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The Pan-Canadian Health Leadership Capability Framework Project: A collaborative research initiative to develop a leadership capability framework for healthcare in Canada

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The Centre for Health Leadership and Research at Royal Roads University was commissioned by the Canadian Health Services Research Foundation to conduct a qualitative research study into the potential content and format of a pan-Canadian health leadership capabilities framework.

This national project was supported and conducted in collaboration with individuals in the Canadian Health Leadership Network (CHLNet), a coalition of Canadian health organizations.

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MAIN MESSAGES

- The Canadian healthcare system needs strong leadership if it is to be sustainable and responsive to the health needs of Canadians into the future. This need is also emphasized in other countries, such as New Zealand, the United States, Britain and Scotland.
- The recent surge in the number of international and Canadian projects studying various aspects of leadership indicates the interest in understanding and better defining leadership. These projects include ones in Britain, Scotland and Alberta; and those being done by organizations such as the Leaders for Life program in British Columbia (LEADS framework), the Canadian Medical Association and the Canadian College of Health Service Executives.
- Developing stronger leadership is not the same as developing stronger management. Stronger leadership is required because of the complexity of the current health systems environment. Related to this are demands for leaders to respond to rapidly changing environments and to create clear visions as well as corresponding incentives for change.
- In this report, the term *capability* is used (versus competency) because the term best describes individual abilities required in the unpredictable, complex and dynamic context in which leadership is required.
- Three goals must be met to develop stronger leadership: 1) to create a common framework that defines what modern leadership in a complex health system is and establishes a common language for individuals across organizational boundaries or professions; 2) to develop more leaders who embrace those capabilities; and 3) to engage Canadian health organizations (delivery, professional, voluntary and academic) in a concentrated effort to create learning opportunities for people and organizations; to implement succession planning and performance management; and to consolidate resources for leadership development and recruitment.
- Health leaders across Canada support a common framework built on three components that must be considered in designing or evaluating activities that aim to foster excellence in leadership. The first component is who the leaders are, their individual values and beliefs (being). The second is the dedication of the leaders to health (caring). The third is what the leaders do (doing). These three components form the basis for five domains of exceptional leadership capabilities. In this framework, it is proposed that exceptional health leaders **CHAMPION caring; CULTIVATE self and others; CONNECT with others; CREATE results; and CHANGE systems.**
- From the perspective of health leaders, the strengths of the framework are its emphasis on the purpose of healthcare (champion caring); its focus on key requirements of successful health systems leadership such as self-knowledge (cultivate self and others); accountability (create results); knowledge mobilization (change systems); and coalition-building across a complex system (connect with others).
- The authors recommend a number of actions to further validate the framework and consider adaptations for use in different contexts.

EXECUTIVE SUMMARY

In spring 2007, a research team based at the Centre for Health Leadership and Research at Royal Roads University conducted a qualitative research study into the potential content and format of a pan-Canadian health leadership capabilities framework.

GOALS

The goals of this study were to:

- articulate the leadership capabilities for a highly functioning Canadian health system;
- test the extent to which the pan-Canadian framework might be endorsed by a range of Canadian health organizations; and
- engage decision makers in discussions about the potential utility of a pan-Canadian framework as a foundation for creating efficient collaborative leadership development opportunities.

RESEARCH FOCUS

Three research questions guided the study:

1. What common capabilities can be identified that describe effective health leaders/managers in the current Canadian healthcare system?
2. Which capabilities are "traditional" ones that should be sustained and which would be considered "new emerging" requirements?
3. How should the framework be utilized or adapted to respect unique contexts in which leadership is needed, such as in aboriginal groups, remote communities and provinces?

ASSUMPTIONS

Four main assumptions shaped the conduct of this study:

- leadership is different from management;
- effective leadership is best characterized as capabilities, rather than competencies;
- effective leadership can be defined and deliberately developed and measured; and
- the capabilities framework must be designed so its intended audience can use it in the intended way.

APPROACH

To prepare this report, a research team adopted a qualitative, action-research approach to gather data from three sources: 1) in-depth interviews with key informants and 10 focus groups across the country with health leaders of major provincial or Canadian health organizations (health authority decision makers, policy makers, clinical leaders and professional organization leaders with representation from a range of age groups); 2) a review of peer-reviewed and grey literature on types and qualities of leadership in public and private organizations, including the health sector, as defined or expressed for the purpose of developing leaders; and 3) analysis of competency/capability frameworks from selected international (United States, Britain, Scotland), Canadian provincial (British Columbia and Alberta) and organizational jurisdictions (Canadian College of Health Service Executives, Canadian Medical Association). In this study the term capability is defined as individual abilities required in the unpredictable and dynamic contexts in which leadership is required.

FINDINGS

The findings of the study suggest that there are three components of exceptional leadership. The first component is who the leaders are, their individual values and beliefs (being). The second is the dedication of leaders to health (caring). The third is what leaders do (doing). These three components interact in the health system to form the basis for five domains of exceptional leadership capabilities, each with four sub-domains. Exceptional health leaders:

CHAMPION caring

- Inspire and encourage a commitment to health
- Show respect for the dignity of all persons
- Act with compassion
- Exhibit fairness and a sense of justice

CULTIVATE self and others

- Demonstrate self-awareness and self-management
- Exhibit character: honesty, integrity, optimism, confidence and resiliency
- Enable others to grow
- Create engaging environments where people have meaningful opportunities to contribute

CONNECT with others

- Communicate effectively with a wide variety of stakeholders
- Build effective multi-disciplinary teams
- Develop networks, coalitions and partnerships
- Navigate socio-political environments successfully

CREATE results

- Develop a shared vision and translate it into action
- Hold themselves and others accountable for results
- Integrate quality improvement and evidence into decision-making
- Manage resources responsibly and creatively

CHANGE systems

- Build personal and organizational understanding of the complexity of health systems
- Mobilize knowledge to challenge processes and guide change
- Lead changes consistent with vision, values and a commitment to health
- Orchestrate changes to improve health service delivery

An additional finding relates to the question, "Which capabilities are 'traditional' ones that should be sustained and which would be considered 'new emerging' requirements?" The *5 C model* contains new capabilities that are necessary for modern health systems leadership. For example, "caring" is given greater emphasis than in traditional health leadership competency frameworks (see Appendix F). The "champion caring" capability includes a strong commitment to caring and health. A commitment to health fits with a focus on healthcare outcomes for patients and clients and also with a renewed focus on population health, healthy workplaces and healthy individuals. A second domain of the framework — "connect with others" — is also more prominent in this framework than in competency frameworks in other sectors. This capability emphasizes the challenge of aligning the interests

of stakeholder groups and individuals from professional bodies and the public and recognizes the massive size and diversity of organizations and individuals in a health system, all of whom must work together in some way for the system to work. Other qualities of leadership that emerged as more important in the current context are in the "create results" and "change systems" capability domains. Specifically, "hold themselves accountable for results" was identified as needing greater emphasis, as was "build personal and organizational understanding of the complexity of health systems" and "mobilize knowledge to challenge processes and guide change."

A third finding relates to the question, "How should the framework be utilized or adapted to respect unique contexts in which leadership is needed, such as in aboriginal groups, remote communities and provinces?" We suggest two approaches. The first is for organizations to use this framework as a unifying umbrella that defines leadership capabilities common to all. The second is to adopt the conceptual approach of the United Nations System Competency Map (which aligns the competencies of individual UN organizations with the six core competencies of their Senior Managers Network) to create a pan-Canadian health system leadership map that connects major provinces and organizations who wish to align their competency frameworks with the pan-Canadian one.

IMPLICATIONS

The consultation conducted as part of this project suggests that there is initial support from a diversity of stakeholders across the country for the concept of a pan-Canadian capabilities framework. It also suggests there are new, emerging expectations of quality leadership that are not well-articulated in existing competency frameworks. It indicates there is significant value – from the perspective of creating a common language, consolidating resources for leadership development purposes, and the need for change within the Canadian system – for organizations to expect leaders to exhibit these qualities in the future. This framework has the potential to engage Canadian organizations and agencies in a collaborative endeavour to develop leadership; encourage collaboration across the health system on succession planning, performance management and combining resources for leadership development and recruitment; and to attract greater resources and energy to leadership development and leadership research. Collectively, these strategies can address the leadership gap in the health system by attracting more people to leadership positions and ensuring that those leaders have the capabilities required to do the work expected of them.

RECOMMENDATIONS

As an integral component of the activities undertaken by the newly established Canadian Health Leadership Network (CHLNet), it is recommended that:

1. a co-ordinated knowledge mobilization strategy be undertaken to disseminate and further validate the framework throughout the Canadian health system;
2. an approach be adopted to align these capabilities with those of existing provincial, national and/or international health capability/competency frameworks, similar to the UN system competency map. This is important so each individual organization can see its own standards of effective leadership as connected to the needs of the Canadian health system as a whole;
3. a series of leadership dialogues be undertaken across the country to discuss leadership in healthcare and the potential value of this framework;
4. a second-stage research project be commissioned to focus on the applicability of the framework to specific contexts, such as aboriginal settings, selected provincial settings or within small, independent agencies that have few resources to invest in leadership development; and

5. additional research on the ability of this framework to build capacity be conducted. The job of leadership is to build capacity by maximizing the use of existing talents and resources to accomplish the purposes of a system. Such research might include determining whether or not organizations that demonstrate the five Cs of leadership capability are more productive than those that don't; analyzing and describing deliberate efforts to apply the framework to implement health systems change; and evaluating how effective development programs are.

CONCLUSION

This project resulted in a draft pan-Canadian health system leadership capabilities framework and undertook preliminary testing of its acceptance and validity through consultation with a range of individuals and organizations across Canada. The study found initial support for both the value of and the content of the framework proposed by this study; its implementation could contribute to efforts to resolve the current leadership gap in the Canadian health system.

CONTEXT

Nationally and internationally, people are examining what makes leaders exceptional and what are the critical competencies or capabilities leaders require to lead and transform modern organizations. The need for stronger leadership for the Canadian health system to adapt and grow into the future has been articulated by a number of individuals and health agencies across Canada in the past two years, including the development of the LEADS capabilities framework in British Columbia.[1, 2, 3, 4, 5] Other sectors and jurisdictions in the western world (such as the National Health Service in the United Kingdom and the National Centre for Healthcare Leadership in the United States) have also recognized the need to modernize leadership and ensure that there are sufficient numbers of qualified leaders to meet the demands of the future.[6, 7, 8, 9, 10] In Canada, health sector, professional association and education leaders are working together in the Canadian Health Leadership Network (CHLNet) to promote a co-ordinated approach to developing high-quality health system leadership.[11] A priority for CHLNet is a pan-Canadian health systems leadership capabilities framework, which expresses the collective views of Canadian healthcare organizations about what exceptional health systems leadership looks like in Canada.*

In the spring of 2007 the Centre for Health Leadership and Research at Royal Roads University conducted a national qualitative research study, in collaboration with individuals in CHLNet, to explore the potential content of a pan-Canadian health leadership capabilities† framework. This work was to build on previous work developing a provincial healthcare leadership capabilities framework with the Health Care Leaders' Association of B.C.‡

PURPOSE

The point of defining a common set of capabilities for health system leaders in Canada is to enable various organizations and agencies to set in motion an array of co-ordinated and mutually beneficial opportunities for people and organizations to develop those capabilities. A clear model of exceptional leadership, endorsed by all agencies in Canada, can help aspiring leaders answer the following questions:

- What kind of leadership (in the form of capabilities) is required to manage and lead the Canadian health system into the future?
- How might these leadership capabilities take shape in my organization?
- What expectations or definitions of best practice do they suggest for me and my organization?
- What do these leadership capabilities look like in my specific role or in the context in which I work, and what guidance do they give me in setting direction for my career growth and/or my professional growth?
- What programs can be designed and delivered to ensure efficient and effective capacity-building in leadership within the Canadian health sector?

In addition, the framework might encourage collaboration across the system on succession planning, performance management, leadership development and efficient and quality recruitment in the Canadian health sector, while at the same time reducing redundancies and combining resources in support of leadership development. A final intended use is that the framework will provide a common language so that individuals conducting projects across organizational boundaries or professions can have a common understanding about quality leadership.

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* At a conference held in Ottawa on May 22, 2007, approximately 100 senior leaders from various agencies across Canada came together to provide input into CHLNet's functions and milestones. As part of that exercise, it was identified that the creation of a pan-Canadian health systems leadership capabilities framework was a desirable outcome within the first year of the coalition's proposed life.

† The term capabilities replaced the term competencies at the point of writing this report.

‡ See the B.C. LEADS Capabilities Framework at www.leadersforlife.ca/files/leads-brochure.pdf.

FORMAT OF THE REPORT

The key research questions, refined in the course of the study, were:

1. What common capabilities can be identified that describe effective health leaders/managers in the current Canadian healthcare system?
2. Which capabilities are "traditional" ones that should be sustained and which would be considered "new emerging" requirements?
3. How should the framework be utilized or adapted to respect unique contexts in which leadership is needed, such as in aboriginal groups, remote communities and provinces?

Developing the capability framework for the Canadian health system built on work done in British Columbia (the LEADS project for the Health Care Leaders' Association of B.C), with additional data generated by collaborating with key individuals and organizations in CHLNet and other organizations across Canada. Part of the project was to investigate whether or not a single pan-Canadian competency framework defining exemplary leadership and management in health could be endorsed by a broad span of Canadian health organizations and to present the preliminary results of this work at a national invitational health leadership summit.

ASSUMPTIONS/PARAMETERS DEFINING THE STUDY

A number of assumptions and parameters helped to define the study.

The four main assumptions are:

1. *Leadership is different from management.*[12] Leadership is the quality we look for to guide us through change in complex environments with uncertain futures and changing/competing societal values. In these environments leadership that is values-based and focuses on gathering support from people is essential to guide organizations into the future. Management, on the other hand, is the quality we utilize in simple and/or complicated environments, characterized by contexts with a somewhat predictable future, addressing problems we have seen before and grounded in essentially stable social values. In these environments, the manager's task is primarily a matter of organizing, planning and controlling resources to build that future. 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 is needed to set direction and management to help us get there. Yet, when the competency frameworks that define expectations for individuals in senior leadership or management positions in health authorities were reviewed, there was a significant emphasis on management qualities and less on leadership qualities. This project was designed to create a balance that is appropriate in today's health environment.
2. *Effective leadership is best defined as capabilities, not competencies.* Early on in the study a decision was made to refer to exceptional health system leadership as *capabilities*, not competencies. There were both conceptual and practical reasons for this. A first conceptual reason is that Webster's Dictionary defines *competent* as properly or sufficiently qualified, adequate for the stipulated purpose. *Competency* implies the bare minimum required to do the job, whereas capability includes competence but also implies the capacity for more.

   A second conceptual reason is that the literature suggests that *competencies* are inconsistent with the nature of leadership – especially transformational leadership.[13, 14] For example, Pawar and Eastman (1997) state "...the effectiveness of a transformational leader is likely to be a result of three aspects...: how receptive the organization is; how closely aligned the required and actual transformational processes are, and the ...transformational leaders' *capabilities* required to carry out the appropriate transformational process" (italics not in original; p. 85).[15] Similarly, Henry Mintzberg

advocates moving from the traditional managerial language of competencies to leadership capabilities; going beyond functions (that is, competencies) to mindsets (capabilities) of leadership.§ [16] 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.

A third conceptual reason to use *capabilities* is that this term 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 tends to refer solely to an individual's ability.[17] In this study, we wished to emphasize both the *individual* qualities and the qualities of *leadership culture* that need to exist and permeate the whole Canadian health system.**

In addition, there were two practical reasons to make the shift in language from competency to capability. First, a number of the participants in the study found it difficult to use the term *competency* to refer to leadership. In the view of many, the term *competency* is most appropriately used in a training context, referring to predictable behaviours (often primarily skill- and knowledge-based) that define what an individual should do in a simple or complicated environment. Individuals are expected to exhibit a set of behaviourally specific outcomes that are common to all.* The second practical reason is implicit in the challenge of this study: creating a pan-Canadian framework for leadership. One cannot define a set of leadership competencies that is common to all organizations. Rather, this study takes the approach that 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 Canadian health system; and then if they so desire, individual organizations can apply those capabilities to their unique situations and circumstances.

3. *Effective leadership can be defined and deliberately developed.* For some, leadership is a quality that exists, like beauty, but cannot be captured or defined. One senior person used the analogy that "leadership is like fog: you can see it, you can feel it — but you can't grab on to it." There is also the old adage, "Leaders are born, not made." Both of these, however, are inconsistent with current research and inimical to the challenge of addressing the health leadership gap. In the past 10 years there was a plethora of research that defines leadership and many attributes of quality leadership. (A recent literature review which builds on an extensive one done for the B.C. project and underpins this work can be found in Appendix F.) 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.[18, 19, 20]

4. *The capabilities framework is intended to have a practical impact on the leadership gap.* There are three ways to address a leadership gap. 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. 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.[21] The purpose of a capabilities framework for health system leadership is to stimulate all three of these opportunities. A framework that cannot be used is of little value. Therefore, a fundamental assumption underlying

§ Henry Mintzberg in his book *Managers, Not MBAs* pointed out that we need to go beyond functions to mindsets (capabilities) of leadership qualities, of which there are five in his view: managing change/reflective mindset; managing relationships/collaborative mindset; managing organizations/analytic mindset; managing context/worldly mindset; and managing change/action mindset.

** Clearly a list of best practice capabilities for health systems leadership has direct relevance to the qualities individuals need to possess. The difference is that those qualities are not specific to each individual; indeed, individuals should decide for themselves which qualities they might wish to develop and what those qualities look like as a consequence of their own strengths, knowledge and skills as mediated through the specific organizational context in which they are working.

* In practice, the term *competency* is often used in health authorities to define scientific outcomes to be demonstrated by employees or professional workers.

this project is that it must have a utilization focus; that is, it is designed to fulfil "...*its intended use by its intended users*"[22] as has been stated in the section on "Implications." There are two sets of intended users: formal leaders and informal leaders in the health system. Formal leaders consist of individual executives and leaders of all Canadian 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 provinces. Informal leaders are those individuals who are not managers but who wish to be active as independent agents in moving the health system forward; that is, the average employee or citizen who chooses to lead. This group of users is consistent with the concept of distributed leadership†† [23, 24] mentioned earlier and complies with the concept of building a transformational leadership culture to move the health sector forward.[14]

The five specific parameters that these assumptions suggest for this project are:

1. The need to articulate a high-level framework: one that can express, in overall terms, the fundamental capabilities of effective health systems leadership that are generic to all health organizational contexts without defining specifics "...that vary depending upon the target audience."[25]
2. The need to create a framework that represents the emerging conceptions of leadership world-wide[22, 26, 27] founded on new emerging skills, current research and the relevance of that research in practice.
3. The importance of building a framework that represents the Canadian health system as a unique context for the application of leadership. Unless the intended users believe it will work and suit their purpose, its relevance for them is suspect.
4. The significance of ensuring that the framework reflects as much as possible the basic elements of effective leadership: its concern for people and tasks;[28] its transformational nature;[29] its values base;[30] and the fact that it does not exist except in action.[31] Consequently, the framework should be expressed in relevant, practical language that speaks to its action focus: verbs instead of nouns.
5. The value of employing an action-research approach that models our best conceptions of leadership: that is, it engages intended users; it brings research and knowledge to bear; it utilizes approaches that are consistent with the study's purposes and encourage "meaning making"; and it gathers support among organizations and individuals, rather than fragments it.

RESEARCH METHODOLOGY

The research questions were:

1. What common capabilities can be identified that describe effective health leaders/managers in the current Canadian healthcare system?
2. Which capabilities are "traditional" ones that should be sustained and which would be considered "new emerging" requirements?

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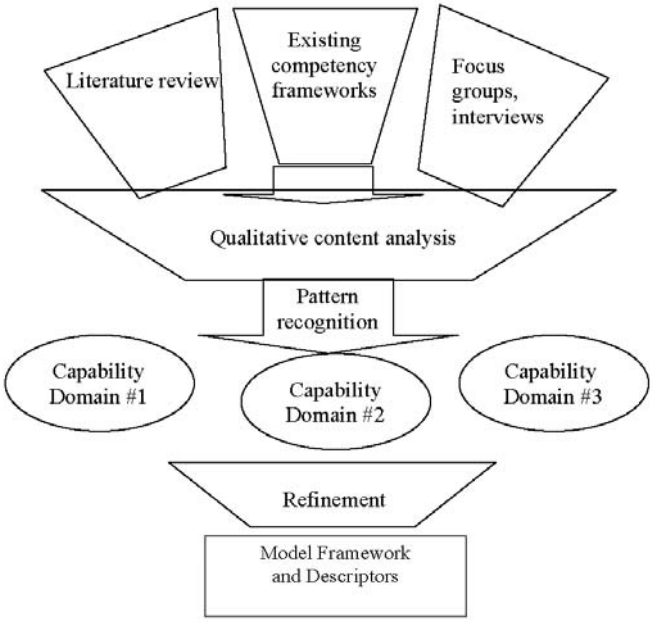
†† Distributed leadership as a concept has three major defining qualities (p. 3):[20]

1. It is an *emergent property of a group or network of interacting individuals*. This contrasts with leadership as a phenomenon which arises from the individual and suggests that there is an interaction factor between individuals and groups that raises the overall productivity from the sum of the parts to greater than the sum of the parts.
2. It suggests *openness of the boundaries of leadership*. This means that it is predisposed to widen the conventional net of leaders, in turn raising the question as to which individuals and groups are to be brought into leadership or seen as contributors to it.
3. It entails the view that *varieties of expertise are distributed across the many, not the few*. It is a way of maximizing the overall contribution of many leaders in many contexts, from individuals, to families, to communities, to interest groups and stakeholder groups, and from the province as a whole.

3. How should the framework be utilized or adapted to respect unique contexts in which leadership is needed, such as in aboriginal groups, remote communities and provinces?

To answer these questions, the approach taken in this study is best characterized as qualitative (that is, action research[32, 33] and ethnographic research[30] done in a constructivist way).[34] There were various stages of data collection and analysis, in which data at one stage of collection were refined, analyzed and interpreted (the overall approach is outlined in Figure 1); then the resulting prototype model was reviewed and analyzed in the next round of data collection.[35]

FIGURE 1: Pan-Canadian Health Leadership Framework Research Methodology



Specifically, we employed the construct of triangulation[32] to find patterns among three different categories of data sought throughout the study. These patterns illuminated certain leadership capability factors, which were then analyzed and reviewed by the research team to determine how best to express them as a capabilities model. Essentially, there were three stages of data collection, analysis, and interpretation. (See Appendix A for specific activities.)‡‡

In summary, the data analysis and interpretation process was essentially analogous to pouring data from three sources into a wide-mouth funnel; and then, for each question, putting it through a series of sieves and gate-ways (represented by the research team) such that what would emerge, from the other end, are key ideas and conceptions that answer the research questions.

‡‡ The Centre for Health Leadership and Research submitted an ethical review request to Royal Roads' Office of Research, which was approved by the ethical review committee. Issues pertaining to confidentiality of informants, gaining informed consent and minimizing potential harm to participants were followed in the conduct of the study.

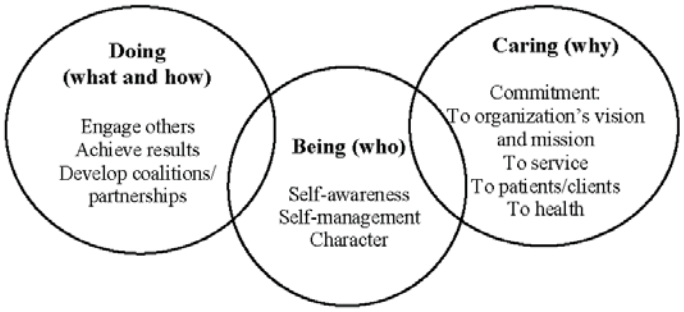
FINDINGS

The findings from this study are organized and presented for each of the three stages around the first question. Findings for the second and third questions are summarized at the end of this section.

STAGE 1

Three overarching components of leadership capability were identified (see Figure 2).

FIGURE 2: Three capability components of effective Canadian health system leadership



The three areas are expressed in terms of who the leaders are, what the leaders do and why the leaders do it:

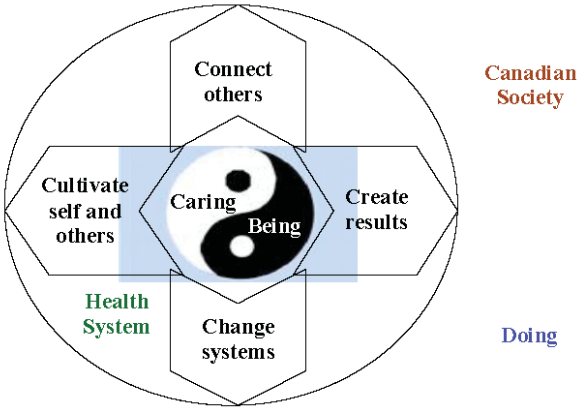
1. *Being* — The first of the three components is characterized as *being*. This is about *who* the leaders are; their values, beliefs and personalities.[36, 37, 38] This component includes the leaders' capacity for self-awareness, self-management and character. This component is not about action. Rather, it is about personal intention: the values, underlying characteristics and ethical framework that inspire and support action for the leaders. Significantly, this component generated more comments from focus groups and informant interviews than any other general topic.
2. *Caring* — The second of the three components is characterized as *caring*.[39] It is about intention as it pertains to the service component of the health system. It is the why of leadership in the Canadian health system. Analyzing the data from recent focus groups across Canada determined that it is not enough to build self-knowledge and understand the what and how of leadership; it is also critical to understand and care about the underlying reason for leadership. This data set is about commitment to the organization's vision and mission, to service, to patients and clients, and to health.
3. *Doing* — The third and final component is characterized as *doing*. This is about the *what* and the *how* of leadership; *intentions in action*. This component includes the B.C. framework domains of engaging others, achieving results, developing coalitions and transforming systems. This component frames the actions necessary from today's healthcare leaders.

In conceptualizing the first draft capability model, it was deemed important to connect the three components of leadership in a coherent model that showed their interaction with the health system itself. For example, being and caring are value- or intention-based orientations of mind; it is only in the doing — by being expressed through the leaders' behaviour and/or the system's culture — that these values and intentions become influential and can be defined as leadership capabilities.

> *Leadership capabilities are created when individuals combine their personal knowledge, skills and attributes (beliefs, attitudes, values) with the dynamics of the contexts within which they work so as to be able to exercise effective leadership in health.*

The first version of the model that was proposed in Stage 1 shows the being and caring components of quality leadership as the foundation of intention-based behaviour; the four capability domains themselves represent those intentions being put into action; the doing component (see Figure 3). Each of the four capability domains has four sub-domains.

FIGURE 3: Pan-Canadian Competency Framework — the 1B 5C model — or BC[5]



This model operates both at the individual and the organizational levels. It is thought to be beneficial in terms of individual leadership development, performance management, career management, specific issues of succession planning, etc. It would also be beneficial in terms of broader initiatives, including organizational development, strategic planning, etc. This model is seen as a call to action, not just for individual leaders in health but for the health system itself.

STAGE 2

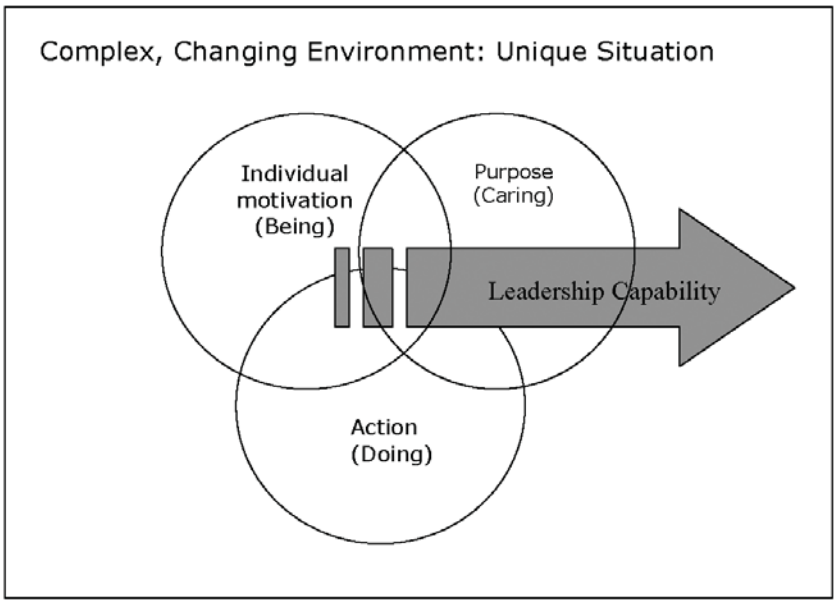
After reviewing the input received from the CHLNet Leadership Summit in Ottawa on May 22, 2007, and after a review of new literature and additional competency/capability frameworks, the original framework was revised. Three specific observations that influenced the change were:

1. A strong endorsement of *caring* as the identity of the health system. This theme was re-iterated by many, as exemplified by these comments from participants at the Ottawa summit:
   - "Leadership needs to demonstrate caring and values."
   - "Caring is the identity of the Canadian health system."
   - "[The n]ew generation of leadership needs caring."
   - "Caring can be expressed as behaviour: active listening; patience with staff; concern about family/family commitments; active participation in programs for patients/clients."
   - "You refer to the being-caring as 'value, or intention-based orientations of the mind' that are expressed in actions. However, you move so quickly to 'actions' and the conversion of actions into competencies, and sub-competencies, that I had to ask myself what you were planning to do about being-caring and how you were going to treat this, if not in the same way as competencies. I fear that your model will be less-powerful if, in its application, there is an assumption that being-caring is a 'given' and that as a pre-requisite, being-caring lies outside of a construct aimed at channelling people to positions of leadership."

2. There was general support for the four domains of the model, with some suggestions for clearer emphasis in some of the sub-domain language.
   - "Flexibility and adaptability don't appear."
   - "Emotional intelligence needs to be highlighted."
   - "Changes systems should be better connected to other domains in the model."
   - "Emphasize self-awareness: can't change what you are unaware of."
   - "Leading by example is missing."
   - "Risk-taking is missing."
   - "Accountability"
3. The overall representation of the model was thought to be essentially "going in the right direction" but in need of tweaking. In the electronic voting conducted as part of the presentation, more than 80 percent of the participants supported moving forward from this model. Some suggestions for adjustment were:
   - "Being and caring at the core, and expressed in a yin-yang model, is confusing."
   - "Do four sub-domains adequately cover everything? Or do we need a fifth: e.g., 'understanding Canadian context and environmental scan'?"
   - "What does 'invoke character' mean?"
   - "Yin-yang icon is possibly inappropriate — are they opposites or are they complements?"

As a consequence, a new framework was constructed. Figure 4 visually portrays how the qualities of the individual leader (being) intersect with the purpose of the health system (caring) and situationally determined actions (doing) to generate required leadership capabilities.

FIGURE 4: Leadership Capabilities as Product of Being, Caring and Doing



During this stage of the study, the combination of data from the literature review, the empirical qualitative data and existing competency/capability frameworks suggested that five capability domains express how the three components (being, caring and doing) intersect to create leadership capabilities to be sought from the individuals and organizational culture in a high-functioning health system (see Appendix D for literature support). Specific sub-domains that comprise the capability domains are outlined below.

Leaders:

CHAMPION caring and compassion

- Show reverence for the dignity of all persons
- Act with compassion
- Exhibit fairness and a sense of justice
- Inspire and encourage a commitment to health

CULTIVATE self and others

- Demonstrate self-awareness and self-management
- Exhibit character: honesty, integrity, optimism, confidence and resiliency
- Enable others to grow
- Create engaging environments where people have meaningful opportunities to contribute

CONNECT with others

- Communicate effectively with a wide variety of stakeholders
- Build effective multi-disciplinary teams
- Develop networks, coalitions and partnerships
- Navigate successfully socio-political environments

CREATE results

- Develop a shared vision and translate it into action
- Hold themselves and others accountable for results
- Integrate quality improvement and evidence into decision-making
- Manage resources responsibly and creatively

CHANGE systems

- Build personal and organizational understanding of the complexity of health systems
- Mobilize knowledge to challenge processes and guide change
- Lead changes consistent with vision, values and a commitment to health
- Orchestrate changes to improve health service delivery

STAGE 3

This model was presented at a session of the National Healthcare Leadership Conference in Toronto on June 11, 2007, for feedback. It was subsequently shown to a focus group of an emerging health professionals' network in Ottawa and to two focus groups in Quebec (one in Montreal and one in Quebec City). Some additional interviews were also conducted. There was general support for these five domains with one exception: there were some debates and polarized views over the use of the word "compassionate."

Some comments suggested that the capability titled "Champion caring and compassion" might need refinement. One person commented that health leaders need to be mindful that the health system has a purpose that distinguishes it from business organizations: the public trust of health. This public trust is critical: leaders have to keep in mind that they are serving the public even when other interests collide with that trust. Such leaders need "drive, passion and

belief" and need to be dedicated to caring. As one individual stated, "We are going towards a more human leadership. Leaders need spiritual elements to find sense in their work, passion in what they do." Some of the discussion centred on compassion as a unique leadership quality versus compassion as a quality infused through all of the system and whether or not compassion needs to be seen in leaders in very senior roles of responsibility in addition to being clearly needed at the individual caregiving level. One suggestion was that "respect" was a better word than "compassion," but the focus groups in Quebec supported compassion and empathy as a key quality for leaders, which tended to represent the views of the previous focus groups. One comment was that "the quality aspect of healthcare is stronger than fairness/justice elements." There was support for the other four domains in all these sessions with comments similar to those from the focus groups held previously. One comment seems to sum up Quebec's experience: "Quebec is distinct but not different and not alone."

The researchers interpreted the data from Stage 3 as supporting the Stage 2 capabilities framework but suggesting that changes were needed to the "Champion caring and compassion" domain of the draft capability framework. "Compassion" was taken out of the domain but left in as a sub-domain. The team also changed "reverence" to "respect" and altered the order of the statements:

CHAMPION caring

- Inspire and encourage a commitment to health
- Show respect for the dignity of all persons
- Act with compassion
- Exhibit fairness and a sense of justice

TRADITIONAL AND NEW EMERGING CAPABILITIES

Traditional healthcare leadership competency frameworks tend to focus on "doing," with some attention to "being" but little explicit commitment to "caring" (see Appendix E which compares health leadership competencies from a number of national and other entities to those developed in this project). Consequently, most traditional frameworks either cover or partially cover the capabilities listed here under "cultivate self and others," "connect with others," "create results" and "change systems" but with little explicit emphasis on "champion caring." The literature review, focus groups and interviews supported the researchers' contention that what distinguishes healthcare from business organizations is the domain of "caring" and a commitment to health. A commitment to health fits not only with a focus on healthcare outcomes for patients/clients but also with a renewed focus on population health, healthy workplaces and healthy individuals.

A second major "emerging" feature of this framework is capabilities that recognize the complexity of the health system. For example, the "connect others" capability was identified and raised to a level of prominence not found in competency/capability frameworks in other sectors. This capability emphasizes the leadership challenge of aligning individuals and groups from a complex number of professional bodies, interest and stakeholder groups, and members of the public to create a quality health system.

Other "new emerging" capabilities are qualities that need stronger emphasis in the "create results" and "change systems" capabilities.

- Within "create results" the area of "manage resources responsibly and creatively" and "hold themselves and others accountable for results" were identified as requiring greater emphasis for health leaders. One interviewee said, "Holding themselves and others accountable is the key capability."
- Within "change systems" leaders need to build more understanding of the complexity of health systems and what that means for improving health service delivery, challenging processes and guiding change.

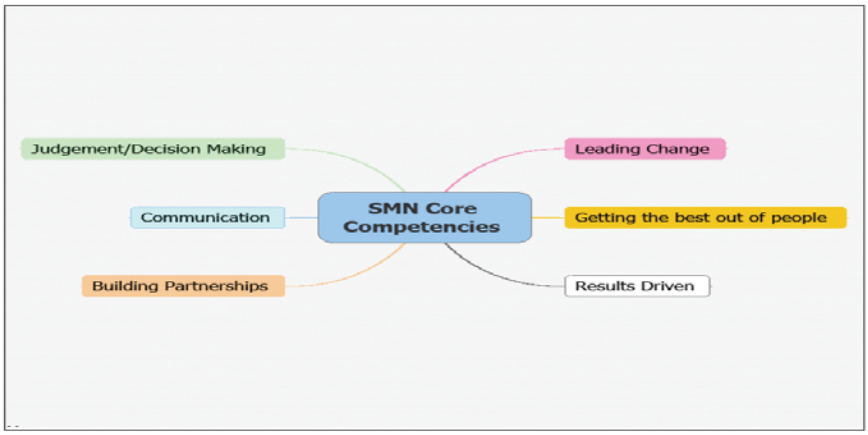
- Supported by the literature and our focus groups and interviews, the researchers came to the conclusion that there appear to be two primary differences affecting leadership in health systems as opposed to most other sectors. The first is the complexity of the health system (mentioned above); the second is the component of "caring" and a commitment to health. A demonstrated commitment to caring would return respect for the dignity of all persons to the health system.§§ A commitment to health fits not only with a focus on health outcomes for patients/clients but also with a renewed focus on population health, healthy workplaces and healthy individuals.

INCORPORATING UNIQUE CAPABILITIES INTO A CORE FRAMEWORK

How should the framework be utilized or adapted to respect unique contexts in which leadership is needed, such as in aboriginal groups, remote communities and provinces?

To create a respectful approach that acknowledges the unique contexts and organizational environments in which leadership occurs, our recommendation is two-fold. The first part is to define leadership in the pan-Canadian context in the form of capabilities, as opposed to competencies, which are to be used as defining expectations from the perspective of specific roles within specific organizations. The capabilities then represent broad domains of effective leadership that would be defined – in reference to context as competencies in each organization – to make sense in the context of an individual's unique environment. The second part suggests that individuals and organizations engage in the activity of defining these capabilities in context; for example, what does "champion caring" look like in the context of being a leader of a particular organization? Or more specifically, what does a leader do – in terms of observable behaviours – in an organization to "orchestrate change to improve health service delivery?" Additional research to document the results of this second stage of work would be extremely valuable for gaining appreciation of the leadership challenges different individuals and organizations face as they build an exceptional health system. An approach to address the unique needs of each health organization or context, when communicating the pan-Canadian framework, might be to align these capabilities with those of health organizations by adopting an approach such as that used by the United Nations System Competency Map.*** This concept was introduced in the May 22 summit and received a positive response from the participants. To align the competencies of individual UN organizations with the six core competencies of their Senior Managers Network, the UN uses a "mind map" approach (see Figure 5).

FIGURE 5: The United Nations System Competency Map



§§ This might mean that organizational structures and practices change, such as the use of respectful language and the elimination of open, gaping hospital gowns.

*** UN System Competency Map. www.unssc.org/web1/programmes/mldp/sms

To use the competency map, one clicks on the relevant core competency and is sent to a page with a definition and a number of competency statements from different UN organizations, such as the World Health Organization (WHO) and UNICEF, relating to that core competency. For example, for the page on "leading change" WHO has two statements – driving WHO to a successful future and promoting innovation and organizational learning – while UNICEF has influence, leading organizational vision and change, and managing organizational learning. One can follow those competencies by clicking on them and viewing the agency's definition and the indicators that demonstrate alignment with the core competency.

IMPLICATIONS

This study emphasized a number of concepts related to quality leadership, leadership development, and their significance to the Canadian health system that have significant implications in terms of suggesting changes to how we approach leadership within the Canadian health system.

- *There is an appetite for a holistic, unifying concept of leadership*. In speaking to more than 100 leaders, we were struck by the appetite for a framework and conceptualization of leadership that is unifying in its format. Health leaders appear to be seeking connections across organizations and provinces and among individuals and agendas. Traditional competency frameworks unique to each organization do not necessarily recognize the interdependence of various organizations in a system; nor are competencies themselves within a competency framework conceived as interdependent qualities. That is why the research team adopted the capability of *connect with others* and is an additional reason to accept the concept of a capability rather than competency (that is, to conceptualize the former as a set of interdependent rather than independent variables in a whole). An organic system recognizes the interdependence of parts and the potential for synergy between those parts, when they interact with each other in a holistic fashion. This framework – in its content and as capabilities – acknowledges that need and presents a model of leadership capabilities that is itself synergistic (that is, a capability as an interaction between being, caring and doing) and suggests five capabilities that work together to create exceptional leadership *for* a system.
- *There is a need to get back to the essence of health*. Participants in this study expressed a deep commitment to caring and health as a fundamental component of effective leadership. This yearning seems to fit with the strongly held Canadian belief in universal health and equitable healthcare outcomes for all Canadian citizens, and with a renewed focus on population health, healthy workplaces and healthy individuals. The framework provides a vehicle for regeneration of that purpose and for its inclusion in all leadership development programs and activities.
- *New and emergent capabilities of leadership are needed in the health system*. There was a general view among many health leaders in Canada that the existing competency frameworks in their respective organizations do not capture the essence of modern leadership required to deal with substantive health systems change. These differences were articulated earlier in this paper. Practically, a new framework should stimulate collaboration across the health system on succession planning, performance management and recruitment, and leadership development. It should attract greater resources and gather existing resources in support of leadership development. Finally, it can act as a tool for accountability and as a focus for capacity-building across the Canadian health system. Ideally, it will also lead to productive further research and activities aimed at closing the Canadian health leadership gap.

The following recommendations use the findings and implications of this research to suggest actions to mobilize the knowledge of this research study and utilize it for maximum capacity-building within the Canadian health sector.

RECOMMENDATION 1
That a co-ordinated knowledge mobilization strategy be undertaken to disseminate and further validate the framework throughout the Canadian health system. Such a strategy might include:

- publishing and distributing the model in the form of a brochure that is simple, visually appealing and that outlines the purpose and intent of the capabilities framework;
- creating a web presence (such as an interactive blog) to allow for ongoing refinement of the model through interaction with interested leaders across the country (potentially as a component of a second-stage research project);
- communicating the content of the model to post-secondary institutions and other organizations that wish to participate in leadership development for the health sector, consistent with the content of the model;
- investigating the potential of supporting the development of three or four regional "leadership centres" comprised of post-secondary faculty and health decision makers to support leadership development in the various regions of Canada;
- creating a standing agenda item at health leadership conferences throughout the country to introduce the capability framework to those discrete audiences;
- developing an organizational ownership strategy to encourage and engage individual organizations to consider using the model as part of their articulation of leadership for their members (especially smaller, less financially viable ones who might not have the individual capacity to create leadership expectations); and
- assisting individual organizations to link their leadership expectations, formal or informal, to the pan-Canadian framework and to use it for succession planning, performance management, leadership development and recruitment.

RECOMMENDATION 2
That an approach be adopted to align these capabilities with those of existing provincial, national and/or international health capability/competency frameworks, similar to the UN System Competency Map.

RECOMMENDATION 3
That a series of leadership dialogues be undertaken across the country to discuss leadership in healthcare and the potential value of this framework; to allow for the creation of voluntary communities of practice of professionals who wish to develop their individual and organizational leadership capability; and to strengthen support for the use of this national framework.

FUTURE RESEARCH

RECOMMENDATION 1
That a second-stage research project be commissioned to investigate the applicability of the framework to specific contexts (such as aboriginal health centres, clinical leaders, etc.) and selected provincial jurisdictions; and the potential of the framework to act as a guide to shape leadership and leadership development in that context. Such research might include:

- further definition and understanding of what the capabilities look like in action for different individuals, organizations, situations and circumstances;
- context-specific descriptions of the interplay between leadership capability and capacity-building (that is, organizational processes and service delivery improvement);
- identification and description of pan-Canadian health leaders' capabilities associated with specific contexts and specific situations (to identify whether or not there are

potential categories of interaction between individual leader capability, organizational culture and unique situations); and

- comparisons of different provinces' receptivity to the model and its appropriateness to individual provinces and their stage of health change and reform.

RECOMMENDATION 2
That additional research funds be dedicated to support further academic research on the ability of this framework to build capacity. Such research might include:

- evaluating new programs that specifically aim to develop the Pan-Canadian Health Systems Leadership Capabilities Framework for individuals and organizations;
- analyzing and describing deliberate efforts to apply the framework to health systems change (such as evaluating deliberate learning interventions, based on the capabilities framework, in which teams of leaders systematically endeavour to employ the framework to guide system-wide change); and
- analyzing deliberate application of the framework in individual leadership development.

CONCLUSION

This project investigated the content of a health leadership capabilities framework that could be endorsed by Canadian health organizations and utilized by leaders at all levels of the Canadian health system. The study found that there is significant support for the idea of a pan-Canadian framework. There is initial support for the content of the framework proposed by this study. The results are consistent with the literature, input received from the many individuals and groups consulted during the research process, and elements of existing competency frameworks currently in existence in provincial, national and international contexts. Additional work to bring the framework to life in context is needed; there is also the possibility of a rich research agenda pertaining to the capacity-building potential of this framework.

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