Leading Health Improvement Programme Evaluation

Final Report

March 2007

Authors: Susan M. Carr, Monique Lhussier, Joanna Reynolds

Project Management Team

Dr Susan M Carr	Reader in Public Health & Primary Care, Community Health & Education Studies Research Centre (CHESs), Northumbria University (Project Manager)
Dr Monique Lhussier	Research Associate, CHESs
Dr Joanna Reynolds	Research Associate, CHESs
Yvonne Howard	Administrator, Health Improvement Research Programme, CHESs

Research Steering Group

Dr Susan M. Carr	Reader in Public Health & Primary Care, Community Health & Education Studies Research Centre (CHESs), Northumbria University (Project Manager)
Dr Monique Lhussier	Research Associate, CHESs
Dr Joanna Reynolds	Research Associate, CHESs
Professor Charlotte Clarke	Associate Dean for Research, Northumbria University
Catherine Hannaway	LHIP
Professor David Hunter	LHIP

Further information available from:

Yvonne Howard yvonne.howard@northumbria.ac.uk 0191 215 6033

Contents

Executive summary

Evaluation Aims

This evaluation aimed to analyse and inform the theory and implementation practice of the Leadership for Health Improvement Programme (LHIP). This process was facilitated by ongoing exchange of information between the research team and the LHIP providers.

The study drew on appreciative inquiry, illuminative evaluation and soft systems methodology.

The evaluation objectives were:

1. To investigate the learning experiences of the programme providers and participants through observation, interview and secondary data analysis.
2. To explore the process of implementing this learning within the participants' role, i.e. exploring the ways in which the LHIP informed participants' leadership for health improvement within their own organisational context, through the analysis of observation, interviews, and specifically requested participant feedback.

These objectives form the two aspects of the research activity.

Background

This programme of leadership for health improvement is based on the framework developed by Hannaway, Hunter and Plesk (2006) which is adapted from the model developed in the Leading Modernisation Programme (Clarke et al. 2004). A Programme Advisory Group (appendix 1) collaborated on the ongoing development of the programme.

It must be recognised that the provision of such a programme is a considerable challenge:

> "Further work is required to delineate what 'effective' public health leadership means both in relation to 'transformational' leadership characteristics we describe and in relation to training and continuous professional development requirements."
>
> (McAreavey, Alimo-Metcalfe & Connelly 2001:460)

Successful local delivery of health improvement is deemed to require leadership development that will facilitate:

- Building whole system relationships
- Understanding and using improvement methods
- Developing exceptional leadership skills to move these areas of work forward

The Leadership for Health Improvement Programme (LHIP) has a number of features which, it was considered, would distinguish it from other such programmes and make it particularly appropriate for health improvement leadership. These are:

- Provision of link between theory and practice
- Linkage of leadership with context
- Recognition of the value of complexity thinking
- Political astuteness
- PDSA methodology
- Flexible, evolutionary, 'real-time' approach to programme detail
- Multi-disciplinary and multi-level approach.

The LHIP framework comprises three interlocking spheres of public health delivery systems & leadership & leadership for health improvement. The framework is presented in appendix 2.

The Leadership for Health Improvement Programme

The programme, comprising of six learning events, commenced in January 2006 and completed in February 2007. A summary of LHIP events is provided in appendix 3.

Nominated participation was open to individuals in a variety of leadership roles from a wide range of organisations including;

- Directors from Local Authorities, including environmental health, education, police, fire service;
- Directors of Public Health and Public Health Specialists from PCTs;
- Leads for Mental Health, Children & Maternity Services, Prison Health;
- Strategic Regional Government Office;
- Public Health Leads from Voluntary Organisations;
- Leads from the Public Protection Agency;
- Leads from NICE, Health Care Commission;
- Lead from the Public Health Observatory;

However, recruitment strategies resulted in the participation of a majority of people from the National Health Service (72.4%). Non NHS participants came from local authorities (17%), the police (3%) the fire and rescue service (2%), the voluntary sector (3%) and other organisations (2%).

On completion of the Programme, participants were expected to evidence key learning outcomes:

- Sharing learning, knowledge and skills with others in their local community
- Accelerated service improvement, by monitoring their progress against their personal improvement plan

Review of the literature

This section of the report is not intended as a comprehensive review of the leadership literature. Rather, it presents key themes, theories and processes of leadership and leadership development pertinent to the LHIP. Five areas of literature were drawn on:

- Improvement policies, processes and guidelines;
- Definitions and constructs of leadership;
- Health improvement leadership;
- Leadership development;
- Knowledge development;

At the end of each section, summary points are highlighted, identifying issues from the literature that have guided the research design and process as well as issues which directed the questioning of the data.

Improvement policies, processes and guidelines

Leadership development within the health and social care services is a core component to the achievement of the government modernisation agenda (Department of Health 1998, 2000). This is coupled with an ethos of joined-up working, collaboration and partnership (Newman 2003), and a resurgence of the role of public health (Department of Health 2004, 1998, Connelly et al. 1999).

This agenda demands public health or health improvement development at multiple levels;

- Those people who currently label their work as public health/health improvement and have a history in this field. The key demand for these people will be to amend their mindset from public health to incorporate health improvement and to enhance cross organisational and multi-disciplinary working.
- Those people holding roles in organisations that have more recently become engaged in the health improvement endeavour, or have recently been formally recognised as doing so.
- Cross organisation developments.

There is therefore a need for leadership development internal to organisations and external across organisations (Goodwin 1998).

The Department of Health Modernisation Agency has already produced considerable guidance on leading and achieving health care improvement. There is, for example, a great deal of information and guidance in the Improvement Leaders' Guide portfolio. One of the key messages (NHS Modernisation Agency 2005) is that:

> "A lot of improvement is about changing mindsets. It is about having the tools, techniques and confidence to work with your colleagues to try something that is different." (p5)

Much work done to date has been focussed on the acute care setting which could be viewed as a much more controlled context than the public health context. This creates some challenges in that there has been acute service dominance and work is needed in transferring the messages. The 10 High Impact Changes for Service Improvement Delivery (2004) is an example of acute care dominance in the examples reported:

1. Treat day surgery (rather than inpatient surgery) as the norm for elective surgery
2. Improve patient flow across the whole NHS system by improving access to key diagnostic tests
3. Manage variation in patient discharge thereby reducing length of stay
4. Manage variation in the patient admission process
5. Avoid unnecessary follow-ups for patients and provide necessary follow-ups in the right care setting
6. Increase the reliability of performing therapeutic interventions through a care bundle package
7. Apply a systematic approach to care for people with long term conditions
8. Improve patient access by reducing the number of queues
9. Optimise patient flow through service bottle necks using process templates
10. Redesign extended roles in line with efficient pathways to attract and retain an effective workforce

There is what could be described as a hierarchy of transferability. Some examples such as improvement of flow, application of systematic approaches, improved access, and role redesign have a clear applicability to the public health context.

The UK Pursuing Perfection initiative identifies a transformed health and social care system as one where

- no needless deaths or disease
- no needless pain
- no feeling of helplessness amongst users or staff
- no unwanted delays
- no waste
- no inequality in service delivery

These ambitions are all applicable to the public health service context.

Summary points

Messages for this evaluation included the need to interrogate the data with respect to diversity of health improvement roles, health improvement mindset development, health improvement tools, techniques and confidence in the public health context.

Definitions and constructs of leadership

The leadership definition debate is longstanding and has adopted different formats over time. Alvesson & Sveningsson (2003) summarise the situation:

> "The variety of constructions of leadership that the different articles within our research project exhibits could perhaps best be seen as a multitude of aspects of exercising leadership in the same organisation, bringing forth the variety, complexity and contradictory talk of leadership."(p1443)

One popular strategy used to define leadership is to compare and contrast it with management (Edmonstone & Western 2002). Dubrin (2001) provides a list of contrasting features detailed in table 1.

Leader	**Manager**
Visionary	Rational
Passionate	Consulting
Creative	Persistent
Inspiring	Tough minded
Innovative	Analytical
Courageous	Structured

Table 1: Management and leadership comparison (from Durbin 2001)

Barker (1997) articulates the distinction as, "The function of leadership is to create change while the function of management is to create stability." (p349)

Many researchers (Barker 2001, Nicholls 1987) suggest a great divide between managers and leaders. Alvesson & Sveningsson offer an explanation of the divide as "between bureaucrats and people with true grit capable of offering strong ideas and a sense of direction with which people choose to comply" (2003: 1436). This type of distinction emphasises what could be termed the more ostentatious elements of leadership. In this discourse, leadership is then a term reserved for the more dynamic, inspirational aspects of what people, especially people in authority, may do.

Alimo-Metcalfe & Lawler (2001) conclude from their study that:

> "… organisations in the UK consider leadership to be of the heroic kind – out there, at the front, beating the way into new markets, sweeping aside competition, and assuming that the workforce will follow." (p389).

Edmonstone & Western (2002) reinforce this, in asserting that an emphasis on the management aspect in leadership definitions

> "has gone hand in hand with a set of seldom- questioned assumptions regarding the legitimacy and pervasiveness of hierarchy and with so called 'heroic' leadership located within the upper echelons of the organisation." (2002: 35)

Reinforcing the dominance of this leadership discourse, Barker (2001) reports that:

> "Just as most English-speaking people use the word 'classical' to refer to any music associated with symphonic or chamber ensembles, most people use the word 'leadership' to refer to any activities or relationships associated with persons occupying top positions in a hierarchy." (p469)

Alvesson & Sveningsson (2003) add a different dimension to this debate by highlighting the conceptualisation of leadership as "the extra-ordinarization of the mundane" (p1435) evident in the special and mystical aura around leadership in the academic literature and the mass media. They also make reference to the "Saviour like essence". This therefore has the potential of defining the role of the leader as righting wrongs and salvaging from threat, rather than progressing or developing. This is in stark contrast to the activities such as listening, chatting and being cheerful which were labelled under the leadership banner in Alvesson & Sveningsson's (2003)

research. They suggest that there is a contemporary leadership discourse which denies or minimises, this facet of leadership.

A brief historical review of leadership theories maps the change from trait, to transactional, to transformational (Alimo-Metcalfe 1999). More recent definitions of leadership demolish the hierarchical construction. Leadership is therefore currently not defined as the activities of, nor confined to, the most senior personnel in an organisation (Hamlin 2002). Rather, leadership can be understood as a more widely dispersed endeavour relevant to all levels of an organisation (Bryman 1996, Edmonstone & Western 2002). Tichy & DeVanna (1986) identify seven characteristics shared by transformational leaders:

- identify themselves as change agents and take responsibility for change
- are courageous and take risks
- believe in and trust people
- have clear values and are value –driven
- are life-long learners
- can deal with complexity, ambiguity and uncertainty
- are visionaries and share their vision

In the current leadership discourse, dominance is given to collective, shared, distributed leadership and constructions such as 'community of practice' (Kouzes and Posner 2003, Horner 1997, Brown & Beech 2000).

Senge (1996: 30) defines leaders as people 'who are genuinely committed to deep change in themselves and their organisation'. Edmonstone & Western (2002) add a learning dimension to this democratisation of leadership, in asserting that leadership is what "enables people and organisations to face adaptive challenges where new learning is required" (2002: 35).

Related to this ability or receptiveness to learn, Clarke et al. (2004) identified three approaches to leadership development in an evaluation of a Chief Executive Development programme. These were:

i. Entrenched /entrenched – where the participants select activities which reinforce historical approaches, thereby limiting challenges to existing practice.

ii. Engaged/entrenched – where the participant engages wit development opportunities with the aim of challenging existing practice, but largely remains in established practices
iii. Engaged /engaged – where participant engages with development opportunities with aim of challenges existing practice and translate this into practice change

Summary points

It is important to take cognisance of the changing discourses surrounding leadership. LHIP participants will have been exposed to varying leadership trends and theories and may therefore have to unlearn as well as learn. Diversity of leadership definitions and styles within the LHIP participants' host organisations may also be highly significant. Individual participant receptiveness to development opportunities may also be an important variable for consideration.

Any degrees of mystique around leadership may have potential consequences for recruitment and barriers to learning. Similarly, definitions around leadership as a heroic endeavour may have appeal to some and create reticence for others.

Exploration of which leadership discourses are at play in the provision of and participation in, the LHIP are important areas for exploration. Questions need to be asked about which discourses are dominant, which are challenged, are there degrees of commonality between participants, which discourses did participants bring with them and meet in practice? Of particular interest are questions around whether any changes are made in the process of focussing on health improvement leadership. In order to capture the different narratives around leadership, the evaluation design must access leadership discourses as they are presented in a variety of contexts.

Health improvement leadership

Alimo-Metcalfe and Lawler (2001) pose the question of 'what is the economy lacking' with respect to leadership? This question can be transferred to the LHIP scenario by posing the question "what is the health improvement 'economy' lacking"? It is useful to highlight two issues for consideration when attempting to answer this question. These relate to the possible focus of health improvement leadership on improving either health care or health, and how distinct these constructs are thought to be. Logic suggests that the former is integral and probably a primer to having a chance of achieving the latter. There has been considerable recent work in identifying

strategies for improving health care; however, their utility in also improving health is not yet clear. Specifically, the consequences of the multi-agency cross organisational working of health improvement activities. The pubic health context is also less 'controlled' than the acute care sector.

McAlearney (2006) highlights that although leadership is central to NHS plans, further research is required to clarify what is at present only an 'outline understanding' of what is required. Caution is sounded at wholehearted adoption of North American transformational leadership theories which can have a male gender and private sector bias. She also highlights the need to consider the detail of the variety of occupations coming under the public health umbrella:

> "Though we do suggest that perceptions of effective leadership in public health medicine corresponds to theories of transformational leadership, specifically UK based theories, it is still too early to suggest that the current findings would also relate to other public health professionals. (p460)

The degree of transference of transformational development emanating from the United States to the UK has been questioned. For example, in a study on leadership constructs in Primary Care Groups, Gaughin (2001) rejected total reliance on adopted models, suggesting that leadership competencies development must happen as a result of an iterative and contextually responsive process.

Some clues as to what is required can be derived from the experience of the development of the New Public Management movement (Osborne & Ferlie 2002). Although accepting that much was transferable from management thinking developed and applied in the private sector, a distinct approach was deemed necessary.

The notion of a leadership community is central to achieving the improved outcomes through a needs led approach desired in the modernisation agenda and NHS Plan. Integral to achievement of this changed approach to understanding need and service response was service improvement capacity. This included process mapping, remodelling and redesigning processes and systems and cross organisational working. Goodwin (1998) emphasises the need for an expanded view on current conceptions of networking, clarifying that the aim of networking will be: "developing and securing external agreement to an agenda for positive change" (p31).

Knight (2002) highlights the importance of networks in community based health and social services as "client well-being depends on the integrated and coordinated actions of many different organisations" (p445). In relation to network research, Knight (2002) exposes four networking systems; individual, group, organisational and inter-organisational.

Health improvement leadership is required by a multi-faceted audience. Connelly et al. (1999) report three types of education and training need:

- Professionals, including managers in the NHS, local authorities and elsewhere, who would benefit from a better understanding of public health and knowledge of how to gain access to more specialist input.
- "….smaller group of hands on public health practitioners who spend a substantial part of their working life furthering health by working with communities and groups
- "…a still smaller group of public health specialists from a variety of professional backgrounds including medicine who need a core knowledge, skills and experiences in areas such as strategy management, team working and leadership as well as technical areas." (1999: 211)

It seems reasonable to assume that there will also be diversity in leadership development needs.

Reference to the Impact Evaluation of the National Public Health Leadership Programme (Williams 2006) provides insight into how health improvement leadership may be addressed. The report makes reference to two programmes; one aimed at senior management level and the other at junior/middle management levels. Both programmes were deemed to be successful, although with some potential limitations highlighted. In particular, and significantly, an indirect route to improvements to public health delivery was noted

> "Although the focus of the evaluation was towards impact on public health delivery, the participants themselves continually brought these issues back to the ways in which they were personally functioning more effectively. It was through changes in themselves, in the ways they related to other people, how they tackled problems, how they worked in partnership and the confidence with which they are able to approach the public health agenda that they and their colleagues and line managers saw delivery being improved. The link between learning from the programme and subsequent improvement in public health delivery can be said therefore to be subtle rather than direct." (p 4)

Williams (2006) draws on Leithwood and Levin's (2005) model of leadership impact on service delivery to expose the timeline.

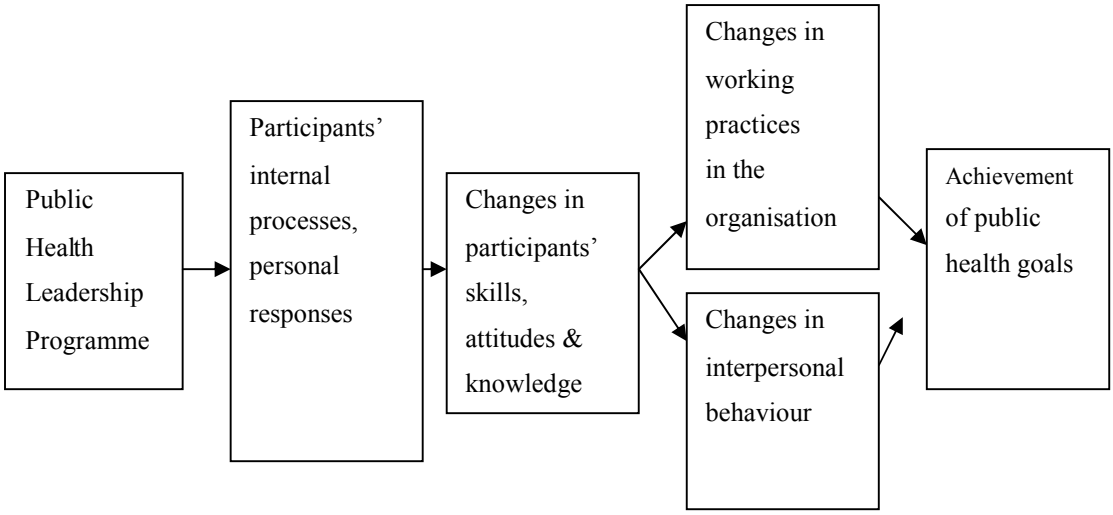


Figure 1: Impact of leadership development on public health delivery (taken from Williams 2006: 5)

Positive outcomes included increased leadership skills, increased influencing skills, self awareness, improved interpersonal relationships, increased insight, improved team working, and increased readiness for new responsibilities. Interestingly, only 38% of participants of the programme delivered in London, and 46% of the participants of the programme delivered in the West Midlands reported increased awareness of the political agenda.

Although change, largely at an individual level, was observed, attributing the casual chain and disentangling the programme impact from that of other concurrent variables was highlighted as being problematic. The evaluation made a number of recommendations which included; making best use of participants' experiences, tailoring the content, focussing on public health and adopting a guided public health approach.

Summary points

Clarification of understanding and expectations of health improvement leadership needs is required. Inherent in this is the transitions that may be required in relation to what has previously been understood as public health leadership. Cognisance will be required of potential diversity of organisation needs and stages of health improvement development.

Networking is identified as a core activity in health improvement. Some analysis of current and developed levels of networking and mechanism for facilitation of this will be required.

Disentangling the impact of leadership development, especially at an organisational level, is a well reported challenge of which this evaluation must be cognisant.

Leadership development

A template produced by Paul Plesk for the Leading Modernisation Programme developed and delivered by the NHS Leadership Centre and NHS Modernisaton Agency details the characteristics of the successful leader (Clarke et al. 2004):

- communicates clear vision, direction and roles
- strategically influences and engages other
- build relationships
- challenges thinking and encourages flexibility and innovation
- develops, enables and encourages others
- drives for results and improvement
- practices political astuteness commits with passion to value and mission
- demonstrates mastery of management skills

McCauley, Moxley and Van Velsor (1998) define leadership development as the "expansion of a person's capacity to be effective in leadership roles and processes" (p25). McCauley (2001) describes three facets of effective leadership development:

- development experiences
- the ability to learn
- the organisational context

The Council for Excellence in management and leadership specify three principles that should underpin leadership development:

- driven from the top with specialist support
- leadership development supports and drives the business
- Consideration of the leadership concept, cultural difference and different development approaches.

Literature on the discipline of improvement (Berwick 1996, Clarke et al. 2004) offers guidance for improvement leaders and highlights key strategy issues such as changing systems rather than changing within systems, clarity and specificity of aim, measurement and learning.

McAlearney (2006) identifies a number of challenges to leadership development specific to health care organisations. In a conceptual model of commitment to leadership development, three factors of strategy, organisation and structure were deemed to be important. Health care organisations were described as having a reputation for 'seemingly chaotic internal coordination' fed by hierarchical structures, cultural gulfs and professional differences. These differences are seen to be the driver to segregate professional groups for leadership development. Another challenge laid in the limited role of organisational learning in healthcare organisations especially the neglect of mistake or error as a source of learning. Health care organisations are described as having a culture where staff development is vulnerable from both an individual and organisation sense. From an individual perspective, attendance at a development is often constructed as taking time away from patient care or diverting money away from patient care. At an organisational level, development budgets were often high on the list to be compromised when financial constraints had to be met. The organisation perspective on and support of leadership development is therefore a crucial aspect. In view of these issues McAlearney (2006) suggests that evaluation criteria for development programmes such as employee satisfaction should be replaced or supplemented with organisation metrics.

The issue of teaching leadership is something with which people have struggled. Barker (1997) highlights that the impact on the teaching remit of the ambiguity surrounding our understanding of leadership. Hay and Hodgkinson (2006:144) offer a solution to what they term the "thorny issue of teaching leadership" by proposing reconceptualising leadership "in a way that is more helpful to our attempts to teach leadership."

The delivery style of leadership development has been scrutinised. Antonocopoulou & Bento (2004) criticise the instructional approach. Rather they emphasis the development of the capability to learn, the willingness to experience the vulnerability

of not knowing and openness to experiencing new situations. They emphasise the benefits of self discovery through action, interaction and transaction. Goodwin (2000) notes that the dominant model has been to deliver development programmes 'off the job' rather than workplace based. Yet, Martins (1999) suggests there is benefit in an integrated approach in a partnership mode between provider and recipients.

George (2000) highlights that while existing studies detail what leaders are like, what they do, and how they make decisions, the effects of leaders' feelings or their moods and emotions and, more generally, the role of emotions in the leadership process, are often not explicitly considered in the leadership literature, with the notable exception of work on charisma. The relative neglect is not surprising as the organizational literature has been dominated by a cognitive orientation with feelings being ignored or being seen as something that gets in the way of rationality and effective decision making. Despite this, George (2000) stresses that that "emotional intelligence, the ability to understand and manage moods and emotions in themselves and others, contributes to effective leadership in organizations." p1027

As Clarke et al (2004) conclude in a review of leadership literature in relation to an evaluation of a Chief Executive Development Programme commissioned by the NHS Leadership Centre:

> "Providing learning opportunities that advance people's skills and knowledge about leadership is inevitably challenging. It is a concept that has at its heart a dynamic tension between judgement, finesse, and decision making, responding and stepping ahead of the field to break new ground. It requires both political acuity and personal vision; confidence to act and determination to stand one's ground." (p10)

Summary points

The evaluation design is cognisant of the need to be vigilant to capturing data on changing within systems, clarity and specificity of aim, measurement and learning. Health and social organisations may present particularly vulnerable development contexts. Not only may organisation impact be a difficult issue to measure, but this may be exacerbated by context. Individuals maybe receptive to development, but

they may meet organisational barriers. There may therefore not be a linear route through individual to organisational change.

The immediacy of the relevance of leadership development to service or organisation intent may be an important issue. This may be influenced by the health and social care culture where allocation of resources to development can be viewed with some reticence, taking the view that this is taking resources away from service provision. This may pose dilemmas for the LHIP, around balancing development that may have immediate translational potential and development that may transcend immediate individual practice. This may be a problem for the LHIP organisers, as while they wished people to translate learning to their own practice, they endeavoured to deliver a programme of events that could transcend individual practices. Expectations may vary around whether single loop or double loop learning (Argyris and Schon 1974) are reasonable programme expectations.

In view of the range of potential leadership constructs, leadership development expectations may be diverse. There may also be levels of ambiguity in expectations as participants and their organisations conception of health improvement leadership may be at different stages of development.

Knowledge development

There are a range of differing views on how best leadership knowledge can be developed. Edmonstone & Western (2002) highlight a tendency within the NHS to focus on individual, rather than on organisational learning and on increasing knowledge acquisition, rather than knowledge implementation. They add that there has been "fashion swings" between intra and extra organisational development activities, and a lack of recognition of the potential for mutual and reciprocal reinforcement between these activities. Antonopoulou and Bento (2004) call for an experiential rather than formal intervention approach to leadership development. Specifically, they describe an experiential approach that is based, not on learning from others, but focussing on making sense of their own experiences, rehearsing practice and nurturing people's leadership potential.

From outside the NHS there are important messages from industry and especially that outside the Western culture. Nonaka & Takeuchi (1995) highlight the neglect of

knowledge creation as opposed to knowledge processing in many management studies. This is significant, as knowledge creation has been identified as one of the most important attributes of the Japanese car industry international competitiveness. The Japanese value system relating to tacit and explicit knowledge also offers guidance for development. The Western approach has been to value explicit knowledge more highly than tacit knowledge, fuelled significantly by the evidence based practice culture. However,

> "..for tacit knowledge to be communicated and shared within the organisation it has to be converted into words or numbers that anyone can understand. It is precisely during the time this conversion takes place – from tacit to explicit, and,…back again into tacit- that organisational knowledge is created." (p9)

Thus, creating new knowledge entails more than the mere acquisition of knowledge. Rather it must be:

> "…built on its own, frequently requiring intensive and laborious interactions among members of the organisation." (p10)

Nonaka and Takeuchi (1995) identify four modes of knowledge creation within organisations:

1. socialisation – tacit knowledge is exchanged through the process of sharing of experiences
2. externalisation – tacit knowledge is articulated into explicit concepts through successive rounds of meaningful dialogue
3. combination – explicit knowledge systematised and documented into a wider knowledge system
4. internalisation – explicit knowledge embodied into tacit operational knowledge

Summary points

A key message for this evaluation therefore is to ensure that exploration is wider than the knowledge acquisition level, but also at knowledge application and creation, at both individual and organisational levels. Another apparently key issue to consider is mix and balance of the formal and experiential components of a leadership development programme.

Evaluation design

Although the prime intent was to evaluate the LHIP, that system could not be looked at in isolation to the multiple organisations or systems of the participants. This research had to consider two separate, but interrelated systems. One system related to the LHIP as a learning endeavour, and the other system active in the research is the organisation in which the participants work, and in which that learning may be applied.

It is important to make reference to other leadership development evaluations to ensure that this study has realistic aims. In particular, it is relevant to note that attribution of causal chain of effect between individual leadership development and organisational impact is reported to be difficult to disentangle and demonstrate (Lee 1994, Flannagan and Spurgeon 1996, Williams 2006). This challenge is perhaps exacerbated by short time scale evaluation where some types and levels of impact may not have sufficient time to come to fruition. With these messages in mind, this evaluation must include a level of caution in relation to identifying and detailing organisational, as opposed to individual impact.

In this section of the report, the guiding evaluation methodologies are discussed. This is followed by a detailing of the evaluation strands. The methodologies detailed in the design were translated to suit the LHIP and the evaluation limitations, such as budget, and the necessity to limit participation demands on the LHIP participant.

Evaluation methodologies

The study required a methodological approach that could capture the process of change in complex multi-professional, multi-agency and multi-sectoral systems. The study therefore used soft systems methodology, embracing appreciative inquiry and illuminative evaluation.

Soft systems methodology (SSM) was originally developed by Checkland & Scholes (1999) as an application of systems theory to 'human activity systems'. The objective of a SSM analysis is to bring about change in these systems of human activity by engaging people in those systems in a learning cycle using systems concepts to reflect on and debate multiple perceptions of the situation being researched. In so doing, it

generates an iterative relationship between theory and practice that will allow for conceptualising and further development of the theory underpinning the programme that is grounded in the practice experiences of the programme participants. It is therefore a form of action research that is ideally suited to analysing and facilitating change management activities in organisations. There is a strong emphasis on the learning experiences gained from using a SSM approach, making this an ideal methodology to adopt in this study, engaging with the community of participants and their work environments in particular.

Appreciative Inquiry (AI) has developed from organisational development initiatives and contains elements of action research, in common with SSM (Reed, 2007). It has an explicit focus on examining the positive and productive aspects of a situation. Respondents are therefore asked to identify what is working well in the individual and organisational practice and to go on to:

> "Envision what it might be like if 'the best of what is' occurred more frequently."… "participants engage in a dialogue concerning what is needed in terms of both tasks and resources to bring about the desired future." (Coghlan, Preskill& Catsambas 2003:5)

AI does not deny or ignore problems but approaches them from the perspective of asking participants what they would like to see more of in their practice or organisation. AI is about trying to find out what works and why it works, and argues that by examining factors that are productive and helpful it is possible to think of ways of extending and developing the positive factors.

AI provided a particularly useful framework for the participants' interviews, since many were experiencing turbulent restructuring in their workplaces. AI facilitated reflection on the positive elements of current practice, so that they could be put to best effect in a new configuration that would enable them to actively engage in health improvement leadership.

Illuminative evaluation (IE) is a qualitative methodology that seeks to describe and interpret. The purpose is to clarify critical processes and to:

> "sharpen discussion, disentangle complexities, isolate the significant from the trivial, and raise the level of sophistication of debate." (Russell et al. 2005)

The integration of SSM, AI and IE enabled the surfacing and discussion of issues particularly relevant to each participant, in their practice context. The fact that it was used as part of a series of 2/3 interviews reinforced this process, as people were able to reflect in between contacts with the researchers. Some participants commented on the fact that their participation in the research enabled them to identify more clearly what they had learned, what they needed to learn, which aspects they had been avoiding, where the tensions were for them, why they were enjoying the programme.

Evaluation strands

The study involved two distinct components of work.

1. Analysis of the learning and development experiences as perceived by the Programme providers and participants.
2. Analysis of the application of learning in practice.

A range of methods of data collection were utilised across both components of the evaluation, capturing the necessary depth and breadth of participants' experiences and perspectives.

Component 1: Analysis of learning and development experiences

This component of work employed participant observation methods, faculty conference call participation, in-depth individual and tripartite interviews and secondary data collation in the form of pre programme questionnaires, event evaluation and data validation with participants. These methodological approaches identified the experiences of participants and providers whilst they were actively engaged in Programme development, delivery or attendance.

Component 2: Analysis of the application of learning in practice

This component of work drew on individual and tripartite interviews, to surface and explore learning in practice.

Individual interviews.

All Programme participants were invited to participate in this aspect of the evaluation and a sample selected to include organisation type and professional background. Drawing on the principles of AI and IE a sample of seven participants were invited to participate in a sequence of two to three telephone interviews in the periods between programme events. Participants were asked to comment on the ways in which their leadership for health improvement had evolved and the synergy and conflicts between their role and the LHIP.

Tripartite interviews.

In order to capture organisation impact of the Programme, participants and their sponsor were invited to participate in a tripartite telephone interview to reflect on the impact of the Programme in relation to their initial needs analysis and the legacy for the organisation. These were timetabled to take place during the final two months of the Programme. All participants were invited to participate in this aspect of the evaluation and a sample of seven were selected, drawing on initial needs analysis data. Given the context of organisational turmoil in which a large number of participants worked, many were no longer working with the person who had initially sponsored them to take part in the LHIP, and struggled to find an adequate substitute. In order to adjust for this, where possible, the third of the series of 2/3 interviews was focused on the organisational view of the LHIP. Sampling decisions for both types of interview were driven by the need to include a diversity of roles, organisations and leadership development needs.

In acknowledgement of the importance of cross organisational learning and partnership working to leading health improvement, all participants were directed to access the *Assessing Strategic Partnership Assessment Tool* developed on behalf of the Office of the Deputy Prime Minister in 2003. This tool was identified by the research team as having the potential to serve as a learning and reflective tool for the

Programme participants. Although it provided a framework to facilitate discussion on partnership work in data collection activities, it had not been well accessed by the participants.

Analysis

Qualitative data collated from the range of methodological approaches described above was analysed using a thematic analysis framework. This was initially based on the domains of successful health improvement systems, successful leader and successful improvement leader. However, because there was a considerable time delay in the participants adopting, and therefore becoming familiar with the framework, this proved a difficult analytic strategy. An alternative approach guided by appreciative inquiry framework was therefore utilised. Thematic content analysis (Denzin and Lincoln, 2000) produced a number of key themes illustrating the participants' experiences and perspectives of the programme, the development of participants' learning and the development of the programme.

A collaborative approach to analysis was employed, within the research team, between the team and the programme leaders (via conference calls), and between the team and programme participants (both informally during events, and formally by facilitating data validation with participants with interim report circulation and presentation at the final learning event). The analysis was also submitted to a double iterative process, one which engaged the programme organisers and participants in commenting or critiquing the analysis as it was progressing, and the other which informed, and was informed by, the system analysis.

Ethical & governance considerations

The research proposal was scrutinised and approved by Northumbria University ethics and governance processes.

Advice was sought from the Chairperson of a Local Research Ethics Committee as to the need for additional scrutiny through this system. The decision relating to an earlier related evaluation (Clarke et al. 2004) that University approval was sufficient was upheld.

The host organisation of each evaluation participant was approached for clarification of their research and governance processes and all necessary approval processes were addressed. Achieving the sample aim of including a breadth of organisation representation was therefore a particularly time consuming process.

The LHIP participants were kept fully informed of the aims, scope and process of the evaluation throughout the programme with regular evaluation update presentations.

Sampling and recruitment

All LHIP participants were invited to participate in all data collection activities (n=58).

The outcomes are detailed in table 2.

Evaluation activity	Agreed to participate	Response rate	Sampled
Secondary data analysis	54	95%	54
Individual interviews	37	68%	7
Tripartite interviews	28	52%	7

Table 2 Evaluation recruitment outcome

Research activity and data collection

The methodologies detailed in the design were translated to suit the LHIP and the evaluation limitations, such as budget and the necessity to limit participation demands on LHIP participant. Four activities were undertaken:

- Secondary data analysis: pre-interviews and event evaluations
- Faculty activity
- Participant observation
- Interviews – individual and tripartite

Secondary data analysis

The secondary data supplied by the programme organisers were used in order to inform and guide subsequent analysis and ensure that evaluative efforts were not duplicated.

Analysis of pre-programme interviews identified four themes:

1. Participants role in public health
2. Leadership styles
3. The LHIP framework
4. Anticipated structure of the programme

1.Participants' role in public health

Participants viewed their role in public health in five different categories:

i] Pro-activity in public health / policy implementations & development

Most participants described their role in terms of ensuring the maintenance of sufficient public health capacity / capability in their area. They were concerned about the achievement of policy driven outcomes, and expressed interest in the ways in which they could "measure improvement". They engaged in public health through leading, co-ordinating, developing, implementing and performance managing. They saw themselves as having a particular role in being innovative and creative in their implementation of PH strategies.

ii] Embedding public health in other things / partnership working

Participants described themselves as having a particular role in strategic thinking, outside of the health services. They were keen on developing collaborations to create opportunities for health improvement, foster in partner organisations a sense of ownership of the health improvement agenda, and generate shared organisational objectives. In this, some participants were moving from being centred on the individual to consider the communities in which they live.

iii] Lobbying

Some participants saw lobbying as an important aspect of their public health (PH) role. By this, they meant finding the local / regional power levers (e.g. funding agencies) and finding ways to engage them in the PH agenda.

iv] Leadership

Participants saw their role as providing strategic coherence / planning, leadership / motivation and performance management on local / regional PH issues. Some were engaged in PH workforce development.

v] Measuring intervention/ evidence base

Participants saw themselves engaged in ensuring the implementation and evaluation of evidence – based interventions. Some were moving to outcome based commissioning, and had to oversee that transition; others had an explicit role of overseeing the achievement of a range of outputs / outcomes. Some were providing, interpreting and delivering health intelligence (data / evidence / indicators etc) to facilitate the generation of health improvement initiatives.

2. Leadership styles

Some participants saw the cornerstone of their leadership style as being their ability to communicate effectively and positively. The empowerment of other people to be creative, take initiatives and gain a sense of ownership was key to achieving their PH visions. Part of this was to promote innovation and "open and free thinking", in their teams. They valued being able to measure the capacity for change and therefore identify the 'movers and shakers' in a multi-agency network.

Most importantly, participants valued the importance of having and communicating a vision for PH locally. This entailed establishing clear and achievable outcomes, and being politically aware. Participants described themselves as 'transformational' or 'transactional', 'collaborative', 'facilitative', 'consultative' or 'inspirational' leaders, but more frequently recognised the necessity to adopt different styles indifferent situations. Some put the emphasis on strong performance management, so that, while the goals are clear to all staff, progress could be made apparent. They applied this to themselves too.

3. The LHIP framework

Participants were very attracted by the integration of the 3 domains, which some found to be closer to the real world, in contrast with other leadership courses. They were however, concerned with the breadth of what was to be covered in the time frame, and the possibilities of implementation, given the 'turbulence' or their work lives. They were expecting the programme to enable them to become more creative thinkers, and gain a greater understanding of whole systems in achieving a cultural change.

Some expressed uncertainty about the 'successful improvement leader' element of the framework. This was linked to a concern over the use of 'improvement science', as an engineering approach which seemed oversimplistic for the more complex world of health improvement. Some could see improvement science working in clear procedural environments (a smoking cessation service for example), but were intrigued to see how the programme was going to apply this to the wider and more complex world of PH.

Noticing the breadth of background of fellow participants, some expressed concern over the NHS dominance, in spite of the multi-agency claim of focus. In this early stage, they hoped that this would be balanced by the content of the programme. In spite of this, many were hoping that the programme would enable them to establish new collaborations, and break down existing organisational boundaries. Other

participants, were concerned about the programme being too challenging for some participants, and not enough for others.

Some participants were concerned that the programme may be over theoretical. They were seeking practical examples, tips, tricks, evidence of 'what works'. The programme struck some participants as being too 'apolitical' in an essentially politicised world. Linked to this was another theme, which emerged from this cluster of questions, which was around the generation of evidence and measurement of outcomes in the most appropriate way.

4. Anticipated structure of the programme

Participants highlighted that periods of instability were the best time to engage in a leadership programme, as they saw it as a key time to be innovative. They commented on the fact that they had little time in between days to do any work.

Most participants stated that they valued expert presentations, but only if they were kept limited in time, focused, and connected to other group work. Some would have appreciated time to prepare for expert interventions, so that the most could be made of their presence. Participants also mentioned that they would appreciate structured group exercises; and others mentioned that unstructured time was important, but should be kept to a minimum to be productive – tea breaks and meal time were thought to be sufficient. In contrast to this, others thought of unstructured time and question time to experts as crucial. This contrast may highlight a recruitment issue, in that participants at different stages of the leadership for health improvement journey present with different learning needs, as highlighted by some participants in the previous questions.

Forums to raise issues for collective input were thought to be crucial for some participants, but were judged 'wooly' by others. Participants thought they needed 'time to reflect':

> "The problem with some events like these is that there is no space: many people (including me) like to have some time to reflect and take stock of what is happening in the plenary / group sessions. Part of that can be

> unstructured networking but it can also just be about sitting down and having some space to reflect – time built in for this would be great"

This implied that once out of the sessions, participants did not have time to read or absorb their learning. "I need time to make sense of what I have learnt and relate it back into the workplace".

In conjunction with the desire for practical exercises and examples, participants would have appreciated a mentoring / buddying scheme in order to apply programme learning in their work practice.

In this question too, participants noted that the majority of participants were from the health sector – some thought that this created an imbalance which did not foster collaboration, as people who came from the health sector spoke a 'common language'; another participant highlighted that this made it difficult to speak openly in the sessions, since participants may be competing for jobs, or interviewing other participants. In spite of this, participants would have appreciated time build into the programme for networking.

Some participants noted that they expected the programme to evolve 'organically', with more presentations and structured work at the start, and more unstructured networking towards the end of the programme.

Reiterating themes highlighted in previous questions, one participant could see how improvement science could work in relation to predictable and organised systems, but was wondering how this would work in public health. "We need implementable standards of public health and top team practice, and I'm not clear how, if it intends to, LHIP takes us somewhere meaningful on that journey."

<u>Event evaluation</u>

In the interests of information completeness, the LHIP organisers provided the researchers with participant event evaluation feedback. High levels of satisfaction were consistently reported. Participants also took the opportunity to feed in comments about how they would like issues to be developed in future events.

Observation of Programme events

The learning events within the LHIP were observed by member(s) of the evaluation team, in order to describe the format and style of the programme; illustrating the context of the learning, and to explore and document participants' learning across the programme. The evaluation team conducted 'participant observation' (Robson, 2002), whereby the observer is either part of, or takes part in, the context under observation. This method can be conducted using varying degrees of participation from the observer. Since relatively few observations were required within this evaluation (i.e. six learning events), the team elected to observe with minimal participation, in order to avoid biasing the data. The observer took part in the learning events as an active listener to the range of speakers, observing and documenting (anonymously) participants' questions, discussion points and ideas generated from the various speakers, workshops and other learning formats within the programme. During each learning event, the observer engaged in informal discussions with participants during recreation points and observed participants' interactions with each other and with the programme leaders. Detailed field notes were made by the observer(s) as each of these activities took place.

In order to ensure transparency of the role of the participant observer at each learning event, programme participants were made aware of the observer's role and of the scope of the observation, i.e. what was being observed and why. Participants were given assurance of their anonymity and confidentiality in any observation data collated. In addition, in order to encourage participants to approach the observer with comments regarding the programme, and to ensure participants' confidence in entering into discussions with the observer regarding their experiences and perspectives of the programme, the observer confirmed with participants during these situations that they were happy to have their comments included in the data set. This transparency also gave participants the opportunity to ask questions about the evaluation and to demystify the role of the evaluator, where this was deemed necessary.

Faculty conference call participation

A member of the research team (SMC) participated in all Faculty Conference calls during the planning and delivery of the LHIP. One function was to clarify the

philosophy and intent of the programme and Faculty debates on the detail of the framework contributed significantly to this. This was also the forum where evaluation design and sampling decisions were shared and debated. Evaluation updates at each conference call engendered discussions as to how best to manage the emerging findings. These discussions also provided opportunities to clarify analysis in progress and relate this to programme philosophy in an iterative manner.

Interviews

Individual interviews

Interviewees were initially asked to specify an improvement aim on which to focus the interview, but this quickly proved difficult for the majority of evaluation participants. For them, interviews focussed on the similarities and singularities between the LHIP in particular, and health improvement more generally, and their practice. This sometimes surfaced a more central position than initially thought by the participants. The discussion was framed around the 3 Programme learning domains and identify evidence of development. This, however, needed considerable nurturing on the part of the researchers.

In line with AI, the interviews have focussed on appreciating what it is about the LHIP that is positive and exploring this by questioning how the LHIP can accommodate the leading health improvement needs of the participants. Over the course of the 3 interviews the interviewees were guided through the appreciative inquiry phases of:

- *Discovering* and *appreciating* phase focussing on what is working well.
- *Dreaming* phase envisioning what might be. Generation of ideas of what might be is facilitated by posing the 'miracle ' question:
- *Designing destiny* phase focussing on how to construct the future and sustain improvements.

Throughout the interview phases, participants were also offered opportunities to participate in the appreciative inquiry strategy of generating provocative propositions, statements that challenge (rather than confirm with) the way that things currently happen in the system.

Bushe (1995) highlights that: "The power of AI is the way in which participants become engaged and inspired by focussing on their own positive experiences". The feedback on the interviews concurred with this statement. Participants reported to find the interview experience beneficial in terms of assisting them to review and articulate what they have achieved.

Seven participants were sampled to participate in a series of three individual interviews spanning the life of the programme. The outcome is detailed below

Participant	Interview 1	Interview 2	Interview 3
1	*	*	*
2	*	*	*
3	*	*	*
4	*	Change of location	*
5	*	*	*
6	*	*	Declined (workload pressures)
7	*	*	Declined

A total of 18 45-60 minute interviews were conducted.

The typical procedure of informed consent was conducted with each participant, where selected individuals were sent information about the purpose of the evaluation (see appendix 3), confidentiality and data protection issues, and were given the opportunity to ask questions before deciding to take part. The invitation to participate in the evaluation stipulated that their participation was anonymous to the programme organisers, and that they could withdraw their participation at any time, without giving any reason. Additionally, participants were invited to take part in each interview (a series of three per participant) via email, where their consent was re-established, and where they received an interview outline, explaining the purpose and proposed content of the interview.

The research team designed the interview schedules (see appendix 4) within the framework of AI, and addressing the ways in which the participants were

implementing the learning from the programme into their local organisational context. The interviews were in-depth, therefore the schedules outlined a framework for the research team to work within, but leaving it broad enough for the participant to describe their own experiences and perspectives on the synergies and conflicts between the learning on the programme and implementing this in practice.

The interviews were conducted via the telephone, enabling the researcher to execute more flexibility in arranging and rearranging interview times to suit demanding schedules. Interviews were audio-tape recorded and transcribed, in compliance with the Data Protection Act (1995).

Tripartite interviews

Seven individuals were contacted during the last 8 weeks of the LHIP and invited to participate in this aspect of the evaluation. The outcome is detailed below:

Participant	Sponsor
1	Organisation structure changes - sponsor no longer in post – individual interview with organisational focus undertaken
2	Organisation structure changes - sponsor no longer in post – individual interview with organisational focus undertaken
3	Participant and sponsor
4	Participant and sponsor
5	No answer –
6	Participant and sponsor
7	Declined –'my sponsor is no longer in a relevant post and I don't feel I can make a comment about organisational impact'

The interviews were audio-tape recorded and transcribed.

Data analysis

Two strands of data analysis have been carried out:

- Thematic Content analysis
- Systems analysis

These analytic activities were undertaken on each data set collected during the evaluation. This facilitated a chronological and cumulative understanding of the issues.

Thematic analysis

During the analysis process, in keeping with AI, four headings were utilised to thematically place and analyse data:

- What participants appreciate
- What participants would like more of
- Visioning the best of what might be
- Learning needs awareness

In order to facilitate a level of collaborative analysis with both LHIP providers and participants, the following template was developed as a mechanism for sharing analysis in progress.

Analysis theme e.g. *what participants appreciate*	Issues for consideration/questioning of data
Paraphrased responses were provided in this column	At the dissemination of the evaluation at the interim stage all recipients were invited to treat this as an active document and to make their own contribution; In the version sent to participants, this column was left blank to allow evaluation team to receive their undirected responses In the version sent to the LHIP Faculty, the evaluation team included their questioning of the data for comment, editing and additions.

Table 3: Template for collaborative analytic activity

Examples of this level of analysis are provided in the findings section.

The thematic analysis activity was then further developed by merging the data into the following headings:

- Programme content
- Programme format and structure
- Programme delivery methods
- Programme Outcomes
- Participant recruitment
- Participant roles and responsibilities
- Programme exit strategies
- Cascading of leading health improvement /organisation issues

The rationale for this is that the balance of the reporting had moved from informing the process of this programme to informing the development of future programmes.

What participants appreciate (paraphrasing)	Analysis of the data / questioning of data
Mix of participants	
It was really useful to be able to get some understanding of how people from different organisations understood things or got from presentations during the table discussions. I was aware of organisation differences – but now I feel I'm beginning to understand why they exist and the reasons for them'	Multi-professional mix appears to be very important ingredient for a successful programme.
I'm seeing the whole system – I can now prepare so much better for communication with different organisations – I give the same message, but I can set it out so that it fits for them and they can potentially see how they can be involved	Participants are learning from hearing views from people in other organisations and are able to translate this knowledge into their practice. The exact added value of the programme – other than the fact that the LHIP allows this cross fertilisation needs to be captured/explored. Participants value the opportunity to share ideas with people who are not their colleagues, who have no vested interest in the situation they are challenged by in their day-to-day work
It is useful to see that other agencies are operating in the same political climate of change, and to see how they cope with it. This helps to step back from work and establish priorities. *Collaborative problem solving with other participants*	Are people problem solving in a way that can be transferred to their practice situation?
I've moved out of my comfort zone in terms of meeting new people and seeing other service/ organisation issues	There can be a level of discomfort in venturing out of the 'usual frameworks and networks - this will be something that the LHIP participants need to be able to facilitate in others

I've met people from a variety of roles in my area, these have been really useful links – there are people now who I feel I could just pick up the phone to or go and knock on their door – before they weren't really accessible to me	Perceptions of lack of receptiveness of others in own or other organisations have been demolished. And wide and strong networks are being forged. However, little reference is made to how this network development will be moved from an individual activity or how such networking processes will be made available to others

Being a programme participant	**Analysis of the data / questioning of data**
I started the LHIP wondering how I would fare mixing with the great and the good, but now I'm starting to believe that it's right for me to be here.'	The LHIP may be a mechanism for developing leadership capacity and nurturing a wider perception of leadership than is often currently held. Programme entry needs to be sufficiently broad and the welcome and nurturing that people have received is important.
The biography book was really helpful in helping me to set myself against the others – it helped me to realise that I may not be a DPH, but I've done lots of other, still very relevant things'	There is a need for participants to find their place in the public health / health improvement arena and be convinced of the equality and worth of their contribution. The LHIP plays a key role in this.
The programme is showing me where I have come from - I understand how I function better	These concerns appear to be generated internally and are not in any way fuelled by LHIP experiences
Developing services the way I am can be a very lonely road – knowing I'm not alone, others are trying to do similar things and meeting similar problems is so helpful	Participants are starting their learning journey at very different points i.e. from doubting if they should be on the LHIP to having experienced several leadership training episodes and have a well developed self identity as a leader Insight development and learning needs analysis is ongoing Some participants appear to be working in non-supportive environments which creates questions about organisation level issues
I've been on several leadership and innovation courses before so I'm not focussing on leadership, but the tools	Is there any danger that participants may be too selective of their learning and lose some interaction potential in the framework - and not actually access the circle overlap learning?

issues *I am not a health improvement leader. I regard myself as a leader and health improvement is a consequence of this.*	Is there a clear orientation to health improvement in the programme, that does not relate to NHS members only? Other participants have commented on the sometimes heavy medical/ NHS emphasis. How could the programme engage people in health improvement and see themselves as central to a health improvement agenda, no matter where they work? For some participants to the interviews, it took a while to recognise part of their work as directly improving health, both on a practical and strategic level. Would there be scope for the programme to help them do that at the outset and then build leadership skills within their identified health improvement practice framework?

Tools	**Analysis of the data / questioning of data**
I have been introduced to so many tools that I was unaware of - the other aspects of the course are helping me see how and when to use them	This seems to be an example of someone actually using the 3 aspects of the framework – it would be useful get participants to articulate this to provide exemplars for others to aim towards.
It all seemed too big with too many obstacles, now I can see that I am a change agent and understand where I am at and see incremental progress	The LHIP has made change manageable. This comment also may be an example of change agents working alone, which questions their leadership role and whether they are addressing this as opposed to just finding more ways of addressing change in smaller /incremental components.
I have used a simplified version of one of the tools (SPC) presented to develop capacity in my team and to work on training issues	It seems that people are using some of the tools presented in the programme; we need to explore in more detail which ones, how they have been used and what the effect of that has been in the participant's practice.
Table top discussion on SPP – only at the end of the discussion did participants raise issue 'did we cover SPP – when in actual fact they had been problem solving by drawing on and sharing past experiences of coping with issues that seem to mirror a problem currently being experienced by one of the group	Do participants follow through presentations during table top discussions or do they use this for networking time? Do people listen to the discussion on change approaches, but remain in their own comfort zone and draw on their own menu of tried and tested approaches
People seemed to struggle to apply the SPP principle in	Participants wanted to use table top discussion time to solve any ongoing HR problems – there seemed to be a potential for the other participants to provide a listening / solution role, which

practice, and decide what was a structure, a process or a pattern. This had a knock on effect in that it did not help them to think about problem any differently. *I'm going in there next week and I'm just going to confront them with some home truths* *I need to shake the system in a sensitive way* *The improvement guides were something that I wasn't aware of and I have found them useful, although the issues are different. They relate to a discrete processes like hip replacement – public health isn't like that*	could become divorced from the 'theory' input. Would there be any potential to have a slot for participants to raise current priority problem that is perhaps dominating them and maybe preventing being receptive to wider thinking and have a guide solution discussion that does make maximum use of the theory input? Do participants need to have some sense of maturing some of their new knowledge etc before applying -i.e. what is their development continuum before they should feel competent – is it at the end of particular session or is that session supplemented by something later in the programme? Diversity in response /application plans Some participants may be experiencing some difficulty in seeing the health improvement /public health application of some of the tools developed for other service sectors

Presentation and practice sharing	**Analysis of the data / questioning of data**
One presentation was really helpful for me – about elderly participants in a programme talking about PDSA – I found that very stimulating and it made me think we could do more innovative and exciting things and there have been areas of my work where I can transfer that type of learning	Examples of creative and innovative practice are appreciated and stimulate people to be innovative and as they see that they can work they have more confidence to try and experiment/ be creative in their own practice
It's given the chance to engage with the wider political agenda *It has helped me to break down development into cycles so that I can see where I'm going and achieve bits of what I want to actually achieve – PDSA has been so helpful in this*	New learning and learning that people did not previously see the relevance of. Participants talk about being more aware of the political agenda at a national and local level, but don't necessarily progress to articulate how they will utilise /engage/ influence this. Participants have had a vision for development / improvement, but needed assistance in finding facilitative tools. The LHIP has provided them with such tools.
The LHIP has made me realise that change will cause chaos, but that this can be positive	There is a sense that some participants have been deterred from leading change, because of the negative consequences they associated with it i.e. chaos that was caused. The LHIP appears to have allowed participants to develop a revised mindset about the consequence of change, that a period of chaos is acceptable and part of the process and something that could be interpreted as indicating that a change process is occurring.
The LHIP has helped me to look beyond my service and organisation –it's not just what's in front of your nose and day to day practice. I need to get others to think that way. I	This appears to relate to development of whole systems, proactive, creative thinking. There is also a suggestion of realisation of the need for organisational learning, although no indication of a strategy to achieve this.

have colleagues who are based in the acute sector who would hugely benefit from the LHIP – although they probably wouldn't see it relating to them, but it does	

What participants would like more of	Analysis of the data / questioning of data
There is so much good information, but I don't have any extra time to devote to the LHIP other than the programme events – they have to stand alone for me and I have some concern that I can't follow up with reading etc'	How self-sufficient can the LHIP be? Do participants need to receive any prioritising on 'extra curricular' activities?
The days are so packed – with exciting and useful information – but I'm concerned that I can't grasp it all' I don't want to loose that excitement, but I'm concerned I will because this is time out and then I go back to reality and lots of unenthusiastic people'	Is there an issue of some of the experience being divorced from practice reality – can anything be done to guard against that?
Time – its so tightly packed – I feel exhausted at the end of the day	The intensity of the LHIP needs to be considered and what the appropriate balance should be about raising enthusiasm and keeping content manageable. It may also be worth considering the balance of new information input and other activities
Visioning and innovation is so important – I would like more of that	This type of remark is often not well 'anchored' as a learning need, but there is a sense that this type of comment is indicative of some experiencing a development / learning need, but not being very clear about what it is and how to best fill this knowledge gap.
I shall miss it when it finishes, I have some concerns how it will be like having a year out and then going back	There is a suggestion here of the LHIP being seen as a 'bolt on' to current role rather than something that needs to be integrated and embedded. This questions the sustainability of the programme in people's practice.
I lead a young team, newly constituted, they are in new	Does the LHIP help participants to help others become health improvement leaders? The

roles that have been created to do things differently - push the boundaries a bit-, I need to help them to be leaders as well because there is still some resistance to new ways of working like this	cascading of skills within organisation has the potential to be tool for sustainability, so that the theories become less person-dependent.
It's helping me to realise that I'm not a maverick, but that what I'm trying to do is what other leaders are trying to do, I'm not on my own here as I am in the clinical setting – that's what I value	There appears to be a lack of organisational recognition and support of improvement leadership activities. Do people need to be equipped to communicate programme learning 'upwards' (i.e. to their managers) as well?
It's difficult to feel that you're learning at these events. It's more like a series of conference presentations. There's lots of information. It's how to get the learning when you are only at events periodically and there's lots of time in between, so it [knowledge] can get lost. *I don't have any time to read anything in between events, there's no time built [new knowledge] in to my role.* *It's very difficult to think about how to implement what you're learning when your organisation and your role is undergoing huge changes. For example, there are lots of merges going on in my organisation, and so I don't know what or how they want me to lead yet. I don't know what*	A few participants reported a tension between receiving lots of information and the process of learning. They voiced a concern that despite a wealth of information being delivered at events, the process link between information and learning was not being addressed. Participants may need more time dedicated to reflection on the possible applications after each session. Times when information is 1) taken in, 2) digested, and 3) possible applications and implications envisaged, may need to be delineated within the programme. Participants are faced with the challenge of how to sustain the learning and knowledge from the programme for use in their role Participants expressed the added challenge of sustainability of learning from the programme- in their current shifting organisational contexts. They reported concerns around how to store the information/ learning from the LHIP and keep it "in date" for their use further down the road

my team will be composed of. I won't know till another 3 or 4 months. I'm not actually able to do any health improvement at the moment. I'm just trying to input into how the organisation will look, the strategies etc. In some ways, the programme is timely because I can think about a lot of the whole systems issues and try to input these into the new strategies for the merged organisation, but in terms of health improvements…(I'm not able to lead on any of these yet).	when the changes have occurred within their organisation and their role is defined and they are feel able to lead on health improvement. There are lots of whole systems ideas that they have taken from the programme and have used to input into the changes / new strategies within their changing organisation. But health improvements have not been made because the system and their role within the system are in flux. This may mean that there is even more pressure for the LHIP to facilitate sustainability in the learning on the programme?
My main challenges are to challenge established power bases – the more help I can get the better	Learning needs about how to constructively challenge current power structures
I really enjoyed hearing from the police and the fire service, I would like more of that – hearing how people are actually using the LHIP and how they are visioning	Participants may be suggesting need for some role modelling opportunities, exemplars of good practice, in and out of the health services.
The forum sessions were good, more of this would be really useful - hearing about others, I find that very beneficial , it's helping me to clarify my role and purpose	
It would be useful to have time set aside to come up with something that is an issue for you and to tell your story	It may be worth considering spending some time taking a problem / situation based approach to learning, by for example asking more participants to present to the group their work environment and how they envisage applying the LHIP principle.

Visioning the best of what might be	Analysis of the data / questioning of data
The LHIP has given me so much useful information and insights, but the current reorganisation etc is in the way, when that all settles I feel that I will really be able to use my learning.	Some participants appear to be waiting for a more stable situation to really begin their improvement agendas. Other participants report that they would be grateful if the LHIP could help them cope with leading health improvement in a context of upheaval and change, but they didn't want that to 'hijack ' the programme.
The bullet points on the framework – reordering could have more impact – such as 'commits with passion' should be at the top	Although the participants have been advised that there is no prioritisation intended in the representation of the bullet points within the LHIP framework, some seem to consider the framework as a given, with which some of them feel little engagement. It may be that an exercise as a group or perhaps as an individual to reorganise them may be worthy of consideration? Should there be a set time after each presentation for a theoretical focus, where participants would situate the presentation within the framework?
Change is something I can cope with now, in fact I see it as positive, it's the lack of consolidation that's my problem	Does the programme help people to introduce sustainable changes within their changing working environments?
I share the learning I experience with the entire Directorate – you can see people picking up how they can use it	The learning is clearly highly relevant and appears to be well integrated by the individual to allow confident sharing. This respondent's position may readily provide them with sharing opportunities – some other participants may have to work to provide sharing opportunities, both upwards and downwards – may this have something to do with where they position themselves as leaders?
I have some young people from outside the health service in my department – they have a bag load of skills - lots of the skills I'm learning now	New learning / unlearning. Is the LHIP just about 'new' learning or does it also have a remit to facilitate 'unlearning' of some mindsets/ practice paradigms

The programme is allowing me to see that I'm going in the right direction and can have confidence in my message and deal with the resistance I meet	The LHIP may be providing concurrent support, but also developing coping strategies for people to draw on after the LHIP completes.

Learning needs awareness	**Analysis of the data / questioning of data**
Most respondents did not appear to be engaging with the LHIP focussing on a specific improvement aim, but rather seeking generic application	This created issues for capturing specific examples of impact.
One participant commented that they had realised through the LHIP that if you could always forecast the consequences of a change action, you would probably never change in the first place and that therefore sometimes blind bold decisions are required	The LHIP may help people to adopt a more strategic view of change, in which while the short term may seem like chaos, there is improvement in the long term.
Participants are familiar with the framework components, and have a strong tendency to use them to report skills they have rather than skills developing/learning needs	It may be that some participants are using the framework as a checklist for achievement, without maximising the circle overlap issues / potential.
I can't be specific about what's helping, but it is	There appears to be a lack of ability to articulate learning needs or achievement, suggesting that a greater level of focus and self assessment could be achieved.
I'm getting so much out of it but I find it difficult to say in detail or to use the model to tell you how it is helping me, but it is	Would it be possible to encourage/facilitate more active engagement with the framework? Some people under utilise the framework - a key factor in anchoring all the presentations /activities.
I really haven't used the framework much until you asked me to have it ready for the interview	Possibly limited amounts of planning for the LHIP events on the part of the participants- could this be addressed with any preparatory directives.
When you are guiding me through the framework now, there are aspects here that I don't really consider – I take	Individual /organisation learning agendas may not be driving learning processes, but accepting all that is offered - this is an important issue as many participants say that they cannot engage

in what's on offer on the day *Using the framework more would be an interesting exercise Looking at the framework now, there are aspects there that maybe I should consider, for example it refers to management and I try not to see myself as a manager, I don't want to go down that route, but I need to consider management don't I ?*	in any extra reading/thinking etc and that the days are very busy and intense – perhaps some prioritisation of their individual learning needs would help to address some of these issues and enhance the learning available from the framework itself. Participants may not be moving out of their preconceived views of their role and their needs by inadequate use of the framework.

Systems analysis

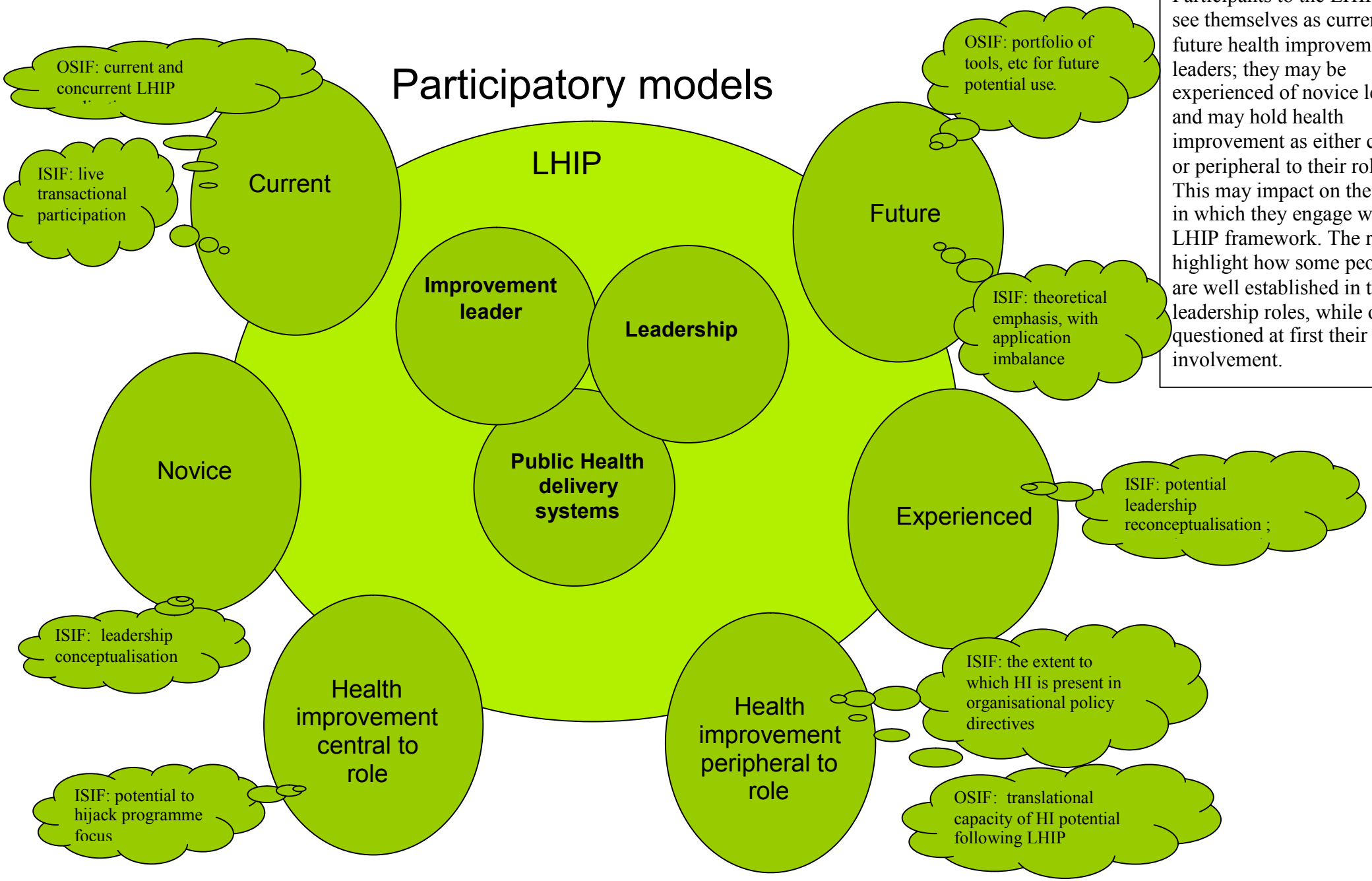
The data has been scrutinised to identify systems active in the LHIP delivery, learning and application processes. These have been cumulatively developed as data has been collected. Systems development provides a qualitatively different, but complimentary way of understanding, collating and presenting the data.

The data was explored to identify and map the systems active in the LHIP. Four systems identified:

- The inquiry system: formal and informal LHIP activities, the participants, the organisations, participant /organization learning.
- Learning systems: unlearning of skills, learning new skills, learning needs, triggers or earning, information/knowledge exposure and organisation support.
- Participatory models: current utilisation of LHIP development, anticipate future utilisation of LHIP development, novice leaders, experienced leaders, health improvement as central to role, health improvement as peripheral to role
- Regional capacity development in health care leadership system: participants, organisation characteristics, organisations, regional potential for health improvement

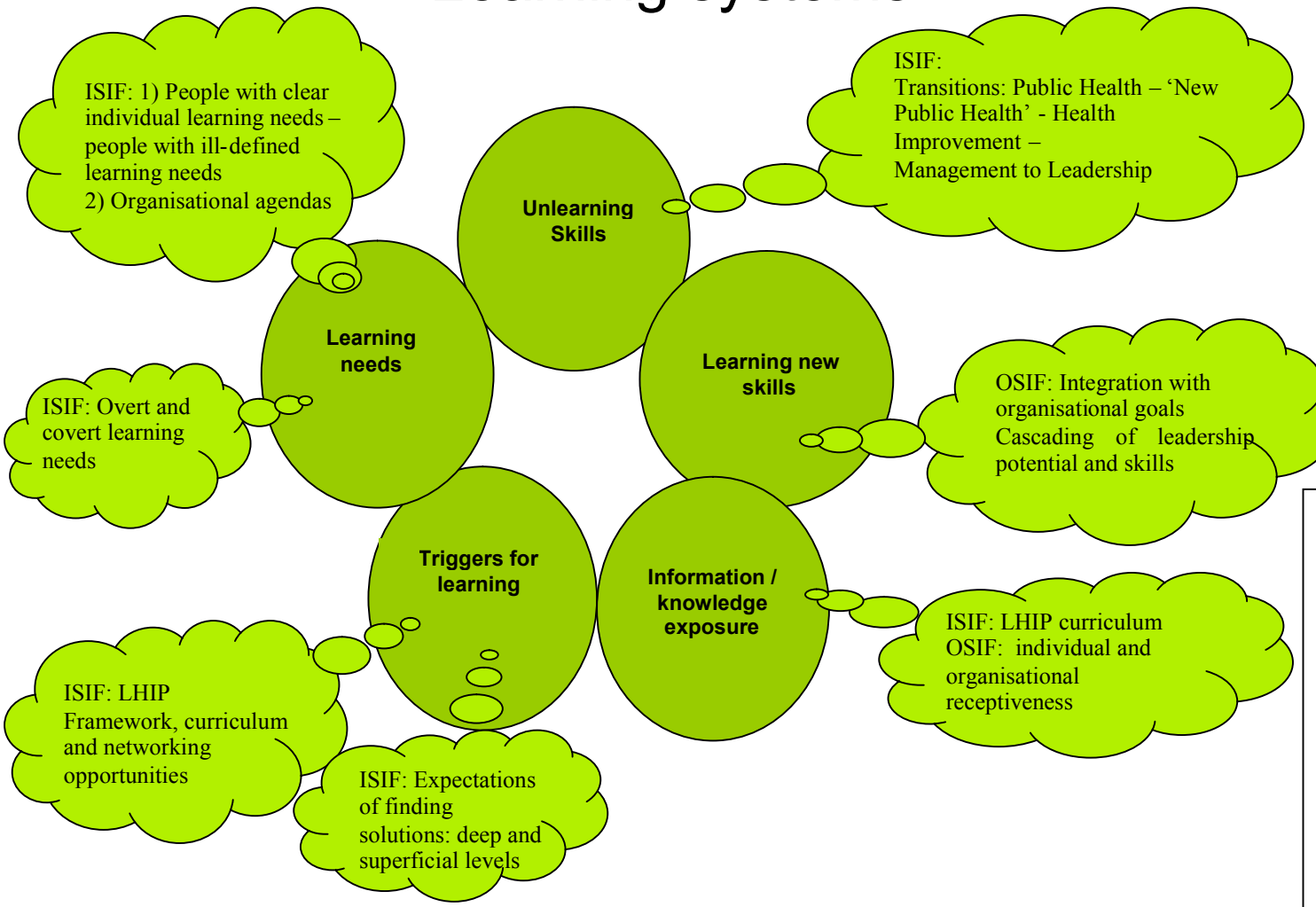
Key:

ISIF	Incoming system influencing factor
OSIF	Outgoing system influencing factor



Participants to the LHIP may see themselves as current or future health improvement leaders; they may be experienced of novice leaders and may hold health improvement as either central or peripheral to their role. This may impact on the way in which they engage with the LHIP framework. The results highlight how some people are well established in their leadership roles, while others questioned at first their involvement.

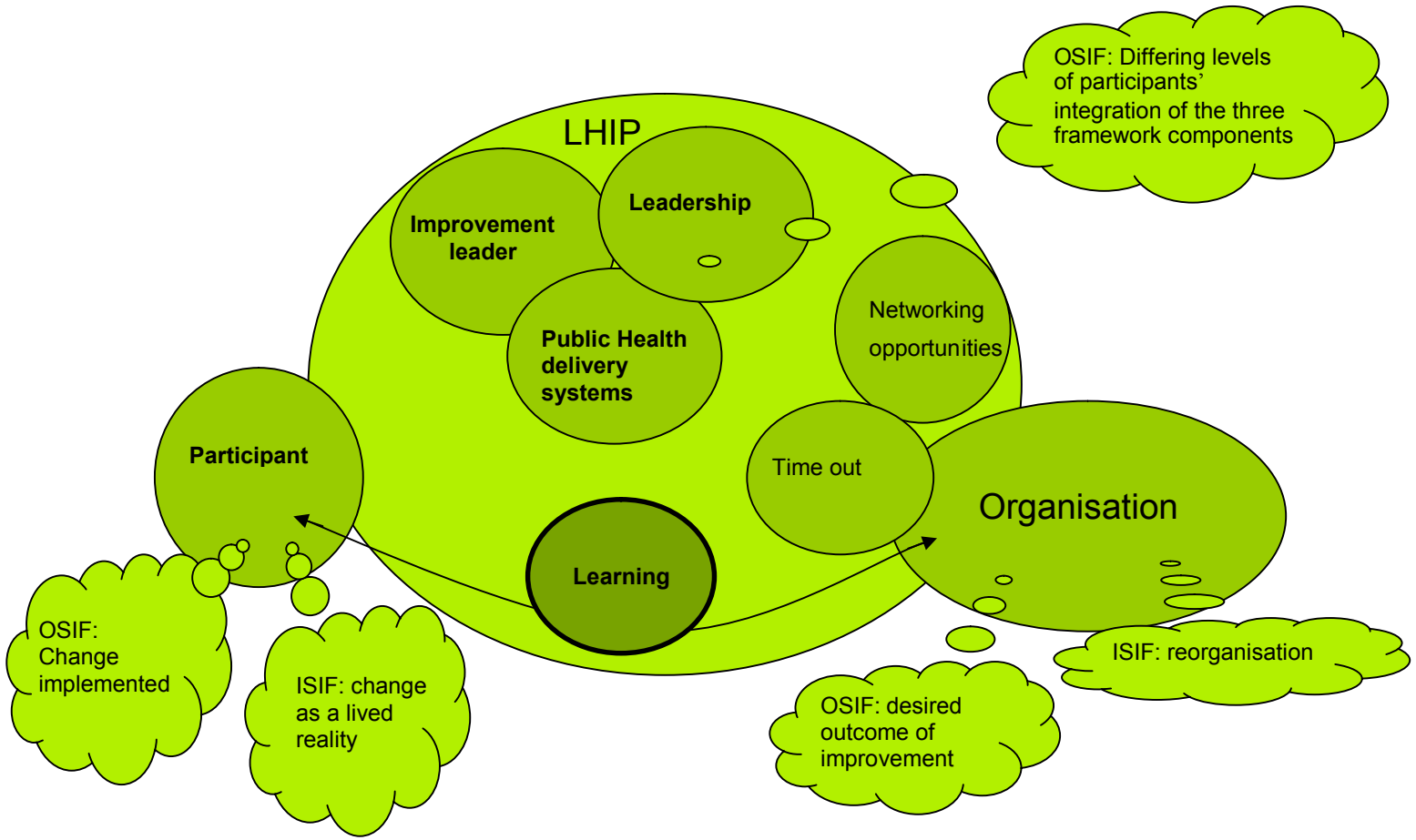
Learning systems



The way in which people conceive of themselves in relation to health improvement leadership (system 1) will determine their learning needs and styles. For example, an established leader may have to unlearn ingrained practices before being able to apply LHIP principles. People demonstrated how they enjoy the networking opportunities and would appreciate more problem/ situational learning examples.

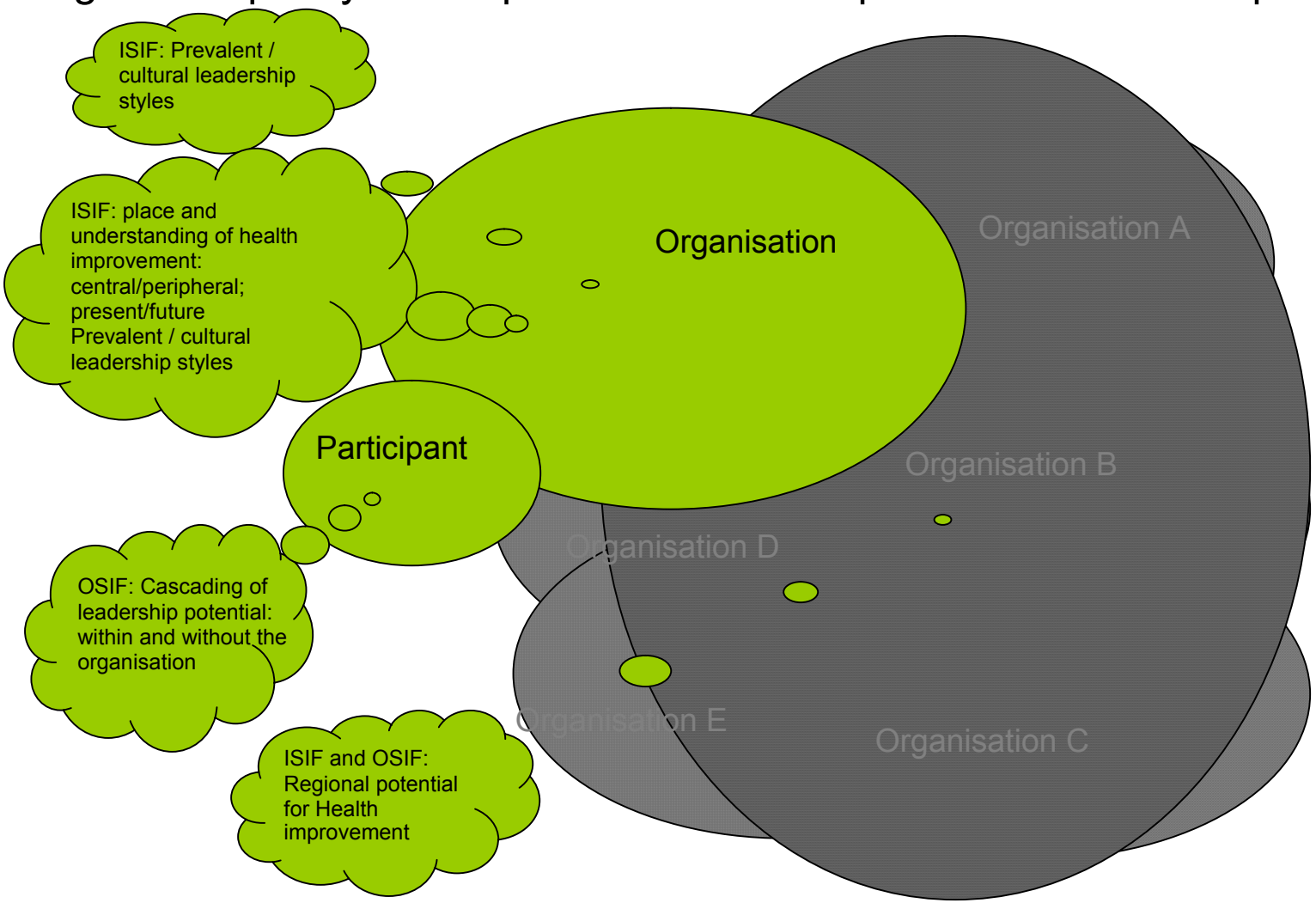
Error!

Inquiry system: the evaluation remit



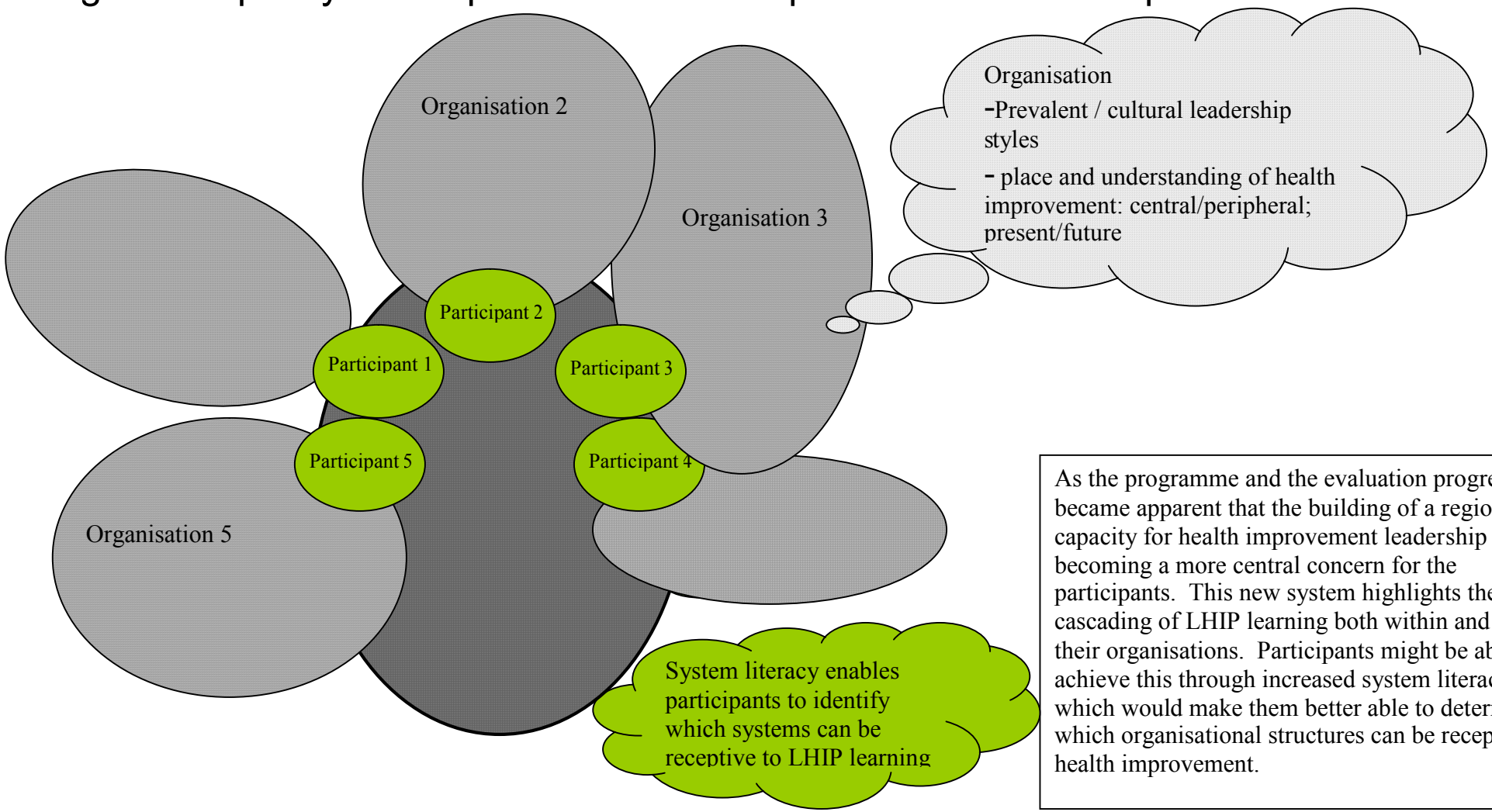
Change is the background to most participants' working lives. Their degree and experience of change will impact on the level of integration of their learning in their practice. As highlighted in the previous section, some participants feel unable to lead in a climate of change, while others see change as a positive that they struggle to sustain. The inquiry needs to focus on the LHIP framework per se, but also how participants feel able to engage with it, depending on the situation within their organisation and their learning and networking opportunities outwith the programme.

Regional capacity development in health improvement leadership -1



The potential for participants to cascade learning from the LHIP within their organisation will determined the embeddeness of their learning. Organisational cultures, both vis a vis leardership and health improvement will determine to what extend this may be facilitated. Lastly, true impact of the LHIP would be achieved through participants created opportunities to collaborate with other regional organisations in order to build capacity in health improvement leadership. This may be initiated through programme participation.

Regional capacity development in health improvement leadership -2



As the programme and the evaluation progressed, it became apparent that the building of a regional capacity for health improvement leadership was becoming a more central concern for the participants. This new system highlights the cascading of LHIP learning both within and without their organisations. Participants might be able to achieve this through increased system literacy, which would make them better able to determine which organisational structures can be receptive to health improvement.

Findings

This findings section is summative in that it results from a triangulation and integrated analysis of all evaluation data sources. Findings will be collated under the headings of

- Programme content
- Programme format and structure
- Programme delivery methods
- Programme outcomes
- Participant recruitment
- Participant roles and responsibilities
- Programme exit strategies
- Cascading of leading health improvement /organisation issues

Programme content

The overriding feedback on this was that people were highly appreciative of the quality of the content of the programme; its relevance, its currency and its flexibility and responsiveness to participant feedback.

> I have been introduced to so many tools that I was unaware of, the other aspects of the course are helping me see how and when to use them.
>
> You got the balance – theoretical side of leadership and then opportunity to talk to people who are leaders

> I really liked what I call the political gossip – by that I mean the regular discussions about what's happening now, the latest news and issues about why it's happening, you know the inside story stuff

Along side very positive messages, participants expressed some concerns. Concern was expressed by a high proportion of the participants about grasping the learning potential of the LHIP. They feared a sense of wastefulness, that they were allowing knowledge and opportunity to slip through their fingers. This was partly linked to the volume of information presented, which could be seen as overwhelming and therefore coulld have the potential to impede learning, and which echoed the concerns they had expressed at the pre-programme interviews:

> There's so much information at these events, but then there's lots of time in between events, and so you kind of forget a lot of it. But then when you come back to the next event and they remind you of what you covered last time, you think "oh yeah! That's what it was about!" So it's hard to remember everything when your job is so busy.

Many participants expressed concern that they would not fully integrate the learning into their knowledge base and repertoire.

> It's difficult to feel that you're learning at these events. It's more like a series of conference presentations. There's lots of information. It's how to get the learning when you are only at events periodically and there's lots of time in between so it [knowledge] can get lost.

Some participants commented on the strong health service focus of the programme content, and in relation to the recruitment balance:

> Because I'm not mainstream health – some of the presentations were rather heavy duty - things I didn't really need to grapple with.

This issue was corroborated by many participants in different forms. The programme was NHS dominated – the interface the NHS could and should have with other agencies/organisations was not fully captured.

> I know a lot more about how the NHS works, but I think it has been very one-sided
>
> I feel that I have had to translate NHS issues and debates for me and then try to transfer –it's been a rather torturous journey
>
> Networking opportunities were great, but to be honest the NHS was too worried about itself to want to buddy up with anyone else
>
> The turmoil in the NHS ruined it for me, it dominated the programme, even the programme leaders were changing jobs, and I feel it lost a lot of the opportunities of what could have been achieved.

Some participants identified that further consideration of organisation size and culture may have been useful

> It seemed to me that the LHIP and all the discussions we had were geared to the large organisation set up – that is not my working environment.
>
> I can appreciate the issue and the necessity to 'rock the boat' sometimes you have to get things done, but rocking the boat in a small scale workplace like

> mine would be destructive – it's too small and too personal for that kind of approach.
>
> I felt that there was only one organisation in vision during the LHIP, I mean we did talk about multi-organisation issues, but I mean rather one organisation type, a sort of one size fits all approach.

Programme format and structure

Participants were highly appreciative of the time span of the programme. They considered that it allowed them to become part of a cohort, to develop networks and relationships, to revisit issues and generally facilitate a cumulative approach to learning and development. Indeed, participants were observed across the programme giving each other support and making suggestions on how to put the learning into practice; sharing 'what worked' for them in their organisation. Many participants commented to the observers at different time points within the programme that the relationships and networks enabled by the programme were its greatest asset;

> I think the greatest asset of the course is the relationships it enables us to create.

Attendance levels show that it was a prioritised event in busy diaries for the majority of the participants. People commented on making considerable effort to ensure that they did not miss any events as these were dates people looked forward to with enthusiasm and anticipation. A typical comment was;

> I try not to let anything get in the way of attending

In slight contrast to this, programme leaders discussed participants' attendance within the programme, highlighting the difficulties in ensuring consistent attendance from each participant across the lifespan of the programme;

> Getting all the participants together all at once is very difficult because they are all so busy. It's frustrating that once the day has been planned and all the effort has gone in to getting the venue right and making sure it's a diary date that everyone can do etc, when people arrive late and leave early, and don't come back in for the closing remarks and thinking about what's next on the programme.

Participants fed back their concern that the final event had not achieved full attendance and they expressed disappointment at this. They of course were not necessarily aware of the very recent changes in employment status of some of their fellow participants that would justifiably inhibit their attendance. There is an issue

here about how much providers share with the group about the personal journeys of individual participants. This is especially sensitive as some of the participants had been potentially competing against other participants for posts in the NHS reorganisations taking place concurrent with the LHIP. This highlighted a paradox for the programme organisers: that of wanting to create and foster a sense of collaborative and cohesive cohort of regional leaders for health improvement, but at the same time that of wanting and needing to respect the confidentiality of individual professional journeys. In this paradox, the maintenance of the latter could come in the way of the former, as present participants could unjustifiably suppose that absenteeism was an indicator of lack of enthusiasm.

A substantial number of people commented that as well as the learning experience, attending the LHIP was also important 'time out' for them - away from their day to day activities, thinking processes and pressures. This was time when they were being developed and nurtured and the focus of attention. This was described as being in contrast to their usual experience of being the one that was seeking opportunities to support the nurturance of other staff within their organisation or team.

> "This is important time out for me, thinking time; I try very hard to protect it"
>
> "Back at the 'ranch' I have to put everyone else first, any development opportunity any training cash; I try to get my team involved. They are a developing team and I am trying to nurture them and keep them enthused. It tends to be either or – them or I and I always prioritise them"

Programme leaders ensured that the LHIP framework was utilised at each learning event, highlighting the components being focussed on with each presentation. However, it appeared to take participants a considerable length of time to engage with the framework.

> To be honest, I was a few sessions in before I twigged that the arrows were put in different places and that this was highlighting what we were doing at that event.
>
> I have really only used the framework lately, it has helped me to see where I have come from - I probably should have used it to guide me as well, but I didn't
>
> How am I using the framework? - Oh you mean the 3 circles, am I supposed to be?

In contrast, there were some examples of the utility potential that some participants experienced in using the framework:

> I have started to really concentrate on the framework now that we are mid way through, in fact I have redrafted it to suit me and what my organisation is beginning to look like
>
> I look at the framework in preparation for my interview with you that is really the only time I use it. It has been really useful though because it has in some ways made me see some of the issues I have been a bit blind to – bits of leadership I don't like etc.

Programme delivery methods

Key note presentations were highly appreciated. Participants really valued having the leading experts of an issue/policy/ theory delivering at the events. These speakers generated great enthusiasm and a sense of looking forward to the next event.

> Some people really fired me up, they had such energy
>
> The speakers were all of such a high calibre
>
> We got to hear from the policy makers – information from the horse's mouth so to speak.
>
> There isn't any session yet that hasn't exceeded my expectations – in terms of the way they make me think

There was a strong sense that the LHIP had to stand alone, as participants reported that did not have time outside of the events to capitalise on their learning.

> I don't have any time to read anything in between events, there's no time built in to my role.

Participants liked the level of timely and relevant information they received:

> We were hearing about policy and strategies just released or on the cusp of being released. You felt you had your finger on the pulse, for a change- normally you feel that you are playing catch up.

Participants liked the table top discussion sessions.

> It was good to have the opportunity to straightaway start to think and debate about issues – the problem was, there was never sufficient time

Some attempted to make the most of this limited time opportunity, by building on relationships established within small subgroups.

> I always tried to sit with the same group – I know we were encouraged to keep changing, but we felt that having the group continuity helped us to get straight into the discussions – we could pick things up from last time etc.

Participants liked the informal discussions at meal times and other recreation points, although there were comments that these times would have been enhanced for non-health service participants if the organisation mix had better greater.

> The breaks were a good time to catch up with people, check how they were doing, where their reorganisation was at etc.
>
> Lunch time etc were good opportunities to keep networking, but my networks weren't really there
>
> For a large proportion of the programme i.e. at least the 2-3 middle events, informal time was taken up with health service people sharing horror stories about their restructuring. Thank goodness I wasn't going through it, but at the same time it meant that for much of the discussion, I felt on the side lines

Programme outcomes

Many positive outcomes were reported, although participants found it difficult to articulate the development process.

> I've changed, definitely changed, but don't ask me what bit of the programme did it for me, I just can't put my finger on it, but it's worked for me
>
> It's raised my profile in my organisation, people are now coming up to me and saying 'what can we do', I'm not sure how this change has happened, some of them will know I'm on the leadership programme and I have tried to make myself more visible and accessible, but somehow, and to be really honest I don't know how its happened, I now seem to have collaborators.

The outcomes reported ranged from an increased capacity for individual self-reflection and an energising effect, to increasing people's political astuteness and confidence as leaders, health improvement tool awareness and enhanced evidence base for practice. These are detailed, with supporting quotes, below.

The LHIP facilitated self-reflection and learning needs analysis:

> It opened my eyes – to myself, my leadership style, my learning needs, my abilities, my situation, where the blocks are for me, health improvement issues, and tools for practice

People reported feeling reenergised by the LHIP.

> After each event I feel as though I've had my battery charged, as though I've been refuelled.

> It's reinforced for me that I should be trying to make the changes I have been trying to - it gives me the energy to continue to deal with the setbacks

Participants reported that health improvement was now more firmly on individual and organisation agendas, but more specifically the former.

> It's always been on my agenda, but sometimes I've questioned if I was right – now I know I am.
>
> It's nice to know that I'm not a maverick, but a health improvement and maybe even showing some health improvement leadership

Participants felt that they had an evidence base on which to base or develop their strategy for health improvement.

> Our outcomes measures have changed, yeah. [and they now include] well-being. I mean, an awful lot of them [outcome measures] are linked into our best value performance indicators. And we're doing public surveys as well on a three yearly rotating basis. So some of the outcome measures will be in there too.

The tools introduced during the programme were frequently mentioned

> The LHIP legacy for me is the PDSA - and the mantra, if you don't at first succeed – keep trying, even if its small bites.
>
> I've got the whole package of handouts, all the tools and they will travel with me to dip in and out of.
>
> I have become more analytical, I now try to workout where we are and how we can best contribute to the public health agenda. I have definitely revised my game.

Participants reported examples of feeling more able to challenge others at different levels in their and other organisations because they had developed increasing confidence in their knowledge and evidence base.

> We've been through quite a lengthy process to look at our outcome measures and we've not completed that yet. But what we've done is we've said what outcomes we want to measure, but actually getting the measuring tool has not been that easy… some things, such as well-being, are quite hard to measure.

As well as an increased knowledge base, participants' confidence was also boosted by having the opportunity to rehearse some of the arguments and discussion during the programme.

> The table tops allow you to share the tensions and the barriers you face and together we put our heads together and come up with answers. Gradually the 'script' is developed and strengthened

> It was so useful to hear presentations from other participants, to hear people honestly recounting how they managed to negotiate something or turn something around. Rarely do people share the warts and all version with you. I suppose that's a sign of the level of trust we developed with each other.

Participants reported to have expanded their health improvement and public health vocabulary – they understood the vocabulary used by different agencies, they could use approved language and could package their interactions in a more effective way. These accounts could perhaps be compared to social marketing applied to progressing the health improvement endeavour.

> I can see now how some previous negotiations failed, how people just didn't warm to my attempts to get things on the agenda or to develop some partnership approach

> I know which buttons to press now, what appeals to different agencies. A lot of this was developed by what you could call the coaching I received from the other participant about what matters to their organisations and why certain approaches would or would not appeal.

> It is invaluable to allow better understanding of NHS and what the key concerns and issues are for those who work in it. You can't get them to pay attention to your issues unless you know their difficulties. It allowed the type of understanding that you could not develop just meeting up with or shadowing people.

By the end of the programme, participants were reflecting on how to define and describe a local system or context and to identify others with a similar system in order to share working practices and aid working in partnerships;

> The emphasis is on strong leadership, locally; how is this managed? The regional dimension is key.

> Place shaping [or context / system shaping]: have you got an identity? Do people see themselves as associated with one area or another? We can say to each other "we have a similar place [or system/context] let's work in the same way". Ensuring district level agreements.

A growing cohesion between participants was observed across the lifespan of the programme. In spite of this, participants highlighted the difficulties in carrying over effective partnerships between their respective practices.

> Integration: what does it really mean and what are we aiming for? Integration is not the panacea that it's made out to be. It's where it's going to make the most sense…not integration per se. There is a clash of different cultures [LA / NHS]. Who are you accountable to? We need joint ownership of targets / aims / outcomes.
>
> Effective partnerships and joint appointments: chicken or egg? [There is] concern in the white paper that the joint appointments mantra is the way to partnership working. Joint appointments *fall out of* effective partnership working.

This is represented on the regional capacity for health improvement leadership development system, on pages 61.

Participants reported to have become more aware of the need for political awareness as well as reporting that their own political astuteness had developed.

> I have become more politically astute
>
> One of the steepest learning curves for me was the different politics in the different organisations.
>
> My understanding of the national and global picture has improved.
>
> I was previously a bit like a bull at a gate; I'm more mature now, appreciating more sides to the situation.

Early on in the programme, and as reflected in the pre-programme interviews, participants demonstrated an ability to think strategically, which was enhanced by programme participation. They also expressed their renewed interest for outcome, rather than output, based evaluations, therefore questioning national public health targets.

> We need to think more on a society, structural level, not just at the individual level; what the individual needs or wants, it's more about what society and communities need
>
> Practice-based commissioning developed in local areas can destabilise the good community practice going on. We need to be saying "we've hit our contraception targets – but has teenage pregnancy dropped?"

At the mid-point of the LHIP, participants reflected on the knowledge / expertise / practice that could be, but was not always, exchanged within partnership working.

> In commissioning, the Department of Health talks about the contributions to the PCT /LA *from* housing, leisure, education etc. Should it not be "*from and to*"? There's a lack of understanding in the NHS about its contributions it can make *to* other agencies. It's always thinking what contributions it can get from other agencies instead.

By the end of the programme, participants were also able to position themselves politically, as health improvement leaders.

> Politicians are more likely to be influenced by special causes, managers are more likely to be influenced by common causes and health improvement leaders have to inhabit the two worlds.
>
> The real drivers for improvement are movement and variation. As HI leaders, we need to look after those in charge of policy and also those who have a stake in HI (clients / multi-agency etc).

Participants reflected on the many public health policies and targets discussed within the learning programme, on two key levels; a) unpicking the definition / aims of policy / targets, and critiquing the *impact* these may have within the participants' own system; within the context of *their own* organisation and b) reflecting on *their role* in leading the translation of these policies / agendas within their own system. Participants reflected on a number of issues around the complexity of this 'local' translation of 'global' policy and targets, including; workforce, budgets, prioritisation of targets, partnership working and local need.

Participants highlighted the need for guidelines on how to prioritise targets, where their role as leaders for health improvement requires them to work with conflicting agendas and prioritise targets for their specific public health context. Participants reflected on the importance of strategic planning within this local prioritisation of targets;

> We need guidance on prioritisation of targets. When there's two competing targets, it's our responsibility to prioritise but we'd appreciate some guidance on how to prioritise based on the department's (DH) strategic knowledge on what will be important next year etc.

At the programme mid-point, participants continued to reflect on policy, unpacking prevalent discourses and the implication on their practice as health improvement leaders;

> "'Fitness for purpose' needs to be in the Department of Health's commissioning narrative; is it?"
>
> "What's the Department of Health's thinking within the commissioning narrative? There's something about the language within this narrative- it's important to get the language right. Because GPs are saying now that the ECM and the children's agenda "is not my business", because the language

> around it doesn't hook them in? Doesn't make them realise it is their business?"
>
> Information governance and the Caldicott principle block a lot of innovation.

Therefore, participants demonstrated their awareness of, and reflected on their leadership role within, the tension between targets, finances and community need (both local and strategic). This reflection on the definition of key targets and agendas, and the ways in which these may translate and impact upon their local organisations, led participants to identify, and consistently seek to address, the gaps in their understanding on how best to implement these agendas locally and strategically (this is illustrated by the inquiry system, on page 59).

LHIP participation enabled many participants to assert themselves as leaders.

> I have developed more confidence in my own abilities – this was due to the mix of the group – some of the people from at least the job titles I had put on a pedestal but when you are along side them – you are an equal
>
> As X's manager , although I haven't had the opportunity to know the detail of what she has been learning, I have definitely noticed that her self confidence has improved – just in a general sense at meetings etc, I suppose that is down to the programme
>
> My manager pushed me to go on the LHIP, I was very unsure, I though 'me' I'm not a leader, I'm not the sort of person who should be there, but my manager said 'you do show leadership, you need to realise that'. Now I do realise and I want more leadership development once the LHIP has finished
>
> You know what was perhaps the most significant outcome for me of the whole programme? It was at the first event when we were given those biographies. I read through them and thought hey I do deserve to be here. I realised that I had been in awe of some titles and this made me realise that people, people just like me, hold those posts. That was a bit of a revelation and now it's happened I still cannot understand why I ever allowed such a debilitating block to occur.

These quotes illustrate the recruitment issues already mentioned, and in part represented in the participatory model system, in that while some participants asserted themselves as leaders in the course of the programme, others came on it with a clear leadership remit. This is also linked to the learning systems identified on page 60, as the way in which people understand their leadership role impacts inevitably on their approach to learning in the LHIP.

Some participants were able to give examples of how they were able to analyse situations from a leadership or a leadership potential perspective.

> The current changes and reorganisations became a focus for the LHIP – disappointingly not challenged from a leadership perspective, but from a 'here we go again' attitude and to be honest a sense of complacency about we are revisiting what we did 10 /15 years ago – that roundabout attitude and mindset in the sector has shocked me. The disappointing thing for me was that they were only using LHIP from point of view of how can I set my stall to ensure I'm one of those with a job at the end of this restructuring.

However, many participants at the end of the programme demonstrated a move from anxiety around job fit and security of their role, to a more confident perspective. The following comments from participants highlight the role the LHIP programme has played in developing this 'role' confidence and in their ability to recognise and respond to a context that is hostile to change;

> Sometimes we have to walk away. It's about fit. Sometimes when trying to bring about change in hostile environment its better to walk away. With the help of this programme and a facilitative system [organisation] you can blossom in your leadership.
>
> You can be transformational around the top priorities and targets for systems and find a common ground between what you want to do and the key objectives and often [you] have to move to a more supportive organisation.

People felt they were more ready to take risks – they particularly valued hearing from other people experiences, especially when people had been invocative and tested boundaries.

> I feel able to dive in, grasp the moment
>
> I suppose one of the most important things I will take away with me is the attitude of seize the moment

People reported to be more aware of leadership styles of others they were in contact with. This enabled them to engage in weighed up situations and amended their approach to suit.

> I can now go into meetings and pretty soon I can calculate what leadership styles are at play and adjust my approach accordingly

People reported to be considering trying to replicate the time out approach with their own teams- the value of thinking outside normal problems and issues.

> I'm going to use this approach with my team – take them away form the usual environment , maybe just for a day or even a half day, but I really think

> there is value in getting out of your usual environment – I really think it releases your thinking, just being in a different environment.

Many participants concluded that the LHIP had speeded up their journey with respect to health improvement leadership.

> I think I was already on my way, but because of the LHIP I'm getting there a lot faster than I would have done if I'd continued to go it alone.

This diversity and quantity of positive programme outcomes was tempered by a substantial proportion of participants consistently highlighting a theme which they termed the 'know-do gap'. They identified a gap in their understanding of how best to translate knowledge gain into practice.

Participant recruitment

In the early part of the programme many participants reported appreciating that they were with 'strangers' i.e. not their immediate work colleagues – this really facilitated allowing them to move out of current problems and organisation issues. Towards the latter part of the programme, people were pondering the consequence of perhaps being the only organisational representative: "what can I do as one individual", "we need more capacity for change, until people higher up the system attend this type of development, I can't do much"

This highlights one of the paradoxes faced by the organisers in wanting to create a regional pool of health improvement leaders from a variety of organisations, and acknowledging the need for organisational support for individual development. This was not always as explicit or active as it could have been:

> My employers agreed to my attendance, but with no specific agenda attached to it - that's not to say they weren't interested because they recognise we need more leadership in the sector to make the necessary changes happen.

> I didn't get the answers I was seeking to move things forward, the interfaces I expected weren't there.

This is represented in the inquiry system, in that organisational goals and support inevitably impact on individuals' learning journey.

Participant roles and responsibilities

There seemed to be a debate about whether attendance at the LHIP should, or could, be a stand alone activity – a number of people, largely on reflection as the programme progressed, wondered if they perhaps should have committed themselves to engage with the programme learning in between events.

> As the programme is coming to a conclusion I'm really regretting not spend more time on it and really I probably could have, no one at work said 'that's all the time you can have', I just made that assumption.
> Observation Jan07

> Really if I'd shown any leadership, I would have negotiated more time out to do more with my learning.

Some people regretted the fact that they did not, at the time, feel able to maximise the chance they had to meet and talk to the high quality speakers:

> We got the opportunity to question the policy makers, although really we didn't do much with that opportunity- I regret that a bit now.

At the same time, participants were very appreciative of the flexibility regarding their level of engagement with extra curricular activities that was offered to them. Many were experiencing a time of such challenge and change that they would not have undertaken any additional activities. However, there was a definite sense that the framework was used more actively by more participants the programme progressed.

Programme exit strategies

A variety of approaches to exit strategy were described:

- Some were pondering the issue and were weighing up possible approaches
- Some were just unsure how they were going to manage exiting from the programme
- Some just wanted it to go on forever
- Some had a very clear strategy – knew what networks they wanted to pursue /develop, what additional learning they required etc

At the final learning event, participants reinforced their anxiety and uncertainty at taking forward the learning, recognising the persistent gap in 'know-do'. Speakers and programme leaders underlined that participants have to persevere and keep "pushing at it".

> We need the policy and the context information, but we also need to know how to take that forward in our own organisations…..how do we keep this

> learning/knowledge (on policy/context) active, how do we keep it going once this formal structure [of LHIP] is finished? The complexity and multiplexity will continue therefore the learning and applying the learning will continue to be important

Some participants expressed concern as to how the network created during the programme would be maintained:

> Need to keep the mix [of participants and perspectives in local networks], not lose it.

They made suggestions as to how some of this dynamism might be maintained:

> Spreading the learning; [is about] encouraging inspiring people to influence at a local level. Perhaps 2, 3 or 4 people from the programme can get together locally. There is value in this cohort getting together a couple of times a year for speakers and development.
>
> Up until now it's been very organic, we need some kind of regional grip on public health locally. A marshalling of resources.
>
> We're thinking about how we could get improvements to systems at a local level. LSP/LEA could have sessions outside normal agendas, to get these issues on the agenda on HI/leadership.
>
> We share the same clients [across agencies]; we all need to be signed up to partnerships. Engagement leadership style is the best way to be, but it's not a natural style for people. We need to ensure people live this brand and urge everyone to be a conscience for everyone you work with.

These last two series of quotes illustrate a potential shift from a model where participants are concerned about cascading their LHIP learning within their organisation, with a potential impact on other regional organisations (system on page 60), to a model where they have become more system literate, and are able to decipher which organisations might be receptive to their LHIP learning (system on page 61).

Some participants were concerned about what expectations they would meet in their organisation.

> I've learned so much, I have been really enthusiastic about is all at work, but now that it is ending I am feeling a sense of panic, panic that people will look on me as the health improvement leader, and I'm far from that, all I feel ready for is to potentially become that because I'm now beginning to understand what it is all about.
>
> What I need now is a mentor or coach to continue to nurture the knowledge and skills I have developed.

Cascading of leading health improvement /organisation issues

Participants discussed their approaches to sharing the learning from the LHIP with their local organisations and rolling out the learning into their local contexts. In the early stages of the programme, the participants reported that they felt they had to be 'selfish' with what they were learning within the LHIP. Rather than immediately feeding back to their organisations, participants reported that they felt the need to digest the information and reflect on it before planning how best to roll it out within their local contexts;

> I need to think about what I think about it all first!

However, in response to this issue of participants being reticent to lead within contexts of significant change, one of the faculty members suggested that effective and successful leaders will continue to lead even if their organisation is going through major changes and shifts;

> A good leader has to lead no matter what the landscape is like; however shaky it is.

These differing views of engagement with change are represented in the participatory model system, as shown on page 57.

Participants asked how to make change happen in old, archaic systems and how to delegate tasks in order to free themselves from the 'doing', to concentrate on leadership;

> How do you expose the archaic systems to fresh air without them crumbling?

Participants also highlighted their understanding of the possible routes and processes involved in sharing the learning from the programme;

> We could take the learning through local networks, to think about how to share the learning from the programme. The concern would be not to get the learning medicalised.
>
> We need to think about what other people need; expose it [the learning] to those who maybe didn't see it as their goal originally. Cascading it down to others [more closed or hard to reach].
>
> We would like the learning sets with multiagency membership to continue. On a journey of self development you need a good mentor; what is that and what does it look like? Others are saying [to us] "will you mentor us?" and we wonder how effectively are we doing that, we would like to discuss this in the LHIP.

Participants consistently highlighted a central theme; the 'know-do gap', as a translation gap between their learning from the programme and their own specific context. This was evident in their reflections and questions to speakers within learning events, their informal discussions with the observing evaluator, and in their individual and tripartite interviews.

> How do we get LSPs to actually deliver health improvement? You can't! LSPs are nice ideas but they don't work.
>
> How do we progress the joint agenda in the current financial climate? We need a joint agenda, after the QoF we need more on Health Improvement.
>
> How do we create more synergy between LAAS, LDPs, CYPPs etc? We need an overarching plan, a community plan? We need the right timeframes, e.g. LDP being developed *after* the overarching plan.
>
> How do we position public health in primary care?

Therefore, in spite of the positive exit strategies that people were starting to elaborate (as exposed above), the weight of cultural, political, organisational and financial barriers was still felt by the participants.

At the same time, by the close of the programme, participants were discussing themes of spreading, cascading and sharing the learning from the LHIP into local receptive systems; mentoring each other and continuing to meet to support and translate the learning locally. It may be that, as they developed their political astuteness, participants were able to identify those organisations / structures within which it was going to be possible to disseminate and translate LHIP learning, and those which would not be receptive in the short term. A starting point was going to be an attempt to maintain LHIP dynamism within participants once the programme finished. This process is illustrated on page 61.

The following diagram refers to how participants may cascade information /learning from the LHIP. Again a variety of approaches may be used – clear strategy incorporated tools already, opportunities, close colleague based, by chance.

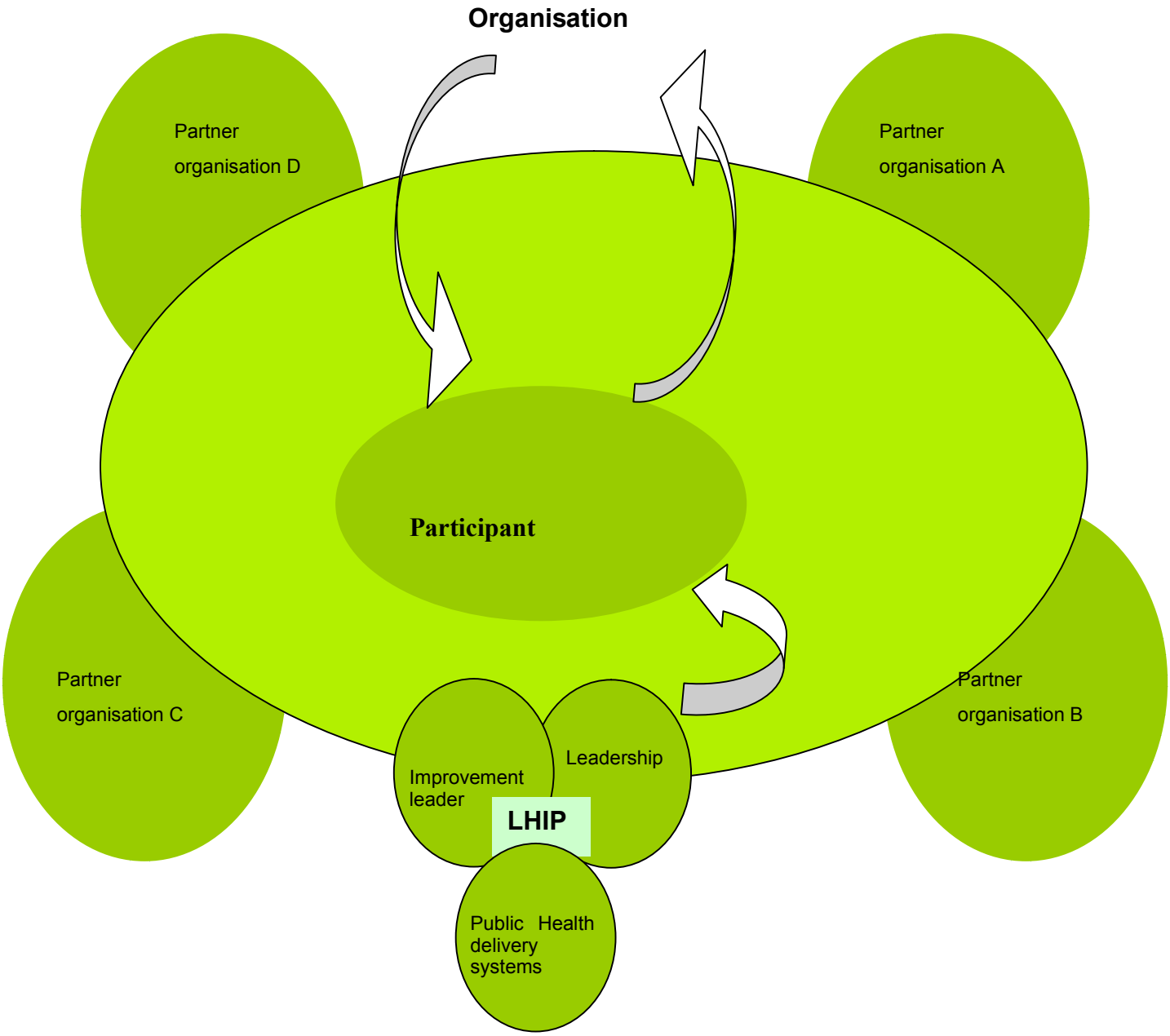


Figure 2: Cascading LHIP learning

Participants described how contingent they felt upon their organisational cultures to cascade LHIP learning, and how they were able to identify unreceptive cultures.

> I'm not convinced the system is ready for transformational leaders. The system will stop the transformation. What can we do to fight the system? We go with what is safe and not what is transformational. To push boundaries it requires transformational leaders to be exposed.

A speaker reiterated this, highlighting the unease employers can feel at transformational leaders within the organisation;

> I'm deeply uneasy about current appointment processes, we don't necessarily get transformational leaders into organisations. They often seem too threatening to organisations to employ, too independent.
>
> Careers can be damaged by being a leader. The LHIP model assumes the system is ok and the system isn't always ok. The context is dangerous at the moment for individuals.
>
> We've pushed the system; pushing the boundaries of transformation
>
> How do we inject entrepreneurship into public health commissioning? By recognising where we do have skills; acting outside the box. But if we're seen as eccentric by the board, we could be fired!
>
> New roles are change agents, therefore they can be viewed with suspicion by peers.

By the end of the programme, participants were highlighting the importance of support in order to deliver their remit of transformational leaders;

> There is a real importance in being supported to be a transformational/ empowering leader. True empowerment happens when you are supported. If commissioning is about hitting you over the head about your performance then looking at what you could have done, this doesn't help you to think outside the box or to think laterally.

Participants identified their need to understand how to make change sustainable;

> When integrating with different systems and organisations, we need brief interventions (with different workforces) that are sustainable. It doesn't have to be the same integration of workforces, it can be change that is encouraged by lots of different workforces, but if they are all saying same message then this reinforces the change, this makes change sustainable.

And suggested some solutions, illustrating their awareness of their own role as leaders within this process, and the initiation of the regional capacity building system (p 63);

> How do we get public health leadership sustained and in the workforce we've already got? It's not just about information giving, public health is good at this. But it needs motivation and opportunities for behaviour change. This is what we're trying to do as Participants [on LHIP]. We have a wider public health workforce – not just NHS – including police and social services.

Discussion

Overall, participants praised the LHIP highly. Although there has been diversity in the evaluation data, there are a number of consistent themes and issues. There has been a high level of retention, programme event evaluations were consistently positive; they expressed admiration for the organisation, the quality and choice of speakers and the networking that was facilitated. Similarly to other leadership programmes, for example that reported by Williams (2006), the LHIP has therefore achieved success. In this discussion, we explore and offer some explanations for this achievement and attempt to highlight the specific attributes of this approach to health improvement leadership development. This leads to a discussion of the various paradoxes faced by leadership for health improvement programme organisers, which aim to inform the development of future such programmes. It draws on the literature on leadership, knowledge development and improvement science, and is inspired by educational theories.

A lot of positive outcome achievement was reported across a diverse set of health improvement leadership development needs among the participants. Outcomes from each sphere of the LHIP have been realised. The programme produced positive consequences on individuals, similar to those reported in other Leadership evaluations, such as improved self-confidence, more reflective, broader thinking, heighten sense of others behaviours and actions(Connell, Humphris & Meyer 2004; Clarke et al. 2004). The LHIP appears to be providing participants with the tools, techniques and confidence which the NHS Modernisation Agency (2005) highlight as important for improvement.

Systems literacy have been enhanced; participants were more able to identify which systems were ready to be challenged and which were not ready yet – they were more able to see where to act. This, in effect, represents a breakdown of the diagram presented in figure 1 (Williams 2006), in that organisational impact can be studied, but in a non-linear and non static, evolving way. This is represented in the 'cascading LHIP learning' diagram (figure 2, page 79), which fosters a conceptualisation of health improvement leadership development as an iterative process, which is contingent, but can also thrive, on an evolving contextual background. In some cases, this meant that people were encouraged to adopt a step by step approach to change

management, in a way that would be most auspicious to the subsequent realisation of leadership for health improvement. These developments are particularly significant in view of the discipline of improvement literature, which highlights the importance of changing systems, as well as changing within systems. It seems that some participants progressed on to lead on health improvement, albeit it being one step removed. They applied whole system thinking, so that health improvement could ensue at a later stage. They manoeuvred change in a way that might make subsequent health improvement leadership happen in a favourable climate.

The format and structure appears to be a critical success factor. Three issues are worthy of particular highlight. 1] The mix of methods utilised in the programme was highly appreciated. What seems to be the ideal delivery approach is some high profile enigmatic speakers, a front loading of policy, time to share experiences, test out ideas, hear about other participants visions. 2] The balance of methods needs to be adjusted as the programme progresses, with more signposting to information sources, to allow more time to be devoted to participants' application discussions. 3] Networks were facilitated and time was provided for them. However, concern was expressed by some participants that although their networking skills had developed, the actual networks with which they had engaged during the programme might not continue post LHIP -perhaps some messages here about participant recruitment to allow this potential to be fulfilled.

The LHIP embraces the four aspects of development programme which are best able to both develop, and transfer, learning (Alimo-Metcalfe & Lawler, 2001):

- It had a strong action learning approach to development. The majority of participants supported the need for action learning sets and a large number joined sets organised by programme leaders.
- The programme used direct personal and business issues as the focus of activity and learning. Participants have derived great benefit from hearing how fellow participants were utilising and applying learning and have suggested that more of this would be appreciated. Table top discussions allowed opportunities for immediate application to personal and business issues. Two issues are perhaps worthy of consideration – whether there needs

to be further facilitation of this to assist participants to work through the learning application as there appears to be some danger that they can revert to current approaches to problems solving etc. The other factors to consider is whether more time needs to be devoted to this, once they had received a considerable amount of theory/information.

- Encourage and expect participants to implement changing their work during participation. Interviews have identified that participants were often not using the LHIP to assist them in achieving a particular aim, but were using in a more scatter gun approach. For them, integration and synthesis of learning might be facilitated by the development of a specific practice focus. Some participants referred to storing up knowledge for future application. It may be that some coaching to establish a strategy to enhance incremental and contextualised use of learning would have been beneficial, so that effectiveness could be maximised. Some participants, however, engaged in this process quite naturally.
- A strong support of senior management is advocated, as well as the support of direct line managers. Although all LHIP participants were sponsored, the level of support was challenged by reorganisation and change within organisations. In some cases, this could reduce the potential for learning application at an organisational level.

In their review of leadership developments, Alimo-Metcalfe & Lawler (2001) identify some additional potential barriers to development initiatives. Some of these are also relevant to the LHIP:

- Poor role modelling by existing leaders – the participants have expressed great appreciation of learning from each other. Part of the difficulty they were experiencing is the extent of organisational change and the scarcity of role models for health improvement. Explicit development of the concept of a health improvement leader could have been useful to some participants. Several have reported to be making limited use of the LHIP framework, and therefore were perhaps missing some of the learning around the integrative aspects of the LHIP that enables the development of health improvement leaders, as opposed to leaders.

- Reluctance of individuals to change, to introduce new ideas and concepts – there is a possible risk here with participants selecting a learning agenda that avoided meeting some challenges i.e. "I'm already a good leader"; "my leadership development skills have already been well developed". At a time of such organisational change, becoming involved in more change and moving out of the comfort zone requires considerable support. More focussed facilitation of applying the learning at table top events might have prevented these participants to rely on 'old' knowledge and working practices.
- Competition with other initiatives – reorganisation, securing posts, job application were all challenges for the LHIP.
- Insufficient time devoted to leadership development – several participants viewed the LHIP as an addition to their workload, something extra to be fitted. This 'bolt-on' approach suggests that some may be engaging in limited application. Any mechanism to break down this attitude would appear to be helpful.

Earlier discussions have highlighted the diversity in leadership constructs that may both influence, and be drawn on, for the LHIP. Focussing on the transparency of the leadership paradigm of the LHIP is an important issue. However, Edmonstone & Western (2002) suggest that the duality transactional / transformational leadership style is simplistic, and quote Kotter (1990) suggesting a model which highlights situations where both types of leadership are necessary concurrently. This is represented in figure 3.

Figure 3: concomitant need for different leadership styles

High		
Amount of change	High Transformational Low Transactional	High Transformational High Transactional
	Low Transformational Low Transactional	Low Transformational High Transactional
Low	**Complexity of organisation**	***High***

LHIP participants came from a variety of complex organisations, in which change was a constant and important factor. They therefore needed to develop the capacity to decipher situations so that the most effective leadership style may be applied in the most receptive context. This is, however, yet over simplistic, as LHIP participants come from a variety of leadership levels. The way to accommodate for this was for participants to enhance their system literacy. By the end of the programme, participants were more able to identify which systems were ready to be challenged, and which were not ready yet.

Given the wide agenda on offer, participants engaged in a prioritisation and selection of learning, which seemed to relate to the learning needs analysis, which was undertaken at the beginning of the programme. There is probably room for participants to more actively engage with this, to provide a template for their learning and participation throughout the programme.

Rogers (1989) discussion on goal setting in learning describes a model which may have some utility in describing an enhanced process of negotiated learning for development activities such as the LHIP.

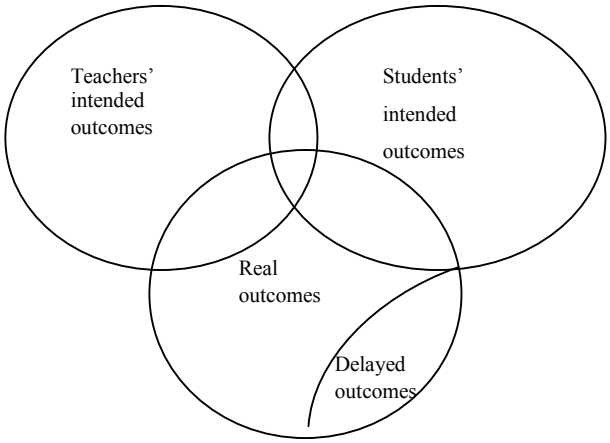


Figure 4: Teacher :learner goal comparisons (taken from Rogers 1989)

Similarly, there may be value in more active engagement with the LHIP framework, in all its integrative aspects, from the beginning of the programme. The approach of designing /including optional, between event, activities seemed to be very useful to that effect. Some strategy for application work between events may be worthy of consideration for future programme development.

What is meant by leadership is a debated issue (McAreavey, Alimo-Metcalfe & Connelly 2001) and there are a range of leadership theories. Analysis of the data in McAreavey et al.'s (2001) research identified 304 constructs relating to leadership. The diversity of needs and outcomes of LHIP was therefore to be expected. This is an example of the different learning journeys that the LHIP has had to accommodate. In aiming to be as inclusive as possible, in terms of organisations involved as well as the breadth of participants, LHIP organisers had to accommodate a variety of learning and unlearning needs. These are detailed in the learning system, on page 58. The first task of the LHIP was therefore to enable people to surface their and their organisation's learning needs, in terms of leadership for health improvement. Reference to Argyris and Schon's (1974) seminal work on theories of action, double loop learning and organisational learning may be helpful to this discussion. The premise of their work is built on the idea that people respond to situations by drawing on the mental maps or theories-in-use they have developed in dominance to any espoused theories. Importantly, people may not be particularly aware of their theories-in-use and if required to rationalise the theoretical basis of their activity would usually refer to espoused theories although this may not provide a comprehensive picture of their practice theory. The LHIP appeared to be active in these processes, in that the package of experiences offered a year time line facilitated surfacing and exposing of both theories-in-use and espoused theories and therefore the mental maps guiding individual approaches to health improvement. The potential consequence of this may be more apparent if we use a travel analogy. The 'contours' of the map have therefore been changed. It may be that during and at the immediate conclusion of the LHIP, some participants may appear to be travelling along the same health improvement journey as before. However, they now may also have different route options that will influence their health improvement journey in the future. To clarify further, we can expose two examples of this process in action during the LHIP. The pre-programme interviews suggested that participants had a well rounded view of leadership and a comprehensive portfolio of styles to draw upon. These could potentially be categorised as their espoused theories. During the programme some of their theories-in-use such as their authority-leadership beliefs were surfaced and tackled and a revised mental map formed. For some there may have been a gulf between theories-in-use and espoused theories, and for others there may have been a very small divide. Any difference would not necessarily be surfaced at the pre-

programme interviews, but during the process of the LHIP. Such differences are likely to have been surfaced during the course of the programme rather than through the pre-programme interviews. In this respect, unless these interviews form part of a strategic intent of harnessing and enhancing learning they present a limited educational value.

Argyris and Schon (1974) explain the process by drawing on a three element model of governing variables, action strategy and consequences and the single or double loop learning that may occur. Simply stated, the pattern of action in single loop learning is to search through ones existing portfolio for alternative strategies when faced with unsatisfactory consequences. This is contrasted to double loop learning where it is realised that it the governing variables that need to be redressed. Perhaps this could be seen as a learning example of changing within a system (single) or changing systems (double).

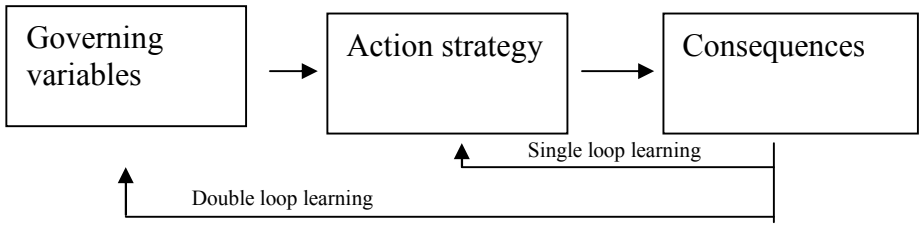


Figure 5: Single and double loop learning

Another strategy to assist with disentangling impact is to refer to adult learning theories. These provide a mechanism to demonstrate the degrees of learning that took place during the LHIP. For example, Bloom (1965) distinguishes between cognitive and affective aspects of learning. Ideally there would be a parallel track of development in both domains so that understanding and value systems are challenged. This was exemplified by one of the participants who emphasised how the LHIP had surfaced the importance of values in leadership. This led the participant to contribute to changing the system within which s/he worked, demonstrating double loop learning and an engagement with affective learning which later led to cognitive synthesis and evaluation. The hierarchy of development would be:

Cognitive	Affective
Knowledge - Recall and recognition	Receiving –receptiveness to stimuli, development of selective attention.
Comprehension – understanding and active exploration	Responding –growth of commitment to the material
Application – using knowledge in practice	Valuing the activity as worthwhile and seeking out of other application and learning opportunities
Analysis – of situations by scrutiny of their constituent components	Judgement making
Synthesis of knowledge – by building up new concepts	Attachment of concepts to values
Evaluation – critique the value of their knowledge in relation to actualisation of goals	Value organisation

Table 4: Blooms cognitive and affective learning taxonomy (taken from Rogers 1989)

By drawing on Bloom taxonomy of learning , participants engagement can be mapped showing considerable movement up the hierarchy during the LHIP and therefore the potential to continue to move thought he hierarchy post LHIP.

Support networks developed well within the LHIP participants, and questions need to be asked about how they can be nurtured on completion of the LHIP, and how others can be developed. Respondents have offered limited reference to how they are intending to utilise their individual networks within their organisation.
Bearing in mind that creating new knowledge entails more than the mere acquisition of knowledge. Rather it must be:

> "…built on its own, frequently requiring intensive and laborious interactions among members of the organisation." (Nonaka & Takeuchi 1995:9)

It is useful at this point to make reference to the three facets of effective leadership development identified by McCauley, Moxley and Vestor (1998). The development experience and the ability to learn facets appear to be adequately addressed, but the organisation context is the facet out with the remit of the LHIP providers and yet crucial to long term opportunities to enhance health improvement practice development. The opportunity to engage in interaction to further develop and create

health improvement knowledge is an area that appears to be worthy of highlighting if not facilitating.

Frequent interaction took place within the LHIP, but the extent of the possibilities for this networking activity to be developed in the participants' organisation needs to be emphasised. Nonaka and Takeuchi (1995) identify four modes of knowledge creation within organisations:

1. socialisation – tacit knowledge is exchanged through the process of sharing of experiences; sharing within the LHIP was active and appreciated.
2. externalisation – tacit knowledge is articulated into explicit concepts through successive rounds of meaningful dialogue: this was potentially fulfilled by the table top discussion, but it may be worth considering framing some of them with this aim in mind.
3. combination – explicit knowledge systematised and documented into a wider knowledge system – the feeding back into organisations was happening and participants reported examples of sharing LHIP acquired knowledge. It may be worth considering if the participants could engage in an exercise to develop some explicit knowledge for wider sharing, on a smaller scale perhaps but something akin to developing organisation case studies, or something similar to the 10 key changes document. This may be a useful concluding and future agenda setting exercise.
4. internalisation – explicit knowledge embodied into tacit operational knowledge

Another facet of the highly valued networking activity during the LHIP warrants some attention. Participants came to the LHIP with a networking agenda, already appreciating its centrality to health improvement endeavours. Participants engaged with networking at every opportunity and many had plans to continue with the network connections they had made. However, participants have not articulated is any enhanced understanding of the networking concept and the four levels of networking – individual, group, organization and inter-organization highlighted by Knight (2002). The potential for four level networking is of course enhanced by the 'shared cognition' in relation to health improvement across LHIP cohort, which covers multiple organisations in one region.

It is common practice in evaluation reporting to produce firm recommendations for practice. This reporting pattern fits well when there are specific lessons to be derived from an evaluation process. However, as the LHIP embraced an enormous range of challenges, following this approach would not do the situation justice. Rather, six interconnected paradoxes faced in the development and execution of the LHIP and through which the organisers had to manoeuvre, are identified. These represent recommendations for decision making debates that would be required for similar programme development.

1) Intra- versus inter- organisational development paradox

An intra-organisational intent could anchor LHIP learning for individual participants, and provide a negotiated space for its operationalisation. The paradox lay in the fact that, through multi – organisation attendance, the LHIP sought to foster inter organisational collaboration and learning.

Consequences for the participants:

This 'inter', rather than 'intra' focus had the potential to partially shelter LHIP learning from organisational change, or to give participants a false option to do one at the exclusion of the other. While these two focuses may work together for some people in some organisations, they could be seen as antagonistic or dualistic in others. The mix of participants and organisations meant that some participants engaged more with an 'intra' agenda, whilst others were ready to think beyond organisational boundaries.

Consequences for the programme management:

An 'intra' focus could have had the potential to maximise learning potential. At the same time, an 'inter' focus fostered the challenging of existing boundaries and creative thinking which underpinned the LHIP. However this, it seems, assumed a strong and stable organisational environment from which participants could have expressed their creativity, or an ability to transcend organisational particularities. Instead, many participants were faced with particularly turbulent reorganisations. Participants' differing abilities to engage in an inter – organisational learning agenda are an inevitable consequence of the inclusion of organisations at different levels of maturation with respect to the health improvement endeavour, exacerbated by a diversity of individual roles representing a spread of organisational levels.

Messages:

While an intra – organisational focus might have facilitated learning and practice applications, the multi – organisational participation fostered creativity in a novel and qualitatively complex way. The format of the LHIP provided the mechanism to enthuse participants of the health improvement potential. While for some, this was very successful, others struggled to think beyond their organisational box.

2) Current reality versus vision and ambition

The second paradox is linked to the first, in that the LHIP aimed to develop a new health improvement leadership cohort, while needing to acknowledge the necessity for learning embeddedness in individual contexts. In this respect, the LHIP was in line with policy and theory, but in many respects ahead of the reality of practice. The paradox is whether one bases a new programme in current practice reality, or whether it vows to work with vision and ambition.

Consequences for the participants:

The consequence for some participants was that they were introduced to some practices that were not happening yet, although ones which they would need to nurture in the future. In order that the programme may be most effective, participants were required to become visionary. While this was timely and inspiring for some, it could prove daunting for those at the beginning of their leadership journey, or who were not clear about their health improvement role.

Consequences for the programme management:

For the programme management, this has consequences in terms of the facilitation of these multiple learning processes. The use of systems, to engage students in identifying and reviewing their learning needs throughout the programme, might need to be considered for future implementations. This would help students to visualise their current situation, and explicitly pinpoint areas for development. While these could be changed and reviewed throughout the programme, a system mapping would anchor learning and reconcile, where that is deemed appropriate, the present vs future dichotomy.

Consequences for the evaluation:

The ramifications for any evaluation endeavour are significant. If development is anchored in the current organisational context, then it may be possible to adopt a linear approach and focus the evaluation activity on the operationalisation of a health improvement aim. Evaluation of the embracement of emerging policy and visioning

demands a different approach and one that is perhaps more ably captured by a systems approach. Integral to the concurrent development of the LHIP was the development of the most efficient evaluation strategy.

Messages:

Traditional learning and evaluation approaches do not adequately reflect the complexity of a programme such as the LHIP, in terms of timeliness in participants' learning trajectories. The approach adopted in the evaluation, and that suggested as a programme learning strategy, may represent an inroad worthy of consideration for future programmes.

3) A two dimensional participation paradox

The programme was also underpinned by two paradoxes resulting from the mix of participants: a) Wanting to promote health improvement as a central idea meant that the organisational mix was heavily weighted towards the NHS. b) Embracing the idea of leadership as democratic and uniformly held responsibility meant that participants could not be expected to be all at the same stage of their leadership journey. The paradox relates to the fact that while a single organisation base or stage in a leadership journey may appear more apt to facilitate individual learning, the mix reflects the LHIP's visionary stance.

Consequences for the participants

The organisational mix had a positive impact, in that it was a driver for health improvement, but at the same time could make people from non-NHS organisations feel alienated from a version of health improvement with which they had had little engagement. The participants' stage of development impacted on how they engaged in the learning process, and how able they felt to cascade and share LHIP learning.

Consequences for programme management

In embracing these two paradoxes in their most innovative version, of mixing both organisational and leadership backgrounds, the organisers showed the creativity and innovation that the programme was promoting. However, this also resulted in participants needing differing levels of support from the organisers. While some of the supporting activities were overtly part of the programme, some were more covert and required extra curricular contacts.

Messages

The organisational and leadership mix meant that the creation of a cohesive cohort was not immediately apparent to all participants. While most participants commented on the potential benefits of having a mix cohort, this meant that for some of them, the LHIP was more about an individual leadership journey than about belonging to a cohesive health improvement cohort.

4) Practice versus principle paradox

A fourth paradox can be framed around the balance between ?health improvement theory for practice or principle for practice and the application of theory in health improvement practice. Participants and in some cases their sponsors, wanted some early 'pay back' from the LHIP. This demand was fuelled by a context both rich in structural change and health improvement policy initiatives. If one conceptualises the engagement in health improvement as a journey, this relates to the participants and their organisations' ability to conceptualise health improvement in a way both in line with national policy documentation, and in a way that could resonate within the organisational context.

Consequences for participants

Many participants therefore engaged with the LHIP in the anticipation of finding 'the way', 'finding solutions', albeit to rather ill defined problems in the majority of cases. One outcome of the LHIP was to enable participants to more clearly define situations and as appropriate, instigate immediate or longer term interventions. At the end of the programme participants were concerned that they may loose some of the LHIP learning and impetus. However, had their learning been about health improvement principles for practice, it would have been less context dependent. This would have enabled them to develop a mindset geared to theoretical insight, which would have in turn relativised the need for quick fixes and straight answers. For some people, the journey was reported to be tortuous in applying the learning to their practice – the dilemma is that the more novice people are to health improvement leadership, the more difficult the journey might be.

Consequences for course management

Engaging every element of a very heterogeneous cohort in the same level of learning may therefore prove to be an unrealistic goal. Early explicit identification of learning needs, through the use of a system mapping for example, and the establishment and

regular review of individual learning strategies may help towards surfacing and accommodating individual complex needs and learning outcomes.

5) Organisational versus individual learning needs paradox

For some people, participating in the LHIP was part of a clear intent for individual development, which was not always anchored in an organisational strategy. While this might appear on one level to give people the freedom to engage in the kind of collaborative working encouraged through the LHIP, it could also impede it. At the same time, in the face of reorganisation events, it could prove particularly challenging to identify organisational learning needs which could stand the test of time.

Consequences for participants

For some, participating on an individual development plan only, navigating their individual learning needs was difficult, as LHIP learning ideally required them to engage in an analysis of the context within which they practiced. As they developed their system literacy, some participants had to come to the conclusion that their current practice environment was not yet ready for transformational leaders, or transformational health improvement (in its own right, or health improvement as a progression from public health) leaders. This meant that they either had to use strategically other leadership styles in order to prepare a more receptive terrain. As a result of this process, some participants considered changing organisation.

Consequences for programme management

This paradox relates to the original aims of the LHIP and their anchorage in either individual, or organisational, practices. The two are inevitably interlinked, since individuals work within, as well as without, organisations, but were sometimes perceived as frustratingly antagonistic.

Messages

Consideration may therefore need to be given to how the individual /organisation balance can be best managed - possibly by group /team attendance or by some proxy format such as enhancing the level to which participants come to the LHIP with an organisational need so that there is clear route back into practice. This relates to the already mentioned learning strategies and the necessity to give people the tools to learn with purpose, in a way that enable them to unravel within a receptive context.

6) The paradox of time

The last paradox relates to the time frame of the programme. In contemporary public health / health improvement development, people want quick fixes, and want to be able to identify, or demonstrate with some degree of precision when they will be able to reap the rewards (individual and organisational) of programme participation. At the same time, participants appreciated the fact that the programme ran over a full year.

Consequences for participants

The timescale of the programme made the development of durable relationships more likely among participants, and increased the cohort cohesion potential. At the same time, changing organisational imperatives and lack of organisational stability over the year of the programme made practice embeddedness of LHIP learning difficult.

Consequences for programme management

This articulation of outcomes from LHIP participation was implicit, rather than explicit, within the programme, but could have been tagged on individual learning plans. This can be illustrated by the horizontal complexity of the learning process, as individuals may be engaged in a multitude of activities, which each have a potential to impact on LHIP learning. A long programme enables people to surface these, and engage in the level of reflexivity necessary to engage with deeper theoretical learning that can transcend organisational particularities in time.

Messages

The timing of the programme posed the question of when contexts can be assessed as receptive to this kind of programme – for some people, the reorganisation agenda drove, and sometimes impeded, their learning – for others, it was the best possible time to be innovative.

Conclusions

As a consequence of the LHIP experience health improvement could now be described as being everyone's business. For those participants who joined the programme already very much 'signed-up' to the concept, it has expanded their understanding of what health improvement leadership means for them and their organisations. For those participants who entered the programme unsure of what health improvement leadership meant for them as individuals and for their organisation, it is now much more firmly appreciated as part of their business. The other dimension of being 'everyone's business' that has been achieved by the multi-disciplinary approach of the LHIP is that there is greater clarity of the whole system of health improvement and the contribution of individual organisations or service sectors to the overall business.

The breadth and intensity of outcome achievement demonstrates that the LHIP framework provided an accurate, timely and comprehensive menu of the components of leadership for health improvement. Further endorsement of this achievement is evident in the broad range of health improvement leadership needs which the LHIP accommodated. The programme was effective along a continuum; for those participants who were coming to terms with applying the health improvement leader label to themselves, as well as those participants who considered that they had a wealth of public health if not health improvement leadership experience and leadership education, such as study at Masters level. It seems reasonable to say therefore that the LHIP has gone some way significant way to addressing McAreavey, Alimo-Metcalfe and Connelly'(2001) challenge of delineating what effective public health leadership is. It is still, nevertheless difficult to conclude with any comment on McAlearney (2006) questioning of transferability of public heath medicine leadership issues to other public health roles. However, what can be concluded is that there may be worth in analysing health improvement leadership need not or even primarily by occupation alone, but by mapping the evolutionary stage of health improvement and leadership constructs and practise within individuals and the organisations in which or with which they function.

Earlier in this report a considerable LHIP evaluation challenge was set in adapting Alimo-Metcalfe and Lawlers' (2001) question of 'what is the economy lacking' with respect to leadership', to the health improvement 'economy'. Analysis of the learning outcomes goes some way to answering this question. What was the health improvement economy lacking? It was political astuteness; policy awareness and engagement; self confidence with respect of one's leadership skills, but also confirmation of health improvement conceptualisation and refinement of the construct; role or practice models; evidence base; and an appreciation of the concurrent need for intra and inter organisational engagement in health improvement.

The LHIP developed a creative and innovative approach to a leadership development programme. It included a range of learning style opportunities, including master classes, key note inspirational speakers, debates, action learning, experiential sharing, day attendance, and residential attendance. Such a programme may benefit from similarly creative participation methods. An example of this could be the use of system mapping, influenced by soft systems methodology in conjunction with a pre-programme interview, that would be continually refined to map individualised development needs, thereby facilitating most appropriate learning experience selection. This could be part of an induction into developing effective and individualised learning strategies which do not necessarily follow a linear pattern. This would expose the multiple pathway potential that the LHIP offers. Its utility may however, extend beyond the programme to provide a template for ongoing development and sustainability.

High levels of appreciation can be a challenging situation for an evaluating team. When respondents are highly and unanimously appreciative of a programme, as they were for the LHIP, there can be a tendency for a rather superficial participant response, such as 'everything about the LHIP is great, I can't really say much more than that can I?' The Appreciative Inquiry and Illuminative Evaluation methodologies in combination provided a mechanism for surfacing the detail of processes and mechanisms that lead to the appreciation. This evaluation therefore makes a methodological contribution to the reported difficulty of attribution of causal chain of effect between individual leadership development and organisational impact.

References

Alimo-Metcalfe B 1999 Leadership in the NHS: what are the competencies and qualities needed and how can they be developed. In Mar A & Dopson S (Eds) *Organisational behaviour in health Care: The Research Agenda*

Alimo-Metcalfe B & Lawler J 2001 Leadership development in UK companies at eth beginning of the twenty-first century. Lessons for the NHS? *Journal of Management in Medicine* Vol 15, No 5, 387-404.

Alvesson M & Sveningsson S 2003 Managers doing leadership: the extra-ordinarization of the mundane *Human Relations* 56 (12) 1435-1459

Argyris C & Schon D 1974 *Theory in practice: Increasing professional effectiveness* San Francisco: Jossey-Bass

Barker R A 1997 How can we train leaders if we do not know what leadership is? *Human relations* vol 50, No 4, 343- 362

Barker R A 2001 the nature of leadership *Human Relations* 54 (4) 469-494

Berwick D, Davidoff, F, Hiatt, H & Smith R (2001) Refining and implementing the Tavistock principles for everyone in health care *British Medical Journal* 232 (7313), 616-620

Bloom B S 1965 *Taxonomy of educational objectives* London, Longman.

Boaden R J 2006 Leadership development: does it make a difference? *Leadership & Organization Development Journal* Vol 27, No 1, 5-27.

Brown M & Beech D 2000 Spontaneous organisation, directions *Ashbridge journal.* Summer

Bryman A 1996 Leadership in organisations (p276-292). In Clegg S R, Hardt C & Nord W R (eds) Handbook *of organisational studies* Sage Publications

Casebeer A L & Hannah K J. 1998 The process of change related to health policy shift: reforming a health care system *International Journal of Public Sector Management* vol 11, No 7, 566-582

Checkland P & Scholes J 1999 *Soft systems methodology in action* Chichester: Wiley

Clarke C, Reynolds J McClelland S & Reed J 2004. Leading Modernisation Programme 1: Evaluation report Northumbria University.

Clarke C, Wainwright D, McClelland S, Swallow V, Harden J, Walton G & Walsh A (2004) The discipline of improvement: something old, something new? *Journal of Nursing Management* 12, 85-96

Coghlan A T, Preskill H & Catsambas T (2003) An overview of appreciative inquiry in evaluation *New Directions for Evaluation* No 100, Winter, 5-
(2005) *Improvement Leaders Guide: Improvement knowledge & skills*

Connell C Humphris D, & Meyer E 2004 Leadership evaluation: an impact evaluation of a leadership programme. Health Care Innovation Unit & School of Management, University of Southampton. http://eprints.soton.ac.uk/14067/ access 14th July 2006

Connelly J, Knight T, Cunningham C , Duggan M & McClenahan J 1999 Rethinking public health : new training for new times *Journal of Management in Medicine* vol 13, No 4, 210-217

Denzin, N and Lincoln, Y (2000) Handbook of Qualitative Research. London, Sage.

Department of Health 2004 *Choosing Health ……..*

Dubrin A 2001 *Leadership. Research findings, practice and skills* Boston, Houghton Mifflin

Edmonstone J & Western J 2002 Leadership development in health care: what do we know? *Journal of Management in Medicine 16:1*, 34-47

Flannigan H & Spurgeon P 1996 *Public sector managerial effectiveness: theory and practice in the National Health Service* Open University Press.

Gaughan A 2001 Effective leadership behaviour: leading 'the third way' from a primary care group perspective J*ournal of Management in Medicine* 15:1, 67-94

George J M 2000 Emotions and leadership : The role of emotional intelligence *Human Relations* 53 (8) 1027-1055

Gibbons P T 1992 Impacts of Organizational Evolution on Leadership *Human Relations* volt 45, No 1 1-18

Goodwin N 2000 The national leadership centre and the national plan *British Journal of Health Care Management* 6:9, 399-401

Goodwin N 1998 Leadership in the UK NHS: 'where are we now? *Journal of Management in Medicine* 12:1, 21-32

Grint K 2005 Problems, problems, problems: the social construction of 'leadership' *Human Relations* 58)11) 1467-1494

Hamlin R 2002 A study and comparative analysis of managerial and leadership effectiveness in the National Health Service: an empirical factor analysis study within an NHS Trust hospital *health services management Research* 15: 245-263

Hay A & Hodgkinson M 2006 Rethinking leadership: a way forward for teaching leadership? *Leadership and Organisation Development Journal* Vol 27, No 2, 144-158

Hammond S A 1998 *Appreciative inquiry* Thin Book Publishing Company

Hannaway C , Hunter D & Pleske P 2006 *need reference in full*

Hardy, B, Hudson B & Waddington (2003) *Assessing Strategic Partnership: The partnership assessment tool* Office of the Deputy Prime Minister, London

Hewison A & Griffiths M 2004 Leadership development in health care: a word of caution *Journal of Health Organization and Management* Vol 18, No 6, 464-473.

Horner M 1997 Leadership theory, past present and future *Team Performance Management* 3:4 270-287

Kouzes J M & Posner B Z 2002 *The leadership challenge* Jossey Bass

Knight L 2002 Network learning: exploring learning by interorganizational networks *Human Relations* 55 (4) 427- 454

Kotter J (1990) *A force for change.* Free Press, New York. In Edmonstone J & Western J (2002) Leadership development in health care: what do we know? *Journal of Management in Medicine* Vol 16, No 1, 34-47.

Lee M 1994 Empowerment, management, management education, power and organisations . in Welshman G, Boydell T, Burgoyne J & Pedler M (eds) *Learning Company Conference Collected Papers* Sheffield p119-130

McAlearney A S 2006 Leadership development in health care: a qualitative study *Journal of Organizational Behaviour* 27, 967-982

McAreavey M J , Alimo-Metcalfe B & Connelly J 2001 How do directors of public health perceive leadership *Journal of Management in Medicine* Vol15, No 6 446-462

McCauley C, Moxley R & Veslor E 1998 *Handbook of Leadership Development* Jossey:Bass

Newell S & Swan J 2000 Trust and inter-organizational networking *Human Relations* 53(10) 1287-1328

NHSE (1999) Leadership for Health

Nicholls J 1987 Leadership in organisations : meta, macro and micro E*uropean Journal of management* 6, 16-25

NHS Modernisation Agency 2005 *Improvement Leaders Guide Portfolio*

Nonaka I. & Takeuchi H (1995) *The knowledge creation company: how Japanese companies create the dynamics of innovation* New York, Oxford

Osborne P & Ferlie E (eds) 2002 *New Public management: current trends and future proposals*. Routledge, London

Robson, C (2002) *Real world research: a resource for social scientists and practitioner-researchers.* Oxford : Blackwell

Rogers A 1989 *Teaching Adults* Open University Press

Russell J, Grennhaugh T, Boynton P & Rigby M (2004) Soft networks for bridging the gap between research and practice: illuminative evaluation of CHAIN *British Medical Journal* 15th May 2004 328

Senge P M 1996 Leading learning organisations *Training & Development Journal* 38:5, 14-19

Tichy N & DeVanna M 1986 T*he Transformational Leader* John Wiley & Sons, New York.

Watson S (2006) Impact Evaluation of the National Public Health Leadership Programme . Draft report January 2006. Henley Management College.

Appendices

Appendix 1 Programme Advisory Group

Professor David Hunter	Professor of Health Management & Policy, Durham University (Advisory Faculty Lead)
Catherine Hannaway	NE Yorkshire & Northern Lincolnshire SHA (Programme Director)
Dr Naomi Brecker	Deputy Head of Public Health, DoH
Dr Valerie Day	Head of Public Health, DoH
Professor Brian Ferguson	Director, Y &H Public Health Observatory, (Programme Participant)
Professor Chris Beasley	Chief Nurse for England, DoH
Yinglen Butt	Public Health Lead Nurse, DoH
Professor Helen Bevan	Director, NHS Institute for Innovation & Learning
Jean Penny	Head of Learning, NHS Institute for Innovation & Learning
Professor Paul Johnstone	Regional Director of Public Health, Y&H
Professor Beverly Alimo-Metcalfe	Professor of Leadership Studies, Leeds University
Tony Elson	Local Authority Advisor, DoH
Professor Charlotte Clarke	Associate Dean, Northumbria University
Dr Susan Carr	Reader in Public Health & Primary Care, Northumbria University
Jayne Browne	Director of Health & Performance Improvement NEYNL SHA
Jim Easton	Chief Executive, York NHS hospitals Trust
Dr Jeffrie Strang	Director of Public Health, Scarborough, Whitby & Ryedale PCT (Programme participant)
Mark Gamsu	Associate Director, Y&H PH Group (Programme participant)

Appendix 2: The LHIP framework

Appendix 3: <u>Individual interview information sheet</u>

Purpose of the study

The evaluation aims to analyse and inform ongoing development of the theory and implementation practice of the Leadership for Health Improvement Programme.

The study will draw on appreciative inquiry and illuminative evaluation.

Objectives

3. To investigate the learning experiences of the Programme providers and participants through observation, interview and secondary data
4. To explore the process of using this learning in the participants work environment to lead health improvement practices through the analysis of individual participant interviews and tripartite interviews with participant and their sponsor.

These objectives form the two aspects of the research activity.

Participation in individual critical reflection interviews

Drawing on the principles of appreciative inquiry and illuminative evaluation sample participants will be invited to participate in a sequence of 2/3 telephone interviews in the periods between programme events. Participants will be asked to comment on how their leadership for health improvement has evolved and the synergy and conflicts between their role and the LHIP. The interviewee will be asked to specify an improvement aim on which to focus the interview. The discussion will be framed around the 3 Programme learning domains and identify evidence of development. The interviews will be tape recorded and transcribed.

Selection of participant to take parting individual interviews

All Programme participants were invited to participate in the individual interview phase and 37 reported positively. A sample of 6-8 will be selected using variables such as role, organisation, and geographical location. The aim being to capture a diversity of experience as well as providing the opportunity for people working in the same geographical area to report on partnership activity/cross agency issues.

I have agreed to take part – can I change my mind?

Taking part is entirely voluntary and you may withdraw at any point during the evaluation.

What will happen if I take part?

One of the research team will contact you to arrange a mutually convenient time for a telephone interview that will last from 30-60 minutes – depending on the time you are bale to allocate to this activity.

Prior to the scheduled time you will receive an outline interview schedule that will give you some pointers to prepare for the interview and a framework to guide our discussions.

We would like to tape record the interview. The tapes will later be transcribed and you will be offered a copy that may be useful for your self-evaluation and also to guide subsequent interviews. The tapes will be securely stored at the University of Northumbria and will be cleaned on completion of the evaluation. Only the research team and the transcribers will listen to the tapes. Any details or quotes used in evaluation reporting will anonymous.

LEADING HEALTH IMPROVEMENT PROGRAMME EVALUATION

Individual interview consent process to be gained at commencement of telephone interview

Interviewee Name _____

Organisation _____

Interviewer Name_____

Interviewer:

"Before we start the interview I would like to clarify your consent to participate and would like to switch the tape recorded on to record that process"

Tape recording commenced:

"Have you received and read the *individual interview information sheet?"*

"Do you have any question you wish to ask?"

"Are you willing for the taping of the interview to continue?"

Appendix 4: Interview schedule

Community Health and Education Studies (CHESs) Research Centre
Northumbria University
Coach Lane Campus East,
Benton,
Newcastle upon Tyne
NE7 7XA
Tel: 0191 215 6217/ 6036

Evaluation of the Leading Health Improvement Programme
Interview guide

Thank you for agreeing to participate in a series of 2-3 interviews over the course of the Leading Health Improvement Programme.

The purpose of the study:

The evaluation aims to analyse and inform ongoing development of the theory and implementation practice of the Leadership for Health Improvement Programme. This is done by exploring the process of using this learning in your work environment, to lead health improvement practices.

The methodology guiding the research:

Don't forget – we are using Appreciative Inquiry (AI) methodology – so we want you to identify **what is working well** in the individual and organisational practice and to go on to "envision what it might be like if 'the best of what is' occurred more frequently." (Coghlan et al. 2003: 5)

This does not mean that we don't want to hear about any problems – we do. AI is about trying to find out what works and why it works, and argues that by examining factors that are productive and helpful it is possible to think of ways of extending and developing the positive factors.

The other element of the methodology is Illuminative Evaluation (IE), a qualitative methodology that seeks to describe and interpret. The purpose is to clarify critical processes and to: " sharpen discussion, disentangle complexities, isolate the significant from the trivial, and raise the level of sophistication of debate." (Russell, et al. 2005)

The interview:

During the first interview we focussed on the first phase of appreciative inquiry – *discovering* and appreciating what is working well. We would like to continue to do this and also move on to the next phases of AI which are *'dreaming'* envisioning what might be and '*designing destiny'* how to construct the future and sustain improvements

We would therefore like to discuss:

- specific examples of how your current and future applications of your LHIP experience and learning
- the synergy and conflicts between your role and the LHIP.

In order to facilitate this, it may be useful to specify an **improvement aim** on which to focus the interview. The discussion will then be framed around the 3 Programme learning domains and identify evidence of development (please find the framework attached).

We have written this guide so that you could prepare for the interview, should you wish to.

We hope you found it useful.

MANY THANKS

LEADING HEALTH IMPROVEMENT PROGRAMME EVALUATION

Tripartite interview information sheet

Purpose of the study

The evaluation aims to analyse and inform ongoing development of the theory and implementation practice of the Leadership for Health Improvement Programme.

The study will draw on appreciative inquiry and illuminative evaluation.

Objectives

1) To investigate the learning experiences of the Programme providers and participants through observation, interview and secondary data
2) To explore the process of using this learning in the participants work environment to lead health improvement practices through the analysis of individual participant interviews and tripartite interviews with participant and their sponsor.

These objectives form the two aspects of the research activity.

Participation in tripartite interviews

In order to capture organisation impact of the Programme, participants and their sponsor will be invited to participate in a tripartite telephone interview to reflect on the impact of the Programme in relation to their initial needs analysis. These will be timetabled during the second half of the Programme. The interviews will be tape-recorded and transcribed. In view of the pace of change and the imminent restructuring in many of the host organisations it is acknowledged that personnel changes may inhibit this aspect of the evaluation.

Selection of participant to take parting individual interviews

All participants will be invited to participate in this aspect of the evaluation and a sample of 5-10 will be selected drawing on initial needs analysis data and using variables such as role, organisation, and geographical location. In order to maximise participation and diversity of experience, participants will be asked to participate in either the individual or the tripartite interview processes.

I have agreed to take part – can I change my mind?

Taking part is entirely voluntary and you may withdraw at any point during the evaluation. Your participation is confidential to the research team, and withdrawal

neither be communicated to the programme managers or impact on your rights to fully participate in the LHIP

What will happen if I take part?

One of the research team will contact the LHIP participant and their sponsor to arrange a mutually convenient time for a telephone interview that will last approximately 30minutes – depending on the time you are able to allocate to this activity.

Prior to the scheduled time you will receive an outline interview schedule and a reminder of your aims of sponsoring/attending the LHIP.

We would like to tape record the interview. The tapes will later be transcribed and you will be offered a copy that may be useful for your self-evaluation and also to guide subsequent interviews. The tapes will be securely stored at the University of Northumbria and will be cleaned on completion of the evaluation. Only the research team and the transcribers will listen to the tapes. Any details or quotes used in evaluation reporting will anonymous.

Would you like any further information, please contact:

Dr Susan Carr, sue.carr@unn.ac.uk, tel: 0191 2156217

Dr Joanna Reynolds, joanna2.reynolds@unn.ac.uk, tel: 0191 2156726

Monique Lhussier, monique.lhussier@unn.ac.uk, tel: 0191 2156036

LEADING HEALTH IMPROVEMENT PROGRAMME EVALUATION

Individual interview consent process to be gained at commencement of telephone interview

LHIP Participant

Interviewee Name _____

Organisation _____

LHIP Sponsor

Interviewee Name _____

Organisation _____

Interviewer Name_____

Interviewer:

"Before we start the interview I would like to clarify your consent to participate and would like to switch the tape recorded on to record that process"

Tape recording commenced:

"Have you received and read the *individual interview information sheet?"*

"Do you have any question you wish to ask?"

" Are you willing for the taping of the interview to continue?"