From Concept to Reality: Putting LEADS to Work

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The ***LEADS*** *in a Caring Environment* framework defines health leadership through five domains:

Lead self;
Engage others;
Achieve results;
Develop coalitions; and
Systems transformation.

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

Dickson and Tholl [1]

Introduction

Our LEADS journey began more than 10 years ago, and more than five years have passed since we published the first edition of this book: *Bringing Leadership to Life in Health: LEADS in a Caring Environment.* Over the past five years, the challenges leaders face have changed markedly in Canada and elsewhere and literature on

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G. Dickson, B. Tholl (eds.), *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, https://doi.org/10.1007/978-3-030-38536-1_1

health leadership has exploded; yet the fundamentals of LEADS-based leadership have withstood the tests of change and time. And as we show in the ensuing chapters, the five domains and 20 capabilities of the LEADS framework, which we call the DNA of health leadership, have been reaffirmed in the living labs of health organizations, put to use in ways we could not have imagined back in 2014.

So why write a second edition and how does it differ from the original? First and foremost, we believe leadership is an ongoing, life-long learning process. After five years of watching LEADS evolve, it was time for us to reflect on what we've learned about putting LEADS to work and share it with you. In many ways the evolution of LEADS is a live case study, as you will read in the coming pages.

Another reason for this update on LEADS is that the challenges of leading change in health care are even more daunting in 2020 than they were just five years ago. Ideological, technological and demographic pressures create demand for transformational leadership in all sectors, but it's arguable health care is more vulnerable than any other to the vagaries of political processes. For example, since 2014 we have seen provincial regionalization of health care delivery migrate to larger and larger organizations: Saskatchewan, Nova Scotia and Manitoba all went from multiple smaller health regions to one province-wide system. Services were also centralized in Ontario.

This edition was also a response to an important change we see emerging, as governments increasingly shift their focus to the overall experiences and needs of the people they are intended to serve. People-centred care is a priority in every developed country and appears in every health authority's strategic plan.

In Australia, as part of that agenda, the central government has introduced a national electronic health record scheme and activity-based funding, two changes aimed at triggering broader people-centred health system changes [2]. These include promoting greater integration of services, using technology to improve patient care, promoting patient and community involvement, bringing primary care closer to home and improving mental health care [3].

In the NHS England a significant emphasis has been put on changing entrenched, bureaucratic top-down leadership practices to include distributed leadership approaches that are aimed at creating more compassionate, caring health care workplace cultures in hospitals and primary care trusts; which in turn, serve the public better [4–6]. In NHS Scotland, "health and social care…is transforming to meet the needs of patients and communities" [7].

In Canada, similar rhetoric is used to justify a multiplicity of change demands: electronic medical records, new models of funding, physician engagement, etc. All provincial governments seem to be focusing on developing "closer-to-home" care models, engaging patients, families and communities in the provision of care. But as Aesop said, "When all is said and done, more is said than done." We saw a need to leverage LEADS to move beyond words and take concrete action to put patients and their families first. In this edition we have expressly added patients and informal caregivers into the lineup of health leaders (see Chap. 13 and the self-assessments at the end of each of the domain chapters).

Governments' focus on health care is inevitable: it is *the* big-ticket item in public budgets. Health issues can eat up a lot of political capital in a hurry, as you will see in some of the vignettes featured in this book. As Jeffery Simpson pointed out in his

book *Chronic Condition*: "Medicare is the third rail of Canadian politics. Touch it and you die. Every politician knows this truth" [8].

Then, too, the pace of technological change is unrelenting. Our ability to share health information in a digitized world has increased exponentially, straining individual capacity to process information. And yet the information keeps coming: we are witnessing a revolution in the very nature of medical care and struggling to understand how genomics [9, 10], proteomics [11, 12], artificial intelligence [13, 14], and robotics [15, 16] will change how health care is delivered and at what price. According to a 2015 Canadian task force report on health care innovation: "Precision medicine heralds a new era for diagnosing, treating and preventing disease that will move away from a 'one size fits all' strategy to a more individualized approach based on a patient's genetic makeup" [17]. These breakthroughs and other technological advances are already challenging health leaders ethically, economically and legally as never before.

The shift in demographics that Western nations are going through has long been foreseen, but is none the less challenging. The aging of the population is filling an acute care system built in the 1960s with patients suffering complex co-morbidities [18], necessitating transformation of the system into one geared to the needs of older patients. As Monique Bégin, the former federal health minister who led the charge to pass the Canada Health Act (1984) wrote in her memoir: "Today's (health) system has to rethink and accommodate seniors' needs at home and in various types of institutions that are totally different from hospitals. It has to reform its culture from within and it is not first and foremost more funding that will assist" [19].

The impact of this trifecta of turmoil—ideology, technology and demography—on health leaders makes leveraging LEADS more important than ever for individuals and for the whole system. As the scope, breadth and pace of change accelerate, so does the need for effective leaders at *all* levels.

Another reason to update the book is that since 2014 we have seen exponential growth in the use of LEADS in three ways we had not anticipated. It has become *the* common vocabulary of leadership for much of Canada, been adopted as a common learning platform and is increasingly being used as a model for change leadership. At the same time, academic interest in health leadership and its role in overall system and organizational performance [20] has greatly expanded. As a result, we have a much bigger body of research to draw on and better understanding of potential uses for LEADS we want to share.

Finally, since 2014, we have seen increased evidence, albeit still limited, of the value for money in investing in better leadership development programs and ways to better measure its impact on organizational performance [21–23]. We see, for example, that NHS England has continued to invest significantly in leadership development [24] and NHS Scotland has developed a unique national approach to grow leadership in that country [25]. In Canada an estimated 80% of Canadian health institutions now have a leadership framework in place and 69% of those health care institutions have adopted LEADS as their preferred leadership learning platform [26]. This further attests to the value for money in investing in health leadership. So we see this book as establishing a baseline against which to measure progress over the next five years. We say more about international efforts in Chap. 11.

Bringing Leadership to Life in Health: A Primer on LEADS

The *LEADS in a Caring Environment* capabilities framework defines high-quality, modern health leadership. As we explain in Chap. 3, LEADS is a leadership framework by health, for health. The acronym represents the five domains of leadership:

- **L**ead self;
- **E**ngage others;
- **A**chieve results;
- **D**evelop coalitions; and
- **Sys**tems transformation.

Each of the domains comprises four measurable, observable capabilities of exemplary leadership. We explain each of the five domains in detail in Chaps. 5–9, along with some of the approaches, techniques and tools supporting use of the framework. In this edition we also feature more case studies, stories and vignettes in each of these domain chapters to help you better understand how LEADS capabilities are being put to work in Canada, Australia and the United Kingdom. So, if you're practice-oriented and want to skip the theoretical foundations for leadership and LEADS, we encourage you to jump directly to Chap. 5: Lead self.

If you want to better understand the challenges of leadership in complex systems like health care, how to grow your leadership capacity, and better understand the changing policy environment shaping how LEADS is being deployed, move on with us through Chaps. 1–4.

Putting LEADS to Work: A Retrospective on a New Perspective

When we wrote the first edition, we used the tag line: "A New Perspective." This was because LEADS was a novel concept and was still in the early stages of the standard "introduction, adoption and diffusion" process of change [27]. As we will explain, we are now well into the adoption upswing and, we believe, entering the rapid diffusion phase of putting LEADS to work as a by health, for health framework.

Back in 2014, the health sector in Canada was largely importing leadership concepts and tools from the leadership articles written by business, for business, with few references relative to health care leadership. LEADS was a new and untested concept. The goal was to integrate relevant constructs of business leadership with health care organizations' competency frameworks and describe leadership in the context and language of health care. The initial efforts to create a toolbox to support development of the LEADS capabilities were quite limited and LEADS support systems were only beginning to take shape (see Chaps. 3 and 11).

Use of LEADS and of the tools in its toolbox has grown significantly over the past five years. LEADS has been put to work in all 10 provinces in Canada, is in use in New South Wales and in other parts of Australia and has influenced leadership development in Israel, Belgium and India.

Importantly, LEADS is not only being used for purposes such as self-assessments and 360 assessments or to help focus teams with a common vocabulary of leadership, or to help in developing personal learning plans. Now it's also helping leaders build bridges with boards, as a basis for developing graduate school curricula, as a foundation for engagement surveys in health workplaces, to shape interviews and as a guide to enhancing workplace health. These and other uses are described in the book. There is even, as we detail in Chap. 11, an infrastructure overseen by LEADS Canada to certify LEADS consultants and facilitators who help build LEADS-based leadership capacity across Canada and globally.

This emphasis on LEADS is not to suggest that other countries like England and Scotland should use LEADS; they have national frameworks and leadership talent management initiatives of their own. Certainly, Canada can learn from them as we outline in Chap. 11, and they from Canada. However, for a country beginning that trek, the LEADS journey has important lessons that can help shape its approach.

What has Changed: Key Ideas

This second edition is built around five cross-cutting ideas, outlined here to help you work through the book. They are:

1. The Centrality of Lifelong Learning for Self, Organization and Systems

LEADS is all about lifelong learning. You will never graduate with a LEADS degree as a fully developed leader because getting better is a continuous process. At the same time, the LEADS framework works for people no matter where they are on the ladder of leadership. It encourages you to lead from who you are and where you are. LEADS is not limited to individuals. We see organizational and systems learning as an analogue to personal learning. Peter Senge's work on systems thinking and the learning organization, begun in the 1990s [28, 29], has been widely embraced and the notion of organizations as learning systems has also been applied to health systems. The theme of learning permeates all chapters in this book.

2. Sharing How LEADS has Been Put to Work in Practice

One of the basic differences between this book and the earlier edition is captured by the title of this chapter, "From Concept to Reality." There are over 30 case studies and vignettes in this edition, each with its own set of insights into *Putting LEADS to Work* (our subtitle). They come from leaders throughout health care—patients, providers, policy makers and administrators. This variety of perspectives helps drive home how LEADS has become more than just a useful leadership framework or learning platform and is now also seen as a way to stay grounded professionally and personally. Many people we interviewed for the book referred to "living LEADS" and spoke of trying to model LEADS in the community as well as in the workplace.

Based on the case studies presented here, when LEADS is put to work—as a way of thinking, acting and developing leadership—it enhances people-centred

care and improves overall system performance. We know that without active leadership in turbulent times, complexity can devolve into chaos. It's the job of health care leaders to ensure complex change does not become chaotic but remains focused on improving health and health care for all. In Chaps. 9 and 10 we discuss the limits of linear, reductionist principles of leadership and how we can put LEADS to work to lead change in a sector increasingly characterized by volatility, uncertainty, complexity and ambiguity (known as a VUCA environment). LEADS could almost have been purpose built for the VUCA world of the twenty-first century.

3. Sharing Our Deeper Understanding of Contextual Leadership

All leadership is a function of time, place and circumstance [30]—that's not new. But, as we discuss in depth in the following chapters, every leader works in a different context that demands customized action. We discuss the environmental, structural and personal contexts that shape leadership as they relate to each of the five LEADS domains.

The second dimension of our discussion on context is to compare the use of LEADS in Canada to other countries' leadership frameworks and talent management strategies to explore approaches Canada might learn from. Each country we profile—Australia, the UK (NHS Scotland and NHS England) and New Zealand—has dedicated significant resources to managing leadership talent. They, like Canada, believe their priorities for reform—integrating services, creating healthy workplaces and making structural reforms—will not be realized without better, more sophisticated and distributed leadership.

4. Sharing Different Perspectives on the Caring Ethos of LEADS

Over the past five years, as the challenges of leading in health care have become more complex, LEADS has helped health leaders stay focused on why they chose to work in a caring environment. We have numerous stories in this book about the importance of caring to individual health leaders, and five invited chapters that focus on the topic.

Another aspect of caring is working to ensure equity, diversity and inclusiveness for everyone in the health care system: providers, patients, families and our diverse communities as a whole. The goal is to have enough leaders of different backgrounds in the health system to understand and reflect the broad range of people it serves. LEADS can help with that by enabling leadership that is attentive to equity, diversity and inclusiveness. To guide us in that effort, we invited Dr. Ivy Bourgeault to offer her insights on linking equity, diversity and inclusiveness to the LEADS domains and capabilities [31]. Ivy's perspective is highlighted in each of the five domain chapters.

5. Sharing and Updating Our Curation of Health Leadership Literature

When we began this journey, there was only limited literature on leadership in the social sector overall and virtually none specifically about health care. Today, there is much more peer-reviewed and grey literature [18, 32–35]. Virtually all of

the sources we quote in this edition were published in the past five years, a testament to how our understanding is growing of the critical role leadership plays in health care.

What Hasn't Changed: Enduring Ideas

While much has changed, the core values and beliefs of the LEADS framework remain. This edition, like the original, is still about helping all leaders better themselves and achieve better results by understanding the growing evidence in support of LEADS-based leadership development and talent management. It's based on the premise each of us is a leader and we are all CEOs of self. The book is intended to help you be a better leader, whatever age or stage you're at in your leadership journey and in whatever role you find yourself in health care.

What else remains unchanged? LEADS is still predicated on the belief leaders are both born and made. Everyone is born with some predisposition toward being able to lead and given the opportunity, can develop those innate talents through hard work, learning from experience and reflecting on what they learn. Both books show how through LEADS, you too can become the leader you want to be (Chaps. 4 and 5 are devoted to this theme).

Another returning idea is the fundamental belief that leadership is less a function of the power or authority (what's called hard power) you may have by virtue of your position, and far more a function of your influence inside and outside the formal hierarchy (soft power). In our view, those functions in modern health organizations and systems are threefold: one, to integrate service for patients and families; two, to create healthy and productive workplaces so people can deliver optimal service; and three, to successfully implement desired health reform policies and practices. These functions are, of course, interdependent but it is important to recognize them also as distinct.

Many prevailing ideas of leadership are artifacts from a bygone era when hierarchy, privilege, gender and restricted access to information determined who had power and who did not. To us, someone who uses authority without showing respectful, enabling behaviour may be less powerful than someone in an informal role who treats people with respect and supports their efforts. Barbara Kellerman makes this point eloquently in her book, *The End of Leadership* [36]. In this edition of our book, we recommend the use of self-directed learning tools to help you leverage your influence (see Chap. 4). For on line access to new LEADS-based tools please visit our website at: http://www.leadsglobal.ca/.

One of the most frequently asked questions over the past five years when we were speaking about LEADS was where's the leadership going to come from to transition health care into the twenty-first century? The answer is clear to us: it has to come from all of us. LEADS is designed to help you develop the capabilities you need to do your part to transform health care. Our hope—and the hope for the system—is this edition of LEADS will help you become the best leader you can be, developing your full potential to meet ever-changing leadership challenges.

Summary

Health leadership is vital for achieving the health care we need. Ensuring services are people-centred, creating healthy workplaces where providers can thrive and give their best care and reforming the systems that deliver that care are the job of leadership. All of us—formal and informal leaders, from diverse backgrounds and in different roles—must work together to get that job done. The LEADS framework is a guide to the leadership needed to do it.

Let's now look a little more closely at the inspiration behind LEADS and the phenomenon we call leadership, in Chap. 2.

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