Putting LEADS to Work as a Change Leadership Model: Integrating Change Leadership and Change Management

10

Graham Dickson and Bill Tholl

The best way to predict the future is to create it.

Peter Drucker [1]

It is trite but true to say that the only constant in health care in 2020 is change. Leaders have no real purpose unless they are trying to create, as Drucker suggests, the changes needed to create a better future.

This chapter picks up where Chap. 9 leaves off. It describes how LEADS can be used as a change model. Of course, there is a bevy of change management models out there to choose from [2–5], each with its own strengths and weaknesses. A recent comparative assessment of three models of change—Kotter, the PROSCI model and LEADS—found, while each has its relative strengths, it is by combining approaches to fit distinct leadership challenges that we see the most success [6].

Three of the advantages we see in LEADS as a preferred change model are: (1) a major function of leadership is to create change; (2) the framework has already gained widespread purchase in Canada as a by health, for health model; and (3) it combines many concepts and ideas from a multitude of change models across its five domains.

We were only beginning to realize back in 2014 that the real leadership challenge of advancing the health agenda in Canada and comparable countries was to find a better, more reliable way of not just managing but leading small- and large-scale change. In this chapter, we profile three case studies where LEADS is being used as a change leadership tool or model. We asked our case study writers to use an after-action review process [7], and by doing so, we explore how exactly LEADS is

G. Dickson (✉)
Royal Roads University, Victoria, BC, Canada
e-mail: graham.dickson@royalroads.ca

B. Tholl
Canadian Health Leadership Network, Ottawa, ON, Canada
e-mail: btholl@chlnet.ca

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_10

being put to work as a model of change. The process asked three key questions: What were the expectations going into the change process? What surprises or wild cards were encountered and what corrective actions were taken? What can we learn from the change process going forward?

Living LEADS: Aligning the Gears

One of the big surprises in writing this second edition is how the framework has changed the way leaders embrace LEADS personally as well as how it is being used as a model of change. For example, here's a story from Ellen Melis, an experienced LEADS facilitator and coach (personal interview 2019 Apr 8).

> *When I ask community leaders: "What's your biggest challenge?" they often say "We're too small to make a difference." LEADS is a big equalizer because it gives voice to everyone on the team, from the C-suite to the front line. It is empowering in that it encourages everyone to think big and to think about the system. It's enabling because it encourages all of us to lead from where we are, from our relative strengths and in our own way. It allows everyone on the team to see the bigger picture.*
>
> *I first start my conversation about change guided by the need to "Listen, listen, listen—and listen most closely to those working at the front line." Change only happens when leaders can take ideas and strategies and put them to work. And this requires a change in mindset, which in turn requires a change in culture. The leader shift required is to understand the critical coming together in the middle, those that can see both the leadership opportunities and the health care delivery and management challenges.*
>
> *In putting LEADS to work as a change model, I start with Mintzberg's* [8] *principle of starting from the middle out rather than the top down or bottom up. I always see the change leadership process as involving three gears. The smallest gear is associated with the senior executives of any organization. They certainly can help create an environment that encourages system thinking around the needs of the patient and/or their families, but they cannot make change happen. It takes a lot of rotations to move the next gear.*
>
> *It is the middle gear, like in a three-speed bicycle, that is critical to converting ideas into action. Again, it takes many revolutions for this middle gear to turn the biggest gear. And, of course, it is the biggest gear—the front-line providers—that make the difference in the care experience. And, once this big gear begins to move, the momentum for lasting change begins. I call this a "feed forward" process and it is the only way to create lasting change in complex systems. The beauty of this metaphor is that it can also work in reverse. By giving voice to the front lines, small changes initiated by the biggest gears can really speed up the attainment of strategic objectives. But this requires a real shift in mental models; a real shift in the culture of an organization.*

Ellen's three gears metaphor provides a powerful image, as it reinforces what we all know: real change only happens when the actions of multiple players line up (the goal of the Achieve results domain). Her story also reminds us that most people in management roles see themselves first as managers and second, as leaders of change. That's why change management seems so comfortable to all of us; it is simply an extension of our role as a manager, and why we all too often think leadership is something we can do from the side of our desk. One of the main objectives of this chapter is to support our contention that "leaders need to think and act like change masters." [9]

Ellen's three gears also remind us of Jim Collin's Flywheel Effect [10]. Collins describes just how challenging it is to initiate change and then sustain momentum, how it seems almost impossible in the early going to even begin to move a big, heavy flywheel like the health care system. Gradually, however, the flywheel gets moving to the point where the change agenda is unstoppable. Probably one of the best examples of this phenomenon is Obamacare in the USA: a change that so far, despite the best efforts of the Republican Party, has not been dismantled.

Ellen "loves LEADS" because it calls upon each of us, whatever our station in life, to see our role as a change leader. Imagine the possibilities if we spent just 10% of our time focused on the future, demonstrating LEADS capabilities and behaviour in support of improvement, reform, adaptation, advancement: whatever term you want to use for change. People need to see themselves as integral cogs in a smoothly functioning series of gears, all pulling in the same direction [8].

LEADS helps to level the playing field, Ellen says, because the LEADS approach to change recognizes that everyone in health care—including patients and families—have a role in leading change; and it outlines the capabilities needed to do so. From an organizational perspective LEADS promotes leading from the middle or at least ensuring that the middle gear (that is, middle management) is connected both to the executive and front-line delivery gears in any health care system. And as Ivy's text boxes have reminded us in each of the domains, bridging the gaps in terms of equity, diversity and inclusivity is part of getting all the gears aligned, with each doing their part to ensure that changes go smoothly.

Balancing the Tension Between Change Leadership and Change Management

Chapter 9 reminded us that leading change in the health sector involves dealing with a big, complex and often non-adaptive system. As Braithwaite et al observe, it is hard to change health care systems because they are so big, so political and so institutionalized, with so many vested interests.

> Construing health care as a complex adaptive system implies that getting evidence into routine practice through a step-by-step model is not feasible. Complexity science forces us to consider the dynamic properties of systems and the varying characteristics that are deeply enmeshed in social practices, whilst indicating that multiple forces, variables, and influences must be factored into any change process, and that unpredictability and uncertainty are normal properties of multi-part, intricate systems [11].

To be effective as a change agent in today's complex health care systems requires leaders to move beyond a step-by-step, evidence-based paradigm of change. Linear, reductionist or Cartesian approaches to leadership in the health sector limit our flexibility to respond to the peripatetic and reoccurring challenges of change.

Linear thinking builds on the adage that the shortest distance between two points is a straight line. It reflects how we have been taught to think, how we are taught to put everything in sequence; in order. One problem solved; move on to the

next: however, in real change, a problem solved at one point might well reoccur at any time in the process of change. As Bill, one of your authors and building on his policy experience observed: "You never really solve serious health policy problems; you substitute one set of problems for another hoping the new set will be more manageable than the old set."

Indeed, we too have argued that alignment of effort is needed if visions are to be achieved and change to be realized (Chap. 7). It's true our best efforts are needed to create as much alignment as possible, in a system that is inherently misaligned. To approach change assuming that a cause-and-effect model of it, predicated purely on logic and reason—and typically associated with the construct of change management—can re-order human behaviour and sustain it, while moving on to the next step in the change process, is naïve. Even though alignment can be created in one moment, in one situation, new events and circumstances may well put it askew, requiring a return to an earlier stage of the change process. Other approaches to change, built around the principles of organic systems thinking, recognize this challenge. There are no straight lines, no simple answers or solutions to help human beings get from the current, unsustainable state to a preferred future state.

Complexity science is characterized by nonlinearity [12]. According to Miles, complex systems and problems require more than simplistic linear thinking [13]. With a complexity science perspective, there is an appreciation of the complex, dynamic and interconnected relationships occurring within a complex system or problem. And, as Dumas and Beinecke remind us: "Change leaders must encourage their organizations to learn, innovate, experiment, and question, preparing their organizations for change by constantly seeking new perspectives, and encouraging participation throughout the organization." [14]

We suggest the need for a fundamental change of our mindsets about change management and change leadership, along the lines suggested by one of the gurus of change management. Here's what John Kotter has had to say about the fundamental difference between change management and change leadership in complex, dynamic systems:

> There is a difference that is very fundamental and it's very big between what is known today as change management and what we have been calling for some time change leadership. Change management tends to be more associated, at least when it works well, with smaller changes. If you look at all the [management] tools, they're trying to push things along; trying to minimize disruptions or keep things under control. It's trying to make sure change is done efficiently. Change leadership is just fundamentally different. It's an engine. It's more about urgency. It's more about masses of people who want to make something happen. It's more about big visions. It's more about empowering lots and lots of people.
>
> Change leadership has the potential to get things a little bit out of control. You don't have the same degree of making sure that everything happens in a way you want and at a time you want when you have the 1000 hp engine. What you want to do of course is have a highly skilled driver and a heck of a car, which will make sure that your risks are at a minimum. But it is fundamentally different.
>
> The world we all know right now talks about, thinks about and does change management. The world we all know right now doesn't do much change leadership since change leadership is associated with the bigger leaps that we have to make, associated with the windows of opportunities that are coming at us faster, and staying open less time; bigger hazards and bullets are coming at us faster. So, you really have to make a larger leap at a faster speed.

> Change leadership is going to be the big challenge in the future. And the fact that almost nobody is really very good at is, obviously, a big deal [15].

As Kotter suggests, getting behind the wheel of a race car is not for the faint of heart. Kotter understands the need for better management and enlightened leadership to come together for success. Managing and leading change can be seen as opposite sides of a piece of paper: they seem like two sides of a coin. But if you twist the paper and join the two ends, you have a Mobius strip; when the two sides no longer appear as opposites, but feed into one another. Change leadership and change management are those two sides.

We are reminded that while people may be forced to change via circumstance or environmental forces beyond their control, leaders need to ensure they and others have some freedom to choose *how* to change and *how much* effort and commitment they want to put into it. All the LEADS domains and many of the capabilities and the variety of ways that they can be put to work embrace the notion of making a choice of how to think about change, how to respond to forces we can't change, and whether or not we wish to be preemptive in shaping the society that will result from those forces.

To illustrate this point, let's look at a change many of us have gone through: renovating a house. "Personally, I hate change, but I love renovating my house," says Rosabeth Moss Kanter, author of the book *Evolve!* [16] Her point: nobody likes change when it's done to them. But change we choose is different; that's the kind of change we're willing to embrace. We own what we help create.

But getting an array of different people to work together to co-create anything is fraught with human foibles. Here's a variation on renovating the house of health care from our colleague Hugh MacLeod in his recent *book Humanizing Leadership*: [17].

> *Although all trade people are certified to perform their job, we observed that not all individuals perform their job to the same level of care and attention. Perhaps it was their individual work ethic that determines outcome; maybe it was the program, apprenticeship, or company they worked for that hinders their ability. Maybe they were wrapped up in personal problems outside of work, unable to separate their personal life from their business life. Or maybe it was fatigue; they have worked too many consecutive days, and the long hours are leading to burn out.*
>
> *Extending beyond the individual worker, maybe the trade person has a personal conflict with their boss, or general contractor. Maybe it is the incompetence of the general contractor and their inability to orchestrate the project. Maybe the tools had an effect on outcome or the new techniques and technologies they have yet to master. Maybe some individuals on the project were working towards professional advancement, while others were complacent with where they are. Maybe some contractors looked for shortcuts, while others were consumed by perfectionism.*
>
> *Ultimately, we learned that we have little control over execution, attitude, behaviours, skills, pride, deadlines, and completion timelines. We witnessed firsthand that trade apprenticeship development programs resulting in trade certifications did not guarantee quality, attitude, pride, and customer service. On sequencing and hand offs between framing, plumbing, electrical, drywall, finishing, and painting, we witnessed how one profession could hold others up and professional rivalry, pettiness, and blaming occurs. We learned that not all these individuals possessed the ability to articulate the problems and solutions and progress with absolute clarity and conviction.*

The truth is that all the answers can be found in the hearts and minds of people. Every individual has the capacity to contribute to organizational growth. Individuals carry the seeds of success: skills, talents, potentialities, and enthusiasm. Unfortunately, for many those same seeds contain too many intellectual, emotional, and systemic barriers. Liberating the "bottoms" and integrating the "middles" is how learning organizations succeed.

Does this resonate with you? The challenges of renovating the health care system are unrelenting and often the locus of control is outside your purview. This renovation metaphor reinforces the key takeaways from Ellen's story about ensuring that all the gears, or sub trades as a general contractor, are lined up; but it also states that to assume that people will act accordingly, and do so with the quality that is envisaged, is misguided. Yes, we must trust people to do their absolute best; but not blind trust. Our job is also to monitor people's efforts and provide supports for their work; and to make the adjustments to the process that are needed. As a recent report from the Health Leadership Academy and McMaster University on scenario planning points out: "Modern health care systems are complex. They continue to evolve under shifting and interacting external forces in difficult-to-predict ways" [18].

The good news is that LEADS, especially when used in concert with other change models, can help to build the case for and help sustain transformational change in the health care system [4]. Change leadership requires we consider (metaphorically speaking) taking a speed-reading course, where we don't read in sequence but in jumps and where we continue to practice, to get better ever faster. As we found in Chap. 9, system thinking and systems leadership is required to transform systems.

Given these limits of reductionist linearity, how can we put LEADS to work as a change leadership model to address the volatility, uncertainty, complexity and ambiguity (VUCA) of health systems change? We explore in the reminder of this chapter the challenges of getting beyond simply managing change [8]. This is the essence of distributed leadership and the power of LEADS as a change leadership tool. Let us explain how to put LEADS to work as a robust change leadership model in the dynamic context of leading change in today's health care system.

LEADS as a Model to Guide Change

Everybody likes progress. It's the changes they don't like!

Will Rogers

The first step in putting LEADS to work as a change model is for you as a leader to acknowledge and be able to clearly articulate why the *status quo* is not tenable or sustainable. This can be for any number of reasons. As we have seen from several vignettes already, the imperative for change is often created externally perhaps by new legislation, by a task force, by a court ruling, by a tragic bus accident or by the vagaries of democratic processes (changes in governments).

But change can also come from within, as this chapter encourages you to think about. Through the *power of one*, leveraging up your personal locus of influence and

power or though the power of working as one as part of an internal team, or an external coalition, you can create or orchestrate the need for transformational change. Regardless of where the impetus for change comes from, it is important that you know why you are championing it and why it is important for you to lead it.

By personally accepting that the current state is not sustainable and then clearly articulating a clear and compelling vision for that better future state, you define a gap between the two that we call the *territory of change*. The size, seriousness or significance of the gap evokes comparison to the first step of John Kotter's [19] change model, creating a *sense of urgency*, often referred to as a burning platform [20]. Let's look now at how the five domains can be reconfigured as a change leadership model.

Five Domains of LEADS as a Change Model

The model reassembles or reframes the five domains as an interactive and iterative unit or operating system. This is depicted in Fig. 10.1.

As Fig. 10.1 below shows, the LEADS domains and capabilities are not just a list, but an integrated whole interacting with one another, in an ongoing series of cycles to move toward the preferred future. The model suggests leadership happens at an operational (or personal and interpersonal) level (left hand side) and at the strategic (organizational or systems) level: (the right side of Fig. 10.1). Activities associated with both are interrelated and interdependent. The gap between the current and future states defines the territory of change: the short vertical black line.

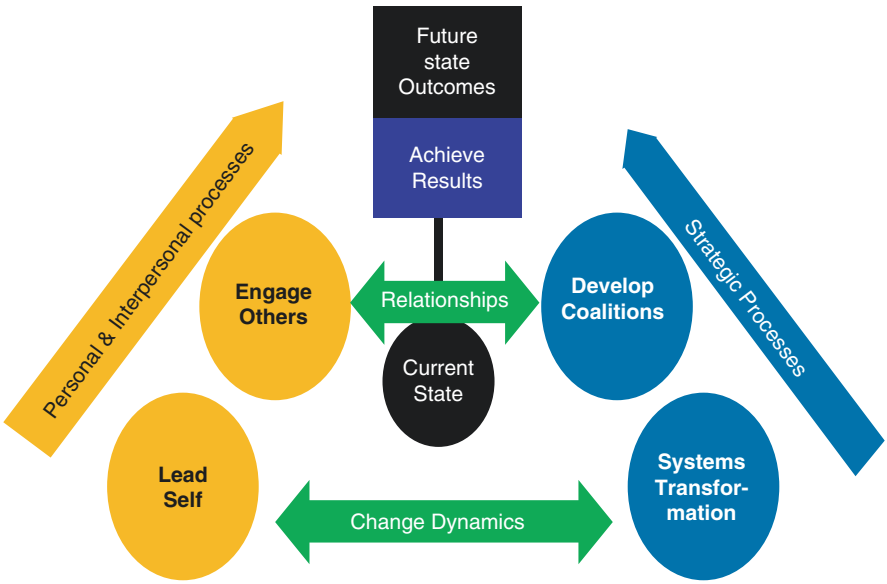

Fig. 10.1 LEADS as a model for change

Assessing the scope and breadth needed for change (context for change) is the first step of your change process. Once you have determined your locus of influence, you need to focus on the Set direction and Assess and evaluate capabilities of the Achieve results domain (featured at the top of the change pyramid) to establish a change destination. Vision, values and desired results help to define the preferred future. The model suggests you determine where the individual, organization or system is relative to the preferred future state. When expressed in measurable terms, the difference between current performance and desired performance shows the breadth and extent of the change you're undertaking. It also suggests short-term measurements (what Kotter called short term wins [21]) that can help guide course corrections along the way.

The other two capabilities of Achieve results (Align decisions with vision, values and evidence, and Take action to implement decisions) suggest ways leaders can align activities to ensure the journey stays on track. As change progresses, the Achieve results domain interacts with the capabilities of the other domains to keep change happening, to continue to achieve alignment of effort, and to help the corrective actions needed as you encounter those rocks in the field described in Chap. 7.

The second component of LEADS as a model of change highlights the need for leaders to have a sophisticated understanding of the human landscape of change and a high level of comfort with ambiguity and action learning. This component is represented by the horizontal green arrow linking the Lead self and Systems transformation domains. To achieve the desired results, you need to be attentive to the ever-changing external environment and need to understand what goes on psychologically when people—you and others—experience change. Individuals need support to transition from getting over the past to get to neutral before they can embrace the future [22]. To achieve a desired future, you and others will also have to change mindsets, behaviour, distribution of responsibility and resources, and the structure and culture of your organization. LEADS' tools, instruments and approaches can help you do that. Everyone involved in both transitions and change—whether they're employees, citizens, patients, or families—need to learn how to embrace change.

The capabilities under the Systems transformation domain show that leaders must clearly understand the dynamics of both large- and small-scale change. These include critical and systems thinking and strategically orienting yourself to the desired future, capabilities which let you outline actions—including supporting innovation and championing and orchestrating change—you'll need to stimulate learning and progress. All of the tools, models, and approaches in Systems transformation stimulate systems and critical thinking so individuals (power of one) and groups (power of working as one) can make choices about where and how change should take place.

Lead self is the personal analogue to Systems transformation. No meaningful change, big or small, can avoid the responsibility of personal change. If we as leaders are asking others to change their behaviour or their mindset as part of a change project, it is incumbent upon us as leaders to model the changes ourselves. The four capabilities comprising this domain—self-awareness, self-management, develop

self and demonstrate character—recognize leaders themselves must change. Some of the changes are psychological, making demands on your emotional intelligence, or testing your resolve; others require you to acquire or unlearn knowledge and skills and others put demands on your integrity and character. Leaders who can't meet those demands have diminished ability to champion change. Above all, you need be authentic when you model those capabilities, or your credibility as a leader suffers.

A third component of the model emphasizes the power of relationships to lead change (the short green horizontal arrow in the diagram). Relationship-building comes ahead of tasks in the process of change and both Engage others and Develop coalitions focus on it—Engage others in the operational or inter-personal context and Develop coalitions strategically, within, or between organizations.

Collectively and interactively, the five domains of LEADS address the actions leaders need to take in order to accomplish small or large system change. Consider reviewing the five domains of LEADS as a territory to be traversed; not a linear sequence of actions to be slavishly adhered to. You may wish to revisit certain places because they need your presence, or because they are necessary for you to replenish your own needs.

Simple Rules and Change: A LEADS Approach

Systems thinking gives rise to a phenomenon called simple rules, which are broad principles of change that leaders can use in many different contexts. Simple rules operationalize the concept of concerted action implicit in the practice of distributed leadership [23]. Allan Best and colleagues, in an article called Large-System Transformation in Health Care: A Realist Review, describe studying transformation initiatives to inform change processes in Saskatchewan [24]. They identified simple rules of large-systems transformation they thought were likely to increase the success of the initiatives.

In adapting these findings, and to assist us in distilling the lessons learned so far from putting LEADS to work as a change model, we propose three simple rules of change which, when interpreted and applied according to LEADS, can help leaders determine what to do and how to do it. The three simple rules are shown in Fig. 10.2.

In keeping with the systems construct of interdependency, the three rules interact with each other on an ongoing, fluctuating basis to lead change. These rules work whether you're attempting to change yourself, your unit, your organization, or system. The diagram shows the context at the centre, as practices associated with each of the three rules interact with and are conditioned by context; and the model itself is placed in a broader environment that also interacts with each component of the model. As the first rule of Fig. 10.2 indicates, you must constantly focus your efforts on improving results. You must always come back to two key questions: what results do we need to achieve? How do we align our actions with desired results?

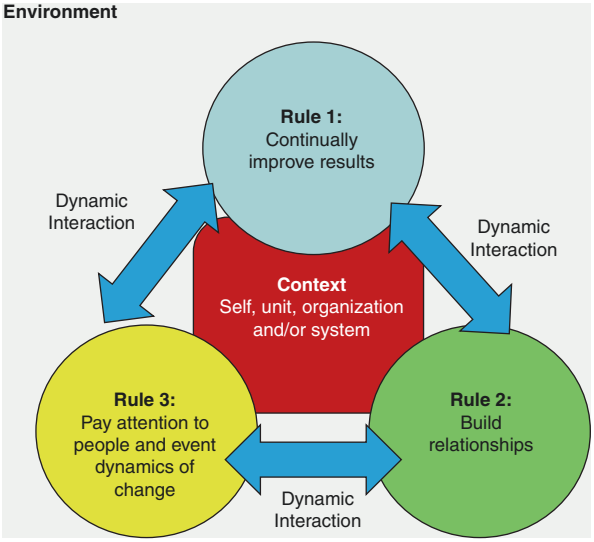

Fig. 10.2 Simple rules for leading change

The second rule is to build trusted relationships. It is through relationships that things get done. The LEADS domains of Engage others (interpersonal relationships) and Develop coalitions (inter-organizational relationships) outline the leadership actions necessary to build those relationships.

The third rule is to pay attention to the people and event dynamics of change. That's because dynamic interplay in a change is always a function of how people react and respond to events, in the larger world or in your change process. These can morph into new and unexpected challenges (Peter's wild cards from Chap. 7), either changing the desired result; or suggesting course corrections to the action plan on how to get there from where you are.

These LEADS change models are custom made by health, for health methods for thinking through and implementing system-wide change: we encourage you to use one of them to make change work. LEADS also provides a set of expectations by which to judge the quality of the change processes, and which could be used to set curriculum for aspiring health leaders. When applied by health care leaders, LEADS guides decision making, policy development and implementation at multiple levels in the system from patient care to system transformation.

Learning Moment

Picture your own workplace or locus of influence. Think about one practice you would like to change, on behalf of patients, families, or the community. Choosing either the five-domain LEADS change model, or the three simple rules approach, outline steps you would take to plan the change (your project).

Consider the following questions:

1. Is your project primarily operational or strategic?
2. In that context, clarify the change gap: the difference between the desired results and the current state of your project. How big a change is it?
3. What systems change implications does the project have? Consequently, what change challenges (unit, department, organization, coalition, system) will you face moving from where you are now to where you want to be?
4. Based on your understanding of the scope and breadth of those external changes, what internal personal challenges will you have to face?
5. Based on how big the change is, who will you need to build relationships with, and why? How will you do it? Are there approaches discussed in the Chap. 6 of this book (Engage others) that would help you build those relationships?

Putting LEADS to Work as a Change Leadership Model: Three Case Studies

Three success stories showcase how LEADS can and is being used by health leaders to lead change, not just react to what the health system is delivering in terms of challenges. Rather than follow either one of the two LEADS models of change directly, each leader has adapted them to context and improved them through their own thinking.

Nadine's Story: Context Is King

Our first case study comes to us from the Canadian province of Newfoundland and Labrador. The context is that in 2006 the government of the day decided to merge eight separate health care organizations into one to form Eastern Health. This regional authority serves the capital city of St. John's and the surrounding rural areas on the Avalon Peninsula. It also provides tertiary care services for the province.

After two years working on the consolidation of management and "back office" functions, the attention of the CEO and the senior team turned to a multi-pronged leadership development strategy. Nadine Whelan, initially as a member of the Organizational Development team and later as the head of the Leadership Development team, identified early on the need to build the strategy around a common framework which eventually turned out to be the LEADS framework. Here's her story.

> *As Nadine quickly found out, the most difficult obstacle to overcome in any post-merger integration process is the clash of cultures. And, as with any successful leadership development strategy, sponsorship from the top was key. Nadine also recognized that the pace of change and level of complexity in a large forming organization presented challenges to everyone's leadership, including her own. Nadine reflected on her own commitment from a* Lead Self *perspective: This is going to be a long journey…what is my vision for this work?*

Nadine also recognized that she had her own values and beliefs about leadership and change and was still working through her own transition to the new organization. She turned to her colleague, Joseé, who was working on an employee engagement and culture strategy. Being strategic systems thinkers, they both saw this work as interconnected and recognized that engaging others and building leadership capacity were critical to success. They also knew that certain results articulated in the organization's strategic and operational plans needed to be achieved and enriched by a broader systems perspective. These results revolved around the triple aim objectives of better health, better care and a better bottom line for the people of Newfoundland and Labrador. "What if, we use LEADS to help us?" Nadine asked.

Against conventional wisdom in change leadership, they took a "middle out approach," believing that's where the leverage was. A core group of 17 people participated in an internal LEADS facilitator certification program. Using LEADS as a change leadership tool, Nadine and this cross-functional, multi-level "volunteer army" [20] *formed a Leadership Network. They used the LEADS model to scaffold their learning, conversations and shared work; they lived LEADS.*

Together, they designed a two-day LEADS learning program with the lofty goal of building leadership capacity through connecting formal leaders and doing workshops on the organization's new strategic plan with the entire team of 650 managers. To support this action learning, Nadine designed a set of "LEADS Change Planning" adaptive leadership questions under each domain to be used by the facilitators to help leaders frame and reframe their change challenges. Workshop by workshop over a two-year period, they fostered a leadership community dedicated to co-creating positive change in the health system.

Throughout this process of change, Eastern Health experienced a series of unforeseen external shocks or crises. There was a crisis over botched breast cancer screening, followed not long after by another public review involving child welfare services which led to leadership changes, but the experiment with LEADS-based change continued. While the new CEO and senior leadership team were occupied with operational issues and rebuilding trust and confidence, Nadine and the growing informal LEADS change team continued the process of engagement in an organic way, working through and with "mavens" or key influencers throughout Eastern Health and, importantly, at every level of the system.

Nadine reflected with Joseé upon the journey and lessons in change leadership. They agreed that in many ways, the change process resembled the diffusion of innovation theory [25], *with early adopters being essential for testing the concept and engaging others. They recalled how the leadership network was essential in bridging formal and informal change approaches, each member playing an important role in helping people understand LEADS and putting it to work in nuanced contexts. One member, Cathy, was critical at first but eventually became an artful practitioner of Systems Transformation and key to helping leaders integrate LEADS with Lean and other improvement science methods.*

"Building relationships and aligning with organizational directions is critical to success in shifting contexts," Nadine said. "You really need to have the contextual agility to identify the change levers, agents and partners. When a new CEO came in with an engagement platform, we had matured our LEADS-based practices and integrated to a point that we were able to step into a new place and meet emergent leadership challenges. Developing coalitions internally provided a solid foundation for advanced leadership and organizational development and, eventually, building a strategic alliance in growing leadership capacity across the province."

Reflecting on the broader lessons in Nadine's story, we see LEADS's three simple rules at play. The expected results were clear: merge eight organizations into one, do it seamlessly from a patients' perspective, guided by IHI's triple aim. Leveraging up existing trusted relationships (Josee) and building new ones (Cathy) became key to delivering on the desired results despite several wild cards (the cancer screening crisis and the new CEO). Nadine and the Eastern Health team made

unanticipated adjustments along the way to keep the change process relevant and embedded the management deliverables the CEO and board were looking for in the LEADS change process. The story also underscores the need to balance change leadership with change management, as Kotter has suggested, which often means ensuring that the urgent (management issues such as dealing with the cancer screening crisis) don't crowd out the important (strategic issues around the merger, for example). One of the biggest lessons from Nadine's story is that "culture is king." When applying the LEADS pyramid of change, we need to remind ourselves of the adage: "culture eats strategy for breakfast."

Nadine's story testifies to the resiliency of both the LEADS model of change and of Nadine and her leadership team. She worked to establish a critical mass for change (her leadership network) and built momentum for the LEADS approach to change. Nadine has since moved on from Eastern Health. Like Collin's flywheel, however, LEADS is now embedded in Eastern Health as a vehicle for leadership development and systems change. This case study also supports the general observation that before you can effectively embrace LEADS as a change model, key team leaders must internalize the LEADS framework.

Finally, out of this process Nadine and her team also developed a change guide that continues to guide them through ongoing system and structural change (see Fig. 10.3).

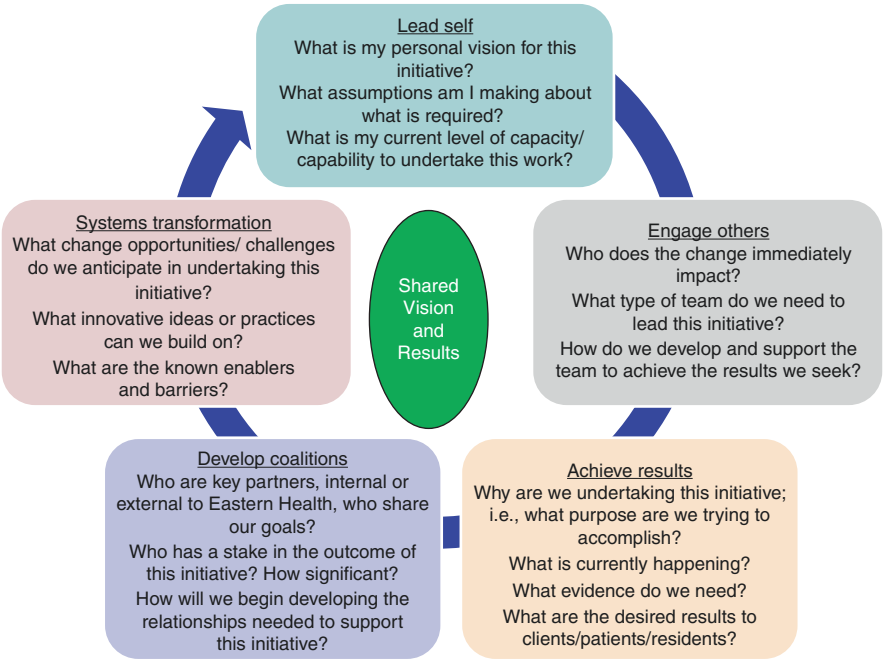

Fig. 10.3 Eastern Health's leadership of change framework as adapted from the LEADS model by Nadine Whelan (with permission)

The Eastern Health model provides leaders with questions to answer as they engage in change, a classic systems approach to change.

You are invited by Nadine—and us—to consider other questions that might populate the LEADS change planning approach used by Nadine and her team.

Hamilton Health Sciences Centre: The Drip Method of Leading Change

Our second case study on putting LEADS to work as a change leadership model is from Hamilton Health Sciences (HHS). HHS is a large academic health science centre in Southern Ontario, with over 15,000 staff, physicians, volunteers and researchers in 10 locations. It's affiliated with one of Canada's 17 medical schools, at McMaster University.

Hamilton Health Sciences was an early adopter of the LEADS framework dating back to 2009, initially sparked by a succession planning imperative. Early on, the two architects of the LEADS journey at Hamilton Health Sciences—Sandra Ramelli and Kathryn Adams—recognized that system change does not come through an orchestrated, top-down plan. In their words: "There are no big bang solutions. Our approach is more like a dripping tap that accumulates a significant amount of water over time: what we call, the 'Drip Method' of leading change." Here is their story of putting LEADS to work as a change model by the installment plan.

LEADS as a change model was not intuitive for Sandra and Kathryn in the beginning. In retrospect, however, LEADS did help guide them as a change leadership tool. Sandra's aha! moment came when she realized: We are the instruments of our success as leaders. As one learns more about LEADS, the framework becomes more intuitive and the capabilities become hard wired in you—they become who you are and how you lead.

While HHS didn't use the five domains of LEADS as a holistic change model in the beginning, our approach was to engage in incremental change using the LEADS domains as a guide. For example, LEADS as a philosophy preaches that who you are gets expressed in the way you behave as a leader. That gave us the confidence that we could lead our way. Also, the distributed leadership philosophy helped us to realize we can't create change without our people being engaged and empowered to actually lead the change with us. The Lead self domain was also an inspiration for us as it underscores that we are the instruments of our own success as leaders and, if we are committed to change, we can enhance and advance our ability to lead. Our work in developing a succession planning model helped us to recognize the value and importance of engaging others when leading change. Once we saw the advantages there, we saw the potential of engaging our people to help build an organization-wide program for leadership development with LEADS as the foundation. Gradually, drip by drip by drip, the water was accumulating and LEADS took hold.

We used the Achieve results capabilities to focus and clarify the results we were looking for. What was our vision? Why are we wanting to shift leadership? Part of the vision was to transform the system. Because we were an organization that was changing--we were transforming our system to a people-centred care model—we needed to change our culture, reaching beyond our walls. Leaders inside and outside our organization became the change agents. We realized we couldn't do this alone. How are we going to build the relationships that we need both internally and externally? Here's where we drew on the Develop coali-

tions capabilities. We realized that if LEADS was our foundation, we had to lead using it and we had to get others to lead, using it, with us.

One of the changes that came from this work was the creation of a Centre for People Development that opened in 2015. It now has oversubscribed programs to develop leaders. The guiding principle is that there is a "leader in every chair." Anyone in the organization who aspires to be a leader can learn what they need to create the change we agree we are collectively pursuing. Now, from a Systems transformation perspective, we see the Centre for People Development as just one important piece in the larger picture of transformation at HHS. We have since coupled overall strategy with leadership; it is part of our success formula. We are showing the value of developing better leaders in terms of achieving our organization's strategic priorities. This is one of the reasons that our CEO champions this work. Developing a LEADS based culture is our true north: you have to live LEADS. When it becomes internalized, we will have changed HHS together. This story can be told in a myriad of ways. We are living LEADS. We now embody it. It's inside us. You don't change who you are at 5 p.m.

We found so many aspects of this story, and the way in which it was told by Sandra and Kathryn, inspiring. While they didn't use the five domains of LEADS in the beginning, their "drip by drip" approach has been successful. In terms of conducting an after-action review against the three simple rules, while the initial impetus for change came from a succession planning imperative, over time it evolved. And, as it evolved, Sandra and Kathryn were successful in building relationships within Hamilton Health Sciences and within the broader health care community.

What was critically important to their success was engaging physician leaders. It started with engaging individual physicians. What started as a trickle, drop by drop, has now translated into physicians being passionate about LEADS and has translated into significant physician participation in leadership development programs offered by the Centre for People Development.

Advancing Psychological Health in the Workplace

For a third case study in putting LEADS to work as a change leadership model we turn to what is being done across Canada to advance psychological safety in the workplace. As adults, we spend more waking hours on average at work than at home or anywhere else [26]. About 30% of all short and long-term disability claims are now for mental health problems and illnesses. Taking a mental health day has gone from being a last-minute day off work to a serious and growing reality of the workplace. The health care sector is anything but immune from this growing challenge. "Staff working in the health care sector are more likely to miss work due to mental illness or disability than people in all other sectors. They face higher rates of burnout, compassion fatigue and sleep deprivation that can affect their psychological health and safety and the safety of their patients" [27].

To address this challenge the Mental Health Commission of Canada developed the National Standard for Psychological Health in the Workplace (the Standard) [28]. The Standard, which is the first in the world, is built around 13 psychosocial factors that can affect the mental health of employees and patients in the workplace.

Building on a strong track record of working together to advance the mental health agenda in Canada more generally, the CEO of the Mental Health Commission and the former CEO of HealthCare*CAN* (one of your co-authors representing Canadian hospitals and regional authorities) shared a common concern about the slow uptake of the Standard in health care workplaces. They agreed to form an issue-specific, time-limited alliance called the "By Health, For Health Collaborative" to help speed it up. They turned to the LEADS framework and one of your two co-authors to help frame a joint action plan.

Here's how LEADS was put to work as a change model to develop a seven-step change management process for accelerating implementation of the Standard in Canadian health care workplaces. The first step in the process was to map the 20 capabilities that comprise the LEADS framework against the 13 action-oriented, psychosocial factors that make up the Standard.

It became clear the factors that make up the Standard aligned very well with the LEADS capabilities, perhaps not surprising, given the emphasis LEADS puts on healthy workplaces and the acknowledgement in the Standard of the importance of leadership. For example, the Centre for Addiction and Mental Health in Toronto used LEADS and the Standard to develop a 360-assessment tool for their leaders that marries LEADS and the Standard to generate the 360 questionnaire [29].

After the mapping exercise, LEADS was used to develop a seven-step process to help health care and other organizations adopt the Standard (*see* Fig. 10.4).

As in the case of the two previous case studies, step one in applying LEADS as a model of change is to develop a clear consensus on what success looks like: in this case creating psychologically safe workplaces (vision and desired results: how will you measure success?) The second step is to assess the current state to determine the leadership gap, using meaningful metrics for the desired result and for monitoring progress. Step three is to ask those leading the change to look in the mirror to ensure they are modelling behaviour consistent with the Standard: can you lead the project if you yourself are psychologically unhealthy? Step four is essentially to put together your guiding team. Step five is ensuring that you are backing up the plan with the resources necessary to execute it. Step six reflects the reality that no organization is an island and the need therefore to work with community organizations, the regional authority or local networks to reinforce adherence to the Standard. And, finally, step seven is to recognize that the Standard is just one, albeit important part of creating a psychologically safe work environment. Laws, regulations, policies, practice and protocols can either help or hinder implementation of the Standard. This is where systems thinking is integral to success in achieving desired results.

In keeping with the Eastern Health model presented earlier, each of the seven steps of this model has a set of guiding questions for the leader. An astute leader will also note—contrary to our earlier statement that linear change models are not the best—this approach is expressed as a seven-step approach, suggesting linearity. However, once initiated, leaders will find themselves moving from one step to another not necessarily in a straight line, but iteratively relative to the needs of the change process. The seven steps are more an intellectual planning approach to help conceptualize the various challenges and see the journey holistically. Once embarked on the journey, you may have to revisit different steps to address new situations, new people, and unexpected events.

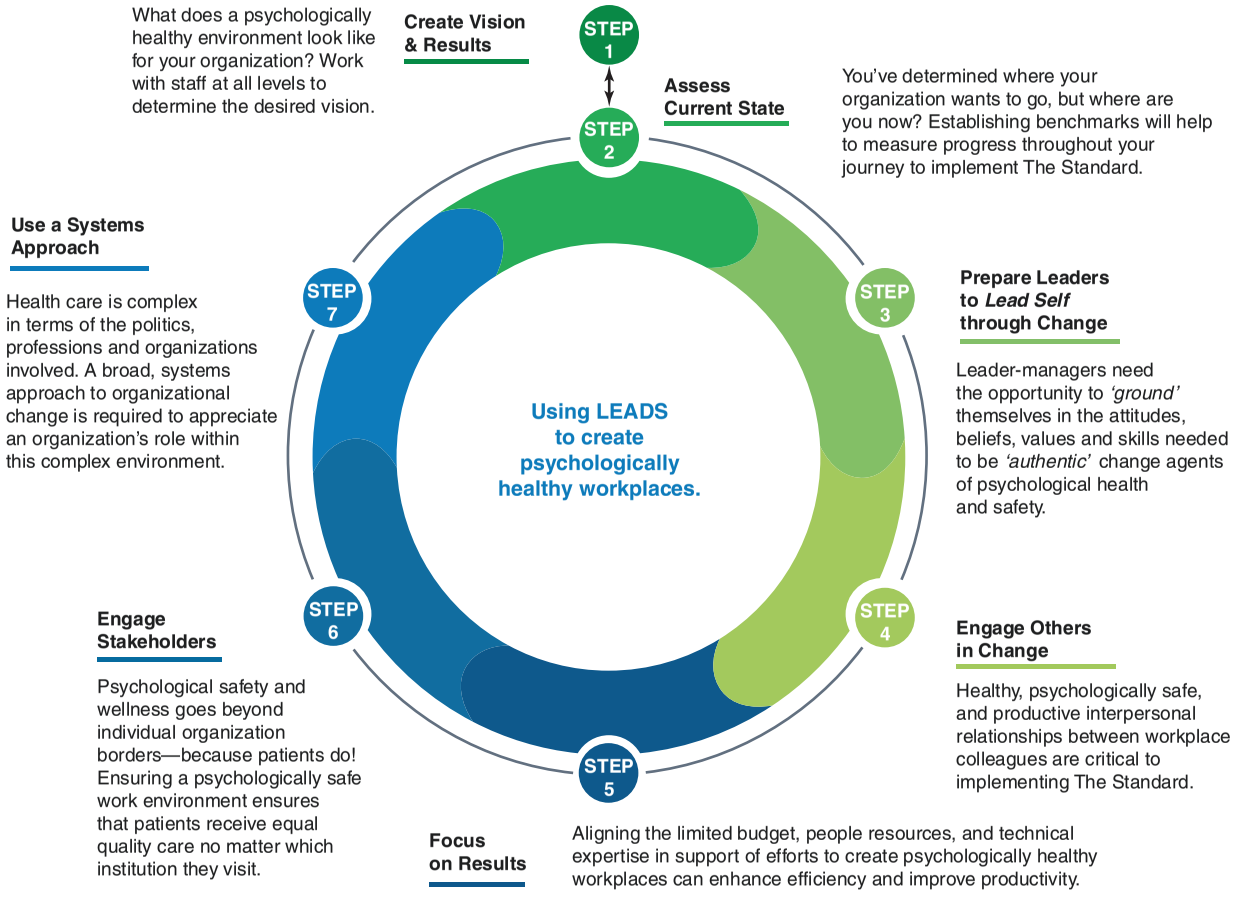

Fig. 10.4 LEADS model to implement psychological health and wellness standards in an organizational context

Three Case Studies: Key Takeaways

Each of these quite different case studies or stories show how the LEADS framework can double as a change model when your put all five domains to work in a holistic, interactive way. LEADS has been used with intention, as in the case of accelerating the uptake of the Standard and Nadine's story. Or, it can be adopted by the installment plan and introduced 'drip by drip' as it was at Hamilton Health Sciences. Don't go into the change process believing that you need to have it all figured out. If you employ LEADS methods, you can learn as you go, relying on others to co-create the desired change with you.

However you choose to use LEADS, either on its own or with other change models, remember the three simple rules of change: be clear about the results you are hoping to achieve; build and sustain relationships with other players; and pay attention to the change dynamics created by events and people you work with. Learn as you go, because nobody has all the answers.

Learning Moment: Healthy Workplaces
Reflect on your own workplace.

1. What evidence do you have, or do you need to have, to assess your organization's efforts to create and sustain a psychologically healthy workplace?
2. Based on that evidence, how healthy is it?

Using one of the change approaches in this chapter, where will you put your efforts to sustain what is working, or to improve what is not?
If not, take the LEADS-base change tool described here and see how you can use it to put the Standard in your workplace.

Summary

To be a good leader is to be good at leading not just managing change. The exercises and stories in this chapter highlight how to use the LEADS framework for that purpose and how important it is for you to see the interdependency of the leadership capabilities in that process. Change is a constant in all health care systems and LEADS can support you as you work with it, by outlining how you need to think and act differently to be a successful change leader.

This chapter describes how change management and change leadership are different. The difference is not determined by the order of magnitude or scale of the change being contemplated, rather by the number of people involved and the complexity of the change. We have reviewed the available literature around complex (non) adaptive systems like health care and how linear or reductionist approaches to change are ill-equipped to address current health care challenges. We see LEADS as

a robust change leadership tool because it's intuitive, because it is a by health, for health framework and because it is built on the foundations of good leadership itself. Finally, this chapter features three live case studies of putting LEADS to work as a change leadership model, showing that like any change model, either using it on its own or in combination with other models, it must be adapted by leaders to each unique context for it to be successful.

References

1. Drucker PF. Managing in turbulent times. London: Routledge; 2015.
2. Dickson G, Lindstrom R, Black C, Van der Gucht D. Evidence-informed change management in Canadian healthcare organizations. Ottawa, ON: Canadian Health Services Research Foundation; 2012. http://www.cfhi-fcass.ca/Libraries/Commissioned_Research_Reports/Dickson-EN.sflb.ashx. Accessed 20 Jul 2019.
3. Rosenbaum D, More E, Stane P. Planned organisational change management: forward to the past? an exploratory literature review. J Organ Change Manag. 2018;31(2):286–303.
4. Al-Haddad S, Kotnour T. Integrating the organizational change literature: a model for successful change. J Organ Change Manag. 2015;28(2):234–62.
5. Antwi M, Kale M. Change management in healthcare: literature review. Kingston: The Monieson Centre, Queens School of Business; 2014.
6. Khaira M. Best practice leadership competencies for effective change management in Island Health. National health leaders conference [unpublished paper]. Toronto, ON: Island Health Authority; 2019. p. 41.
7. Salem-Schatz S, Ordin D, Mittman B. Guide to after action review. Version 1.1: Center for Evidence Based Management; 2010. https://www.cebma.org/wp-content/uploads/Guide-to-the-after_action_review.pdf. Accessed 28 Aug 2019.
8. Mintzberg H. Simply managing. San Francisco, CA: Barrett-Koehler; 2014.
9. Dickson G. Health reform in Canada: enabling perspectives for health leadership. Healthc Manage Forum. 2016;2016:1–6.
10. Collins J. Turning the flywheel: a monograph to accompany good to great. New York, NY: Harper Business; 2019.
11. Braithwaite J, Churruca K, Long J, Ellis LA, Herkes J. When complexity science meets implementation science: a theoretical and empirical analysis of systems change. BMC Med. 2018;16:63.
12. University of Victoria. Complexity science in brief. Victoria, BC: University of Victoria; 2012. https://www.uvic.ca/research/groups/cphfri/assets/docs/Complexity_Science_in_Brief.pdf. Accessed 19 Aug 2019.
13. Miles A. Complexity in medicine and healthcare: people and systems, theory and practice. J Eval Clin Pract. 2019;15(3):409–10.
14. Dumas C, Beinecke RH. Change leadership in the 21st century. J Organ Change Manag. 2018;31(4):867–76.
15. Kotter J. Change management vs change leadership – what's the difference. 2012. Place unknown Video: 5 min, 4 sec. https://www.youtube.com/watch?v=2ssUnbrhf_U. Accessed 28 Aug 2019.
16. Kanter RM. Evolve!: succeeding in the digital culture of tomorrow. Boston, MA: Harvard Business Press; 2001.
17. MacLeod H. Humanizing leadership. Vancouver: Friesen Press; 2019.
18. DeGroote MG. Health Leadership Academy. Preparing for the alternative futures for health: why navigating the disruptive forces of healthcare require transformational leadership. Hamilton, ON: McMaster University; 2019. https://healthleadershipacademy.ca/files/2019/04/Alternative-Futures-of-Health.pdf. Accessed 29 Aug 2019.
19. Kotter JP. A sense of urgency. Boston, MA: Harvard Business Press; 2008.

20. Galloppin L. The giant misunderstanding on burning platforms. Online magazine for organizational change practitioners. 2011. http://www.reply-mc.com/2011/01/17/the-giant-misunderstanding-on-burning-platforms/. Accessed 19 Jul 2013.
21. Kotter J. Leading change: why transformation efforts fail. Harv Bus Rev. 1995;1995:59–67.
22. Bridges W. Bridges transition model. London: MindTools; 2019. https://www.mindtools.com/pages/article/bridges-transition-model.htm. Accessed 29 Aug 2019.
23. Currie G, Lockett A. Distributing leadership in health and social care: concertive, conjoint or collective? Int J Manag Rev. 2011;13:286–300.
24. Best A, Greenhalgh T, Lewis S, Saul J, Carroll S, Bitz J. Large-system transformation in health care: a realist review. Milbank Q. 2012;90(3):421–56.
25. Lidblad J. A review and critique of Rogers' diffusion of innovation theory as it applies to organizations. Org Dev J. 2003;21(4):50–64.
26. Mental Health Commission of Canada. What's the issue? Ottawa, ON: Mental Health Commission of Canada; 2019. https://www.mentalhealthcommission.ca/English/what-we-do/workplace. Accessed 23 Aug 2019.
27. Dickson G. Transforming healthcare organizations. Healthier workers. Healthier leaders. Healthier organizations. Ottawa, ON: Mental Health Commission of Canada; 2018. https://www.mentalhealthcommission.ca/sites/default/files/2018-11healthcare_crosswalk_eng.pdf. Accessed 23 Aug 2019.
28. Canadian Standards Association (CSA) in Association with the Mental Health Commission of Canada. Psychological health and safety in the workplace—prevention, promotion, and guidance to staged implementation. Ottawa, ON: Canadian Standards Association (CSA) in Association with the Mental Health Commission of Canada; 2013. https://www.csagroup.org/documents/codes-and-standards/publications/CAN_CSA-Z1003-13_BNQ_9700-803_2013_EN.pdf. Accessed 20 Jan 2019.
29. Dickson G. Mapping the national standard for psychological health and safety in the workplace to the LEADS in a Caring Environment capabilities framework [unpublished commissioned report]. Mental Health Commission of Canada: Ottawa, ON; 2018. https://www.mentalhealthcommission.ca/sites/default/files/2018-11/healthcare_crosswalk_eng.pdf.