# Summary Report
# National Stakeholders' Workshop

# Human Resource Needs of Canada's Health Leadership and Management Sector

*The Canadian College
of Health Service Executives
In partnership with:
The Academy of Executive
Nurses
The Canadian Society of
Physician Executives
Human Resources Skills
Development Canada*

*March 23rd & 24th, 2005*

# ACKNOWLEDGEMENTS

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# 1. EXECUTIVE SUMMARY

## 1.1  KEY PARTNERS

The Canadian College of Health Services Executives (CCHSE), the Academy of Canadian Executive Nurses (ACEN), and the Canadian Society of Physician Executives (CSPE) are working together as lead partners to address the knowledge gaps about the present and future leadership/management cohort in health care and carried out a situational analysis to:

- Identify key data and information requirements
- Collect and review existing information on leadership and management in the health care sector and
- Identify and explore the barriers/opportunities that would affect the feasibility of conducting a full study of the Canadian health leadership/management sector.

We gratefully acknowledge Human Resources Skills Development Canada (HRSDC) for their financial contribution for this initiative, and their input and feedback in regards to human resources, situational analysis and sector studies.

## 1.2  NATIONAL STAKEHOLDER WORKSHOP

The National Stakeholders' Workshop was conducted in Ottawa on March 23 and 24th, at the Southway Inn in Ottawa.  Over 43 participants attended representing a broad geographical range of key stakeholders from across Canada, from various industry types and levels (e.g. training and education, service delivery, planning, regulatory, rural, urban, national, provincial, regional, etc.).  The full list of participants is found in Appendix B.   Each participant received an information package containing among other things, a copy of the Situational Analysis Discussion Paper – Version 1.0, and the key questions to be addressed at the workshop. The questions pertaining to health service executive/leaders were focused on creating a common definition, identifying critical competencies, addressing recruitment and retention issues, considering what methodology would be appropriate for a sector study, and identifying the next steps.

The workshop opened with an introduction by Major-Général Lise Mathieu, Director General of Health Services for the Ministry of Defense, followed by five key note speakers (the first three representing the three project leads), Dr. John Hylton, President and CEO of the College of Health Service Executives (CCHSE), Patricia O'Connor, Past President of the Association of Canadian Executive Nurses (ACEN), Dr. Don Atkinson - Chief of Staff for the Lakeridge Health Corporation and the Canadian Society of Physician Executives (CSPE) followed by our funding partner Eric Perreault, Principal Analyst for Human Resources and Skills Development Canada (HRSDC) and Robin Buckland, Senior Policy Analyst of Health Canada. The topic and main points of each presentation are elaborated on in 2.2 Setting The Stage.   In

preparation for the small discussion group and plenary sessions, Lorna Romilly, Consultant, presented the key findings from the Situational Analysis Discussion Paper (see Appendix D for the full presentation).

The balance of the workshop was interspersed with two special guest speakers via telecommunications, Ida Goodreau, CEO of Vancouver Coastal Health, and Gérald Savoie, CEO of Montfort Hospital, Ottawa, a series of small discussion groups based on an established set of key questions, and large plenary sessions to review and ratify the recommendations made during the small group discussions.

## 1.3  KEY QUESTIONS

Below are the key questions as posed to the workshop participants, whose work on these questions form the body of this report:

### I  DEFINITION

1.  How do we make sure the definition and study will reflect different structures in a way that serves both provincial and national interests?

### II  HUMAN RESOURCES

2.  ***Critical competencies for leading/managing health care organizations***

    2.1    What are the critical competencies (e.g. skills, knowledge, abilities, attitudes, values) that health care executives currently exhibit which allow them to move through, or across, the health care system?

    2.2    What are the competencies that we are not seeing now but will be needed in the future?

3.  ***Recruitment and Retention***

    3.1    What could we do to increase the attractiveness of the environment for health care executives/managers?

    3.2    What has been our experience in terms of succession planning?

    3.3    Is there a cohort of people who are being exposed to different management/leadership levels and moving across operational functions and facilities?

    3.4    What about the use of mentoring, coaching, and professional development?

    3.5    Is there a shortage of health executives /managers or leaders within our organizations and/or in terms of the number of interested/qualified individuals available externally?

### III NEED AND METHODOLOGY FOR A SECTOR STUDY

4.1    Is a pan Canadian study feasible given the barriers?  Can we reconcile the differences? If so, how?

4.2    How can we link a new pan Canadian study with previous studies? How do we take advantage of existing and other opportunities related to health human resources planning and research?

4.3    Is there a need for a sector study?

4.4    How do we get partnership (stakeholders, provincial/territorial governments) buy-in?

4.5    What is our communication/marking plan?


## 1.4   DEFINITION AND COMPETENCIES

Two special guests, Ida Goodreau, President and CEO of Vancouver Coastal Health, and Gérald Savoie, CEO of Montfort Hospital in Ottawa, spoke (via teleconference) on the critical leadership competencies, seen as needed in health care and how they were different and similar to those in the business world. Similar competencies outlined by each of the speakers included leaders who were strategic, visionary, values-based, excellent communicators, innovative in terms of looking for solutions with evidence-based competencies required in the public sector.  Both speakers also emphasized leaders must also be able to execute, manage change, be accountable, develop good relationships and partnerships and produce results.

Following the speaker presentations, small discussion groups independently worked to develop a definition of leadership.  A consensus on a common definition was reached as follows:

**Recommendation 1:** To consider the following as the industry's definition for a health care leader:

> *A health care leader is… an individual who creates vision and goals, and mobilizes and manages resources to produce a service, change or a product consistent with the vision and goals.*


## 1.5   HUMAN RESOURCES

### 1.5.1 Competencies of a Health Executive/ Leader

A consensus was reached regarding competencies for health care leaders.  Competencies were grouped into three distinct categories: business acumen, personal attributes, and those that crossed over both business acumen and personal attributes.  It was felt this way of describing competencies helped to fully express the breadth of the learned and innate skills, knowledge, ability and aptitude required for these positions.

**Recommendation 2:** The following competencies be considered as standards when addressing Human Resource leadership issues pertaining to training, certification, recruitment, retention and evaluation, as follows:

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***Business Acumen***

- Executes, delivers on the mission
- Obtains, mobilizes, aligns resources
- Accountability
- Evidence-based decision-making
- Legal
- Results Oriented
  o manages organizational performance
- Risk Management
- Focus on the product or service; in health care – focus on the patient/customer and patient services – critical piece

***Personal Attributes***

- Political acumen
- Visionary
  o longer term focus
  o accepts mistakes; helps others
- Values-based
- Ethics
- Communicator
  o represents and advocates
  o leads multi-disciplinary groups/ teams
  o mentor, teacher, supporter
- Active Listener
- Relationships/Partnerships Network
- Common sense
- Emotional intelligence
- Problem-solving

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***Crossover*** (both business acumen and personal attributes)

- Innovation
- Strategic change management
- Organizational development
- Systems thinking, perspective
- Life long learning

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Some suggested that knowledge of the health system also be considered for inclusion in this framework.

## *1.5.2 Recruitment and Retention Issues*

Three discussion groups explored different facets of recruitment and retention: increasing the attractiveness of the environment (workplace), experience with succession planning and shortages/broadening the pool.

### 1.5.2.1   Increase the Attractiveness of the Work Environment

**Recommendation 3:**  Increase the attractiveness of the work environment by:
- Becoming a learning organization
- Creating flexibility in the work environment (e.g., job sharing, flex hours)
- Appropriately recognizing and celebrating the leaders' accomplishments
- Providing personal coaches (the top can be a lonely place)

- Being inclusive and transparent in regards to decision making
- Creating a safe place to work (e.g., mistakes are seen as a learning opportunity rather than incompetence).

### 1.5.2.2      Experience With Succession Planning

Experience with succession planning is limited due to many factors but recommendations included the following:

**Recommendation 4**

Create a positive climate for growth opportunities by:

- Identifying suitable internal candidates and developing them through mentoring/coaching and developing programs and opportunities (both formal and informal) for them.
- Supporting mentors using the work of a number of existing organizations:  CHSRF – EXTRA program, CCHSE, the Dorothy Wylie Institute and Capital Health in Edmonton.

## *1.5.3 Shortages/Broadening The Pool*

There are significant anecdotal reports about shortages of health executives/leaders within our organizations, although few studies on the subject have been conducted.  There appears to be a shallow pool of qualified/ available candidates to meet a raised 'bar of expectations' in part due to the creation of large and complex health care service entities.  With competing demands there is less opportunity for identification and mentoring of potential talent.

**Recommendation 5:**  The CCHSE should play a key role in developing tools and instruments, a self-assessment program and working with other agencies such as the Canadian Council of Health Service Accreditation to assist leaders and managers with the process of succession planning.

## 1.6   NEED AND METHODOLOGY FOR A SECTOR STUDY

### *1.6.1 Is there a need for a sector study?*

The consensus among all three-discussion groups was 'yes'.  The workshop deliberations have highlighted serious issues that need to be addressed through greater knowledge and research that ultimately will lead to recommendations for change, including funding alternatives and "getting this issue on the radar screen" in an effective manner.  This needs to be part of national, provincial and territorial agendas.

### *1.6.2 Are we ready for a sector study?*

There was significant support and willingness to move forward as it was felt that the timing is right, and that something needs to happen now.  Albeit, there is some preliminary work that needs to be done before we proceed with a full study particularly in terms of collecting data and information on the sector.

### 1.6.3 Components that need to be in place

A consensus was reached regarding what needed to be in place to conduct a full sector study.

**Recommendation 6**: There is a need for a full sector study and we should prepare to move forward on this initiative by ensuring we have, prior to conducting a full study: a business case, buy-in of/ support from key stakeholders, appropriate briefing materials, and understanding of lessons learned from other sector studies.  It was recommended also that we:

- Build broad consensus on a common definition (we are partly there).
- Identify the current number of leaders/manager in Canada (data/stats).
- Ensure there is political will and support
    - From individuals who will ultimately implement the study and
    - Buy-in of federal, provincial, and territorial  government decision makers.
- Identify and secure resources (dollars) to continue the planning process.
- Identify a governance process and structure including a steering committee, and management and advisory groups as required.
- Ensure there are compelling arguments - a 'burning platform' (i.e. health executives should be studied as an essential part of the health system affecting patient care delivery).
- Write a clearly defined business plan which defines who we are, the issues, what a leader is, critical needs (i.e., recruitment and retention), and the benefits of strong leadership.

## 1.7  WHAT'S NEXT?

To get the pieces in place and follow the strategies outlined in the workshop requires champions throughout the system to lead in the networking process and to talk to key stakeholders (political informants and decision makers).  This multi-pronged strategy can only bear fruit if success is achieved in establishing buy-in from provincial/territorial governments and other decision makers, as support, financial and other resources are required from these groups in order to successfully carry out a full sector study.

### 1.7.1 Establishing Stakeholder Engagement and Buy-In

**Recommendation 7:**  Ensure that the key stakeholders who have not been represented to date are engaged in the process and included in the activities identified in this workshop.

### 1.7.2 Establishing a Communication/Marketing Plan

**Recommendation 8:**  The Policy and Research Advisory Committee of CCHSE should address the issue of stakeholder engagement in greater detail and the Plan should be circulated to the Workshop participants for feedback.  The Advisory Committee should take on the responsibility of ensuring the plan is executed.

# 2. BACKGROUND PRESENTATIONS

## 2.1 BACKGROUND

Before undertaking a major sector study of health care executives/managers, the Canadian College of Health Services Executives (CCHSE) along with their partners, the Academy of Canadian Executive Nurses (ACEN), the Canadian Society of Physician Executives (CSPE) and Human Resources Skills Development Canada (HRSDC), wished to address the knowledge gaps about the present and future leadership/management cohort in health care and carried out a situational analysis to:

- Identify key data and information requirements
- Collect and review existing information on leadership and management in the health care sector and
- Identify and explore the barriers/opportunities that would affect the feasibility of conducting a full study of the Canadian health leadership/management sector.

Participants in this workshop received this report, a Situational Analysis, and a series of questions prior to attending the workshop. These included:

- A common definition of health service executive/leader
- Critical competencies for leading/managing health care organizations
- Recruitment and retention issues
- Need for, and methodology for a sector study
- Next steps

## 2.2 SETTING THE STAGE

**Major-général Lise Mathieu**, Director General of Health Services for the Ministry of Defence, a CCHSE board member and the chair of the Steering Committee for this project, welcomed participants to the workshop. Four partners had launched this project with the overall aim of determining whether a sector study of health executives/ managers in Canada was needed. The workshop was designed to have broad sector representation from across the country. She said that while clinicians are the foundation of the health system, leadership sets them up for success.

Key Note Speakers presented on various topics related to this project. The following are snap shots of their presentations.

**Dr. John Hylton**, President and CEO of the CCHSE talked about the genesis of the project.  The Canadian Institute of Health Information (CIHI) had completed a report on health personnel, primarily on physicians and nurses with a short chapter on health executives.  Also there have been a number of occupational studies about health personnel but no national ones on health executives.  The availability of information in the CIHI report allows for identification and analysis of policy issues: whether we train enough, import enough health personnel, etc..  In another report the Health Council of Canada said that we need leadership in health human resources, leadership in the training of interdisciplinary teams and in information systems but there was no discussion of leadership of the health system.   A focus on health care leadership is especially critical given the issues we currently face: difficulty attracting executives, aging in our senior ranks, succession planning that needs improvement, and people are not wanting the lifestyle of senior leadership positions.  Five years ago, there was an initial stakeholders meeting and discussion of some of these issues.  Now we are hoping for a signature event starting a process that will lead to significant movement charting our next steps.

**Dr. Don Atkinson**, Chief of Staff for the Lakeridge Health Corporation, and representing CSPE spoke on the role of CSPE.  Established in 1998, CSPE is working to meet the identified need of physician executives for support and exposure to quality physician executive programs.  More and more clinicians are assuming leadership and management positions.  His role is to provide support to this project on behalf of CSPE with the anticipation that this workshop would start discussion on who will be the leaders of the future and what competencies those leaders should have.

**Patricia O'Connor**, Past President of the ACEN talked about the role of ACEN.  The workshop was an important step forward and we have the opportunity to bring some creativity.  Health care is the largest component of the Gross Domestic Product and leadership needs some attention.  Everyone present at the workshop is an architect of our health system.  ACEN's purpose is to bring a national voice and forum for executive nurses.  Among its objectives are to influence and participate in setting policy and directions, and provide support for the development of current and emerging executives.  It has launched the Canadian Journal of Nursing Leadership and a Canadian Consortium for Nursing Research and Innovation.  ACEN has four key priorities:  patient safety, workload, research and leadership development.

**Robin Buckland**, Senior Policy Analyst, Human Resources Strategies Division of Health Canada, spoke on the role of Health Canada.  The Pan Canadian Health Human Resource Strategy came out of the 2003 First Ministers' Health Accord that focused on securing and maintaining an optimal health workforce in Canada and supporting overall renewal of the health care system.   Twenty million dollars has been allocated to three specific areas of interest:

- Pan Canadian Health Human Resource Planning – ensuring that Canadians have access to health human resources by increasing the evidence base and capacity for HHR planning and providing opportunities where jurisdictional, inter-jurisdictional and national projects can come forward.

- Inter-professional education for collaborative patient-centered practice.
- Recruitment and retention – encouraging people to enter the health care field and take an interest in health care careers; increasing the supply of health care providers; improving diversity; improving working environments.

While leadership is implicit in these areas, she said that the workshop might need to make it explicit.

**Eric Perreault**, Principal Analyst for HRSDC gave the definition of a Sector Study.  HRSDC works in partnership with a Sector Council to conduct sector studies, which can include different primary and secondary human resource research studies on various areas.  While there are no limits as to what sector studies can examine, most focus on data gathering and analysis.  However, they also need to ensure that all key players, such as the provinces, are on board and that the partners have consensus and support the study as well as the recommendations generated by it.  Consensus is important in order to create an HR strategy that can be implemented.

**Lorna Romilly**, author of the Situational Analysis Discussion Paper, provided an overview of the key human resource issues in the sector.  The paper reviews existing literature and studies on health executives/managers in Canada and constitutes a foundation piece on which the sector can reach a first consensus on its HR priorities.  It also brings to light what some of the key gaps are in current information on health executives/managers in Canada and feeds into a strategy for further research work such as a Sector Study.

**Kathy Bugeya**, the Facilitator, commented on the structure of the day.

## 2.3  BROAD REPRESENTATION

Ensuring as broad representation of groups as possible was thought to be important for a sector study. The facilitator asked the group who they would expect to participate and who was missing from this stakeholders' discussion.  Participants' suggestions included the following representation:

- Northern and remote communities
- Leadership of the system (one participant said this should be the focus rather than urban or rural)
- Aboriginal organizations from all over Canada (part of the culture is the distance)
- Academic programs
- Boards of directors who have the responsibility and accountability for strong administration
- System-wide leadership – provincial governments; need their buy-in and understanding of their concerns
- A true cross-section – emphasis on the emerging/developing people in the trenches – high potential people who are asking do we want to do this not just senior levels now.

- Need for student representation – looking at succession planning, a balanced life
- Generation X representatives
- Representatives from the IT community, e-health areas
- Canadian Association of Academic Health Councils
- Representatives from the private sector – need to look at other sectors
- Appropriate Quebec representation
- Representatives from care delivery settings, primary care settings.

One participant mentioned that with respect to the question, 'Who needs to be involved?, it is important to distinguish among those who are key informants, stakeholders per se, and members to form a Steering Committee. Another mentioned that schools of health administration were missing from this discussion, acknowledging there was a representative from the UBC MHA program.  Another participant wanted to impress on the group the need to include northern/rural leadership development, retention and recruitment issues, and the area of cultural sensitivity.

## 2.4  PRESENTATIONS ON CORE COMPETENCIES

As a springboard to the discussions two special guests had been invited to address the workshop: Ida Goodreau, President and CEO of Vancouver Coastal Health, who came to health care from the private sector and Gérald R. Savoie, the CEO of Montfort Hospital in Ottawa, who has moved through the ranks of the hospital system to become CEO, spoke (via teleconference).  Each speaker was asked to present on the following question: Are the critical competencies seen as needed in the health care environment the same as those required in the business world? The competencies as outlined by the guest speakers were similar in that they both included strategic, visionary, values-based, excellent in communications, innovative in terms of looking for solutions with those needed in the public sector having more emphasis on being values-based and excellent in communications.  A leader also had to have the ability to execute, manage change, be accountable and develop good relationships, partnerships with accountability for results having more emphasis in the public sector.

One individual was asked to respond to each of the speakers.

### 2.4.1    IDA GOODREAU

Ida Goodreau talked about leadership challenges for the future and said that health care shared the same issues as most other sectors:
- Aging leadership – increasing demand due to demographics
- Environment of significant change
- Limited resources – financial and human
- New technology – introduction and adoption; there may be significant new opportunities from technology – how do we use it; ethical issues

- Increasing public expectations about what the system should deliver beyond the current clinical requirements (e.g., population health perspective)
- Large system perspective – health care organizations continue to be more complex; need skills to mobilize resources and manage large systems.

She described the characteristics of leaders in both the private and public system and said the competencies for each sector were a matter of degree with some being more required in one or the other.

| LEADERSHIP COMPETENCIES | PRIVATE | PUBLIC |
|---|---|---|
| • Strategic | Y | Y |
| • Visionary | Y | Y |
| • Values-based | Y | YY |
| • Excellent in communications (inspirational & motivational) | Y | YY |
| • Innovative – in terms of looking for solutions | Y | Y |

In addition to strong problem-solving skills, health care leaders also need the skills outlined in the next table.  Clearly in the private sector the ability to execute is up-front and drives the organization.  In the public sector accountability and targets are less clear.  Building relationships and partnerships is important in both.

| LEADERSHIP COMPETENCIES | PRIVATE | PUBLIC |
|---|---|---|
| • Ability to execute | YY | YY |
| • Change management | Y | Y |
| • Accountability/results orientation | YY | Y |
| • Relationships/partnerships | Y | Y |

She said the framework underpinning both the public and private sectors is essentially the same.  The role of leaders regardless of where they are is to create a vision and then to translate that vision into reality by mobilizing resources – both human and capital – to create a service, a change, or a product in pursuit of an overarching vision and goal.

Leadership gaps in health care identified by Ms. Goodreau included the following:

- Management skills are a huge and important area; neither current leaders or educational institutions are providing the following elements:
  - Within the context of large systems, need better systems tools and understanding of processes
  - A systems orientation
  - Operational excellence – delivering a service in a way that optimizes resources – best quality at the lowest cost; most efficient at delivering what the consumer wants
  - Performance management – there has been more focus in health care but still a long way to go – but not to adopt the excesses of the private sector
  - Accountability for results – we need to find ways to instill a desire to achieve results
  - Change management – we are going to continue to go through evolution and change.
- Leading/managing a network – health organizations are now part of a network of providers who all have a stake in the health outcomes of the population. Key elements include:
  - Common goals – need to plant common goals to bring people together
  - Partnerships and collaboratives
  - Multiple stakeholders & disciplines
- Diversity – the health care sector is a bit of a monoculture – need to bring in different perspectives.
  - Broader perspectives – the role of physicians is a critical component; have to start training physicians in management skills much earlier in their careers
  - Richer experiences - bringing in people with skills from other areas
  - Multi-skilled
  - Improved understanding of the health care consumer – need to bring in those who would help us understand the health care consumer better.

**Questions from the Participants**

***How did you feel, as a professional administrator, when you came into health care and what experience did you have? What do you feel about performance agreements and accountability?***

What was helpful was that health care was going through significant change with the creation of health authorities and government financial restraints so that created an environment where someone with a different background was welcomed. The mix of industry insiders and outsiders helped to create an environment and diversity where different perspectives were welcome. Vancouver Coastal had a good team of physicians and administrators who accepted differences and I was able to bring in a couple of people from the private sector, as well as the head of the nurses' union into senior positions.

Fundamental for health care are performance agreements. If we don't find ways to be accountable for results we will continue to lose credibility with the public. We need to be much more transparent and open with the public with respect to targets, etc. so they see progress being made. A performance agreement allows government to target things the health authority has to deliver and to give the heath authority more autonomy and creativity within defined boundaries.

***Comment on systems thinking - the focus on systems thinking and leadership of large systems is important – most of the administrators in Ontario are silo thinkers – it's hard to be a systems leader in this way?***

If you take a 'human being' approach to care, it forces you to think in a seamless, systems approach.

***Comment on values based leadership – as networks get larger we are getting out of touch with front-line leadership.  We need to get in touch with front-line workers – not to lose sight of the fact that we are a human touch environment – a huge issue in health care.***

We assume that our workforce will be there with us.  I have never worked anywhere where there is so little thought put into the welfare of the front-line workers.  We don't pay attention to them and we have the poorest safety record of any organization.  We need to make workers feel valued in our industry.

***Do strong values work against building networks, bringing in other skill sets?***

The challenge in health care is to be very clear about values that bring us together – focus on health outcomes; treat people equally; care available to all – these are not optional.  Then there are different perspectives that can be helpful and can make us more responsive but we need to draw a line in the sand for some values.

### 2.4.2    RESPONSE TO IDA GOODREAU

Harry Parslow was asked to comment later in the day on Ida Goodreau's presentation, and the following is a synthesis of his response.  He provided some background saying that there has been significant change in BC with the provincial government adopting a business philosophy across the board.  The government recruited business people for board members and the boards represent the same kind of members you would see on a business board.  Business principles are far more evident than ever before.  He indicated that, what Ida didn't mention was the significantly different requirements for political skills in public areas.  There is a need for transparency – you say what you are going to do and you do it.

He said that he had seen successive rounds in service delivery change – accountability to government has been substituted for accountability to the community.  There is almost a complete absence of evidence that these large systems work.  We have beliefs, preferences – yet we continue on this path.

### 2.4.3    GÉRALD SAVOIE

Gérald spoke about critical competencies, leadership issues and gaps.  Key business skills identified by Mr. Savoie were:

- Transformational leadership
- Issue of accountability
  - o    Need to develop business acumen such as financial analysis, working capital management
  - o    Analytical capability
- Understanding of legal issues/contracts is sometimes lacking
- Excellent grounding in ethics – serious – very important ethical issues
- Dealing with organizational development
  - o    Whole issue of organizational behaviour and human inter-relationships; interpersonal relationships – active listening
- Change management – dealing with constant change – people used to have time to think about change but it is happening at such a pace today.  You need a chance to accomplish a change and get used to it and then move on; can get exhausted now from changes happening in the middle of other changes.  At some point you need to complete a cycle.
- Professional development
- Common sense
- Marketing – we are marketing ideas, change, values – these are critical skill sets
- Partnerships – developing partnerships; changing culture of an organization
- Emotional intelligence

Younger people come with a different perspective.  They are not going to work like his generation or that of his parents.

While the above skills are endemic to a number of industries, health care is unique for the following reasons:

- The 24/7 operation, 365 days a year is a challenge
- Greater risk in dealing with patients – risk associated with everything we do
- How you achieve best practices is really based on the relationship you can have with key groups such as physicians who are not employees.  Leadership in this situation requires the ability to persuade, to present, the ability to develop compelling positions based on evidence; emotional intelligence.  It is the age of evidence-based practice.  The system depends on it – relates to ethics and skill sets.

Mr. Savoie then spoke of transformational leadership drawing from his experience with Montfort Hospital during a time of tremendous turmoil.  His organization went through a court case in the Court of Appeal in Ontario in December 2001 to fight their closure.  They received constitutional protection, the only hospital in Canada, to not be closed.  At the time they had achieved 95% efficiency, the highest efficiency level in the

province.  But they also had 95% employee turnover yet still managed to maintain quality of care.  After the win the staff collapsed – the organization went through the same trauma and same high levels of stress as people do with long-term change.  The organization can heal but it is a 4 to 6 month venture.  You need a leadership style that delivers; that makes decisions rapidly.

**Questions from the Participants**
**Comment on cycles of change.  Can we be running too fast and how dangerous is that to us?  What other ideas allow healing?  The younger generation is not willing to put up with current environments.  The highest degree of concern by staff is that managers are burning out.**

Our organization got into the whole issue of the quality of work life.  We did a survey of all staff which took them 1 ½ hours each to complete – went into the bleakest moment in their history; ended up with 300 things that were wrong.  We decided on a new way of doing business; assigned 17 staff and 3 managers to have full control as to what to do.  This group could tell management what to do.  75% of the staff agreed with what they were going to do.  For the 25% who didn't we made individual deals.  We have had sessions on interpersonal relationships, balance of work life.  We haven't had any complaints in 1-½ years and have a very high rate of retention.

### 2.4.4      RESPONSE TO GÉRALD SAVOIE

Dr. Mary Ellen Jeans responded to Gérald Savoie's presentation later.   She reiterated the important competencies he had stated:  She disagreed with accepting that physicians are the only drivers of the system saying that people are working together in collaborative teams and have to find a way to do that with physicians.   There is a lot of shared leadership at the senior levels.   She didn't hear enough emphasis on the patient as a focus and the patient's family.  And that we need to make sure that this interaction is all about quality.

She commented on Montfort's battle that government doesn't see the link between administration and patient care and that link should be mentioned more often, and that this kind of situation heightens the importance of a broad range of competencies.  We also learned that challenging the process is important, although keeping the hospital open is not always the best thing.  The really big leadership challenge is to try to move people when there is no fear.  There is a need for transparency and valuing employees – a compassion for them and their position.  Don Atkinson added that your insight into your own competencies is important.  If you recognize you are not as strong in some areas you can add the skills you need.

# 3. REPORTS FROM SMALL DISCUSSION GROUPS

The rest of the workshop was devoted to small and large group discussions by the participants on a series of questions that had arisen from the Situation Analysis. Small groups worked independently to develop a common definition of leadership/management, identified core competencies, recruitment and retention issues, a methodology for a sector study and made recommendations for 'next steps'. Following the reporting back from each of the small discussion group sessions to a larger plenary session a consensus resulted in recommendations. (A full reporting of the discussion in each breakout session can be found in Appendix A)

## 3.1 A COMMON DEFINITION OF LEADERSHIP/ MANAGEMENT

Participants were asked to discuss the following question in three small groups:

*To arrive at a common definition that not only reflects different structures within our health care system but also provincial/territorial and national interests, are there key segments of the health service executives/leaders group on which we should focus initially and ultimately study?*

From the discussions a common definition was constructed.

**Recommendation 1:** To consider the following as the industry's common definition for a health care leader:

*A health care leader is… an individual who creates vision and goals, and mobilizes and manages resources to produce a service, change or product consistent with the vision and goals.*

## 3.2 COMPETENCIES OF A HEALTH EXECUTIVE/LEADER

A consensus was reached regarding competencies for health care leaders. Competencies were grouped into three distinct categories: business acumen, personal attributes, and those that crossed over both business acumen and personal attributes. It was felt this way of describing competencies helped to fully express the breadth of the learned and innate skills, knowledge, ability and aptitude required for these positions.

**Recommendation 2:** The following competencies be considered as standards when addressing Human Resource leadership issues pertaining to training, certification, recruitment, retention and evaluation, as follows:

| | |
|---|---|
| **_Business Acumen_**<br><br>• Executes, delivers on the mission<br>• Obtains, mobilizes, aligns resources<br>• Accountability<br>• Evidence-based decision-making<br>• Legal<br>• Results Oriented<br>  o manages organizational performance<br>• Risk Management<br>• Focus on the product or service; in health care – focus on the patient/customer and patient services – critical piece | |
| **_Personal Attributes_**<br><br>• Political acumen<br>• Visionary<br>  o longer term focus<br>  o accepts mistakes; helps others<br>• Values-based<br>• Ethics<br>• Communicator<br>  o represents and advocates<br>  o leads multi-disciplinary groups/ teams<br>  o mentor, teacher, supporter<br>• Active Listener<br>• Relationships/Partnerships Network<br>• Common sense<br>• Emotional intelligence<br>• Problem-solving | **_Crossover_** (both business acumen and personal attributes)<br><br>• Innovation<br>• Strategic change management<br>• Organizational development<br>• Systems thinking, perspective<br>• Life long learning |

Some suggested that knowledge of the health system also be considered for inclusion in this framework.

### 3.2.1  Future Competencies/Attributes

The participants also thought the following were important for the future as the system evolves:

- There will be a need to elevate recognition for younger workers, to be cognizant of the needs of different generations re: what they value in the workplace, recognize people leading from within the organization.

- There will be a greater demand for systems intelligence, systems orientation, and cognitive complexity.

- Recognition that whole sections of the organization are going to be needed in knowledge translation

- The role of the leader in influencing recognition and action on the determinants of care will be more important

Some questions asked:  Do we need a central registry to track people who meet these criteria? Should we formally certify/regulate them?   There was also discussion around the need to be involved in a process of validating the competencies and a need to look at gaps.  We also need to

develop operational definitions around the competencies.  Some suggested that we may need some sampling – front line managers have some of these competencies.  This could be part of a sector study.


## 3.3   RECRUITMENT AND RETENTION OF HEALTH CARE LEADERS

Three discussion groups explored different facets of recruitment and retention:  increasing the attractiveness of the environment (workplace), experience with succession planning and shortages/broadening the pool.


### 3.3.1     INCREASING THE ATTRACTIVENESS OF THE WORK ENVIRONMENT

The group assigned the issue of what could be done to increase the attractiveness of the environment for health care executives/managers made the following recommendations:

**Recommendation 3:**  Increase the attractiveness of the work environment by:
- Becoming a learning organization.
    Some examples:
    - Encourage mentorship (internal)
    - Provide continuing education programs/support for clinical and non-clinical staff
    - Use technology and the electronic highway; partnerships with the university/private industry
    - Use performance reviews to assess competencies for staff at various levels that incorporate their goals – linked to learning support
    - Physicians have some unique hurdles  - need to determine effective early pathways
- Creating flexibility in the work environment (e.g., job sharing, flex hours)
- Appropriately recognizing and celebrating the leaders' accomplishments
- Providing personal coaches (the top can be a lonely place)
- Being inclusive and transparent in regards to decision making
- Creating a safe place to work (e.g., mistakes are seen as a learning opportunity).


### 3.3.2     EXPERIENCE WITH SUCCESSION PLANNING

Another group explored our experience with succession planning.  Experience with succession planning is limited due to many factors such as:
- It is getting lost in amongst more time sensitive priorities.
- It isn't always embedded in the mission/vision/values
- Time workload issues

- Fear of the competition / mentoring your replacement, so therefore don't do it
- Creating barriers
- Not always an expectation
- Perceptions don't allow for cross-disciplinary mentoring

**Recommendation 4:**  Create a positive climate for growth opportunities by:
- Identifying suitable internal candidates and developing them through mentoring/coaching and developing programs and opportunities (both formal and informal) for them.
- Supporting mentors using the work of a number of existing organizations:  CHSRF – EXTRA  program, CCHSE, the Dorothy Wylie Institute and Capital Health in Edmonton.

### 3.3.3    SHORTAGES/BROADENING THE POOL

A third group explored shortages of health care leaders and how to broaden the pool.  Our experience tells us there is a shortage of health executives/leaders within our organizations, although there  few studies on the subject have been conducted.  There appears to be a shallow pool of qualified/ available candidates to meet a raised 'bar of expectations' in part due to the creation of large and complex health care service entities.  With competing demands there is less opportunity for identification and mentoring of potential talent.

Capturing a single picture of the number of health care leaders at a given point in time is complex and we can't really know if we have the right number with the right skills.  The College has a role to play in helping us ensure that we are getting the best in the industry, for example, developing tools or instruments for self-assessment, and working with other agencies such as the Canadian Council of Health Service Accreditation.

There are other industries that demand the same core competencies as health care:  social services, education, municipalities, human resources, IT, marketing, communications and the military.  What may be different is the ethical optimization of resources, the patient focus and the fact that it is a demand/then supply operation.

**Recommendation 5:**  The CCHSE should play a key role in developing tools and instruments, a self-assessment program and working with other agencies such as the Canadian Council of Health Service Accreditation to assist leaders and managers with the process of succession planning.

## 3.4 THE NEED FOR, AND METHODOLOGY OF, A SECTOR STUDY

The last discussion sessions were around exploring the methodology of a sector study.  Groups were asked some questions to discuss.

- Given what we have discussed during the past two days do we need a sector study?
- Are we ready for a sector study?
- What components need to be in place before we can begin a sector study?
- How would we go about getting these pieces in place?
- Are all the key players on board?  If not, please identify.
- What other steps could we take to ensure the players who are not represented here are engaged in the process once these proceedings are available.

### 3.4.1     IS THERE A NEED FOR A SECTOR STUDY?

The consensus among all three-discussion groups was 'yes'.  The workshop deliberations have highlighted serious issues that need to be addressed through greater knowledge and research that ultimately will lead to recommendations for change, including funding alternatives and "getting this issue on the radar screen" in an effective manner.  This needs to be part of national, provincial and territorial agendas.

### 3.4.2     ARE WE READY FOR A SECTOR STUDY?

There was significant support and willingness to move forward as it was felt that the timing is right, and that something needs to happen now.  Albeit, there is some preliminary work that needs to be done before we proceed with a full study particularly in terms of collecting data and information on the sector.

### 3.4.3     COMPONENTS THAT NEED TO BE IN PLACE

A consensus was reached regarding what needed to be in place to conduct a full sector study.

**Recommendation 6***:* There is a need for a full sector study and we should prepare to move forward on this initiative by ensuring we have, prior to conducting a full study: a business case, buy-in of/ support from key stakeholders, appropriate briefing materials, and understanding of lessons learned from other sector studies.  It was recommended also that we:

- Build broad consensus on a common definition (we are partly there).
- Identify the current number of leaders/manager in Canada (data/stats).
- Ensure there is political will and support
  o From individuals who will ultimately implement the study and
  o Buy-in of federal, provincial, and territorial  government decision makers.
- Identify and secure resources (dollars) to continue our planning process.

- Identify a governance process and structure including a steering committee, and management and advisory groups as required.
- Ensure there are compelling arguments - a 'burning platform' – health executives should be studied as an essential part of the health system affecting patient care delivery.
- Write a clearly defined business plan which defines who we are, the issues, what a leader is, what we need (i.e., recruitment and retention), and the benefits from strong leadership.

### 3.4.4    GETTING THESE PIECES IN PLACE

David Moore from HRSDC said the sector study may be funded by government but it is the stakeholder groups along with the guidance of HRSDC and the ACHDHR HHR planning committee who determine the content of the study.  There may be some financial support available for planning and developing action steps.

To get the pieces in place and follow the strategies outlined in the workshop requires champions throughout the system to lead in the networking process and to talk to key stakeholders (political informants and decision makers).  This multi-pronged strategy can only bear fruit if success is achieved in establishing buy-in from provincial/territorial governments and other decision makers, as support, financial and other resources are required from these groups to successfully carry out a full sector study.

### 3.4.5    ESTABLISHING STAKEHOLDER ENGAGEMENT AND BUY-IN

We can take the following steps to ensure those who have not been represented are engaged in the process:

- Ensure feedback to those who were invited but could not attend
- Determine how to share proceedings with relevant others
- Broader distribution beyond attendees and non-attendees – interested parties
- Get written feedback
- Marketing
- Networking - In-person conversations
- Finding the win/win critical factors

**Recommendation 7:**  Ensure that the key stakeholders who have not been represented to date are engaged in the process and included in the activities identified in this workshop.

### 3.4.6    ESTABLISHING A COMMUNICATION/MARKETING PLAN

Stakeholder engagement was identified as a critical issue as was communication with stakeholders throughout such a project.

**Recommendation 8:** The Policy and Research Advisory Committee of CCHSE should address the issue of stakeholder engagement in greater detail and the Plan should be circulated to the Workshop participants for feedback.  The Advisory Committee should take on the responsibility of ensuring the plan is executed.


## 4.  IDENTIFYING NEXT STEPS

A number of strategies were identified by the participants for continuing with this work:


1.     Develop a Business Case
- Show need – we need a sector study to provide evidence to allow informed decisions about what to do; people can then make changes.
- Provide information/definitions
    o   Need to show that health care leaders are needed to make the huge transformations required in the health system; that they can help shape the vision; they manage and mobilize health care resources; we need to link the relationship of leadership and the delivery system; link the management role to what happens at the front line.
    o   Health care leaders are responsible for managing huge numbers of people.
    o   They have accountability for billions of dollars
- Identify who we will count and the numbers of people we are talking about.
- Clarify the key questions – number of people, scope, span of control?
- Describe what outputs – recommendations expected?


2.     Identify key stakeholders who need to/should be involved (e.g. mandated to deliver services, funding entities).
- Get support/buy-in from governments:
    ▪   Conference of Deputy Ministers to determine their criteria for leadership, their issues, what they think is needed
    ▪   Health Ministries – connect with Deputy Ministers/Assistant Deputy Ministers around further defining requirements.
- HRSDC – Advisory Committee – meet with them
- Identify champions to approach influential people we know
- Include the Conference Board of Canada and other parties who could not be here
- Connect with universities as potential key stakeholders.


3.     Identify and secure resources (dollars) to continue our planning process.

4.   Approach stakeholders with a briefing document which highlights (from the Situational Analysis and the workshop) the following:

- Include compelling arguments – 'burning platform' – that health executives should be studied as an essential part of the health system affecting patient care delivery.
- Here are some of the issues we think are important and need to be addressed.
- What the benefits would be to them and what difference we think this will make.
- Like a classic government briefing note – strategy, options, next steps, results.
- Ask them:  What do they think?  What else can they add?

5.   Develop a mini team to analyze other successful sector studies – nursing, physicians, and home support.

6.   Determine methodology and possible research topics.

- Need to make clear what a sector study would lead to
- What the return on investment would be.

## 5.   CLOSING REMARKS

Dr. John Hylton provided the closing remarks indicating that we now have a direction with which to move forward.  HRSDC has funded a Task Force to look at going further towards a road map and governance structure, and may be developing some recommendations.  He said, "We're at the beginning of the beginning" and thanked everyone for his or her participation.

# APPENDIX A: SMALL GROUP DISCUSSIONS

The following materials are recreated as they were presented by the groups and from their flip charts.

## 1.    A Common Definition and Competencies

### 1.1      GROUP 1

Who are the people making the big decisions in the health care system?  What questions do we want to be able to answer at the end of the day.

Outcome:
- How many leaders are needed?
- Competency/quality of leaders?
- Demographics?
- Capacity to train?
- Help/hindrance to the process?

*Functional Definition*
- Vision – creates, develops, implements
- Values
- Goals
- Time frames – management effectiveness
- Resource allocation – attaining and mobilizing vs. allocating
- Representation and advocacy – political sensitivity
- Managing performance

Not driven by a professional organization.

Give context around this piece

Should leadership be regulated?

To find out who the managers are ask the Executive Assistant who is on the distribution list for the executive group or who the CEO communicates with.

Who is involved:  team leaders who further the vision; those charged with the responsibility

Find out who is willing to move or relocate.

System perspective – large organization – more levels

What is a national/provincial resource?

## 1.2    GROUP 2

What are we going to do at the end?

Let's define the end product – want to be able to recognize what the leadership characteristics are

Target – those folks currently working in the health care organizations but need to look at every organization related to the health care system; maybe in organizations responsible for the health of the population.

Sustainable leadership – focusing on needs as a whole.

### *Broad Definition*

Individual who:

- Brings vision
- Succeeds at achieving something the organization didn't think it could; or responsible for working towards this
- Manages other people – has people reporting to him/her
- Is responsible for resources
- Has the authority to make decisions
- Has a position of influence and authority
- Leads a health services team, multidisciplinary, professional

Factors in determining if they are a leader – scope of job, size of budget, span of control, relationships, and knowledge.

### *Summary definition:*

A leader:

- Inspires a shared vision and the determination to carry it out
- Creates opportunities for ways to achieve the vision
- Is responsible for and mobilizes resources
- Builds relationships – gets buy-in for the vision
- Leads multi-disciplinary groups
- Has the authority to make decisions

### *Competencies*

- Change management
- Visionary leadership

- Chief communication office – keeping relationships going
- Lifelong learners – commitment to helping people grow
- Evidence-based – knowledge management – learning and feedback
- Delegation
- Effective at recognition and empowerment
- Accepts mistakes and risk taking
- Common sense
- Systems thinking
- Role as a servant leader
- Innovation
- Understanding the political dimensions – emotional intelligence
- Understanding of accountability and that we are spending taxpayers dollars
- Commitment to quality

You should have the same competencies regardless of where a manager works in the system.

Can all these be taught?
- Should have interdisciplinary training and understanding
- Should expose leaders to broadest range of competencies and then support with mentoring and teaching

For the future:
- Elevate recognition for younger people
- People will demand to work at their full scope of practice
- Recognize people leading from within the organization
- Greater demand for system intelligence
- Whole sections of the organization are going to be needed in knowledge translation – how different technologies influence care
- Cognitive complexity
- More important role influencing the determinants of health – gets back to knowledge translation – technologies, information management change the major determinants of health

### 1.3    Group 3

Definition of leaders in health care or leadership:

- Creates a vision an d goal

- Mobilizes and manages resources to produce a service, change or product consistent with the vision and goal
- Creates a vision and aligns people with it
- Inspires people and mobilizes them to translate the vision into reality

## 2.    Recruitment & Retention

### 2.1    GROUP 1

This group discussed the question:

***Is there a shortage of health executives/managers or leaders within our organizations and/or in terms of the number of interested/qualified individuals available externally?***

The following comments were made:
- Don't know the answer to the first part because we don't know the second part.
- Experiencing a shortage
  o Even the plum jobs don't generate the numerical quality as they have in the past on any search
- Jobs have changed – large systems unknown territory
- Anxiety provoking situations – boards, government involvement, deficits
- Leaders haven't paid enough attention to positive aspects of their work
- Used to be able to move people around to develop them – now people in positions with narrow scope and they don't get external experience
- Not a lot of willing candidates
- It's a shallower pool – takes longer to fill positions
- Identify the pool and then attract – now more about attraction
- The bar of what's expected is higher
- Quite often specific skills required
- Two parts – technical skills (bar up) and motivation and fit (people not risking)

Is there a shortage?  Evidence points to a shortage of people with the skill sets and risk friendliness to do the job.

Re: numbers
- Maybe can get from Directories or other studies
- When you are looking at numbers – how do you define specifics around the pool
- It's a supply and demand question
- Maybe it's not an important question – the question is can we recruit the right people

- o But much higher intensity to finding the right person
- How often do we settle for mediocrity
- The prize positions now are research positions
- Have to create opportunities
- Organizations failing to get executives calling search firms – pool tightened throughout organizations
- As quickly as we get the numbers they will change – need to be constantly updated
- Haven't spent enough time coaching/mentoring, finding career opportunities

Other issues:
- See a shortage of people moving up in health care – but with other organizations maybe not
- Can look to other industries – same skills – social services field, education, municipalities, and specialized areas such as HR, IT, innovation, marketing, consulting, communications, and military.  Also need internal candidates exposure to these.
    - o What are the unique characteristics of health care; there are other industries that may be the same – sacredness of patient/provider relationship, emotional/physical intimacy may be different.
    - o In other industries can balance effectiveness vs. price – health care can't balance this
    - o Health care is demand and supply – a critical skill is the ethical optimization of resources
- Need to examine what the Executive Team looks like in big systems
- The College has a huge role in ensuring we get the best
    - o Rural/urban issues
    - o Self-assessment program such as the one at ACHE is a powerful tool
    - o Accreditation piece

## 2.2     GROUP 2

This group discussed succession planning, specifically:
***What has been our experience of succession planning? Is there a cohort of people who are being exposed to different management/leadership levels and moving across operational functions and facilities?  What about the use of mentoring, coaching?  What about professional development?***

- Gets lost in the more time sensitive priorities
- No time to look at potential
- Heavy workload/cross sharing

- Should always be in the forefront of thinking
- Union issues at the front-line level
- We create our own barriers; fear of loss of job/position
- Need to seize opportunities
- Needs to be embedded in the vision/mission/values and make it transparent part of the culture and strategic direction
- Formalize coaching and mentoring
- Include in performance expectations
- Perception doesn't allow for cross-discipline mentoring

How can we identify people?
- Through behaviour and attributes
- Casting net wide to include "diamonds in the rough"
- Mentoring/coaching needs to be developed
- Need to develop programs/opportunities both informal and formal
- Creating a positive climate for growth and opportunities

Current programs:
- EXTRA
- CCHSE Fellowship program
- CCHSE Chapters
- Dorothy Wylie Institute
- Capital Health initiatives

## 2.3 GROUP 3

This group dealt with the question:
***What could we do to increase the attractiveness of the environment for health care executives/ managers?***

To increase the attractiveness of the environment for leaders – environment – what will it look like current – future – both?

- Change span of control – unrealistic – stretched; unanticipated consequences – difference between steps is huge
- Where are the leaders to come from when we only give people a choice to touch a small part of the "elephant"?
- How do we give this/create this opportunity?

- o Money – health care dollars vs. private
- Compensation for what people are doing
- Image
    - o Is it what it needs to be to attract people
    - o What do we not do
    - o Restructuring has had an impact
    - o Perception of incompetence; leadership vilified
    - o Workloads increased
    - o Unstable environments increased
    - o We don't complete change cycles; leaders don't get a sense of satisfaction as change doesn't allow products
    - o Vision of the organization not clear any more as we don't know where we are going
- Politics – impact doesn't allow benefit of bringing forward skills/knowledge/competencies
    - o Don't know who is directing your work – government or the organization


What we could do?
- Become learning organizations
    - o Mentorship
    - o Upgrade programs
        - ▪ Continuing education
        - ▪ Professional and non-professional; clinical and non-professional
    - o Assessment to determine competencies, to determine growth path
    - o Mistakes a learning opportunity – high risk life
    - o Empowerment to make a difference – learn how to impact
- Flexibility around terms of engagement
    - o Part-time and full time; flux hours; bank salary and take sabbatical
- Recognition and celebration
    - o Concierge services
    - o Help employees meet all needs
- Personal Coach
    - o CASO – mentorship program – develop workplan; dollars to support
- Inclusiveness and transparency
    - o Where is the voice of the front line?
    - o Concept – Town Hall focus group; Star Team – what to use; need to do to help move up
- Create safe place – nurturing

- o Give a sense of security
- Professional Associations
  - o Reach out to serve communities
    - Teleconferencing
    - On-line courses
    - Electronic highways
    - Partner with large firms to lend feasibility
  - o Forums – put students on agenda and ask questions; get students together to get input
  - o Research – is leadership on the agenda? – for nursing –yes
  - o Focus on leaders
- Give priority for leaders to be effectively in touch with staff – outcome: staff more supportive of leaders; leaders should make the time for employees
- Compensation – part of the quality of work life
- Farm teams – line level, managers, supervisors
- Improve the quality of work life for leaders
- Support for physician leaders – huge step; often no supervisor experience; must maintain clinical competencies to practice.

## 3. Need and Methodology for Sector Study

The groups addressed questions related to the need for, and methodology of, a sector study:
- Do we need a sector study and are we ready for one?
- What components need to be in place before we can begin and how could we go about getting these pieces in place?
- Notwithstanding identified differences/barriers, are there some tangible steps we can take as part of a pan-Canadian study?
- How can we link a new pan Canadian study with current/previous studies?
- How can we take advantage of existing and other opportunities related to human resource planning and research?
- What are the next steps and what do we need to do to get partnership (stakeholders, provincial/territorial governments) to buy-in?

### 3.1 GROUP 1

Do we need a sector study?     Yes
Are we ready?
- Recognition across the country that something needs to happen
- Timing is right

- Are we ready to really frame the issues – need some work
- Need to get people on board
- Everyone involved in implementation needs to be on board – need buy-in from key influencers – provinces, health authorities, educators, private sector affiliates, thought leaders, provincial and national professional associations, CCHSE, ACEN, CSPE, CAN
- Maybe need to categorize list – stakeholders, advisors, etc. – depends on whether they have a role in implementation – provinces/territories/ federal government
- Has to be seen by this group that it is important and needs attention –burning platform
- Ready to build a burning platform – if we don't invest now the system will fall apart in 10 years
- Need to look at how it pays dividends in the short term – political agenda – how do you capture their attention – finding out what's in it for them
    - Huge structure changes – know how difficult it is to recruit; need success around their initiatives
    - Need to sell what are the competencies that make for high performers; need to be careful about the approach – don't want to suggest that we have incompetent people
    - Need to go out to them with a sales pitch that includes bringing them to the point that people are here.
    - Need to approach government informants – those to whom government people talk to get their information – we should be able to identify them quickly

Methodology for a sector study:
Feasible?
- Have some sources of data related to other organizations
- May be could use a sampling frame and use our definition and core competencies
- Look at working conditions, recruiting, etc. – then could make some statement about what we might need.
- Demand and supply of leaders – what are all the programs that would lead to more managers with the right skill sets
- Could do an initial survey of how serious a problem it is – importance and dollars spent – then take those and drill down to focus on them
- In terms of fleshing out – a business case
- What is the end?  Outcomes?
    - Stocktaking exercise
    - How do you develop the research questions?

- o How many do we have?
- o How many do we need?
- o What is the profile?
- o Gaps – training, etc
- o Informs the policy phase
- Pre-research phase – more exploratory; frame the questions
- Who has the most influential people in health care?
  - o What would convince them to buy in?
  - o What are the gaps?
- Every jurisdiction can't do this on their own – but they want data on a province by province basis

Possible strategies:
- Use what we have – Bernie Blais is in the Deputy Ministers Council; incoming Deputy in Ontario will be chair; BC was chair.
- Health Council of Canada – get on June agenda
- Go to Advisory Committee – Health Canada is the Secretariat
- Aboriginal funding – HHR
- Exploratory phase; research phase – maybe more than one; policy and implementation phase
- Maybe could go to a few ADMs/DMs with an Executive Summary – ask them what is missing?  What would sell it to you?  Could be conceptualized as part of the exploratory phase.
- Steering Committee – permanent group
  - o Deputy Ministers
  - o Others
  - o Representatives from other groups
  - o Can be 30 people
  - o Can form task groups for pieces
- Need an end date
- Innovation economy and leaders of economic engine
  - o Expanded to government levels too
  - o Need a few champions at the DM levels – new DM in Manitoba was the CEO of Association – need to get all jurisdictions
- Further exploratory phase
  - o To work on these issues
  - o Then could do a road show to the provinces

> o Academic educators – MHA programs – as part of it – key stakeholders and
>   endorsers.

## 3.2    GROUP 2

Do we need a sector study?
- Is leadership on the political agenda?  No
- Need to get resources from government sources or no go
- Fast track – a sector study may take 3 to 5 years.  Is there a fast track?
- Learn lessons from other sector studies

Possible funders:
- HRSDC
- CHSRF
- Apply for research study dollars
- Cycles – health service delivery series
- Run forums to set ideas distilled
- Very competitive dollars

Next steps and what we need to do to get partnership:
- Need data and evidence to move forward – issues are not going away
  - Need terms of reference for each component
    - Common definition – leader
    - Data and statistics
    - Political will and support
- Create structures to meet
  - ID partners – support application –funding resources
  - Stakeholders – who
  - Governance process
  - What process to get pieces in place, and who to engage – events to attend to
    network.

What are some of the tangible steps we can take?
- What has been done in other countries?  Complete the picture?
- Leadership on the agenda – provinces reports include leadership
  - What are provinces expected to report – terms of reference – providers

Sector Study

- Number of recommendations – key portion – crisis in leadership; better manage resources
    - Implement and act on them
    - Problems – sustainability of rural/remote
- Package of information
    - Defining the sector
    - Data and information – what's in place to sustain
    - Recommendations
- Do in cooperation with a group that has the ability to compile a proposal and work with the data and communicate the results – CIHR/CHSRF

## 3.3    GROUP 3

Do we need a sector study?     Yes
- We need something and sector stakeholders need to own it

Are we ready?  Not quite yet
Components needed – what's needed first?
How do we go about getting the pieces in place?
Are the key players on board?
What steps to engage missing stakeholders?
- Compelling argument that health executives should be studied – necessary part of the overall system – link into 2003 and 10 year HHR plan
- Clearly defined business plan that articulates what the sector intends to do to address the issues.
- Clear definition of 'leader'
- Make the case, secure the buy-in of provinces and territories
    - Breakdown of research by province and territories
- Sector study – define who you are and what are the issues
- Really identify what information we need re: retention and recruitment – implies additional due diligence to gain clarity – e.g. testing 'successful' attributes
- Can do a sector study that begins with testing and validation of a leadership model that clearly defines attributes of excellence and leadership
    - This provides conceptual definition of leader with which we identify candidates who have these attributes/capacity
- Need to go to a smaller group that is representative enough and charged with moving forward beyond
- Federal and provincial representatives – provincial Ministries

- Categories of CCHSE workshop
- Broader distribution of proceedings beyond attendees and non-attendees
- Conference call with those who were invited but couldn't attend to discuss and get their input.

Strategy – Business Case
- Get buy-in
  - Partners – Deputy Council, HSRDC – get health care on the agenda, political – provincial territorial; D. Phillipon – champion – Executive forum – new Deputy; Health Council of Canada – Michael Dector

Methodology
- Determine support

# APPENDIX B: PARTICIPANTS

*Chair of the Session*

Major-général Lise Matthieu, CHE, Director-général of the Health Service, Ministry of National Defense, Ottawa, Chair of the Steering Committee, member of the CCHSE Board

*Presenters*

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# APPENDIX C : SECTOR STUDY VS. SITUATIONAL ANALYSIS - A PRIMER

**Sector Studies** (Source:  Human Resources and Skills Development Canada)

Sector studies are comprehensive, forward looking, cooperative data (primary and secondary) development, gathering and analysis exercises which:

- develop knowledge and make recommendations about how to resolve priority current and future labour market and human resource demand and supply issues for a particular industrial sector;  and
- reveal data gaps that remain and suggest how to fill them in future.

Meant to contribute significantly to a well-functioning (sector of the) labour market, a sector study provides the evidence to inform the development of an HR strategy to ensure that the supply of workers in the sector will meet demand.

Sub-objectives of sector studies are:

- to define, understand and anticipate skill requirements and other human resource development and management issues;
- to produce findings that are based on multiple lines of evidence;
- to validate findings with all key stakeholders;
- to develop strategic recommendations;
- to obtain buy-in from key stakeholders to develop an HR strategy including actions to take to implement the strategy.

Sector studies examine both current and *future* human resources development and management needs, issues and challenges facing a particular industry or occupation.  These analyses typically examine all aspects of the Health Human Resources Conceptual model[1].  For example, they examine demand for the services provided by the sector, supply of skilled labour, the impact of financial resources, and impacts on outcomes.  Also examined are: the impact of changing technology, the need for skills upgrading and the adequacy of existing training.

More specifically, a sector study develops/collects information on:

- Variables affecting demand for the service performed by the occupations in the sector.  In the health field variables affecting demand for services includes such things as:

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[1] O'Brien-Pallas, Tomblin-Murphy, Birch, Baumann, 2001 (adapted from O'Brien-Pallas & Baumann, 1977)

- epidemiology, demographics, legislation, regulation, practices, protocols, cures, lifestyle changes, environmental causes, preventative medicine, accessibility, expectations, health care insurance plan coverage, etc
- Variables affecting supply (stock and flow) of workers;
- Workforce profile – structure of the industry, geography (of facilities, health care providers) numbers of people working in the occupation(s), hours, worker characteristics and employee/employer/client relations;
- Political and policy influences on the sector;
- Current and emerging scopes of practice;
- Models of delivery of service;
- Image of the sector, worker recruitment and retention;
- Training, professional development, and skills gaps (current and emerging);
- Career progression and mobility (factors affecting retention);
- Working conditions, quality of life, and worker health and satisfaction;
- Technological innovation and trends, and their impacts on HR;
- Immigration and emigration;
- Compensation and remuneration practices and trends;
- Human resource practices – utilization, productivity, management, development, planning.

Methods used to gather the information include: doing literature reviews (if not already done in a situational analysis); conducting surveys; analyzing public, survey or administrative data; doing focus groups and key informant interviews, etc.

Sector studies involve: the gathering of multiple lines of evidence; in-depth analysis; a cooperative approach; identification of feasible solutions and future directions for the development and implementation of a human resources strategy for an industry or occupation. Ideally, a sector study should lead to action and not merely sit on a shelf.  Therefore it should involve (possibly in a following phase) the development of a detailed action plan to implement the priority recommendations that came from the analysis.  The strategy should include the activities that will be undertaken to implement the recommendations, by whom, how, by when, expected outcomes (what the activities are expected to influence), etc.

Studies are directed by a steering committee made up of key stakeholders who may be implicated in the eventual recommendations including the employers, workers, unions, education, governments, and others. Responsibilities of a steering committee are:
- Consult and communicate
- Approve terms of reference for the analysis
- Provide guidance to the project manager and any contractors
- Participate in sub-committees

- Recruit independent consultants
- Help set up the research
- Provide input at meetings
- Review and approve consultant/researcher reports or other deliverables
- Represent constituents in the organizations they represent
- Help to reach consensus
- Help to facilitate access to data
- Communicate about the study findings
- Determine and promote follow-up activities

<u>Benefits of a Sector Study</u>

Steered by a committee of committed partners representing all key stakeholders and regions of Canada, sector studies:

- incorporate previous research/work on human resources;
- provide a common base of evidence and trend analysis to improve understanding about the labour market and HR challenges in the sector;
- help build consensus on causes of problems and priorities;
- help stimulate creation of innovative solutions;
- help all stakeholders better understand each others needs and what they need to do to improve human resource management at a macro level;
- help build commitment to take actions needed to resolve HR problems; and
- establish collaborative relationships that outlive the study (even in the absence of a Sector Council).

**Human Resources Situational Analysis**

In the context of the Sector Council Program, a human resources *situational analysis* can be described as a description of the recent and current human resources situation in an occupation or sector, which is prepared by ordering (organizing and prioritizing), analyzing and interpreting existing human resources information, without carrying out the in-depth primary data gathering that would take place in a more comprehensive sector study[2].

Involving the gathering and analysis of secondary data, a situational analysis is shorter, less expensive, less comprehensive and less in-depth than a sector study.

A situational analysis:

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[2] Adapted from Hohea, Hogarth, J. Glossary of Health Care Terminology, Copenhagen, WHO Regional Office for Europe, 1978.

- builds partnerships and explores existing data, literature, and ongoing data development and research activities to set the stage and scope for, and avoid duplication in a subsequent sector study;

- allows for a multi-disciplinary approach to developing a research framework and terms of reference;

- varies according to the context and nature of the sector or occupation(s) that is being studied;

- is the first step before final definition of a problem(s) is (are) agreed upon;

- is meant to be a preliminary step to help delimit a sector study that could otherwise have a very large scope (many potential occupations and services);

- intends to build a better understanding of the context or situation for all stakeholders;

- allows for a systematic identification of potential sources of data, data gaps, major trends, issues and challenges; and

- provides direction for the next steps (which is often, depending on the results of the situational analysis, a full-fledged sector study).

A Steering Committee is recruited to steer the situational analysis, which is intended to prepare for a subsequent sector study. The steering committee is usually made up of key stakeholders from occupations in question, the employers, labour, education and governments. Responsibilities of a Steering Committee are (essentially the same as for a sector study) to:

- Consult and communicate
- Approve terms of reference for the analysis
- Provide guidance to the project manager and any contractors
- Participate in sub-committees
    - Recruit independent consultants
    - Help set up the research
- Provide input at meetings
- Review and approve consultant/researcher reports or other deliverables

- Represent constituents in the organizations they represent
- Help to reach consensus
- Help to facilitate access to data
- Communicate about the situational analysis and findings
- Determine and promote follow-up activities

# APPENDIX D: SITUATIONAL ANALYSIS DISCUSSION PAPER

By: Lorna Romilly

The following was presented in a power point presentation, and appears here in a text format.

## DEFINITIONS

Defining and counting health care executives/managers is not straightforward. Mostly what we know comes in pockets of information and uniformity of definitions and data collection is major issues. Also titles for the most senior and second-in-command positions across the country are pretty uniform but if you want to define positions below that in the hierarchy it can get murky. The National Occupational Classification system of HRSDC for senior and other managers in health care includes other social service and non-profit managers so it is difficult to get a clear number. The Canadian Institute of Health Information currently uses the membership of CCHSE as its number.

So the first issue is to achieve a consensus on a definition or definitions that allows for management principles, leadership and concrete ways of describing these positions so they can be counted, studied, compared and analyzed.

## HEALTH HUMAN RESOURCES

Health human resource issues and integrated planning have been identified by a number of groups as key priorities. There is activity federally and in the provinces/territories but it is primarily around health professionals such as nursing and physicians. The First Ministers Accord has promised $85 million over five years to improve national HHR planning and coordination, including better forecasting of HHR needs. The federal/provincial/territorial (F/P/T) Advisory Committee on Health Delivery and Human Resources (ACHDHR) has a mandate to provide strategic evidence-based advice, policy and planning support on HHR planning matters and as a link to other initiatives.

A few provincial studies have addressed HHR issues around health executives/managers: Newfoundland and Labrador created a profile of health system managers; recommendations on integrated planning, succession planning and the appropriate supply; Nova Scotia has a section in a HHR study which includes data on health managers; Quebec has done an extensive study.

So there is much agreement on HHR planning as a key issue and some work on trying to bring all of the stakeholders together but many barriers to coordinating HHR planning and the collection of data nationally, particularly on health executives/managers.

## SUPPLY — IS THERE A "LOOMING" LEADERSHIP CRISIS?

Ensuring the right number of health managers/executives with the right competencies available to lead and administer health services where and when needed is complex and influenced by many factors.  Part of the problem identifying shortages relates to the lack of a common standard for defining adequate staffing levels, for example spans of control are very large in large regional health authorities.  People are very concerned about the aging of the senior health executives with a number nearing retirement within five to 10 years and also concerned that replacements with the right skills may not be available.  On the other hand changes in the delivery of services may mean the need for fewer managers (depending on spans of control).

There is data in some provinces about the supply of health service executives/managers, some evidence of reduced numbers, no evidence about what the right number might be and anecdotal evidence of shortages , but no available national data about whether there is a shortage or not.

## PRODUCTION OF HEALTH SERVICE EXECUTIVES/ MANAGERS AND LEADERS

Ross Baker points out that a validated set of competencies for a complex field such as health care leadership are likely to be extensive.  It won't be simple to get consensus on the necessary work tasks and work processes needed for successful outcomes; educational and experiential needs of health care leaders will vary.  A number of competencies have been identified as important by Canadian health care leaders and in the literature.  Some are: communication skills, commitment to the consumer, effectively relationship building, systems thinking, political awareness and sensitivity, critical thinking skills, managing change and transition, ability to manage the culture, effective use of resources.  Everyone has his or her favourite and we could argue over the list.

There are many ways to develop leaders but formal training seems to have been the primary vehicle in Canada, along with executive programs. The Centre for Education Statistics study, commissioned by Health Canada, may be able to track those receiving MHAs and their flow through the system. Others argue for organizations developing leaders internally but leadership development is often put aside during tough times and competing demands.

Formal succession planning in health care organizations is limited. Best practices in succession planning suggest that we need to identify talent early, give them cross-functional assignments, use objective criteria to assess potential and benchmark candidates against one another and against "best" leaders.

So we don't know if we are producing the right number of future health executives/managers with the right competencies or if we are developing our current managers a planning for succession in the best way possible.

## MANAGEMENT, ORGANIZATION AND DELIVERY

The quality of working life, how the system is organized and the design of management positions all have an impact on health executives' ability to do their jobs. A high quality-working environment is at least as important as financial incentives to attracting and retaining people. Span of control, autonomy, professional development opportunities are all considered important.

## GAPS IN EXISTING DATA

There are many gaps in existing data about health executives/managers in the Canadian health care system particularly in the areas of supply and production. We have some data through the National Occupational Classifications but it is impossible to determine a number for health care executives/managers alone from current ways of collecting data. (The five NOC classifications that include health care managers total about 70,000.) In addition unless we have agreed upon definitions we don't know what should be included. We also don't know whether different models of organization, such as program management, need fewer managers, more clinical managers and what kind of different models occur across the country. In their study Nova Scotia found that quantitative data received from various bodies varied in content and format, relative to their data elements, definitions, time frames and format. They also found that it was challenging to collect comprehensive supply data for non-regulated occupations.

## OPPORTUNITIES

There is funding earmarked for national coordination and planning and investment in health human resource modeling and policy research and a linkage of HHR planning to system design issues in the advisory structure to the Conference of Deputy Ministers.  The Canadian Health Services Research Foundation and others have also identified HHR planning as a number one research priority.

How do we take advantage of these initiatives and make sure that health executives/managers are included in them?

A Comprehensive Health Human Resource Study
of Health Care Leadership and Management in Canada
# National Stakeholders Workshop
*March 23rd & 24th, 2005, Ottawa*
## *Questions for Discussion*

## I      Definition

1.      How do we make sure the definition and study will reflect different structures in a way that serves both provincial and national interests?

## II     Key Human Resource Issues

**2.     *Critical competencies for leading/managing health care organizations***

2.1     What are the critical competencies (e.g. skills, knowledge, abilities, attitudes, values) that health care executives currently exhibit to allow them to move through, or across, the health care system?  What are the competencies that we are not seeing now but will be needed in the future?

**3.     *Recruitment and retention***

3.1     What could we do to increase the attractiveness of the environment for health care executives/managers?

3.2     What has been our experience in terms of succession planning?  Is there a cohort of people who are being exposed to different management/leadership levels and moving across operational functions and facilities?  What about the use of mentoring, coaching?  What about professional development?

3.3     Is there a shortage of health executives/managers or leaders within our organizations and/or in terms of the number of interested/qualified individuals available externally?

## III     Methodology for a Sector Study

4.1.     Is a Pan Canadian study feasible given the barriers?  Can we reconcile the differences?  If so, how?

4.2     How can we link a new Pan Canadian study with current studies such as those on physicians and nurses and previous studies?

4.3     How do we take advantage of existing and other opportunities related to health human resource planning and research?

## IV     So What's Next?

5.1 How do we get partnership (stakeholders, provincial/territorial governments) buy-in?

5.2 Communication/marketing plan?

## Some Background for the Question

## Definition

**How do we make sure the definition and study will reflect different structures in a way that serves both provincial and national interests?**

Current definitions of managers by Stats Canada all refer to those in health care or related organizations who organize, direct, control and evaluate:

> Senior managers plan, organize, direct, control and evaluate, through middle managers, membership and other organizations or institutions that deliver health…services. They formulate policies which establish the direction to be taken by these organizations, either alone or in conjunction with a board of directors.

> Other managers: plan, organize, direct, control and evaluate the delivery of health care services, such as diagnosis and treatment, nursing and therapy, within institutions that provide health care services.

> Managers in the health care sector who are responsible for activities other than the delivery of health care services such as government managers plan, organize, direct, control and evaluate the development and administration of health care policies, social policies and related programs designed to protect and promote the health and social welfare of individuals and communities.

CIHI uses – a health service executive assumes a leadership role in a management position in the Canadian health system and provides services of the highest quality, with the best use of available resources, in an environment that is conducive to employee morale.

Any definition has to include those who manage processes, i.e. staff roles and clinical managers, who have additional responsibilities to their management role. One study, conducted in Ontario hospitals, discusses the emergence of non-management leadership positions to support professional practice.

Do these definitions help us know who to count as a health executive/manager?

If so are they enough? What else is needed?

If not – how could we define health executives/managers so we can count, study, compare and analyze them?

# Some Background for the Question

## Key Human Resource Issues
*Critical competencies for leading/managing health care organizations*

> **What are the critical competencies (e.g. skills, knowledge, abilities, attitudes, values) that health care executives currently exhibit to allow them to move through, or across, the health care system?  What are the competencies that we are not seeing now but will be needed in the future?**

Much has been written around the competencies of leaders in business and health care but how do these fit with health executive/managers jobs across the continuum of care, across public and private health care organizations and across provinces and territories?  Are the health executive/management jobs even similar across the spectrum?  A comparison of competencies outlined in various literature and national bodies is provided here to provoke discussion.

| Competencies | | | |
|---|---|---|---|
| **Canadian College of Health Service Executives** | **Canadian Literature/Interviews in the Situational Analysis** | **National Centre of Health Care Leadership US[1]** | **Leadership Institute Modernisation Agency NHS, UK[2]** |
| ***Leadership***<br>Vision<br>Team capabilities<br>Flexibility<br>Personal management<br>Commitment | Able to create shared values and strong vision that inspire people<br>***Effective relationship building***<br>Working through people to enhance their accomplishment<br>Empowering broad based action<br>Ability to share leadership; fostering teamwork, collaboration<br>***Managing change and transition***<br>Flexibility in managing change | ***Leadership***<br>Communicate a shared vision<br>Champion solutions for organizational and community challenges<br>Energize commitment to goals | ***Setting Direction***<br>Broad scanning<br>Seizing the future<br>Intellectual flexibility<br>***Delivering the Service***<br>Leading change through people<br>Empowering others |
| ***Communication***<br>Verbal<br>Listening<br>Written | ***Strong communication skills***<br>Listening and verbal communication important | ***Collaboration & Communication***<br>Develop cooperative relationships and effective information exchanges<br>Effective oral & written communications<br>Effective group | ***Delivering the Service***<br>Effective and strategic influencing<br>Collaborative working |

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[1] Taken from a presentation by G. Ross Baker, Developing Core Competencies for Health Care Leadership to an Invitational Symposium, National Centre of Healthcare Leadership.
http://www.nchl.org/ns/powerPoint/developingCore_files/

[2] From the NHS Leadership Qualities Framework of the Modernisation Agency, Leadership Centre of the National Health Service, UK

| Competencies | | | |
|---|---|---|---|
| **Canadian College of Health Service Executives** | **Canadian Literature/Interviews in the Situational Analysis** | **National Centre of Health Care Leadership US[1]** | **Leadership Institute Modernisation Agency NHS, UK[2]** |
| | | processes<br>Approaches to enhancing teamwork | |
| ***Lifelong Learning***<br>Self-directed learning<br>Teaching/mentoring/<br>Facilitating | Understanding personal leadership styles | ***Learning & Performance Improvement***<br>Continuously assess, benchmark and improve the quality, safety, and value of healthcare<br>***Professionalism***<br>Commit to personal and institutional development | ***Personal Qualities***<br>Self belief<br>Self awareness<br>Self management<br>Personal integrity |
| ***Consumer/Community Relations***<br>Public relations<br>Responsiveness<br>Partnerships | Increased emphasis on public relations<br>***Commitment to the Consumer***<br>***Effective Relationship Building***<br>Ability to build relationships, networks and sustaining alliances<br>Image building with the public | ***Collaboration & Communication***<br>Develop cooperative relationships<br>***Personal & Community Health Systems***<br>Integrate the needs of individuals of the community, optimizing opportunities to improve the health of the populations served | |
| ***Political and Health Environment***<br>Political awareness and sensitivity<br>Health environment<br>Determinants of health | ***Effective Relationship Building***<br>Building good board relationships<br>Political awareness and sensitivity | ***Professionalism***<br>Stimulate social accountability and community stewardship | ***Setting Direction***<br>Political astuteness |
| ***Conceptual Skills***<br>Analysis & synthesis<br>Problem-solving<br>Systems thinking<br>Emotional intelligence | Systems thinking<br>Systems-driven leadership<br>Critical thinking skills<br>Emotional intelligence<br>Creativity | | |
| ***Results Orientated***<br>Management<br>Planning<br>Implementation<br>Monitoring/<br>evaluation | ***Ability to manage the culture***<br>Creating and sustaining inclusive environments<br>Creating an engaging environment<br>Anchoring changes in the culture | ***Leadership***<br>Energize commitment to goals<br>***Management Practice***<br>Identify, evaluate and implement strategies and processes designed to yield effective, efficient, & high-quality customer oriented hc | ***Setting Direction***<br>Drive for results<br>***Delivering the Service***<br>Holding to account |
| ***Resource Management***<br>Human resources<br>Financial resources<br>Capital/material assets<br>Information | Human Resource management<br>***Effective use of resources***<br>Being accountable<br>Efficient and effective management of assets | ***Management Practice***<br>Design a functional organizational structure<br>Manage resource allocation processes effectively | ***Delivering the Service***<br>Holding to account |

| Competencies | | | |
|---|---|---|---|
| **Canadian College of Health Service Executives** | **Canadian Literature/Interviews in the Situational Analysis** | **National Centre of Health Care Leadership US[1]** | **Leadership Institute Modernisation Agency NHS, UK[2]** |
| ***Compliance to standards*** Accreditation Ethical Standards Legal Standards | Policy development | ***Learning & Performance Improvement*** Use evidence & knowledge of best practices to improve care and services Contribute to improvement in health care to reduce adverse events. ***Professionalism*** Demonstrate ethics, values and professional practices | ***Personal Qualities*** Drive for improvement |

# Some Background for the Question

## Key Human Resource Issues
### *Recruitment and retention*

> **What could we do to increase the attractiveness of the environment for health care executives/managers?**

The quality of working life, how the system is organized and the design of management positions all have an impact on health executives/leaders' ability to do their jobs.  A synthesis paper by the CPRN, *Creating High-Quality Health Care Workplaces,* drawing widely on workplace and organizational research, outlines four main components of a high-quality workplace:

1. The work environment broadly considered, workplace culture and the human resource practices that shape it.
2. Job design and organizational structure (including technology)
3. Employment relationships, which covers issues from trust and commitment to communication, leadership
4. Industrial relations – relationships among employers, unions and professional associations.

A international study done in 1991 on defining excellence in health service management, with 93 health service executives in 14 successful hospitals in the US, Canada and the UK, found eight factors of success:

1. Emphasis on formal corporate and strategic planning processes
2. Willingness to embrace and improve quality
3. A belief that people management is critical – through the development of effective human resource management policies and procedures, information systems, effective training programs, change management programs and remuneration and benefit programs
4. A commitment to organizational flexibility and improved organizational climate: welcoming change
5. Acceptance of the need for delegated budgetary responsibility especially to clinicians, and the convergence of the medical and managerial interests
6. An uncompromising attitude to improving information systems.
7. A belief that competition between hospitals can lead to efficiency.
8. A focus on continuously reducing costs and improving productivity.

What might we do to improve our environments and still create success for our organizations?

# Some Background for the Question

## Key Human Resource Issues
### *Recruitment and retention*

> **What has been our experience in terms of succession planning?  Is there a cohort of people who are being exposed to different management/ leadership levels and moving across operational functions and facilities? What about the use of mentoring, coaching?  What about professional development?**

A number of those interviewed commented on succession planning:

- In terms of succession planning, we can't take the past situation and extrapolate it into the future.  Competition for good people is significant but that experience is off-set by how we make use of existing resources.  People in clinical professions are being trained in management.  There is a cadre of physician leaders (number of graduates from the Physician Manager Institute) who are moving into CEO slots.  There appears to be a gap and may be a crisis at the VP level – those being promoted moving into CEO positions are not rotating through positions to get a broad view of the organization.  VPs of Human Resources are not stepping back far enough to look at the potential within organizations.  We have to look at transitional strategies – we can't generate managers/leaders overnight.

- People in senior positions are going to be retiring in the next 10 years and they are not mentoring the next level; boards are not bringing in new blood and are often recycling "the old guard".

- We also have to rethink what we mean by succession planning.  The days of the 30-year employee are gone.  Over the last few years a senior management change has meant that different skill sets are valued.  The younger generation is not going to work as the boomer generation or older ones did.  They say let me give you five years and then I'm looking.

The CCHSE report to the Romanow Commission says that opportunities to develop succession planning for the senior levels have been reduced with the elimination of many middle management levels and little time to coach and mentor younger leaders.

# Some Background for the Question

## Key Human Resource Issues
### *Recruitment and retention*

> **Is there a shortage of health executives/managers or leaders within our organizations and/or in terms of the number of interested/qualified individuals available externally?**

Ensuring the right number of health managers/executives with the right competencies, available to lead and administer health services where and when they are needed is complex and influenced by many factors. Indicators can include vacancy rates or administrators perceptions of the staffing situation at their institution. Some objective indicators may be: vacancy rates, turnover, overtime/excess hours working, unemployment rates. What do we know about these indicators for health executives/managers?

- A survey of 108 Canadian health care CEOs in 2001 found that 31.5% of this group were 55+ years of age, 9.26% over 60; only 9% were 35-44 suggesting only a small pool of future leaders.

- A study in Quebec talks about 50% of senior managers reaching retirement age within 5 years. But recently the health system has reduced 160 health organizations to 9 and hired younger CEOs.

- A Newfoundland and Labrador study estimated 53% of their managers would retire in 10 years assuming a retirement of 55. Turnover rate was 16%. 95% said they worked overtime every week; 33% said they worked more than 15 hours. Managing the workload was reported as the biggest challenge but most were satisfied with their jobs.

- The average age of health service managers in Nova Scotia was 47.

- The CCHSE report to the Romanow Commission describes "…a significant depletion in the ranks of health service leaders over the past five to seven years", partly due to the merging of organizations and partly because of the aging leadership group moving into retirement.

- Those participating in a CCHSE Leadership Symposium and some of those interviewed, however, were not sure there was a crisis. The reduction in number of positions may balance the aging of executives.

# Some Background for the Question

## Methodology for a Sector Study

> **Is a pan Canadian study feasible given the barriers?  Can we reconcile the differences?  If so, how?**

### Data challenges

- Incomplete and inconsistent data and no commitment to a common standard or common data gathering system.  A number of limited datasets are being maintained, not linked and are usually designed for a purpose other than planning.  If collecting data from health organizations they have multiple HR software systems.

- The following data issues come from the Nova Scotia study:

  o Confidentiality is a key issue

  o Individual and aggregate reporting is an issue

  o Quantitative data received from regulatory bodies and professional associations, educational institutions and employers varied in content and format, relative to their data elements, definitions, time frames, and format.  These organizations have varying data requirements and resources based upon their mandates and interests.

  o Education and training information on funding programs, students, enrolments, faculty was not available from a central source

### Other challenges:

- Complexity often defeats a comprehensive approach – different level of standards; different visions; poor communication

- Accountabilities in health human resources are diffuse and there is no coordinating mechanism to pull them together

- Lack of political will to build appropriate national information systems

# Some Background for the Question

## Methodology for a Sector Study

### How can we link a new pan Canadian study with previous studies?

How can we link with planning being conducted nationally and provincially/territorially - to the Pan Canadian Health Human Resources Strategy, the study by the Centre for Education Statistics? Can we build on or incorporate the studies from Quebec, Newfoundland and Nova Scotia?

### How do we take advantage of existing and other opportunities related to health human resource planning and research?

Possible opportunities:

- Funding earmarked for national coordination and planning

- Linkage of health human resource planning to system design issues in the advisory structure of the Conference of Deputy Ministers.

- Priority setting exercise by national health service research organizations has identified health human resource planning as the number one research priority. Is there research that could be commissioned by these organizations?

- Substantial investments in health human resource modeling and policy research – stronger and larger research community interested in linking with decision makers to support evidence-based policy. How can we take advantage of this?