Fostering Leadership for Health System Redesign in BC

From Dialogue to Action

Hosted at Sneq’wa c’lun / Blue Heron House
Royal Roads University, Victoria BC

February 27, 2015
Planning Committee
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Suggested citation:

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EXECUTIVE SUMMARY

The BC Dialogue session brought together health leaders to determine actions that could and should be implemented over the next twelve months to enhance leadership and health systems reform in BC. The focus was on how to increase and improve leadership talent, to assist health leaders in their continuing efforts to reform the provincial health system, and to coordinate action with other health service delivery jurisdictions across the country. Three specific purposes framed the day’s discussion:

◆ Support the development of a health leadership action plan in BC
◆ Propel health leadership in BC forward
◆ Achieve participant willingness to co-fund and co-organize activities

Dialogue Results: Supporting Health Leadership Development in BC

At the end of the day, there was broad consensus among participants that existing systems do not need to be recreated. The way forward must involve concerted action, achievable steps and information sharing. The principle barriers to action were seen to be fragmentation and lack of information sharing, as well as funding to ensure sustained action and outcomes. A broader range of stakeholders, particularly health professional representatives, including physicians, must be included and patient voices must continue to be included. The changing nature of challenges in health care requires systems wide thinking, support for leadership development, and systematic evidence. Building on Canadian-wide initiatives, a BC health leadership plan is needed that is founded on shared purpose, increases capacity and capabilities of our health leaders, builds on evidence to date and leading practices, utilizes a common leadership language, and develops an accountability framework for its success. Only by working together, will we be able to improve system performance that will ultimately benefit the patients and citizens of Canada.

Strategic Foundations for a BC Action Plan

I. Form a provincial steering committee to explore next steps and steer the process.

II. Coordinate and establish a coherent provincial strategy
   - Develop an action plan to generate the leadership talent needed to support BC health system change priorities; and
   - Measure the impact of that action plan on achieving BC health system change priorities.
   - Be broadly inclusive.

III. Make concerted, province wide efforts to raise and to pool investments by all partners.
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PROLOGUE

On December 3, 2014, a broad array of health leaders met to investigate the value of, and shared commitment to, a provincial strategy to grow leadership talent in health in the province of British Columbia.

Participants gathered at the Sneq'wa e'lun (Blue Heron) House on the historic grounds of Royal Roads University, which is in the traditional land of the Songhees and Esquimalt Nations. Asma-na-hi Antoine, Manager of Indigenous Education and Student Services at Royal Roads University, introduced us to the story of how the elders gathered to discuss different name options for the house and how it then went to a vote from the community. They believe "Blue Heron" House was chosen due to its meaning.

The Blue Heron brings messages of self-determination and self-reliance. They represent an ability to progress and evolve. The long thin legs of the heron reflect that an individual doesn’t need great massive pillars to remain stable, but must be able to stand on one’s own. Blue Herons have the innate wisdom of being able to maneuver through life and co-create their own circumstances. Blue Herons reflect a need for those to follow their own unique wisdom and path of self-determination. These individuals know what is best for themselves and need to follow their hearts rather than the promptings of others. The Blue Heron symbolizes patience, grace, balance, elegance, and determination.

The symbolic meaning of Sneq’wa e’lun Blue Heron House coincided with an experience Dr. Graham Dickson had when he founded the Centre for Health Leadership and Research. After relating his experience and noting its relationship to the founding of the Centre, Dr. Dickson welcomed participants to the Dialogue.
I. BACKGROUND TO THE BC REGIONAL DIALOGUE ON LEADERSHIP FOR HEALTH SYSTEMS REDESIGN

The day began with a review of several publications on leadership in health, which were released in Canada and British Columbia in 2013 and 2014. These studies and reports, were summarized and provided to participants prior to the session. Dr. Dickson outlined how they collectively articulate current and possible future roles for leadership in supporting health reform implementation. Coinciding with these reports, the BC Ministry of Health released a policy paper on February 2014 entitled Setting Priorities for the BC Health System, providing further impetus for reform in BC.¹ Dr. Dickson outlined key points that were appropriate for underpinning a discussion toward creating a provincial strategy for a leadership action plan for health reform.

The Need for Systems Reform

Several publications issued in 2013 and 2014 on health systems reform converged on the importance of working to achieve results now and the role leadership must play in accomplishing successful transformation. These reports, outlined below, also highlighted a significant leadership gap between the skills and abilities of Canada’s health system leaders and the challenge presented by the need for reform. The leadership gap exists across a variety of settings, within the health professions and across a variety of health service delivery organizations, such as regional authorities, networks, hospitals, and primary care delivery systems. In all studies, though, possible approaches to moving forward were outlined, emphasizing the potential for leadership to effect change within a reform agenda.

◆ A report issued by the Health Council of Canada² noted that there were key factors for success in health reform, which included strong program leadership and administrative and clinical champions.

◆ In Paradigm Freeze: Why it is So Hard to Reform Health-care Policy in Canada,³ the authors argue that, by and large, self-interest among vested parties has resulted in mostly meagre health reform across the country. Based on 30 case studies, the book chronicles four decades of attempted policy reforms. Yet reform—especially large scale reform to deal with emergent challenges such as chronic disease and system sustainability—requires enlightened self-interest; that is, leadership that puts the interests of the patient and citizen first, and the interests of the provider second. Where is leadership on this issue?

André Picard, journalist and 2012 CIBC scholar in residence with the Conference Board of Canada wrote, in *The Path to Health Care Reform: Policy and Politics*\(^4\) that “We need leadership....a uniquely Canadian style of leadership—[which is] conciliatory and cooperative [and] ranges from individual citizens taking more responsibility for their health to vested interests putting some water in their wine and political leaders implementing the solutions they know are required” (p. 190).

In *Creating Strategic Change in Canadian Healthcare*,\(^5\) Don Drummond observed that the absence of federal and cross-provincial direction poses significant challenges to reform, but that individual provincial governments may succeed by embracing a few good ideas and focusing on them.

The specific challenges identified in the cross-Canada reports point to the need to acknowledge the leadership gap, develop an awareness of the attributes of leadership required to fill that gap, and support leadership to enable change. The foundations needed to generate the leadership for change were also outlined in the Canadian Health Leadership Network (CHLNet) action plan\(^6\), which suggests that what is required is “a multi-pronged and collaborative strategy to achieve large scale, transformational change” (p. 2). In February 2014, the BC provincial government joined this chorus by articulating priorities for health system change.

These sources all point to the need to examine the foundations of better leadership to guide health reform.

### The Leadership Gap

Several papers released in 2014 defined the leadership gap and gave it substance. Three reports articulated the leadership required to address the challenge of health reform. A fourth document set the stage for action.

- *Leadership and Health System Redesign (LHSR) Cross Case Final Report.*\(^7\) This four year project included five regional case studies, including one BC, and one national case along with a cross-case synthesis report. At the end of the project, a deliberative dialogue

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\(^5\) Drummond, D. (2014 May). *Creating Strategic Change in Canadian Healthcare*. The Monieson Centre, Queen’s School of Business: Kingston. Click for [link](#).


\(^7\) Dickson & Tholl with regional authors (2014). *Partnerships for Health System Improvement: Leadership and Health System Redesign Cross Case Analysis, Final Report*. Victoria, BC: Royal Roads University. Funding for the LHSR study was provided by the Canadian Institutes of Health Research and Michael Smith Foundation for Health Services Research Foundation. Click for [link](#)
The session was hosted through the McMaster Health Forum\(^8\) to tease out action conditions based on the findings. The multiple cross-Canada regional studies in the LHSR project identified a leadership gap; that the gap highlighted key leadership attributes such as systems thinking, strategic thinking, visioning, and self-leadership; that the existing *LEADS in a Caring Environment*\(^9\) capabilities framework captured most of the qualities required for leaders of reform; and that a more extensive effort needs to be made to develop leadership talent management across the country. The focus on systems thinking explicitly pointed to the need for less self-serving thinking and more enlightened, patient-centred leadership.

- The Canadian Health Leadership Network’s *Benchmarking Survey Report*,\(^{10}\) which reflected leaders perceptions across Canada, identified that:
  - there is a leadership gap in terms of the leadership needed to meet the challenges of reform; and
  - the gap is more of a skills gap than a gap in the numbers of leaders.

- **The Canadian Health Leadership Action Plan**\(^{11}\) outlines five pillars for a pan-Canadian approach to developing leadership that are: a shared vision; common leadership language such as LEADS; evidence on innovation and leading practices; enhanced capacity and capabilities; and measures and evaluation.

These studies and reports collectively created a compelling rationale for discussing leadership and health systems reform in BC now. The BC Regional Dialogue symposium was designed to bring together key stakeholders and participants who could work together to discuss how to ensure that the leadership needed to support health reform in the province will be supported and available.

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\(^9\) The *LEADS in a Caring Environment* framework was developed in British Columbia out of an initiative which originated in 2004 to respond to leadership needs in health care. It is used by most health authorities in BC.


BC Regional Dialogue: Purpose

- Support the development of a health leadership action plan in BC
  - Share information and empirical evidence.
  - Create a practical framework for an evidence-informed action plan
- Propel health leadership in BC forward
  - Align with broader CHLNet and other pan-Canadian approaches.
- Achieve participant willingness to co-fund and co-organize activities
  - Create and implement a provincial action plan in BC
  - Determine who may lead this initiative and when.

Domains of Discussion for Health System Redesign

The BC Dialogue symposium was informed by insights from the LHSR study. The first discussion of results was held as a deliberative dialogue symposium on March 2014 as part of the McMaster Health Forum series. Participants identified three domains for action:

- **Coherence.** Bringing coherence to local, provincial, regional and national calls to action to prepare leaders for health system transformation efforts. The McMaster Health Forum participants noted that this needs to be done by acting locally, connecting regionally, and incorporating broader national and global learning;

- **Dialogue.** Promoting dialogue about the LEADS in a Caring Environment Framework, complex adaptive systems, talent management and supporting leadership engaged in transformation. This also includes supporting work on credentialing, coherence of curricula, development of information databases, human resource planning, and on expectations for leadership programs;

- **Network.** Strengthening the network(s) involved in identifying and evaluating innovative practices in transformative leadership and in the enhancement of leadership so that successes can be shared and scaled up.

BC Health Leaders’ Dialogue

To discuss the developments to date and issues raised by the various studies, reports and events, the BC Dialogue symposium drew together representatives of regional health authorities, the Ministry of Health, research and higher education communities, patient advocates, granting foundations, the BC Health Leadership Development Collaborative (BC Collaborative) and the Canadian Health Leadership Network (CHLNet). The goal was to discuss the implications of the recent work on leadership for health systems transformation in British Columbia.
II. PROCEEDINGS OF THE BC REGIONAL DIALOGUE

The Dialogue was structured with a matrix co-interviewing method. Participants were invited to use their experience and knowledge to co-interview each other on four topics. The topics were based on the recent publications reviewed above: (1) “churn”, or the apparent constant state of change; (2) the need for a more robust investment in leadership development and succession planning; (3) the need to foster leadership to achieve a true culture shift to a more patient centred system; and (4) the possible foundational steps for a made-in-BC action plan.

The highlights of the matrix method discussion are presented below, organized by the lines of inquiry. The key questions are presented first, followed by discussion details and suggestions for action. Each of the four dialogue groups presented summary proposals to the whole group and the room was invited to indicate support. With the exception of the proposals around churn, which were qualified, each set of Dialogue suggestions received almost unanimous support.

A. Addressing Churn

One main finding of the LHSR study (2014) is that greater collaboration (for example, shared or distributed leadership) and less churn (for example, turnover and the impacts of political processes) are needed for health care reform to succeed. Three key questions were posed around churn.

Key Dialogue Questions
◆ How well does the concept of churn capture your work environment?
◆ How do you, personally, cope with or manage constant change?
◆ How could greater collaboration and less churn be encouraged in the BC health system?

Participants were asked what should be done about constant change, or churn, which occurs due to the impacts of political processes and seemingly constant personnel turnover. The importance of this seeming constant condition came from the five LHSR case studies, which concluded that greater collaboration and distribution of leadership is needed for health care reform to succeed in a context of churn.

After co-interviewing their peers, the dialogue group suggested that churn is not the problem, in the sense that there will always be change due to a will to improvement. While not all the symposium participants agreed with this sanguine acceptance, they did agree with the observations that three interrelated dimensions were relevant to succession planning and development:

◆ planning
◆ collaboration
◆ engagement
More detailed comments pointed to the stress of constant change and focused on building professional as well as personal resilience. These observations connect with the themes under Fostering Leadership (below) in suggesting that time for self-care is important for health professionals. In addition, participants noted that unexpected or poorly understood changes in direction can be disheartening, causing people to settle for what they can do, rather than to continue to aim for best performance. As a result, participants noted, churn can lead to personnel turnover as people become demotivated.

Participants also noted that simultaneous but different change occurring at different levels within an organization can cause disconnect. Churn may be more pronounced at senior levels, where duties and organization structure change together, while at the front line, change may be experienced in a different sense. People at different levels need to operate with more awareness of each other to enable effective leadership. They need to recognize that churn may be personally and professionally affecting those at senior levels more comprehensively, even while front line staff are also challenged to maintain connection to new strategic direction.

The group reported that churn can also cause disconnect between an understanding of the mission and vision of an organization and new directions. There is a potential, therefore, for a gap or lack of alignment between units or between senior levels and front line practitioners. An organization which is experiencing internal fractures is not only challenging to those who work within it, it is also more difficult for other organizations to work with. Churn may therefore cause a ripple effect with other health organizations, suppliers or professional bodies. These effects may be disorienting, and demoralizing, and work against productive outcomes.

In spite of the gloom around churn, participants noted that churn myth-busting must also happen. A mythology has developed around churn, and has become part of the problem. Participants noted that there is an opportunity to address change productively with more attention to communication and feedback. There is also much that is known about the science of organizational change, and participants suggested that this should be more effectively used, drawing on organizational science from outside health care.

Finally, comments pointed to the need for planning for personnel turnover. Personnel turnover amplifies churn that is not well managed, yet personnel turnover is itself a constant presence and could be productively addressed.

The churn dialogue group summarized their feedback by saying that although the characteristics of churn and health systems reform may work against each other, they could be productively reconfigured.

- Corporate memory systems are threatened by churn, but could be deliberately nurtured in the context of churn by acknowledging churn as an ongoing state of improvement.
◆ The 'shelf life' of any change depends on the organization, but strategies to work with change could be customized for all levels of the organization and roles.
◆ Change could be incorporated into work culture as a norm.
◆ Governance needs to develop long term / big picture strategies to minimize the negative aspects of change and organize the impact of any specific change.

The Dialogue group noted that constant change is a reflection of the urge to improve health care, but instead of focusing on churn as the problem, they focused on accepting churn and offering space for leadership.

Suggested Actions on Churn
1. Study the impact of churn
2. Reward development of corporate memory systems
3. Promote collaboration within teams / organizations as a resilience factor
4. Support learning opportunities
5. Prioritize healthy risk (change for the chance of improvement)

B. A More Robust Investment

The LHSR study found that we need more robust succession planning and leadership development across systems. For example, we need to connect across the physician and non-physician communities. Other countries, such as the UK and Australia, invest more in these efforts.

Key Dialogue Questions
◆ Are efforts toward leadership succession sufficient (i) in your organization, and/or (ii) in BC?
◆ Do you agree that BC could use greater investment in leadership development, or does BC just need different ways of collaborating within the current envelope of investment?
◆ What steps should be taken so that each group, including physicians, can be a part of a solution?

The dialogue questions focused on whether sufficient resources were available, and whether more investment could make a difference. In particular, the questions (reflected from findings of the LHSR study) focused on whether sufficient effort was being made to engage all sectors of health care, physicians in particular.

In responding to this question, participants did not feel sufficient attention was being paid to collaboration and, although resources were being expended, it was not coordinated or focused enough.
The dialogue group also noted a disconnect between how leadership could serve organizations and what it is currently being relied on to do. They suggested that a shift in mindset needs to occur to move to a systematic, longer-term investment. Some of the main conclusions drawn from the co-interviewing process were:

- Succession planning is currently NOT being done consistently.
- Succession planning needs to be defined as part of talent management.
- A systems perspective is required.

Further comments focused on roles and stakeholders:

- Physicians occupy a unique space in the health system and they need to both assume more leadership and be incentivized to do so (noting that currently moving into leadership may involve a reduction in income). Although some improvement is happening in new training, physicians are typically clinically trained without reference to the system within which they will work. One outcome is that they have a limited sense of ownership in or understanding of health system reform.
- Strategic planning needs to occur at the executive level, including succession planning for critical groups such as physicians.
- The formal, hierarchical structure of health care can be an impediment to succession planning; and, the inclusion of unionized staff also makes it more complex to coordinate with succession planning (there was not unanimous support of this latter statement).
- Investment and spending needs to be done carefully and with intentionality.

In summary, the dialogue group reflected back a work smarter ethic, rather than expend more. They emphasized that coordination is required, and pointed to the recent BC Ministry of Health Setting Priorities document, which iterates the focus on working collaboratively. The group suggested that it seems like a very timely opportunity to coordinate action between the provincial government and the health authorities.

**Suggested Actions on Investment**
The dialogue group referenced the recent Setting Priorities document (2014) to underscore groundwork already laid by the BC Ministry of Health toward a more robust investment in leadership:

In a sector driven by the commitment and skills of its professional and support staff workforce, an engaged, skilled, well-led and healthy workforce is a critical strategic asset. A number of key actions will be taken, [including] . . . (2) Ensure the development and implementation of a leadership and management development framework for the health system [and] (3) Continue to develop and strengthen professional development and quality assurance mechanisms. (p. 37)
The group proposed the following two key steps to actualize these recommendations:

1. That the Ministry of Health advocate priorities in a co-creative way with partners across professional disciplines, including physicians, as well as with health organizations, to enact strategies based on shared vision for health care reform.
2. To sufficiently resource actions so that plans may be actualized.

These suggestions were unanimously supported, though participants noted that the next step is actually the most challenging: to follow through.

C. Fostering Leadership

The BC Ministry of Health Setting Priorities document cites the cultural shift to patient centred care as the first priority for the next three years. To truly transform health care to a patient or people centred system, the LHSR study suggests that greater collaboration is required amongst providers, patients, and community members. Yet the LHSR study also suggests that such collaboration challenges leaders’ conventional notions of autonomy, accountability, and collaboration.

Key Dialogue Questions
- Do you agree with the statement that notions of greater collaboration challenges leaders’ conventional notions of autonomy, accountability, and collaboration?
- If yes, in your view, how do those conventional notions have to change?
- Have you had a leadership development experience that is relevant to this issue?

Participants agreed with these statements and noted that a culture change in health care environments is needed in order to be successful. They identified three important steps for
fostering leadership and moving forward to a patient centred system. The first step was to identify existing leadership opportunities, the second, to engage a planning team including a representative cross-section of individuals, and the third, to ensure coordination with the national CHLNet Action Plan. Participants recommended establishing a timeline for next steps and accountability.

The discussion also focused on some important conditions and contexts that must be acknowledged. First, leadership development depends on motivation and buy-in. Second, workplace culture must be addressed and, third, understanding of the way the whole system works is necessary. These were further detailed by the topic group under three clusters.

**Processes and systems must be leveraged to allow patients’ voices and leadership to come through**

Participants agreed with the spirit and intent of the Dialogue questions, which asked whether it was important to prioritize a cultural shift to patient centred care. However, they noted that the current hierarchical command and control structure encourages an environment oriented towards achieving externally regulated standards of perfection, rather than an environment oriented toward improvement, which involves risks. Risk in this case does not refer to risks with patient safety; but the opposite, focusing on risking performance standards to change systems.

The command and control structure was seen as something that is familiar and comfortable. Listening to patients provides a challenge to the expert orientation of the health care system, but being open to non-expert voices is not something that can only be achieved by mandate. It must involve many practitioners and support staff in being willing to listen and collaborate on outcomes. Participants noted that supporting leadership has interesting implications:

- Moving away from a command and control requires thinking about complex adaptive systems and one’s role within them.
- A different skillset is needed. Supporting leadership is very much about (a) relationship building, (b) systems thinking, and (c) viewing others’ perspectives.

These thoughts suggest that a broader cross-disciplinary perspective is required, as well as engaging individuals in a change in thinking about their roles. The shift to inclusion of patient centred care also raises a question about who the leader really is, if it is not the person at the top of the hierarchy.

**Organizational structure, roles and responsibilities**

The second theme that the dialogue group focused on involved the cultural rules within health systems and the way networks function. The functioning of the systems of health care means that a leadership approach relies on collaboration, and there are both challenges in shifting to such a systems approach and in maintaining it which challenge the culture or ways of working in health.
The implications for individuals are that collaboration depends on how individuals behave in a structure. There is both opportunity and risk. Practitioners at any level cannot bemoan barriers; they must ask how they contribute to a problem and what they contribute to resolving it.

There are implications for training arising out of a systems orientation. Training in health care is typically clinically focused, and awareness of how the whole system works might need to be cultivated. Cultural traditions may need to be challenged about roles and ways of working.

**A mindset or cultural shift must occur**

The dialogue session posed a question about whether fostering leadership might challenge people’s notions of their own autonomy, accountability, and collaboration. Participants agreed. The sense of ego, or self, might be challenged. In addition:

- There needs to be ownership and a willingness to accept and share accountability
- Shifting to leadership requires a balance between ego (sense of self) vs. risk (sense of coordination action for patient outcomes as well as willingness to take risks)

Participants noted that sometimes the current environment is not healthy for care providers and part of culture change is moving to support health care providers. However, being involved in leadership development had improved their health self-care. They linked this to taking more responsibility, reflecting how cultural shifts had systemic effects.

The three themes of risking change to include patient voice, taking opportunities, and reconsidering the self in the system, stack on top of each other. Considering a cultural shift which prioritizes outcomes, such as patient centred care, requires awareness about how systems and processes interact. Thinking about a collaborative environment raises questions about roles within those systems, and therefore focuses on levels of individual responsibilities and opportunities within systems. Focusing on roles and ways of working draws attention to the necessity of a change in culture, including self-care along with care of others. These changes shift the system to one of being a healthy and healthful system.

To address these complex issues, participants recommended that a convenor assemble a cross-disciplinary team to discuss system wide challenges. However, to delimit discussion and ensure action, this group also suggested time limits and deadlines with defined action steps be established.

**Suggested Actions to Foster Leadership**

In summary, the dialogue group focused on establishing a convenor to design a strategy to maximize the impact and reach of leadership development to meet the needs of the system and the people we serve.
1. Identify (and inventory) existing leadership development opportunities (by the end of June)
2. Convene a cross-section think tank (design team) to develop our path forward (by the end of October 2015)
3. Ensure a strong link to the CHLNet Action Plan.

Symposium participants strongly endorsed these recommendations. Of note is the interest in coordinating between BC and pan-Canadian work so as not to reinvent the wheel.

D. Creating a BC Action Plan

The Canadian Health Leadership Network (CHLNet) has articulated a frame for a national leadership action plan, organized as five pillars: (1) collective vision; (2) common leadership platform, (3) evidence on innovation and leading practices; (4) enhancing capacity and capabilities; and (5) measurement and evaluation.

Key Dialogue Questions

◆ What components or aspects of the CHLNet Action Plan may apply in BC?
◆ Under what conditions would you and/or your organization support a BC – centric action plan?
◆ The BC Health Leadership Development Collaborative (BCHLDC) has a provincial role in leadership development. What might be done to enhance its profile and reach?

One of the questions put to participants was to consider the degree to which BC needed to develop a new or independent BC action plan, the degree to which coordination could or should be shared with national organizations, and the approach that might be most effective to executing a plan. Participants unanimously agreed that what was needed now was not a wholesale new development, but to act, coordinate and leverage strengths. Instead, three main themes focused on the big picture.

Theme #1 - VISION is all important, however…

◆ Vision must be accompanied by measurement and evaluation
◆ Evidence must focus on whether better leadership leads to better outcomes
◆ Clear direction is needed to coordinate all the components which are already in play

Theme #2 - Ministerial commitment is needed to co-create a BC accountability framework

◆ Evidence is needed (both qualitative and quantitative)
◆ Room for flexibility is important
◆ Resources are needed for the entire journey; without sufficient resources, initiatives will falter or be limited
◆ Building capacity for research, education and systems transformation is important
◆ Documents must be clear
◆ CHLNet should be used as a resource
◆ Including patient voice and experience is important for achieving best outcomes

Theme #3 – It is important to be more strategic and have stronger ministerial leadership and health authority mandates.

Key issues include the following:
◆ Achieving sustainability;
◆ Avoiding being too micro in focus: The example given was that LEADS may be too focused at the micro level. Instead, more research and advocacy on barriers is needed (stronger systems focus, rather than individual level focus);
◆ Engaging more partners – including physicians and other practitioners;
◆ Maintaining and strengthening partnerships; and
◆ Being cognizant of scope tensions between inclusion and focus.

The underpinnings of these three themes arose from observations that there is a strong need for more common language so as to communicate easily, be aware of what is happening in other jurisdictions, and take more coordinated action. The gap was not in the steps that had been taken to date, but in the need for more networking, awareness and collaboration. Symposium participants strongly agreed with these conclusions. Also, although the dialogue group noted that there was an opportunity for coordination from federal leadership, in the absence of federal leadership, they suggested that the next step was to work together to implement systems wide change based on recommendations and findings to date across Canada. It was important, this group said, to leverage current health authority and provincial impetus in a coordinated way and not to wait.

Suggested Actions to Foster Leadership
1. Create an asset map
2. Define success, both at the micro level and macro level
3. Identify long term needs
4. Investigate the return on investment (gather evidence, do research)
5. Form a task group to accomplish these aims under BCHLDC

Dialogue Summary: Take Action Now

Discussion of the four topics of the Dialogue highlighted the range and depth of perspectives and experiences of participants. As a result, the dialogue was nuanced and grounded in the realities of working to change health systems, whether from a provincial or organizational leadership development perspective or from within care settings and units.
Participants concurred with recent study findings and reports on the issues facing health care reform. These key issues underlined the need to consistently share information within BC and across Canada, to define leadership itself, to identify roles, to develop a coordinating body and to be accountable. Participants were unanimous on the need to move forward. Steps, they said, should recognize strengths that are already present, broaden inclusion, be clear, and not repeat prior work. The suggestions converged on three main themes:

- Build on strengths and achievements to date
- Coordinate with national initiatives and directions
- Network to assist coordinated action

These themes were underpinned by characteristics that were frequently mentioned:

- Ensure that evidence is generated (conduct research and evaluation)
- Include patient voice and experiences
- Pay attention to the scale at which change is operating, the experiences at various levels within organizations, and the interaction of churn across systems
- Support self-care among health practitioners (change the culture within health)
- Work together with a systems focus

There was momentum to act now, rather than studying to make a new plan.
III. CONCLUSIONS OF THE BC REGIONAL DIALOGUE

There was remarkable convergence on next steps from the four Dialogue groups. After reviewing the suggestions, evaluations and comments, the planning committee identified cross-cutting themes, including five foundational steps and several strategic directions.

Participants strongly agreed that future work in BC should build on the work that has already been accomplished. They saw value in the work of independent organizations, which have been working similar goals since 2004, when the journey to identify and develop a leadership framework for BC began. Participants also suggested that we need to act quickly, and seize the opportunity to reflect on this journey now without worrying about perfection. They wanted to learn about activities in other organizations. “We operate in silos too often,” one participant said. The next steps have to involve more networking opportunities, and explore linkages arising out of those opportunities.

Foundations for Action

1. Generate more evidence linking leadership to health and health care outcomes, including
   a. return on investment
   b. better definition of the ‘leadership gap’
2. Establish a common language of leadership
3. Ensure patient voice and public input is included
4. Secure resources for the entire journey (i.e. from emerging to executive leadership)
5. Connect to the provincial vision for health reform by strengthening strategic partnerships and collaborative efforts

Strategic Directions

Follow Through With Planning
Participants agreed that there should be a secretariat to follow up on the Dialogue results. This follow up planning should be strategic and not just representational, and it should be funded to enable further dialogue. Various organizations were mentioned as candidates, but no decision was made.

Track Progress
A secretariat should develop consensus on how to track adopted objectives and develop a reporting structure. Individuals noted the congruence between various Dialogue group suggestions and the BC Governments’ Setting Priorities document. However, feedback to track action is an important component of ensuring challenges are addressed. A final point was that milestones should be celebrated, partly to communicate good news and partly to share information.
Build on Foundations and Link to Canadian Initiatives
There was no interest in preparing a completely independent, stand-alone BC path. Participants were interested in leveraging networks and assets that are available in BC and building on the strengths. The suggestions for action converged on building on actions that have already been identified and utilizing resources in knowledge and methods, which have already been developed, including through the Dialogue work. There was motivation to be both effective and efficient and to avoid ‘recreating the wheel.’ This was also accompanied by a desire to work together:

◆ Reflect on the extent of effort and achievement to date
◆ Work across health system silos
◆ Align with the Setting Priorities for the BC Health System (BC Ministry of Health) and the CHLNet Canadian Health Leadership Action Plan
◆ Capitalize on the groundwork that has been done

Build on Strengths, Define Leadership and Re-examine LEADS
A number of comments converged on the need to examine the concept of leadership and agree on definitions of leadership, the leadership gap, and return on investment. Along with this, there was a suggestion to re-examine the LEADS in a Caring Environment framework to ensure how it is being used and its utility. One participant also suggested that it would be important to borrow from other sectors that have successfully initiated change: that health care leaders need not look only internally.

Be an Informed Network
Participants applauded the amount of recent work reflected in studies and reports on leadership. They suggested that the various flows of work should be consistently shared across Canada. Time for reflection, such as the BC Dialogue, was identified as an important resource, and additional value would come by regularly coordinating information and strategic objectives. In summary, the goals could be:

◆ Share information
◆ Agree on common values, goals or initiatives
◆ Take time to reflect on challenges together

Determine Accountabilities
A work plan should incorporate accountabilities, including to patients and clients and those who work in the health care system. Participants recognized that the meeting included decision makers, researchers, patient advocates, policy officials, and directors of programs, but no front line staff. Although they recognized that it would be challenging to imagine an appropriate forum that would be inclusive enough, participants were clear that effective change could not go forward without the input of those who do the work and experience the care. Accountability, in this sense, appears to mean inclusion, knowledge, appropriate goals and feedback. In addition, as recognized above, return on investment is also important.
Three Key Steps for a BC Action Plan

Based on the findings, the planning committee prepared the following three key actions, which summarize the dialogue.

Key Action 1: Form a Provincial Steering Committee

Compose a provincial steering committee to explore next steps and steer the process.

◆ Be broadly inclusive, and ensure representation by:
  o The BC Health Leadership Development Collaborative
  o The Ministry of Health
  o Patient representatives
  o A CHLNet liaison
  o Members of the research communities (for example, BC and other universities) which are conducting research and programming related to leadership of health system change
  o Representatives of physicians in BC and other provincial professional bodies, and
  o Health research funding bodies, such as Michael Smith Foundation for Health Research or SPOR BC.12

Key Action 2: Coordinate and Establish a Coherent Provincial Strategy

◆ Develop an action plan to generate the leadership talent needed to support BC health system change priorities; and
◆ Measure the impact of that action plan on achieving BC health system change priorities.

The action plan will:

◆ Recognize regional differences and that approaches to change should be customized for all levels of the organization and roles.
◆ Be built, as appropriate, on the similar foundations to the CHLNet action plan including: a collective vision for the work; a common leadership language (LEADS-like); gathering more evidence on innovation and leading practices; enhance capacity and capabilities; and measuring and evaluating results for success.
◆ Incorporate change into the work culture as a norm.
◆ Emphasize leadership qualities needed for healthier workplaces.
◆ Emphasize leadership qualities needed for better employee, physician, and other professionals’ engagement.

12 Strategy for Patient Oriented Research (BC)
Key Action 3: Pool Investments

Make concerted, province wide efforts to raise and to pool investments by all partners to:

◆ Place greater emphasis and more organizational focus on leadership succession planning (growing our own leaders).
◆ Agree on a common language of leadership moving forward (for example, including a future evolution of LEADS).
◆ Link all leadership development efforts within BC to ensure participants work on and develop methods to lead health change priorities in the province.
◆ Minimize churn in leadership positions, through better selection, support, and improved opportunities to learn on the job.
◆ Include patient, staff and community voices in development of comprehensive leadership planning.

These three key actions build on the reports and research studies that gave rise to the BC Regional Dialogue and the discussions and conclusions of the Dialogue itself. They also acknowledge the uniqueness of BC within the context of the need for priorities for change in Canada.

The BC initiatives can also continue to leverage the work of CHLNet and other national work to link provincial initiatives in areas of similar interest or provide a means of communicating and sharing vision and information.

Looking Forward

BC has a unique opportunity to build on the foundation of years of innovative work represented by the development of the LEADS in a Caring Environment framework, the work of the BC Health Leadership Development Collaborative, and other recent initiatives, to build a new provincial exemplar of leadership development. Research shows that current leadership practice needs to be more strategic, systems oriented and patient-centred. Dialogue participants agree that new frameworks are not needed. The challenge is that, as in most jurisdictions across Canada, current efforts in developing leadership are fragmented and ad hoc.
## APPENDIX 1: DIALOGUE ATTENDEES

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Ms. Michaela Baer</td>
<td>Patient Representative, Patients Canada</td>
</tr>
<tr>
<td>Dr. Allan Best</td>
<td>Member, Canadian Academy of Health Sciences</td>
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<tr>
<td>Mr. Doug Blackie</td>
<td>Director, Recruitment and Retention Initiatives, BC Ministry of Health</td>
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<tr>
<td>Dr. John Cairns</td>
<td>President, Canadian Academy of Health Sciences</td>
</tr>
<tr>
<td>Ms. Lori Charvat</td>
<td>Corporate Director, People Strategies, Providence Health Care</td>
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<tr>
<td>Dr. Heather Davidson</td>
<td>Assistant Deputy Minister, BC Ministry of Health</td>
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<tr>
<td>Dr. Graham Dickson</td>
<td>Principal Investigator, LHSR Research Project</td>
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<tr>
<td>Dr. Chris Eagle</td>
<td>West Champion, Canadian Health Leadership Network (CHLNet)</td>
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<tr>
<td>Ms. Susan Good</td>
<td>Director, Leadership and Organizational Development, Fraser Health</td>
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<tr>
<td>Dr. Charlotte Gorley</td>
<td>Research Associate, Centre for Health Leadership and Research, Royal</td>
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<td></td>
<td>Roads University</td>
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<tr>
<td>Ms. Kelly Grimes</td>
<td>Executive Director, Canadian Health Leadership Network (CHLNet)</td>
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<tr>
<td>Dr. Brigitte Harris</td>
<td>Director, School of Leadership Studies, Royal Roads University</td>
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<tr>
<td>Mr. Jason Kennedy</td>
<td>Leader, Change Imperatives and Employee Engagement, Interior Health</td>
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<tr>
<td>Ms. Dawn Kirkham</td>
<td>Specialist, Leadership Development and Change, Island Health</td>
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<tr>
<td>Dr. Ron Lindstrom</td>
<td>Director, Centre for Health Leadership and Research, and Principal</td>
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<td></td>
<td>Investigator – BC Node, LHSR</td>
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<td></td>
<td>Royal Roads University</td>
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<tr>
<td>Ms. Zoe MacLeod</td>
<td>Director, Centre for Coaching and Workplace Innovation, Royal</td>
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<td></td>
<td>Roads University</td>
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<tr>
<td>Ms. Colleen McGavin</td>
<td>Patient Representative, Patients as Partners / Patient Voices Network</td>
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<tr>
<td>Ms. Kelly McQuillen</td>
<td>Executive Director, Services to Adults with Developmental Disabilities, BC Ministry of Health</td>
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<tr>
<td>Dr. Dayan Muthayan</td>
<td>Program Medical Director – Patient Access and Care Transitions, Fraser Health</td>
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<tr>
<td>Mr. Peter Norman</td>
<td>Principal and Facilitator, Challenge Education Associates</td>
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<tr>
<td>Dr. Linda Peritz</td>
<td>CEO, Institute for Health System Transformation and Sustainability</td>
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<tr>
<td>Dr. Don Philippon</td>
<td>Research Team Member – Prairie Node LHSR Research</td>
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<tr>
<td>Ms. Rachael Roberts</td>
<td>Lead, BC Health Leadership Development Collaborative</td>
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<tr>
<td>Ms. Barb Stoddard</td>
<td>Program Head, MA Leadership with Health Specialization, Royal</td>
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<td>Roads University</td>
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<tr>
<td>Dr. Silvia Vilches</td>
<td>Mitacs Elevate Postdoctoral Fellow, Centre for Health Leadership and Research, Royal Roads University</td>
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<tr>
<td>Dr. Martin Wale</td>
<td>Deputy Chief Medical Officer, and Executive Medical Director, Medical Affairs and Research, Island Health</td>
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</table>
Facilitator
Peter Norman, Associate Faculty
Royal Roads University, and
President of Challenge Education Associates

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