, 2019 Data Collection and Analysis	• Form Steering Group and ensure accurate records of meetings • Determine project scope and finalize methodology • Confirm funding and budget • Undertake needs assessment (what do people need?) • Identify available resources (inventory of tools from LEADS Exchange Days, LDI toolkit, international bodies, meta reviews of literature on wise practices, etc.) • Collate initial data and present gap analysis to Steering Group	$5,000 for health researcher/consultant
Phase 2: August 1 to October 31, 2019 Guide and Toolkit Development	• Develop guide, selection criteria and list for key informant interviews (national and international) • Conduct key informant interviews • Conduct literature review with a final report produced • Confirm conceptual framework with classification/buckets of tools, methodology to assess/validate tools and determine when to use (context). • Create an annotated table of contents for the guide	$8,500 for health researcher/consultant plus in-kind support
Phase III: November 1 to January 2020 Electronic Version Finalized and Shared	• Liaison and updates with the Steering Group • Preliminary PowerPoint on findings • Determine the structure and flow of the electronic toolkit • Present draft to CHLNet partners on November 19 for input • Convert the paper version of the Guide and Toolkit to electronic form compatible with the LDI Toolkit. • Knowledge Dissemination Strategy	$5,000 for IT support
TOTAL BUDGET		$18,500

[1] Additional funding from other partners beyond the $18,500 budget would help conduct the key informant interviews, allow us to secure more academic involvement, widen the literature review/tool collection and scope of the project, and develop further the online capabilities of the guide/toolkit.

Appendix A: Terms of Reference for Wise Practices for Health Leadership and Leadership Development Steering Group

Purpose

To provide stewardship of a project on *Wise Practices for Health Leadership and Leadership Development* to ensure it achieves its goals and is conducted in an effective and efficient manner (i.e. high quality and within budget).

Goals of the Project

- To review and assess the literature on the most current and relevant evidence and knowledge pertaining to effective approaches for leadership development (Canadian and international); and their application in programs.
- To turn this evidence and knowledge into action on how to enable the effective introduction, adoption and diffusion of leadership development theory and practice (i.e. guide, toolkit, checklists, community of practice, action research project, etc.) to leadership development efforts.

Duties and Responsibilities

- Undertake a needs assessment of CHLNet network partners.
- Identify and engage additional stakeholders and experts on wise practices to gather other evidence and identify gaps for health leadership development practices.
- Discuss findings, gaps and how best to share this knowledge and evidence.
- 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 Co-Chairs.
- Maintain quality records of meetings.
- Distribute agenda and materials one week ahead of the meeting (responsibility of Co-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 Canadian Health Leadership Exchange and Acceleration Working Group for approval.
- Ensure approval of major deliverables and decisions of the steering group through a motion of partners and input from funders.

Composition

- Co-Chairs: Dr. Gillian Kernaghan (St Joseph's Health Care London) and Maria Judd (CFHI)
- Health Leadership Exchange and Acceleration Working Group Co-Chair, Wendy Nicklin
- CHLNet Executive Director, Kelly Grimes
- CHLNet Senior Research Advisor, Graham Dickson
- CHLNet Senior Policy Advisor, Bill Tholl
- LEADS Canada Director, Brenda Lammi
- Network partner/funder representatives:
    - Andrea Johnson, Nova Scotia Health Authority
    - James McAndrew, Island Health
    - Sharon Bishop, Saskatchewan Health Authority
    - Stevie Colvin, Alberta Health Services
    - Judy Wyllie, Hôtel-Dieu Grace Healthcare Windsor
    - Rita Notarandrea, Canadian Centre on Substance Use and Addiction
    - Maryanne D'Arpino, Canadian Patient Safety Institute
- Knowledge Experts
    - Jaason Geerts, Cambridge University
    - Ellen Melis, Unlimited Potential
    - Dr. Johny Van Aerde, CSPL
    - Ingrid Richter, University of Ottawa
    - Knowledge Mobilization expert (TBD)

Appendix B: Saskatchewan Health Authority Sample for Collective Leadership Readiness

CONVERSATION GUIDE

Collective Leadership Readiness Assessment – Portfolio Level

Purpose of Collective Leadership Readiness Assessment: To be used as a conversation guide to understand the current level of readiness in moving toward a culture of collective leadership and to identify opportunities for improvement and focus future action.

Portfolio Name: _____

Step 1 As a portfolio team reflect on the statements below drawing from your working knowledge and recent experience collaborating on organizational design.

Step 2 Discuss and agree on a rating using the scale provided – circle the rating that applies. Go with your gut reaction – don't over think it!

Step 3 Based on the ratings selected, identify opportunities for improvement.

Step 4 As a portfolio team, what are the 1-2 areas that you would like to focus on in the next year?

A. The desired collective leadership culture and leadership practices in use include the following:

We as a portfolio team…

1. Collaborate across boundaries

Think and act as individuals			Collaborate across boundaries consistently
1	2	3	4

2. Engage staff at all levels of the organization

Inform	Consult	Involve	Co-design
1	2	3	4

3. Engage patients, families and residents at all levels of the organization

Inform	Consult	Involve	Co-design
1	2	3	4

4. Promote clinical leadership at all levels of the organization

Inform	Consult	Involve	Co-design
1	2	3	4

5. Commit to and demonstrate transparency and openness in sharing information

Protect and control decisions and information			Open and willing to share decisions and information
1	2	3	4

6. Accept responsibility for outcomes

Reward/blame individual team members for outcomes			Collectively own outcomes, both successes and failures
1	2	3	4

7. Learn from errors or failures

Not seeing errors or failures as an opportunity to learn; instead used for shame and blame; find fault in others			Welcoming the learning from errors or failures to continuously improve
1	2	3	4

8. Value and celebrate staff

Undervalue contributions based on where people are positioned in the hierarchy			Seeing everyone as a valued contributor and appreciate and support staff
1	2	3	4

9. Develop others

No intentional effort to create opportunities for others to lead and develop			Proactively create opportunities for others to lead and develop
1	2	3	4

Based on the portfolio dialogue – and "best guess" assessment above – what are the 1-2 areas that you, as a newly formed team, would like to focus on in the next year to co-create a collective leadership culture within the SHA?

Focus area #1: _____

Focus area #2: _____

Appendix C: Patient Safety Culture Bundle for Leaders