LEADS at a Glance:

Using LEADS as an enabler of change in healthcare

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"Leadership is the collective capacity of an individual or group to influence people to work together to achieve a common constructive purpose: the health and wellness of the population we serve."
Dickson and Tholl[1]

Summary:

LEADS in a Caring Environment is a 'by health, for health' leadership framework providing a common language of leadership. It has five domains: ***L**ead self; **E**ngage others; **A**chieve results; **D**evelop Coalitions; and **S**ystem transformation.* Each domain is comprised of four measurable and observable capabilities that together can help leaders throughout the health system reach their leadership potential.[2]

Over the past decade and more, LEADS has gained increased acceptance across Canada, with 80% of healthcare organizations using a leadership framework having embraced LEADS.[3]. The LEADS framework has been adopted by the 40+ partners of the Canadian Health Leadership Network and serves as the basis for credentialling health leaders through the Canadian College of Health leaders and physician leaders through the Canadian Society of Physician Leaders.

Internationally, the LEADS framework (or versions of it) have been adopted in an increased number of countries, beginning with Health Workforce Australia (2013). It is now in use in several other countries, including Belgium, India, and the Middle East. LEADS Global and CHLNet, have presented the LEADS framework in a variety of international events, including most recently convening a Canadian panel as part of the inaugural Health Leadership Forum convened by the International Leadership Association (ILA).

Background:

Strong leadership continues to be essential to advancing the health of a population and to enhancing both organizational and system performance. Chris Ham from the King's Fund in the UK stated, "leadership is the golden thread that runs through any discussion of NHS reform and improvement".[4] The Health Council of Canada in its summative report[5] concluded that "…strong leadership (is) an absolute necessity if meaningful transformation of our health system is to occur. We view leadership as the foundation for the other key enablers (of health system transformation) because it supports and provides momentum to move actions towards attaining health system goals." The report goes on to stress that "leadership needs to be continual, dynamic and responsive to changing needs".

[1] Dickson G, Tholl B. Bringing Leadership in Health to Life: LEADS in a Caring Environment. Springer. 2020
[2] See link to brochure here: LEADS_Canada_Brochure_2016_EN.pdf
[3] Canadian Health Leadership Network (2020). Benchmarking Health Leadership in Canada: Report of CHLNet Steering Group. Link here: CHLNetBench2 1-3-25.pdf
[4] Ham, C. How can improving leadership help to transform the NHS? London: The King's Fund.19 May 2014. Available from: https://www.kingsfund.org.uk/blog/2014/05/how-can-improving-leadership-help-transform-nhs
[5] Health Council of Canada "Better health, better value for all: Refocusing healthcare reform in Canada" 42p.

The need for LEADS-based leadership has never been more in evidence as health leaders cope with the unprecedented leadership challenges posed by COVID 19. LEADS Global and CHLNet have partnered on an ongoing research project around "Leading Thru the COVID Crisis". This research has reinforced many of the underpinnings of leadership captured in the definition of leadership above, namely, the need for leaders to act in concert through purposeful partnerships to tackle such a major leadership challenge. It also underscores the importance of distributive leadership, recognizing that your locus of influence is far more important than any locus of power or authority that may be conferred on you as a health leader. Health leaders at all levels are being challenged. And we are once again recording just how critical effective leadership is in protecting our most vulnerable and in planning for better pandemic planning in the future. According to a recent CHLNet study into the validity of LEADS in leading through a pandemic, it was concluded that the framework continues to provide a robust means of leading change and an intuitive guide for practicing leadership for maximum impact "Most LEADS practices pre-COVID were shaped by the existing context. Post COVID it might well be that the job of LEADS-based leadership is to challenge that existing context."[6]

Three Functions of Leadership

We have found through our research in support of the 2nd Edition of the LEADS book that leadership has three essential functions. The *first* is to integrate otherwise disconnected processes to ensure access to maximum quality personal health care. The *second* is to create safe, healthy workplaces. The *third* is to facilitate meaningful and sustainable health reform, where necessary. Effective change in all three requires exceptional leadership: from administrative leaders, nursing leaders, physician leaders, and patient/community leaders. In addition, as the COVID crisis has demonstrated so powerfully, the system must identify leaders *at all levels*—within each community, each health care organization, each health system, nationally and globally. In our view, the LEADS framework provides a common vocabulary for all components of the Canadian health system—regardless of profession, role or position—to work together to achieve these goals.

Leadership as LEADS

The *LEADS in a Caring Environment* capabilities framework (LEADS) provides a customized *By Health, For Health* framework for responding to this growing need for a concerted, coherent, and sustainable strategy for strengthening health leadership capacity in Canada.[7] The LEADS capabilities framework features five domains: ***L****ead Self,* ***E****ngage Others,* ***A****chieve Results,* ***D****evelop Coalitions*, and ***S****ystems Transformation*. Each of these five domains consists of four core measurable capabilities. The 20 capabilities make up what we refer to as your DNA as a health leader.[8]

LEADS is being used as a foundation for leadership development country-wide, helping unite health clinical professionals with health administrators in a common quest for improved

[6] Dickson G, Taylor D, Hartney E, Tholl B, Grimes K, Chan MK, Van Aerde J, Horsley T, & Melis E. (2021). *A LEADS lens on the Pandemic: What Have We Learned.* Manuscript submitted for Publication.

[7] Dickson, G. & Tholl, B. (2020). *Bringing Leadership to Life in Health: LEADS in a Caring Environment.* London UK: Springer Publishing.

[8] Canadian Health Leadership Network (2020). *Benchmarking Health Leadership in Canada: Report of CHLNet Steering Group*. Link here: CHLNetBench2 1-3-25.pdf

leadership through sharing a common language. A shared vocabulary can unite us in collective action: "*[If]/when medical leaders are to lead the way forward in this century towards the transformation and improvement of healthcare across the globe then we must work between us towards a simple yet clear vocabulary that we can share with our clinical, management and technical colleagues at every meeting and every report*."[9] The LEADS framework has also enabled the sharing of leadership support and development tools across the country through, for example, "LEADS Exchange Days" held in conjunction with the National Health Leadership Conference(NHLC) each year. Indeed, the NHLC program is now mapped against the LEADS framework to assist leaders in pursuing the personal leadership plans.

The Canadian Health Leadership Network (CHLNet) has been instrumental to increasing awareness about the importance of leadership in general and championing the adoption of LEADS Canada and, working through LEADS Global, abroad.[10] CHLNet is a value network committed to helping its partners enhance capacity to identify, develop, support, and celebrate excellence in health leadership. CHLNet includes over 40 national and provincial/territorial network partners (and is growing) that have all endorsed the *LEADS in a Caring Environment* capabilities framework. According to a recent CHLNet benchmarking study, there has been a doubling of formal leadership training programs over the past five years across Canada, with 89% of healthcare institutions reporting such programs (both intramural and extramural). Of those programs, 80% now identify LEADS as their preferred pedagogical or learning platform.[11]

Part of the reason for this rapid and extensive uptake of the framework is that the evidence supporting each of the five domains has been continuously updated by subject matter experts to reflect the most recent research. Although the LEADS framework represents a solid, research-based approach to leadership, its application needs to be adapted to specific health systems and their cultural context. Health Workforce Australia, for example, adopted a version of the LEADS framework in July 2013, based on this principle. After all, leadership is situational; what good leadership looks like in one country may differ from another (behaviorally speaking), even though the principles are the same.[12]

LEADS, as a *By Health, For Health* framework, has both construct and face validity. As noted, is the result of an extensive and ongoing review of the literature the research into health-sector specific leadership[13]. It also reflects the results of early pilot projects across the country and a series of more recent studies that have validated the fundamentals of LEADS in myriad ways, both via independent academic evaluation and in terms of being put to work in practices across Canada.[14]

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[9] Shannon T. as quoted in Dickson G, Van Aerde J. Enabling physicians to lead: Canada's LEADS framework. *Leadersh Health Serv* (Bradf Engl). 2018;31(2):183–194.
[10] Tholl, B. (2014) Taking a Value Network from Concept to Reality: Canadian Health Leadership Network (A case study). *Healthcare Management Forum* pp117-121.
[11] Canadian Health Leadership Network (2020). *Benchmarking Health Leadership in Canada: Report of CHLNet Steering Group*. Link here: CHLNetBench2 1-3-25.pdf
[12] Dickson, G. and Van Aerde, J. (2018). Enabling physicians to lead: Canada's LEADS framework. *Leadership in Health Services.* Vol. 31 Issue. 2, pp. 183-194.
[13] Dickson, G. & Tholl, W. (2020). *Bringing Leadership to Life in Health: the LEADS in a Caring Environment Framework*. — a New Perspective. Springer: UK.
[14] Ibid.

In terms of 'face' validity, LEADS has proven to be intuitive for leaders. It is proving to be a helpful guide for leaders *at all levels* in thinking through the change leadership challenges in various contexts, including the unprecedented challenges posed by COVID.

- *"L" -- Lead Self*--suggests that the leader must be absolutely clear about how their own personal values align with the public health objectives of helping first those that need it most; that we understand the strengths and limitations we bring to the challenge of creating necessary changes (as the evidence evolves); that we are willing to learn and adapt our own behaviour to reflect the demands of those changes; and that we need to be conscious of the demands on our character such changes will require in terms of surfacing unconscious biases in terms of Equity, Diversity, Inclusiveness (EDI).

- "E" -- *Engage Others*—asks the leader to ensure there are developmental opportunities in place to assist health providers in developing the knowledge, attitudes and skills needed to address leadership challenges. In the context of COVID, this has involved leading care teams in the treatment of COVID-19 patients in ICUs or coordinating efforts across jurisdictions to acquire and distribute both efficiently and equitably vaccines as they become available. It also asks us to contribute to creating an environment in the workplace that is psychologically healthy and conducive to change; to communicate effectively to engage patients, providers, and employees in creating rapid responses to an evolving threat; and to build the inter-professional or multi-disciplinary teams needed to learn how to better work together to effect change (made more difficult in the virtual work world of COVID and post-COVID).

- "A" -- *Achieve Results* emphasizes clarity of purpose, alignment of action, and measurement of success. COVID-19 has tested our agility as leaders, as the new variants arrive, and our values as a society as the virus exposes fractures in our health care systems. As the evidence continues to evolve daily, leaders have been required to constantly assess and evaluate how best to protect public health in leading through COVID.

- "D" -- *Develop Coalitions* expects leaders to ensure that all partnerships—internal and external—focus on the patient and family; are deliberately and effectively stewarded; appropriate knowledge is shared across boundaries, and that political skill is utilized to facilitate collective action. Responding to the COVID-19 crisis has caused an unprecedented degree of federal-provincial collaboration and cooperation across party lines, as the virous respects no boundaries. Fit-for-purpose networks have been formed to bring together the scientific and policy communities, such as the CanCOVID network.

- "S" --*Systems Transformation* expects the leader to think critically and to think about how the different parts of our healthcare systems work together, or not. COVID-19 has exposed, for example, the need to think longer term about the need to strengthen Long Term Care standards and the hazards of thinking in silos. We are also seeing leaders embracing innovative practices that have been slow to be introduced, adopted and diffused, such as the adoption of virtual care and other digital solutions (i.e., COVID Vaccine Finder App).

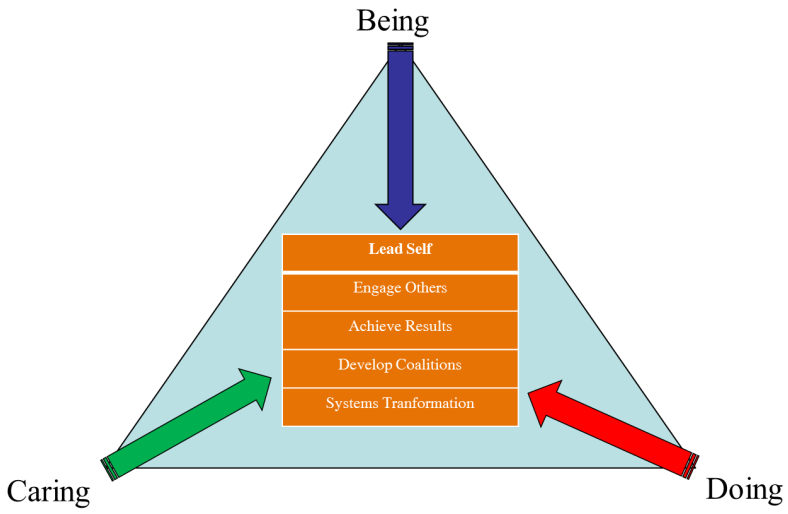
All leadership is a function of time, place, and context. Although the LEADS framework is a great starting point for developing leadership skills in support of change—its implementation has evolved in keeping with the evolving Canadian health organizational context. The importance of contextual leadership has never been more in evidence than during the COVID pandemic. Leadership styles have had to evolve as the pandemic has endured. While command and control and pacesetting leadership was both necessary and expected during the early stages of the pandemic, we have seen an evolution over time to more collaborative or distributive leadership.[15] Consequently, any practical application of the framework reflects the cultural and political context of the specific organization and its communities.

As the co-authors of the 2nd Ed of the LEADS book, we are committed to a future of modern health leadership, where leadership is defined not solely in terms of the power a leader wields or by the resources at a leader's command, but also by a leader's ability to influence, engage and mobilize others toward a constructive common purpose. The basic premise is that your locus of influence far exceeds any locus of power or authority you may have. This concept of distributed leadership—in the case of any health organization in Canada, fully embraces physicians, as well as patients and their families as leaders in promoting people-centred care in the health system.[16]

LEADS as a Process for Change

The five domains of the *LEADS in a Caring Environment* framework—*Lead Self, Engage Others, Achieve Results, Develop Coalitions*, and *Systems Transformation*—reflect leadership in action in health (see Figure 1). This action is the "doing" part of leadership, which follows a deep commitment to caring for others ("caring"—the identity of the health system) and recognition that the person you are, is the leader you are (the "being" component of effective leadership).

Figure 1: The three components of effective health leadership



[15]. Dickson G, Taylor D, Hartney E, Tholl B, Grimes K, Chan MK, Van Aerde J, Horsley T, & Melis E. (2021). *A LEADS lens on the Pandemic: What Have We Learned.* Manuscript submitted for Publication.
[16] Dickson, G and Tholl, B (2014). *Bringing Leadership in Health to Life: LEADS in a Caring Environment—A New Perspective*, Springer: UK.

Being (who the leader is) and caring (the *why* of doing leadership in health) take expression (doing) as the five domains of effective leadership in the *LEADS in a Caring Environment* framework. Each domain entails four leadership capabilities, for a total of 20 capabilities in the framework. These capabilities are actionable in that they represent caring and being in action and, therefore, are observable by others. It is appropriate at this point to say a few more words about the concept of a *caring environment*. Almost anyone who works in the health system cares about health and wellness of the population; at least, we assume it is a force impelling individual to choose this line of work. And thus, the focus on people-centred change leadership in this program.

Yet despite how well motivated all of us may have been initially to care in our job or profession, the routines, policies, procedures, protocols, and practices—imposed, professionally valid, and derived from a caring motivation—can quickly become ends in themselves. Caring, in terms of truly connecting with the welfare of another human being, can become buried beneath such administrative provisions. After a while, it is easy to simply use the concept of caring as a mantra, without truly practicing it. But what does this situation mean for leaders?

First and foremost, it means ensuring that caring, as a real and situational response to a need, drives a leader's behaviour, personal, interpersonal, and strategic. Second, it relates to the *Engage others* domain in the framework. Leaders create healthy and caring environments—cultures, climates—in which others work. At the core of that caring environment is tangible evidence of an ethos of compassion[17] and empathy for others, which plays itself out as putting the patient, client, or citizen's welfare at the centre of the decision-making process. Caring manifests itself through the leader's actions, either personally or strategically, in response to the follower's needs. The leader must then ensure that actions taken by and within his/her unit meet those needs.

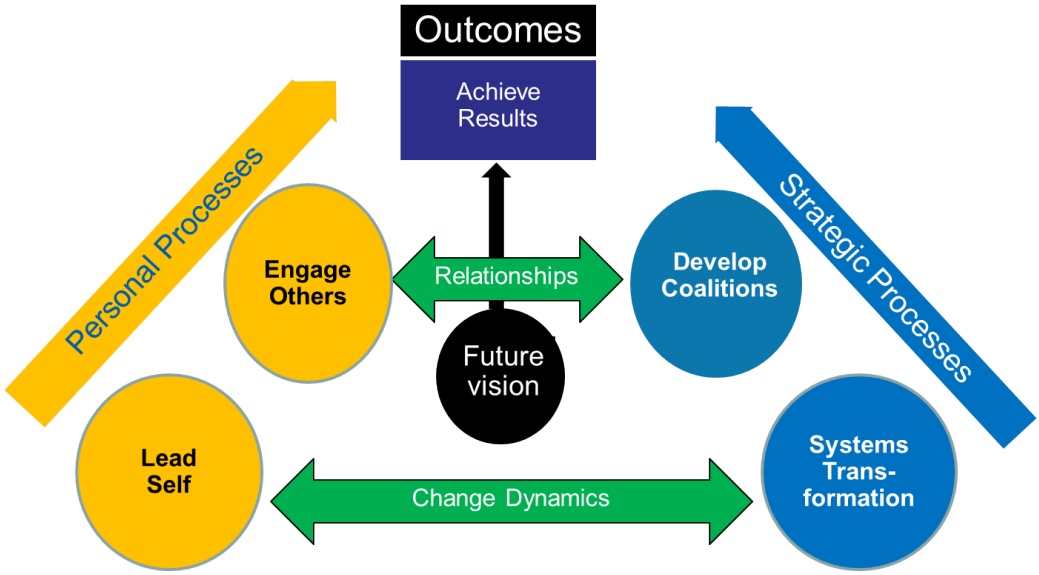
One of the greatest challenges for those who take on the mantle of leadership is to retain a personal perspective and emotional maturity that enables them to bear the inevitable burden—and joy—that creating a caring environment entail. The *LEADS in a Caring Environment* framework outlines what such an ethos of caring looks like in action—it details the capabilities that leaders need to create a caring environment as they try to create change in their organization, or the health system more broadly.

The five domains of the *LEADS in a Caring Environment* framework are, at once, both independent in terms of behaviours and interdependent in terms of net effect. Although the domains can be observed separately as discrete sets of capabilities, they also interact with one another to create effective leadership. For example, the capabilities relevant to the *Systems Transformation* domain come into play with the capabilities of the *Lead Self* domain to leverage success in providing the courage and confidence to generate strategic change in different contexts: the latter for the individual who chooses to lead; the former for the leader who operates in an organizational or systems context.

[17] Hodges BD, Peach G, & Bennett J. (Eds.). *Without Compassion, there is No Healthcare: Leading with Care in a Technological Age*. (2020). McGill-Queen's University Press.

Similarly, the five domains of the framework are a regimen, or approach, to leading change. The diagram in Figure 2 below shows how the five domains work together to guide change. Figure 2 is explained as follows. The LEADS framework consists of one outcome domain: *Achieve Results*, and four process domains: *Lead Self*, *Engage Others, Develop Coalitions,* and *Systems Transformation*. The four process domains are employed by the leader to achieve the outcomes identified by the *Achieve Results* domain.

Figure 2: The LEADS in a Caring Environment Framework as a Guide to Change



The logic is as follows. When a change is envisaged in a system (i.e., a shared vision for change based on a caring ethos), the leader needs to articulate the Achieve Results in the LEADS framework (i.e., the results that need to be achieved by this change) in a clear, concise, and compelling way. These results represent the future state, in terms of envisaged outcomes for the change; they are the tight components of the change plan: its North Star if you will. *Achieve Results* is at the pinnacle of the hierarchy of leadership capabilities because it is the product that all the processes of leadership, both personal and strategic, are aiming to achieve.

Figure 2 suggests there are two processes associated with leading change: change dynamics and trusted relationships. These are the twin elements of any change leadership plan: i.e., the leader is free to adjust and alter his/her processes to adapt to the situational environment to ensure the envisaged results are achieved.

Lead Self and *Systems Transformation* are sets of capabilities that leaders employ to address change dynamics. *Systems Transformation* is a strategic set of capabilities: i.e., the ability to deal with employee receptivity to change, public support, change resistance, etc. It is leadership at a distance, exercised through policy, procedure, structure, and culture. *Lead Self* is a personal set of capabilities: i.e., the ability of leaders to deal with their mindset on change, take steps to change their habits, recognize their mental models, and meet the challenges to their character that leading the change will require of them.

The second process element in the hierarchy is the challenge of building trusted relationships. *Engage Others* and *Develop Coalitions* are the two dimensions of the relationship process. The *Engage Others* domain and capabilities address the people challenges of effective interpersonal relationships. The *Develop Coalitions* domain addresses relationship building at a strategic level; that is, building support across units, across organizations, and with customers and the public in support of change.

Collectively the four process domains of the LEADS framework and the one outcome domain, *Achieve Results*, comprise a model to guide change. If the leader uses this model to structure and focus their influence to create change, and if that influence is implemented effectively, the outcome will be achievement of the anticipated results of the change. If they are not, the approaches taken need to be reassessed and adjusted to achieve the defined results in keeping with a standard *Plan-Do-Study-Act* or PDSA cycle. Ultimately, the LEADS framework is a model for thinking through and implementing system-wide change: one that the leader is encouraged to use to scope out the true challenges and demands of making change work in a systems context.

Going forward, we will continue to strengthen the LEADS framework with the real-world data being compiled across Canada and internationally in terms of how it is being put to work in ways that we could not have imagined when we started this journey over a decade ago.

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