The LEADS in a Caring Environment Capabilities Framework: The Source Code for Health Leadership

3

Graham Dickson and Bill Tholl

Leadership is the art of accomplishing more than the science of management says is possible.

Colin Powell [1]

Leadership isn't management and it's not administration. It's energy, influence, perseverance, resiliency, dedication, strategy and execution—applied in the real world of people to create change. As Colin Powell said, "Leadership is the art of accomplishing more than the science of management says is possible." [1].

The ever-more complex challenges facing modern health systems demand sophisticated leadership. That leadership—as we defined it in Chap. 2—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.* The LEADS in a Caring Environment Capabilities Framework—the focus of this chapter—is the evidence-based translation of that definition into action: what leaders do to respond to these challenges.

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_3

LEADS in a Caring Environment

The source code of life is the DNA molecule. Each molecule comprises a common set of nucleotides but combines them in unique ways to produce all the proteins in the human body and create the unique characteristics of each of us. So it is with the LEADS framework in the world of health leadership: its 5 domains, each with 4 capabilities, are the source code of leadership, able to be combined in endless permutations or combinations to respond to the changing circumstances, external pressures and people involved in each situation a leader faces. The framework is outlined below (Fig. 3.1).

Lead self: *Self-motivated leaders...*

Are self-aware:

- Aware of their assumptions, values, principles, strengths and limitations

Manage themselves:

- They take responsibility for their own performance and health

Develop themselves:

- They actively seek opportunities and challenges for personal learning, character building and growth

Demonstrate character:

- They model qualities such as honesty, integrity, resilience, and confidence

Engage others: *Engaging leaders...*

Foster development of others

- They support and challenge others to achieve professional and personal goals

Contribute to the creation of healthy organizations

- They create engaging environments where others have meaningful opportunities to contribute and ensure that resources are available to fulfill their expected responsibilities

Fig. 3.1 The LEADS in a Caring Environment capabilities framework [2]

Communicate effectively

- They listen well and encourage open exchange of information and ideas using appropriate communication media

Build teams

- They facilitate environments of collaboration and co-operation to achieve results

Achieve results: *Goal-oriented leaders…*

Set direction

- *They inspire vision by identifying, establishing and communicating clear and meaningful expectations and outcomes*

Strategically align decisions with vision, values and evidence

- *They integrate organizational missions, values and reliable, valid evidence to make decisions*

Take action to implement decisions

- *They act in a manner consistent with the organizational values to yield effective, efficient public-centred service*

Assess and evaluate

- *They measure and evaluate outcomes. They hold themselves and others accountable for the results achieved against benchmarks and correct the course as appropriate*

Develop coalitions: Collaborative leaders...

Purposefully build partnerships and networks to create results

- *They create connections, trust and shared meaning with individuals and groups*

Demonstrate a commitment to customers and service

- *They facilitate collaboration, cooperation and coalitions among diverse groups and perspectives aimed at learning to improve service*

Mobilize knowledge

- *They employ methods to gather intelligence, encourage open exchange of information, and use quality evidence to influence action across the system*

Fig. 3.1 (continued)

Navigate socio-political environments

- *They are politically astute. They negotiate through conflict and mobilize support.*

Systems Transformation: *Successful leaders...*

Demonstrate systems/critical thinking

- They think analytically and conceptually, questioning and challenging the status quo, to identify issues, solve problems and design and implement effective processes across systems and stakeholders

Encourage and support innovation

- They create a climate of continuous improvement and creativity aimed at systemic change

Orient themselves strategically to the future

- They scan the environment for ideas, best practices, and emerging trends that will shape the system

Champion and orchestrate change

- They actively contribute to change processes that improve health service delivery.

Fig. 3.1 (continued)

Caring

Our research, reinforced since the release of the first edition, is unequivocal: the essence of effective health leadership is the ability to care for the health and well-being of others. The common thread that unites people who work in health care—administrators, physicians, nurses and the thousands of other health and social service professionals working in the system—is caring about the health and well-being of others. For a health provider, caring means delivering the best service with compassion, respect, and empathy. For the leader, it means creating a physically and psychologically safe environment for your team, caring for yourself, and acting in ways in which caring shines through every day. Caring is the *why* of leadership in health care.

However, caring alone does not make an effective leader. Just like clinicians, who if they care too much for others can end up not enough caring for themselves,

a leader can develop what is known as compassion fatigue [3], a combination of burnout and secondary traumatic stress in the workplace. One study showed that compassion fatigue inhibits nurses' ability to foster the caring behaviour necessary for optimum patient outcomes. Look what one leader did to counteract compassion fatigue, for herself and her nurse colleagues:

Putting LEADS to Work: Caring in Action

Nurses and doctors are renowned for their commitment to caring. Caring was what nursing was all about for Dorothy, a nurse leader. It was why she went into nursing; it was why she remained in nursing.

She began to wonder why nurse's caring had been silenced. What were they afraid of? Her dream was to give voice to nurse's story of caring, so she did. She met with colleagues in practice circles. The discussions that happen in the circles facilitate a deeper understanding of a hurt or incident, what happened, and ideally lead to greater satisfaction among the people who participate.

Dorothy used the practice circle to allow nurses to share memories of caring and non-caring among themselves; to re-learn the excitement and commitment to caring that brought them to the profession, and to reduce the stress of over caring.

In the practice circles the nurses experienced the power of storytelling to move them from silence to voice, to illuminate their experiences for shared reflections and allow them to imagine their desired future. Practice circles gave them three kinds of sight: hindsight, insight, and foresight, and in doing so, re-energized their ability to care for patients [4].

Just as balance is required in health, balance is also required in care. That requires an individual whose caring is fully integrated with who they are (being) and how they act (doing). Being encompasses your values, beliefs, attitudes and personality. Doing is the action you take, inspired and enabled by your being, so what you do expresses your character. Combined with your interpersonal skills and strategic abilities, being and doing allow you to influence the actions of others to create meaningful change (see Fig. 3.2).

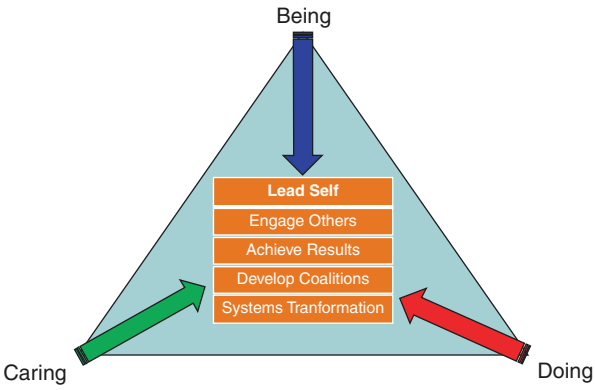

Fig. 3.2 Caring, being and doing interact to generate the LEADS in a Caring Environment capabilities framework

Environment

Originally, the word "environment" in the title of the LEADS framework was used to capture the concept of leadership as an organic system. Now it's often used to denote *context*, which is increasingly used in much of the recent leadership literature to describe the external factors around leadership [5]. We use the two terms interchangeably, to recognize that both the context in which leadership takes place and leadership itself are organic—that is, the ever-fluid human environment of health care is influenced by individual leadership actions and vice-versa.

Jean-Louis Denis and colleagues see the health system in Canada as a series of ever-larger systems, from micro (patient-provider) to mega (systems-citizen), with primary care practices, hospitals and regional health authorities nested within each other [6]. Whether leadership is micro—such as on one nursing station—or macro, at the level of a health authority or province—it interacts with factors in the broader environment that have the potential to change it. Your effectiveness as a leader will come from how you understand and respond to the interdependent dynamics among you, the people you're leading, the environment in which change is happening and whether you can bring others together to work with you collectively on problems.

Peter Senge and colleagues call people who can foster collective leadership "system leaders" (the example they give is Nelson Mandela) and say "At no time in history have we needed such system leaders more." [7] Only through collective leadership, they say, will we be able to solve problems like climate change, youth unemployment, or destruction of eco-systems: problems that all of us face together. System leaders have three core abilities:

- Seeing the larger system of which the problem is a part;
- Fostering reflection and creating generative conversations;
- Shifting the collective focus from reacting to problems to co-creating the future.

Following the LEADS framework should help you to become a system leader, able to work collectively to solve big problems.

Capabilities

Henry Mintzberg, a Canadian guru in leadership and management, advocates moving away from traditional *business* language such as management functions and competencies and referring instead to leadership mindsets or capabilities [8]. We decided early in our work on LEADS to refer to the requirements for exceptional health system leadership as capabilities. We had both practical and cultural reasons for that choice.

First, we think the term competency is most appropriately used in training to refer to a basic skill set—the skills and knowledge individuals need to do their jobs in a predictable environment. In that sense, competencies can be expected of managers whose job it is to address questions such as: *What is it we want to do?* and *How do we do it well?*

Leadership capabilities, on the other hand, lift you beyond a basic skill set, allowing you to build on your training by incorporating your unique knowledge, vision and values into your interaction with colleagues and the environment. Managers tell people what to do in a predictable environment; leaders set a direction and engage people so they are willing to head somewhere new. Competencies are also less likely to continue developing throughout a lifelong journey. Over the years, you may find yourself able to lead well in one situation but not in another; exploring the reasons for that is part of continuously building your capability toolkit and part of lifelong development and growth. To help you with that process, each of the five LEADS domain chapters has a self-assessment exercise at the end that poses questions tailored for five contexts for the practice of leadership—informal leader; front-line supervisor, mid-manager, senior leader and executive leader.

Framework

We use the word framework in connection with LEADS to make it clear the domains and their capabilities outline the parameters of leadership, but don't include all the details that make up leadership. The LEADS framework is designed to be tailored by individual leaders according to their own individual strengths, weaknesses and character.

Another way to look at it is that the five LEADS domains are like the rooms in a house—a kitchen, living room, bathroom and two bedrooms. Each room has features common to all houses—a counter in the kitchen, a shower in the bathroom, closets—which are the capabilities. But rooms are different in different houses and even in the same house they change over time, with redecorating and renovation. You, the leader, are the householder, choosing colours, furniture, art. In the same way, your leadership reflects what you choose to emphasize among the domains and capabilities.

The Validity of LEADS: Can You Depend on It?

How confident can you be that the LEADS framework represents an accurate and valid treatment of health leadership in Canada, and health sectors in general? You might be excused at this point for saying to yourself "Well, some of this sounds good—some of it seems sensible—to what extent can it be validated by research? And even if validated, what traction does it have in the real world of health leadership?"

In the research world, a good study exhibits two forms of validity. The first is *construct validity*: do the findings and results of the research reflect the data and is the logic of interpretation sound and reliable? Researchers go to great pains when they are publishing to show the steps taken to create construct validity. Because this is not a peer-reviewed journal, we will give just an overview on the rigour of our research, and the processes of interpretation that ultimately led us to LEADS.

The second form of validity is called *face validity*, where the findings of the research resonate with people who are the users of the research. The findings make sense to them, considering their own experiences of leadership. The LEADS framework appears to satisfy a growing community of practice of health leaders in both aspects of validity.

Construct Validity of LEADS

Behind the apparent simplicity of the LEADS framework lies a 12-year process of research, dialogue, discussion and use of LEADS. The research was initially carried out by two research teams from Royal Roads University working with health care decision makers across Canada. More recently the LEADS Collaborative, a team of academics and practitioners who are dedicated to ensuring the evergreening of LEADS, has taken the lead. There are more details on research in Chap. 11; what follows is a short summary.

The work on LEADS has been done in three phases. The first phase (2006—2009) was what's called "participatory action research," where research is conducted in cycles of experimentation and reflection by the research team on important questions[1] [9]. This phase was done in three cycles. The second phase (2010–2014) consisted of early efforts to employ LEADS, and a 4-year action research project involving six case studies [10]. The third phase—between 2014 and 2019—comprised an evaluation of the impact of LEADS and a review of the literature published since the original research. That recent research is the focus of this second edition.

Three studies done between 2014 and 2018 confirmed the construct validity for the LEADS framework. The first, completed in 2014, was a Partnerships in Health Systems Improvement research project, funded by the Canadian Institutes for Health Research and the Michael Smith Health Research Foundation in BC. The purpose of the project was to observe leadership in action during ongoing change: six sites, five provincial and one national, were chosen to do the action research. The final report found "Five out of the six case studies…showed LEADS as a useful expression of the leadership qualities required to guide leadership talent management" [11].

Two additional studies found LEADS had robust construct validity [11, 12]. In 2018, a systematic review of the literature was commissioned by the Canadian Health Leadership Network and the Canadian College of Health Leaders. The

[1] Traditionally, participatory action research is conducted by a team of both academic researchers and decision makers, who are trying, together, to use inquiry-based methods to generate change in the context of the real world and study it at the same time. It is called the action research phase because most of the activities were formally undertaken using a participatory action research approach. Consequently, the research was conducted in cycles, each consisting of ongoing steps of research; sharing those findings with decision makers, refining the research, and bringing it back to researchers, until the product (ultimately LEADS) was consistent with the 'construct' of the research process.

analysis found that "across all groups of articles anchored in different discipline domains, the articulation of health leadership research aligns with LEADS…the results show that there does not appear to be any domain- or capability-specific revisions needed to maintain the conceptual currency of LEADS at the time of writing." [13] A 2015 study done by the McMaster Health Forum outlined evidence supporting many of the capabilities of LEADS [14].

Face Validity of LEADS

There are two tests of its face validity. First, its initial appeal: is LEADS intuitive enough, accessible enough and accurate enough in its portrayal of leadership to be accepted at all levels of the health system—from executive offices to people on the front lines of care? Second, is LEADS useful and effective for developing leadership, managing talent and planning succession?

LEADS had strong initial appeal. Between 2006 and 2008, the Health Care Leaders' Association of British Columbia, a voluntary professional association of individuals and the province's six health authorities[2] formally endorsed LEADS as a foundation for their leadership endeavours. In November 2009, the Canadian Health Leadership Network[3] (CHLNet) entered a formal agreement with Leaders for Life, a BC legacy organization responsible for giving birth to LEADS, which has subsequently given way to LEADS Canada, to jointly increase awareness of the *LEADS in a Caring Environment* framework and the availability of LEADS-friendly leadership tools across Canada [15]. CHLNet—which has more than 40 regional, provincial and national members—has used LEADS as the foundation for its strategic directions from its inception in 2009 to today. In 2010, the Canadian College of Health Service Executives (now the Canadian College of Health Leaders), endorsed the framework as the foundation of leadership development for its members, and for a certification program for its continuing professional development programs.

The second phase of face validation, from 2009 to the publication of this book, could be called practical research. Over that decade, the LEADS framework was

[2] Vancouver Island Health Authority (VIHA; now Island Health); Provincial Health Services Authority (PHSA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); and Fraser Health Authority (FHA) are the six regions in British Columbia, that offer full programs of health services to British Columbians. Note: the PHSA is a quaternary service delivery entity that offers provincial programs in cancer, transplants, etc. in partnership with the other five regional health authorities.

[3] The Canadian Health Leadership Network (CHLNet) is a not-for-profit, **value network** comprised of over 40 health organizations across the country. The network facilitates or brokers joint work among and between its Network Partners; using the LEADS framework as a foundation for much of that work. This joint work cuts across the health disciplines and across the lifecycle of leaders. CHLNet believes that leadership is a life-long pursuit and is Canada-wide. It is through this joint work that CHLNet produces a unique value, adding to the growing number of individual leadership initiatives across Canada.

tested through its use by hundreds of people and organizations, and we give some examples of its impact on them throughout this book.

LEADS has shown itself to be flexible enough to be useful in a broad range of organizations and settings, according to an impact assessment of six organizations commissioned by the Canadian College of Health Leaders in 2016.[4] The assessment found no single best way to implement LEADS. Instead, each organization developed an approach that worked for their context, resources, and strategic aims. LEADS continues to work for the five health organizations, despite ongoing change [16].

LEADS also appeals to both genders—throughout this book you'll see stories from many female leaders who view LEADS as emancipating and empowering, giving them the licence to lead.

LEADS has been embraced by people from many different cultures, including Dr. Arun Garg. Dr. Garg is the founder of the Canada India Network Society, a practising physician for over 40 years, a clinical professor at the University of British Columbia and an adjunct clinical service professor at Simon Fraser University. The following is a condensed version of a piece he wrote about the similarities between LEADS and yoga.

Even though I was born in the birthplace of yoga, I never understood or related to it. It was an exercise program, difficult postures and twisting of body, which were beyond my comprehension.

This all changed after my meeting with Swami Baba Ram Dev, first in 2008 during his short visit to Vancouver, followed by a visit to India and a personal meeting with him. He told me yoga is a path of action, affirmation and achievement. Rereading the Bhagwat Gita showed me that the narrative is based on yoga philosophy and all our actions are part of yoga fabric.

At the same time, I started to work with the LEADS framework, which stands for: Lead self, Engage others, Achieve results, Develop coalitions and Systems transformation. The program provides a strong basis of leadership through these five areas, which to me resonated with five yogas of raja, karma, bhakti, jnana and gyan.

Raja yoga of Patanjali teaching is the foundation, like a foundation of a home. Its eight limbs form the basis of living, the rules of the game and basis of yoga philosophy and are similar to the five domains of LEADS.

Bhakti yoga and Jnana yoga reflect the LEADS domain of Lead self. Bhakti, the first pillar, relates to consciousness and doing things with passion and commitment. Jnana is the third pillar, and connects meditation, mindfulness and concentration.

Just Baharat speaks to the power of relationships, and the leader should provide opportunity to all to dream and achieve, which echoes engaging others. Another teacher, Swami Patel says "Little pools of water tend to become stagnant and useless. But if they are joined together to form a big lake the atmosphere is cooled and there is universal benefit," which links to Develop coalitions.

Karma yoga, the second pillar of yoga, is following your dreams to action—Achieve results. Gyan yoga is the roof under which all the above live, the overarching guide of building real knowledge and links to Systems transformation.

I marvel at the insightfulness of ancient sages and rishis to express these thoughts so clearly. These are as real today as they were thousands of years ago.

[4] The six organizations were: Island Health, Alberta Health Services. Saskatoon Health Region, Sunrise Regional Health Authority, Canadian Agency for Drugs and Technology in Health and Health PEI.

The Ongoing Appeal of LEADS

In 2019 the reach of LEADS—both in terms of numbers of organizations using it as well as the scope and breath of its application—vastly exceeds what it was in 2014. In the first edition, we said four primary factors have driven its widespread acceptance and use—common vocabulary, a collaborative approach, an emphasis on inclusiveness and knowledge mobilization practices.

A common vocabulary is a powerful tool to unite, rather than divide. As Dr. T. Shannon said:

> "[If]/when medical leaders are to lead the way forward in this century towards the transformation and improvement of healthcare across the globe then we must work between us towards a simple yet clear vocabulary that we can share with our clinical, management and technical colleagues at every meeting and every report." [17]

LEADS can stake a claim to be that shared vocabulary. As you will see in Chap. 11, LEADS has been adopted as the foundation for leadership learning and practice in almost 70% of Canada's health organizations [18]. It provides the foundation for distributed leadership because people who must practise leadership interdependently can now do so with a shared understanding of how to conduct their work. It limits talking at cross-purposes and mitigates misunderstandings. In addition, a clear and shared vocabulary for leadership helps leaders see themselves as united in a common endeavour: to knit together a system that is increasingly fragmented, yet under pressure to work as a system.

In keeping with the need to overcome system fragmentation, we have focused on collaborative approaches from the beginning. LEADS is a philosophy of distributed leadership that promotes cooperation and collaboration. LEADS categorically states that all of us—regardless of profession, organization, or enterprise—are dedicated to achieving the same results: the health and wellness of the people we serve. We believed Canada needed all CEOs, organizational development professionals, universities and others invested in better leadership to be encouraged—and empowered—to work together to increase collaborative leadership in health.[5]

The third factor promoting acceptance of LEADS is its inclusiveness, the belief that anyone can increase their innate ability to lead, an idea that has gained broader acceptance since the first edition. Evidence shows that well designed and delivered leadership development programs (see Chap. 4) can provide a significant return on investment to organizations [19]. The goal of LEADS is to build leadership capacity throughout the health system, horizontally as well as vertically across organizations. When leadership qualities are distributed throughout organizations

[5] In Chap. 11 we discuss the Canadian Health Leadership Network's *Leadership Development Impact Toolkit,* which has been designed for member partners to use to assess the impact of leadership development. This is a consequence of many studies that show that leadership development can make a significant difference, both in terms of individual development as well as organizational development.

and systems, it will be much easier to rally the innovation and flexibility required to meet the challenges of twenty-first century healthcare.

A fourth factor in LEADS' broad appeal is the knowledge mobilization strategies being developed to make research on leadership more accessible and usable. The complex research that went into creating LEADS and the subsequent research that validates it are of little value without products and tools ready for every-day use. This concept underpins the work of LEADS Canada, and the LEADS Exchange Days [20] that are held each year as part of the National Health Leadership Conference put on by the Canadian College of Healthcare Leaders and Healthcare*CAN*.[6]

We think knowledge mobilization has helped make LEADS the predominant approach to building leadership capacity across Canada. For example, let's look at how LEADS is being put to work in Fraser Health, the largest of five regional health authorities in British Columbia and one of the original adopters of LEADS. Fraser Health has worked hard at mobilizing knowledge to make LEADS relevant and practical.

> *The senior administration at the Fraser Health Authority has been engaged with LEADS from the outset, building it into many different facets of personal and organizational leadership and human-resource development, including by:*
>
> - *Integrating LEADS capabilities with management competencies to develop a "leadership and management responsibilities profile" that guides development of new managers in Fraser Health.*
> - *Creating personal learning plans that require leaders to assess themselves based on the responsibilities in the leadership and management profile and to keep journals reflecting on their LEADS capabilities.*
> - *Using LEADS-based questions and assessments to identify high-quality leaders in its selection and succession processes.*
>
> *In keeping with two Systems transformation capabilities—encourage and support innovation and champion and orchestrate change—Fraser Health launched a Centre for Excellence in Health Care Leadership in the spring of 2019. The centre's goal is to provide access to the latest research and trends in leadership and organizational development and help leaders learn and work together.*
>
> *One of the centre's first actions was to review the value of the LEADS framework in Fraser Health, and whether it was consistent with the leadership qualities found in the survey. Its conclusion was LEADS should continue to be the foundation of Fraser Health's leadership, organizational and human-resource development work.*
>
> *Moving forward, Fraser wants leaders who are clear, courageous and caring. These qualities sit on top of the LEADS framework, providing clarity about three priorities that all leaders in Fraser should strive to achieve. They are the fundamental principles of leadership important to Fraser Health.*
>
> *Fraser Health is reaching out to others who share its values and commitment to leadership, in the hope other organizations will join it in the work of the Centre for Excellence in Health Care Leadership (Personal communication, Yabome Gilpin-Jackson and Gabriele Cuff, 2019 Jul 31).*

[6] Healthcare*CAN* is the national voice of healthcare organizations and hospitals across Canada. Its goal is to improve the health of Canadians through an evidence-based and innovative healthcare system.

LEADS and Other National Frameworks

Further validation of LEADS' effectiveness (and increasing interest in the professionalization of leadership) can be found in the similarity between it and other health leadership frameworks, including Health LEADS Australia and the Health Education and Training Institute of New South Wales Leadership Framework, the United Kingdom's National Health System Healthcare Leadership Model, and the UK's Faculty of Medical Leadership and Management's Standards. LEADS-based programming has also been used in Belgium and India.

The United Kingdom (England)

The National Health Service (NHS) Healthcare Leadership Model, which is designed to help NHS employees become better leaders in their day-to-day roles, has been revised since we first wrote about it. This new framework, like LEADS, encourages distributed leadership: "The Healthcare Leadership Model is useful for everyone because it describes the things you can see leaders doing at work and demonstrates how you can develop as a leader—even if you're not in a formal leadership role." [21] The NHS Leadership Academy developed the evidence-based model, based on what it learned from its previous framework and on "what our patients and communities are now asking from us as leaders." [22] There are nine elements to the framework:

- Inspiring a shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capacity
- Influencing for results

There are significant overlaps between dimensions of the NHS framework and LEADS. Several of the NHS dimensions can be seen as interchangeable with LEADS domains—Leading with care, Influencing for results and Engaging the team match three of the Engage others capabilities: *Contributes to the creation of a healthy organization, Communicate effectively* and *Build teams*. The NHS dimensions of Inspiring a shared purpose, Sharing the vision, Evaluating information and Holding to account are like the four capabilities of Achieve results, and so on.

There are also differences of emphasis between the two frameworks. LEADS focuses more on system-wide collaborative leadership, while the NHS framework's scope is limited to interpersonal or organizational use. As well, while the NHS

LEADS Standards	UK Leadership and Management Standards for Medical Professionals
Lead Self • Are self aware • Manages self • Demonstrates character • Develops self	**Self** • Self-awareness and self-development • Personal resilience, drive and energy
Engage Others • Foster development of others • Contribute to the creation of healthy organization • Communicate effectively • Build teams	**Team Player/ Team Leader** • Effective teamwork • Cross-team collaborations
Achieve Results • Set direction • Align vision, mission, vision values and evidence to make decisions • Take action to implement decisions • Assess and evaluate	**Corporate Responsibility** • Corporate team player • Corporate culture, improvement and innovation
Develop Coalitions and Systems Transformation	**Systems Leadership**

Fig. 3.3 Comparison of LEADS to the Faculty of Medical Leadership and Management's Leadership and Management Standards for Medical Professionals

model talks about elements of self-leadership, it does not have a specific dimension for leading self, as LEADS does [23].

Since our first edition, the UK's Faculty of Medical Leadership and Management has created standards for medical professionals. These standards define what effective medical leaders do and how they do it (Fig. 3.3).

Australia

In 2010, Health Workforce Australia (since dissolved) was a national coordinating body dedicated to system reform. In 2011 it released the *National Health Workforce Innovation and Reform Strategic Framework for Action, 2011–2015,* calling for "a leadership framework that defines the capabilities needed for leaders in all areas of health." Subsequently a draft document called *Health LEADS Australia* was released for public consultation. The framework (Fig. 3.4) was formally endorsed in June 2013 [24].

The Health Leadership Australia framework is closely related to the Canadian Leads in a Caring Environment framework [25]. Four of its five domains are almost identical; the one that differs is the LEADS Canada domain of Develop coalitions. In the Australian model, that concept is captured in Engages others, while the D in Australia is Drives innovation—which reflects the high priority innovating for reform and improvement had in Australia at the time of the framework's release.

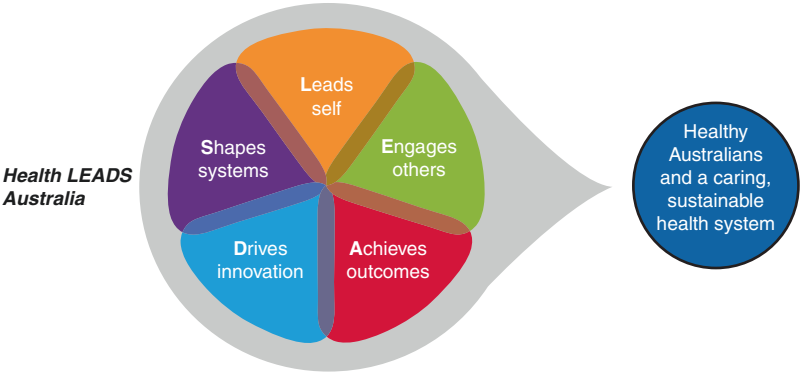

Fig. 3.4 Health LEADS Australia

Fig. 3.5 Health Education and Training Institute: NSW Leadership Framework

Once Health Workforce Australia was closed in 2014, responsibility for Health Leads Australia was taken over by the Ministry of Health. As a result, the framework has "not yet been fully developed as envisioned…and has only partially fulfilled the purpose" [25] of providing a consistent national approach to develop health care leadership. However, there has been some development by some organizations across Australia. These efforts are described in Chaps. 11 and 12.

The state of New South Wales in Australia endorsed a version of the Canadian LEADS framework in 2013. The Health Education and Training Institute leadership framework for New South Wales Health (Fig. 3.5) lists the five domains in a different order and packaged slightly differently but have very similar content to Canada's LEADS [26].

Summary

We opened this chapter by calling the five domains of LEADS, each with its four capabilities, the source code for health care leadership and a framework for individual, interpersonal, and strategic leadership talent management. Let's close with a story of truly inspiring leadership that underscores how LEADS is being put to work.

Suann Laurent was the chief operating officer of the Saskatchewan Health Authority on April 6, 2018, when the bus carrying the Humboldt Broncos hockey team was in a terrible crash, which killed 16 people and injured 13 others—players, coaches and team personnel. Suann had to respond to the unthinkable, immediately.

Suann's initial reaction—as a senior Saskatchewan health leader—was to focus on her organization's vision: Put the patient and family first. "We had faced nothing remotely like this. Regardless, I knew we had to show up for the victims and for the families. Results for them—not for us—were foremost in our minds throughout the many days of the crisis. They still are today."

In a riveting talk at the National Health Leadership Conference in St. John's Newfoundland a few months after the crash, Suann explained how she has for many years used the LEADS framework as a guide to her leadership. "I use the LEADS framework all the time…it is an inventory for me of the key factors I need to consider in order to show up for others." It kicked in as she prepared to deal with the Humboldt crash.

She and her colleagues, for example, kept the victims' and families' welfare foremost in their minds as they made decisions. Knowing that relatives of the injured couldn't leave the hospital to attend community vigils and memorial services, Suann and her team arranged to have the services streamed into the hospital. "We knew that the relatives of the players still in the hospital wanted to show solidarity with those who had suffered even more than they were, and that the sense of community was central to them. We had to do this." [Achieve results].

On the Sunday after the Friday crash, the coroner informed Suann and her team that two of the victims of the crash had been misidentified: a player who had died had been reported as injured while a player reported dead was, in fact, in the hospital. "We—the whole team—myself, other representatives from the health authority, RCMP, government officials and the coroner—came together quickly," she said. "While we were all very shaken, we agreed we needed to put the families and victims first, so we immediately decided that there would be no finger pointing. Our hearts told us to reach out to the families of those two poor boys. And that's what we did immediately."

Throughout, regular meetings were held with stakeholders including the school system, community representatives, the health authority, the RCMP, government officials and the coroner [Develop coalitions]. Suann credits these ongoing sessions with ensuring the focus was always on the welfare of the victims and families and on helping the community to heal, and that decisions were always made in their best interests.

Another key element of her response was to be present with those delivering the care, who had seen and responded to terrible things [Engage others]. "We couldn't have asked for more from them than they gave. They were caring and professional. Indeed, all we had to do was trust them to do their job. Yet, showing up for them was vital. They needed to see us, to know that we had their back in such an emotionally draining time. After all we weren't on the front line, they were."

Suann had moments of soul searching as she strove to manage herself during conversations with grieving parents, distraught citizens and overwhelmed caregivers—all the while building her own resilience. She did that by debriefing with colleagues, close friends and

family. She was also careful to monitor her own mental and physical state. "After the first three days—Tuesday morning—I realized I was out of gas and was going to do others more harm than good. I gave myself permission to go home and sleep, refill the tank. That is something I had never done before at work." [Lead self].

Suann also described what we call an "after-action review" during the crisis: regular meetings of stakeholders to discuss what happened the day before, what they would face that day and how to handle tomorrow. Longer term, the Saskatchewan Health Authority organized a review to determine what went well during the overall response to the crash and what might be done better in the future if there is ever another such event.

Suann concluded her talk by saying "If you use the framework, it helps you lead with integrity. But to do so you need to consider all of the domains as part of a whole. Some people see LEADS as a bunch of pieces; but to me, it is the whole of leadership in healthcare; and if you use it that way, it brings integrity to your leadership."

References

1. Wise wisdom on demand. 2013. http://www.iwise.com/TPU7r. Accessed 11 Jul 2013.
2. Leads Collaborative. LEADS in a caring environment [brochure]. CHLNet: Ottawa; 2013.
3. Kelly L, Runge J, Spencer C. Predictors of compassion fatigue and compassion satisfaction in acute care nurses. J Nurs Scholarsh. 2015;47(6):522–8.
4. Dougherty K. Caring leadership: voices of nurses. In: Picard M, Dickson G, editors. Royal Roads University leadership programs. Victoria (BC): Royal Roads University Leadership Programs; 2002.
5. Oc B. Contextual leadership: a systematic review of how contextual factors shape leadership and its outcomes. Leadersh Q. 2018;29(1):218–235. doi:https://doi.org/10.1016/j.leaqua.2017.12.004; and Dickson G. Leadership theory as a driver of executive leadership practice in healthcare. In Raz M and Loh E. editors. Cases for health executives: the principles of practice. Taylor and Francis Group (AUS). Forthcoming 2019.
6. Denis J-L, Lamothe L, Langley A. The dynamics of collective leadership and strategic change in pluralistic organizations. Acad Manag J. 2001;44(4):809–37.
7. Senge P, Hamilton H, Kania J. The dawn of system leadership. Stanf Soc Innov Rev. 2015;13(1):26–33.
8. Mintzberg H. Managers, not MBAs: a hard look at the soft practice of managing and management development. San Francisco: Barrett-Koehler; 2004.
9. Stringer E. Action research. 3rd ed. Thousand Oaks (CA): Sage Publications; 2007.
10. Dickson G, Tholl B, Baker, GR, Blais R, Clavel, N, Gorley C. et al. Partnerships for health system improvement, leadership and health system redesign: Cross-case analysis. Ottawa: Royal Roads University, Canadian Health Leadership Network, Canadian Institutes of Health Research, Michael Smith Foundation for Health Research; 2014. http://tinyurl.com/qh6ogzu. Accessed 22 Aug 2019.
11. Moat KA, Lavis JN. Dialogue summary: fostering leadership for health-system redesign in Canada, Hamilton: McMaster Health Forum; 2014. https://www.mcmasterforum.org/docs/default-source/Product-Documents/issue-briefs/fostering-leadership-health-system-redesign-canada-ib.pdf?sfvrsn=2. Accessed 21 Nov 2015.
12. Marchildon G, Fletcher A. Prioritizing health leadership capabilities in Canada: testing LEADS in a Caring Environment. Health Manage Forum. 2016;29(1):19–22.
13. Cikaliuk M. Pre-phase preliminary intelligence gathering report: LEADS in a Caring Environment capabilities framework. [unpublished research report]. Ottawa: Canadian Health Leadership Network and the Canadian College of Health Leaders; 2017.

14. Lavis JN, Moat K, Tapp C, Young C. Evidence brief: improving leadership capacity in primary and community care in Ontario. Hamilton (ON): McMaster Health Forum. 2015. https://www.mcmasterforum.org/docs/default-source/product-documents/evidence-briefs/leadership-capacity-in-ontario-eb.pdf?sfvrsn=2. Accessed 18 Sep 2019.
15. Philippon D. The leadership imperative in publicly funded universal health systems with a particular focus on the development of the Canadian Health Leadership Network (CHLNET). Ottawa: Canadian College of Health Leaders; 2011. http://chlnet.ca/wp-content/uploads/Don-Philippon-Fellowship-report-.pdf. Accessed 13 Jul 2013.
16. Vilches S, Fenwick S, Harris B, Lammi B, Racette R. Changing health organizations with the LEADS leadership framework: report of the 2014-2016 LEADS impact study. Ottawa: Fenwick Leadership Explorations, the Canadian College of Health Leaders, & the Centre for Health Leadership and Research, Royal Roads University; 2016. https://leadscanada.net/document/1788/LEADS_Impact_Report_2017_FINAL.pdf. Accessed 18 Jun 2019.
17. Shannon T. as quoted in Dickson G, Van Aerde J. Enabling physicians to lead: Canada's LEADS framework. Leadersh Health Serv (Bradf Engl). 2018;31(2):183–194.
18. Canadian Health Leadership Network Breakfast Session. Does Canada have the leadership capacity to innovate? Benchmark 2.0. Toronto: National Health Leadership Conference; 2019. http://chlnet.ca/wp-content/uploads/NHLC-CHLNet-Breakfast-Session-2019-V02.pdf. Accessed 20 Aug 2019.
19. Jeyaraman M, Qadar SMZ, Wierzbowski A, Farshidfar F, Lys J, Dickson G, et al. Return on investment in healthcare leadership development programs. Leadersh Health Serv (Bradf Engl). 2018;31(1):77–97. https://doi.org/10.1108/LHS-02-2017-0005.
20. The LEADS community for practice exchange day. Ottawa: LEADS Canada and the Canadian College of Health Leaders. 2019. https://www.leadscanada.net/site/2019day. Accessed 18 Sep 2019.
21. NHS Leadership Academy. Healthcare leadership model; 2019. https://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/. Accessed 13 Jan 2019.
22. NHS Leadership Academy. How the healthcare leadership model has been developed. 2018. https://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/healthcare-leadership-model-developed/. Accessed 13 Jan 2018. This website also refers the reader to the secondary research, done by John Storey and Richard Holti, working with the Hay Group, who carried out a review of current literature and research on leadership models and behaviours. You can download Holti and Storey's paper @ https://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2014/10/Towards-a-New-Model-of-Leadership-2013.pdf.
23. NHS Leadership Academy. The nine leadership dimensions; 2018. https://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/nine-leadership-dimensions/connecting-our-service/. Accessed 13 Jan 2018.
24. Health Workforce Australia. Health LEADS Australia: The Australian Health Leadership Framework. Adelaide (SA). Health Workforce Australia. 2013.
25. Shannon E, Sebastian A. Developing health leadership with Health Leads Australia. Leadersh Health Serv (Bradf Engl). 2018;31(4):413–25. https://doi.org/10.1108/LHS-02-2017-0002.
26. NSW Health leadership framework. Sydney (NSW): Health Education and Training Institute; 2019. https://www.heti.nsw.gov.au/education-and-training/our-focus-areas/leadership-and-management/nsw-health-leadership-framework. Accessed 31 Jan 2019.