Dialogue Summary

Preparing Emerging Leaders for Alternative Futures in Health Systems Across Canada

7 March 2019

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McMaster Health Forum
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Authors
>
> Kaelan A. Moat, PhD, Managing Director, McMaster Health Forum, and Assistant Professor, McMaster University
>
> Kerry Waddell, M.Sc., Lead, Evidence Synthesis, McMaster Health Forum
>
> John N. Lavis, MD PhD, Director, McMaster Health Forum, and Professor, McMaster University

Conflict of interest
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> The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary but the authors had final decision-making authority about what appeared in the dialogue summary.

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Dialogue
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> The stakeholder dialogue about preparing emerging leaders for alternative futures in health systems was held on 7 March 2019 at the McMaster Health Forum in Hamilton, Ontario, Canada.

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SUMMARY OF THE DIALOGUE

Dialogue participants agreed that the framing of both the expected and alternative futures in the evidence brief was a helpful jumping off point, and most also agreed with the four dimensions of the problem as they were outlined: 1) health leaders are often trained for leadership roles in specific sectors and settings, and not equipped to work across health and social systems; 2) there is a lack of coordinated efforts to establish and collectively pursue health-system leadership development; 3) health leaders largely focus on incremental change rather than anticipating or stewarding alternative futures; and 4) health-system arrangements are not aligned to support the identification, development or cultivation of emerging leaders. While all of these aspects were considered important, participants spent the majority of the deliberation about the problem focused on four challenges that were related to, but framed slightly differently than, the dimensions covered in the brief: 1) the current leadership culture is not conducive to preparing emerging leaders for expected and alternative futures (which cut across all of the dimensions of the problem outlined in the brief); 2) there are few mechanisms in place to ensure emerging leaders develop the competencies they need (which mostly related to the first and fourth dimensions); 3) insufficient progress has been made in ensuring there is diversity among those in leadership positions (which related mostly to the second dimension); and 4) insufficient progress has been made in understanding existing leadership capacity in the context of expected and alternative futures (which mostly related to the second and fourth dimensions).

In deliberating how to prepare emerging leaders for both expected and alternative futures, dialogue participants generally agreed with the three elements presented in the evidence brief: 1) establish a collective vision for the competencies emerging leaders need to be prepared for alternative futures; 2) identify and develop the training programs required to foster these competencies among emerging leaders; and 3) identify and develop the complementary system initiatives required to address system initiatives required to support emerging leaders in practice. However, participants suggested a number of nuances to each of the three elements, including: adding several competencies and personal characteristics to those described for element 1; adjusting the focus of existing programs to emphasize relatively underdeveloped areas (e.g., the 'develop coalitions' and 'systems transformation' elements of LEADS) and contribute to building a culture supportive of distributed and diverse leadership in element 2; and embedding leadership development within a rapid-learning health-systems framework in element 3.

When considering what next steps different constituencies could take to help in preparing emerging leaders for expected and alternative futures, participants identified six areas for action: 1) cultivating a culture that is conducive to developing the types of leaders needed in the future (e.g., individuals accepting failures associated with risk-taking) and incentivizing emerging leaders to develop the competencies required to lead; 2) integrating leadership development within existing and emerging system-transformation initiatives; 3) ensuring that emerging health-system leaders have exposure to a broad range of sectors and industries (e.g., the start-up community) that can provide novel insights about various approaches to leadership; 4) fostering the establishment of better mentorship from senior leaders in the health system; 5) engaging emerging leaders more regularly and strengthening approaches to succession planning to ensure these emerging leaders are set up for success; and 6) exploring opportunities to create a 'home' for health-leadership development and professionalization in Canada.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants agreed that the framing of both the expected and alternative futures in the evidence brief was a helpful jumping off point, and most also agreed with the four dimensions of the problem as they were outlined:
1) health leaders are often trained for leadership roles in specific sectors and settings, and not equipped to work across health and social systems;
2) there is a lack of coordinated efforts to establish and collectively pursue health-system leadership development;
3) health leaders largely focus on incremental change rather than anticipating or stewarding expected and alternative futures; and
4) health-system arrangements are not aligned to support the identification, development or cultivation of emerging leaders.

While all of these aspects of the problem were considered important, participants spent the majority of the deliberation focused on four challenges that were related to, but framed slightly differently than, the dimensions presented in the evidence brief. These are:
1) the current leadership culture is not conducive to preparing emerging leaders for expected and alternative futures (which cut across all of the dimensions of the problem outlined in the brief);
2) there are few mechanisms in place to ensure emerging leaders develop the competencies they need (which mostly related to the first and fourth dimensions);
3) insufficient progress has been made in ensuring there is diversity among those in leadership positions (which related mostly to the second dimension); and
4) insufficient progress has been made in understanding existing leadership capacity in the context of expected and alternative futures (which mostly related to the second and fourth dimensions).
Each of these challenges is summarized below.

Current leadership culture isn't conducive to preparing emerging leaders for expected and alternative futures

During deliberations about the problem, participants emphasized the role that the health-system leadership culture in Canada has in creating challenges for preparing emerging leaders for expected and alternative futures, and identified three particularly challenging characteristics of this culture.

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue brought together 20 participants from across Canada (including seven policymakers and managers, nine stakeholders, three researchers and one emerging student leader), and was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:
1) it addressed an issue currently being faced in Canada;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on three elements of a potentially comprehensive approach for addressing the issue;
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three approach elements, and key implementation considerations;
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of an approach to addressing it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) it did not aim for consensus.

The dialogue did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior health-system leaders typically need to engage elected officials, boards of directors and others on detailed commitments.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

The first problematic characteristic of the leadership culture identified by participants was that there is no value placed on, or formal investment in, leadership as a core element of achieving health-system goals. Dialogue participants suggested that one reason this may be the case is the difficulty of displaying 'value for money' in leadership investments. Many participants saw this as being underpinned by the belief that investments in health are always better spent on front-line care. A number of participants raised the issue that it is politically challenging to justify redirecting spending from front-line care to leadership development. Other participants noted the lack of buy-in to ensure resources are allocated to help support leadership development. Participants described how this was evident through the limited interest among potential leaders (e.g., medical students), and could at least partly stem from the perception that, despite one's efforts as a leader, it is remarkably difficult to overcome challenges, pursue innovative solutions, and achieve impacts, especially when compared to clinical practice. One participant stated that, in the health system "return on investment may be 5% change in the indicator you're interested in for your 100% effort, compared to 200% change for 50% of your effort in the private sector," so leaders need to be prepared for limited results (and in some cases failure). Other participants focused on the limited control and autonomy that health-system leaders have over the actors in the system who are required to help achieve a vision, noting in particular the example that most doctors act as their own bosses. Participants noted that this is unique in healthcare compared to many other 'safety-critical' industries, such as aviation, where leaders have control over much of what is required to make the system run smoothly. In reinforcing this point, one participant suggested that without this control, it is difficult for those in senior leadership positions to move 'one laundry worker from one hospital to another,' let alone make the more drastic changes that would be required to help steward real innovation and change in a health system.

The second problematic characteristic of the leadership culture that participants identified as a challenge is that there is no consistent (or shared) vision for leadership in Canadian healthcare. Some participants acknowledged that this particular issue was one that had been raised on a recurring basis in the last few years (including in previous stakeholder dialogues convened by the McMaster Health Forum).

The third problematic characteristic of the leadership culture was that there is no path to impact, and participants described this in three main ways. First, a number of participants noted that leadership is hierarchical and roles-based, when it should be distributed and flexibly adopted among individuals who are well-positioned to lead at various levels of the system. Furthermore, a number of participants suggested that leadership in healthcare carries with it the assumption that 'emerging' means young, and this tends to shape the approaches taken to identifying and supporting emerging leaders. However, in many cases it could be that 'emerging leaders' in the health system are not young, but those who bring expertise – from other parts of the health system and, when appropriate, other sectors – that could be viewed as beneficial. Participants re-iterated that this more inclusive thinking is needed. Second, participants noted that there is an aversion to risk, low tolerance for change, and rigid accountability structures that punish leaders for failure, which leads them to make safe, low-risk decisions rather than pursuing transformative change. Participants suggested that one reason for this is how we measure leadership and what we choose to measure as success. In particular, for many health-system leaders, success is measured based on their ability to balance the budget rather than considering other competencies. Similarly, the health system does not do a good job of 'measuring what matters,' particularly when it comes to patient experience, where better alignment is needed between health-system goals and the data and decision supports available to 'move the needle.' A number of participants noted that this was an important challenge given it resulted in many lost opportunities, particularly with the rapid development in areas like artificial intelligence and 'big data.' Third, participants described the general unwillingness among individuals and organizations to learn from outside of the healthcare sector even when there are appropriate opportunities for gaining insights about novel ways of thinking through transformational change. They suggested that this view may be underpinned by a perception that healthcare is too unique and complex. Similarly, there is a general unwillingness to accept solutions that are not 'made in Canada,' with dialogue participants suggesting that this stems from a protection of our public healthcare system. This characteristic of the current leadership culture reduces the likelihood that leaders are empowered to recognize how new ideas (e.g., distributed leadership) and approaches to leadership that are embraced in

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other industries (e.g., intrapreneurship and entrepreneurship) can be leveraged as appropriate to strengthen health systems in Canada. While most participants agreed with this point, one participant raised the counterpoint that there are, in fact, unique attributes of health systems that make it very different from other industries, and these should be acknowledged within this conversation. For example, the fact that the most highly trained individuals are also the front-line workers providing the services in the health system is quite different from many other industries, so a new way of conceptualizing how to make the most of learning is likely required in this context. Some participants suggested that the notion of a 'learning health system' could be a step in this direction.

Despite these major challenges related to the culture of leadership in Canadian health systems, some participants acknowledged that there are some reasons for positivity, given that thinking does seem to be shifting. For example, there is a growing awareness that innovations in technology present significant opportunities, and that leadership is an important part of ensuring these types of opportunities can be embraced. One participant reminded others that the ways in which culture can be shifted in Canada towards being even more supportive of preparing emerging leaders to thrive in expected and alternative futures needs to be grounded in the dominant values of Canada, which are going to be different than those in other contexts (e.g., the U.S. where private payers play a major role).

There are few mechanisms in place to ensure emerging leaders develop the competencies they need

Participants also emphasized the need to acknowledge that, despite a general agreement about the competencies required for emerging leaders to thrive in the expected and alternative futures presented in the evidence brief, there are few mechanisms in place that would support them to develop these competencies. Within this conversation, four contributing factors were highlighted.

The first factor that participants identified was the system's failure to train leaders in ways that would enable them to thrive by ensuring they are exposed to all facets of the health system. One participant suggested that most existing leaders are trained for traditional hospital administration, not in more dynamic ways of thinking that are well-suited to the types of futures considered in the brief, such as rapid learning and improvement. Another participant raised the challenge that there are few opportunities to ensure leaders can learn all facets of the health system (e.g., front line to hospital leadership) and political system (e.g., government relations) in which they work. In reaction to this, another participant working in technology suggested that, in many other industries, those who are being prepared to take on leadership roles are often expected to gain hands-on experience in all facets of 'the business,' including on the front line. However, the participant noted that this is not the case in healthcare, where it is rare for a leader to have experience across all sectors and settings that make up the healthcare system (e.g., home and community care, primary care, specialty care, rehabilitation care, long-term care and public health).

The second factor identified by participants was that there are a lack of signals sent about the importance of leadership in the health system, and a lack of rewards for those who put effort into developing themselves as health-system leaders. Participants emphasized that even in professions such as medicine, where part of the expectation in training programs is that individuals will need to develop leadership capabilities (e.g., through the CanMEDS framework), students have little time to focus on developing these skills, given residency programs place little emphasis on the kinds of leadership competencies that are required and rarely require the demonstration of these competencies in accepting students into residency rotations. This point holds true for those already in the profession as well, for whom there is little time available to help foster the development of the competencies needed. Furthermore, a number of participants stated that there are too few considerations about the importance of leadership in existing hiring practices. Despite general agreement on the types of competencies that are needed among system leaders, these are not systematically used by boards and senior managers, nor are candidates asked to provide evidence that they have demonstrated these competences. Finally, there is also uncertainty around what types of signals and rewards are optimal in the context of trying to attract and retain the 'best and the brightest' – and in particular those best-positioned to lead in the context of expected and alternative futures – to cultivate leadership competencies for the health

system. This uncertainty is further complicated by individuals continuously reinventing themselves, shifting career paths, and looking for new ways to develop personally and professionally.

The third factor identified by participants was the lack of early and frequent engagement of emerging leaders. Specifically, a number of participants noted that there is little effort to proactively identify and harness talent that can help establish cohorts of emerging leaders for positions in the future. One participant emphasized that there were no Canadian analogues to what exists at the Cleveland Clinic in the U.S., which proactively engages and supports emerging leaders through exposure to many different potential career paths through opportunities for hands-on learning in various healthcare settings

The fourth factor identified by participants was that there was currently not enough emphasis placed on succession planning. While related to the third factor above (proactively identifying potential leaders), many participants identified this as a distinct issue. In particular, some participants stated that existing leaders have a big role to play in helping to ensure the next generation aren't only identified, but have the opportunity to learn (and apply in real-world settings) all of the types of knowledge and skills they'll need to lead in the future.

Insufficient progress has been made in ensuring there is diversity among those in leadership positions

The concept of a lack of diversity in efforts to develop and support stronger health-system leadership was raised by many participants throughout deliberations about the problem. In particular, participants highlighted four different types of diversity challenges:
1) a lack of ethnocultural diversity and cultural sensitivity among existing health-system leaders, which is particularly problematic given Canada is made up of a very diverse population;
2) a lack of gender diversity, with an under-representation of women in leadership positions, which some participants also flagged as being at odds with the fact that a majority of the health workforce in Canada is comprised of women;
3) a lack of Indigenous representation in leadership positions within the health system; and
4) Indigenous leadership gaps within Indigenous communities, which can be particularly challenging to overcome given many of these communities exist in remote locations that are far removed from the traditional 'hubs' of leadership, including those within larger Indigenous communities, resulting in lost opportunities to gain and share insights and knowledge.

In the context of preparing leaders for expected and alternative futures, a number of participants felt that these gaps represented missed opportunities for broadening ways of thinking. One participant noted that without diverse perspectives around the table, individuals are less likely to break out of their traditional way of doing things, which can perpetuate the existing cultural challenges outlined earlier. On the positive side, another participant noted that despite the gap related to Indigenous leadership, some Indigenous-led organizations, such as Cree Health, had begun to lead their own initiatives in leadership development and succession planning.

Insufficient progress has been made in understanding existing leadership capacity in the context of expected and alternative futures

The point was raised by a few participants that in order to move forward, we need to better understand our starting point. While it was generally the view of a minority of participants, those with a relatively deep understanding of existing leadership initiatives in Canada stated that, despite some efforts being pursued to map out health-system leadership capacity in Canada during the last decade (e.g., CHLNet's benchmarking study, which is about to enter its second wave), there are many unknown details. This includes understanding whether existing leaders have the full range of competencies required to lead within the expected and alternative futures presented in the evidence brief, and where there is potentially latent capacity that could be tapped into to support the development of future leaders for a number of alternative scenarios in healthcare.

One participant disagreed with this particular challenge as being unique to leadership, and stated that other participants should remember that there are also gaps in understanding existing capacity across many different roles in the health system in general.

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH

During deliberations about the three elements of a potentially comprehensive approach to address the problem, most dialogue participants agreed that the elements presented in the evidence brief were generally promising. However, participants suggested a number of nuances in pursuing the elements based on their previous experience either working in leadership positions in the health system or working with leadership training and development programs. The deliberation on each of the elements is summarized below, while three overarching themes related to the full array of elements are considered in the following section.

Element 1 - Establish a collective vision for the competencies emerging leaders need to be prepared for alternative futures

When deliberating about the first element – establish a collective vision for the competencies emerging leaders need to be prepared for expected and alternative futures – a number of participants made the point, and most agreed, that the standard competencies required to prepare emerging leaders for expected and alternative futures are already covered by core leadership frameworks such as LEADS. Participants did not spend much time deliberating on this element given the overall agreement on using the LEADS framework. However, participants also suggested that the LEADS competencies needed to be complemented by additional competencies and by support for the development of complementary personal characteristics.

The additional competencies suggested by participants as being complements to the standard competencies included:
- risk/opportunity management skills;
- communications, conflict resolution, and constituency management skills; and
- political astuteness.

The additional personal characteristics suggested by participants as being complements to the standard competencies included creativity, resiliency, integrity and humility.

Element 2 - Identify and develop the leadership programs required to foster these competencies among emerging leaders

When deliberating about the second element – identify and develop the training programs required to foster these competencies among emerging leaders – participants identified the need to adjust the focus of existing programs in Canada in at least three ways: 1) an earlier focus within training (and re-training) initiatives on building a culture supportive of distributed leadership and diversity; 2) a greater substantive focus on insufficiently addressed areas (e.g., the 'develop coalitions' and 'systems transformation' elements of LEADS) and 'unlearning' when shifts in emphasis are required as leaders transition between roles; and 3) a greater procedural focus on how leadership programs are delivered (e.g., customization, learning from new contexts, new types of exposures, and ensuring opportunities for continuous learning).

With respect to the first proposed adjustment (building a culture supportive of distributed leadership and diversity), dialogue participants emphasized that this would include promoting distributed leadership within their own organizations and promoting it among the next generation of leaders. Further, participants also noted that a significant focus would need to be placed on ensuring leadership programs are recruiting and retaining diverse candidates in training programs. Participants stated that diversity would need to be

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considered from a number of perspectives, such as gender, ethnocultural background, types of professional experience, and geographic location.

With respect to the second proposed adjustment, participants suggested that leadership programs need to give greater substantive focus to areas in the LEADS framework that have not previously been emphasized by many training programs (e.g., the 'develop coalitions' and 'systems transformation' domains), and there was agreement among most participants that there was a gap in capacity among current health-system leaders with respect to these domains. Further, some participants considered that it may be necessary for individuals entering leadership training programs to 'unlearn' (or shift emphasis in) certain ways of thinking and strategies that they adopted in clinical or other roles, but that are not relevant to (and in some cases detract from) leadership positions. For example, one participant noted that physicians are often trained to be independent decision-makers with complete autonomy over their practice, creating an expectation that they aren't supposed to ask for help. However, while this characteristic may be appropriate in clinical settings, once these same individuals move into leadership roles it is problematic given the need to coordinate the many actions of many actors. In this scenario, willingness to ask for help can become a very positive attribute.

With respect to the third proposed adjustment, participants highlighted that training programs should give greater procedural focus to the ways in which they can provide new types of exposures, customize training programs, and ensure opportunities for continuous learning. Participants first highlighted the need to ensure trainers and mentors in leadership programs are themselves well trained, with exposure to (and ideally with practical experience) working in different parts of the health and social systems. Some participants stated that this is essential experience from which to draw to successfully guide others. Participants also emphasized the need for diversity among these trainers so as to expose emerging leaders to different types of leaders and leadership positions. The need for customization in training programs was also discussed, including customizing the content and delivery method to consider and incorporate when necessary:

- local conditions or challenges (e.g., information technology deployment in remote First Nations communities);
- the tacit knowledge individuals may bring into the training program (e.g., having prior experience as an executive in a healthcare organization);
- the types of knowledge that emerging leaders may need in the future (e.g., health and social systems; political astuteness);
- unique supports that exist from outside the specific discipline or sector where the individual is working;
- novel approaches like simulations and voluntary 'fear' engagements that are available to help push individuals out of their comfort zone and use new competencies; and
- the optimal length of programs (e.g., executive mentorship versus longer courses).

Finally, participants suggested increasing opportunities for continuous learning of leadership competencies outside of formal training programs, noting that this could include mentorships or placements with leaders in the health system, ad hoc webinars, and simulations or networking events that would allow emerging leaders to practise their competencies and gain awareness of any new developments in leadership research.

Element 3 - Identify and develop the complementary system initiatives required to support emerging leaders in practice

During deliberations about the third element – identify and develop the complementary system initiatives required to support emerging leaders in practice – participants considered a number of opportunities to address system-level challenges (e.g., ensuring the right incentives are in place to foster leadership development) within the broader context of embedding leadership development in a rapid-learning health-systems framework. Specifically, participants described the need to move quickly and nimbly, taking advantage of the significant amount of research that has been conducted relating to leadership, and using this to inform decisions about how best to align system initiatives with training efforts. In discussing this, participants also suggested pursuing a number of reforms across five of the seven characteristics of rapid-learning health systems, which are described below. The fourth and sixth characteristics (ensuring decision

supports are available, and establishing the competencies for rapid learning and improvement, respectively) weren't explicitly discussed by participants during this part of the deliberation.

With regards to the first characteristic of a rapid-learning health system – engaging patients (or in this case participants) in picking the 'needles' that need to move (i.e., care experiences and health outcomes that will be the focus of rapid learning and improvement) – dialogue participants suggested pursuing co-design of programs with emerging leaders and other stakeholders in the health system in efforts to ensure that programs are well suited to meet the system's needs. For the second characteristic – harnessing the data needed to identify problems and monitor progress in rapid learning and improvement – participants emphasized the need to assess the existing level of leadership competencies that exist in the country and collect data on any gaps that may exist. Building on the need for additional information, participants emphasized how collecting and synthesizing the existing body of research evidence on health-system leadership should be prioritized under the third characteristic – pulling in the rapid-cycle research needed to support rapid learning and improvement. Participants spent a significant amount of time deliberating actions under the fifth characteristic – aligning governance, financial and delivery arrangements to support rapid learning and improvement – focusing in particular on establishing incentives and rewards for:

- those individuals who step forward to take on leadership positions;
- being exposed to different levels in and parts of the system (e.g., front-line to mid-level to senior management and across the full array of health and social services);
- identifying and scaling up innovative processes; and
- re-framing risks as opportunities and seeing risk-mitigation strategies as necessary complements of risk-taking.

Finally, participants deliberated about the final characteristic of a rapid-learning health system – developing a culture that supports rapid learning and improvement – and suggested the creation of a pan-Canadian owner for health-system leadership that is able to embody and begin to spread a culture that is supportive of leadership and leadership development. However, many participants agreed that a new organization did not necessarily need to be created, but rather an existing organization could take on the role, provided the right coordinating structures and mechanisms are in place.

Considering the full array of approach elements

In considering the full array of approach elements, participants acknowledged three overarching themes in relation to each of the elements and that anchored the deliberation:

- there is general agreement about the competencies required of existing and emerging leaders (which relates to element 1);
- different contexts will require different approaches to support the training and development of successful leaders (which relates to element 2); and
- it is likely that new ways of thinking (e.g., analytical frameworks and innovative concepts) need to be adopted to foster the establishment of the right set of system-level complements that can support the development of leaders (which relates to element 3).

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

The deliberation about implementation considerations was brief and focused, with particular attention given to the barriers to pursuing change that exist in Canada. Specifically, these barriers include an entrenched hierarchical leadership structure that isn't conducive to addressing the full array of leadership needs within the context of expected and alternative futures, such as distributed leadership (which relates to element 2 and element 3), as well as the limited value placed on leadership development as an overarching health-system goal (which relates to element 3). Despite these barriers, participants also acknowledged that the potential for leveraging existing initiatives that can be leveraged (e.g., Emerging Health Leaders and Canadian Health Leadership Network), alongside the rapid changes unfolding in health systems around the country, present unique opportunities that could help to promote progress in strengthening leadership.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

When considering what next steps different constituencies could take to help move forward in preparing emerging leaders for expected and alternative futures, participants identified six areas for action:

1) cultivating a culture that is conducive to developing the types of leaders needed in the future (e.g., individuals accepting failures associated with risk-taking), and incentivizing emerging leaders to develop the competencies required to lead;
2) integrating leadership development within existing and emerging system-transformation initiatives;
3) ensuring that emerging health-system leaders are exposed to a broad range of sectors and industries (e.g., entrepreneurs in the start-up community) that can provide novel insights about various approaches to leadership;
4) fostering the establishment of better mentorship from senior leaders in the health system;
5) engaging emerging leaders more regularly and strengthening approaches to succession planning to ensure these emerging leaders are set up for success; and
6) exploring opportunities to create a 'home' for health-leadership development and professionalization in Canada.

>> **Contact us**

1280 Main St. West, MML-417
Hamilton, ON, Canada L8S 4L6
+1.905.525.9140 x 22121
forum@mcmaster.ca

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