BRANCHES OF KNOWLEDGE: **COMPREHENSIVE ARTICLES ON LEADERSHIP**

GENESIS

OF THE LEADERS FOR LIFE FRAMEWORK

LEADS SELF

ENGAGE OTHERS

ACHIEVES RESULTS

DEVELOPS COALITIONS

SYSTEMS TRANSFORMATION

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leadersforlife.ca

Table of Contents

3 Executive Summary

5 Genesis of the LEADS Framework

6 Why Leadership in Health
8 Background to LEADS
10 Dispelling Some Leadership Myths
12 Some Assumptions Shaping the LEADS Framework
14 The Project
16 The Logic of the Inquiry
18 The Results
25 Conclusion
26 End Notes

32 Appendices

32 Appendix A
36 Appendix B

Executive Summary

In British Columbia, as in many other jurisdictions in Canada and across the globe, leadership has gained significant attention in the last ten years[1]. Leadership is vital to the success of change and quality improvement in the health and social service sectors.[2] There is also a growing sense of urgency that leadership of change is needed. As the 2008 *Getting Our Money's Worth* report on health care in the province of Quebec states: "Everyone is aware of the difficulties of the health system, yet the situation is not changing quickly enough."[3]

Recently, in British Columbia (BC), and also across Canada, there has been a growing demand for focused investment and planning to address a perceived 'leadership gap' in the Canadian health system.[4] For example, Stephen Lewis (2007) and Roy Romanow (2007)[5] —two well-known health experts - have stated that improved leadership is a key to making the changes that are necessary (e.g., waitlist management, fiscal sustainability, primary care reform, end-of-life care[6]). The Leaders for Life Program in BC is a provincial effort aimed at overcoming this leadership gap[7].

The BC Leaders for Life Program

In January 2006, in response to a business plan submitted to the BC Ministry of Health, the Health Care Leaders' Association of British Columbia (HCLABC), in collaboration with major health employers and post-secondary partners, received a $3.0 million grant to build a learning program that would enhance the overall quality and quantity of health leaders in BC. The result was the creation of the *Leaders for Life* Program in British Columbia.[8] The originators of *Leaders for Life* fashioned it on work done by the National Health System to develop health leadership in the United Kingdom[9] (which the Chief Executive Officer of the Health Care Leaders' Association had participated in early in his career before coming to Canada).[10] A starting point for that project was the formulation of the LEADS framework,[11] the genesis of which is the focus of this paper.

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The Genesis of the LEADS framework

Why Leadership in Health?

Most of us have seen news stories where individuals describe experiences of elderly patients suffering or people dying because of shoddy care. There is a subtle subtext to these stories: the hospital manager, the day care manager, or the government minister responsible for the system has somehow mismanaged it. And how easily media-generated perception becomes truth in the public's eye! We see many articles anticipating the future demise of the health system as we know it. Regardless of whether or not these anecdotes are truly representative of poor leadership, some argue that the media controversy is itself a symptom of a lack of leadership in the system. For example, a colleague recently stated: "the public image of health care is damaged because individuals in the system do not see it as a system. Indeed, it is their own behaviour of pointing fingers at other components of the system, and blaming each other for its woes, that damages its image in the public eye."[12] Leadership—the capacity to influence others to work together to achieve a constructive purpose—is required to make the system work as a system. The Health Care Leaders' Association of BC is dedicated to creating the quality of leadership within the BC system that will address this issue.

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Many readers who work in the private sector will not be surprised to hear that improved leadership is fundamental to the future success of the health system. Nor will many people in health prevention, health promotion, and acute care in Canada. But what might surprise both groups is the lack of resources and credible research into leadership in the health sector, particularly in Canada. Often the literature that is referenced in the health sector profiles studies in the private sector from the United States.[13] Given the fact that the Canadian health system is dramatically different in design, purpose, and social importance than it is in the US and that private enterprise is somewhat distinct from public service delivery, it is surprising that this condition exists. Although other leadership studies are available—for example, the Goffee and Jones[14] work in the UK that outlined the qualities of leadership of CEO's in successful British corporations—there

has been little such work in Canada, and even less in the health sector.[15] Given the "situational" nature of leadership—i.e., that the qualities that work in one situation do not necessarily work in another—how do qualities of leadership in other sectors translate into the Canadian health environment?

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In the past two years, the Centre for Health Leadership and Research at Royal Roads University has had the opportunity to work with the Health Care Leaders' Association of BC to address this question. The LEADS project is one result of that collaboration. The specific task was to define a set of qualities of leadership and management that could become the foundation of a provincial leadership capacity enhancement initiative. This new definition would raise the quality and quantity (depth and breadth of experience & knowledge) of modern health leadership throughout the health system of British Columbia, and contribute to improving the image of the profession.

Background to LEADS

In the winter of 2004, the Health Care Leaders' Association of British Columbia (HCLABC) and Royal Roads University co-sponsored a symposium on strategic leadership for health care reform in Canada. Twenty-three senior executives from the health sector across the province and about 50 Masters of Arts (Health specialization) learners from Royal Roads University participated. The purpose of the symposium was to define the concept of strategic leadership for health care reform: what it looked like, whether it was needed in the current health environment, why it was important, and what, if anything, could be done to improve efforts in British Columbia to develop strategic leadership.[16]

This symposium was notable primarily for four reasons. First: Dr. Penny Ballem, Deputy Minister of Health in BC at the time, spoke about the 'crisis' in management. She argued that over the years many mid-management positions had been taken out of the health system and that as a consequence it was in danger of being severely under-managed. Second: Bill Tholl, CEO of the Canadian Medical Association, spoke eloquently about the fact that if there were to be a strategy for leadership development, no one organization in Canada could do it by itself. He coined the phrase, "leadership without ownership"—a principle that suggests many organizations would have to collaborate and share the ownership of a meaningful leadership development process, especially if it was to create a culture shift within the health system.

Third: the Health Care Leaders' Association of BC and Royal Roads University, who were responsible for producing a document to summarize the symposium's proceedings, became deeply committed to working together to turn that document into an action plan, and to use that plan as a foundation for seeking funding and support for a provincial leadership development initiative.[17]

Finally, there was a strong consensus amongst the participants that the kind of leadership needed to guide the Canadian health system into the future was both qualitatively and quantitatively different from the leadership currently in practice. And most importantly—and germane to this article—was the implicit

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agreement that leaders of the future will not be developed without formally defining the qualities of exceptional leadership in a BC context.[18]

With this as background—and with the foundation of ten year's experience working with leadership competency frameworks as part of the leadership programs designed and delivered at Royal Roads University—the Centre for Health Leadership was commissioned by the Health Care Leaders Association of BC and the *Leaders for Life* Program to "define" exceptional health systems leadership in British Columbia. The LEADS framework is the product of this work.

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Dispelling Some Leadership Myths

Before moving on to a discussion of the LEADS Framework itself, it will be useful to identify some of the myths that permeate discussions of leadership that would need to be addressed "head on" for the project to make sense.

One myth is that *Leaders are born, not made*. If this were so, then there would be no point to developing definitions of leadership, or in offering leadership programs. As Vince Lombardi stated,

> *Leaders aren't born, they are made. And they are made just like anything else, through hard work. And that's the price which all of us must pay to achieve any goal that is worthwhile.*

Leadership is an art[19] and like any other art, its "craft" and "expression" can be learned and developed. Indeed, it is a rare artist that has not "studied" his or her discipline, and practiced it. So it can be—should be—with leadership.

Another pair of related myths is that *there is no difference between leadership and management, or that if there is a difference, one is more important than the other*. This is not the case. Leadership is the quality we look for to guide us through change in complex environments with uncertain futures, and in circumstances with changing or competing societal values. Management, on the other hand, is the body of knowledge and skills we use to organize, plan, and control resources when direction has already been set. When society is going through major change—as it is today with demographic challenges, health challenges, technological advances, and environmental challenges never-before faced—both leadership and management are required. Leadership sets direction and engages people in a willingness to go in that direction; management organizes the resources to help us get there. The recent 2007 Conversations on Health, and the change they presage for British Columbia, will require both leadership and management to create change.[20] Consequently, any framework that defines effective leadership in today's health world must capture the right balance between leadership and management.

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Finally, there is a myth that *leadership is touchy-feely*, comprised of soft, as opposed to hard skills. If that is the case, why is leadership so difficult?

As one participant in a recent program said, "Gosh, these soft skills are hard to master!" The truth here is that leadership is composed both of soft skills (i.e., people oriented skills such as interpersonal communication, inspiring, encouraging, empowering) and hard skills (i.e., planning, organizing, measuring, accounting). Blake and Mouton,[21] two of the first writers in the field of leadership, made this clear. They stated that good leaders take care of both task and consideration—that is "'getting the job done", while considering, at the same time, the needs, aspirations and purposes of the people being led.

Some Assumptions Shaping the LEADS Framework

A number of guiding principles shaped both the process used to create the LEADS framework, and the construct of the LEADS framework itself. These principles were:

The LEADS Framework must reflect the noble purpose of "leading to health."

For years, the public, in survey after survey, have indicated that health is the among the most important public policy issues to be addressed. Improving the health of Canadians requires leaders with a deep commitment to the "calling" of health. Therefore, language used to describe exceptional health systems leadership must reflect the unique challenges of leading to that calling. Similarly, programs and initiatives that are aimed at assisting others to learn leadership require an approach and method that is unique to leading to that calling.

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Leadership is intended to have a practical impact on the BC leadership gap.

There are three ways to address a leadership capacity gap.[22] The first is to raise the overall quality of leadership by increasing the number of leaders. The second is to raise both the number of leaders and the quality of those leaders. And the third is to create a leadership culture throughout a system—such that everyone in that system contributes as a leader to its success. This is known as *distributed leadership.*[23] The purpose of the LEADS framework for health system leadership is to stimulate a shared awareness of quality leadership throughout the BC health system, to provide a common framework for developmental programs, and to provide standards to aspire to in terms of a systems leadership culture.

A health systems leadership framework must have direct utility.

A third principle underlying this work was that the project had to have a *utilization* focus, i.e. be designed to fulfill "*…its intended use by its intended users.*"[24] There are two sets of intended users: formal and informal leaders in the health system. Formal leaders consist of individual executives and leaders of all BC health organizations. Included also are leaders and managers of key interest groups, professional associations, provincial and national associations, and of course, leaders at the policy and operational levels in individual health authorities. Informal leaders are those individuals who are not necessarily in formal management positions, but who wish to be active as independent agents in moving the health system forward; i.e., the employee or citizen who chooses to lead. This group of users is consistent with the concept of "distributed leadership" mentioned earlier, and need to be active participants if a transformational leadership culture to move the health sector forward is to be built.

Effective leadership can be defined, and deliberately developed.

For some, leadership is a quality that exists, like beauty, but cannot be captured, or defined. There is also the old adage, "Leaders are born, not made." Both of these constructs, however, are inconsistent with current research, and inimical to the challenge of addressing the health leadership capacity gap. The past ten years have produced a plethora of research that defines leadership and many attributes of quality leadership.[25] There is also significant evidence that leadership can be learned, just as musical talent or athletic talent can be developed through practice, visualization, and of course, knowledge and skill acquisition.[26]

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The Project

The vision[27] for the LEADS project was to identify the leadership and management capabilities needed for the future health system.

As a first step in scoping out the project, HCLABC and the Centre for Health Leadership and Research hosted a symposium in April 2006, to identify key concepts, ideas and practices that would have to be employed to ensure that the project would be successful in fulfilling its intentions.[28] Representatives of BC health authorities, the academic community, national health organizations and international experts attended this event. The four-member research team followed this event by laying out a plan to accomplish the work associated with this project. The plan was as follows:

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Purpose: The purpose of this project was to provide individuals and organizations in the BC health sector with a clear picture of, and a set of standards for, the knowledge, skills and attitudes a leader must have if they are to be successful in stewarding the health system into the future.

Principles: There were six key principles guiding this activity:

1. The inquiry will be guided by a desire to maximize benefits for participating BC's health organizations, and their national partners.
2. It is important that the resulting framework reflects the foundational elements of effective leadership: its task and consideration dynamic;[29] its transformational nature;[30] its values-orientation;[31] and the fact that it does not exist except in action.[32] Consequently, the framework should be expressed in relevant, practical language that speaks to its "action" focus: verbs as opposed to nouns.
3. In recognition of quality work already done in many health organizations related to competency development, contributions from those organizations will be used as the foundation for the BC Competency framework. In addition, there is a need to create a framework that represents the emerging conceptions of leadership provincially, nationally, and world-wide[33] [34] [35] founded on new emerging skills, current research, and the relevance of that research in practice (i.e., the utilization focus).

4. Action research methods are the best approach to take to this project because these methods allow the project to: be responsive and flexible to conditions and challenges within the health sector; enhance the quality of results through a collaborative research process; and, create and share new knowledge with all participating organizations (assuming they are well-implemented!).
5. All participants will attempt to model the qualities of leadership they are trying to define.
6. Resources will be used efficiently to deliver maximum value.

Research method: In keeping with action research methods, the project had nine steps of action and reflection. They were:

1. Analyse existing provincial, national and international competency frameworks.
2. Conduct literature search for "best practices" in health leadership.
3. Engage key players from the BC Ministry of Health, health authorities, professional groups and interest groups and create a Field Action Group to work with the principal researchers.
4. Develop an interview protocol and focus group protocol.
5. Conduct informal focus groups where possible with key groups of leaders.
6. Conduct interviews with senior leaders in BC's health sector.
7. Analyze data.
8. Create a capabilities model and represent it in print and visually.
9. Engage partners/stakeholders in meetings to revise, refine framework.

All of these activities were carried out between April 15 and September 30, 2006.

At the end of this process, the model was presented at the HCLABC Annual Conference in October, 2006, and final input was received from a large contingent of members. Between that date and December 31, 2006, the results of the research were then transformed into brochures and booklets, to make the LEADS capabilities framework accessible to programs and services.

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The Logic of the Inquiry

The logic of the approach was to triangulate data from three sources: (1) existing competency frameworks in health organizations from BC, nationally, and internationally; (2) a comprehensive literature review of salient leadership literature, especially focusing on health leadership, and preferably health leadership in Canada; and (3) empirical data drawn from about 40 interviews of mid-senior health leaders in British Columbia. The data analysis stage would seek robust patterns that would emerge when all three data sources were reviewed, to identify key leadership concepts and practices germane to all three data sources. Figure 1 below outlines the logic:

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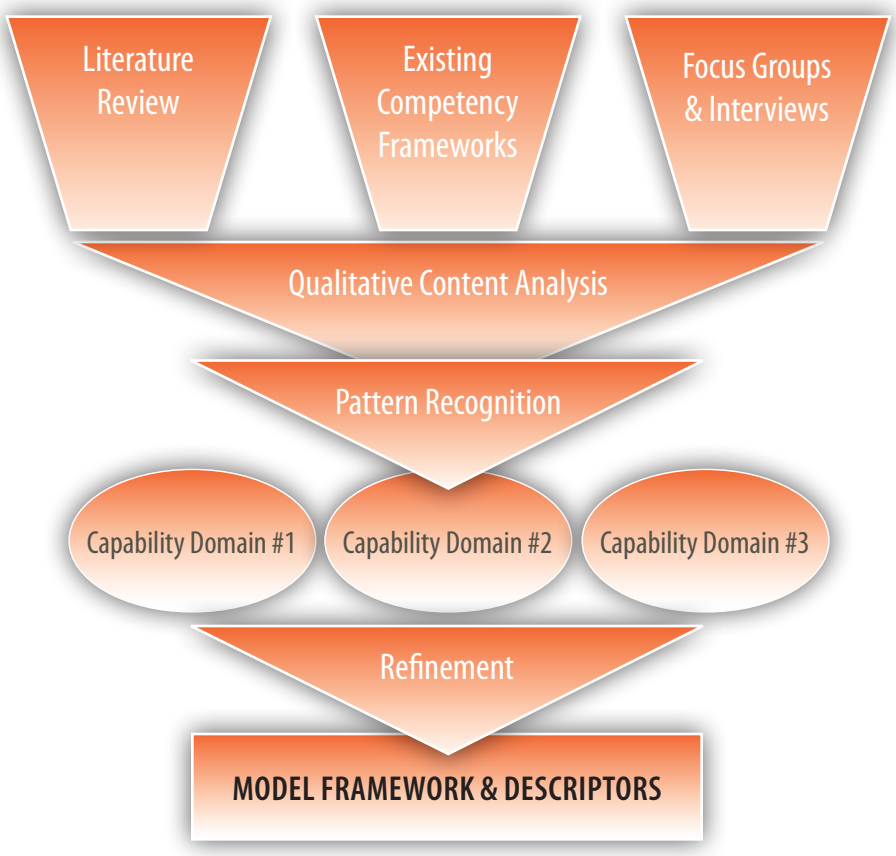

Figure 1: The logic of the competency project approach

From the data gleaned from interviews and focus groups, and from the existing competency frameworks, there were over four-hundred and fifty individual statements about specific competencies, both those currently in use in existing health authority frameworks and those seen as potential and desirable. Once the named ideas were compiled, they were clustered according to overarching theme. Thirty overarching themes emerged from the four hundred and fifty four named concepts and ideas when the raw data was referenced to key themes. The outcome was a list of competency clusters, each with a weight as identified by the quantitative analysis.

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Competency clusters were then further grouped according to the general focus of intent as described by participants or as revealed in the literature. The next step in the data analysis process was a final refinement of the data by comparing the themes to existing themes in the literature and in existing health authority competency frameworks. The purpose was to develop a comprehensive, simple and meaningful model that would appropriately reflect all considerations and that could be utilized according to the needs of all participants. In other words, it had to be intuitive and utilitarian and it had to reflect the various competency frameworks currently in use. This process was undertaken not as a simple and further reduction of data, but simultaneously with the process of developing an explanatory model. Numbers of competency foci in the two stages of analysis varied from three to six depending on the stage of development of a meaningful model. The final model is described in the next section of this paper.[36]

The Results

There were four primary results from this project. They were: (1) The creation of a utilitarian framework that was conceptually sound and practical and the same time; (2) The acceptance and adoption of that framework by the *Leaders for Life* Program in BC; and in some health authorities; (3) The creation of an electronic method of displaying the Framework based on the United Nations model[37] and its link to existing competency work done in other health agencies; and (4) Some conceptual insights into the limitations of competency models for leadership development, and the potential utility of a "capabilities" model specifically for developing leadership. Each of these will be discussed in turn.

The LEADS Framework: An Overview of Exceptional Health Systems Leadership

As the LEADS project progressed, numerous conceptual models to explain the emerging model were developed and ultimately discarded. Some of those models (see Appendix A) tried to show, visually, the complexity of health systems leadership, as one moves from simple to more complex leadership positions in the health system; others attempted to show the conceptual linkages between the various elements of the emerging LEADS framework; yet others tried to define capabilities by hierarchical position descriptions. In almost all instances the visual representation of the model was so complex that it made it very difficult to be used.

The final model is a simple list of five key leadership capabilities necessary to create an exceptional BC health system.

The final model is a simple list of five key leadership capabilities necessary to create an exceptional BC health system. At the highest level of simplicity, the model was presented as the LEADS acronym; one letter for each of the five competency domains of exceptional health leadership. The framework is as follows:

Leads self

Engages others

Achieves results

Develops coalitions

Systems transformation

A more complete version of the framework is shown in Appendix B.

The model is composed of five major "capability"' domains, each with four sub-domains that further clarify the expectations of and guidelines for exceptional health leadership. From an "elegant simplicity" perspective, the model is easy to remember and yet at the same time represents five discrete set of capabilities that in the light of the feedback received: it captures the essential elements of effective leadership and management.

The LEADS framework is consistent with emerging research into leadership but presents it in a sequence and order that represents an expanding application of leadership skill in the health sector. For example, many authors (e.g., Covey[38], Senge,[39] Leatt & Porter[40]) state that leadership begins with knowing why one chooses to lead and then self-directs their own development. However, the *Leads Self* dimension of the LEADS framework takes those concepts and expresses them in practical terms relevant to the health sector's specific context. The pattern of contextualizing theoretical constructs of leadership into health situational language continues throughout the framework. For example, once a leader understands why they lead, they then need to progress to the next stage of leadership which is to engage immediate allies who are willing to pursue a vision they collectively share (*Engages Others*). Effective leadership then ensures the shared vision is expressed in measurable outcomes, and that those outcomes drive implementation (*Achieves Results*). The next domain (and here the framework takes us from the actions of conceptualizing a leadership project from an immediate "tactical" perspective to the "strategic" or organizational/systems perspective) suggests that good leadership determines which organizations and groups must "be on side" for implementation success, and then connects with them (*Develops Coalitions*). The final step in leadership (before the cycle begins again) is implementing change on a system-wide scale: *Systems Transformation*. Thus an individual leader, when employing the leadership practice guidelines of the LEADS framework, can move a proposed change that is little more than a "gleam in the eye" to a major systemic change aimed at improving service delivery in health.

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Essentially, the framework expects that a good leader must answer five key questions for success as they move through a major change initiative:

1. Why am I leading, and how do I prepare myself to do so?
2. Who do I need to engage in order to take the first steps forward, and how might I do that?
3. What results do I (we) want to create and do I have the skills to ensure they are achieved?

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4. Which organizations or groups do I need active participation from in creating those results?

5. What changes/actions do I need to take so as to maximize the potential for meaningful change, in my organization and/or system?

The Value of the LEADS framework in BC: A Foundation for the *Leaders for Life* Program

Feedback from individuals and organizations who have seen the communication materials used to express this framework[41] suggested that the LEADS model was clear and simple enough to be accessible to the average health leader (i.e, they could use it in the context of their work). In other words it appears to have face validity; in that it mirrors, at first glance, people's immediate conceptions of quality leadership. It also has construct validity in that it is consistent with both the literature and existing competency frameworks.

The framework—in its high level and detailed form—is being used as a foundation for shaping the content and focus of the various programs *Leaders for Life* is developing.

Initially there were some concerns expressed that the "management" capabilities were assumed rather than explicit in the language of the framework. To address this concern, the framework was developed to greater levels of detail to identify the management skills associated with each of the domains of effective health leadership.[42]

Given these attributes, the LEADS framework was adopted by the *Leaders for Life* Program. The framework—in its high level and detailed form—is being used as a foundation for shaping the content and focus of the various programs *Leaders for Life* is developing, and for the programs it chooses to endorse so as to promote leadership development in BC. It is also being used as a framework to guide selection processes for individuals who wish to take advantage of the *Leaders for Life* scholarships for leadership development; and is the basis for the creation of a 360 assessment instrument that will assist each *Leaders for Life* participant to get a clear picture of where they wish to develop their leadership capability; and who wish to follow a self-directed, or program-driven path to improved performance as a leader.[43]

The developers of the *Leaders for Life* Program had no desire to compete with existing health authority efforts at leadership development; indeed, they wanted to complement them.

This was especially important to the *Leaders for Life* Program because its developers were very conscious of the fact that the programs they were developing to support leadership development in the BC health sector needed to be adding value to what already existed in the system. The developers of the *Leaders for Life* Program had no desire to compete with existing health authority efforts at leadership development; indeed, they wanted to complement them. In that regard, value could be added by developing a framework of leadership that shows common expectations of effective leadership, applicable across all health entities. If this framework was cutting

edge, reflective of emerging research, and valid and reliable, then it could inform individual health authorities of where their existing frameworks might be bolstered. A second value was its ability to cohere conceptions of leadership across a system: in other words, to engender discussions and practices of leadership across existing silos and boundaries such that connections can be made more easily. And a final component of value for an overarching framework was its utilitarian value: i.e., a framework that could be integrated into day-to-day decision making as it pertains to the exercise of leadership, and of course, to guide leadership development activities wherever possible.[44]

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There are three examples of evidence that speak to the value created by the LEADS framework project. At the time of writing, two health authorities had employed the Senior Executive LEADS framework document[45] to guide the selection process employed for the filling of senior executive positions vacant on executive teams. In another instance, it was used as the framework to be used to evaluate a senior executive. The Ministry of Health in BC has used the LEADS framework for developmental purposes for its executive. In a fourth instance, a Health Authority adopted the high level LEADS framework as its overarching leadership/management framework; and then, in conjunction with *Leaders for Life*, conducted a study to define what the five LEADS domains looked like in action for four groups of managers: senior executives, mid-managers, front line supervisors and employees.

The Importance of an Integrating Framework for BC Health Systems Leadership

One of the biggest challenges facing the research team at the outset of the LEADS project was to ensure that the resulting expression of health systems leadership would be supported by, and to a significant extent congruent with, expectations in each of the health authorities and agencies in the health system in BC. After all, individual health authority frameworks represented key attributes of leadership and/or management deemed vital for success in that health authority's context. For them not to see the contribution the LEADS framework might make to embellishing their own frameworks, or not to see the potential contribution an overarching framework might make by creating a unified view around exceptional health leadership in BC, would doom this project—and the *Leaders for Life* Program more generally speaking—to failure. At the same time, it was important that the framework represented exceptional health leadership as described in the literature and similar international projects; and that it was seen to represent the attributes leaders require *today* to address system challenges. And it was noted, too, that small health agencies did not necessarily have a framework to define leadership, and

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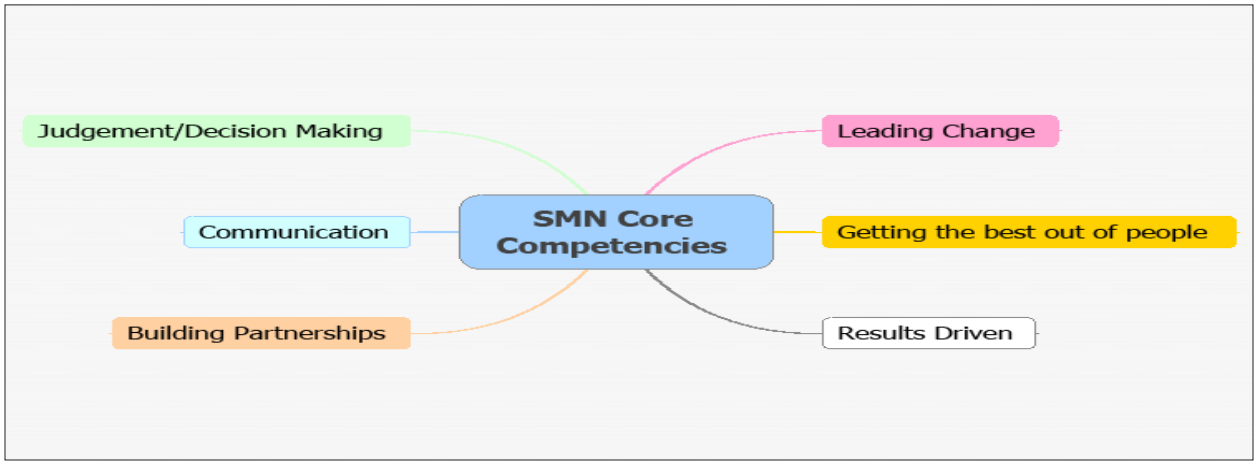
in that instance, an overarching framework such as LEADS would be of direct benefit to those organizations.

In all of these instances, however, cooperation and collaboration with the health authorities and other key agencies in the health sector in BC was required. So to develop a competency framework using methods that were in and of themselves cooperative was important so as to not alienate different health agencies from cooperating with the overall *Leaders for Life* Program. Thus the action research approach taken to the project. Secondly, the LEADS framework must demonstrate—as the first project out of the *Leaders for Life* gate—that it was in and of itself, adding value to the system, and that it would continue to do so.

As the project progressed, it soon became apparent that there was some consternation amongst representatives of the health authorities who were invited to assist with the LEADS framework's development. Some representatives could not initially see how such an overarching framework could be developed and used such that it would not encroach upon their own independence and autonomy. Views and perspectives on the use of, and meaning of, such competency frameworks differed from health authority to health authority. The potential of imposition of such a framework on them—given the climate of centralism prevalent in the minds of many in BC—was very real.

To resolve this issue, the research team tabled a leadership competency model from the United Nations to act as a guide to resolution. In order to align the competencies of individual UN organizations with the six core competencies of their Senior Managers Network (SMN: http://www.unssc.org/web/programmes/ML/smn/, accessed on June 10, 2008) the UN uses a "mind map" approach (see Figure 2 below).

Figure 2: The United Nations Competency 'Mind map' starting web page.



This approach was followed to show the linkages between the LEADS framework and the six provincial leadership competency frameworks (see Appendix C for a chart showing the linkages). To use the LEADS capabilities online map you click the relevant LEADS domain and are sent to a page that has a detailed definition of the components of that domain, and then a number of competency statements from different health organizations, such as the Fraser Health Authority, or the Provincial Health Authority, relating to that core capability. For example, for the domain of "Leads Self" the Fraser Health Authority has five statements, one of which is "strives for personal mastery—participates in life long learning", which maps to the "Develops Self" sub-domain of the Leads self capability. You can observe each health authority's connection to the LEADS framework by clicking on the domains and viewing the agency's definition and the indicators that demonstrate alignment with the LEADS core capability.

LEADS: a capabilities framework, as opposed to a competency framework

The reader might have noticed that throughout this paper we are referring to the LEADS framework as a Health Systems Leadership and Management *capabilities* Framework, not a *competencies* framework. Early on in this project a decision was made to define exceptional health system leadership as *capabilities*, not *competencies*. *Competency* implies the bare minimum required to do the job; whereas *capability* includes competence but also implies the capacity for more. Also, the literature suggests that *competencies* are inconsistent with the nature of leadership—especially transformational leadership.[46] [47] For example, Henry Mintzberg advocates moving from the traditional managerial language of "competencies" to leadership "capabilities" going beyond "functions" (i.e., competencies) to "mindsets"(capabilities) of leadership.[48] This approach suggests that while a *description* of what good leadership looks like is possible, a "best practice" *prescription* common to each individual is not.

Early on in this project a decision was made to define exceptional health system leadership as *capabilities*, not *competencies*.

The *capability* versus *competency* distinction is very important to position the LEADS framework for the philosophy of self-directed leadership development that underpins the *Leaders for Life* Program. This philosophy acknowledges as does Kouzes and Posner[49] that "Leadership is an art, a performing art, and the instrument is the self." This approach suggests that individuals need to choose a behavioural attribute or skill that they need to develop that is consistent with their own talent, character and personality; and that what that looks like for one individual as a "best practice" will differ from another, even in a similar situation. Research has also shown that learning goals that are generative and process-oriented are more powerful than performance goals that are outcome-based.[50] The LEADS framework takes a form of the former, rather than the latter.

Also, the term *capabilities* is typically used in the business literature to refer to both a collective cultural ability of an organization or business, as well as an individual ability. The term *competency* is usually used to refer solely to an individual's ability.[51] In the LEADS framework, we wished to emphasize the both the *individual* qualities and the qualities of *leadership culture* that need to exist and permeate the whole Canadian health system, consistent with the concept of distributed leadership.[52] As stated in the LEADS brochure,

> *Anyone—regardless of their role, or the position they occupy in the health system—must be able to lead themselves, engage others, achieve results, develop coalitions, and conduct systems transformation. For each of the LEADS domains, "effectiveness" differs, depending on the context, or arena of action, in which an individual can exert influence. To create a leadership culture, each person in the system, regardless of position or title, must exercise leadership when it is required. This is distributed leadership.*

A final practical reason to use the term *capability* versus *competency* is to brand the LEADS framework as an overall "guide" to effective leadership practice, one that is distinct from the specific challenges of effective leadership within a specific employer's context. One cannot define a set of leadership competencies that are common to all health authorities and professional organizations. Rather, one can build a description of the broad capabilities that good leadership must create within a specific systems context that is consistent with the overall mandate and purpose of the BC health system. Then if it so desires, individual organizations can apply those capabilities to their unique situation and circumstance.

A final practical reason to use the term *capability* versus *competency* is to brand the LEADS framework as an overall "guide" to effective leadership practice.

Conclusion

This paper describes a complex and significant project that has identified a set of five "BC Health Systems Leadership & Management Capabilities" that are the foundation of the BC *Leaders for Life* Program. The LEADS Framework, as this foundation is called, outlines four attributes of effective leadership in each of the five domains. It represents the distillation of input from

- key informant interviews of senior and mid-level leaders from all health authorities in British Columbia;
- content from existing provincial and national health leadership and management frameworks; and
- contributions from the research into effective leadership.

The process used to develop the framework was a collaborative and inclusive one, aimed at ensuring that the product was valid, reliable, and utilitarian: i.e., that it could be used for the purposes intended. The LEADS Framework was intended to be used as criteria for selection and assessment for individuals to enter and move through the *Leaders for Life* Program; to serve as a curricular guide as to content of *Leaders for Life* endorsed and developed programs; and to cohere the BC health system around a set of leadership attributes that define the culture of what a highly functioning health system be like. Progress has been made—now what remains to be determined is the overall impact of such a developmental process on the future of the BC health system itself.

The process used to develop the framework was a collaborative and inclusive one, aimed at ensuring that the product was valid, reliable, and utilitarian.

End Notes

1 Goodwin, N. (2005) *Leadership in health care: A European perspective*. United Kingdom: Routledge Publishing. House, Hanges, Javidan, Dorfman, and Gupta (Eds.) (2004). *Culture, leadership and organizations. The GLOBE study of 62 societies*. London, UK: Sage. International Initiative for Mental Health Leadership (2007) *Leadership Training Programs and Competencies for Mental Health, Substance Use, Health, and Public Administration in Eight Countries*. Boston MA USA: Suffolk University; and Dickson, G., Briscoe, D., & Rowlands, G. (2005). *Leadership Without Ownership: Developing Strategic Leadership For Health Reform*. An unpublished White paper for discussion in the BC Health System. Royal Roads University at Victoria, Canada.

2 Boaden, Ruth. (2005) 'Leadership development: Does it make a Difference?' *Leadership & Organization Development Journal*, 27, 1. 5-27; Degeling. P and Carr, A. (2004). 'Leadership for the systemization of health care: the unaddressed issue in health care reform.' *Journal of Health Organization and Management*, 18, 6, 399-414; and Dickson, G. and Briscoe, D., Fenwick, S., Romilly, L., MacLeod, Z., (2007). *The Pan-Canadian Health Leadership Capability Framework Project: A collaborative research initiative to develop a leadership capability framework for healthcare in Canada*. A Final report submitted to Canadian Health Services Research Foundation, Ottawa, Ontario. Accessed on 31/07/08 at http://www.chsrf.ca/pdf/Health_Leadership_Framework_E.pdf.

3 Gouvernement du Québec (2008) *Getting Our Money's Worth*, Summary Report of the Task Force on the Funding of the Health System. Accessed on 01/08/08 at http://greatdivide.typepad.com/across_the_great_divide/files/SommaireENG_FinancementSante.pdf

4 Leatt P., & Porter J. "Where are the Healthcare Leaders? The need for investment in leadership development." *Healthcare Papers* 4(1):34-6. (http://www.longwoods.com/hp/4-1Leaders/HP41Leaders.pdf); Penney, C. (2007) *Report of the Canadian Health Leadership Network (CHLNet) Summit*. Ottawa: Canadian Health Services Research Foundation. Accessed on 02/08/08 at http://www.chsrf.ca/research_themes/pdf/CHLNet_Summit_Report_2007_e.pdf. and Leeb, K., Zelmer, J. and Taylor, B. (2005). 'CIHI Survey: Canada's Health System: Transitions in Leadership.' Healthcare Quarterly, 8, 1, 33–34.

5 Lewis, S. (2007, June) '*Learning From the Best and Learning From the Worst: What the World Can Teach BC About Improving Health and Health Care*.' Presentation at the International Symposium on Health Innovation, British Columbia Conversation on Health. Vancouver, Canada: and Romanow, R. (2007, June). *Canada's Health Temperature*. Justice Emmet Hall Memorial Lecture. Presentation to the National Healthcare Leadership Conference, Toronto, Canada. Roy Romanow is a former Premier of Saskatchewan who was commissioned in 2002 to conduct a Royal Commission on the state of the health care system in Canada.

6 See Ward, Tom. (2007). *A Background and Commentary to The Conversations on Health*. An unpublished paper prepared for The Centre for Health Leadership and Research Royal Roads University. Victoria: British Columbia (October).

7 Leaders for Life, (2008) *Shaping Health with Vision*. Accessed on 31/07/08 at http://www.leadersforlife.ca/.

8 Rowlands, G. (2007). *Leaders for Life: Shaping Health with Vision*. A presentation at the Health Care Leaders of BC Annual Conference, Vancouver, BC (October). Conditions for the grant were that HCLABC had three years to work on a "proof of concept"—that is, to demonstrate that a leadership development program could be designed that would attract leaders to it for further development, and that would show that investing in leadership development can indeed address the leadership gap. For the current state of the program or further information, see the Leaders for Life website (http://www.leadersforlife.ca/); accessed on December 7, 2007.

9 Geoff Rowlands (2004), Chief Executive Officer of the Health Leaders Association of British Columbia, Personal communication December 7. Clark, J. (2008) Director, International programs, Institute for Innovation and Improvement. *Personal Communication*, April 29; and NHS Institute for Innovation and Improvement (2008). *Medical Leadership Competency Framework—Homepage*. Accessed on 02/08/08 at http://www.institute.nhs.uk/assessment_tool/general/medical_leadership_competency_framework_-_homepage.html.

10 See Dickson, G., Briscoe, D., & Rowlands, G. (2005). *Leadership Without Ownership: Developing Strategic Leadership For Health Reform*. An unpublished White paper for discussion in the BC Health System. Royal Roads University at Victoria, Canada.

11 The foundational paper outlining this project was produced by the Centre of Health Leadership and Research at Royal Roads University (2006), entitled *British Columbia Health Leadership Enhancement Initiative: The BC Health Leadership Competency Framework Project*. An unpublished working paper, Royal Roads University. The LEADS acronym and framework are detailed further on page 9.

12 Geoff Rowlands, Chief Executive Officer of the Health Leaders Association of British Columbia, personal communication.

13 For example, the Berwick Institute for Health Improvement; the Gallup corporation's work on engagement; and Jim Collins' study profiled in the book Good to Great, are often referred to as providing guidance to quality leadership. In the latter, Collins defined what quality leadership is: humility, combined with a fierce commitment to "big hairy audacious goals:, facing up to "brutal truths" and then moving forward; and Berwick focuses in on the leadership strategies for meaningful organizational development. Also, the Canadian Medical Association's PMI program (five modules, PMI standing for Physician Management Institute) extensively utilizes articles from the Harvard Business Review as resources for their programs.

14 Goffee, R. & Jones, G. (2000). Why Should Anyone Be Led by You? *Harvard Business Review*. September-October. They suggested that good leaders demonstrated vulnerability at select times, were willing to practice what they call "tough empathy", gathered intelligence well, and "dared to be different". But which of these qualities—if any—translate into a health environment, and indeed, are applicable across the health system? And especially, the Canadian health system?

15 One recent Canadian study into leadership—but not specific to the health sector—is by to be found in the book by Amal Henein and Francoise Morissette (2007) entitled *Made in Canada Leadership: Wisdom from the Nation's Best and Brightest on the Art and Practice of Leadership*. Toronto: Jossey-Bass.

16 There were four key speakers at the symposium: brought in to stimulate discussion and to "model" the kind of leadership that was being discussed. They were John Clark, from the UK's leadership development program; Bill Tholl, CEO of the Canadian Medical Association, Dr. Penny Ballem, Deputy Minister of Health in BC; and Lise Mathieu, Brigadier General from the Canadian Forces Health Services. Their talks were interspersed throughout two days of interactive sessions. For example, an open space activity was used on the first day of the symposium to gather from the participants their concepts and ideas about what the qualities of strategic leadership are that are needed for health care reform in this province to be successful.

17 See the white paper referenced as follows: Dickson, G., Briscoe, D., & Rowlands, G. (2005). *Leadership Without Ownership: Developing Strategic Leadership For Health Reform*. An unpublished White paper for discussion in the BC Health System. Royal Roads University at Victoria, Canada.

18 With this foundation, Geoff Rowlands, Executive Director of the Health Care Leaders' Association of British Columbia, tirelessly lobbied senior executives within the BC health sector, and the senior executive of the Ministry of Health, to leverage some funding to support the proposed action plan. In January, 2005, he was successful: $3.0 million was granted from the BC Ministry of Health to support development of a province-wide leadership development plan: with a three year window to develop a proof of concept; that is, a strategy and action plan for leadership development that would be accepted by the BC health system; that would be proven to be successful in generating the leaders that are required; and that would be supported by the various partners in the BC health system.

19 Kouzes, J. M. and Posner,. B. (2003). *The Leadership Challenge*. San Francisco: Jossey Bass.

20 Ward, Tom. (2007). *A Background and Commentary to The Conversations on Health*. An unpublished paper prepared for The Centre for Health Leadership and Research Royal Roads University. Victoria: British Columbia (October).

21 Yukl, G. (1998). *Leadership in Organizations*. New Jersey: Prentice-Hall (p. 54–56). Robert Blake and Jane Mouton in 1964 developed the managerial grid theory to describe managers in terms of concern for people and concern for production, and they proposed that effective managers have a high concern for both.

22 Weiss, D.S. & Molinaro, V. (2005). *The leadership gap. Building leadership capacity for a competitive advantage*. Wiley and Sons: Mississauga ON.

23 National College on School Leadership, (2003). *Distributed Leadership*. http://www.ncsl.org.U.K./media/3C4/A2/distributed-leadership-literature-review.pdf#search=%22 National % 20 College%20on%20School%20Leadership%20and%20distributed%20leadership%22. Accessed September 24, 2006.

24 Quinn Patton MQ & Quinn Patton MQ. (1997). *Utilization-Focused Evaluation: The New Century Text*. 3rd Edition, Sage Publications, January. p. 63; (italics in the original)

25 Briscoe, D. & Romilly, L. (2006). A Competency Framework for BC Health System Leadership: A Literature Review. An unpublished working paper. Royal Roads University (August).

26 Dickson, G. & Hamilton, D. (2006). *Twenty-first Century Leadership Development*. B.C. School Leadership e-journal. Edition 5: May. Vancouver: UBC Faculty of Education; and Canadian Medical Association (2006). *Where Preparation Meets Opportunity*. (Brochure). Ottawa: ON, Canada

27 This vision was crafted by the research team after the first meeting in April 2006, when key stakeholders and other interested parties were brought together to help shape the project. It represents the sentiments and results of that meeting.

28 Representation at that symposium was from three health authorities (Interior Health; Vancouver Coastal; Vancouver Island), the BCMA, UBC, RRU, HCLABC, the CMA, and the United Kingdom's National Health Modernization Agency

29 Yukl, G. (1998). *Leadership in Organizations*. New Jersey: Prentice-Hall (p. 54-56). Robert Blake and Jane Mouton in 1964 developed the managerial grid theory to describe managers in terms of concern for people and concern for production, and they proposed that effective managers have a high concern for both.

30 Bass & Stogdill. (1990) *Handbook of Leadership*, 3rd ed., New York, NY: Free Press.

31 O'Toole, James. (1996). *Leading Change. The Argument for Values-Based Leadership*. New York: Ballentine

32 Hodgkinson, C. (1996). *Administrative philosophy*. Oxford, UK: Redwood Books.

33 Contained in the literature review for the LEADS project, previously referenced, was an extensive analysis of existing leadership and management competency frameworks for BC health authorities. See Briscoe, D. & Romilly, L. (2006). *A Competency Framework for BC Health System Leadership: A Literature Review*. An unpublished working paper. Royal Roads University (August).

34 Scottish Leadership Foundation (2007, June). Leadership and Management Framework. (Discussion paper). Edinburgh, Scotland.

35 House, Hanges, Javidan, Dorfman, & Gupta (Eds.) (2004). *Culture, leadership and organizations. The GLOBE study of 62 societies*. London, UK: Sage.

36 See Nasmyth, G. (2006). Healthcare Leadership Competencies Data Analysis Preliminary Report. Unpublished working paper prepared for the Centre for Health Leadership and Research at Royal Roads University (September 7).

37 UN System Competency Map. Found at: http://www.unssc.org/web1/programmes/mldp/sms

38 Covey, S.R. (2004). The 8th Habit. New York: Free Press.

39 Senge, P. (1999). The Dance of Change. New York: Doubleday

40 Leatt P., & Porter J. "Where are the Healthcare Leaders? The need for investment in leadership development." *Healthcare Papers* 4(1):34–6. (http://www.longwoods.com/hp/4-1Leaders/HP41Leaders.pdf)

41 For example, the Leaders for Life LEADS brochure; the on-line model that links key elements of the framework to BC health authority competency frameworks, and national and international frameworks; and the detailed booklet expressing the behaviours required of a senior leader who is modeling the framework in action). In addition, the model has been used at a number of conferences to engage people in discussions of the attributes of leadership needed to move change forward in the health care system, and participants have expressed pleasure at its utility.

42 See *Health Leadership & Management Capabilities Framework for Senior Executive Leaders*. Accessed on-line at http://www.leadersforlife.ca/files/leads-final-for-consultation.pdf. December 6, 2007.

43 The Leaders for Life Program is developing a suite of developmental opportunities for its future members. Some of these opportunities are self-directed and self-managed; i.e., the individual establishes their own plan for learning based on an assessment of their skill set as it pertains to the LEADS Frameworkstandards. Others are pilot programs that have either been developed by Leaders for Life to have curricula based on the content of the LEADS Framework; or that are being developed by others (e.g., UBC, Simon Fraser University, or Royal Roads University) that aim at developing the attributes of the LEADS Framework.

44 Value could also be added—at a later stage of the Leaders for Life Program--by building learning opportunities that address the needs of individuals in the system for which developmental opportunities don't address. An additional way to build value is to develop programs that are too expensive to develop for small numbers of individuals in each health authority (i.e., it may be prohibitive for an individual health authority to develop a developmental program for senior executives if they have only four or five candidates; but if there were 20-30 candidates province-wide, such a program is cost-effective). A common leadership framework is needed to cohere the program so as to be relevant to individuals from a variety of employers in the province.

45 *Health Leadership & Management Capabilities Framework for Senior Executive Leaders*. Accessed on-line at http://www.leadersforlife.ca/files/leads-final-for-consultation.pdf. December 6, 2007.

46 Pawar B.S. & Eastman K.K.. (1997). *The Nature and Implications of Contextual Influences on Transformational Leadership: A Conceptual Examination*. The Academy of Management Review, 22(1) Jan., 80–109.

47 Down C, Martin E, Hager P and Bricknell L. (1999). *Graduate attributes, key competence and judgments: exploring the links*. EPI Group, RMIT and RCVET, University of Technology, Sydney. HERDSA Annual International Conference, Melbourne, 12–15 July.

48 Mintzberg, H. (2004). Managers, not MBA's: *A Hard Look at the Soft Practice of Managing and Management Development*. Barrett-Koehler: San Francisco. Mintzberg pointed out that we need to go beyond 'functions' to 'mindsets'(capabilities) of leadership qualities—5 in his view –managing change/reflective mindset; managing relationships/collaborative mindset; managing organizations/ analytic mindset; managing context/worldly mindset; managing change/action mindset.

49 Kouzes, J. M. and Posner,. B. (2003). *The Leadership Challenge*. San Francisco: Jossey Bass.

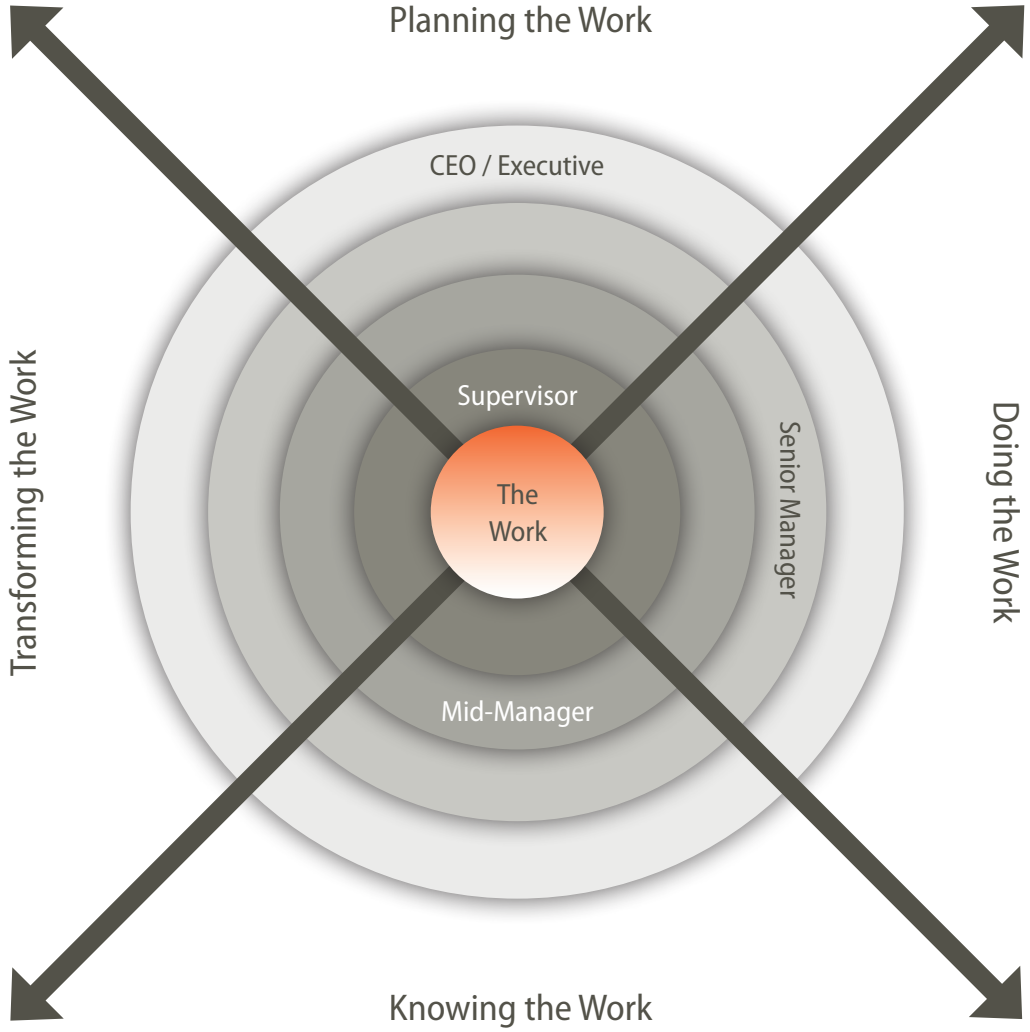
50 Seijts, G.H. & Latham, G.P (2006). *Learning goals or performance goals: Is it the journey or the destination?* Ivey School of Business, The University of Western Ontario. May/June 2006. London: Ontario

51 Kesler GC. (1995) *A Model and Process for Redesigning the HRM Role, Competencies and Work in a major Multi-National Corporation*. HRM Journal, University of Michigan, Summer.

52 Clearly a list of 'best practice' capabilities for health systems leadership has direct relevance to the qualities individuals need to possess. However, the distinction that is being made here is that those qualities are not necessarily specific to each individual. Indeed, it is our contention that each individual should decide, for him or herself, which qualities they might wish to develop, and what those qualities look like as a consequence of his/her own strengths, knowledge and skill; as mediated through the specific organizational context in which they are working.

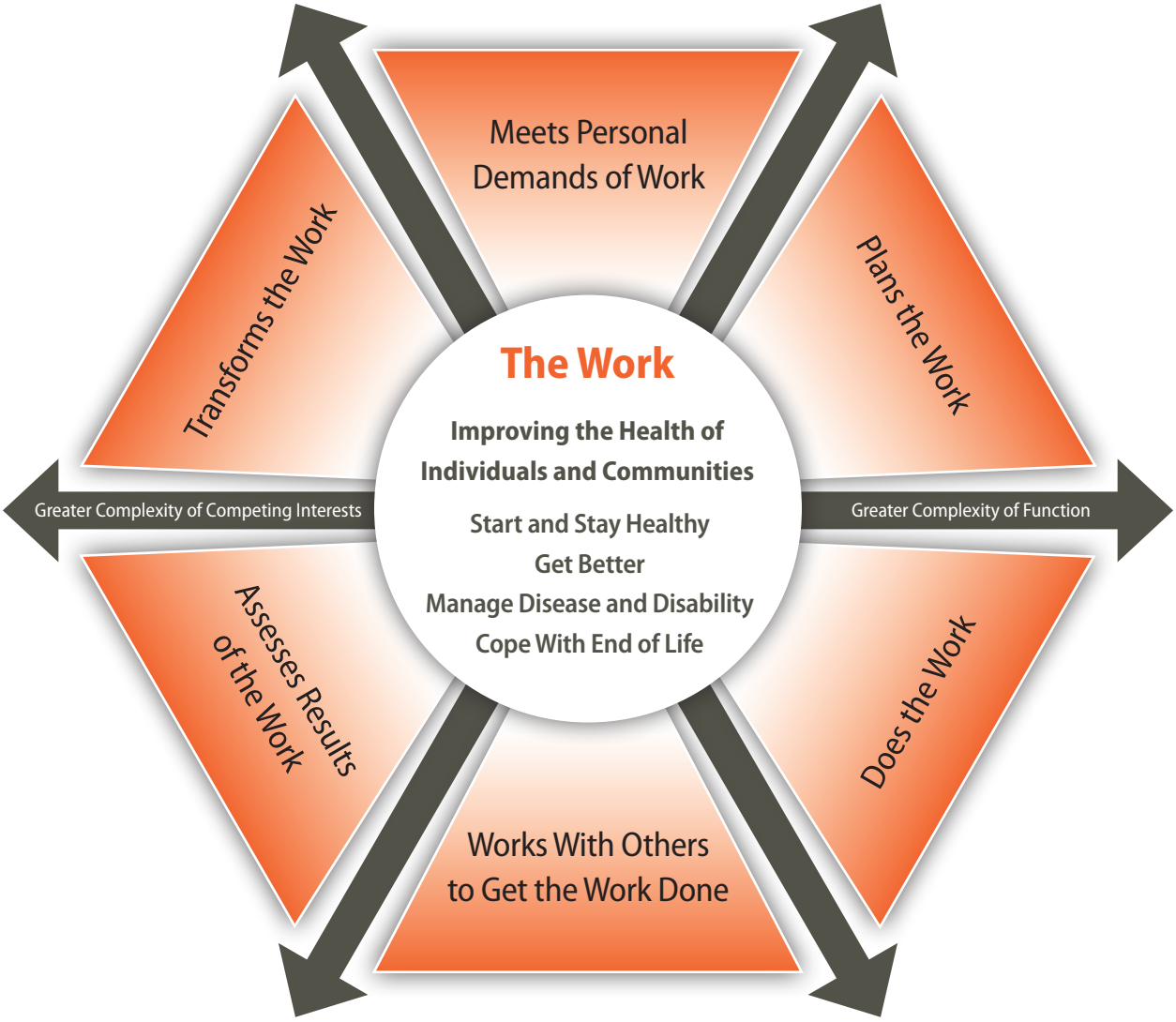
Appendix A: Model 1

Leadership Model for Health Competencies—Initial Conceptual Model



Appendix A: Model 2

Health Systems Leadership Competencies—New Model Based on Feedback



Appendix A: Model 3

Health Systems Leadership Competencies—New Model Based on Feedback

Appendix A: Model 4

Health Systems Leadership Competencies—LEADS Framework

Appendix B: A comparative chart showing linkages between Health Authority competency frameworks and the provincial LEADS framework.

BC Health Leadership Capabilities		FH	IH	NH	Providence	PHSA	VCH	VIHA
Leads Self	Is self-aware	Y	Y		Y	Y		
	Manages self	Y	Y			Y		Y
	Develops self	Y	Y	Y	Y	Y	Y	
	Demonstrates character	Y	Y	Y	Y	Y	Y	Y
Engages Others	Fosters development of others	Y	Y	Y	Y		Y	Y
	Contributes to the creation of a healthy org.		Y	Y				Y
	Communicates effectively	Y	Y	Y	Y	Y	Y	
	Builds teams	Y	Y		Y	Y	Y	
Achieves Results	Sets direction	Y	Y	Y	Y	Y	Y	Y
	Strategically aligns decisions with vision, values & evidence	Y	Y		Y		Y	Y
	Takes action to implement decisions	Y	Y	Y	Y	Y	Y	Y
	Assesses and evaluates			Y	Y	Y	Y	Y
Develops Coalitions	Purposefully builds partnerships & networks to create results	Y	Y	Y	Y	Y	Y	Y
	Demonstrates a commitment to customers&service	Y	Y	Y	Y	Y	Y	
	Mobilizes knowledge			Y	Y	Y	Y	Y
	Navigates socio-political environments	Y	Y	Y	Y	Y		
Systems Transformation	Demonstrates systems/ critical thinking	Y		Y	Y		Y	
	Encourages and supports innovation	Y	Y	Y		Y	Y	Y
	Is strategically oriented towards the future	Y	Y	Y	Y	Y	Y	Y
	Champions & orchestrates change	Y	Y	Y	Y	Y	Y	Y

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