PARTNERSHIPS FOR HEALTH SYSTEM IMPROVEMENT
LEADERSHIP AND HEALTH SYSTEM REDESIGN
CROSS-CASE ANALYSIS FINAL REPORT

CIHR IRSC

MICHAEL SMITH FOUNDATION FOR HEALTH RESEARCH
Discover. Connect. Engage.

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Key Messages

Current Capacity:

- The challenge of creating large-scale change requires levels of systems thinking, strategic thinking, relationship development, and self-leadership that supersede the current capacity of many formal leaders.
- Quality physician leadership—at all levels—is required for reform to be successful; yet that capacity is only engendered through exemplary practices of ongoing, meaningful physician engagement.
- Political dynamics and regular turnover among ministerial, senior policy, public service leaders, executive, and organizational leaders impede leadership of large-scale change over time.
- Collective leadership capacity[1] requires alignment of thinking and action amongst formal leaders that challenges traditional conventional notions of autonomy, accountability, and collaboration that they currently bring to their role.
- The ongoing need to expend energy to overcome factors that impede change—structural, cultural, and political—are draining the capacity of Canada's leaders faster than that capacity is being rejuvenated.

Gaps Between Current and Leading Practices Described in the Literature

- The findings support many of the leading edge practices, models, and theories of leadership found in the literature. However, they do not suggest "validation" of one theory over another—in fact theory validation is not the point of the study. Understanding leadership better is; and there is some illumination related to existing leadership theories inherent in the data.
- Four key ideas emerging in the leadership literature were highly relevant to interpreting findings from the case studies: trait theory of leadership; shared or distributed leadership; substitutes for leadership; and complexity leadership. In addition, some strong support for the construct of authentic leadership and servant leadership emerged.
- Four out of the six case studies (with the exception of Quebec and BC which did not address the use of LEADS) showed that the *LEADS in a Caring Environment* (Dickson, 2010) capabilities framework, adopted by many jurisdictions and agencies across Canada is increasingly being accepted as a "common language" of leadership across

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[1] Collective leadership capacity refers to the overall capacity to lead as exhibited by all formal and informal leaders in the system. This term is not to be confused with the construct of distributed leadership, shared leadership, or collaborative leadership, terms with unique definitions within the literature.

organizations and professions, and could be used as a foundation for more coherent, collaborative efforts at leadership talent management and succession planning.

- Individual case reports highlighted several leadership capabilities that were not expressly identified in the LEADS framework (e.g., courage, credibility, and trustworthiness); although they may be subsumed under higher level language (e.g., character).

Knowledge Mobilization

- Current effort by individuals and organizations to translate and mobilize knowledge and best practices of effective leadership in Canada is ad hoc and peripatetic.
- There would be value in a strategic focus being brought to bear on systematic succession planning and leadership development.
- The importance of mentoring and sponsoring emerging leaders was a common theme seen across cases.
- National initiatives in Australia and the UK to foster system-wide leadership development and succession planning should be looked at to guide a similar initiative in Canada.
- The need to have a clearing house to identify leading practices, and the potential for standardized credentialing of leaders were mentioned in more than one case.

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Executive Summary

Background

The purpose of the *Leadership and Health System Redesign* research study was to explore the leadership dynamics at play in Canadian health reform and to develop leadership capacity in the Canadian health system through applied research and knowledge mobilization. The study makes an important contribution to our understanding of how different forms of leadership are shaping health reform in Canada and the complex array of factors that make leadership of large scale reform very challenging. It illuminates the need for much greater clarity about what concepts such as distributed and complexity leadership look like in practice, and how important it is to do further research on how those models can be used to influence transformation in a decentralized health care system. Results highlight the need for a more coordinated Canadian strategy for leadership talent management and succession planning and a more robust, systematic and comprehensive approach to research and knowledge mobilization on best practices of leadership.

The four-year project was overseen by a network of senior decision-makers and health researchers, and was funded through Canadian Institutes for Health Research (CIHR) and Michael Smith Foundation for Health Research (MSFHR) grants, with acknowledgement to the MSFHR Health Services & Policy Research Support Network. The case studies explored leadership dynamics at play across Canada in redesigning the health system. One national and five regional projects were carried out to explore and understand the leadership dynamics at play across Canada in redesigning the health system:

- National Node Project on Access, Quality and Appropriateness
- British Columbia Project on Integrated Primary and Community Care
- Prairies Project on Shared Services in Saskatchewan
- Ontario Project on New Models of Primary Care Delivery
- Quebec Project on New Models of Primary Care Delivery
- Atlantic Project on Engagement (one study in Nova Scotia on physician engagement, and one study in the Eastern Region of Newfoundland on employee engagement)

Research Design

Three core research questions framed the research:

1. What is the current state of health leadership capacity in Canada?
2. Where are the gaps between current practices and leading practices?
3. How can knowledge of effective leadership be mobilized by the network to enhance the development of quality health leaders?

To answer these questions, a longitudinal participatory action research (PAR) approach was employed (three cycles over two years). The research is both exploratory and interpretive, aimed at helping leaders and health researchers to understand the deeper meaning and

challenges associated with leading health reform. The study was conducted in two stages. In the first stage each of the six case studies utilized mixed qualitative methods to gather data over three cycles. They described, in rich, thick case reports, the practice of leadership in real life reform situations. In stage two a cross-case analysis was conducted. Common themes relating to the three questions guiding the study were identified. The longitudinal method recognized the ongoing, iterative development of understanding leadership of change and its dynamic manifestation through time, circumstance and situation. This document reports on the second stage (i.e. cross-case analysis) of this study.

Findings

Leadership Capacity

Each of the case study reports analyzed respective data to determine the leadership capacity required to create change in their specific context. Common themes that occurred were identified.

With respect to the first research question, cross-case data suggests that Canada does not have the leadership capacity that is required to lead significant health reform. Findings included:

- The challenge of creating large-scale change requires levels of systems thinking, strategic thinking, relationship development, and self-leadership that supersede the current capacity of many formal leaders.
- Quality physician leadership—at all levels—is required for reform to be successful, yet that capacity is only engendered through exemplary practices of ongoing, meaningful physician engagement.
- Political dynamics and regular turnover among ministerial, senior policy, public service leaders, executives, and organizational leaders impede leadership of large-scale change over time.
- Collective leadership capacity requires alignment of thinking and action among formal leaders that challenges conventional notions of autonomy, accountability, and collaboration that they currently bring to their role.
- The ongoing need to expend energy to overcome factors that impede change—structural, cultural, and political—is draining the capacity of Canada's leaders faster than that capacity is being rejuvenated.

Reinforcement of Leadership Literature and National Standards

- Our collective research reinforced some basic leadership concepts found in the literature regarding the practice of leadership in health reform. Trait leadership, distributed leadership, substitutes for leadership, and complexity leadership were strong themes. In addition, some support for the constructs of authentic and transformational leadership (closely related) and servant leadership arose.

- Cross-case results show a continued reliance in some parts of the health system on hierarchical, heroic leadership models. However, formal leaders no longer have the same power or privilege as before. Informal leadership is also emerging.
- Health service delivery is increasingly complex and interconnected, yet the forces of fragmentation—perceived negative politicization, turnover of leaders, constitutional and organizational structure, and the plethora of organized professional organizations that each have a stake in the process—prevent alignment of effort.
- Leadership for large-system health reform requires striking the right balance between centralization and decentralization forces, formal and informal leadership, individual and organizational accountabilities and authorities, organization and system performance, and alignment of effort across boundaries.
- Our current individualistic leadership cannot sustain large-scale health reform. Shared, distributed models with an understanding of associated authorities and accountabilities need to emerge. As a consequence, there would be value on a more strategic focus being brought to bear on systematic succession planning and leadership development (see the knowledge mobilization points below).
- In this study, the *LEADS in a Caring Environment* (Dickson, 2010) framework was referenced in many cases as having potential as a foundation for the above-mentioned succession planning and leadership development needs within the Canadian health system. It has many similarities to Health LEADS Australia and the National Health Service Leadership Framework in England (currently under revision) that are being used to underpin system-wide strategic approaches to creating reform.

Knowledge Mobilization

- Individual and organizational effort to translate and mobilize knowledge and best practices of effective leadership in Canada continues to be ad hoc and sporadic. This is a contributing obstacle to sustained, positive health system reform.
- Both collective and individual approaches to creating a better bridge from the research world to the policy world are required. The research literature suggests, for instance, that systematic leadership talent management (e.g., succession planning and leadership development) are sound organizational investments in this regard.
- Informants across nodes suggest there should be increased focus on succession planning and leadership development (including mentoring and coaching). Leaders reported the need to develop and support new innovation pathways to effect a stronger national approach to leadership development, although local efforts must continue.
- Canada appears to under-invest in knowledge translation. Post-secondary institutions should play an integral part in this function.

Conclusion

Leadership matters to overall organization and system performance. Cross-case analysis supports the general thesis that the pace and breadth of health reform demands sophisticated shared leadership. Contradictions—context contradictions: e.g., between structure and desired structure to facilitate change; practical contradictions—e.g., between effective politicization and negative politicization; and human contradictions—e.g., between an intellectual understanding of complexity behaviour and the emotional demands of behaviour change—create a landscape for the practice of leadership for health reform that makes it exceedingly challenging. Canada's traditional approaches to leadership development and its current individualistic practice do not provide the leadership needed for large-scale health reform.

New, distributed approaches to leadership emphasize a common vision for change, systems-level thinking, alignment of effort, and re-balancing leader accountability and responsibility. Like other developed systems, Canada could invest in a national strategy for leadership development, mentorship and succession planning based on a common 'for health, by health' leadership platform across the country (i.e. LEADS).

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Acronyms

AQA	Access, Quality and Appropriateness
CH	Capital Health
CHLNet	Canadian Health Leadership Network
CCM	Comprehensive Care Models
FATT	Fully at the Table
FHG	Family Health Groups
FHN	Family Health Networks
FHO	Family Health Organizations
FHT	Family Health Teams
FMG	Family Medicine Group – Group de médicine de famille
IPCC	Integrated Primary and Community Care
IWK	IWK Health Centre
KT	Knowledge Translation
KM	Knowledge Mobilization
LEADS	**L**ead Self, **E**ngage Others, **A**chieve Results, **D**evelop Coalitions, **S**ystem Transformation in a Caring Environment
LHIN	Local Health Integration Network
NPLC	Nurse Practitioner Led Clinics
PAR	Participatory Action Research
PCN	Primary Care Networks
PHSI	Partnerships for Health System Improvement
RHA	Regional Health Authority
RNPGA	Rural and Northern Physician Group Agreement

Cross-case Analysis Final Report

Introduction

The purpose of the *Leadership and Health System Redesign* project was to help develop leadership capacity in the Canadian health system through applied research and knowledge translation. The project was stewarded by a network comprised of senior decision-makers (under the auspices of the Canadian Health Leadership Network [CHLNet representing over 40 health organizations]) and representatives of the health leadership research community from nine universities across Canada (with Royal Roads University [RRU] as institution of record) in a unique collaborative partnership – a *network of networks*.

The intention was to build a bridge between researchers and leaders in the field of leadership. The Canadian Institutes for Health Research under the Partnerships for Health System Improvement (PHSI) grants and the Michael Smith Foundation for Health Research provided the funding for this four-year project ($450,000 over four years, with $400,000 in kind from project partners). Ethics approval for the overall study was granted by Royal Roads University, and each node received ethics approval or ethics certificates from their respective universities.

Six case study projects undertook to explore and understand the leadership dynamics at play across Canada in redesigning the health system:

1. National Node Project on Access, Quality and Appropriateness
2. British Columbia Project on Integrated Primary and Community Care
3. Prairies Project on Shared Services in Saskatchewan
4. Ontario Project on New Models of Primary Care Delivery
5. Quebec Project on New Models of Primary Care Delivery
6. Atlantic Project on Employee/Physician Engagement (two case studies)

This report provides a cross-case analysis of these six case studies based on the following three research questions that guided the study:

1. What is the current state of health leadership capacity in Canada? What is working, or not working, in terms of stimulating and supporting health system transformation, and what contextual factors influence effective leadership action?
2. Where are the gaps between current practices, the evidential base in the literature, and the expectations for leadership outlined in the emerging health leadership capability/competency frameworks (e.g., LEADS capabilities framework), and how might a set of national standards for leadership be structured?
3. How can knowledge of effective leadership be translated and mobilized by the network into approaches, programs, tools and techniques to develop a culture of effective leadership in Canada, and enhance the development of quality health leaders?

Figure 1: Six Node Health Leadership Case Study Projects

Leadership in Health Systems Redesign Research Projects Across Canada

National Node Project:
Access, Quality, & Appropriateness

Prairies:
Shared Services in Saskatchewan

Atlantic:
Employee (EHR)/ Physician Engagement (CH/IWK)

BC
Integrated Primary and Community Care

Quebec & Ontario (2):
New Models of Primary Care Delivery

$817,500 –CIHR Grant ($350,000),
MSFHR Grant ($100,000) and in kind contributions.

In addition to the research itself that aimed to understand leadership in action, there were also the twin goals of:

1. Building an integrated regional and national knowledge translation and knowledge mobilization (KT/KM) strategy that distills the knowledge from the case studies and translates it into practice; and
2. Developing a sustainable *network of networks* in health leadership research that will last well beyond the PHSI funding envelope and timeframe.

The impetus for this project was to examine leadership in situ at the micro, meso and macro levels of the Canadian health system[2]. Five years ago, the health system was challenged by economic constraints, and the ability to provide effective leadership was emerging as a critical success factor for the sustainability of the health system across Canada (Canadian College of Health Service Executives, 2009; Canadian Health Leadership Network, 2009). In response to this growing challenge, health ministries, health authorities and senior leaders of health professional

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[2] See Table 1. Each case is identified as either macro, meso, or micro in scope.

organizations across Canada had initiated collaborative strategies to build evidence-informed leadership capability within the health system.

This challenge grows larger as comparative country analyses, such as those prepared by the Commonwealth Fund (www.**commonwealthfund**.org), show Canada's continued downward slide. The Health Council of Canada has recommended more "supportive leadership"; the Premiers' report *From Innovation to Action* (Health Care Innovation Working Group, 2012) identified "present leadership" as one of four critical factors for better system performance; and the Health Council of Canada's November 2013 report *Better Health, Better Care, Better Value for All: Refocusing Health Care Reform in Canada* calls for strong leadership as the first of five key enablers of high performing systems."[3] Leadership is now on the policy agenda of most provincial governments in Canada. However, there is a lack of research on, and understanding of, the ways in which different forms of leadership – especially highly distributed and networked forms of leadership – affect health system reforms and improve overall performance (Currie and Lockett 2011; Dickson 2009; Fitzgerald et al., 2013).

Consequently, the purpose of the *Leadership and Health System Redesign* research study was to explore the leadership dynamics at play in Canadian health reform and to develop leadership capacity in the Canadian health system through applied research and knowledge translation. The findings from this project advance this body of evidence and are outlined in the next sections, following an initial overview of the research methodology.

Research Methodology

Each case study employed the same foundational methodology for research. A decentralized approach to participatory action research (PAR) was used (Reason & Bradbury, 2008; Smith et al., 2010; Swantz, 2008). Each node research team was free to use PAR methods that suited their context. A multiple-case comparative approach (Yin, 2009) was then employed for interpretive purposes. Given the decentralized method to this project, modifications were made for each node and these are summarized in Table 1.

Decentralized Approach

The methodology employed to answer the questions was chosen to reflect the unique context of distributed or shared responsibility for service delivery in the Canadian health system. Canada is a Westminster-style federation with a Canada-wide set of interlocking provincial/territorial universal health insurance programs, guided by the spirit and intent of national standards as set out in the Canada Health Act (1985). This decentralized approach is due to the fact that constitutional responsibility for health service delivery resides primarily at the provincial and territorial level (except for specific services delivered by the federal government to first nations

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[3] Health Council of Canada. (September, 2013). *Better Health, Better Care, Better Value for All: Refocusing Health Care Reform in Canada.*

and aboriginal peoples and to employees of national agencies, such as the Department of National Defence).

Participatory Action Research

To understand the leadership dynamics of health system delivery in Canada, all six nodes conducted up to three rounds of participatory action research into the practice of leadership during ongoing health system redesign initiatives (Reason & Bradbury, 2008; Smith et al., 2010; Swantz, 2008). "PAR is a process of systematic inquiry in which those who are experiencing a work-related problem participate with trained researchers in deciding the focus of knowledge generation, in collecting and analyzing information, and in taking action to improve the conditions or to resolve the problem entirely" (Rosskam, 2008, p.3). This approach was operationalized by seeking cases at different levels of the system and in diverse regions across the country, including one national case to explore change on a Canadian scale, and adapting the PAR method to each individual context. The method reflects a need to adapt to the decentralized or 'loose' governmental stewardship and approach to leadership of health care in Canada (Currie & Lockett, 2011; Tholl & Bujold, 2011).

The longitudinal PAR approach (i.e., three cycles of participatory action research over two years—see Figure 2) utilized a mixed qualitative methodology to gather data (Brydon-Miller et al., 2011; Lincoln & Guba, 1985; Stringer, 2007) and a case study method to explain and interpret it (Creswell, 1998; Flick, 2007; Stake, 1995; Yin, 2009).

In PAR, participants are seen not only as participants but also as research collaborators or partners who are actively involved in research activities (Rosskam, 2008). There is a desire to create reflexivity, which emphasizes "mutual dependence of researcher and the researched, their influence on actions taken, and that sensemaking emerges from the dynamics of process." (Tedmanson & Banerjee, 2010, p.3). The goal of PAR is to produce change-oriented research through dialogue and interaction, and to produce results that participants can use in their own organizations (Brydon-Miller et al., 2011). The specific approaches employed in each case are outlined in Table 1. The PAR approach recognized the ongoing, iterative development of understanding phenomena such as leadership of change, distributed leadership and its dynamic manifestation through time, circumstance and situation. Approaches across cases differed in the extent to which PAR was employed and in the degree of the researcher in the process.

The research project was both exploratory and interpretive, aimed at helping readers to understand the deeper meaning and challenges associated with leading health reform (Dickson & Tholl 2014; Greenfield, 1979 cited in Gronn, 2002; Krauss 2005; Nicklin 2012; Varney 2009). Each of the six cases explored, documented, interpreted and described, in rich, thick case reports, the exercise of the practice of leadership in real life situations demanding or requiring its skills in creating change (Lincoln, 2010; Lincoln & Guba, 1985). For brevity's sake, these data can be found in the separate case reports.

Multiple Case Comparative Approach

The project employed a multiple case comparative analysis approach (Burns, 2010; Houghton et al., 2013; Yin, 2009) to investigate, and if possible, to elucidate common themes and practices regarding effective leadership for health reform in Canada, and the factors that both impede and facilitate its distributed action (Currie & Lockett 2011; Gronn 2002; Dickson & Tholl, 2014) in a Canadian context. The overall methodology leading to this cross-case analysis report is shown in Figure 2. A case-study method is appropriate to investigate new areas in which knowledge is sparse or missing, and when complex phenomena are being studied (Creswell, 1998; Flick, 2007; Stake, 1995).
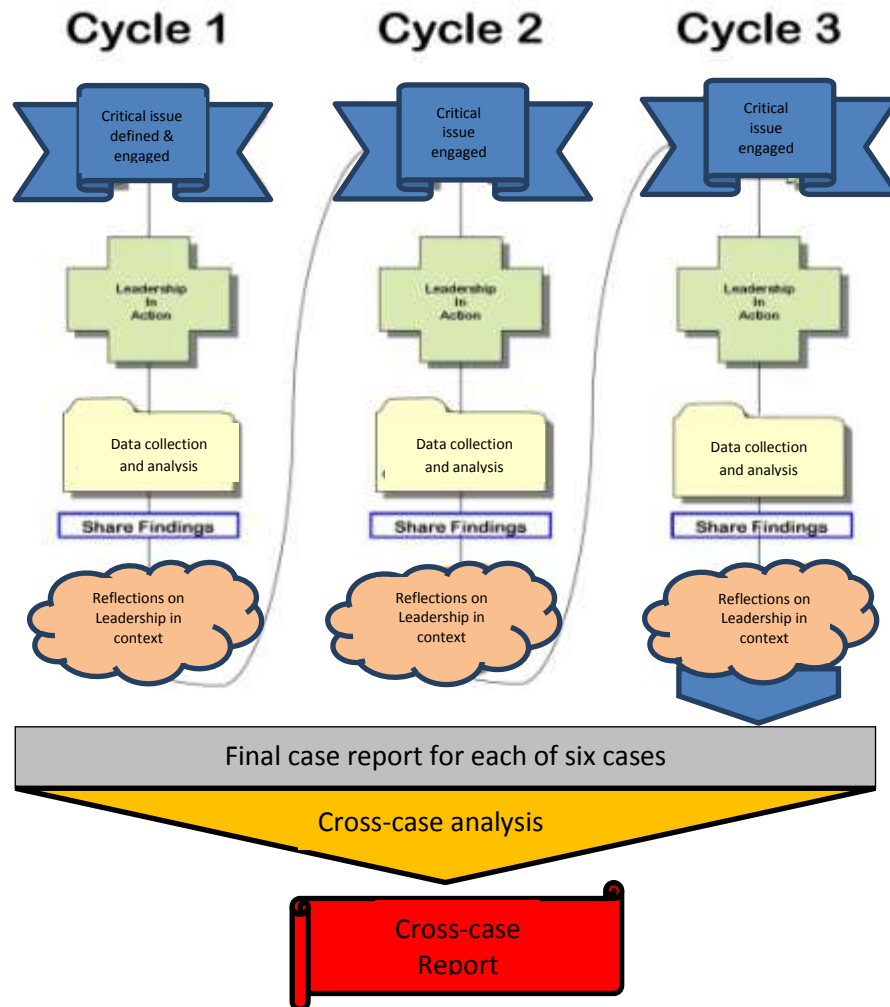
Data Collection Method

The primary data collection method was the semi-structured interview (Qu & Dumay, 2011), which "… allow(s) for exploration of emerging themes, which can elicit further data collection (Erlandson et al., 1993), and which served as "a reflective process characterized as informal conversations to enable participants to describe their experiences on their own terms" (Stringer, 2007, p. 69). It was anticipated that this method of data collection would facilitate a wide variety of impressions and experiences from which to draw further connections. Interviewers were sensitive to observations and clues as to the emerging themes, conflicts and difficulties that developed during the interviews. Interview protocols to guide the semi-structured interview were created. Several nodes also used focus groups (Jayasekara, 2012; Rosskam, 2008). One node used a modified Delphi method[4]. Another used a critical incident technique[5]. Limitations and ethical considerations can be found within each node case study report.

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[4] The Delphi method has been defined as "a method for the systematic solicitation and collection of judgements on a particular topic", which occurs "through a set of carefully designed sequential questionnaires interspersed with summarized information and feedback on opinions derived from earlier responses" (Delbecq, Van de Ven, & Gustafson, 1986, p. 10). The method is commonly used for examining "subject matter where the best available information is the judgment of knowledgeable individuals" (Ziglio, 1995, p. 15).

[5] Critical incident technique is recognized as a best practice approach to competency modeling (Campion et al., 2011) and is a set of procedures used to collect observations of situations and events that are memorable to organizational members (Flanagan, 1954).

Figure 2: Three Cycles of Participatory Action Research and Cross-case Analysis

Data Analysis

Thematic analysis, a qualitative method, was used to code data from within and across the cases. NVivo 9 software was used to organize the data to create parsimonious themes within the node data, and to better make comparisons across the cases (Boyatzis, 1998; Fereday & Muir-Cochrane, 2006).

In qualitative research, a code is a summative word or phrase that captures the character of a particular piece of data (Saldaña 2009). Two main approaches to coding, inductive and deductive, were used in this analysis process. Inductive coding is exemplified by the "open coding" used in grounded theory research (Auerbach & Silverstein, 2003). In this "bottom-up" approach, the researcher does not begin with any pre-existing codes and instead looks for repeating ideas, which are gathered to eventually become codes. In contrast, deductive coding begins with a preliminary set of codes, which are usually drawn from existing research.

However, these codes are used flexibly and new codes are added as necessary to account for unanticipated ideas that emerge as coding proceeds (Gilgun, 2011).

Cross-case coding was done in two rounds by at least two people out of a team of three research team members (each was skilled in NVivo analysis) to ensure consistency. In both rounds, all three researchers inductively coded one case report as a trial or pilot case. Key codes from each report that were likely to be found in other reports were compiled into a preliminary list to be used deductively on the subsequent reports. However, the list was treated flexibly and new codes were added to account for new ideas and contextual factors in each study. The second round of coding employed the themes from round one deductively but flexibly, allowing for comparison between the two rounds and capturing changes over time.

After the second round of coding was complete, codes were consolidated into broader themes and sub-themes that addressed the main research questions that guided the study. The resulting Excel matrix with themes, sub-themes and representative leader quotes, was presented to the cross-case panel in November 2013. The coding confirmed some of the panel members' preliminary observations and also revealed themes that had not previously been noted (e.g., the importance of alignment).

Table 1 outlines the differences in research methodology among the six node projects. Each regional node operated within its own situational context and unique circumstances. The unit of analysis varied from micro, meso and macro levels of the health system. As well, modifications to the application of PAR did occur and are highlighted.

Table 1: Research Methodology Overview by Node

Node and Project Title	Situational Context	Unit of Analysis	PAR Application
NATIONAL NODE **(Macro case)** **Leadership of Changes Associated with Creating Access, Quality and Appropriate Care**	The national goals of access, quality and appropriateness (AQA) were chosen through a consultation process facilitated by CHLNet. AQA was seen as the foundation for reform as reflected by: the key elements that are embedded in Canada's universal health care as defined in the Canada Health Act; and a consensus on the current national challenge of curtailing health care spending, while retaining a financially sustainable, high quality system.	Conducted action research into the practice of leadership to create health system redesign in a national context. Twelve study participants were chosen by a national health leaders network (Canadian Health Leadership Network) based on their knowledge of health care, current involvement in health reform, and acknowledgment by peers as a major contributor to efforts in leading health reform in Canada.	AQA reform goals focused discussion for this four year endeavour including how these three goals interacted and the efforts being undertaken to lead reform. A series of sub questions were adapted and used for the national node study. A semi-structured interview process garnered data across three cycles of research. A six to eight month interval between interviews occurred. The methodology in the third cycle of action research shifted from individual interviews to focus groups. NVivo analysis generated central themes and answers to the questions for each cycle. Findings were also aggregated after cycle three and interpretative insights drawn.
BRITISH COLUMBIA NODE **(Micro case)** **Exploring Leadership During Implementation of the Integrated Primary and Community Care Initiative**	In September 2010, the Integrated Primary and Community Care (IPCC) initiative began in BC with a Ministry of Health paper. The vision was to explore the qualities of leadership, significance of leadership, and the factors that influence leadership effectiveness in different contexts, to effect change in support of the integration of primary and community care in Chilliwack. The objective was to acquire a better understanding of leadership capabilities needed in a change	IPCC across the local, regional, and provincial levels. The Chilliwack Community Based Service Delivery Area within the Fraser Health Authority was chosen because they were furthest in implementing IPCC. Fraser Health is the largest and one of the fastest growing health authorities in BC and serves more than 1.6 million people. It contains a diverse population of First Nations peoples, Asians, Indo-Canadians, Koreans, and Filipinos	Three cycles of PAR using a set of questions in semi-structured interview format and a focus group as a means of data collection. Observational data was also collected from Fraser Health IPCC Steering Committee meetings and Ministry of Health Integrated Leadership Committee meetings. At the end of each data collection cycle the findings were shared with participants for the purpose of opening discussions on leadership and how perceptions of leadership change over the course of the research project.

Node and Project Title	Situational Context	Unit of Analysis	PAR Application
	initiative that includes different agencies and different locations, and the complexities of leadership relationships that exist throughout the different levels in different contexts.	and is home to about 40% of all British Columbia's immigrant population. A significant proportion of this population is elderly, resulting in a steep increase in the prevalence of chronic disease.	
PRAIRIE NODE (Meso case) **Shared Services Initiative**	Shared Services originated with the 2009 Patient First Review. The research was designed to shed light on how issues of accessibility and quality, as well as how efficiency and effectiveness are negotiated in the context of a distributed model of health system leadership, governance, and decision-making. The broader context of Shared Services includes the 2008 creation of a single regional health authority in Alberta, known as Alberta Health Services. Shared Services hopes to achieve economies of scale and scope through a unified health care system, but without the need to establish a single, hierarchical organization and avoid the problems associated with Alberta-style centralization. In April 2012, the Saskatchewan Association of Health Organizations (SAHO) amended its bylaws to produce a central office, known as 3sHealth, for Shared Services in Saskatchewan.	Shared services to achieve cost savings in supply management and business functions common to the province through the active co-operation of 12 delegated health regions, the Saskatchewan Cancer Agency and the independent health care organizations and health providers, including physicians, that contract with these provincial organizations. The study was designed to assess leadership at various stages in Shared Services as the initiative progressed. Three groups represented three levels of health system engagement: Group One included governance and directional stewardship at the ministry and health region executive level; Group Two consisted of Shared Services senior leadership immediately below the CEO level at collective and individual project stream levels; and Group Three included front-line leadership of existing business	Three cycles of PAR. Cycle One examined leadership throughout the stages of commitment in principle and design. Cycle Two focused on the leadership being exhibited in two Shared Service business streams that had experienced some progress in implementation. Cycle Three examined recent developments in these two business streams (procurement and human resources). Cycle One generated 39 semi-structured individual interviews and involved an assessment of the collective results in order to create a Delphi survey distributed to those same participants. Cycle Two consisted of interviews with 16 participants and two focus groups with front-line managers from each business line. The decision-maker partners and the 3sHealth executive team met and it was suggested that some challenges identified in Cycle Two might no longer be applicable due to 3sHealth's activities in the preceding months. Capturing changes occurring in the intervening six months, Cycle Three involved key informant interviews with six leaders in Groups One and Two as well as a

Node and Project Title	Situational Context	Unit of Analysis	PAR Application
		units within each project.	small focus group and one key informant interview involving five Group Three managers.
ONTARIO NODE **(Micro case)** **Role of Leadership in the Development of Family Heath Teams and Nurse Practitioner Led Clinics**	Examine leadership dynamics in the context of primary care reform efforts. More specifically, the roles and actions of provincial and local leaders in the creation and implementation of Family Health Teams (FHTs) and Nurse Practitioner Led Clinics (NPLCs) in the early 2000s. These are inter-professional teams of primary care providers that deliver a comprehensive array of services to patients. The key difference between the FHT and NPLC models is NPLC model shifts the focus from family physicians as the primary contact for patients to NPs. Study also compared the FHT model with the FMG (Family Medicine Group) model in Quebec.	Provincial and local practice levels. The local analysis conducted in context of the broader policy environment that facilitated and/or impeded the creation and implementation of these models. The inclusion of a macro-system and policy level analysis is based on the assumption that changes in the provincial political, economic, and healthcare contexts created an opportunity for change that had not previously existed. Three high-performing FHTs and one NPLC were selected. Provincial and local leaders were interviewed.	Two cycles of PAR. The first cycle involved completion of a literature review and key informant interviews with provincial and local leaders. A summary of key findings was distributed to study participants describing the factors that serve as facilitators or impediments to change; the roles and actions of leaders in system transformation; and lessons learned in this change effort. The second cycle consisted of follow-up interviews with some of the participants in the original high-performing FHTs and NPLCs to assess issues identified in the first cycle, the roles and activities of leaders in addressing these issues, and the strategies for moving forward. A final report summarized finding of both cycles and disseminated to all participants.
QUEBEC NODE **(Micro case)** **New Primary Care Models: Challenges of Creating Family Medicine Groups (FMGs)**	In early 2000, the Quebec government supported implementation of new primary care services organizations called FMGs. A province-wide initiative was launched to improve responsiveness and access to primary care and to integrate primary care more effectively in health and social service networks. FMGs appear	Three high performing FMGs were identified. Criteria for selection: size of group; distribution of cases among urban and rural areas; and affiliation with a university or not. In two of the three FMGs, four members were interviewed; the physician leader (or executive director), an associate physician, a	Three cycles of research were conducted to identify the evolution of leadership roles and capacities through change process. Six sub questions were created. Each cycle, used semi-structured interviews with physicians and managers within three selected FMGs. The first cycle of research process consisted of data collection and analysis. The second cycle consisted of

Node and Project Title	Situational Context	Unit of Analysis	PAR Application
	promising to address challenges facing primary care services, such as improving accessibility and coordination and integration of care. The shared responsibility of FMGs and health and social services centers in delivering primary care services limits the potential of FMGs. The objective was to examine leadership dynamics and the process of change in the context of primary care reform, more specifically for development of FMGs. The study also compared itself to Ontario's FHT model.	nurse and an administrative officer. In the last FMG, five members were interviewed; the executive director, two associate physicians, a nurse, and the administrative officer.	returning a brief synthesis of the main results to the participants (including physician leaders) in order to get their insights on leadership roles, activities and dynamics identified. Their feedback led to confirmation of, adjustment of, and creation of a revised analysis of the leadership process. Further, a second round of interviews with participants examined the evolution of leadership roles and activities, the new obstacles and challenges in exercising leadership, and strategies used to solve these problems and challenges. The third cycle consisted of a focus group with physician leaders to discuss and adjust final results.
ATLANTIC NODE (Micro cases) **Dynamics of Engagement of Health Care Providers**	The Nova Scotia (NS) project centred on physician engagement while Newfoundland and Labrador (NL) focused on employee engagement. NS Project: two organizations collaborating on physician leadership program called Fully at the Table (FATT). NS objectives to: clarify the connections between physician engagement and health system redesign; identify the leadership capabilities that are key to advancing physician engagement; and advance and make accessible contextual factors that relate to increasing physician	NS: physicians in Capital Health (CH) and the IWK Health Centre (IWK). NL: Managers/leaders in Eastern Region of Newfoundland. Both used the process as the unit of analysis. In NL, the implementation of a leadership framework for directors and managers within the context of increasing engagement among management and employees at Eastern Health. In NS, intended to capture contextual elements that shape the current situation and	In NS, three cycles were used. Researchers collected data during the first cycle through using semi-structured interviews. This was done in relation to FATT, a physician leadership development program at Capital Health. The second and third cycles involved participants in clarifying leadership actions related to physician engagement within and beyond FATT. For cycle two, NS researchers determined that richer information might be obtained using critical incident technique (used in cycle three as well). Cycle Three was a focus group aimed to explore and interpret Cycle Two results. In addition, NS researchers and leaders met twice to

Node and Project Title	Situational Context	Unit of Analysis	PAR Application
	engagement. NL Project: province combined Eastern Region and undertook deliberate activities to advance leader engagement as result of an employee survey. NL objectives to: further understanding of the linkages between leadership and employee engagement; assess the effects of leadership capabilities on core engagement drivers, specifically, perceptions of senior leadership and organizational reputation; and identify key leadership practices that positively influence manager and employee engagement.	drive the need for advancing engagement in health care with implementation of FATT and other initiatives.	review, interpret, and act on emerging results. Informal communications (conversations, meetings) between the researchers and leaders enhanced information exchange. Leaders openly discussed challenges and researchers provided intuitive knowledge to advance leadership throughout the project lifecycle. In NL, interviews and focus groups were used to gather data through two cycles. The research was divided into two main phases or cycles for data collection: a situational analysis of the context of engagement and the need to institute a leadership strategy to enhance engagement; and a second PAR phase that examined the institution of the leadership framework and how that has influenced engagement. Data for cycle one consisted of two data collection methods; individual interviews and one focus group. Data for cycle two consisted of four focus groups with new managers, managers, directors, and LEADS faculty.

Thematic Analysis

Key findings were identified during a one-day cross-case analysis session in November 2013. The meeting included both researchers and decision-makers across all nodes. Two cross-case analysis methods were used during the meeting. First, themes were generated through an affinity diagram alignment exercise. In this exercise, a representative of each node presented the key findings of their node on colour-coded paper. All findings were then grouped by similarity to identify broader, overarching themes. The coloured paper clearly showed which case each theme was found in and therefore how widespread each theme was across cases. The affinity exercise was followed by a review of the NVivo coding results. The comparison highlighted the congruencies and a few differences between the two methods. Where there were discrepancies, the group discussed the differences and resolved them based on their tacit knowledge of the case content and of the issues involved. Both sets of findings are integrated and synthesised below and further in the discussion.

Limitations

There are some limitations to the study. As Tedmanson & Banerjee (2010, p. 3) state, "results in text alone does not suffice". Transcribed interview and/or focus group data are the primary data available to researchers in each study. In most cases the researchers were not able to attend or participate in meetings, nor did they have access to the myriad of documents, agendas and papers that would comprise the overall gamut of activity associated with the critical issue being investigated in each case (Yin, 2009). Unless decision-makers bring additional data, or provide opportunities for researchers to attend 'in situ' events, the interpretive context is not as broad as it might be. Second, the researcher's exposure to the 'active world' of each interviewee must be considered perception as opposed to fact (Lincoln & Guba, 1985). Third, generalizations are not the purpose of this study; any finding or statement implying such is inconsistent with the methodology. Interpretation and understanding of the change dynamics at play are its purpose. As a cross-case longitudinal report, recurring patterns are chronicled and interpretations of the meaning of those patterns are presented, but no attempt to generalize or theorize from these perspectives can or should be made (Flick, 2009; Yin, 2009).

Another limitation is that the amount of description, analysis, or summary material in each case varies according to the writer and their interpretation of events (http://cgi.stanford.edu/~dept-ctl/tomprof/posting.php?ID=1013). Although efforts were made to ensure comparable thickness of case reports (Houghton, et al., 2013; Lincoln & Guba, 1985; Taylor, 2013), they did vary. The comparability across cases is also limited by variance in researcher experience, knowledge of the leadership literature and, of course, time devoted to the project. Finally, a cross-case analysis—although lengthy as this one is—cannot portray the unique situations and circumstances that gave rise to a particular phenomenon in an individual case. Although patterns may be perceived across cases, understanding the dynamics that led to the unique manifestation of that pattern in a particular case cannot be determined. For that reason, the reader is encouraged to read the

original case reports to get a more compelling flavour of some of the key findings of this cross-case analysis.

Findings

The cross-case PAR findings are discussed below in relation to the three overarching research questions around leadership and health system redesign.

Question One: Current State of Leadership Capacity in Canada

The first question for the study was comprised of one major question and two sub-questions. They are:

> *What is the current state of health leadership capacity in Canada?*
> > a. *What is working, or not working, in terms of stimulating and supporting health system transformation, and*
> > b. *What contextual factors influence effective leadership action?*

The purpose of this section is to share perspectives by including the voices of the study participants in the six cases of this research project. The results do suggest that for meaningful, large-scale, and relatively quick reform to happen—i.e., to move beyond the natural evolution of any system so as to keep in synch with the changing world around it—Canada does not have as much capacity as it might need, and much more could and should be done to enhance it. We appear to "have aspirations for 21st century leadership, but have 20th century skills" (national case).

There are five primary findings in regard to Canada's current leadership capacity:

1. *Creating large-scale change requires levels of systems thinking, strategic thinking, relationship development, and self-leadership that supersede the current capacity of many formal leaders.*
2. *Quality physician leadership—at all levels—is required for reform to be successful; yet that capacity is only engendered through exemplary practices of ongoing, meaningful physician engagement.*
3. *Political dynamics and regular turnover among ministerial, senior policy, public service leaders, executive, and organizational leaders impede leadership of large-scale change over time.*
4. *Collective leadership capacity[6] requires alignment of thinking and action among formal leaders that challenges conventional notions of autonomy, accountability, and collaboration that they currently bring to their role.*

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[6] The term 'collective' as used in this statement is used to suggest the wholeness of, and sum of all the capacity of individual leadership that exists in the system. It is not used to suggest a model, theory, or approach to how that collective capacity might work together (e.g., distributed leadership, shared leadership, etc.)

5. *The ongoing need to expend energy to overcome factors that impede change— structural, cultural, and political—are draining the capacity of Canada's leaders faster than that capacity is being rejuvenated.*

We will discuss each of these five findings in turn.

1. *Creating large-scale change requires levels of systems thinking, strategic thinking, relationship development, and self-leadership that supersede the current capacity of many formal leaders.*

Two of the cases examined large-scale change; i.e., change at the provincial level (prairie case) and at the national level (national case). In three cases (Ontario case, Québec case, and BC case) the unit of analysis for change were localized primary care organizations, but comments were made about efforts to create primary care reform system-wide at the provincial level. Comments on the ability to create province-wide change were also made in the context of the Atlantic cases regarding employee and physician engagement.

The size and complexity of provincial systems, and the national system, pose significant challenges to systems thinking and aligned strategic action. At the largest scale of change—the national level as represented by the national case—there was great scepticism about the capacity to lead large-scale change. Throughout the tenure of the study there was a growing awareness of the interconnectedness of the different facets of the AQA agenda, the complexity of it, and the lack of strategic alignment across the system to deal with them as whole. One interviewee stated: "In Ontario LHIN board chairs and the CEOs meet regularly with the ministers and the deputy minister but…that…is not system leadership. I just think that it is too much around operational daily issues and not enough around long term strategic issues."

There was concern about the absence of any national vision: "There is no common vision particularly at the national level…we are crying out for it," stated an interviewee. There was also a growing awareness "of the need for a large system plan of action." But there were concerns expressed about the leadership capacity to lead the change such a vision and action plan would require: "We know 'what to do', but we seem incapable of executing the 'how'". Another remarked, "Big learning curves are required to effectively lead in complex healthcare systems."[7]

Vision and systems thinking were also important findings in the prairie case. The first cycle of the study found that the Shared Services Saskatchewan vision was not permeating throughout the system to the front-line leaders, who in turn found it difficult to articulate and justify the necessary changes to their staff. This resulted in a lack of engagement among front-line leaders. Competing system priorities (e.g., the Lean initiative) also hindered engagement, as front-line

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[7] Finding 3, regarding the high churn rate among senior policy and executive leaders, helps to explain the absence of a coherent shared vision.

leaders had not received a clearly communicated vision that aligned these other priorities with Shared Services from a systems perspective.

Systems thinking and strategic alignment at the provincial level were also relevant in the physician engagement case in Nova Scotia. One interviewee stated that "the question for me...is how do we raise the level of conversation from within organizations to be more structured outside of organizations? It is too big...we don't have a body that's responsible for that". Similarly, in the employee engagement endeavour in Newfoundland (as part of the Atlantic case) it was stated that new managers "had to have a better knowledge and understanding of the socio-political context in which they were working. This context is quite complex and changing and takes time to more fully understand much less use that understanding". In the Quebec case, physician leaders reported "the lack of overall vision of the development of FMGs on the part of both regional health authorities (Agences de la Santé et des Services Sociaux) and Quebec Federation of General Practitioners (Fédération des médecins omnipraticiens du Québec-FMOQ)" hindered change. In BC, a physician commented on a desire for a more structured change management approach stating that "we didn't follow the approach that modern management practice should".

Over time, in large-scale projects, it is also hard to maintain focus and momentum on a particular project. For example, in the prairie case, efforts to implement shared services were, according to one representative of the interviewees, "worse when it came to engagement" at the end of the project compared to the beginning of it because of competing provincial initiatives. In this case a Lean initiative - and demands on leaders to embrace it - was perceived as crowding out the shared services priority. It prompted one manager to say, we are "doing half of everything" but "not a whole of anything". A similar phenomenon occurred mid-stream in the BC integrated community care case study, but in this case due to a loss of key players who were stewarding the project. In contrast, where there was sustained leadership within effective and well-thought out policy frameworks that took a systems view, and where provincial-wide strategic actions aligned efforts at the local level (e.g., Ontario's approach to supporting FHTs), implementation of change was significantly enhanced.

Relationship building was identified as key to effective large-scale reform. In the national case, the comment was made that "coalitions...are absolutely the life-blood of reform". Another interviewee stated, however, that existing coalitions between organizations are "extremely fragile….because they rely on volunteer good will which can end in a change in leadership or a change opinion or a change in your mind….It is exhausting".

There was also a consensus across cases that more communication and engagement are desirable in change, but there is less and less time to devote to those relationship building skills. This view was not just about coalitions between organizations, but also relationship-building within project teams for change projects. Large-scale change ultimately creates the need for small-scale change. There clearly is a need to grow leadership capacity in methods and approaches to enhance effective communication and relationship-building: e.g., how to conduct

crucial conversations, deep listening, leadership styles and communication, coaching skills, and running an effective meeting, to name a few. In the Quebec and Ontario cases, leaders who were successful in relationship-building and communication exhibited "intensive communication, attending associate physicians' expectations and fears regarding change, tact, diplomacy, and the ability to bring associates together for the proposed creation of FMGs" (Québec case); and "were able to obtain the buy-in and trust of their colleagues and external partners by facilitating meetings that allowed for open dialogue and communication, sharing information on the initiative, and inspiring and creating a shared commitment on the vision of the organization; and negotiating to resolve conflicts" (Ontario case).

However, other cases identified the need for better communication skills. In the BC case, the statement was made that "the timeframe for doing a really good robust engagement wasn't there" and in the prairie case that "overall, coalition building appears to have been strongest at the senior leadership level where they are beginning to think more as a system. However, this is far less pronounced among front-line leadership level". At the same time, front-line and mid-level leaders in the prairie case reported that the strategic use of existing coalitions, networks, and working groups to advance Shared Services goals had been central to the success of the initiative, indicating that many were beginning to recognize the value of systems thinking.

Self-leadership was identified as necessary for leaders who engage in large-scale reform. In Ontario, where FHTs have been developed since 2006—and represent at least partially a successful large scale change—the minister who initiated the policy framework to encourage their creation, was described as a highly credible leader because he was "honest, confident and resilient in the face of adversity". This example stands out in contrast to "ministerial accountability and responsibility waxing and waning depending on the political environment" that characterized the national agenda of access, quality and appropriateness (national node). Although character elements were identified as fundamentally important, they were only partially in evidence within leaders' reflections of their styles and actions.

In the prairie case, leaders recognized the importance of personal leadership generally, but in practice gave very little time and attention to developing their own personal leadership ability. Leaders in Saskatchewan valued traits such as integrity, credibility, and trustworthiness in all actions, having commitment and perseverance, and showing some humility and flexibility (along with self-awareness and self-development), yet these traits were "downplayed and undervalued in practice" (prairie case). In the national case, a comment was made that "good policy is about courage...where are the brave, courageous leaders out there"? It appeared that leaders gave very little time and importance to self-reflection. Without that it is hard to see how leaders can improve their performance.

In summary, large-scale change for significant health reform to take place on either a provincial or national scale demands a level of leadership knowledge, performance, and quality that is significantly greater than most leaders have been prepared for in terms of the complexity of the health system. As one national case interviewee stated, "we lack the capacity to accept that

change (is required)...we haven't prepared people in this country to really do that on a broad scale basis" (national case).

2. *Quality physician leadership—at all levels—is required for reform to be successful; yet that capacity is only engendered through exemplary practices of ongoing, meaningful physician engagement.*

Four of the six cases commented directly on the fundamental importance of quality physician leadership for effective health reform to take place. They also commented on the difficulty in accessing that capacity except in a few pockets of the system. Three of the four cases (national, BC, Ontario, and Québec) dealt with change issues relative to health service delivery, and in that context, physicians who were able to exercise leadership were vital to reform efforts. The Atlantic case in Nova Scotia focused on specific efforts in two health agencies within that jurisdiction to develop physician leaders with the intent of engaging them in creating effective reform.

In two of the cases—Québec's change initiative regarding FMGs and Ontario's investigation of FHTs—successful models of change were reviewed from a retrospective perspective. In both cases they highlighted the importance of effective physician leadership for change to happen at the local level. Both profiled examples of where physicians led the specific projects being studied to fruition. "The desire for the changes was motivated by the vision of physician leaders who engaged and convinced other family physicians to participate" (Québec case). They were "the main drivers of change" (Québec case). Physicians "engaged and convinced other family physicians to participate in the FHT model" (Ontario case). Physicians who were successful had "a lot of charm", were "very cooperative—absolutely not autocratic, and participatory", (Québec case), that were some of the qualities of leadership identified earlier as needed during reform efforts.

At the provincial policy level, physician leadership had both a positive and negative influence. In Québec, "there is strong leadership for the transformation of primary care at the local level, coming from physician leaders...but a lack of vision and leadership at the regional (regional health authorities) and provincial (ministry of health)" (Québec case). In Ontario, the minister of health appointed a provincial physician lead for the initiative, who "helped to ensure that the new primary care model was a key agenda item for the Ontario Ministry of Health and Long Term Care, while also creating a credible and expert linkage to the family physician and broader medical community" (Ontario case). The Ontario College of Family Physicians also played a key role in assisting family physicians during the process, but in Québec, the Québec Federation of General Practitioners (Fédération des médecins omnipraticiens du Québec-FMOQ) was not supportive. Interestingly, the Ontario Medical Association was also not supportive and indeed created delays in implementation, and it was the minister's political courage, acumen and strong vision (going directly to local family physicians to consult) that mitigated their opposition.

The three other cases highlight the challenge of creating and sustaining sufficient physician leadership capacity to lead change. In Nova Scotia the case profiled efforts of "two organizations...collaborating to advance physician engagement by offering a physician leadership program called "Fully at the Table" (FATT) and through other activities". They found that physicians would "benefit from more unity and collaboration" throughout the system. The data highlighted an organizational need for system-wide systems thinking development for both physician and non-physician leaders for the "maintenance of physician engagement". In the BC case study "the key players were the health authorities and the division physicians, and the relationships developed between the two over time". At the end of the third cycle of data collection, key informants stated "there is a widening disconnect (because)...they spoke in different tongues." One physician commented that "...administrators tend to use buzzwords and 'corporate speak' that is foreign to physicians".

In the national case project on access, quality and appropriateness, physician leadership was also highlighted as either a major facilitator of change (when it was present) or a major impediment to change (when it was absent). In this case physician leadership was identified as key to the success of the Saskatchewan's Lean and surgical initiatives (the Saskatchewan Medical Association [SMA] was and is supportive), and the Ontario Quality Council's efforts to address issues of appropriateness (individual physicians stepped forward to lead major projects) were examples provided. However, the overall sentiment from the interviewees was that "there is a deficit for physician leadership". "Not physicians leading health systems, (but) true physician leadership, with the capability of being both clinical providers and at the same time as they are leaders" (national case). While physician leadership was not the focus of prairie case, it became evident that the future of Shared Services Saskatchewan as it pertains to matters that impact clinical practice will require significant ongoing physician engagement and leadership. However, physicians were only marginally involved in the development of the Shared Services vision and implementation, and most leaders in the initiative recognized the additional challenge involved in bringing physicians into such an initiative after the fact.

Overall, if leadership capacity for reform is to improve in Canada, a concentrated effort is required to build on the pockets of success, to engage the broad community of physicians in reform, and to actively provide them with the skills of leadership to do so.

3. *Political dynamics and regular turnover among ministerial, senior policy, public service leaders, executive, and organizational leaders impede leadership of large-scale change over time.*

Large-scale change takes significant time. For example, Dan Florizone (former Deputy Minister of Health in Saskatchewan), referred to the Lean change in that province as a 50-year project[8].

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[8] Florizone, Dan. (2011, May). Putting Patients First: Using Lean to improve the Patient Experience in Saskatchewan *CareOregon Portland, OR May 2011.* Accessed on January 1, 2012 at: www.careoregon.org/Res/Documents/Transforming Health Care/CSSI/FlorizoneKeynote.pdf

Based on results from the six cases, it appears that Canada's political dynamics and accelerated turnover of people in leadership roles makes sustained, long-term change exceedingly difficult.

Political dynamics were strongly at play in almost all cases. In the Atlantic case project in NL the negative media coverage associated with the Cameron Inquiry[9] resulted in "the government...(being)... seen to be taking a greater role in the running of the RHA", and therefore it "really drives much more directly a lot of what we do and so it takes away some of our autonomy to do within our organizations". These political dynamics were seen by some as negative, impeding their autonomy; others neither good nor bad. "Some of the things that we may feel is a priority, but...what government feels is a priority is going to take priority, it's what gets funded....and so I think that...it can be a facilitator depending on what the focus is but it can also become somewhat of a barrier". The reorganization of health care into fewer and larger health authorities and the negative media coverage and the politics associated with the Cameron Inquiry created the demand for improved leadership, but also generated distractions and a lack of focus that impeded the efforts of leaders to make the changes necessary. For some, the uncertainty of these dynamics led to "just waiting" for clarity of direction (i.e., followership), rather than taking action.

In other cases political dynamics were seen as impediments to large scale change. Some leaders perceive "undue influence" when different groups (e.g., the OMA in Ontario) publicly challenge, for self-interest reasons, proposed changes (Ontario case)—even though the Canadian political process encourages such action. Others see the inability of 14 different constitutional entities to cooperate on a common agenda (even though there are common problems) as a consequence of the political electoral process within each of those jurisdictions, and the realities of adversarial politics (national case). Others become frustrated when politicians and interest groups choose not to address an issue (e.g., appropriateness) because it is a "pretty highly charged political issue—particularly with medical professions" (national case) or because it is difficult for the politicians and the public to understand. Still others perceive political dynamics (as generated in the context of electoral cycles) as resulting in abandoned priorities for initiatives that need long-term commitment to succeed. In the prairie case, for example, all three groups of leaders interviewed about Shared Services implementation "mentioned their concern about the government's political willingness to follow through on the reform when the 'rubber hits the road' in the implementation stage".[10] With respect to change in the province of Ontario, the comment was made in the context of the national case that "Health authorities— LHINs, etc.—are being more and more affected by short term political imperatives" and won't stick with long term change initiatives".

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[9] The Cameron Inquiry was initiated in 2007 to investigate the conduct of the Newfoundland and Labrador Eastern Health Authority with respect to errors in cancer testing. See http://www.cihrt.nl.ca/

[10] This concern diminished somewhat during the third cycle of interviews but not completely.

Whereas many of the above statements regarding political dynamics emphasize impediments to leadership of long term change, some (as in the Newfoundland case discussed earlier) said that politics are neither good nor bad, simply a reality of life. In the BC case the point was also made that "people who don't work in the ministry feel that the politics get in the way...what people don't understand is that politics are where we are today. It shouldn't be seen as a barrier but seen as what is driving us and our job is to constantly bring information back to the politicians of the day for accountability purposes so if it is not working we can look at options and strategies on how we are going to understand that better and make refinements in our processes". The Canadian context is defined by politics—politics can be seen as a source of impediments to long-term change, but also the process by which the right way forward is found.

Most cases also pointed to increased turnover among ministerial, senior policy and public service leaders, and executive and organizational leaders, as an impediment to sustained change. "CEOs are turning over at a more rapid pace than in the past", and "deputies are not there long enough"" were comments made in the national case.[11] In the BC case, the observation was made that there was too much turnover among leaders and executives that resulted in "an atmosphere of constant churn". The latter made it difficult to maintain relationships needed because of the energy, time, and trust required to establish new relationships. In two cases the point was made that turnover is required when "new blood is needed to relieve tired and overwhelmed leaders" (BC case). Regardless, if turnover is to relieve tired leaders, or is too constant, both reflect a low level of leadership capacity in the system. Diminished longevity of administrative leaders also creates some cynicism of professionals who more often than not pursue a career in one community or organization and see administrators come and go with their pet projects rather than sustain effort on organizational priorities.

This factor also detracts from long term and sustained change, as it creates conditions in which relationships are continually splintered and having to be rebuilt. Rapid turnover of leaders—in senior or junior roles—requires constant re-learning of the system, truncating of and rebuilding of relationships, new priorities replacing old ones, and significant breaks in momentum for change due to "institutional memory loss." It also creates almost a fracture point within organizations, where clinicians and mid-managers are often in their roles for a lifetime; and feel they are the pawns of senior leaders who come and go.

4. *Collective leadership capacity requires alignment of thinking and action amongst formal leaders that challenges conventional notions of autonomy, accountability, and collaboration that they currently bring to their role.*

Results from all six cases suggest that the natural tendency to fragment--i.e., work independently or in silos, as provinces, regions, national organizations, etc.—is 'natural' in the Canadian health system, and current conventional notions of autonomy, accountability, and

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[11] Indeed, to illustrate this point, between the beginning of the project and the end of the interview cycles, over a third of the 12 interviewees had either changed roles or moved to different organizations.

how to collaborate are out of synch with those required for collective action on reform to emerge. Evidence suggests that many individual leaders make efforts to 'overcome' those natural forces and create alignment of action with authorities and accountabilities, but in many instances those efforts are not strong or sustained enough. For example, interviewees in the national case state that while Canada is a country with "tremendous leaders with great potential" they "are often not allowed" to exercise that leadership due to the fragmentation forces within the system (along with the forces of negative politicization and turnover mentioned earlier, they cite the lack of a national vision and the loss of "the convener of the system...the federal government" as factors not allowing that leadership to emerge). "We've lost our way", said one interviewee (national node). It appears that although there is a growing awareness of the need for greater collaboration at a national level, progress to do so is slow.[12]

Similar statements were made in a provincial context where there is no apparent reason for the lack of a provincial convener or steward. Constitutionally, provincial governments are the convener for provincial change. However, even there fragmentation seems to overcome efforts to collaborate. For example, in the Atlantic project in Nova Scotia it was stated "that policy alignment among provincial governments, medical professional associations, and health care organizations is key to successful physician engagement and system redesign". But "our research suggests a lack of leadership at the level of the system" (Atlantic case, Nova Scotia). In the BC case, similar challenges were experienced. Informants spoke about how the structural changes support or hinder progress: "Legislation needs to be aligned. Currently we have several acts that support a silo structure and if IPCC is to truly be engrained, the acts will need to reflect the integration". In the prairie case (even though it is seen by many to be making the greatest strides in alignment), the "research showed that in health systems marked by a distribution of leadership responsibility, vision and engagement do not always permeate to leaders at the front-line level". This comment was made even though senior leaders initially perceived that they had done a good job of doing so. Other cases (e.g., Ontario and Québec) highlighted the need to improve leadership capacity at the governance and regional levels. This view was underscored by the comment that "LHIN Board chairs and the CEOs meet regularly with the ministers and the deputy minister but...that...is not system leadership. I just think that it is too much around operational daily issues and not enough around long term strategic issues" (national case).

Disparate or fragmented effort can also be a consequence of a lack of alignment between accountabilities and authorities. In the Ontario case report, accountability was built into the process of implementing FHTs. Physicians had to apply and meet criteria established by the government and local LHINs for approval to begin. However, in many of the other cases, when

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[12] For example, there is progress in efforts for what are called the "C-Group' leaders to collaborate [C-Group being national organizations such as Canadian Institute for Patient Safety, Canadian Hospital Association, etc.] but that progress is slow and tentative.

change is happening, aligning accountabilities with new responsibilities was seen to be lacking. In the national case there was "fragmented accountability across jurisdictions and within organizations", when referring to the C-group mandates (i.e., a variety of Canadian agencies responsible for health information, technology assessment, patient safety, etc.). In the BC case, "there has been a big reorganization of home health in terms of how they work and the way they work but they are not really working with us any differently than they always have". In other words, as change happens, people are finding it difficult to align accountabilities with new responsibilities. In the Atlantic Nova Scotia case, when commenting on the ability to create change, the statement was made that "there was no accountability for it so why would they spend their resources? And when I say resources, I mean their time on something". In the prairie case, this need to align accountabilities and responsibilities was essential to Shared Services' success: "the accountability to system-wide networks and organizations versus traditional accountabilities to a single organization" was a major challenge.

Another factor reducing capacity might be that although individual leaders sometimes make a strong effort to collaborate, the collective will to do so is not there: "….if we can just park our collective egos, get out of this passive-aggressive nature, and work as a collaborative we could be stronger" (national case). In terms of both commitment and skill, one informant said "I am not sure we have identified what the actual goal is and the expectation around true coalition or collaboration or integration. Obviously that leads to a skill deficit".

5. *The ongoing need to expend energy to overcome factors that impede change—structural, cultural, and political—are draining the capacity of Canada's leaders faster than that capacity is being rejuvenated.*

The observations made to this point suggest that the energy leaders have to spend in the Canadian health system to overcome the structural, cultural, and political forces that define the landscape of large-scale change is prodigious. "The fatigue of trying to move into any kind of change agenda is very hard on everyone, but especially senior and mid-level leaders. It's exhausting to try to get anything moving and keep it moving" (national case). It is not surprising that those who do put themselves out to foster and initiate change find that their efforts sap their energy over time. But there does not appear to be a systematic effort—province and nation-wide—to recharge leaders.

Current efforts to support leadership development in Canada are disjointed and insufficient. Programs such as *Fully at the Table (FATT)* for physicians in Nova Scotia or the *EXTRA Program* offered through the Canadian Foundation for Health Improvement exist but are limited in the number of participants and always crying out for resources. They don't begin to meet the collective need for leadership capacity development. The BC case found that "participants made no mention of leadership development programs or opportunities" and informants perceived that "formal learning is a luxury". People are working 14 hour days at it is, so taking time off for formal learning is impossible for many (including ministry personnel). Physician leadership development and leadership mentoring emerged as desirable, but the approaches need to allow

for physicians to take time off. In the prairie case "Leaders across all three groups...requested future learning opportunities that would improve their own leadership development and enhance their change management skills" yet time pressures and competing priorities continued to act as barriers to personal leadership development.

The five key themes of this section pertaining to leadership capacity illustrate perspectives that help the reader answer the study questions themselves by hearing the voices of the participants in the six cases of this research project. The five perspectives that are shared do suggest that for meaningful, large-scale, and relatively quick reform to happen—i.e., move beyond the natural evolution of any system so as to keep in synch with the changing world around it—Canada does not have as much capacity as it might need, and much more could and should be done to enhance it. They also suggest that there are many contradictions present in the current system; push, pull forces that both push people toward wanting to pursue change, but pulling them away from being able to do it. We will say more about the contradictions in the discussion section that follows the findings section.

Question Two: Gaps between Current Practice and Evidential Base

The second question of the study was:

> *Where are the gaps between current practices, the evidential base in the literature, and the expectations for leadership outlined in the emerging health leadership capability/competency frameworks (e.g., LEADS capabilities framework), and how might a set of national standards for leadership be structured?*

Much of the leadership literature was reinforced across cases. As stated in the national case report, in no way can the findings suggest "validation" of one theory over another—in fact theory validation is not the point of the study. Understanding leadership better is, and for proponents of those theories, there may be some illumination inherent in the data. Across cycles and in many of the cases, three key ideas emerging in the leadership literature were highly relevant to interpreting findings from this cross-case analysis: shared or distributed leadership; substitutes for leadership; and complexity leadership. In addition some strong support for the constructs of authentic and transformational leadership[13] and servant leadership emerged especially at the national node level. All of these interpretative insights are deliberated in the discussion section of this report.

The environment of the health system is complex, requiring sophisticated, high-impact leadership. It appears that systems thinking has improved over time at the senior level but not at the front line. Self-awareness was found to be lacking at all levels of leadership; this was a key finding in the prairie case and indicates the need for leadership development and training opportunities. In health systems marked by a distribution of leadership responsibility, vision and engagement do not always permeate to leaders at the front-line level.

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[13] These two concepts of leadership have a strong correlation.

The *LEADS in a Caring Environment* capabilities framework was addressed directly by the national case, prairie case and Atlantic case, and was generally supported. Five out of the six case studies (with the exception of BC, which did not address the LEADS framework in their study) showed LEADS as a useful expression of the leadership qualities required to guide leadership talent management. Evidence shows that context is very important in moving LEADS forward. Some leadership capabilities were found to be less strong across the cases, especially *System Transformation*. Also the capabilities of *Lead Self* and *Develop Coalitions* seem to be underweighted. While participants in the prairie case emphasized several leadership capabilities that are captured by the LEADS framework, there were some additional attributes identified including: long-term vision; credibility and trustworthiness; commitment and perseverance; and humility and flexibility. In the Québec node, regarding the development of FMGs, more capacities were related to the components *Develop Coalitions* and *System Transformation*, with the development of new care organisation (e.g., advanced access), inter-professional collaboration and partnerships (e.g., care pathways, shared care programs). The BC case found that funding, time, and travel limitations hindered *Engage Others* to send staff to formal learning events for professional development.

Consensus around some of the common leadership capabilities needed for reform was realized. Although informants identified courage and resilience as key to initiating change (and is inherent in dealing with those structural and cultural impediments), few were able to sustain that effort except on the margins. Whether that is due to a realistic fear of being sacked, the personal travail that goes with the simple demands of running their own organization, or simply the lack of a will to change oneself is for them to determine. Overall, the common capabilities identified through the cases are listed in Table 2 (with some variation in language):

Table 2: Common Leadership Capabilities Needed for Reform Across Cases

Leadership Capabilities	*Description*	*No. of cases in which mentioned*	*# of direct references*
Strategic Thinking	The ability to analyze situations, devise appropriate, timely and broad interventions, and develop actions for implementation that will creatively leverage an existing situation for maximum benefit *over a long term time period.*		
• Stakeholder engagement	Creating strategies and tactics so different stakeholder and interest groups would work together to support change.	6	89
• Alignment and vision	The degree of integration of an organization's or system's core structures, processes, and skills, as well as the degree of connectedness of people to the organization's (or system's) strategy.	6	38
• Relationship building, coalition building and management	Building strategic relationships across departments, across organizations, and across systems, and the ability to manage and sustain those relationships.	6	78
• Strategic planning	A disciplined process of setting out a long-term direction for an organization or system based on a clear sense of where the organization or system is going (vision, values), where it is currently (current state, environmental scan), and related strategies to move from where it is to where it wishes to be.	5	27
Complexity Theory and Systems Thinking	Complex adaptive systems require adaptive, agile leaders who can think and act at a systems level. Leaders need to be able to use and understand the complex nature of healthcare systems, particularly systems' unpredictability, fluidity, and organic development. "Someone who fundamentally believes the whole system needs to work as a whole and the inter-connecting parts are linked….".	5	56
Change and Innovation	The ability to conduct small or large-scale change for health care improvement.		

Leadership Capabilities	Description	No. of cases in which mentioned	# of direct references
• Change management or innovation work	Identifying and championing innovation and creative ideas; working with staff to engage them in the change process.	6	59
• Empowerment	Empowerment is the combination of strategies and behaviours employed to increase the capacity of individuals, professionals, or consumers to make choices and to transform those choices into desired actions and outcomes.	6	48
• Champion for change	Creating change both within micro-systems and larger systems. Specific skills include recognizing emerging windows of opportunity for change.	4	7
• Ability to create a culture of openness and safety	Leaders take actions to build trust, transparency, and a receptivity to learning as cultural attributes of an organization's or system's environment.	4	39
Teamwork	The process when a small group of people—multi-professional, management, etc.—need to work together to achieve a common goal.	5	15
Effective Two-Way Communication	Effective teams require frequent, open, and honest communications, both interpersonally (i.e., the ability to have open and honest conversations) and strategically. Leaders try to listen and make sense of the difference voices; political masters, employees, customers.	4	56
Emotional Intelligence	Self-awareness, self-regulatory skills, other-awareness or empathy, and relational skills.	4	26
Character	Character qualities or virtues that individual leaders are asked to demonstrate in order to be genuine.		
• Commitment	Importance of having a fervent belief and commitment to a universal, publicly-financed healthcare system. What is "important is the patient" should be a driving force behind reform.	5	27

Leadership Capabilities	Description	No. of cases in which mentioned	# of direct references
• Resilience	A specific character element emphasized repeatedly was resilience. Comprised of confidence, longevity, flexibility, strength of conviction, consistency, keeping perspective, and optimism.	3	33
• Courage	The quality of mind or spirit that enables a person to face difficulty, danger, pain, etc., and persevere in spite of the challenge.	3	12
• Service philosophy	Ability to suppress personal ego and act in the interests of patients or citizens. To put own perspectives aside and consciously communicate and reframe into others' perspectives, and to be objective.	3	10
Role Model and Mentor	The leader is a role model and a mentor to others. Leading by example, and willing to guide others in their development when requested to do so.	6	43

Table 3 provides an overview of findings for each of the six cases for leadership capacity, capabilities and the enablers and challenges to leadership.

The need for leading practices and standardized credentialing arose in the cases, especially at the national level. The NHS, like Canada and Australia, is undergoing significant changes and challenges not seen before. Canada, like the NHS, "will need to accentuate different, or at least, newly prioritised, staff behaviours. This in turn means there will be a requirement for different priorities in leadership behaviours" (Storey & Holti, 2013). This perspective lends credence to the desirability of a set of standards for Canadian health leadership, whether LEADS or not, that can set the bar for both leadership practice and leadership development if significant reform is to happen. A lot of leadership training is around self-knowledge and self-reflection, not how to make change happen. Competency frameworks create opportunities to have this conversation. It is hard to envisage a true distributed leadership system without a common language around leadership.

Table 3: Synthesis of Findings Regarding Leadership Capacity, Capabilities, Enablers and Challenges

Node and Project Title	Leadership Capacity	Leadership Capabilities	Enablers	Challenges
NATIONAL NODE **Leadership of Changes Associated with Creating Access, Quality, and Appropriate Care**	Canada does not have the leadership capacity required to lead significant health reform. Some believe there is individual capacity in the system but it is sprinkled sparsely throughout and held back by structural, cultural, and political factors that delimit the ability of leaders to be effective. If the standard for assessing leadership capacity is well-organized, well-functioning distributed or shared leadership that generates productive, progressive large scale change, then Canada does not have that capacity. Change fatigue is growing among senior leaders. Consistency of leadership and a renewed focus on clinical leadership are required.	• Emotional intelligence • Enlightened self-interest • Personal commitment to a universal health system • Character • Resilience • Longevity • Ability to access and use data for decision-making • Creating and leading change • Complexity theory and systems thinking • Team-building/teamwork • Effective two-way communications	• Federal funding • Performance indicators • Electronic information systems • Technology assessment • Quality councils • Health regions	• Federal spending • Policy • innovation • Shared vision • Inequities • Focus on strategic issues • Deep change • Local politics • Technology • Lack of systems knowledge • Public awareness • System complexity
BRITISH COLUMBIA NODE **Exploring Leadership During Implementation of the Integrated Primary and Community Care Initiative**	BC will see a tide of people leaving their work and retiring due to demographics. This situation will no doubt have a profound effect on our society and our health care	• Self-awareness and self-management • System awareness and systems thinking • Courage • Relationship building • Commitment, respect,	• Celebrating successes • Alignment of goals • Open communication • Engagement at local levels • Engagement • Commitment to vision	• Constant turnover • Cultural differences • Configuration of delivery models (structures and processes) • Public perception

Node and Project Title	Leadership Capacity	Leadership Capabilities	Enablers	Challenges
	system. Leadership will be impacted and challenged as the younger generation appears to have a different view of work / life balance. Need to develop succession plans and provide leadership development for leaders. Senior leadership must be in touch and engage with local levels, not leading from afar.	• and integrity • Vision of the future • Communication and listening • Continuous learning • Openness to change	• Collaboration • Common language (especially physicians and administrators)	• Strong personalities and attitudes • Constant change • Demographics • Politics (elections) • Data sharing • Technology and software
PRAIRIE NODE Shared Services Initiative	Importance of: vision, engagement, political will, and personal leadership. In health systems marked by a distribution of leadership responsibility, vision and engagement do not always permeate to leaders at the front-line level. Engagement was hampered by several key factors; time limitations caused by multiple mandated priorities, front-line leaders not being empowered to lead, only to manage, and doubts about political will to carry through with a change. Systems	• Vision; communicating a clear vision, aligning decisions and actions with vision • Long-term vision • Engagement of all relevant system actors • Development of personal leadership abilities • Demonstrating systems thinking • Ability to align competing priorities • Credibility and trustworthiness • Commitment and perseverance	• Engagement (of all system actors, meaningful consultation, engagement using communication) • Clear vision / clear communication of vision • Communication (increased frequency, transparency, well-timed) • Development of leadership skills / change management skills • Exchange of tools,	• Vision • Engagement • Political will • Personal leadership • A potential lack of alignment (or lack of understanding about the alignment) between shared services and the two quality improvement tools being emphasized by the ministry – Lean and *hoshin kanri* • Confusion, particularly amongst front-line leaders, about the

Node and Project Title	Leadership Capacity	Leadership Capabilities	Enablers	Challenges
	thinking of senior leaders progressed significantly although less marked, front-line leaders' system thinking developed through increased interaction with their provincial counterparts. There was a lack of reflection on personal leadership. Many front-line leaders felt that their leadership ability was constrained by the "command and control" structure of the health system.	• Humility and flexibility • Modelling qualities such as integrity, honesty, resilience, and confidence • Being a champion for change to improve health services • Creating disconnections, trust, and shared meaning with others	lessons, and strategies with other locations • More direct engagement of senior leaders with those on the front-line. • Senior leaders better understand daily operations on the front-line • Increased latitude and opportunities for front-line leaders to shape or initiate Lean and *hoshin kanri* initiatives in their own business lines; • Inclusion of front-line leaders in more system-wide (i.e. provincial) *hoshin kanri* planning processes	precise role of 3sHealth in the system • Distributed leadership in a decentralized health system
ONTARIO NODE **Role of Leadership in the Development of Family Heath Teams (FHT) and Nurse Practitioner (NP) Led Clinics**	According to the LEADS framework, provincial and local leaders focused on systems transformation, engaged others, achieved results, developed coalitions and lead self. Other	• Self-awareness • Determination and commitment • Clear values and principles • Seek new ideas, innovations, and	• Government policy leadership • Distributed leadership • Government funding and compensation • Previous primary care reform	• Lack of government support for initial organizational development activities, particularly around the development of

Node and Project Title	Leadership Capacity	Leadership Capabilities	Enablers	Challenges
	characteristics emerged. Respect, credibility, approachability, commitment, perseverance, and trustworthiness could be found under *Leads Self*. Creating an environment of transparency could be included as part of sub-theme 'Contribute to the Creation of Health Organizations' in the *Engaging Others* dimension. Finally, advocating for and mentoring team members could be included in the sub-theme 'Build Teams' within the *Engaging Others* dimension. The sub-theme 'Assess and Evaluate' within the *Achieve Results* dimension did not emerge as part of leadership capabilities. Also confirmed the importance of plural leadership.	solutions to complex problems • Creates coalitions and partnerships • Champion change • Political intelligence to know when to act and when not to • Negotiate through conflict and mobilize support • Confidence and courage to persevere in the face of resistance • Effective engagement • Visionary • Respected • Credible • Supportive • Approachable • Problem-solvers • Knowledgeable • Strategic thinkers • Mentors	• Vision of lead physician or nurse practitioner • Consultation at local level • Application strategy to become part a FHT • Collaboration relationship between executive director and lead physician • Involvement of lead physicians in recruitment of team members • Creation of new structures and processes • Balance of administration in the organization that is capable of managing the organization, but not stifling local innovation • Continuous engagement of all staff members • Providing team members with the	effective governance, and the development of key support services (e.g., legal, human resources, finances etc.) • Recruitment and retention of non-physician professional health care providers • Achieving the buy-in of a few outlier physicians who have not endorsed the vision of the FHT model and who rarely refer patients to non-physician professional providers or their programs • Succession planning • Physicians identifying more with their FHO than the FHT, • Turf issues between stakeholders with respect to the Health Links initiative

Node and Project Title	Leadership Capacity	Leadership Capabilities	Enablers	Challenges
			autonomy to be innovative and creating a culture in which "we learn from our mistakes" • Developing strong partnerships with other primary care and community organizations to build a continuum of care and examining opportunities for alignment of resources to improve capacity to serve patients	
QUEBEC NODE **New Primary Care Models: Challenges of Creating Family Medicine Groups (FMGs)**	More distributed leadership observed during the development of FMGs, across associate physicians, nurses and managers. Many practices of leadership observed in the FMGs studied here are consistent with the LEADS framework, especially around the components *Engage Others, Achieve Results, Develop Coalitions,* and *Systems*	• Communication and engagement • Attending to physicians' expectations and fears regarding change • Tact and diplomacy • Ability to bring associates together for the proposed creation of FMGs • Negotiation with RHAs • Communicate shared	• Voluntary approach to physician involvement through use of incentives • Vision and role of physician leaders • Professional values of physicians • Organizational structure, such as a cohesive team or a clinical structure • Centralization of	• Lack of overall vision in development of FMGs • Rigidity of the criteria of the clinical model • Lack of communication, responsiveness, and support from regional health authorities for allocation of resources • Lack of continuous identification and

Node and Project Title	Leadership Capacity	Leadership Capabilities	Enablers	Challenges
	Transformations. However, while LEADS framework underlines leadership capabilities related to assessment and evaluation practices, leaders within FMGs were not involved in the assessment of their clinical practices and processes regarding health outcomes. Since the implementation of clinical information systems is recent, physician leaders have not yet collected data and measured clinical outcomes of FMGs. In that regard, government has not developed benchmarks and innovative policies in order to enable and encourage local and regional efforts to evaluate FMGs' performance in terms of accessibility, coordination and integration of care within the health system network. In terms of *Engage Others* capacity, regional health authorities have not communicated	vision • Empower and train staff • Delegation of management of care services or programs to their associates • Align actions with collective vision, goals, and mission of FMG • Facilitating environments of collaboration and cooperation among team members to achieve results • Building coalitions	power in the hands of executive directors facilitated the implementation of new activities • Project managers dedicated to FMGs implementation	monitoring of the needs of FMGs from regional health authorities in order to sustain their development • High turnover among project managers dedicated to FMGs implementation (within regional health authorities)

Node and Project Title	Leadership Capacity	Leadership Capabilities	Enablers	Challenges
	effectively with FMGs and fostered the development of FMGs.			
ATLANTIC NODE (Nova Scotia and Newfoundland cases) **Dynamics of Engagement of Health Care Providers**	*NS physician engagement*: Systems thinking is a key leadership competency because of physicians' unique roles as boundary spanners within the system and because of their level of power and influence within the system. Current state of leadership capacity is varied with a lack of leadership at the system level. Higher-level organizational leaders stressed the importance of seeing health care as a system and advancing collaboration among entities in this system while lower level leaders struggled to create collaborative relationships. *NL employee engagement*: Found LEADS is very much a distributed leadership model, but not all saw that as the actual leadership model that was in place. To	NS: • Systems thinking • Change management • Relationship building • Building coalitions • Managing performance • Knowledge and awareness • Effective communication • Motivation and commitment • Personal characteristics NL: • Service orientation • Managing social relationships • Managing team dynamics • Program development and cognitive ability • Knowledge • Emotional intelligence • Follow through • Vision	• Build coalitions • Policy alignment among provincial governments, medical professional associations, and health care organizations • Leadership as a national influence • LEADS framework • Creation of new and larger RHA • Desire to build a common culture • Recognition of the importance of engagement • Support within the organization • Plan of action • Designated accountabilities • Use of multiple strategies and tools to promote engagement	• Government (taking greater role in RHA) • Negative public opinion • Creation of new RHA • Differences in focuses within the organization • Lack of active sponsorship for leadership at the executive level • Turnover • Resistance to change • Complexity and silos of structures • Building trust

Node and Project Title	Leadership Capacity	Leadership Capabilities	Enablers	Challenges
	some, leadership was still quite hierarchical and top-down and that made the capabilities in the systems transformation part of LEADS more challenging because greater autonomy was required to use these capabilities. Leadership areas to strengthen were communication, attention to diversity, and creating a culture of diversity.	• Visibility • Inclusiveness • Sensitivity to the diversity and differences • Thinking in a transformative way • Role model and mentor • Caring • Empowering • Consistently and fairness		

Question Three: Knowledge Translation and Mobilization

The third question was as follows:

> *How can knowledge of effective leadership be translated and mobilized by the network into approaches, programs, tools, and techniques to develop a culture of effective leadership in Canada, and enhance the development of quality health leaders?*

Current efforts to translate and mobilize knowledge and best practices of effective leadership in Canada continues to be a challenge and is both ad hoc and sporadic. The value of knowledge mobilization (KM) is to enhance efforts regarding succession planning and leadership development, by ensuring they are built on the most recent and reliable research. Findings suggest that KM occurred in this study on three levels. The first two levels were observable *within* the duration of the study. The third level relates to suggestions for KM subsequent to the study, the primary focus of the above question.

The first level of internal KM might be best termed, 'in-house' KM—i.e., leadership knowledge mobilized during the study by internal participants to alter their own behaviour. In at least three cases (BC, national, and prairie) the PAR approach (which relied on dialogue between decision-makers and researchers) resulted in decision-makers altering their leadership behaviour based on findings as the cycles of research progressed. In the national case, individual leaders discussed findings with management teams, and the interview dialogues facilitated greater reflective practice on their part. In an example from BC, the participant leaders from the provincial Ministry of Health were keen to use the findings in the Implementation Leadership Committee session which includes leaders from the Ministry of Health and all health authorities in BC. They actively responded to the challenge of what they would do differently moving forward both at the individual and collective level. In the prairies, greater efforts to communicate the vision for the Shared Services Initiative (SSI) were made by senior leaders when Cycle One findings revealed that those in mid and front-line roles felt that communication had not happened.

On a second front, 'in-house' KM across the network itself relied primarily on email dialogue and discussion, regular teleconference meetings and face-to-face sessions. Efforts to develop a user-friendly electronic KM framework, plan, checklist, and tracking worksheet for project knowledge exchange activities did not meet with significant uptake. Similarly, the Web 2.0 interactive electronic community of practice (e-COP) established to support the overall project and each of the six case studies received limited use.

A second level of KM within the study was the effort made to share the results of the study externally, as it was proceeding. Presentations (e.g., three at the National Health Leadership Conference) were made on the whole study on many occasions. Individual nodes conducted learning sessions (e.g., prairies, BC) to share knowledge as the project progressed. It is hard to judge the success of these initiatives in terms of stimulating use of the knowledge generated, as no evaluation of these activities was conducted.

The third form of KM focused on the challenge of mobilizing the leadership knowledge within the health system itself. Informants in the national case argued that Canada needs to develop a national research and knowledge mobilization strategy around leadership of health reform. "…There needs to be some part of the agenda that is focused on developing models and strategies that are going to have long-term impact on performance….we don't do that very well in this country….we have a $200 billion delivery system and we spend almost nothing on delivery system research". They also stated that the lack of a national convener for leadership training and support (e.g., organizational supports, mentors/coaches, support networks) in Canada is a critical issue, and that leadership development should be institutionalized as a life-long commitment of individuals in leadership positions. In the BC case, a similar point was made, stating that they were able to "compile a comprehensive inventory of the ways, approaches, programs, tools that could be implemented to develop a culture of effective leadership in Canada", but that any such efforts need to be "tailored to fit the local environment".

New pathways to disseminate emergent research knowledge of leadership and change in a more streamlined way should be explored to bring greater coherence to the prodigious amount of disconnected leadership development that is being undertaken. Cross-case analysis highlighted the importance of mentoring, and putting leadership knowledge especially in the hands of physicians. The Atlantic case (Nova Scotia) argued that a Coalition for the Advancement of Physician Engagement (CAPE) could be established, "to involve the highest-level executive leaders of physicians across organizations within Nova Scotia (and perhaps beyond)" in a partnership aimed at enhancing physician leadership and involvement in health reform.

Budget cutbacks often mean sacrificing leadership development budgets and more strategic investments are required; they are the tools to put the new knowledge in the hands of leaders. Post-secondary institutions are an integral part of this.

Canada should be more strategic at a systems level especially at the interprovincial level with leadership development linked to tackling current problems. For the Ontario case, the most common change affecting FHT performance was the development and approval of formal quality improvement plans in alignment with the requirements of the Ontario provincial government and Health Quality Ontario (HQO). The new IDEAS program in Ontario is a good example of a collaborative effort between the University of Toronto, Heath Quality Ontario, and Institute for Clinical Evaluative Sciences to build capacity in quality improvement and change management (based on the intermountain approach as mentioned by a few interviewees and as chronicled in the literature (e.g., Baker, 2011; Denis et al., 2013; Dickson, 2012).

Discussion

Highlighted below are the interpretive insights across cases to the study questions, and longitudinally through the four years of conducting the study that arose including: alignment (vision, policy, system to local levels); complex systems thinking; two-way communication and

engagement; context; reinforcement of leadership theory; politics; contradictions; and the longitudinal approach of PAR.

Alignment

A shared vision aligns efforts to create health reform (Kantabutra & Avery, 2010; O'Connell et al., 2011). Across cases, the presence or absence of a shared vision either enhanced reform or impeded it, regardless of system level. In the national case, the lack of a shared vision for reform of Canada's health system was highlighted as a major issue. In the prairie case, the statement was made that "findings not only highlight the importance of vision and engagement...but also suggest that these are areas of continuing weakness in Canadian health leadership". In the Québec case there was strong vision for the transformation of primary care at the local level, coming from physician leaders of FMGs and managers of CSSS, but a lack of vision and leadership at the regional (regional health authorities) and provincial (ministry of health) levels—the former enhancing and the latter slowing down implementation. In Ontario, the executive directors and lead physicians/nurse practitioners who pursued the vision of FHT commensurate with the provincial vision were successful, but when significant shift in policy and vision came from the Ministry of Health and Long Term Care, impetus for change was obstructed.

The absence of a common vision contributes to a disconnected and fragmented Canadian health system. Multiple sources of leadership are required to expend energy to overcome natural structural boundaries to create change across those divides (Currie & Lockett, 2011). No agreed-upon vision also promotes individualistic leadership. Yet Jean-Louis Denis (2002) noted that a focus on individualistic leadership "appears ill-suited to the workings of complex organizations marked by a fragmented authority structure". It is the role of strategy and policy to create a common vision, to align effort with that vision, to allocate resources to supporting change, and for the system itself to develop the leadership we need with the skills to do that. Is the lack of a common vision because Canada doesn't have the leadership capacity it needs, or is it in fact the cause of that capacity gap? Regardless, if large-scale health reform is expected, leaders must step up and create a common vision for it. Or is that just too big a challenge within the Canadian system as it is constructed?

One Atlantic (Nova Scotia) interviewee stated:

> "*The question to me still is how do we raise the level of conversation from within organizations to be more structured outside of organizations? It is too big. And part of the reason it's too big is because we don't have a common language for having conversations about it. We don't have a common language because we don't have a body that's responsible for that. So within organizations, we develop common language and culture that tie us together. Above organizations, we don't have a body for that. And so you know, our key recommendation today is where is that, who's accountable for that, and how can we contribute to having that occur?*"

There were many examples of leaders stepping up and attempting to build a common vision and to create alignment. In the national case, the nascent and fragile Health Care Innovation Working Group, working across provinces was mentioned. Interviewees also emphasized efforts to build connections between CEOs on data quality, and efforts to build relationships with the consumers, patients and the community (e.g., Capital Health and Fraser Health). Recent efforts to build stronger relationships across C-Groups were also mentioned, even though there is still a strong sense of disconnect between national organizations and their mandates.

However, these efforts were acknowledged as being time consuming, slow, and energy draining. Unless collective efforts to create a common vision, to create structures to support implementation of that vision, and to sustain the energy of leaders, natural fragmentation of the system will prevail and large-scale change is doubtful.

A Complex Systems Thinking Perspective

As discussed in the BC case report, the health system can be considered a 'complex adaptive system' in that it is a system comprised of subsystems (Dickson & Tholl, 2014; Edgren & Barnard, 2012; Ford, 2009; Paina & Peters, 2012; Sturmberg et al., 2012). Each of these subsystems has its own processes, feedback loops, relationships, and hierarchies. The subsystems are interdependent on each other with multiple connection points, subject to the dynamics of internal and external forces, and are adaptive in their capacity for experiential learning. There is significant evidence in the interview data that leadership at the provincial and most certainly at the national level is dealing with complex, rather than simple or complicated environments; and is therefore constrained in its intentions by the qualities of such environments (i.e., competing interests of professional groups, provinces, and entities; disparate and incomplete communication and understanding of the whole—e.g., as demonstrated in the agendas of access, quality, and appropriateness; turbulence [i.e., constant change]; and rapid and constant turnover of leaders). Kauffman (1980) adds "the common mistake is to deal with one subsystem in isolation, as if it didn't connect with anything else. This almost always backfires as other systems respond in unanticipated ways". The Atlantic case discussed how formal education in systems thinking is an important component and there is a need to offer systems training in medical schools as part of the curriculum.

Two Way Communication and Engagement

A good leader must have the ability to communicate clearly but through a two-way process because it is important to impart information but it is equally important to listen and to hear what others are saying (Birken et al., 2014; Zaheer et al., 2014). Effective communication enhances engagement (Dickson & Tholl, 2014). In the Atlantic case (Nova Scotia), feedback was found to be vital for learning and innovation. It informs on the effectiveness and efficiency of current processes while signalling the necessity for change when necessary (Latham & Locke, 2002). Implementers of the FATT program surveyed participants at the end of the program and annually. The feedback gained from these surveys has been used to modify program content as can be noted from the inception of the program and its current format. For employee

engagement, it was important to know how influence is exerted e.g., the importance of the front-line manager and the impact that person can have on staff, or for others, the visibility of senior management.

In the prairie case, engagement was hampered by several key factors: time limitations caused by multiple mandated priorities (e.g., Shared Services, Lean, and *hoshin kanri* planning); front-line leaders not being empowered to lead, only to manage; and doubts about political will to carry through with a change, especially after leaders had seen many top-down initiatives dropped from the policy agenda before or during the early stages of implementation. However, engagement did increase over time because of regular communication and updates, as well as regular committee meetings and visioning sessions involving a cross-section of managers and front-line employees from across the province. In the Québec case, regional health authorities did not communicate and engage effectively with FMGs and fostered the development of FMGs.

Results suggest that the "balance sheet" between the ability of Canadian health leaders' collective ability to work together and the forces creating fragmentation remains fluid but relatively unchanged since the inception of the study (four years ago). To paraphrase one interviewee: the 'tugs' that keep us apart are much stronger than the 'hugs' that pull us together. In the national case the Premier's Healthcare Innovation Working Group (http://www.conseildelafederation.ca/en/initiatives/128-health-care-innovation-working-group) had promise, but has made little progress : "The premiers' working group is not a game changer" (national case). The "C- Group" still work independently for the most part, rather than collectively.[14] The closing of the Health Council of Canada (http://www.healthcouncilcanada.ca/) will eliminate a key player, and its mandate as a national, independent, non-profit organization to monitor and report on the progress of health care renewal, will be sorely missed. Other ways to achieve its valued mandate should be created. In the prairie case, many participants believed that Shared Services in general had the potential to make a major difference in overcoming the "natural fragmentation" of the health system as it brings people together, but that its success is marginalized by competing priorities within the system.

Throughout the national case there was an increased awareness on what leaders can do together to slow down or reverse the fragmentation of the Canadian healthcare system. There was also a growing desire to have a national convener (in the absence of the federal government) as they look for ways to work in concert. Yet there was little clarity on who might take on that role. Current and emerging leaders did agree on the need to step up the overall efforts to mentor and coach the next generation of senior/executive leaders.

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[14] This is a group of some eight pan-Canadian organizations cutting across the dimensions of information dissemination (Canadian Institute for Health Information), cross national performance indicators (Health Council of Canada), standards setting (Accreditation Canada) and technology assessment (Canadian Agency for Drugs and Technology in Health). Some interviewees did indicate that the "C-groups" are making genuine efforts to find ways to collaborate more effectively, but as yet little progress has been made.

Importance of Context

The literature shows three sources of strategic influence to overcome fragmentation: structural alignment, cultural alignment, and political alignment (Bolman & Deal, 2008; Dickson, 2012). Existing contextual factors—structure, culture and politics—appear to be stronger than many leaders realize—sometimes so strong as to be unassailable (existing constitutional responsibilities, funding structures, professional self-interest, for example). Yet all of these factors are human creations, and therefore can be changed by human effort. A conscious and deliberate effort to change them requires an equal effort to change our leadership mindsets and behaviours (Beard, 2014; Jacobson, 2013; Kennedy et al., 2013).

In particular, the findings section of this paper suggested that to challenge these structures, and to take action to overcome them, traditional notions of leader autonomy, locus of control, accountability, and collaboration are required. Although there is a palpable desire and intellectual commitment to do so on behalf of many leaders, most struggle. For example, with regard to acting more strategically (i.e., regarding accountability), one national case interviewee stated "our boards should be operating on a five to ten year horizon, I should be operating in a three to six year horizon, the VPs should be operating in a one to two year horizon and the executive directors should be running the show day-to-day. But we don't do that… they are energized, but they are constrained by the tyranny by the day-to-day activities at the operational level". In the prairie case, competing priorities (Lean, *hoshin kanri*) pose an on-going challenge. Although political will was a key challenge early in the prairie case study, a provincial cabinet decision made in early 2013 to move forward on Shared Services had diminished these concerns somewhat by the third cycle.

Reinforcement of Leadership Theory

Five theories found in the leadership literature were highly relevant to interpreting findings from the node projects. These include shared or distributed leadership, substitutes for leadership, complexity leadership, authentic/transformational leadership, and servant leadership. Although results show there is a continued reliance in some parts of the health system on hierarchical, heroic leadership models, formal leaders no longer have the same power or privilege as before. These theories are discussed further below.

Shared or Distributed Leadership

Distributed leadership, while not a new concept as it has grown largely out of the education sector, is relatively new to health. Throughout this study the term 'distributed leadership' has been used by some, but other terms have been used interchangeably to convey a similar meaning (e.g., shared leadership, collaborative leadership). This can create conceptual confusion. Bolden (2011) identifies related terms including shared leadership, collective leadership, collaborative leadership, co-leadership, emergent leadership, dispersed leadership, and distributive leadership. Moreover, Bolden observes that this is further confused by the preference of different disciplines to use different terms, for example, medicine tends to use 'shared leadership' while business and management use 'distributed leadership'. Geography

further confuses, with the UK using the term 'distributed leadership' and the US using the term 'shared leadership'. So, it is little wonder that while the concept of and desire for distributed or collective leadership is a key finding in this study, there is a myriad of terms to describe it.

Essentially, the concept of distributed leadership is that "leadership - like power and like information - can be moved between people at differing levels of the organizational or societal hierarchy" (Jackson & Parry, 2011, p. 102). On the other hand, critics, at least from the perspective of the education sector, point out that this may be a passing fad, and that it is difficult to reconcile distributed leadership with how power and accountability are distributed in hierarchical organizational structures (Corrigan, 2013).

While the findings of this study have highlighted, at least in rhetoric, the importance of distributed or collective leadership as desirable in the health system as a departure from current practice, putting this into practice will likely prove very difficult given the multi-level, multi-stakeholder, multi-jurisdictional, hierarchical, and political realities inherent in the health system. A bold re-think is needed if we are to embark on this path collectively. In particular, what it looks like in actual practice needs to be further investigated and delineated.

Currie and Lockett (2011) illuminate possibilities for practice in their discussion of conjoint and concerted components of distributed leadership. "Concerted agency" refers to the structural and political practices that encourage and/or demand collective action (e.g., the implication from one interviewee that all the CEOs in the country could be in one room and work together to generate a reform agenda). "Conjoint agency" refers to the mindsets and pre-dispositions of individual leaders to work together; that is, to see their work as connected and interdependent (e.g., the awareness and mental acceptance of the value of meeting in one room to generate a reform agenda). There is little evidence in the interview data that leaders in the Canadian health system currently step out to build or sustain infrastructure to ensure concerted action (except in a very personal organization-related way e.g., the quality measurement initiative from 11 CEOs and efforts in BC to work with CEO colleagues on specific projects); nor that they have a shared understanding of the interdependence of their work that actually influences their behavior on a regular basis. Further investigation of what could be done to enhance and grow concerted and conjoint agency amongst Canadian health leaders might well be productive in the next stage of this study.

Substitutes for Leadership

The substitutes for leadership theory suggest that there are a variety of situational variables that can substitute for, neutralize, or enhance the effects of a leader's behavior. Neutralizers are variables that paralyze or mitigate the effectiveness of something else. With respect to leadership, this term may be applied to contextual variables which make it effectively impossible" for leadership to make a difference. Podsakoff and MacKenzie (1996) conducted a meta-analysis to determine whether or not evidence for the existence of substitutes could be found, and argued that "on average, the substitutes for leadership uniquely accounted for more of the variance in the criterion variables than did leader behaviours". This study showed that

although many of our leader-informants are working hard to create transformation, they identify numerous contextual variables that impede their ability to do so. It may well be that the power of those contextual variables, and the sheer number of them, is the main reason that their behaviour is not as effective as they would like it to be.

The leader-substitute construct simply suggests that in addition to influence (the currency of leadership) residing in an individual, it also resides in structures (policies, procedures, power distribution) and culture (collectively and unconsciously understood mindsets and ways of doing things) (Avolio, Walumbwa,& Weber, 2009). For example, the structure of political democracy ensures that every five years (maximum time frame) there will be an election and a new government formed. That creates a dynamic of decision-making and action within government that appears to limit commitment to long term change. Similarly, year-to-year budget cycles mitigate long term planning.

Authentic and Transformational Leadership

Many of the attributes or traits of effective leadership described in the findings section in answer to the second question support the constructs of both authentic and transformational leadership. A strong relationship exists between the concept of authentic leadership and transformational leadership. Authentic leadership is defined by Luthans and Avolio (2003) as comprised of four dimensions, including self-awareness, transparency, ethics and morals, and balanced processing. Transformational leadership contains attributes of inspiration, intellectual stimulation, and individual consideration (Bass & Riggio, 2006 as cited in Tonkin 2013). Tonkin's article also points out that though the relationship is a strong one, the two constructs are not the same thing. He contends that the dimensions of authentic leadership also embrace ethical and transformational leadership. Also, the correlation tables provided by Tonkin (2013)indicate that the relationships among transformational leadership factors are about the same as the relationships among the authentic leadership factors. Given the findings of this study, both constructs are reinforced as viable in terms of engaging others in health reform.

Complexity Leadership

Many writers contend that modern health care is a complex adaptive system (Heifitz, Grashow, Linsky, 2009; MacLeod, 2011; Schneider & Somers, 2006; Sturmberg, O'Halloran & Martin, 2012; Tan, Wen & Awad, 2005). Complex systems extend some of the ideas of the substitutes for leadership theory in that large systems with almost an infinite number of variables can take on a life of their own; they can become self-organizing (Best, Greenhalgh, Lewis, et al., 2012). The veracity of these ideas was supported by our interviewees. However, complexity leadership does not suggest that leaders cannot influence the system. They can. However, their actions must be directed at using tools consistent with an organic systems approach (Dickson & Tholl, 2014). Best el al. (2012) suggest, for example, that "simple rules" followed by all leaders could facilitate change. However to do so means giving up traditional methods of control (charisma, command and control) and giving it away to trust others to co-create the future of the health system.

Complexity leadership refers to the perspective on leadership that sees the environment or context for action as a complex, turbulent entity that is very unpredictable, self-organizing in many instances, and rife with unanticipated consequences of action (Denis, Langley & Rouleau, 2010; Dickson & Lindstrom, 2010; Ford, 2009). This has given rise to a perspective of leadership that suggests the leader cannot be anywhere as deliberate and determinate as a leader might be in a simple, or complicated system (i.e., where variables are known; cause and effect is understood; and overall, actions can have their consequences predicted (Glouberman & Zimmerman, 2002).

Servant Leadership

Greenleaf (1997) describes healthcare leaders as "servant leaders", people whose role and responsibility is to represent the needs of others and act on their behalf. Health leaders serve and lead patients, providers and citizens; you dedicate your time to their health and wellness and to the system that supports them. Servant leaders make a commitment to sacrifice for the common good as the essence of leadership. Servant leadership is more global than Western; it reflects virtues highlighted in the five major religions — Buddhism, Christianity, Islam, Hinduism, and Judaism. J. R. Wallace (2007) says each of those religious traditions "provides a series of individuals as role models who exemplify leadership behaviour as well as acceptable life patterns, not to mention their inclusion of heroes and heroines who arise in times of crises to provide guidance and inspiration".

Given the importance of "serving patients and the public" it is interesting to note that there is such an emphasis on contextual factors such as self-serving interests of professional organizations, individuals, and groups as impediments to reform. We appear to have a provider-focused rather than a consumer focused system. In a UK report (King's Fund, 2013), the primary theme is that leaders allowed other priorities and factors to cloud their decisions that deaths occurred and patient focus has been lost (Francis, 2013).

Individual Behaviour Change

The PAR process allowed leader participants to reflect or consider changing their own behaviour. One interview stated that the process "helps people sharpen…focus; determine qualities needed to move agendas forward;" another that "Points-in-time reflections help course correct". For the national node, one interviewee used a knowledge mobilization product of cycle one (the *Shifting Sands* document produced by CHLNet to summarize key insights for decision-makers from cycle one of the overall project) as a discussion point with his senior management team. Within the prairie node, leaders identified and requested learning opportunities that could improve their own leadership development and enhance their change management skill. In the prairie node, in early cycles, systems thinking was evidenced by the highly-emphasized "think and act as one" mantra underlying shared services. In the last round of PAR, two senior leaders spoke about the "old ways" and "new ways", indicating the shift from regional to integrated, provincial-level thinking.

Politics

From the respondents' point of view, and in the context of large-scale health reform, negative perceptions re the political process were described by a number of studies (national case, Atlantic case, BC case). When hot button issues appear to be magnified out of proportion through the megaphone of the media and adversarial partisanship; when divisions between organizations in the political fabric calcify so as to pit one group against another; or when politicians are perceived as inserting themselves into responsibilities delegated to other leaders, politics can be perceived to have a divisive effect on health reform. Others referenced quick changes of direction and perceived abandonment of initiatives that were once high priority as inimical to the long-term change needed on a large-scale basis. Some mentioned scapegoating: when difficulties emerged with implementation of policy "in the field", there was sometimes a tendency by politicians and other leaders to find a culprit and threaten dismissal. Also, the very timing of the political cycle (four years between elections) was cited by some as too short to sustain the long-term commitment that was necessary. Such perceptions of the political process can condition people running the services to act as followers—i.e., not challenging or taking initiative—or feeling whip-sawed and disempowered, pawns in a political process that appears to be dedicated to short term interest rather than a commitment to long term reform. This perception of politics—when it becomes a "mental model"[15] (Senge, 2002; Zaphron & Logan, 2009)—can create problems that are less real than perceived.

A few statements were also made about the virtues of politicization (BC case, Nova Scotia case). Politics is what takes place within the rules (Crick, 2005), and is enshrined in the formal political process itself (big "P" politics) as well as the dynamics of interchange within a democracy (small "p" politics). A democratic polity benefits from freedom of speech, freedom of association, and freedom of religion: qualities that are embedded in the political process as enacted by interest groups and associations that can advocate for their position in a democratic context. Indeed, Medicare itself was a product of a deeply divisive and political tumult (i.e. the 23-day doctors' strike in Saskatchewan in 1962). Politics are a permanent part of the fabric of the public enterprise of health in a modern Canada. It was also clear that many liked the independence that the democratic political process bestowed upon them; and the autonomy of action their roles provided them. Therein lies a deep-seated contradiction inherent in the challenges of leading large-scale health reform: one that itself may find its origins in the accelerating pace of change in society and how democracy is interacted in a modern, information-rich state (Oblensky, 2010).

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[15] A mental model is defined by Peter Senge as ""deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take action. Very often, we are not consciously aware of our mental models, or the effects they have on our behaviour" (p. 8).

Contradictions and Conflicting Dynamics of Leadership

Contradictions—as the last sentence in the previous section highlighted—appear to define the challenge of leadership of large-scale change in Canada. A major phenomenon giving rise to this study was that the pace of change is accelerating in health care. When change accelerates in the environment, paradoxes—contradictions—occur. Charles Handy wrote in 1995 that "socioeconomic change has proceeded at an appreciably faster and more deranging pace than he had anticipated, creating a fresh new series of puzzlements". Contradictions are differing perspectives, or "ways of seeing the world" that appear to be opposed to one another.

Many contradictions emerged over time in this study with respect to leadership of health reform. Is that surprising in 2014, when the pace of change has grown exponentially since 1995? If what Handy said then was true, it is "truer" in spades now. So what might the prevalence of burgeoning contradictions have in explaining this study's findings?

When contradictions entrench themselves in a dispute, they create negative conflict, which either stalls or mitigates concerted energy. When contradictions are unconscious rather than conscious, they create incongruity of thought and puzzlement, creating confusion, a sense of ambiguity, and the appearance of complexity. Such an environment can lead to inconsistency of effort, and stalls personal or collective action. Indeed, much time and effort can be expended to simply exist with contradictions as opposed to explore them and use them productively. Unless the leader can find within him or herself the ability to generate synthesis (a combination of two or more entities that together form something new), and then coalesce action around that new way of being, innovation and change can be stalled. Martin (2009) calls this integrative thinking, a systems thinking ability needed for effective health reform.

The findings of this study--based on the data from the six cases and this cross-case analysis-- suggest that the main reason for "spinning the wheels" in leading health reform are the immense number of contradictions that exist within the system *due to change itself and the conditions that both create and impede change.* For simplicity sake, we will divide those contradictions into three categories; systemic contradictions, practical contradictions, and personal contradictions. Collectively these contradictions define the environment for modern health leadership and make contemporary leadership difficult. For synthesis, they also demand leadership skills of a higher order and distinct from conceptions of leadership many leaders have grown up with (e.g., the demands of distributed versus individualistic leadership; the demands of operational leadership versus systemic leadership) (Ford, 2009; Oblensky, 2010).

Systemic Contradictions

Certainly the dynamics of technology, rapidity of change in the external environment, and burgeoning medical challenges associated with a society of abundance versus scarcity has changed the game of leadership. Social media, just-in-time decision-making, the explosion of knowledge and a media-dominated public discourse has altered the balance of power between formal leaders, the consumer public, and governments. Collective decision-making in a context

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whereby dialogue and discourse is conducted in an open marketplace and fuelled by ever-changing information is both enhanced by those circumstances and impeded by them. Collective decision-making can be enhanced because communication and intent can be immediately communicated. It is impeded because society still embraces democratic notions of freedom, competition, and preservation of independent interest. Leaders appear to be caught up in a society that is going through a tectonic shift of formal-informal leader responsibility in a time where large-scale reform is possible yet due to the same factors, difficult to achieve. It is almost as if the abundance of the system impels the parts of that system to bolster their independence, while at the same time, the nature of the problems that need to be solved require the exact opposite.

Such a constantly 'shifting sands' policy environment creates a number of contradictions that leaders must deal with. The most egregious example is found within the communication and knowledge arena. Social media, news media, the internet, and medical technology have sped up the ability to acquaint people with the problems that need fixing (hence the demand for change in health care) and some of the technological solutions; but have not yet been systematically harnessed by the health system to solve them (except in isolated cases). An entrepreneurial business marketplace creates the tools and sells them; but those very tools are not affordable to the formal system itself. Recent efforts to regionalize service delivery across vast geographical regions is possible due to the virtues of modern communication and information technology; but without a commensurate knowledge of how to use that technology for its promise and without the funds to buy it a disconnect emerges.

A second contradiction that emerges in the socio-economic context is the contradiction that is created between the formal leader in the health system and the informal consumer leader. In modern society, the informal leader can marshal knowledge and information and share it like a virus; sometimes creating mass movements galvanizing public support for specific health issues (just watch the news to see the multitudinous disease-specific or case-specific advocates gaining access to the public). Formal leaders may in fact wish to do similar things; but are hamstrung by policies, procedures, ethical guidelines, privacy laws, that are artifacts of an age where knowledge was scarce. They don't have the luxury of singular focus: having the need to maintain a focus on all aspects of the system on a day-to-day basis and resist being whipsawed by the vicissitudes of public opinion. Informal leaders often are spurred by passion and common sense; they are not hamstrung in their vision by policy, procedure, rule of law, etc. and due to that very same freedom to act, can access the media when their case is compelling (and controversial). Contradictions arise when the two remain separate and isolated - and don't find ways to work together to create innovation in the system.

Practical Contradictions

Practical contradictions are also legion. There is the operational versus strategic contradiction. As service delivery entities get larger, senior leaders need to act more strategically, and eschew operational demands, the very demands in which they excelled prior to be being promoted into

those senior positions. A second is that large-scale change takes time whereas the current turnover of leaders and the realities of the existing political process do not provide that time. A third is the tension between the collective accountability required of distributed leadership and the individual accountability of designated leadership (Best et al, 2012). A fourth is the contradiction inherent in dealing with the ever-increasing number of individuals who need care (because the system has been so successful in treating them) and the reluctance of the taxpayer to fund the requisite expansion of services. And finally, there is the professionalism contradiction; professionals (e.g., doctors), who want to retain their independent professional status, and who have professional organizations to protect it, while at the same time having to be partners in the health reform process, a partnership that requires flexibility in terms of changing those professional practices. Current patterns of structure, culture and politics within the Canadian health system reinforce an operational focus, short timeframes for decision-making, and designated accountability. Countervailing structures, cultural values, and political actions need to be found to redress the balance (Oblensky, 2010).

Personal Contradictions

The third set of contradictions is personal contradictions. Change demands that leaders—and followers—change their behaviour. The sheer number of contradictions described above suggest a myriad of behaviour changes for leaders: being better systems thinkers; strategists; communicators; coalition builders; information experts; team-builders; servant leaders—the list goes on and on. But each behaviour change is a discreet act of both will and corresponding action. Behaviour change illuminates the first human contradiction: how does one find the reflection and practice time in the very demanding environment in which demands are insatiable, and that mitigates against these very actions? And given this circumstance, how much behaviour change can any individual take on?

Leaders seem to find themselves in a place—this study suggests—where their intellect tells them that they have to create significant reform to be relevant, and that they also have to master a whole new array of skills to be successful at doing so. Yet their emotions tell them that to take the time to learn new skills or unlearn behaviours that are no longer desirable, and that got them to a pre-eminent position, leaves them vulnerable. Is it surprising that letting go of what one knows and does well, to grab on to something that takes will and effort to develop—and maybe never do well—gives such leaders pause?

A third personal contradiction is the ego—altruism paradox. Serving the patient, having a common vision dedicated to quality patient care, motivates many a health leader. However, when to do so means giving up something in their self-interest—e.g., remuneration, independence, clarity of role and/or status—then the demands of the ego can come into conflict with the demands of public service. If it is consistently easier to go with the ego as opposed to altruism, because structural and cultural factors reinforce self-gratification—then to deliberately deny oneself those benefits for altruistic purposes can ultimately wear any leader down over the case of a career.

A fourth such contradiction was the tension between independence of leaders and interdependence of leaders, represented by individualistic versus distributed references to leadership. On many occasions the interviewees seemed to long for greater alignment of effort—e.g., common vision, national convener for leadership and succession planning—but on the other hand, prized their independence and separate accomplishments. This contradiction was described by one interviewee as acting as 20th century leaders in a 21st century world.

The contradiction is created by the word leader itself. Almost by definition, a leader requires a follower. But in a distributed leadership approach, who is the follower? Or does the term not make sense in that context? Is follower another term for anyone who is not in a formal leadership position, or someone--regardless of role--who simply does what he or she is told?

Distributed leadership is a euphemism for the sharing of a leadership role—amongst formal leaders, informal leaders, doctors, clinicians, and consumers—that assigns to each a temporary responsibility that constantly shifts locus of control depending on situation and circumstance, and whose influence is required to maintain momentum for that change. But what does that look like in practice, and how does it affect learned notions of responsibility and accountability? Will formal leaders "give up power and control" to informal leaders (e.g., employees, clinicians, consumers) in the best interests of the change process? Distributed leadership is a glib phrase, an admirable concept—but a difficult one to operationalize. Practically speaking, a leader in the health system—formal or informal—may be excused for not understanding the ambiguity of process inherent in the term, as it plays out in the practicality of such an approach.

Essentially, the larger the number of contradictions in a system that a leader has to juggle, the harder it is to fulfill his or her leadership role. Contradictions themselves require sophisticated, integrative leadership skill: "Individuals with high levels of integrative complexity are open to divergent views and able to reconcile contradictions" (Tjosvold et al., 2014, p. 552). Leaders need time for synthesis; skills for synthesis (e.g., systems thinking, creativity, dialogue skills, visioning skills), and skills of process rather than direction (Dickson & Tholl, 2014; Oblensky, 2010). And these skills need to permeate the whole system.

Knowledge Translation and Mobilization

A second goal of this study was to contribute to building an integrated regional and national knowledge translation and knowledge mobilization (KT/KM) strategy that distills the knowledge from the case studies and translates it into practice. The study succeeded in doing that on a small scale, through its own KT/KM efforts (chronicled in a separate report), and through the experience of PAR itself.

PAR methodology demonstrated both the challenge of a shared approach between researchers and decision-makers, highlighting the diverse worlds of both. The PAR approach can be described by way of a metaphor. It involves two trains travelling on an apparent collision course down in a valley. More traditional research methods would have the researchers observing from a hill top: not engaged in the travel, but observing it. Noting that the two trains might be

on a collision course, the traditional researchers would make every effort to carefully monitor the relative speed of the two trains, trying to estimate the time of the impact. Once the trains collide, the researchers would focus on calculating the casualties from the train crash and tracing the reasons for the crash, perhaps a failure of a traffic light or failure to take a siding. Several months later the study would be published in a journal and perhaps be factored into a change in transportation safety standards.

In contrast, PAR has the researcher involved in the transportation process. They are engaged, observing and monitoring—from a central hub—the actions that are taking place. The researchers, seeing the oncoming train, would radio the engineer saying: "Do you see that oncoming train? "Do you suppose we should take some evasive steps, such as taking that siding that is coming up?" The researcher, metaphorically, is not in a position to actually take decisions; but to inform them in real time. Decision-making is the engineer's job or the senior health decision-maker's job. But in the PAR process, embedded researchers do provide advice and feedback at each cycle, giving the decision-makers an opportunity to make mid- course corrections in leading healthcare reforms. However, in so doing, the diverse worlds of both researcher and decision-maker still come into play. Researchers need time to access, interpret, and share data. Even in a PAR study "cycles" that proscribe findings being shared every six months and processes that limit decision-maker/researcher interaction cannot necessarily respond to emergent need or circumstance. Decision-makers want short, succinct (No more than three pages!) reports. Researchers feel a need for complete documentation. Similarly, the different uses of language and methods of thinking/interpreting the same phenomena often occurred. On numerous occasions the PI (researcher) and PI (decision-maker) found themselves clarifying understanding and meaning over simple concepts (e.g., what is meant by next steps item on the agenda: for the researcher it was "what next" with respect to subsequent research; for the decision-maker, it was "what are the implications for action" regarding policy implications of the study). PAR goes a long way to minimizing those differences, provides a container (process) to work out those differences, but does not totally bridge the gulf—a real gulf—between the two worlds.

The study also explored mechanisms to scale knowledge mobilization efforts up across the health system. One of those methods is to develop a robust national initiative regarding leadership development and succession planning. System-wide strategic efforts to mobilize research knowledge to improve leadership and succession planning are being undertaken in Australia and the United Kingdom (Dickson and Tholl, 2014). The research literature suggests, for instance, that systematic succession planning and leadership development are sound organizational investments in this regard (Cummings et al., 2010; Titzer & Shirey, 2013; Trepanier & Crenshaw, 2013). Based on the capacity issues discussed earlier, if there is a latent desire to enhance capacity based on best practice knowledge of contemporary health leadership, Canada might look at these practices and learn from them. In both those jurisdictions, national leadership and management competency frameworks underpin the investment. In Canada it is primarily left to individual jurisdictions and local universities to

provide programs based on whatever framework they believe is of value. However, a common framework builds a common language around leadership. In Canada, the LEADS framework might be an appropriate framework around which to build such an initiative. Post-secondary institutions might be encouraged build the framework into their programs as the desirable outcomes of learning.

In terms of addressing the leadership capacity gap, the following ideas distilled from the six cases aim at improving research and knowledge-mobilization efforts:

- Coordinate existing research and knowledge-mobilization capacity in the discipline of health leadership through one or more centres of excellence (e.g., re-affirm the value of a national network of researchers and decision-makers dedicated to conducting Participatory Action Research for salient projects in small and large-scale health reform; and to continuously refresh our knowledge of what works and what doesn't work.
- Set up a one-stop shopping centre that coordinates knowledge regarding evidence of best practices regarding models of small and large-scale health reform.
- Invest nationally and regionally—on the par with Australia and the UK--in more coordinated and coherent leadership development programming for all leaders, to help them move more quickly from 20th century to 21st century leadership (e.g., systems thinking, strategic thinking in a large regional and provincial context, teamwork, collaboration, and self-reflection); and to recharge their batteries when in need of a refresh.
- Consider utilizing the LEADS framework as an organizer for knowledge mobilization (e.g., best practices, tools, techniques, new research) in support of leadership talent management and succession planning.
- Conduct research to establish critical success factors and metrics of success to systematically grow leadership capacity, and to assess capacity in the context of the leadership needed to generate health reform.
- Establish a broader applied research agenda into themes such as complexity leadership, distributed leadership, authentic leadership, servant leadership; and best practices associated with them in the context of generating small and large-scale health reform.

How these ideas might be done, by whom and when are important considerations that will not be addressed in this document because they are beyond the scope of the six case reports and this report. A subsequent component of the overall project, a deliberative dialogue (hosted by the Health Policy Forum at McMaster University) will dedicate itself to exploring the implementation considerations of all findings of the six cases and this report.

Summary

This *Leadership and Health System Redesign* research study had three primary goals. A first goal was to explore the leadership dynamics at play across Canada in the context of health reform. A second goal of this study was building an integrated regional and national knowledge translation and knowledge mobilization (KT/KM) strategy that distills the knowledge from the case studies and translates it into practice. A third goal was developing a sustainable *network of networks* in

health leadership research that will last well beyond the PHSI funding envelope and timeframe. Consequently the project was designed to encourage researchers and decision-makers to work together to use PAR as a vehicle to achieve those goals. A short summary of progress toward the goals is outlined below.

Goal One: Exploring the Dynamics of Leadership of Health Reform

Large scale health reform requires alignment of action across systems, sophisticated distributed leadership, and clarity of a shared agenda. It is necessary because the policy environment in which health care exists is unpredictable and rapidly changing. Yet it is that very change that creates numerous conflicting and therefore intellectually and emotionally challenging contradictions that today's leaders have to grapple with as they contemplate major change. Each leader—and leaders collectively—are caught by the need to sort through the ambiguity and confusion that these contradictions create. If they are to be successful, then the very patterns of thinking and behaving that define the current system, and that have led to the diminished capacity of its leadership cadre, must themselves be challenged and replaced by countervailing patterns and behaviours commensurate with the desired future. Those new patterns have to be created –they do not necessarily exist; nor will they simply reveal themselves through research. They will be created by leadership minds that embrace the challenge, see the strength in collective human will and action, and who craft creative new pathways to harness that will and action in a collective enterprise.

Goal Two: Building an Integrated Regional and National KT/KM Strategy

This study—and the efforts within it—have created some nascent foundations for an ongoing regional and national KT/KM strategy. Many actionable suggestions from study participants and from the individual cases have been proposed (as detailed in the findings and discussion sections of this paper). Additional dialogue to clarify this goal and recommendations to action have been set out in a companion document prepared based on the deliberative dialogue hosted by McMaster University on March 4, 2014 as the final phase of the PAR study.

However, because of the dynamics described throughout this cross-case analysis, as it relates to leadership of change, these efforts will require new ways of thinking, new practices to be sustained, and new attitudes regarding power, resource allocation, and responsibility/accountability to be sustained. An integrated KT/KM strategy requires the same behaviour change on behalf of the researchers and decision-makers in this study that were required to fulfill its mandate; and is a microcosm of the behaviour changes required of people who lead it that health reform itself requires.

Goal Three: Developing a Sustainable Network of Networks in Health Leadership Research

To some extent the goal of developing a sustainable network in health leadership research has been achieved. The results of the PHSI project have stimulated the creation of a national health

leadership action plan, stewarded by the Canadian Health Leadership Network. That plan has been fuelled by research knowledge derived from the PHSI project, and from additional research (e.g., benchmarking study http://chlnet.ca/benchmarking-study). Decision-makers—many of whom were involved in this project—are now actively contributing to or promoting that action plan. In addition, key researchers and decision-makers involved in this project have applied for a second PHSI grant to further the research needed in the field of distributed leadership. At the time of writing news of a successful application (or not) has not been received.

Conclusion

The *Leadership and Health Systems Redesign* Participatory Action Research (PAR) project explored the dynamics of leadership of health reform across Canada. The project, funded by CIHR and MHSRF, involved a complex partnership between researchers and decision-makers and took four years to complete. Findings suggest that health reform in Canada is not proceeding at a satisfactory pace due to a gap in the leadership capacity needed to lead it; that a national strategy to grow and develop leadership talent is needed; there is a growing consensus around the need for a shared leadership platform (e.g., LEADS); and that a key component of that strategy is a robust national research and knowledge mobilization initiative.

However, the study also suggests that the way forward is itself a major leadership challenge. Health leadership will be a key factor in the success or failure of major health system reforms in Canada and internationally, but an immense effort will be required to adjust and alter the systemic, practical, and personal contradictions that currently define the leadership and reform landscape. Canada's health system has evolved to a decentralized system and yet there is limited knowledge on how to make leadership—and change—work in such a context. More research on this is warranted especially around new models and theories such as distributed or complexity leadership.

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