KO AWATEA

White Paper Series

The Ko Awatea Leadership Academy

Number three in a series

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Section I: Introduction

It is well recognised that the New Zealand (and global) health system is at a tipping point, that the status quo is unsustainable and change is essential. There are complex system issues and new solutions must be found for Counties Manukau District Health Board (CMH) to continue to operate effectively, affordably and sustainably. Unless new and adaptive approaches are taken, the system will not be in a position to achieve the necessary performance and results required to improve the health of its population.

In May 2012, Inaugural Visiting Chair at Ko Awatea Professor Sir Mansel Aylward agreed with and verified previous work done by CMH that identified the following key challenges faced by CMH (and most other health organisations in the developed world):

- Increased demand (population growth, ageing, pharmaceutical/medical/technical advancements);
- High expectations (of the public, politicians and health professionals);
- Financial stringencies (which may well decrease funding in real terms);
- A lack of urgency (within certain constituencies that system change is required);
- Moral and economic imperatives to reduce social inequalities and inequities; and
- The need for integration (of hospital, primary care and community at the local level).

In order to address the above challenges and progress the transformational change proposed, Aylward, Gray and Muth recommended that CMH build leadership capacity and capability with the early advent of a Leadership Academy, delivering Health Improvement and Transformational Change at Ko Awatea. This recommendation was strongly supported by Dr Stephen Hunter, the second Ko Awatea Visiting Professor, who interviewed a number of CMH's aspiring clinical and non-clinical leaders during his time in Ko Awatea in May 2012.

In order to achieve the transformational change required, strong and relentless leadership is essential. All healthcare systems in the world that are recognised as among the best in terms of quality outcomes and cost have strong clinical and non-clinical leaders who are aligned in their efforts. They also place clinicians (doctors, nurses, allied health) at the heart of transformation efforts by providing them with leadership development to enable them to take a central role in the reform of health services. There is a need to promote health management and leadership as a highly respected and desirable career choice that requires the same level of academic rigour, recognition and reward as other specialised professional health careers.

Counties Manukau has developed Ko Awatea as a system level response to creating a high performing health system. It operates to enable improvement and transformation to provide the best and most innovative solutions to healthcare challenges. It supports professional growth, learning and knowledge sharing, innovation and skills development for health system improvement. Ko Awatea currently offers multiple training and learning opportunities in partnership with renowned international experts and institutions such as the IHI, Oxford Centre for Health Transformation, and Public Health Wales. Current courses include, for example, Executive Quality Academy, Breakthrough Series College, Aspiring Leaders programme, CMH management programme, and Innovation College professional development programmes. However, there are now opportunities to build on these programmes and create a Leadership Academy for Health Improvement and Transformational Change driven by a framework for action that incorporates a 'whole of system' approach (including representation from other sectors known to contribute to the social determinants of health).

Ko Awatea is well positioned to commence development of the Leadership Academy which will become an 'engine of change', building leadership capacity capable of delivering step change advancements in innovation, integration and quality improvement.

Scoping the requirements for development of a Ko Awatea Leadership Academy

This paper provides an initial step in developing the Ko Awatea Leadership Academy and includes:

- Scoping out the steps and process required for the establishment of a Leadership Academy. This should include:
    - international literature review on best practice in leadership development,
    - recruitment and selection of participants,
    - structured personal and professional development and transfer of knowledge through learning sets,
    - face to face skills development and education within a group setting via a taught leadership development programme,
    - individual coaching and mentoring,
    - applied workplace projects,
    - development of networks and peer support through a 'faculty' and an opportunity for 'fellowships',
    - a mixture of classroom, work place and e-learning,
    - a whole of system multidisciplinary and inter-sectoral approach, and
    - programme evaluation.
- Presentation of a paper that outlines how to establish and operationalise the Ko Awatea Leadership Academy including:
    - a Ko Awatea model,
    - action plans and work programme commencing with Assessment Centre and Learning Sets, and
    - detailed budget – initial and ongoing.
- Presentation of paper to the Director Ko Awatea and Manager WC&L
- Presentation of model to the ELT
- Appropriate CEO and/or Board approval of the Ko Awatea Leadership Academy to commence development and delivery.
- The scoping and coordination of Request for Proposals to the market for the delivery of:
    - The Assessment Centre
    - Core Curriculum
    - Learning Sets

The work described above is led by Pam Muth who is guided by a Project Steering Group consisting of:

- Jonathon Gray, Director - Ko Awatea
- Gloria Johnson, Chief Medical Officer - CMH
- Penny Impey, Clinical Nurse Director - Ko Awatea
- Haidee Davis, General Manager – Ko Awatea
- Jenna Clarke, Acting Manager – Centre for Workforce and Leadership Capability
- David Galler, Clinical Director Leadership – Ko Awatea
- Sybil Hau, Special Projects Coordinator – Ko Awatea

Additionally, Professor Sir Mansel Aylward is involved in guiding and reviewing the work outlined above.

Section II: Methodology for development of the Ko Awatea Model

The development of the Ko Awatea model was informed by an international literature and programme review (Sections III and IV), Project Steering Group meetings, individual interviews with key CMH personnel, interviews with experts outside CMH (Sir Mansel Aylward, staff from Kaiser Permanente, Dr. Stephen Hunter, etc), a series of consultation sessions with staff, an on-line consultation/survey, and presentation and feedback from various committees within CMH (Enabling High Performing People Programme Board and the Project Steering Group).

Project Steering Group meetings

The Project Steering Group, described in Section I, provided input into the project at regular intervals. The initial meeting occurred at the inception of the project. Major decisions regarding the scope and direction of the Academy were made at the initial meeting, which drove the development of the model. The decisions made by the Project Steering Group are detailed in Section V of this paper.

The Project Steering Group reviewed and provided feedback on the literature review and the proposed model. This input was incorporated into the draft model and into the Consultation Guide.

The Project Steering Group was again convened following the consultations in order to address the outstanding issues identified throughout the process. An Issues Register was created that identified ten issues that needed to be resolved before the model could be finalised. The board considered each of the issues and gave recommendations that were incorporated into the final model.

Interviews with key CMH personnel

The initial interviews with key CMH was essential in driving the development of the model and in working out the process for seeking input from a wider stakeholder group. Interviews were held with Jonathon Gray, Director-Ko Awatea; David Galler, Clinical Lead for Leadership; Jenni Coles, Director-Hospital Services; Martin Chadwick, Director-Allied Health; Denise Kivell, Director of Nursing; Mary Seddon, Clinical Lead-Centre for Quality Improvement; Gillian Cossey, General Manager-Surgical and Ambulatory Care; Jenna Clarke, Acting Manager-Centre for Workforce and Leadership Capability; Janet Anderson-Bidois, Senior Legal Advisor, and Allison Enright; Employee Relations Advisor. Additionally, Gloria Johnson, Chief Medical Officer was involved in reviewing and editing early drafts of the model.

Interviews with experts outside CMH

In addition to the interviews outlined above, there were a series of interviews/conversations with experts in the field of leadership development in New Zealand and Australia and specifically with health leadership development in the USA and UK. These discussions focused on best practice and operational details of various models of leadership development.

Professor Sir Mansel Aylward was consulted numerous times during the process of developing the model. He gave input into the scope of the literature review and the design of the model based on his international experience. Stephen Hunter was also consulted during the process – he provided input via email and by releasing unpublished papers that he had authored related to building leadership capacity among doctors.

Presentations and feedback

The Leadership Academy model was presented to the Enabling High Performing People Programme Board prior to conducting the consultation process. Feedback was given and incorporated into the consultation sessions.

Additionally, information sessions on the Ko Awatea Leadership Academy model were conducted for all interested staff following the consultation process. Five sessions were held and the final draft model was presented. These sessions did not seek feedback from attendees; rather it was for informational purposes.

Consultations and survey

A consultation process was established that included face-to-face interviews and an on-line survey. The consultation sessions and the survey were announced in the Daily Dose and specific invitations for the face-to-face sessions went out to Directors and General Managers who were encouraged to send the invitations to interested staff. A consultation guide was developed which gave an overview of the model with consultation discussion questions embedded in the text. This guide was used to focus the discussion during the sessions.

Sixteen face-to-face sessions were scheduled for participants including staff from Strategic Development (including HR), Ko Awatea (including Nursing Professional Development), Nursing and Midwifery, Allied Health, SMOs, Maaori Health and Pacific Health, DHB Managers and non-clinical professionals, Unions, Unregistered staff, and RMOs. In total, over 120 people provided input through the face-to-face sessions.

The survey was available for on-line completion for a two-week period. It included 13 questions derived from the face-to-face consultation guide. A separate, abbreviated version of the consultation guide was developed for survey respondents and the survey was programmed so that people were required to read the consultation guide prior to answering questions. The survey was developed in Survey Monkey and results were automatically aggregated inside the software. In total, 54 people responded to the on-line survey.

Section III: Literature review

Identification of best practice

There is a plethora of information on leadership development from within and outside the health sector. Many aspects of leadership development are similar across disciplines and much can be learned by reviewing leadership training across sectors. In particular, business schools and private business organisations often have very high quality leadership development programmes that represent best practice and could be relevant for the Ko Awatea Leadership Academy.

The first step in the literature review was to define what 'best practice' entails in terms of developing future leaders through a systematic approach. This review focused on both the public and private sectors and considered sources from within and outside the health disciplines. As this reviews notes, much of the leading strategy for developing leadership capability comes from business however; the health sector also has numerous examples of outstanding leadership development programmes that have proven to be successful for their organisations.

Defining best practice

Best practice in leadership development is not static – it responds to emerging issues, changing environments and new research. Most literature recognises that best practice is multifaceted and involves numerous broad components. Typically these components include elements such as:

- the design of the process/programme,
- the experience of participants,
- programme content/curriculum/competencies,
- learning/teaching methods,
- coaching and mentoring for participants, and
- measuring results and outcomes of the programme.

Best practice in business

Business organisations routinely measure and publish best practice against actual practice within companies/corporations – this, in turn provides an opportunity for others to learn and improve from those that are doing it well. It also provides competition between and among companies who are seeking to improve their financial position through hiring and retaining the 'best' leaders in the industry. The lessons learned from this type of approach have direct applicability to development of the Ko Awatea Leadership Academy as it represents a robust, transparent, and evidence based way to design, implement and evaluate the programme.

The specific actions outlined as 'best practice' by business leaders in 2011 and reported in *Leadership Excellence 2011* are summarized in the table below and fall into the components outlined above.

Process/Programme Design	• Define what leadership means and build a model for developing it. • Participants must 'own' their development. • Design the programme to deliver a certain kind of leader. • Align leadership development with the culture,

	values, and strategies of the organisation. • Align leadership behaviours to strategy. • Assure top leadership commitment, sponsorship and visibility. • Design the programme in multiple dimensions, phases and delivery platforms. • Predetermine what you want the participant to know, be and do as a result of the leadership development.
Experience	• Offer on the job assignments. • Encourage leadership roles in extracurricular and volunteer activities. • Action learning – performance with reporting, shared learning and action items. • Build in simulation, pilot or small-scale project. • Focus on experiential learning – emphasize experience over classroom training. • Tailor Leadership Development to business realities. • Embed real world problems into programmes; provide immediate feedback; connect to projects with real consequences. • Bring together leaders from disciplines to work on projects. • Rotate participants across disciplines, divisions, functions and geographies. • Teach participants ways to cope with the social and political elements of leadership.
Content/curriculum/competencies	• Design learning modules that reflect up to date and relevant topics. • Define the deficiencies and gaps and identify the critical content and topics. • Use case studies, stories, culture, and values. • Use team building exercises and activities. • Design different agenda and curriculum for different levels of participants (e.g. emerging leaders, middle managers, executive) each within a strategic context • Define a set of organisation specific competencies to guide leadership development efforts. • Focus on a few tailored competencies and build in the ability to shift when strategies change. • Develop a competency model that sets behavioural expectations for leaders at all levels. • Identify leadership competences that drive business results that allow leaders to move from people and project management skills to strategic business and operations management. • Create fluid designs that incorporate 'just in time' response elements, including eLearning and blended learning solutions.

Learning/teaching	• Create individual development plans. • Involve leaders in developing other leaders. • Use external coaches and deploy 360-degree assessments and feedback tools along with feed-forward activities. • Target all levels of leadership. • Use multi-dimensional learning designs and platforms. • Build a sustainable leadership pipeline, assess leadership potential, identify successors and place these people into the correct leadership development programmes. • Integrate leadership development processes with performance management, succession planning, recruitment and selection, promotion and compensation, and organisational culture.
Coaching/Mentoring	• Engage senior leaders as teachers, mentors and coaches. • Monitor progress on action learning. • Use both internal and external coaches/mentors. • Agree on performance standards. • Link stated values and actual behaviours of participants to measurements. • Gain support from direct managers and from people outside the management chain.
Results/outcomes	• Conduct an employee orientation. • Define and communicate expected results that link with strategic activities. • Measure and track results against desired strategic outcomes. • Require accountability for behaviours, performance and financial results. • Consider a broad scope that includes all leadership recruitment, placement and succession planning; development of the benchmarks and pipelines, and filling critical gaps in leadership roles. • Assess leadership outcomes informally and anecdotally with connection between leadership development and bottom-line outcomes.

In addition to the best practice components outlined above, there is also an abundance of literature that explores best practice *specifically* in teaching/learning methods for leadership development. There seems to be general agreement that the best practice methods include the following methods (Day 2001):

- 360-degree feedback (or some sort of multi-source rating of performance),
- coaching (focused one-on-one learning),
- job assignment (duties outside one's regular responsibilities that stretch the individual's leadership capabilities),
- mentoring (longer-term developmental relationships),

- networks (connecting to others across boundaries),
- reflection (making sense of the experience), and
- action learning (project-based work that enhances learning in a contextual and strategic way).

Organisations that provide best practice leadership development focus not only on the training but also assess the impact of the programme. While many of the evaluation efforts are informal there are good examples of more rigorous evaluations that show return on investment, behavioural change and improved leadership capabilities. One such evaluation method is a 360-degree or multi-source rating assessed at both pre-training and post-training.

Best practice in the health sector

There are numerous examples of health organisations that are doing well developing their leaders through participation in intense leadership training opportunities and other engagement strategies. Examples include Kaiser Permanente (USA), Intermountain Health (Utah), and Jönköping in Sweden, among others. Each of these programmes has a common element in that they recognise that a cross-disciplinary approach that includes clinicians (doctors, nurses, and other allied health professionals) as a core part of the leadership team is essential for success. Indeed, there is clear evidence that healthcare cannot be led by professional managers alone and that involving clinicians in leadership roles, spread across an organisation is essential to attain excellent health outcomes for patients and the broader community (Mountford and Webb 2009).

Additionally, Stephen Hunter (2009) asserts that best practice in leadership development for *doctors* must include having senior executives involved in each stage of progression from initial contact with, as a minimum, the Chief Executive and Medical Director prior to their appointment into a clinical role, to high visibility and participation of the senior executive in medical practice programmes. Hunter argues that the content of the programme is probably less important than who has been seen as responsible for delivering it and who is visible during the process. Indeed, the evidence shows that the effectiveness of these programmes are significantly reduced if the senior executive is absent from the process (Luft et al 2003). Hunter also provides specific guidance related to best practice in leadership programmes for clinicians. He states that programmes should encourage clinicians to question the status quo and should provide clear guidance as to how they might best go about influencing change, including ensuring that they have adequate mentoring, support and clear contact both within clinical and general management so that their ideas for the better can be implemented.

Principles of best practice

Day 2001 describes general principles of best practice in leadership development – these principles support the ideas expressed above and offer a foundation from which to design the Ko Awatea Leadership Academy. Day's summary of best practice principles include:

- Successful leadership development efforts require an influential champion (preferably the CEO).
- Leadership capacity is everywhere; leadership development initiatives should be orchestrated throughout the organisation.
- The most effective leadership development practices are tied to specific business imperatives.
- Leadership development is used to socialise managers on key corporate values and build a strong, coherent culture.

- Leadership development is a systemic process and not an event.
- Successful leadership development depends more on consistent implementation than on using innovative practices.
- An important job of leaders is to make more leaders. High potential leaders make for effective leadership preceptors in designing and delivering the curriculum.
- Leadership development is about creating entrepreneurial change agents who provide creative solutions in ambiguous situations.
- Leadership development is an investment in the future. Like most investments, it may take years before the dividends are realized.

Best practice in context

Leadership development 'in context' does not equate to just a locale specific approach – rather it means people from that locale coming together to learn to lead together and to address real challenges together (James 2011). A 2011 King's Fund paper provides several case studies of best practice for health leadership development and concludes that:

> "First, individuals can only be effective as leaders if the organisation recognises many collective practices and contributions to the organisation as leadership, and does not *solely* embrace an idealised idea of the heroic leader…
>
> Second, the health care context requires people who do not identify with being a leader to engage in leadership. Leadership must be exercised across shifts, 24/7, and reach to every individual; good practice can be destroyed by one person who fails to see themselves as able to exercise leadership, as required to promote organisational change, or who leaves something undone or unsaid because someone else is supposed to be in charge. The NHS needs people to think of themselves as leaders not because they are personally exceptional, senior or inspirational to others, but because they can see what needs doing and can work with others to do it.
>
> Third, health care requires colleagues from diverse professions and with competing perspectives on what is important to work collaboratively to meet organisational aims…..
>
> Fourth, developing individuals without working with them to simultaneously change the system will not lead to organisation change. Organisation change is not achieved by the development of unconnected individuals, no matter how much investment is made in this."

Conclusion

The findings from the literature review provide a foundation from which to build a viable leadership development programme at CMH. Many of the centres of excellence reviewed combine numerous practices and integrate various techniques of leadership development in making their programmes holistic and systemic in nature. Effective leadership development programmes function with interdependence of the various practices rather than as a collection of independent programmes (Day 2001).

Section IV: Programme review

This programme review focused on identifying centres of excellence in leadership development from high performing organisations internationally and included both private and public organisations within and outside the health sector. Specifically, the following leadership development programmes were reviewed.

Health organisations

- Kaiser Permanente (USA)
- Intermountain Healthcare (USA)
- Harvard – School of Public Health Executive and Continuing Education programme (USA)
- NHS Leadership Academy (UK)
- King's Fund (UK)

Non-health related organisations

- Harvard Authentic Leadership Institute (USA)
- Melbourne Business School – Mt Eliza Executive Education (Australia)
- University of Michigan – Ross Business School (USA)
- Deloitte (International)
- KPMG (International)
- McKinsey (International)
- Center for Creative Leadership (USA)

The review explored the ways that these leadership development programmes dealt with pragmatic factors such as; the type of leadership the organisation seeks to achieve, identifying participants, levels of training offered through the programme, timeframes, curriculum – including management skills training, and teaching methods. The findings for each of these characteristics are discussed below.

Leadership type

There are two prominent leadership development aims – one is focused on individual leadership and the other is based on a distributed style, which suggests that leadership is needed at all levels. Much of the current practice in health (Kings Fund, Intermountain Healthcare, and NHS Leadership Academy) involves a distributed style whereby the leadership development programme focuses on the *organisation* rather than the individual. This type of leadership assumes that collective, collaborative and distributed forms of leadership are better models for dealing with contemporary challenges. Certainly, individuals are still important in this context but the distributive approach means that leaders are taught to develop skills to manage and lead in a collaborative way within the context of the whole organisation.

On the other hand, there are business schools and corporate programmes that focus primarily on the individual leader. Their curriculum offers more individual skill development with less emphasis on organisational change and working with others to achieve results. These programmes tend to concentrate on leader development as opposed to leadership development (Day 2000).

Many programmes operate as a hybrid model which focuses on both leadership styles and recognises that both approaches are needed depending on the context and the objective.

Distributive leadership emphasizes engagement, rights and responsibilities and asks people to get involved with the way things are done in general and done to them. However, the fact remains that there will always need to be 'individuals' who will stand up and take the lead on these issues as not everyone has the desire, or ability to do so. A hybrid approach is important as it allows leaders to be identified across an organisation and gives them the platform to demonstrate and develop their individual leadership capabilities while at the same time applying it within the context of the organisation (Aylward 2012).

Participants

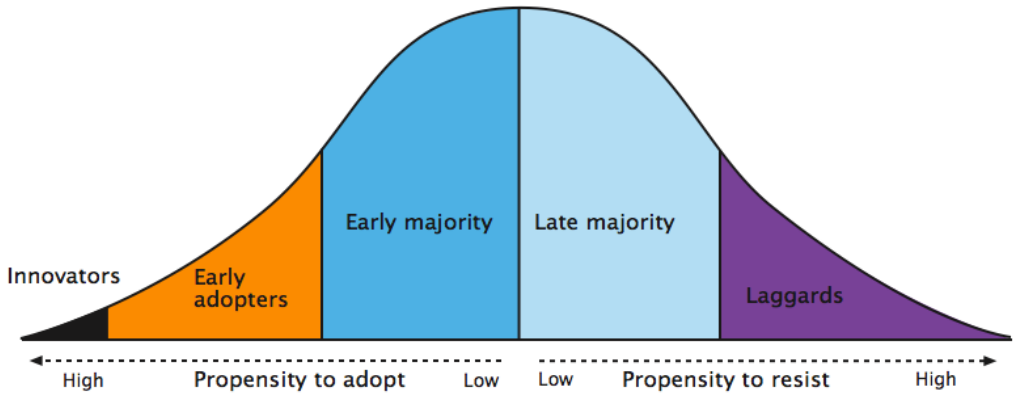
This review found that programmes are mixed on the type of participant allowed to enrol in their leadership development programmes.

Some programmes are strictly 'clinical' in nature and cater only to professionals within the acute care settings (Kaiser Permanente) – in fact there are numerous examples of specific clinical leadership development programmes that are exclusively for doctors (Group Health, Kaiser Permanente, Intermountain Healthcare). These programmes operate primarily as a sub-set of a broader Leadership Development strategy.

Others outside the health sector provide leadership training to a wide variety of professionals and believe that varying backgrounds add value (Univ of Michigan, Harvard Authentic Leadership Institute, Melbourne Business School, KPMG, and Deloitte). Still others (King's Fund, NHS Academy) are embarking on 'cross system' training – recognising that changing outcomes for populations takes more than just the health sector. These programmes have begun to provide cross-sector leadership training to 'emerging leaders' in the hope that the relationships, common goals and common languages will equate to better population outcomes in the long run. Aylward (2012) argues that a cross-systems approach that includes a common language, common goals, and common understandings is essential and that 'clinical leadership' is best described as relevant to all who are involved in smoothing the passage of the patient through the system.

Targeting participation

The Intermountain Health leadership programme uses Roger's Diffusion of Innovation model to target their leadership training. Rogers model (see figure below) proposes that adopters of any new innovation or idea can be categorized as innovators (2.5%), early adopters (13.5%), early majority (34%), late majority (34%) and laggards (16%), based on the mathematically based Bell curve. Each adopter's willingness and ability to adopt an innovation depends on their awareness, interest, evaluation, trial, and adoption.



Intermountain targets their leadership training to innovators and early adopters first. These two groups represent a fairly small subgroup of the whole organisation and are the individuals who tend to be willing to invest in change. Intermountain has found that once this group starts to achieve success word of mouth and showcasing the successes are an effective way to influence the people in the early majority and finally to the late majority.

Levels of training

Most programmes offer a variety of training suited to different experiential levels of participant and are designed to meet the aims and challenges of the organisation. The most common levels throughout the reviewed programmes include:

- emerging leaders – 3-10 years experience,
- managers – those already in management roles mid-career,
- executive – those in significant leadership roles already, and
- other – some programmes (McKinsey, KPMG) target recent graduates and students.

As would be expected, each level has very different course content and therefore, it is important to provide these programmes separately so that teaching and learning can be appropriately tailored to the experience of the participants. Many of the programmes offer two or more levels of training through their academies and some only offer Executive level training.

Timeframes

Many programmes provide 'intensive' leadership development focused on the individual and lasts for 1-2 weeks. This is common for the Executive level training (Harvard, Ross, Melbourne, Kaiser) but much of the literature argues for a long term commitment and suggests a 'fellowship' model that lasts for 8-12 months (Intermountain, King's Fund, NHS) especially for cohorts such as emerging leaders.

Curriculum

The curriculum, of course, depends on the experiential level of the participant and the timeframe allowed for the activity. That said, there are general topics that are included in most all programmes reviewed. These include:

- understanding yourself and your management/leadership style,
- exercising judgement and wisdom,
- critical thinking and appreciative inquiry,
- leadership vision,
- innovation – management and approach,
- managing and implementing change in complex organisations and complex systems,
- using influence and persuasion,
- building networks and leveraging social capital, and
- building high performing teams.

Clinical leadership development differentiates itself from generic leadership development in that it provides participants with courses that are directly linked to clinical care. This is usually done *in*

addition to the traditional leadership development topics outlined above. The Intermountain Healthcare Leadership Development programme includes specific clinical topics in their core curriculum – these include additional topics such as:

- managing clinical processes,
- modeling processes/data types/designing data systems,
- pragmatic science,
- understanding variation,
- clinical integration,
- quality control costs/tracking costs,
- quality improvement leadership, and
- patient safety.

Many programmes also offer management skills training to their participants – especially for those cohorts who are emerging leaders and/or not already in management roles. Topics such as accounting/budgeting, human resources management, and communication skills, are provided during the course to prepare young professionals as they move into management roles.

Teaching methods

Most leadership development programmes (both in business and healthcare) use the best practice methods outlined by Day (2001) and discussed previously in this report. They typically use a combination of methods including initial assessment, face to face sessions with didactic and group participation components, case studies, applied student projects that are endorsed by line managers, individual learning sets, mentoring/coaching, and on-going consultation.

Of note is the importance of 'improvement projects' in the Intermountain programme. They describe these projects as *the* essential element of the course and outline 3 major roles that these projects serve.

1. Projects give adult learners the hand-on experience that makes the learning real, translating theory into applied practice.
2. Projects produce real results for the sponsoring organisation. They are the main method of showing direct return on investment. They justify the substantial expenses (in time and money) that the organisation must allocate to conduct the training.
3. Projects provide a very potent means to evaluate what works (or doesn't work) within the course. They are the primary metric for continuously improving the course itself.

The Intermountain programme requires every participant to complete a project and formally present the project to peers in order to graduate from their Leadership Development Programme.

Another interesting and noteworthy part of the Intermountain programme is the significance they attach to the 'graduation' from their course. They regard graduation as a classic example of reward and recognition and believe that it delivers the message that, from this point forward; the graduate has the concepts, tools and personal commitment to bring other health professionals and their organisations to a new level of quality performance. The Intermountain 'graduation' occurs immediately after the students give their project presentations and consists of four components.

1. A thank you from the course leader. They believe that it is important that the course leader hand each participant their diploma, shake hands, congratulate them, and say 'thank you'.

2. Something physical to make the 'thank you' real. Intermountain prepares framed graduation certificates (diplomas) specifically designed to have the look and feel of a Masters Degree certificate.
3. A symbol that the graduate can wear or display. This usually is in the form of a high quality 'nice' wearable piece of jewellery that is unique, obtainable through no other source that clearly sets the graduate apart and marks them as a quality leader within the organisation.
4. Recognition – Intermountain posts the project storyboard on their website and also encourages their graduates to display real storyboards within the halls, central offices, lobbies, or lunchrooms of the organisational facilities.

Conclusion

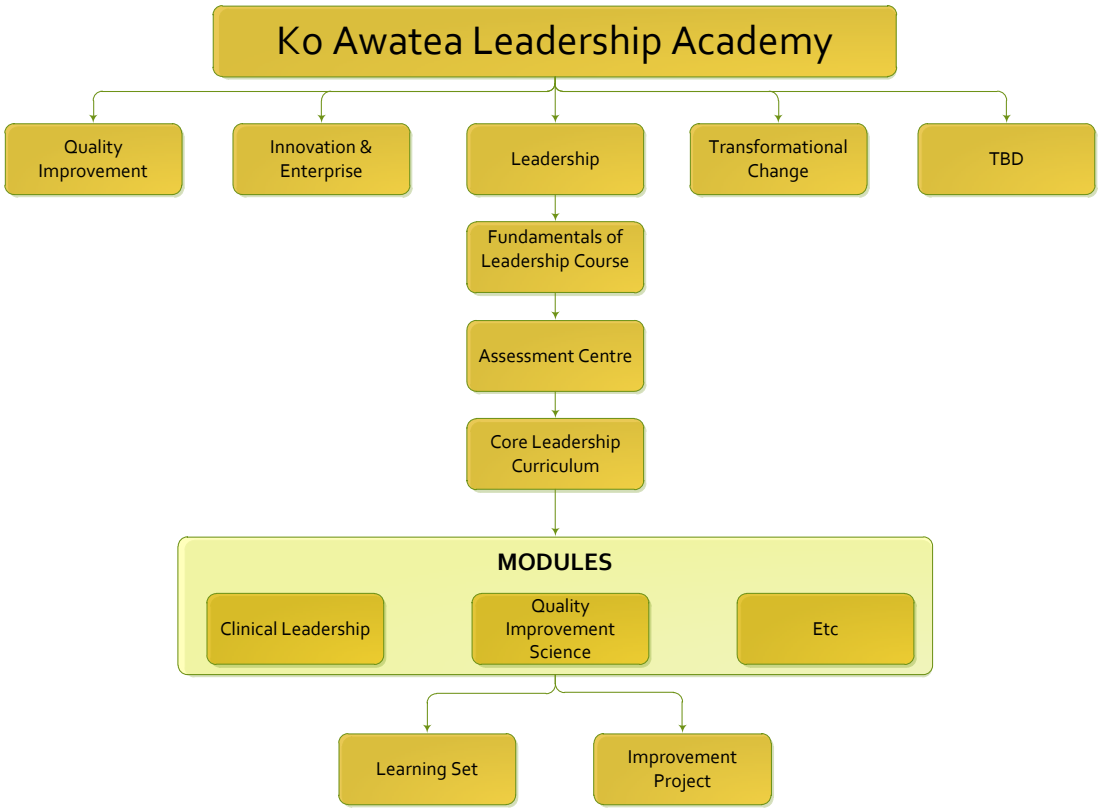
There is general consensus that adult learners need a variety of teaching methods in order to absorb and retain learnings. Each programme reviewed, regardless of the level of participant, used an integrated and holistic approach to present their curriculum and used a variety of 'teachers' to deliver the courses. The programmes all emphasised the importance of a very senior leader being 'the face' of the programme and drew their coaches and mentors from recognised leaders both within and outside their organisation. All programmes also were clear to their participants that they will, in the future, be called upon to participate as coaches and mentors for future cohorts – thus perpetuating the leadership cycle.

Section V: The Ko Awatea model

The Academy

An Academy is an institution of higher learning providing specialised education for the advancement of learning, knowledge and applied competency within a specific field. The Ko Awatea Leadership Academy will create a forum where multidisciplinary leaders (clinician, managerial, and unregistered staff) from across systems and sectors can work together in a culture of learning to build system capacity for improving quality, outcomes and cost and realise CMH's aim to be the best healthcare system in Australasia by 2015.

In the first instance, the Academy will offer leadership development as *the* core component. However, the Academy could expand to include other components such as Quality Improvement, Innovation and Enterprise, Transformational Change, etc in the future. The figure below provides an overview of a potential future state for the Academy, which includes the various components, but only details the specifics of the leadership offering as it will be the first component to be developed and implemented. All other offerings will be developed in turn.



Organisational leadership statement

The CMH Executive Leadership Team developed and approved an organisational leadership statement that provides a foundation for the type of leader sought through the Leadership Academy. The statements sets out expectations for potential applicants and defines the standard for leaders within the organisation. The CMH leadership statement is as follows.

We want leaders who:

- Have a passion to improve the health of New Zealanders;
- Action and practice a vision, strategic direction and values consistent with their organisation;
- Understand our Triple Aim strategic objectives and Achieving A Balance as the way we achieve this;
- Have invested in their knowledge and understanding of Maaori and Pacifika in New Zealand, understand and put into practice leadership to improve the health of these populations in their respective fields and encourages others;
- Have invested in their knowledge and understanding of vulnerable families in New Zealand, understand and put into practice leadership to improve family health in their respective fields and encourages others;
- Are confident and want to improve the ways they can lead and get the best out of a multi-cultural workforce working with a multi-cultural population;
- Appreciate the funding environment and see this as an opportunity to get more value out of the systems;
- Are inspirational, competent and credible so that people respond positively to their lead;
- Are proactive 'doers' who have the ability to convert vision into action.

Background

The Ko Awatea Leadership Academy will provide the organisation (and ultimately the sector) with a pipeline of highly capable, innovative and engaging leaders who are ready, willing and able to lead health system transformation. Drawing on the considerable work already done with CMH leadership in collaboration with strategic partners and visiting experts, and the literature and programme review described in this report a number of core components for the Ko Awatea Leadership Academy have been established. These components require the model to provide the platform for:

- A model for leadership, which draws from local and international evidence of the 'best of the best'.
- A process for selection of high potential candidates using an assessment centre approach that incorporates the 'fish bowl' principle.
- Face to face skills development and learning within a group setting including a 'taught' leadership development programme.
- Individual coaching and mentoring from identified organisational leaders and Academy members.
- Personal and professional development and action learning through facilitated Learning Sets.
- Applied workplace projects to achieve improved outcomes and provide opportunities for experiential learning.
- Opportunities for fellowships.
- A mixture of classroom, workplace and e-learning.
- A 'whole of system' approach.
- Promotion and structured recognition of the central role of clinician leaders in the reform of health services.
- Integration of existing Ko Awatea improvement and leadership development programmes (e.g. IHI capacity building programmes and Student Chapter).
- Measurement of programme outcomes.

Additionally, at the first Project Steering Group meeting several critical decisions were made that informed the developed of the proposed model. Specifically, the project team made the following recommendations:

- That the Leadership Development programme is multi-disciplinary and that staff from medicine, nursing, allied health, management and unregistered staff be encouraged to apply.
- That the Academy will, in the first instance, focus on Leadership Development for emerging leaders – those with 3-10 years of experience in the health sector but who are not already in leadership positions in the organisation.
- That the aim of the Leadership Academy will primarily embrace the philosophy of distributive leadership.
- That the selection process will be transparent and will not be a 'shoulder tapping' exercise.
- That the leadership development programme should be conducted over an 8-12 months period and not be offered as a 'short, intense, one-off session'.

The New Zealand context

The Ko Awatea Leadership Academy is based on best practice internationally. While the literature review (Section III) and programme review (Section IV) do not include New Zealand sources the model has inherently built-in principles of fairness, teamwork and transparency that are deemed so important at Counties Manukau Health and in New Zealand. Indeed, the model strives for a culturally appropriate approach that is consistent with the vision and values of CMH and with the values and aspirations held by the diverse populations that call New Zealand home. The model recognises that new leaders in contemporary society need to be able to work across cultures and nationalities without compromising their own core set of values and principles.

It is a fact that the Maaori and Pacifika populations are under-represented in the health workforce. Subsequently, they are also under-represented in leadership roles within the health sector generally and Counties Manukau Health specifically. The Ko Awatea Leadership Academy hopes to address this by providing leadership training that is significantly correlated with the traditional values and principles held by Maaori (e.g. distributive leadership philosophy, working as a team in a highly participatory manner, having a common vision, equality of leader and follower, etc).

It is well known that contemporary Maaori leaders have the added challenge of negotiating the influences of traditional values and Maaori leadership principles and those of mainstream society (Katene 2010). That said, many of the values held to be essential in traditional Maaori society are still highly relevant now and the mark for leadership success for Maaori is providing leadership based on traditional principles while managing the interface (Mead 2006).

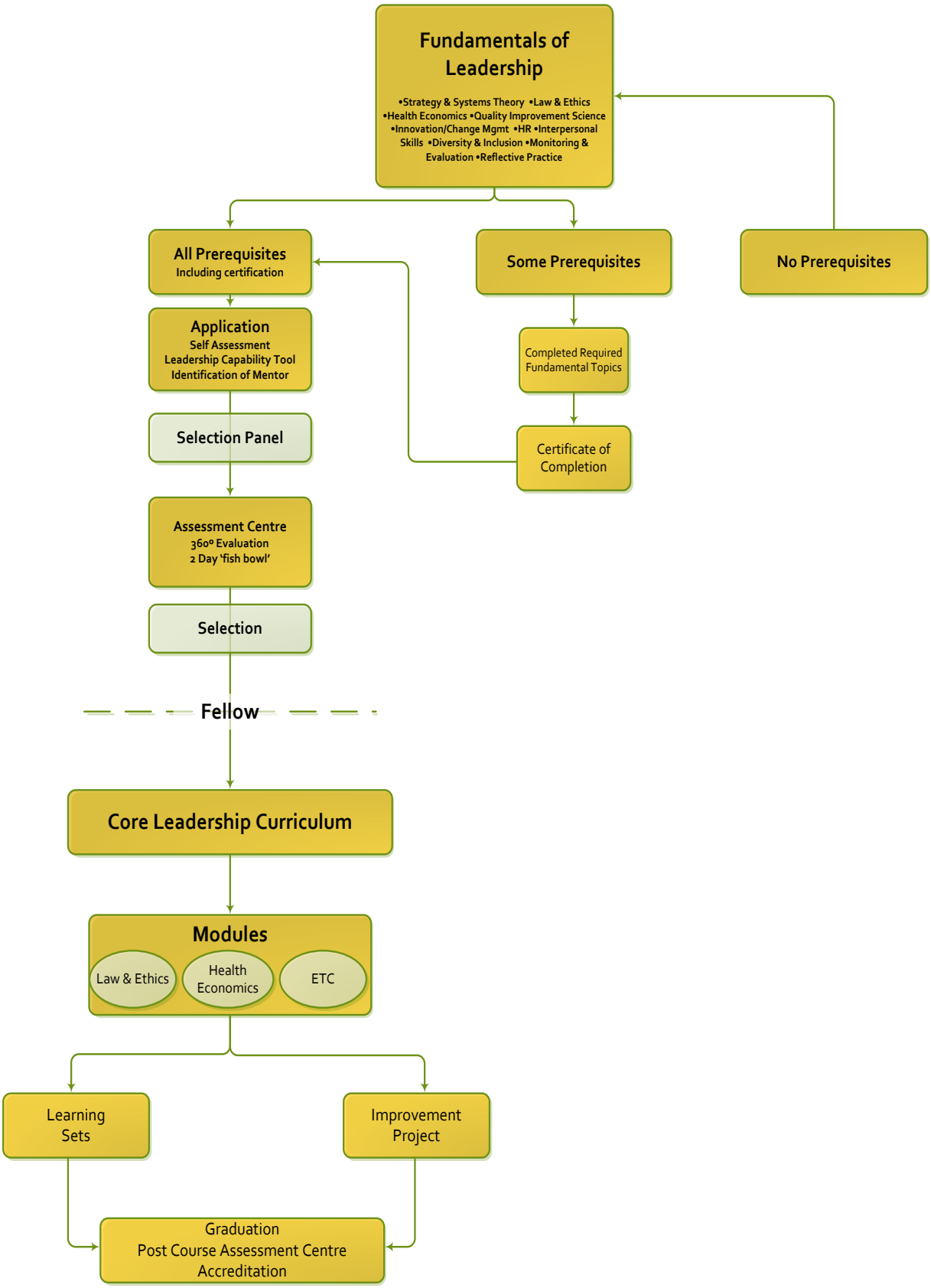
Proposed structure of the Ko Awatea Leadership Academy

It is important that the Academy is not seen as an 'exclusive club' only for a select few. Indeed, the distributive model endorsed by the Project Steering Group prohibits that. The proposed solution to this is to have a portfolio approach to leadership development whereby all those who seek leadership development through the Academy will receive a Fundamentals of Leadership Course whilst a smaller group will be selected to have a more in depth leadership development programme. The Fundamentals of Leadership Course will be open and available to **all** CMH staff and will include essential topics that will serve as 'prerequisites' to advancement into the more specific leadership development programme. The Fundamentals of Leadership Course will focus on a broad but not

deep range of skills universally needed for career progression (e.g. strategy and systems theory, law and ethics, health economics, quality improvement science, etc). Whereas, the core leadership development programme will provide participants with an intensive leadership development opportunity that involves a core leadership curriculum with focused modules for leadership development, tailored learning sets, and an improvement project. The core leadership development programme will be offered to cohorts of individuals (approx 20-25) who have completed the Fundamentals of Leadership Course and who have been appraised and selected as having real aptitude, capacity and motivation to becoming the next generation of leaders within CMH. Because the Academy is open to all levels of staff there may be a need to provide additional support to participants who are unfamiliar with certain aspects of the leadership curricula (e.g. academic style writing, understanding health statistics, etc). This support will be individualised and will be present throughout the tenure of the leadership course.

While the core Leadership Programme is only open to emerging leaders at all levels of the organisation, the Fundamentals of Leadership Course, which is open to all, could serve as a 'refresher' or an opportunity to up-skill current Managers in the CMH system. More in-depth modules, which mirror the Fundamentals of Leadership topics, will then be available for those Managers who seek further study related to specific topics.

The figure below provides a high level overview of the proposed structure of the Ko Awatea Leadership Academy – this structure is based upon a portfolio approach which requires applicants to complete prerequisites before being considered for enrolment in the core leadership development programme and assumes that each applicant has completed the Tikanga Best Practice course and the Pacific Cultural Competency in Health course. Each component of this structure is described in detail below.


Fundamentals of Leadership
•Strategy & Systems Theory •Law & Ethics •Health Economics •Quality Improvement Science •Innovation/Change Mgmt •HR •Interpersonal Skills •Diversity & Inclusion •Monitoring & Evaluation •Reflective Practice
All Prerequisites
Including certification
Some Prerequisites
No Prerequisites
Application
Self Assessment
Leadership Capability Tool
Identification of Mentor
Completed Required Fundamental Topics
Selection Panel
Certificate of Completion
Assessment Centre
360º Evaluation
2 Day 'fish bowl'
Selection
Fellow
Core Leadership Curriculum
Modules
Law & Ethics
Health Economics
ETC
Learning Sets
Improvement Project
Graduation
Post Course Assessment Centre
Accreditation

Eligibility

The Ko Awatea leadership development programme's eligibility criteria focuses on the following categories of people:

- emerging leaders who have 3-10 years experience in the health field,
- multi-disciplinary including clinicians (doctors, nurses, allied health), management/administrative personnel, and unregistered staff, and
- CMH staff initially, although the intent is to expand to other community service providers once the programme is established within CMH.

Once the eligibility criteria are met, the programme will target the innovators and early adopters described in the literature review and will specifically seek individuals who have:

- Intellectual vitality,
  - Initiative
  - Curiosity
  - Interested in expanding horizons
- Demonstrated leadership potential,
  - Contribution at work and in personal life
- Positive personal qualities,
  - Good communication skills
  - Results oriented
  - Flexible and adaptable
  - Financial astuteness
- Innovative thinking,
- Ability to develop and maintain positive working relationships across disciplines.

The selection process

The selection process for the Leadership Academy must be fair, transparent and based on objective criteria. It must also embrace a multi-disciplinary approach that does not favour one discipline over another and must allow flexibility for those candidates who have prior training or experience in the Fundamentals of Leadership topics. Additionally, all candidates who apply to the comprehensive leadership development programme must show that they have completed the Tikanga Best Practice training and the Pacific Cultural Competency in Health course.

The selection process must also assure that the diversity in the community that CMH serves is reflected in the participants who are offered an opportunity to build a leadership portfolio.

The proposed selection process for the Academy is based on a portfolio approach and inherently focuses on the innovators and early adopters described previously, however, it also offers the option of portfolio development for all staff. Each step in the selection process is outlined below.

Step 1 – Fundamentals of Leadership Course: Leadership, knowledge and skills

The first step in the approach is completion of the Fundamentals of Leadership Course, which is open to all and includes prerequisite topics needed to advance to the comprehensive leadership stream. For those candidates with prior training or experience in the required Fundamentals of Leadership topics an option of 'testing out' of required coursework can be considered. When all prerequisites are complete (or they have 'tested out') participants will receive certification of successful completion of the Fundamentals of Leadership Course. This certification will allow them

to advance to the next step in the selection process should they choose to do so. Staff who are interested in advancing to the core leadership tract will be encouraged to discuss this with their managers at their performance review so that their desire to pursue this will be well known and documented in their staff development plan.

Step 2 – Application

In order to move to step 2, the participant must provide evidence that they have completed the Tikanga Best Practice course and the Pacific Cultural Competency in Health course. Once completion of those courses are determined, the next step is an application process whereby each candidate is assessed in several ways including a self-assessment, completion of a standardized tool that predicts leadership capacity, identification of a mentor, and potentially a behavioural interview with a selection panel. The selection panel will also conduct interviews with the applicants' managers in order to ascertain the level of support for the applicant progressing to the leadership tract. Additionally, each applicant will be required to provide the selection panel with at least one other referee (preferably one that is in a management or leadership position within the organisation) who can speak to the applicants' leadership potential. The selection panel will meet to discuss each application along with findings from the interviews and will select up to 40 applicants to progress to the next step – the Assessment Centre.

A process to assure that there is representation that reflects the diversity of the population served by CMH will be developed in order to address the current imbalance of these groups in leadership positions at CMH and in the health sector more broadly.

Step 3 – Assessment Centre

The forty candidates selected for advancement in Step 2 will then go through an 'Assessment Centre' where they will complete a 360-degree evaluation and will participate in simulated real work challenges. The focus of the Centre activities and evaluation will be on innovation and leadership capacity. Participants will be continually observed and assessed against agreed criteria in a 'fishbowl' environment by assessors selected locally and externally. Each person going through the assessment centre will work with an assessor and will leave the experience with an individual development plan and a mentor regardless of whether they advance to the next step or not.

Mentors

Mentors are an important part of the Ko Awatea Leadership Academy and have a pivotal role to play with future leaders. Each applicant will be asked to identify a mentor as part of their application process based on their learning needs and their career goals and objectives. If they are unable to identify an appropriate mentor within the organisation the selection panel will assist them. Mentors will be required to attend a training session that outlines their roles and responsibilities and they must agree to carry out these roles and responsibilities before they are assigned to an applicant.

The primary responsibility for mentors assigned to applicants who do not go on to become Fellows is to provide support and guidance around the individual development plans. Mentors should encourage their assignees to address the areas outlined in the plans and should meet regularly to discuss progress. They should also encourage their assignee to re-apply to become a Fellow once they have achieved the goals that have been set in the plan.

The primary responsibility for mentors assigned to Fellows is to provide support and guidance throughout the core leadership development programme. The mentor should have regular meeting with the Fellow to discuss progress and should be a source of wise counsel to Fellows as they face the challenges of their course work and their everyday jobs. Mentors do not need to intervene on behalf of a Fellow – rather they should help the Fellow problem solve and should guide them to

successfully navigate the issue to resolution. Mentors should be a source of encouragement to Fellows regardless of whether they are facing challenges or not.

Fellows

The candidates who rank highly in the Assessment Centre (20-25 individuals) will be invited to become 'Fellows' and advance on to the comprehensive leadership development programme. Each of the invitees will be informed of the expectations of Fellows (e.g. must attend and participate in all sessions, must complete a project, etc). The Fellows will be required to sign an agreement stating that they agree to all programme requirements as outlined – this agreement will also be counter-signed by the Fellow's supervisor and General Manager.

The organisational commitment to Fellows, in addition to having a mentor, includes having their manager or another senior person meet regularly to identify and resolve obstacles the Fellow is encountering, ensure that there are opportunities for the Fellow to apply their learning at work, and ensure the necessary resources are in place to enable Fellows to be absent from the workplace in order to participate fully in the leadership development programme activities.

Each of the applicants not chosen to progress to being a 'Fellow' should be informed of the decision via a thoughtful and sensitive letter (email) that informs them of the decision, details the areas for improvement, and encourages them to advance their individual development plan through further training and or experience. The letter should also encourage these applicants to re-apply for consideration as a Fellow when they have progressed further with their development plans. As stated previously, each of these applicants will be assigned a mentor to work with. A key role of the mentor will be to monitor and review progress on the individual development plan and to encourage the participants to continue to pursue a leadership tract.

The Ko Awatea Leadership curriculum

Fundamentals of Leadership Course

The model proposes that monthly seminars be made available to ALL interested staff so that they can begin to build a leadership portfolio. As described previously, the Fundamentals of Leadership Course will consist of 'prerequisite' topics that will focus on the things that potential leaders need to know in order to succeed in the long term. The model assumes that these topical seminars will be 2-4 hours in length and will include didactic and group activities as the teaching model. The Fundamentals of Leadership Course will be an on-going effort and topic seminars will be repeated on an annual or bi-annual basis. In future it may be possible to have the seminars available on-line for staff interested in certain topic areas.

Along with the monthly seminars, the Fundamentals of Leadership Course will periodically be offered as an intensive session over a long weekend – this will allow people to complete the prerequisites in a short timeframe, which may be beneficial for some situations. Weekend sessions will be conducted twice yearly or as needed and will be limited only to emerging leaders who seek to apply to the core leadership course.

Additionally, an option for an assessment of skills and 'testing out' of required topics should be offered to those candidates with prior training or experience in individual topical areas. A tool could be developed or adopted and used to measure the skill level of the candidate in terms of each of the required topics. If the candidate 'passes' the assessment they will be exempted from attending that topical seminar and will receive a certification that acknowledges their skill level in that topic.

Upon completion of the Fundamentals of Leadership Course each participant will be issued with a certification of completion. This certification will allow them to advance to the next step in the selection process should they choose to do so.

The Fundamentals of Leadership Courses will be taught by outside experts who are paired with internal staff so that the learning is based on current best practice and theory but also has a contextual component which is applicable to CMH. Internal staff will be selected using an Expression of Interest process. Topics for the Fundamentals of Leadership Course include the following topics:

- Strategy and systems theory
- Quality improvement science
- Monitoring and evaluation
- Innovation and business acumen
- Health economics
- Law and ethics
- Human resources/employee relations
- Interpersonal skills/relationships/communication
- Diversity and Inclusion
- NZ health system
- Leadership
- Change management
- Reflective practice

Additionally, several optional topics will be made available as e-learning opportunities. These optional topics include:

- Project Management
- IT systems and technology

All non-optional topics are required to be completed before applying to the leadership tract. For those staff not interested in pursuing the leadership tract, or others outside the emerging leaders category (such as Managers) *all* topics are optional and will be based on interest and ability to attend. Everyone attending the Fundamentals of Leadership Course should understand that the course is first and foremost an opportunity for professional development and secondly that it is the entry point into a more focused leadership development opportunity. Not all participants who attend the Fundamentals of Leadership Course will want to proceed to the core leadership programme – this decision should not diminish their ability to seek certification nor should it imply that they are less important learners than those who seek to pursue the leadership tract.

In terms of course content, Ko Awatea currently offer numerous continuing education opportunities for the staff of CMH – these offerings will not be duplicated in the Leadership Academy, rather many of the offerings will be integrated into the topical seminars described above.

Comprehensive leadership development programme

The proposed comprehensive leadership development programme for Fellows includes four distinct components:

1. core leadership development training (including classic leadership topics and modules that mirror the topics offered through the Fundamentals of Leadership Course),
2. individual learning sets (based on the findings from the Assessment Centre),

3. improvement projects that are contextual and link to CMH strategy, and
4. graduation, accreditation and post-course assessment centre.

The comprehensive programme will last between 8 – 12 months and will require significant commitment of time, money and good will from participants and the organisation. Without buy-in and commitment from middle managers up to CEO this initiative will fail. Executive level commitment is essential for funding, vision and general support but even with strong support from ELT organisation wide commitment to the effort is needed. Managers need to commit in terms of allowing their staff to participate by giving them time to attend the required training *and* by offering them the ability to test their learning in their work environment. Fellows should not be expected to carry a full workload while participating in the core leadership development programme – some accommodation needs to be made to free up adequate time for them to actively participate in this development opportunity. It is projected that Fellows will need to spend between 4 -6 days per month on their leadership development through this programme.

Core leadership development training

The proposed model involves hiring an outside firm to deliver the core leadership curricula based on best practice. This core curriculum will include topics such as those described in the literature review. The core training will emphasise the fundamentals of leadership and will contextualise this to a health setting. The core curricula will be taught using best practice methods tailored to the learning styles of young adults. The training will be conducted in 1-2 day sessions either monthly or bi-monthly over the full course of the programme (8-12 months). It is expected that the outside trainer will require Fellows to complete some pre-course reading and reflecting activities and that homework assignments may be required.

In addition to the classic leadership curricula described above the core leadership training will include optional, on-line modules that will address specific leadership training needs. The specific topics for these modules build on the Fundamentals of Leadership Course topics and provide the learners with more in-depth content. Each Fellow will be required to select at least one module to complete during the programme with the option of accessing other modules as time permits.

The modules will be open to all and will be designed to build on the introductory courses in the Fundamentals of Leadership Course. Importantly, non-Fellow learners (e.g. Managers) will have access to these modules and will be able to gain credit for completing the modules.

Due to time and resource constraints development of the modules will occur over a matter of time. It is anticipated that in the first year 2-3 modules will be developed followed by two additional modules per year.

Individual learning sets

The proposed model includes facilitated learning sets that are designed for the individual based on findings from the 360-degree feedback and the other activities included in the Assessment Centre. Fellows will be organised and matched into learning sets of 5-8 members – this allows intelligent and highly confidential peer support for personal and work issue problem solving and strategising. Again, as with the core leadership curricula, learning sets will be contextual and will relate directly to Fellows' work at CMH. The model assumes that the learning set groups will meet with a facilitator for a half day six to eight times over an 8-12 month period.

Improvement projects

The importance of improvement projects in leadership development programmes has already been discussed and will not be repeated here. The proposed model emphasises the projects and allows for individuals or teams to work on their projects 1-2 days per month. It is important to note that while projects must be contextual and directly linked to the CMH strategic plan – they also need to drive participants' learning and therefore should be projects that the Fellows themselves choose, from a menu of strategically aligned projects. If a Fellow(s) desires to conduct an improvement project that is not on the approved menu of strategically aligned project there will be a process in place whereby they will be required to develop a project brief that describes the proposed activity and outlines the strategic relevance and the benefit to CMH in completing the project. The project brief will then be submitted to a small internal committee consisting of members of the ELT for approval/disapproval.

Each project, whether it is an individual or a group, will be assigned a coach to work with the learners. These coaches work with the individual or team between sessions, through face-to-face meetings (if possible), email, video conferencing or telephone. Beyond facilitation and support, the primary role of the coach is accountability. The coach should set intermediate and final deadlines and should track progress on those deadlines. The key factor for a coach is to insure that Fellows have a solid project to report on at the final session. While having a 'hands-off' approach to coaching may seem counter-intuitive, the whole point of the project is to have participants actually doing the work that drives the learning. The final responsibility for hands-on projects should always rest with the learner.

Coaches do not need to be 'experts' in areas specific to the project – rather they should be someone from within the organisation (Ko Awatea) who has expertise in problem solving through process improvement and who has personal experience with the application of tools and methods to drive change. Coaches will be identified through an Expression of Interest process and selected by a small selection committee. All coaches will receive training on their roles and responsibilities associated with this project.

Graduation, post-course assessment centre, and accreditation

Upon completion of the comprehensive leadership programme a 'graduation' will be held which will be hosted and facilitated by the CEO, Board Chair and Director of Ko Awatea. The graduation agenda will be built around presentations of the improvement projects as these projects represent the cumulative learnings for each participant and mark the beginning of the emerging leaders' responsibility to lead other health professionals and their organisations to a new level of quality performance**.** Each Fellow will be required to participate in the project presentation and all projects will be presented even if they are not complete at the time of the graduation. Other details that could be adopted for the Ko Awatea graduation are discussed in the literature review – all are designed to reward and recognise the effort each Fellow has put into developing their leadership potential and also signals an expectation of future leadership responsibility for each graduate.

Following the graduation the emerging leaders cohort will come together formally for one last activity. This activity involves an assessment centre approach and will include a 360-degree post-test and review of individual development plans. This post-course assessment will provide data for comparison of individual leadership capabilities and will allow training staff to assess the effectiveness of their curriculum. The activity will also be designed to demonstrate to each Fellow how they have grown in their capacity to lead change thus giving them confidence as they go forward in their careers.

The comprehensive leadership development curriculum will be submitted to the appropriate body for endorsement of accreditation. The accreditation sought will be one that is widely recognised,

portable, applicable to a wide range of disciplines, and considered as a component of a Masters Degree. A 'menu' of accreditation options will be available for each Fellow to choose based on their needs and career goals.

Measuring results and outcomes of the programme

As reported in the literature review, best practice for leadership development includes the measurement of results and outcomes of the programme. There are numerous ways to evaluate results and outcomes and an evaluation plan should be developed prior to implementing the programme and 'built in' to the implementation of the programme. It will be difficult to measure some outcomes in the first few years of operation but mechanisms for data collection must be put in place early on so that outcomes can eventually be measured and tracked over time. Of utmost importance in the early stages of the Academy is to conduct a formative evaluation so that lessons can be learned in real time and activities/methods adjusted as necessary. In due time, a summative evaluation should be conducted to test return on investment and change in health outcomes.

Staff familiar with evaluation methodology and research design will conduct the formative/process evaluation 'in-house'. These evaluation staff will be embedded with the Academy implementation team so that they are involved early in the implementation process. They will design an evaluation strategy that offers advice on implementation strategies based on their on-going evaluation. The summative evaluation would best be conducted using an outside expert so that there

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