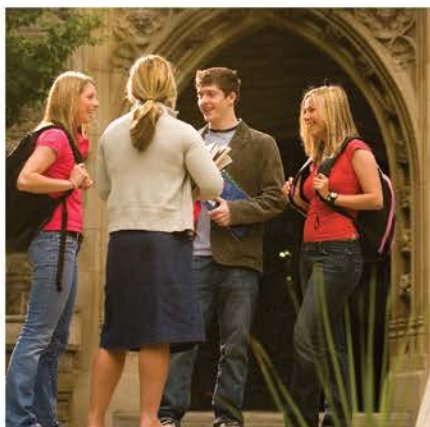




DIALOGUE  
SUMMARY



IMPROVING LEADERSHIP  
CAPACITY IN PRIMARY  
AND COMMUNITY CARE  
IN ONTARIO



30 JANUARY 2015

**EVIDENCE >> INSIGHT >> ACTION**



**Dialogue Summary:  
Improving Leadership Capacity in Primary and Community Care in Ontario**

30 January 2015

## *Improving Leadership Capacity in Primary and Community Care in Ontario*

### McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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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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## SUMMARY OF THE DIALOGUE

Participants generally agreed with two key points raised in the evidence brief that informed their deliberations:

1) Ontario's primary- and community-care sectors are increasingly being called upon to work as part of an integrated system to achieve key health-system goals related to access, quality, health outcomes, and value for money; and 2) these sectors have not been supported to develop the strong management, governance and leadership at multiple levels of the health system needed to achieve these goals. They identified four inter-related aspects of the problem as the most salient: 1) framing the problem accurately is difficult given challenges in determining the true magnitude of existing gaps in primary and community care leadership in Ontario; 2) existing leadership potential in the province is untapped; 3) the lack of emphasis historically placed on the importance of primary and community care in the health system has led to structural deficiencies that are difficult for any leader to overcome; and 4) the fragmented nature of primary and community care has further compounded leadership challenges.

Participants suggested the following re-ordering of the options proposed in the evidence brief: 1) convene a provincial committee charged with supporting the integration of (and filling of gaps in) leadership initiatives in primary and community care as part of a larger strategy around health-system leadership development, with the Ontario Primary Care Council (OPCC) suggested as the committee to do this in primary care and with a separate group bringing together stakeholders in community care; 2) develop, disseminate and support the use of an inventory of resources that can support leadership development as part of this larger strategy; and 3) identify current and emerging leaders in primary and community care and support their participation in a provincial leadership initiative. Some participants argued that these priorities need to be supported with a clear vision for primary care and community care as the centre-piece of the health system, and with supports for transitioning from practice to leadership positions (e.g., training, mentorship and payment to offset the loss of time for patient care).

Most dialogue participants stated that, as next steps, they were willing to support three broad types of initiatives to improve leadership capacity in primary and community care in Ontario: 1) continuing to push for a vision, structures, resources and supports for patient-centred primary and community care at the centre of the health system, so that existing and future leadership capacity is harnessed towards an agreed vision, able to function within appropriate structures, and enabled with appropriate resources and supports; 2) supporting a provincial committee to develop a provincial strategy for health-system leadership development in the primary-care sector (and that the OPCC would be an appropriate body to take on this work); and 3) supporting a similar but separate approach undertaken by the community-care sector, keeping in mind that these two sectors need to share a vision for patient-centred care, and therefore need to come together to share experiences and learn from each other whenever possible.

## SUMMARIES OF THE FOUR DELIBERATIONS

### DELIBERATION ABOUT THE PROBLEM

At the outset of the first deliberation, many dialogue participants acknowledged that the ways in which the evidence brief conceptualized the broad features of the problem were an appropriate reflection of current leadership dynamics in Ontario's primary- and community-care sectors. In particular, they agreed that: 1) Ontario's primary- and community-care sectors are increasingly being called upon to work as part of an integrated system to achieve key health-system goals related to access, quality, health outcomes, and value for money; and 2) these sectors have not been supported to develop the strong management, governance and leadership that are needed at multiple levels of the health system to achieve these goals.

Dialogue participants identified four inter-related aspects of the problem as the most salient: 1) describing the problem accurately is difficult given challenges in determining the true magnitude of existing gaps in primary and community care leadership in Ontario; 2) existing leadership potential in the province is largely untapped; 3) the lack of emphasis historically placed on primary and community care in the health system has led to structural deficiencies that are difficult for any leader to overcome; and 4) the fragmented nature of primary and community care has further compounded leadership challenges.

First, many dialogue participants highlighted the fact that, at present, it is difficult to know the real extent of the leadership gaps in Ontario's primary- and community-care sectors, which makes it difficult to know how much attention to give to this problem. The challenge with documenting existing leadership gaps was attributed to a number of underlying factors, including:

- the absence of a shared understanding among health-system policymakers and stakeholders about what is meant by leadership in primary and community care, including inconsistent conceptualizations of and terms used to describe the many different types of leadership (e.g. shared leadership versus distributed leadership versus traditional leadership), the capabilities of strong leaders (e.g., leading self, engaging others and achieving results, among others), and the nature of and relationships among these capabilities (although the LEADS in a Caring Environment Capabilities Framework is increasingly being adopted by organizations across Canada);

#### **Box 1: Background to the stakeholder dialogue**

The stakeholder dialogue 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 Ontario;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three options (among many) for addressing the policy issue;
- 4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three options for addressing the problem, 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 options for 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.

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.



- a failure to clearly articulate the diverse leadership needs in primary and community care, particularly as the sector continues to broaden the range of governance and management models being used; and
- the lack of a comprehensive inventory of existing leaders in the province and of indicators and targets for the system's leadership needs.

On the whole, most participants agreed that these factors have created a challenging and confusing environment within which to establish the scale of the leadership problem that exists. However, most participants agreed that the perceived gaps in leadership reflect a real problem in the system, and as such warrant attention.

Second, there was broad agreement among dialogue participants that existing leadership potential in the primary- and community-care sectors has gone largely untapped. One participant noted that the expansion in the number of primary-care professionals in the province over the last decade means that more people are now available to 'step up to the plate' and become leaders. A second participant responded that, while many existing and new primary-care professionals have great potential in that they are trained clinically to a high standard and are intellectually capable of assuming leadership positions, many of these professionals are also naïve with respect to the capabilities required to be successful leaders. A number of participants agreed that leadership potential is underutilized in both primary care and community care, and several offered potential reasons for this: 1) current training programs are not developing or nurturing this potential among future primary- and community-care professionals; 2) leadership is not explicitly valued in the primary and community-care sectors; and 3) leadership is not supported in these sectors through incentives, training programs and peer mentorship. As one participant suggested, this has created a system where "latent leaders will remain latent."

Third, dialogue participants almost universally agreed that the lack of emphasis historically placed on primary and community care as the centre-piece of the health system has led to structural deficiencies that are difficult for any leader to overcome. Framing what is perhaps the same idea in another way, some participants stated that the lack of leadership in these sectors shouldn't be surprising given the sectors have never been prioritized by governments to 'lead the way' in the health system (and as such, the need for health-system leaders has never been articulated and then addressed). Several participants mentioned that investments in leadership have traditionally been made in the acute care sector, not in the primary- and community-care sectors. Furthermore, it was suggested that the primary- and community-care sectors don't reward good leadership, and that there are even disincentives to taking on leadership positions in these sectors (with negative salary implications given as one example). One participant noted that the situation in Ontario contrasts sharply with the National Health Service in England, which has invested heavily in leadership development. Many participants suggested that, over time, these factors have contributed to a lack of leadership capacity, which in turn leads to challenges in the development of future capacity (and which also contributes to the untapped leadership potential mentioned above).

Some participants suggested that the lack of investment in primary- and community-care leadership is largely a political issue, related to a lack of government will. Specifically, participants suggested that the government has not placed primary and community care at the top of their health agenda in the past (although many participants acknowledged that this is changing), and power imbalances mean that the hospital sector has more influence on where investments in capacity are made (although recent reforms of and investments in Ontario's primary-care sector suggest that this is also likely to change). With that said, one participant held up physicians as a good example of how to "give up" some of their power in the interest of strengthening the primary-care sector in Ontario, through the expansion of multidisciplinary teams and models of care that are led by non-physician primary-care professionals (e.g. Nurse Practitioner-Led Clinics). A related challenge noted by some participants was that perceived re-investments from front-line care to leadership development in primary care may not be politically feasible, given the public may not view it as an important dimension of service improvement.

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Fourth and finally, many participants suggested that the fragmented nature of both primary and community care – where the care provided by individual private practitioners and independent organizations is poorly coordinated and minimally integrated – has further compounded leadership challenges. Several participants agreed that one of the major negative effects of this fragmentation was the fact that this has reduced the number of leadership roles that exist, particularly in primary-care settings where solo practice has historically dominated. A number of participants highlighted that the shift towards new models, in which primary-care professionals are increasingly responsible for the oversight of large multidisciplinary teams of professionals, would change things. However, several participants noted that at present, professionals stepping into these leadership positions are not being supported to build their capacity to lead, which can result in frustration and burnout and a further loss of capacity in the sector. One participant also noted the shift from practice and organizational leadership to the type of system leadership required of those involved in HealthLinks has also brought to light shortfalls in how the system identifies, supports and rewards leaders. Several participants agreed that these shortfalls will need to be addressed sooner than later.

On a related point, one participant highlighted that the emergence of new models of primary care created challenges in determining how leadership needs differed across models and professional groups (e.g., Family Health Teams likely require different leadership than Community Health Centres, and both in turn likely have different needs than Community Care Access Centres). Some dissenting voices emerged to challenge this point, suggesting that there isn't a need to differentiate leadership capacity from one setting to the next given good leaders are able to adapt and learn new skills if and when they shift settings. One participant suggested that, overall, the main challenge within the dynamic and changing environment of primary and community care was identifying potential leaders who can work at the interface of these intersecting and overlapping care systems, and supporting them as they lead in the 'interstitial spaces' between them.

## **DELIBERATION ABOUT POLICY AND PROGRAMMATIC OPTIONS**

### **Option 1 - Develop, disseminate and support the use of a toolkit to support leadership development in primary and community care**

Deliberations about the first option centred around two main questions: 1) is there value in the use of a toolkit to support leadership in primary and community care; and 2) if toolkits are a valued approach, how might stakeholders be engaged to provide feedback about the development of one that is appropriate in the Ontario context? The deliberation also provided an opportunity for those who did not believe there was value in this approach to share their rationale for this position.

Several participants fully supported developing, disseminating and supporting the use of a toolkit for promoting leadership development in the primary- and community-care sectors, noting that toolkits can be used strategically as a way to signal the need for change, and as a way to prompt the necessary behaviour and cultural changes in the sectors. While many participants agreed that the development and dissemination of a toolkit is a good first step, given it can be acted upon quickly, they noted the importance of developing it in a way that is flexible and adaptable to different contexts. Furthermore, many participants suggested that building on and learning from other successful approaches to leadership development – including approaches used in the military or in corporate management – was an essential element of ensuring that the content of a toolkit had the best chance of achieving results in primary and community care. Several participants also agreed that those developing a toolkit must think through who the target audience for such a resource was, with one participant suggesting there were at least five target audiences from primary and community care that needed to be considered as prospective leaders who could benefit from a toolkit:

- front-line primary and community health workers;
- mid-level managers in primary health and community care organizations;
- senior managers in these same organizations;
- senior executives in larger organizations and in governing/administrative roles; and
- senior executives in governing bodies and professional groups that operate at a sectoral or system-wide level.

In addition to the positive aspects of option 1, participants also considered some of the key challenges associated with a toolkit. Many stated that, if pursued alone, a toolkit is not very promising given that it is unlikely to have much system-wide impact. Instead, this approach should be considered as part of a broader strategy that considers leadership development as a longer-term process that includes professional development, mechanisms to identify leadership opportunities and supports for transitioning into these opportunities, and career planning over the span of years. As a related point, one participant suggested that using ‘toolkit’ as the frame for this idea may not be appropriate, and prompted other participants to consider using the term ‘curriculum’ instead.

Those participants who found value in this approach suggested that there was a need to engage the full range of stakeholders as well as members of the community throughout all stages of the toolkit’s development. One participant noted that the process of engagement, in and of itself, is an extremely important process. Several participants suggested that the Ontario Primary Care Council (OPCC) was likely a good starting point for some of this collaborative work, given it can act as a champion for the work while also contributing to the establishment of a vision for leadership in primary and community that policymakers and other stakeholders could adopt and use. One participant argued that the whole process needs to focus on primary care, but with consideration given to the health system as a whole. Also, because of this need for an integrated strategy, some participants noted that community-care leaders should consider undertaking a similar approach in parallel with the one for primary care, which could lead to the development of compatible strategies that use common language and thereby enable all stakeholders to work towards the same goals, despite obvious differences across the two sectors.

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There were also several participants who opposed the idea of developing a toolkit to support leadership development in primary and community care. The majority of participants who held this position pointed to the fact that there isn't a clear vision for leadership in primary and community care in Ontario yet, and as such, it is nearly impossible to determine the content that a toolkit or curriculum ought to have. Several participants believed that without clear signals from the top (e.g., government committing to adopt the LEADS framework province-wide), the types of leaders and the kinds of skills that leaders need to possess cannot be determined. On the whole, while many of these participants were open to the idea of considering the utility of a toolkit as one component of a broader strategy that included several other options, many didn't think that the option addressed the root causes of the problem that were highlighted earlier in the deliberations.

### **Option 2 – Convene a provincial committee charged with supporting the integration of (and filling of gaps in) leadership initiatives in primary and community care**

Deliberations about option 2 resulted in the majority of participants coming to an agreement that a provincial strategy for leadership development was the approach that was most promising among all that were covered in the evidence brief. Participants noted that this option was likely politically and technically feasible, particularly in the primary-care sector given many efforts are already underway to bring stakeholders together. The specific example that was discussed at length was the OPCC, a committee of some of the province's key primary-care stakeholders focused on ensuring the system is providing timely access to patient-centred care. Some concerns were raised with having the OPCC lead this work, including: 1) whether the OPCC had a mandate that included this type of work; 2) even if its mandate is considered to include this type of work, whether the OPCC needed a specific mandate from government in order to secure the necessary resources and visibility to carry this out; 3) whether the OPCC has the experience needed to develop a system-level leadership strategy; and 4) whether the OPCC could ensure it was representing the views of the health workers represented by the founding member groups. However, participants also cited several benefits of charging the OPCC with the task of supporting the integration of (and filling of gaps in) leadership initiatives in primary and community care. These included the fact that the OPCC was already formed and has a mandate that could encompass this work, that it already includes representative primary-care organizations in Ontario, and that it already has good connections with the Ministry of Health and Long-Term Care.

While the option was viewed favourably, some participants noted that important groundwork needed to be laid either prior to developing a formal leadership strategy or early on in the process. This included articulating a shared vision of primary and community care among all engaged stakeholders, emphasizing the importance of the patient at the centre of the health system, and engaging government to catalyze the focusing of attention on primary care. Additionally, some participants noted that it would also be helpful to systematically conduct an inventory of leaders in primary and community care in Ontario. The rationale put forward by those advocating for an inventory was that developing a strategy would be difficult without knowing the status quo and hence the gaps that need to be addressed by a strategy. Because the community-care sector is not represented in the OPCC at this time, and because of the differences between the primary-care and community-care sectors, participants emphasized that a similar entity may be necessary to bring together the varying constituencies within the community-care sector. This was seen as especially important given recent trends towards moving more care into the community, and related changes in the health workforce. However, it was expressed that even though the community-care sector is not at the point of developing such an entity at this time, the primary-care sector should move forward, with appropriate consideration given to the community-care sector. A related note was made that the mental health and addictions sector, while currently different than, and separated from, the primary-care and community-care sectors, also faces challenges in leadership development and needs to be considered explicitly in the development of a health-system leadership strategy.

### **Option 3 – Identify current and emerging leaders in primary and community care and support their participation in a national leadership initiative**

Given that option 2, slightly re-framed as developing a provincial leadership strategy, emerged during deliberations as the preferred approach among participants, many viewed the national perspective incorporated into option 3 as a non-starter. One reason given by many participants was that a national focus may not be realistic given that healthcare is organized at the provincial level in Canada and there is little national collaboration on this issue. Participants pointed out, however, that many levels (including the federal level and cross provincially) could be looked at for learning opportunities. Participants also suggested that learning from other jurisdictions internationally could be useful for Ontario. For example, some European countries (e.g., the U.K.) seem to have a stronger vision for primary-care leadership that could provide fodder for a leadership strategy for Ontario. However, while acknowledging that other countries' experiences can offer motivation, some participants cautioned that it may not be feasible to transfer policies or practices from Europe to Ontario because of different health-system arrangements (e.g., remuneration mechanisms). As such, some suggested that looking at other provinces, while perhaps not ideal, was probably the most useful given "we work within the same [national] context." One final point that helped to buttress support for a provincial strategy over a national strategy was related to Ontario's distributed authority for healthcare. Some participants noted that while this dynamic is often viewed as a challenge, it should also be viewed as an opportunity to introduce and learn from pilot projects.

### **Considering the full array of options**

Generally, the deliberations led dialogue participants to support a re-framed version of the three options as part of a comprehensive strategy for primary care and community care leadership development in Ontario, with a re-ordering reflecting how the approaches and their elements ought to be prioritized:

- 1) convene a provincial committee charged with supporting the integration of (and filling of gaps in) leadership initiatives in primary and community care as part of a larger strategy around health-system leadership development in primary and community care, and as a means to engage government to catalyze the focus of a primary and community care-led and patient-centred health system (with the OPCC suggested as the obvious candidate to act as the provincial committee and with, in addition, a separate process needed to bring together stakeholders from the community-care sector);
- 2) develop, disseminate and support the use of a toolkit, curriculum or what was later called simply a 'resource listing' as part of this larger strategy for health-system leadership, which can then act as a signal about the need for change, and support the government in defining a clear vision and in prioritizing health-system leadership within Ontario's primary- and community-care sectors; and
- 3) identify current and emerging leaders in primary and community care and support their participation in a provincial leadership initiative.

Participants several times reiterated that one of the most important elements underlying this way forward is the articulation by government of a clear vision for the central role of primary care and community care in Ontario's health system, and in achieving key health-system goals. They also reiterated the importance of establishing the supports required for professionals who are transitioning from practice to leadership positions (e.g., training, mentorship and appropriate compensation for the loss of time given to patient care).

## **DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS**

Deliberations about implementation considerations included a discussion about barriers and opportunities for improving leadership capacity in primary and community care in Ontario. Two main barriers surfaced through these discussions, namely a lack of resources and inertia, both of which were said to be a challenge at multiple levels of the health system. The lack of resources was considered to manifest itself both in the lack of time to develop (and participate in developing) an overarching vision and strategy, and in the lack of dedicated financial resources to support leadership development. The inertia was attributed to multiple sources: 1) the perceived need to try to make the strategy perfect and entirely inclusive before moving forward; 2) widespread acceptance (and in some cases comfort with) the status quo; and 3) a lack of political will. Participants suggested three approaches to overcome these contributors to inertia. First, with respect to the need for a perfect and fully inclusive strategy, several participants felt that it was important to acknowledge that a strategy did not need to be perfect (and probably couldn't be perfect) or fully inclusive of all stakeholders before moving forward. Instead, it was important to initiate action first to get things moving forward, and then worry about refining and perfecting once in motion. Second, in order to overcome widespread acceptance of the status quo, several participants noted that there was a need for a culture change, which could include challenging current leaders to move away from continued investments in acute and more generally front-line care almost exclusively, and towards investments that also included leadership development and other activities that help to ensure that the right mix of care gets to those who most need it. Third, turning to a lack of political will, several participants noted that it was important to have a dedicated lead who could engage the premier of Ontario, which would help facilitate both the development of a leadership strategy and the broader intersectoral action needed to support primary and community care. Suggestions included the assistant deputy ministers involved in the human resources and transformation portfolios. However, the high turnover in such top leadership positions was noted as posing a problem for long-term change in Ontario.

Despite the barriers acknowledged by participants, many opportunities surfaced as well during the deliberations. First, bringing stakeholders together under the umbrella of leadership initiatives was viewed as an opportunity to develop a consolidated vision of primary and community care among a wide range of stakeholders, which until now was thought not to have occurred in Ontario. Second, the recent release of the Ontario Health Innovation Council's report was viewed as an opportunity given it had already placed many of the issues discussed at the dialogue on the Ontario government's agenda. Third, current variations in models of care, particularly in primary care, were viewed by many participants as opportunities for innovation as well as for advancing the study of leadership (e.g., what kinds of leadership characteristics are useful in all settings versus particular settings). HealthLinks was given as a particularly interesting model of care, but it was also noted that other models (e.g. Family Health Teams and Nurse Practitioner-Led Clinics) also offered significant learning opportunities. Fourth, several participants felt that there is currently a large untapped pool of capable young professionals who could rise to leadership positions if given the proper training and supports. Fifth, one participant suggested that the plan to change the family medicine curriculum could provide an opportunity to integrate leadership skills training into this curriculum. And, lastly, while not related to the kinds of professional leadership that served as the primary focus of deliberations, some participants noted that the Supporting Patient Oriented Research (SPOR) initiative provided an opportunity to develop citizen and patient leadership capacity in the health system.

## **DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES**

At the conclusion of the dialogue, each participant reflected on the next steps that could be taken. On the whole, participants' suggested next steps fell into three broad types of commitments.

First, all groups and organizations should continue to push for a vision, structures, resources and supports for patient-centred primary healthcare at the centre of the health system, so that existing and future leadership capacity is harnessed towards an agreed vision, able to function within appropriate structures, and enabled with appropriate resources and supports.

Second, a guiding provincial committee should develop a provincial strategy for health-system leadership development in the primary-care sector, keeping the following points in mind:

- 1) the OPCC would be an appropriate body to take on this work;
- 2) the government should endorse this mandate and provide the resources necessary to develop and implement the strategy;
- 3) from a process perspective, the provincial committee should:
  - a) identify and engage a champion within government who can help push these ideas forward,
  - b) engage existing centres of expertise and draw on the best available evidence in developing the strategy,
  - c) ensure the strategy revolves around patient- and community-centred care,
  - d) remain cognizant of the full breadth of key stakeholders (e.g., midwives, not just nurses and physicians) and work to engage them in this process,
  - e) assess the current level of available leadership capabilities across sectors,
  - f) recognize the broad array of leaders in the system and the different contexts in which they work, and both inspire and engage them through the strategy,
  - g) define the roles of and partner with patients in developing and implementing the strategy,
  - h) give explicit attention to equity considerations related to both citizens/patients and providers (e.g., Aboriginal, francophone, aging, and rural or remote individuals, as well as emerging leaders),
  - i) keep community-care leaders informed of the work, support community-care leaders as they move forward in addressing leadership capacity in their sector, and identify and capitalize on synergies between sectors whenever possible,
  - j) learn from and share lessons with other provinces and countries; and
- 4) from a content perspective, the strategy should:
  - a) emphasize the focus on outcomes (e.g., better access, quality, health outcomes and value for money), and link the proposed structure and processes to these outcomes in order to facilitate monitoring and evaluation,
  - b) propose how to measure, plan and monitor leadership capacity,
  - c) promote the most robust leadership framework available (which may turn out to be the LEADS framework),
  - d) define key concepts and the current landscape for leadership development (e.g., leading in the 'interstitial spaces'),
  - e) include a common curriculum for leadership development in complex adaptive systems,
  - f) cover the full spectrum of selection, preparation, support (e.g., communities of practice and mentorship) and continuous improvement of leaders,
  - g) provide a resource listing and perhaps other elements of a toolkit that can support the organic development of leadership capacity, not just its purposeful development,
  - h) be customizable to the needs of different professional groups and system contexts while providing opportunities for cross-group and cross-context learning.

Third, a similar, but separate, approach should be undertaken by the community-care sector, keeping in mind that these sectors need to share a vision for patient-centred primary healthcare, and therefore need to come together to share experiences and learn from each other whenever possible.



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