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DESIGNING AN INNOVATIVE AND IMPACTFUL EXECUTIVE EDUCATION PROGRAMME THROUGH CREATIVE ALLIANCES: A CASE STUDY IN THE ENGLISH NHS

DISEÑANDO UN PROGRAMA DE EDUCACIÓN EJECUTIVA INNOVADOR E IMPACTANTE A TRAVÉS DE ALIANZAS CREATIVAS: UN ESTUDIO DE CASO EN EL NHS INGLÉS

Ann Mahon[1]

Abstract

Business schools are often criticised for failing to provide industry and public services with the skills and talents they need. This paper presents a leadership development case study and tells the story of how Alliance Manchester Business School, with the University of Birmingham as part of a KPMG-led creative alliance, worked with the English NHS to create a leadership development programme, aimed at changing the culture of the NHS.

In the wake of a major inquiry into leadership failures the challenge to change the culture of NHS management and leadership was profound. A call was issued for providers to work in partnership with the NHS Leadership Academy to design and deliver a suite of leadership development programmes. This case study focuses on one of these programmes, the MSc Healthcare Leadership, also known as the Anderson programme.

The pedagogical approach of the programme is blended learning, emphasising multi-disciplinary and integrated content, experiential learning and a regard to both content and process. Key design features and challenges are explored in relation to how we achieve participant-centred learning, how we achieve impact beyond the individual and how we combine a leadership development programme with an academic programme.

The programme is having the greatest impact at individual and team levels and on

[1] *British. Professor of health leadership and head of the health management group at Alliance Manchester Business School (AMBS), the University of Manchester, England. Professor Mahons research interests and publications are primarily in the field of health and public policy and evaluation. She also specialises in learning and personal development for public sector managers and leaders and has extensive experience of designing and managing successful and effective leadership development programmes at scale. E-mail: ann.mahon@manchester.ac.uk*

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career progression and promotion. There is some evidence of organisational impact but this is inhibited by the lack of engagement and organisational support from sponsors. The case study offers an example of how business schools, working as part of a creative alliance, can offer innovation in the design and delivery of leadership development programmes and respond to increasing demands for customisation, evidence of impact and blended interventions.

Keywords: *Executive education; leadership development; experiential learning; talent management; National Health Service (NHS).*

Resumen

Las escuelas de negocios a menudo son criticadas por no proporcionar a la industria y los servicios públicos las habilidades y talentos que necesitan. Este documento presenta un estudio de caso de desarrollo de liderazgo y cuenta la historia de cómo Alliance Manchester Business School, con la Universidad de Birmingham como parte de una alianza creativa liderada por KPMG, trabajó con el NHS inglés para crear un programa de desarrollo de liderazgo, destinado a cambiar el cultura del NHS.

A raíz de una importante investigación sobre las fallas de liderazgo, el desafío de cambiar la cultura de gestión y liderazgo del NHS fue profundo. Se emitió una llamada para que los proveedores trabajen en asociación con la NHS Leadership Academy para diseñar y entregar un conjunto de programas de desarrollo de liderazgo. Este estudio de caso se centra en uno de estos programas, el MSc Healthcare Leadership, también conocido como el programa Anderson.

El enfoque pedagógico del programa es el aprendizaje combinado, enfatizando el contenido multidisciplinario e integrado, el aprendizaje experiencial y el respeto tanto del *contenido* como del *proceso*. Se exploran las características y desafíos clave del diseño en relación con la forma en que logramos el aprendizaje centrado en los participantes, cómo logramos un impacto más allá del individuo y cómo combinamos un programa de desarrollo de liderazgo con un programa académico. El programa está teniendo el mayor impacto a nivel individual y de equipo, y en la progresión y promoción de carrera. Hay algunas pruebas de impacto organizacional, pero esto se ve inhibido por la falta de compromiso y apoyo organizacional de los patrocinadores. El estudio de caso ofrece un ejemplo de cómo las escuelas de negocios, trabajando como parte de una alianza creativa, pueden ofrecer innovación en el diseño y ejecución de programas de desarrollo de liderazgo y responder a las crecientes demandas de personalización, evidencia de impacto e intervenciones combinadas.

Palabras claves: Educación ejecutiva; desarrollo de liderazgo; aprendizaje experimental; gestión del talento; Servicio Nacional de Salud (NHS).

Introduction

Universities in general and business schools in particular, are often criticised by the business community for failing to provide industry and public services with the skills and talents they need for competitive advantage or successful development and implementation of strategy (Currie, Davies and Ferlie, 2016; Datar, Garvin and Cullen, 2010; Moldoveanu and Narayandas, 2016; Navarro, 2008). The gap is not just in relation to the acquisition of skills "the skills gap", but also the application of skills, "the skills transfer gap" (Moldoveanu and Narayandas, 2016). At the same time, economies and industries across the globe and in public and private sectors, are being reshaped as they operate in increasingly VUCA (volatile, uncertain, complex and ambiguous) environments (Lubeck, Cheng, Myszkowski, Doedijins Drew and Snow, 2016) and as they prepare to respond to the megatrends driving change. Based on 1,344 interviews with CEOs in 68 countries, PricewaterhouseCoopers (PwC) identified the top five megatrends that are re-shaping the business landscape (PwC, 2014) These are technological advances (identified by 81% of CEOs), demographic changes (61%), shifts in global power (59%), resource scarcity and climate change (46%) and rapid urbanisation (40%) (PwC, 2014). In the same survey 63% of CEOs reported that the availability of relevant skills to respond to these megatrends is a serious concern (PwC, 2014).

In the past, management programmes delivered in university-based business schools, have focused on domain or functional knowledge, rather than the practice of management or an understanding of interpersonal relationships (Datar, Garvin and Cullen, 2010; Navarro, 2008). In this traditional approach, the expertise is deemed to reside within academia, with faculty being the subject matter experts, with the role of conveying their mastery of a subject to their students. This is now neither desirable nor acceptable. Business schools within universities and other executive education providers, must innovate if they are to survive in an increasingly demanding and competitive market. Moldoveanu and Narayandas (2016) and others have warned that unless business schools adopt greater flexibility and agility in the design and delivery of executive education offers, other providers will occupy their space (Hall and Rowland, 2016; Mintzberg, 2004; Moldoveanu and Narayandas, 2016). However, this change does not seem to be happening at pace. In research that looked at current demands on leadership, and endeavoured to explore the linkages between management education and agile leadership in the UK, Hall and Rowland (2016) concluded that syllabi do not offer the opportunity for leaders to develop the skills that organisations expect. This is because curricula are characterised by an emphasis on content rather process (Hall and Rowland, 2016). In a US study of the core curricula of MBA programmes in top ranking business schools, Navarro drew a similar conclusion. His web-based survey revealed the traditional mode of leadership development organised around "functional silos" and "dominant design" prevailed (Navarro, 2008). In addition to concerns about out-dated pedagogy business schools have also been identified as being insular and exclusive. Currie et al., make a plea to business schools to "lower their walls" and work more collaboratively with other university departments if "grand challenges" are to be addressed in a way that creates social value (Currie et al., 2016).

Such collaboration, however, needs to move beyond university partnerships if business schools are to maintain their market position as serious providers of executive education (Lubeck et al., 2016). Indeed some companies have begun to steer away from recruiting on the basis of qualifications and are increasingly recruiting on potential and developing talent in-house, reflecting a lack of confidence in educational systems, both schools and universities, to develop the skills required by industry. Relevance to the workplace is not just about developing the right skills and attitudes, it is also about providing opportunities to apply and develop them. The AMO framework offers a model for assessing the impact of talent management initiatives. Here, the impact of talent management strategies is a function of ability (A), motivation (M) and Opportunity (O) (Boselie, Dietz and Boon, 2005; Collings and Mellahi, 2009).

Many different business sectors and academic disciplines have an interest in the concept and application of innovation. Perhaps as a result of its vast appeal, multiple definitions appear in the literature. Baregheh, Rowley, and Sambrook (2009) undertook a content analysis of extant definitions of innovation and identified the key attributes present in the multiplicity of definitions. These key attributes relate to the type of innovation, stages of development, the social context, the means of innovation and the aim of the innovation (Baragheh et al., 2009). For the purposes of this paper, these attributes will be applied to a leadership development programme, within an overarching framework that focuses on three key elements. The first element is the generation of new ideas or demands from the client, customer, provider or consumer; the social context that precedes or triggers the innovation. The realisation, or translation, of these demands into practice, is the second element. The third is the subsequent creation of value for the client or customer. The case study is framed around these three elements of innovation.

So, how are business schools responding to the challenge of supporting organisations to manage and develop their talent in innovative and impactful ways? Through an exploration of these three elements, this paper tells the story of how Alliance Manchester Business School (AMBS), in partnership with the University of Birmingham and as part of a KPMG-led creative alliance, worked with the world's fifth largest employer and largest single healthcare system in the world, to create an innovative leadership development programme, which aimed to change the culture of the NHS. The case study showcases how a business school, as part of a creative alliance, can meet the demands of a major public sector employer in England.

The story begins by setting out the context that generated new ideas and demands for the management and leadership development of mid-level managers and leaders in the English NHS. It then describes how these ideas were realised though creative alliances and the design and delivery of an innovative academic and leadership development programme. The value created, in terms of impact on individual participants, their teams, organisations and the health and social care system, is assessed. Finally, the key findings, learning points and implications for future research are summarised.

The context and the generation of new ideas and demands

The National Health Service (NHS) in the United Kingdom (UK) developed out of a post-war consensus that had declared a new war on the five giants of want, disease, squalor, ignorance and idleness (Timmins, 2001). Based on the principles of comprehensive and universal coverage, funded through general taxation and free at the point of use, its creation was seen as the world's biggest experiment in public services (Timmins, 2001). Rudolf Klein captures the essence of the introduction of the NHS into post-war Britain:

> *"It was the first health system in any Western society to offer free medical care to the entire population. It was, furthermore, the first comprehensive system to be based not on the insurance principle, with entitlement following contributions, but on the national provision of services available to everyone. It thus offered free and universal entitlement to State-provided medical care. At the time of its creation it was a unique example of the collectivist provision of health care in a market society". (Klein, R., 1983, p.1)*

The cracks, however, soon appeared with unanticipated escalations in demand, unexpected continued inequalities in access and health outcomes and persistent financial challenges (Chester, 1956; Gray, 1982; Klein, 1983; Timmins, 2001).

Today, the NHS is the world's fifth biggest employer with 1.7 million workers in the UK and 1.2 million in England. Since 2010 there has been an increase in all staff groupings, except management and 'back room' or 'back office' functions. There are also significant shortfalls in the nursing workforce and the impact of Brexit, on a system where 10% of doctors, 5% of nurses and many more care workers come from EU countries, remains uncertain (Kmietowicz, 2016). In respect of management, it is estimated that there are 21,000 managers and more than 9,000 senior managers, representing approximately 4% of the NHS workforce in England (King's Fund, 2017). Since 2010 the number of managers has reduced from 38,297 to 30, 932 in 2017. This reduction is the result of organisational restructuring, as well as a commitment from the government to reduce NHS administration costs (King's Fund, 2017). It is likely that this is a significant underestimate of the management and leadership workforce, as many management and leadership roles are carried out at all levels of the NHS workforce and not exclusively by those employed in dedicated management or leadership positions (Mahon and Young, 2006).

Seventy years on the NHS is a source of national pride, political fodder and is constantly under the gaze of the media. New technologies, demographic changes, political and economic instability have generated a system that is under considerable financial pressure and that is struggling to reconcile meeting financial targets with the delivery of safe and high quality care (Smith and Walshe, 2016; Chambers, 2016). Throughout the history of the NHS, scandals, public inquiries, news reports and, more recently, social media, have highlighted failings in care and leadership (Black and Mays, 2013; Martin, 1984; Walshe and Higgins, 2002) without necessarily leading to significant or enduring change in culture and practice (Walshe and Higgins, 2002). One of the most prominent public inquiries into

failings of care in the NHS is the Francis Inquiry, with the first report being published in February 2013 (Francis, 2013). This inquiry focussed on the failure of patient care in Mid-Staffordshire NHS Foundation Trust located in the midlands of England, between 2005 and 2009. The Francis reports found that although some individuals were responsible for failure of compassionate care, the problems were systemic. Connections were made between failure of patient care with failures of leadership in all of the NHS organisations within the regional system and from the Board down (Chambers, Thorlby, Boyd, Smith, Proudlove, Kendrick and Mannion, 2017; Francis, 2013). Patients' experiences of care was poor and, at times, appalling. Patients, their relatives and their carers, were not listened to (Francis, 2013). In essence systemic failures in leadership were uncovered, with all parts of the regional system playing its role (Chambers, et al., 2017; Francis, 2013). In addition to extensive news media coverage there was a strong collective response through social media, particularly through twitter. Market surveys have found that members of the public trust NHS managers fair less than they trust doctors and nurses (Mahon, 2013). The doctors in Mid-Staffordshire had lost trust and confidence in managers and leaders and following the publication of the Francis reports, the public were losing confidence in the management and leadership of the NHS.

There is extensive evidence that poor management and leadership has a negative impact on patient experience and care and there is also a growing body of evidence that connects good leadership and effectiveness management with patient outcomes at Board level (Chambers, Harvey, Mannion, Bond and Marshall, 2013; Chambers, et al., 2017), team level (West and Mackiewicz, 2016) and at the level of individual behaviours (Goleman, 2000). So leadership matters, but what style of leadership? The law of requisite variety, derived from cybernetics, tells us that systems with the greatest flexibility are more likely to thrive and survive. A biological system survives as far as it is able to mobilise responses that match a range of situations (Ashby, 1956). Applied to human systems, individuals, teams and organisations must be able to respond flexibly to meet challenges and opportunities. For Goleman, leadership style can and should be a strategic choice (Goleman, 2000). In order for managers and leaders to possess a repertoire of leadership styles and to have the skills and judgment to select and enact the appropriate choice, the aim of any leadership development programme should include self-awareness, awareness of the impact of self on others, knowledge and understanding of the range of leadership styles and strategies and the skills and opportunity to take up a style in practice. As Goleman observes:

> *"The best leaders don't know just one style of leadership – they're skilled at several, and have the flexibility to switch between styles as the circumstances dictate". (Goleman, D., 2000, p15)*

Goleman argues that leadership style influences the climate (or atmosphere) of an organisation and that this in turn influences performance. Building on research by the consultancy group Hay, he describes six distinctive styles, each of which is considered to work better in certain circumstances than in others. The six leadership styles are coercive, authoritative, affiliative, democratic, pacesetting and coaching. In Goleman's model,

climate refers to six key factors that influence an organisation's working environment. These six factors are the flexibility and freedom from bureaucracy to innovate; a sense of responsibility to the organisation; the level of standards that people set; accuracy of performance data, including the appropriateness of performance related rewards; clarity about mission and values and finally, the degree of commitment to a common purpose. Each of the six individual leadership styles was found to have an impact on each of the six factors relating to climate. Goleman's summary of the relationship between each of the six leadership styles and the organisational climate is set out in table one.

Table one: A summary of Goleman's six leadership styles

	Coercive	Authoritative	Affiliative	Democratic	Pacesetting	Coaching
The modus operandi of the leader	*Requiring or demanding immediate compliance*	*Mobilising people towards a vision*	*Creating harmony and emotional bonds*	*Building consensus through participation*	*Setting high standards for performance*	*Developing people for the future*
The phrase that captures the essence of the style	*Do what I tell you*	*Come with me*	*People come first*	*What do you think?*	*Do as I do, now*	*Try this*
Emotional intelligence competence underlying the style	*Drive, initiative and self-control*	*Self-confidence, empathy and a catalyst for change*	*Empathy and communication*	*Collaboration and team leadership*	*Conscientiousness, drive and initiative*	*Self-awareness, developing others and empathy*
Situations when the style is most effective	*In a crisis*	*When a new vision is needed*	*To motivate people during stressful times*	*To achieve engagement, consensus and buy-in*	*To get quick results from a highly motivated and competent team*	*To develop people and improve performance*
Overall impact on climate	*Negative*	*Most strongly positive*	*Positive*	*Positive*	*Negative*	*Positive*

Source: *Adapted from Goleman, D., 2000, p22*

As shown in table one, two of the leadership styles are found to have a negative impact on climate. These are coercive and pace-setting setting leadership styles. So, how does this relate to leadership in the NHS? At the same time as the Francis Inquiry was reporting its findings, a survey of senior NHS managers found the dominant style of leadership was pace-setting. This may explain some of the failures in leadership in Mid-Staffordshire, because although this style may reflect good intent, it has a negative impact on climate, stifling innovation, diminishing a sense of responsibility to the organisation and reducing standards of care (Lynas, 2015). This is consistent with the findings from the Francis Inquiry (Francis, 2013; Chambers et al., 2017).

With a workforce characterised by pace-setting senior leaders and negative organisational climates (Lynas, 2015), loss of public confidence in management and leadership of the NHS,

a damning public inquiry and hostile media and social media reporting, the challenge to change the culture of NHS management and leadership was profound. Tinkering around the edges was not an option. The scale of the problem meant that leadership in the NHS required a fundamental review. The political climate was enabling – a coalition government was in power, austerity was not yet a reality of life and the NHS had just established a new Leadership Academy that had drive, ambition and passion to make a difference.

It was against this background that the NHS Leadership Academy in 2012 approached the CEO of the NHS and asked for funding for a suite of leadership development programmes for all tiers of managers and leaders in the NHS (EFMD, 2016). This ambition, in terms of reach, impact and levels of funding was unprecedented. A call was issued for providers or consortia to work in partnership with the NHS Leadership Academy to design and deliver these leadership development programmes. The call was not for a programme blueprint, but rather for a provider or Consortium who could respond at pace, at scale and deliver customisation, with an emphasis on equality, diversity and inclusion, value creation, patient and participant-centred design and innovative curriculum design.

The creative alliance and programme design

In response to an invitation to tender, issued by the NHS Leadership Academy at the end of 2012, KPMG convened a partnership which included AMBS, the University of Birmingham, voluntary sector organisations, small and medium enterprises, as well as international partners such as Harvard School of Public Health. All of the partners within the creative alliance had worked with at least one of the other partners before forming a consortium. For example AMBS and the University of Birmingham had worked together for over ten years delivering jointly accredited award bearing leadership programmes, including education programmes for the NHS graduate management schemes, and already had in place a memorandum of agreement between the two institutions.

As part of the tender writing process members of the consortium spent many days working together, face to face or virtually, exploring design options, but more importantly developing our shared values, trust and agreeing ways of working. Significant time was also invested in preparing for and rehearsing the two day pitch. This time investment was significant and intensive. It helped to produce a plausible and credible creative alliance and engendered personal and professional relationships based on trust, challenge and shared values.

The Consortium was successful in its bid to design and deliver two programmes; one for middle managers aspiring to more senior positions (The Elizabeth Garrett Anderson programme[2]) and one for aspiring directors (The Nye Bevan programme[3]). This paper

[2] This programme was named after Elizabeth Garrett Anderson who was an English physician and suffragist and the first woman to qualify as a physician and surgeon in England.

[3] This programme was named after Aneurin (Nye) Bevan who, as Minster of Health, was a key figure in the establishment of the NHS.

focuses exclusively on the former. The NHS Leadership Academy became a part of the creative alliance and a consortium was formed in February 2013. Expectations were high and there was a sense of urgency. The Consortium had just over 8 months from being awarded the contract to recruiting its first intake in October 2013.

The programme

The Elizabeth Garrett Anderson programme is a 2 year leadership development programme. It is hybrid in design and award with successful completion resulting in an MSc healthcare leadership from the Universities of Manchester and Birmingham in England and a senior leadership development award from the NHS Leadership Academy, based in Leeds, in the North of England. The programme focuses on leaders and managers who occupy a particular position in their organisations and the emphasis is not in identifying key individuals, but rather identifying key positions within the organisations, with the potential to influence and change organisational culture. Middle managers, with the desire to move into more senior positions are the target audience. They are expected to be in roles that involve leading teams, complex projects, services or systems of care and aspire to more senior roles. The programme seeks to develop the knowledge, understanding, intellectual, practical and personal skills of participants through a blended learning approach. Before describing the pedagogy in more detail, the structure of delivery and participant profile will be outlined.

The participant profile is multi-disciplinary, multi-organisational and drawn from over 500 organisations in the English NHS. Over 2500 participants have registered on the programme since it was launched in October 2013 and over 1000 have graduated with the dual awards. Despite this scale, a participant-centred and personalised relationship is achieved with participants through a tutor trio and a cohort model of delivery. Participants are recruited to individual cohorts of 48 participants and 3 tutors are allocated to each cohort. Within the cohort, each tutor has one tutor group of 16 participants and each tutor group is divided into two action learning sets. The three tutors work together with a single cohort for two years and each tutor is a personal tutor for their group of 16. So, although almost 50 cohorts of 48 participants have been recruited through 12 intakes over four years, a participant-centred and personalised programme is offered on an almost industrial scale.

Pedagogy

The pedagogical approach adopted is that of blended learning, characterised by multi-disciplinary content, such as psychology, sociology, politics, business, management and leadership integrated into online modules, alongside experiential learning and a regard to both content and process in all elements. A key design feature is the parity of esteem given to the experiential elements of the programme compared with academic elements. Experiential learning is mainstream and participants are required to attend all elements of

the programme. There is no space for the "dominant design" model of delivery, identified by Navarro (2008). The role of tutors on the programme is not as subject matter experts or conveyors of domain knowledge but rather as facilitators of learning. Those registered on the programme are referred to as participants, not students, to emphasise the active adult learning pedagogy. The key elements of the blend include experiential learning through residential workshops and action learning sets, on-line modules delivered via a virtual campus and work-based application of learning through assessment. In addition tutors offer one to one and group tutorials.

Experiential learning

Four residential workshops are delivered during the programme and are primarily experiential in design. They include the introduction of various theory and practice based leadership development interventions such as the Organisational Workshop based on the work of Barry Oshry and John Watters (Living Leadership, 2018), which explore power and authority in systems, the Myers Briggs Type Indicator (MBTI) which explores personality type based on Carl Jung's theory of personality (OPP, 2018) and the NHS Healthcare Leadership Development 360 model (NHS Leadership Academy, 2013). The dimensions of this 360 model were employed in the external evaluation of the programme which will be reported later in this case study (Ipsos MORI, 2017). The nine dimensions are: influencing for results, connecting our service, sharing the vision, holding to account, developing capability, inspiring shared purpose, engaging the team, leading with care and evaluating information (NHS Leadership Academy, 2013).

Another experiential learning intervention is the action learning sets. Participants meet on 11 occasions in action learning sets of 8 participants. Eight of the sets are facilitated by the tutor and three are self-managed by the set. In the action learning sets participant present real live management problems to the group. Group members, through active listening and good questioning, explore the nature of the problem and options for action. In between set meetings participants implement a management action and report back on learning and impact at the next set meeting. The focus in the sets is on process and group dynamics, as well as task. This action learning process encourages both reflexivity and reflection (Boshyk and Dilworth, 2010; Weinstein, 1999).

The Virtual Campus

The taught element of the programme is delivered on line through six modules, Module 1 to 6. Modules 7 and 8 are the research based elements of the programme involving research methods and a healthcare leadership case study. Modules 1 and 6 focus on self and the individual as leader and they are 10 academic credits respectively. Modules 2 and 5 are weighted at 20 academic credits each and both modules focus on different aspects of leadership and team effectiveness. Modules 3 and 4 are 30 academic credits each and focus on different aspects of leadership in organisations and systems. The taught element

is 120 credits and the remaining 60 credits are gained through the research methods and a healthcare leadership case study.

Table two: Programme modules delivered via the virtual campus

Module 1: Understanding and developing leadership practice (10 credits)
Module 2: Building foundations for team effectiveness (20 credits)
Module 3:Making sense of organisational values, engagement and service delivery (30 credits)
Module 4: Delivering system wide co-ordinated care (30 credits)
Module 5: Creating engaging and learning cultures (20 credits)
Module 6: Evaluating my leadership behaviours and impact (10 Credits)
Module 7: Developing organisational research study skills (20 credits)
Module 8 Healthcare leadership case study (40 credits)

Source: *Internal programme specification document*

Two years after the programme commenced a full review of the VC content and structure was undertaken in response to participant feedback. The changes made included merging modules 7 and 8 into one single module. The programme for participants starting from intake 8 onwards therefore consists of seven modules.

Work-based application of learning

Assessment is important. Research and experience tells us that serious engagement with material that generates deep learning really occurs when programme participants focus on what is required for the assessment (Bloxham and Boyd, 2007). In their review of the evidence for assessment Bloxham and Boyd conclude that:

> *"...assessment strongly influences students' learning, including what they study, when they study, how much work they do and the approach they take to their learning". (Bloxham and Boyd, 2007, p29)*

The assessment for each module includes a critical assignment and between one and three work based assignments, depending on the weighting of the module. Critical assignments are primarily designed to assess the academic learning outcomes, while work based assignments are designed to assess the impact of the learning in practice. Crucially, priority is not given to the academic element and participants must pass all work based assignments in order to pass each individual module. This conveys a powerful message to participants about the duality of the award and integration of the academic elements with the application of learning.

The programme is underpinned by four core leadership principles and three golden threads that define the prevailing view of what high quality leadership should be focussing

on in the NHS. These principles and threads informed both the content and the pedagogy of the programme design and they evolved in the early stages of programme design and in consultation patients and carers.

Table three: Principles and golden threads underpinning design

Core leadership principles	Golden threads
• Making person-centred co-ordinated care happen • Creating a culture for quality • Improving the quality of the patient experience • Understanding self to improve the quality of care	• Focus on: • The patient experience • Care quality and safety • Equality, diversity & inclusion

Source: *Internal programme materials*

It is beyond the scope of this paper to detail all of the design features and challenges associated with the programme. Some of these are summarised in table four and are explored by addressing three key questions:

1) How do we achieve participant-centred learning on an industrial scale?

2) How do we deliver a programme that goes beyond individual learning and has an impact on teams and organisations?

3) How do we combine a leadership development programme with an academic programme?

Table four: Summary of design features and challenges

Design questions	Design features	Challenges in practice
How do we achieve participant-centred learning on an industrial scale?	Cohorts of 48 in large, medium and small group formations Trios of tutors – continuity and personalisation Action learning sets offering peer support Flexibility in the use of the Virtual Campus (VC)	Recruitment of tutors with relevant breadth of skills Trio dynamics and impact when a tutor or participant leaves Travel to action learning sets
How do we deliver a programme that goes beyond individual learning and has an impact on teams and organisations?	VC content - individual, team and organisation reflected in all elements of the module and residential design Work-based assessment Targeted recruitment application throughout	Engagement with NHS and organisational support Recruitment of participants Diversity of learning styles Heterogeneity of participant experience
How do we combine a leadership development programme with an academic programme?	Experiential learning Reflexivity Skills set of tutors Duality of award - hybrid	Getting accreditation from two universities within an 8 month timeframe. Recruiting tutors Contradictions in roles Balance between duality of award

Source: *Table constructed by author based on programme documentation, observation and personal experience as programme director.*

Value creation

Evidence about value creation comes from independent and internal sources. In early 2016 the NHS Leadership Academy commissioned Ipsos MORI, a leading market research company, to carry out an external evaluation of the programme. Their evaluation focused on the first two intakes, representing 11 cohorts of 48 participants and included a scoping exercise, an online survey of participants and 15 case studies with key stakeholders (Ipsos MORI, 2017). Internal evaluation is extensive and includes on-line surveys undertaken for each module and residential workshop, 7 focus groups conducted just over halfway into the programme and an exit survey carried out at the final residential workshop. Such comprehensive evaluation exceeds standard university requirements for module and programme evaluation and reflects the requirements relating to the governance of the programme. Finally, the programme has been nominated for and won a number a number of awards, each of which involved external scrutiny of the programme and can be seen as an endorsement of its innovative approach and acknowledgement of impact (EFMD, 2016).

An assessment of value creation, drawing on all of these sources, will focus on two areas of impact: the programme outcomes and career progression. In addition the sources of support from within and outside of the programme can be regarded as particularly significant drivers, or inhibitors, of impact. The role of support will also be explored.

Programme outcomes

The external evaluation sought to understand the extent to which any positive changes in leadership practice or outcomes for the teams, services and organisations that participants' worked in, was due to their engagement on the programme. Internal evaluations of modules assessed the extent to which participants reported that learning outcomes for the module had been achieved. Focus group evaluations, conducted by the programme directors, add some additional insights. Taken together these sources of evidence allow us to assess the impact of the programme at the individual, team and organisational levels.

Programme outcomes – individual levels

Ipsos Mori reported that 9 out of 10 (87%) participants involved in their survey would speak highly about the programme. In order to assess the impact of the programme at the individual level, respondents were asked to self-assess their effectiveness pre- and post-programme across nine dimensions of leadership practice that form the NHS healthcare leadership model. Participants' self-assessed mean rate was higher post-programme for all of the dimensions, with 95% reporting increased effectiveness in their individual leadership practice in at least one of the dimensions. For example, self-assessing on a scale from 1 to 10, the mean responses for "influencing for results" increased from 5.6 to 7.85 (+2.25), "connecting our service" increased from 5.78 to 7.98 (+2.17) and "sharing the vision", which increased from a mean of 5.81 to 7.95 (+2.14). Most participants

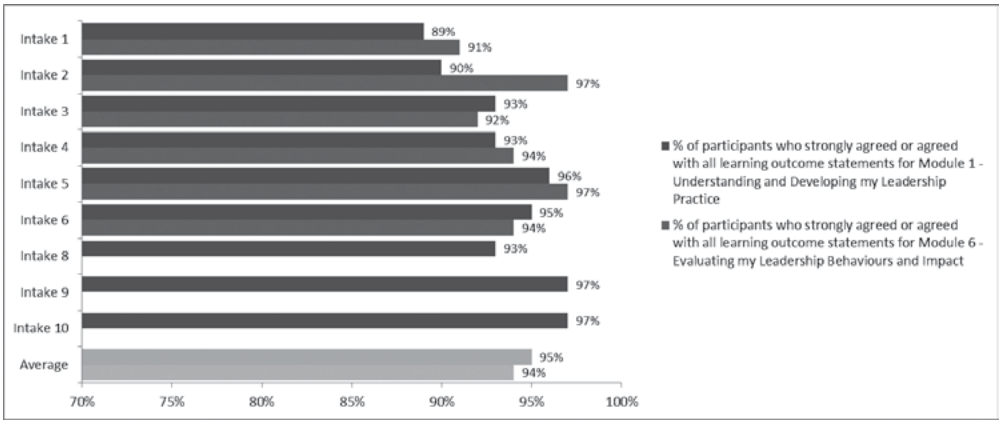
reported incremental change across all dimensions, whilst smaller numbers reported larger improvements in effectiveness or no improvement at all, across a smaller number of dimensions. The authors conclude:

> *"Overall, these findings appear to point to an incremental change in overall self-reported leadership effectiveness which translates into largely consistent perceived improvement across all nine leadership domains. This is corroborated by the findings from the case studies…" (Ipsos MORI, 2017, p16)*
>
> *and;*
>
> *"Overall, those interviewed unanimously thought that participation in the Programme coincided with a notable improvements tin their effectiveness as leaders, and these improvements were typically seen to be as a result of participation in the Programme". (Ipsos MORI, 2017, pp16-17).*

Participants, and those working with them in their organisations, identified key drivers for change as being improvements in confidence, self–reflection, adopting a more strategic and holistic view of their service area or organisation and being able to connect their leadership practice with relevant evidence and theory (Ipsos Mori, 2017). Focus groups, carried out by programme directors, corroborate this.

The internal on-line survey of modules also gives us some insights into programme outcomes. At the end of each module participants are asked to indicate the extent to which they strongly agree, agree, disagree or strongly disagree that various aspects of the programme design have been met. Modules 1 and 6 focus on various aspect of "self as leader". Figure 1 shows the mean number of participants, for each intake, who reported that they strongly agreed or agreed that learning outcomes for these modules have been met.

Figure 1: Participants' reports of impact of the on-line learning modules focussing on self as leader, by intake



Source: *Anderson programme internal evaluation*

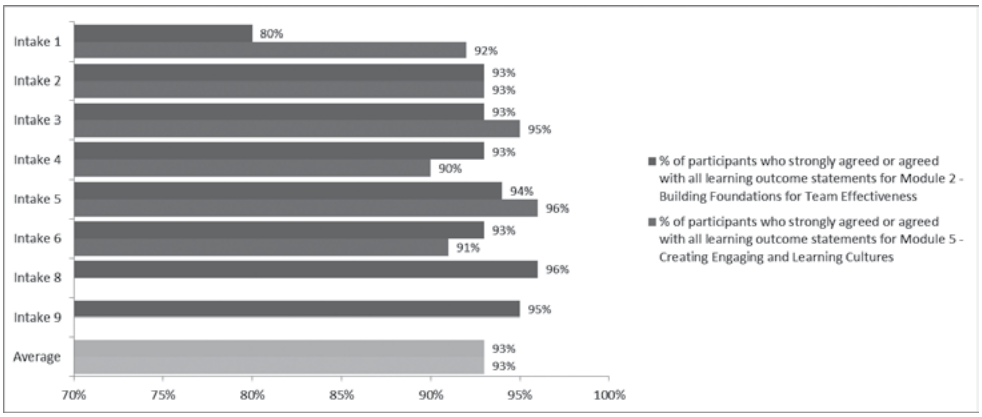
Overall the findings are very positive with at least nine out of ten participants reporting the learning outcomes had been met. The overall average is 95% for module 1 and 94% for module 6. Evaluations are slightly lowever for module 1 on intakes 1 and 2, relfecting early implementation challenges. More recent evaluations of module 1 report very high rates of agreement that learning outcomes have been met, reflecting positively on a full review of programme content and the extensive experience that faculty now have in the delivery of this programme. The role of tutor support in driving the impact of programme outcomes will be discussed later.

Programme outcomes – team and service levels

The external evaluators collected a range of measures relating to perceived outcomes on team working (Ipsos MORI, 2016) and found that participants perceived positive outcomes in a number of areas of team working. For example, 81% reported that the impact of the programme on team morale was very or fairly positive, 78% reported this for communication between teams and 74% for connection between organisations. 70% also reported that the programme fairly or very positively impacted on the quality of care and the patient experinece. The figure for patient outcomes was 68%. The evaluation found that particpants perceived the programme to have had less of an impact on financial efficiency at team level, so that 51% reported a postive impact on the financial efficiency of teams and 32% on the financial efficiency of organisations.

Again, the internal on-line survey of modules gives us some insights into programme outcomes at team and service levels. Modules 2 and 5 focus on various aspects of team effectiveness and team leadership. Figure 2 shows the mean number of participants, for each intake, who reported that they strongly agreed or agreed that learning outcomes for these team focussed modules have been met.

Figure 2: Participants' reports of impact of the on-line learning modules focussing on team leadership, by intake



Source: *Anderson programme internal evaluation*

Programme outcomes – organisations and systems level

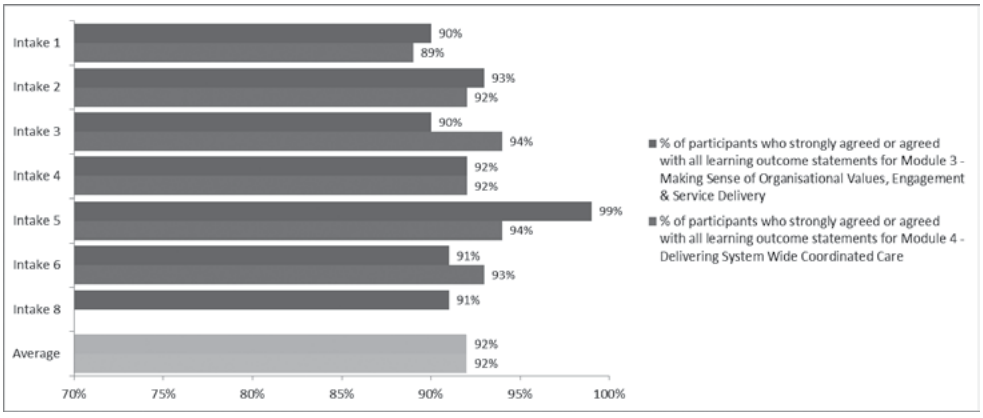
Although the external evaluation found evidence of the impact of programme interventions on aspects of individual, team and service delivery, the evidence of how the programme might have impacted on the wider organisation and system was more limited. Nevertheless the impact of the programme on organisations is described through the case studies, where organisational relationships, service delivery and wider organisational outcomes are reported. The evaluation shows:

> *"...evidence of the link between improved working relationships and other service / organisational-level outcomes (e.g. efficiency and quality of care), both through the involvement of their team directly, but also through improved information-sharing. In some cases, this was also related to an ability of the participant to think more strategically and therefore represent their team / service better in higher-level conversations and make positive contributions, for example in developing new service offers." (Ipsos MORI, 2017, p27)*

In relation to system-level outcomes the authors report it was beyond the scope of their evaluation to assess this and indeed such an impact would be expected to take longer to yield measurable outcomes, compared to changes in individual leadership practice.

Finally the internal on-line survey of modules gives us some insights into programme outcomes at the organisation and system level. Modules 3 and 4 focus on various aspects of organisational change and leadership. Figure 3 shows the mean number of participants, for each intake, who reported that they strongly agreed or agreed that learning outcomes for these organisationally focussed modules have been met.

Figure 3: Participants' reports of impact of the on-line learning modules focussing on organisational and systemic leadership, by intake



Source: *Anderson programme internal evaluation*

The evaluations are positive although overall the proportion of participants reporting that they strongly agree or agree that learning outcomes have been met is slightly less than those reported for the modules that focus on self and team.

Programme outcomes: self, team, organisation and system

The evidence demonstrates the positive impact of the programme on leadership practice. Impact has been greatest on individual leadership practice and team leadership. Organisational and system level impact is harder to assess. Reports from participants suggest that the "skills transfer gap" on this programme is greatest at the organisational and systems level, than at team or individual levels, where the participants may exert more influence and authority. The high ratings for learning outcomes on the organisational modules may appear at odds with the challenges reported in relation to organisational support. It does suggest however that the participants are acquiring the skills needed but have less opportunity, or organisational support, to transfer these particular skills into practice.

The focus groups and final residential workshop exit survey offer a more qualitative and deeper insight to the programme. The high impact on self and team was echoed with enhanced confidence, visibility, self-awareness, resilience, better decision making at individual level. On team working, participants reported clearer objectives, better communication and greater impact and visibility. Participants reported less control over organisational and system impact, possibly relating to their positional influence and the degree of organisational sponsorship, engagement and support.

Support

The nature and extent of support is a likely driver of how positively participants' experience the programme and associated outcomes (Ipsos MORI, 2017). Support comes from a range of sources and two are emerging as key in enabling participants to achieve programme outcomes; a lack of organisational support and engagement is experienced as inhibiting the impact of the programme, whilst tutor support is experienced as crucial in maintaining engagement on the programme. The findings are consistent across both external and internal evaluations.

The external evaluation reported a perceived lack of support from peers, line managers and organisations. This was experienced by some at the application stage but was seen as particularly problematic while completing the programme. In contrast tutor support rated consistently high and is seen as crucial in supporting participants to develop the skills and maintain the motivation to engage with the programme. 95% of Ipsos Mori respondents reported tutor support was very or fairly good. The corresponding figures rating support from other participants on the programme was 92%, the team participant was leading was 78% and the NHS Leadership Academy was 75%. However support from NHS organisations was the least favourable (Ipsos MORI, 2017).

The nature of the tutor-participant relationships was noted to be built on "bi-directional trust, openness and honesty" and their role as facilitators of learning in an adult to adult relationship, was acknowledged as key (Ipsos MORI, 2017). These findings echo the discussions in focus groups where participants emphasise the importance of tutor and peer to peer support, particularly on the experiential element of the programme, in supporting their development and maintaining motivation. Organisational support including having time to study, is frequently raised in the focus groups.

Systematically identifying key positions and targeting the incumbents for leadership development is one of a series of interventions associated with talent management (Collings and Mellahi, 2009) and indeed it is the starting point for many talent management strategies. This is what the Anderson programme is doing in its recruitment strategy. Instead of focusing on key performers, the focus is on key positions. Importantly, however, Collings and Mellahi (2009) also point out:

> *"While the organisation's strategic human capital is encompassed in the employees of the organisation…it is the organisational systems and processes which create and manage this strategic human capital and ensure that its contribution is maximised. Human capital is of little economic value unless it is deployed in the implementation of the organisations strategic intent". (Collings and Mellahi, 2009, p307)*

The evidence presented in this case study, in relation to organisational support and engagement from sponsor organisations, suggests that limitations in the opportunity to transfer knowledge, inhibits value creation. This is consistent with Boselie's model, which sees impact as a function of ability (A), motivation (M) and, crucially, the opportunity (O) for application (Boselie et al., 2005). Limited opportunity may impact on retention as participants may seek new roles in organisations that are more receptive to change, or seek new roles that give them the influence, authority and organisational climate to apply their learning. The impact of increasing ability and motivation without supporting opportunities to apply these skills in practice is worthy of further research.

Career Progression and Promotion

Completion of the programme has a positive impact on the careers of participants and this is supported by evidence from both the external evaluation and the exit survey conducted at the final residential event.

In the external evaluation 61% of the survey participants reported that they had changed role since they started the programme and of these 76% were working in a more senior role (Ipsos MORI, 2017). It was not just participants reporting career enhancement or development within existing roles; line managers and other colleagues reported observing the impact of the programme on participants' practice and their careers. In some cases new roles were being created specifically for individuals to acknowledge their potential and development (Ipsos MORI, 2017).

During the final event for an intake, each cohort is asked to complete a short questionnaire asking about their career development since being on the programme and whether they believe this to attributable to the Anderson programme. To date, 1054 participants across Intakes 1 to 6 have completed the questionnaire. Just over half of the participants (N = 542 / 51%) reported that they had been promoted whilst on the Anderson programme and 89% of these attributed their promotion to the programme. This figure was slightly higher for Intake 1 and 2 participants (96% and 90% respectively) than for Intake 3, 4 and 5 participants (85%, 85% and 88% respectively), but rose again to 90% for respondents from Intake 6. From Intake 4 onwards, participants were also asked about their gender and ethnicity. The aggregated data for Intakes 4, 5 and 6 shows little or no differences in reports of promotion by gender or by ethnicity. 54.2% of men were promoted compared to 52.5% of women.

Table five: Participants reported as having been promoted by gender

Gender	Total No. of Respondents	Promoted (N)	Promoted (%)
Female	425	223	52.5%
Male	192	104	54.2%
Did not disclose	9	7	77.8%
Total	626	334	53.4%

Source: *Anderson programme internal evaluation*

In relation to ethnicity, the numbers for each of the 15 ethnic groups are too small for meaningful comparisons. If we combine these fifteen into three groups representing those from Black, Asian and White communities, the figures reporting promotion are similar as shown in table six.

Table six: Participants reported as having been promoted by ethnicity

Ethnic Groupings	Total No. of Respondents	Promoted (n)	Promoted (%)
White	525	279	53.1%
Black	45	23	51.1%
Asian	40	20	50.0%
Other	2	1	50.0%
Did not Disclose	14	11	78.6%
Grand Total	626	334	53.4%

Source: *Anderson programme internal evaluation*

The Learning

At least four key learning points can be distilled from this case study. First, a lot can be achieved in a very short time within a creative alliance and with due attention to identifying shared values and agreeing core themes and design principles early on in the process. Investing time in relationships is important, especially when working intensively and at pace. Second, a hybrid programme that combines academic elements with experiential learning and resulting in both academic and professional awards can be successful if parity of esteem is given to experiential components and work-based application, alongside the academic elements. Third, a more rigorous assessment of value creation is limited because of the absence of comparison groups, the problem of attribution and the time required for systemic impact to embed. These limitations were also noted by the external evaluator (Ipsos MORI, 2016). Explicit attention to the information requirements and methodologies for assessing value creation should be given from the outset. Finally, two key aspects of recruitment emerge as important to value creation. The first aspect relates to engaging all stakeholders. This case study has shown that the potential to apply learning in the workplace is inhibited by variations in organisational support and engagement of sponsors. Although there was high engagement with the commissioner, the NHS Leadership Academy, they are a national organisation and the individual NHS organisations, where participants are employed, are more distant. Emphasis needs to be placed on securing engagement and buy-in from organisational sponsors, in order to maximise value creation. Future models of recruitment to programmes of this nature should place a premium on stakeholder and sponsor engagement. The second aspect of recruitment is ensuring that participants are recruited at the appropriate level in their organisation so they have the authority and influence to apply learning, alongside appropriate organisational sponsorship.

Implications for research

Areas for future research in relation to the three elements used to frame the case study can be identified. First there is the importance of having an understanding of the social context that precedes or triggers the demand for innovative leadership development. What particular problems are such programmes seeking to address? How do these vary across different sectors and cultures? Second, how are such demands translated into effective leadership development programmes? What particular blend of interventions works best, with which groups and under what conditions? How can organisations best support their employees to yield a return on investment? Finally, what is the best way to measure the impact of leadership development programme? There is a desperate need to move beyond participant satisfaction and measures of individual behaviour change towards the use of more nuanced and rigorous metrics to assess the impact of leadership development programmes on organisational performance and productivity.

Summary and Conclusion

This case study demonstrates that, despite some challenges, business schools can remain key players in the future delivery of executive education. By "lowering their walls" (Currie et al., 2016) they can work with clients and other partners to address both the "skills gap" and the "skills transfer gap" identified globally and across all sectors (Moldoveanu and Narayandas, 2016). Within a creative alliance, university-based business schools can be agile and flexible. Although arising out of a very specific context, the expectations of the NHS Leadership Academy for their programmes, are fairly typical of industry in general. Many of the themes identified in a review of market demands for executive education coincide with the desires of the NHS Leadership Academy at the time of procurement. Their emphasis on customisation, agility, diversity, participant-centredness, value creation and co-creation are consistent with the demands of industry (Lubeck et al., 2016). The learning through this programme has been bountiful. There remains ample opportunity to further enhance design and delivery of executive education through creative alliances and in order to maximise value creation. A summary of the case study is offered in Table seven.

Table seven: Summary of the case study

The context
A public inquiry reveals systemic failures in leadership in the NHS. Senior leaders prefer a pace-setting style of leadership creating negative organisational climates. Loss of trust and confidence triggered leadership development at an unprecedented scale.
The creative alliance
A creative alliance between Alliance Manchester Business School and partners in other universities, the voluntary sector, small and medium enterprises and a large consultancy was forged. All partners in the creative alliance had worked with at least one of the other partners before forming a consortium which included the programme commissioner.
The programme
The Elizabeth Garrett Anderson Programme is a 2 year leadership development programme. Over 2500 participants have registered on the programme since it was launched in October 2013 and over 1000 have graduated with the dual awards of an MSc in Healthcare Management from Alliance Manchester Business School and the University of Birmingham and a senior healthcare leadership award from the NHS Leadership Academy. A participant-centred and personalised programme is achieved through particular structural and pedagogical features of the programme. A key feature of design is the parity of esteem given to the experiential elements of the programme compared with academic elements.
Value creation
The evidence from internal and external sources demonstrates the positive impact of the programme on leadership practice and team leadership. Just over half of the participants who have completed the programme (N = 542 / 51%) reported that they have been promoted whilst on the programme. 9 out of 10 of these attributed their promotion to the programme. Organisational and system level is harder to assess. Participants reported less control over organisational and system impact relating to their positional influence and the degree of organisational sponsor engagement and support.

Continues...

Learning
A lot can be achieved in a very short time within a creative alliance focusing on shared values, core themes and design principles. Investing time in relationships is important when working intensively and at pace. A hybrid programme that combines academic elements with experiential learning and resulting in both academic and professional awards can be successful if parity of esteem is given to experiential components and work-based application, alongside the academic. A more rigorous assessment of value creation is limited because of the absence of comparison groups, the problem of attribution and the time required for systemic impact to embed. Emphasis needs to be placed on securing engagement and buy-in from organisational sponsors, in order to maximise value creation.
Implications for research
Further research is needed to understand the social context that precedes or triggers the demand for innovative leadership development, to support the translation of such demands into effective leadership development programmes and to develop more nuanced and rigorous metrics to assess the impact of programmes on organisational performance and productivity.

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