Northumbria Research Link

Leadership for health improvement – implementation and evaluation

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Abstract

Purpose – The purpose of this paper is to present a co-authored reflection on the health improvement leadership development programme and the key evaluation messages derived from piloting in an English National Health Service region. It highlights the specific attributes of this approach to health improvement leadership development and clarifies health improvement development issues.

Design/methodology/approach – Appreciative inquiry and soft systems methodology are combined in an evaluation approach designed to capture individual as well as organisation learning and how it impacts on leadership in specific contexts.

Findings – The evaluation exposes the health improvement leadership needs of a multi-organisation cohort, offers some explanations for successful achievement of learning needs while also exposing of the challenges and paradoxes faced in this endeavour.

Originality/value – There are limited reported templates of how to develop leadership for health improvement. This paper details a whole systems approach, acknowledging the impact of context on leadership and an approach to evaluating such complex initiatives.

Keywords Leadership, Health services, Service improvements, National Health Service, United Kingdom

Paper type Research paper

Introduction

Leadership development within the health and social care services has been a core component of the UK government's modernisation agenda since it first entered office in 1997 (Department of Health, 1998, 2000). This is coupled with an ethos of joined-up working, collaboration and partnership and a renewed interest in the importance of public health (Connelly *et al.*, 1999; Wanless, 2002, 2004; Department of Health, 1998, 2003, 2004; Hunter, 2003) in the strategic implementation of government policy directed towards health improvement and tackling health inequalities (Department of Health, 2003, 2006). This is highlighted in the recent "Commissioning framework for health and well-being" (Department of Health, 2007, see Chapter 9) which refers to the need for building strong and effective multi-organisational leadership and commissioning capability at local level.

With respect to health services, the former National Health Service (NHS) Modernisation Agency produced considerable guidance on leading and achieving

health care improvement. An example is the guidance in the Improvement Leaders' Guide portfolio. One of whose key messages 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 (NHS Modernisation Agency, 2005, p. 5).

However, most of the thinking and effort on leadership has focused on health care services. While the transferability of the messages, tools and techniques to a public health setting may be possible in part, the leadership challenge in public health is altogether of a different order in terms of its complexity, especially in respect of its multi-faceted nature and the sheer diversity of stakeholders engaged in its pursuit. The fact that the public health field is riven with so many uncertainties and imponderables, together with matters of balance and political judgement, is what contributes to the enormity and complexity of the health improvement challenge. Developing and providing a programme for leadership for health improvement, and one that is grounded in understanding the policy context, is therefore a formidable task (Hunter, 2007). McAreavey *et al.* (2001) highlight three key challenges: defining "effective public health leadership", establishing its relationship to transformational leadership, and clarifying the training and continuous professional development needs.
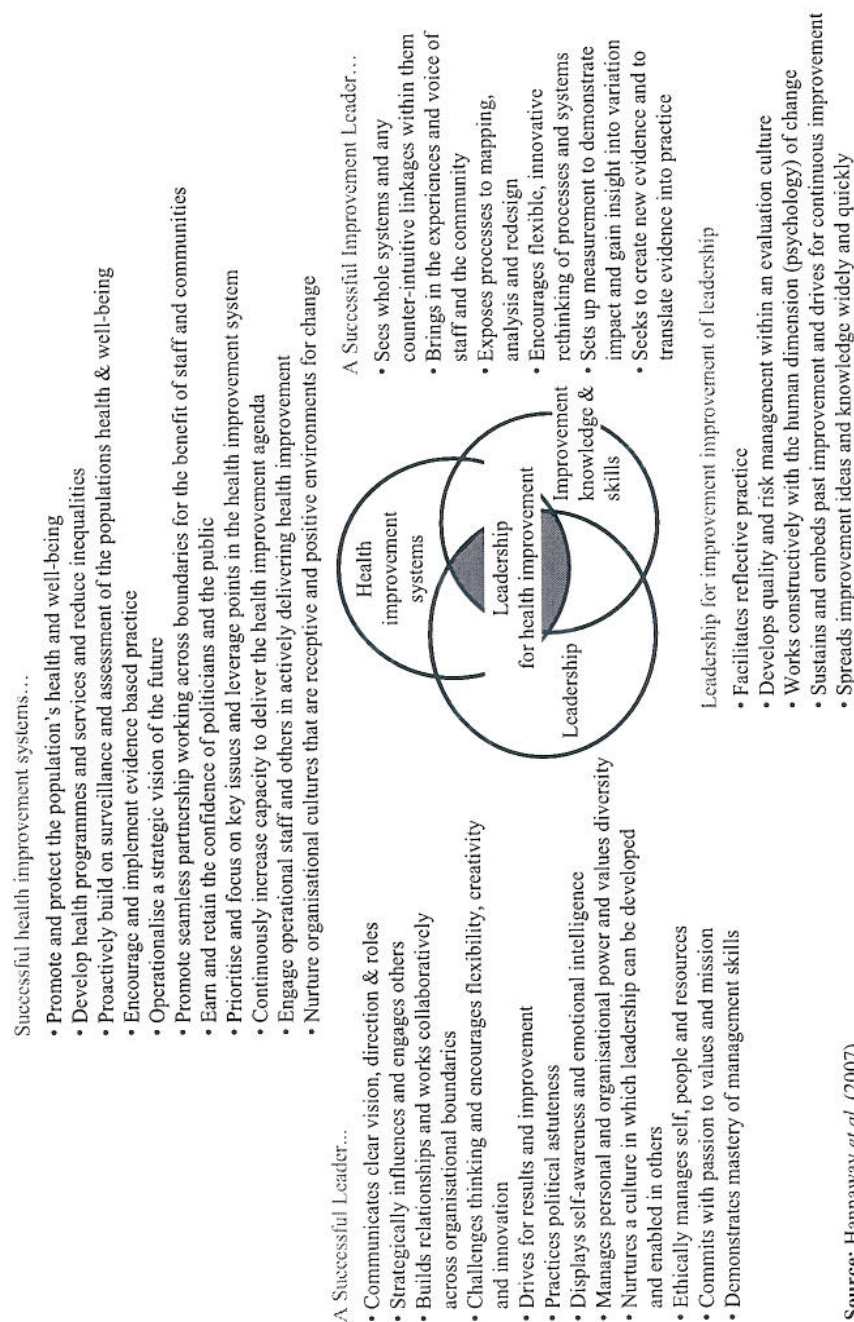
Alimo-Metcalfe and Lawler (2001) have explored what makes for effective leadership, and question how this might be facilitated. This article seeks to address these issues, drawing on the leadership for health improvement programme (LHIP) (Hannaway *et al.*, 2007), and its evaluation conducted by Northumbria University (Carr *et al.*, 2007). This paper presents a co-authored reflection by the programme developers and evaluators on the innovative ethos of the LHIP and the key evaluation messages derived from the piloting of the programme in an English NHS region.

The leadership for health improvement programme (LHIP)
The LHIP framework was developed to address some of the challenges highlighted the previous section. It is focused on the interlocking spheres of public health delivery systems, public health leadership and leadership for health improvement, underpinned by principles of building whole system relationships and understanding and using improvement methods (Figure 1). The programme that was finally launched comprised six learning events delivered over a 14 month period (January 2006-February 2007), and preceded by a launch event and a taster of what the principles of improvement science could offer those working in public health.

Nominated participation was open to individuals in a variety of leadership roles from a wide range of organisations engaged in public health, even if they did not consider themselves to be directly engaged in public health work. The LHIP was developed with an awareness that it would present significant challenges in accommodating the perspectives and needs of non NHS agencies. Despite the programme directors' efforts to enrol non-NHS participants, recruitment resulted in the participation of a majority of people from the NHS. Those who did take part from outside the NHS came chiefly from local authorities, the police, the fire and rescue service, the voluntary sector, and other organisations. Altogether a total of 58 participants registered for the LHIP.

Successful health improvement systems…

- Promote and protect the population's health and well-being
- Develop health programmes and services and reduce inequalities
- Proactively build on surveillance and assessment of the populations health & well-being
- Encourage and implement evidence based practice
- Operationalise a strategic vision of the future
- Promote seamless partnership working across boundaries for the benefit of staff and communities
- Earn and retain the confidence of politicians and the public
- Prioritise and focus on key issues and leverage points in the health improvement system
- Continuously increase capacity to deliver the health improvement agenda
- Engage operational staff and others in actively delivering health improvement
- Nurture organisational cultures that are receptive and positive environments for change

A Successful Improvement Leader…

- Sees whole systems and any counter-intuitive linkages within them
- Brings in the experiences and voice of staff and the community
- Exposes processes to mapping, analysis and redesign
- Encourages flexible, innovative rethinking of processes and systems
- Sets up measurement to demonstrate impact and gain insight into variation
- Seeks to create new evidence and to translate evidence into practice

Health improvement systems

Leadership for health improvement

Improvement knowledge & skills

Leadership

Leadership for improvement improvement of leadership

- Facilitates reflective practice
- Develops quality and risk management within an evaluation culture
- Works constructively with the human dimension (psychology) of change
- Sustains and embeds past improvement and drives for continuous improvement
- Spreads improvement ideas and knowledge widely and quickly

A Successful Leader…

- Communicates clear vision, direction & roles
- Strategically influences and engages others
- Builds relationships and works collaboratively across organisational boundaries
- Challenges thinking and encourages flexibility, creativity and innovation
- Drives for results and improvement
- Practices political astuteness
- Displays self-awareness and emotional intelligence
- Manages personal and organisational power and values diversity
- Nurtures a culture in which leadership can be developed and enabled in others
- Ethically manages self, people and resources
- Commits with passion to values and mission
- Demonstrates mastery of management skills

Source: Hannaway *et al.* (2007)

Figure 1.
LHIP framework

Literature

This literature review is intended to surface some of the issues inherent in the challenge of providing and measuring strategies for developing leadership for health improvement. A pertinent review is therefore provided, which also acknowledges the wider literature base. It therefore explores the current state of knowledge around leadership definitions, definitions of leadership for health improvement, target populations for health improvement leadership development, and how health improvement leadership can be effectively provided and measured.

The precise definition of leadership is much debated, and has adopted different formats over time (Western, 2007; Day and Harrison, 2007). One popular strategy has been to compare and contrast it with management (Edmonstone and Western, 2002). Alvesson and Sveningsson (2003, p. 1436) 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". 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 and Lawler (2001, p. 389) reiterate this, highlighting 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.

This is corroborated by Alvesson and Sveningsson (2003, p. 1,435), who highlight a conceptualisation of leadership as "the extra-ordinarization of the mundane" evident in the special and mystical aura around leadership in the academic literature and the mass media. This potential to right wrongs and salvage from threat is in stark contrast to the activities such as listening, chatting and being cheerful which were labelled under the leadership banner in their research.

A number of authors have questioned the perception of a clear black and white distinction between leadership and management. For example, Minzberg (2004) rejects the distinction on the grounds that managers have to lead and leaders have to manage. Similarly, Goodwin (2006) and Hunter (2007) argue that the two functions cannot be regarded as completely separate.

A brief historical review of leadership theories maps the change from trait to transactional to transformational leadership styles (Alimo-Metcalfe, 1999). More recent definitions demolish the hierarchical construction, and see it as a more widely dispersed endeavour relevant to all levels of an organisation and acknowledging multiple discourses (Bryman, 1996; Edmonstone and Western, 2002; Alimo-Metcalfe and Aliban Metcalfe, 2005; Ford, 2006). In the current leadership discourse, dominance is indeed given to collective, shared, distributed leadership and constructions such as "community of practice" (Kouzes and Posner, 2003; Horner, 1997; Brown and Beech, 2000). The LHIP responded to these recent developments through the recruitment strategy. As a result, participants were drawn from a variety of backgrounds and organisations.

Within the debate around delineation of leadership for health improvement, 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. For example, caution is sounded at the wholehearted adoption of

North American transformational leadership theories which can have a male gender and private sector bias (Gaughin, 2001). Another issue to consider relates to the possible focus of health improvement leadership on improving either health care or health, and how distinct these constructs are thought to be. The underpinning premise is 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. In this context, the LHIP had much to do to implement health improvement leadership, and it is hoped that this paper can contribute to the debate.

Despite the inconclusive nature of the debate regarding the conceptualisation of leadership for health improvement, the evolving policy agenda and academic developments are contributing to the growing demand for a comprehensive definition of health improvement leadership for a diverse professional population (Hunter, 2007). This context of working with a still evolving concept, with which wider professional populations need to engage, posed particular challenges to both programme providers and evaluators.

Connelly *et al.* (1999) report three types of education and training needs with regards to health improvement leadership, related to three distinct professional groups. The first consists of professionals from a variety of backgrounds who need to gain a greater understanding of public health generally, and need to know how and where to access specialist input when it is needed. The second group includes public health specialists who need to hone their strategic management and leadership skills. The third consists of community based public health practitioners, who may need both public health and leadership grounding. One of the key challenges of any health improvement leadership development endeavour, therefore, is the breadth and diversity of needs to be addressed.

Approaches to leadership development have changed over time (Hernez-Broome and Hughes, 2004; Murphy and Riggio, 2003; Pearce, 2007) distinctions between leader and leadership development have been articulated (Iles and Preece, 2006) and the requirements for single and multi-sectoral contexts highlighted (Armistead *et al.*, 2007). There are, however, limited reported templates of how to develop leadership for health improvement. One relevant source is Watson's (2006, p. 4) report on such an endeavour, namely the National Public Health Leadership Programme. This work provides insight into the mechanisms of how public health 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, the authors noted an indirect route to improvements to public health delivery, through personal development:

> 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.

The authors concluded that it was impossible to establish a direct and straightforward link between programme learning and improvement in public health delivery.

McAlearney (2006) identified a number of challenges to leadership development specific to health care organisations. In a conceptual model of commitment to leadership development, the 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 were seen to be the driver in segregating professional groups for leadership development. Another challenge lay in the limited role of organisational learning, especially the neglect of mistakes 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 organisational perspective. From an individual perspective, attendance at individual development events is often constructed as taking time, or money, away from patient care. At an organisational level, training and development budgets are often notoriously high on the list to be axed when the pinch of financial constraints is felt.

The LHIP was developed in large part because it was felt that prevailing offerings in leadership were heavily biased towards health care services and that the few aimed at public health fell short of what was required, as set out earlier in the paper. The LHIP did not attempt to compete with, or replace, the existing National Public Health Leadership Programme. But it did endeavour to focus more on the relationship between the policy and organisational contexts and how it impacted on leadership in specific contexts. It also sought to emphasise the breadth of the public health task and the need to take it outside of a still essentially medical, or medically/NHS-led, model. In its ambition, it echoed the view articulated by Wanless in his review of public health:

> An essential element of "full engagement" is the recognition that the greatest contribution to public health is made by individuals in the "wider" public health workforce, many of whom have job titles that do not mention public health, or even health. The Specialist public health workforce is an essential, but small, component of the public health function and to achieve greatest impact must engage with and harness the resources of other contributors across all sectors (Wanless, 2004, p. 70).

Hence, the programme deliberately dropped the word "public" from its title to signal its appeal to organisations, notably local government, outside the NHS. Despite this, there were fewer participants from local government than might have been desired. This may be an indicator of how health is viewed in local government and, if so, is in contrast to the NHS where similar programmes attract much interest and recruitment is rarely a problem unless resources become squeezed in which case training and development budgets are the first to suffer. But at the time of the LHIP, NHS resources were reasonably plentiful and public health was seen as a deserving cause.

The final issue we wish to address in this literature review is that of the effective evaluation of impact. This is acknowledged as being complex and may be tackled from a range of perspectives such as proximal, distal, individual or organisational (Williams, 2003; PSLC, 2006). Establishing a casual chain of effects and disentangling the leadership development programme impact from that of other concurrent variables has been highlighted as being problematic (Watson, 2006; PSLC, 2006). Drawing on Leithwood and Levin's (2004) model of leadership impact on service delivery, Watson (2006) exposes a time spectrum of impact whereby leadership programmes influence participant's internal processes, which induces changes in their skills, attitudes and knowledge. This, in turn, results in changes in organisational working practices and in

the participant's interpersonal behaviour. This timeline of impacts leads to the achievement of public health goals. With respect to an individual and organisational balance, McAlearney (2006) suggests that evaluation criteria for development programmes such as employee satisfaction should be replaced or supplemented with organisation metrics.

For the purposes of this paper, four key summary points may be identified from the literature. The detail of leadership for health improvement is still being debated, acknowledging that it involves multiple professional groups with multiple development needs. Definitions of leadership and associated approaches to development have changed over time, with a dominant current discourse being that of shared leadership. Evaluation of leadership development is recognised as complex and may be tackled from a range of time and contextual dimensions. Although literature on leadership development and its evaluation is extensive, that relating to public health is limited.

This brief literature highlights the challenges faced by both the LHIP organisers (CH and DJH) in setting up the programme, and the evaluators (SC, ML and JR) in designing an evaluation strategy that could capture individual as well as organisational health improvement leadership development. The evaluation therefore aimed to:

- enable participants to delineate what these constructs meant for them individually;
- explore how their conceptualisation progressed through the programme; and
- examine the practice implications of this.

Evaluation framework
The evaluation required a methodological design that addressed the complexity of change in complex multi-professional, multi-agency and multi-sectoral systems. It was therefore guided by appreciative inquiry (AI) (Hammond, 1998), soft systems methodology (Checkland and Scholes, 1999) and illuminative inquiry (Russell et al., 2004). Soft systems methodology (SSM) was originally developed as an application of systems theory to "human activity systems". Participants identify systems or components of activity influencing a particular endeavour, and consider changes required in these systems to achieve a desired aim. In this case the systems included health improvement leadership regional capacity development, inquiry systems, participatory systems and learning systems. SSM generated an iterative relationship between theory and practice that allowed for conceptualising and further development of the theory underpinning the programme 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 organisation.

AI has developed from organisational development initiatives and contains elements of action research (Hammond, 1998; Coghlan et al., 2003). It has an explicit focus on examining the positive and productive aspects of a situation. AI does not ignore or deny problems. Rather it aims 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.

Illuminative evaluation (Russell *et al.*, 2004) is seeks to clarify critical processes by guiding participants to disentangle the complexity of their experiences and thereby to isolate the significant from the trivial. Feedback from participants reported that this questioning approach adopted during interviews allowed them to move beyond the level of, for example reporting enjoyment and learning during the programme, to be able to identify learning specifics, reveal learning avoidance practices and explain why they were enjoying the programme.

The evaluation involved two distinct components of work:

(1) *Analysis of learning and development experiences.* This component of work employed participant observation methods, faculty conference call participation, in-depth individual interviews, and interviews with organisational sponsors of participants, as well as 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.

(2) *Analysis of the application of learning in practice:*
   - *Individual interviews.* All programme participants were invited to participate in this aspect of the evaluation and a sample of seven was selected to include a variety of organisational type and professional background. They 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.* Participants and their sponsors were invited to participate in a tripartite telephone interview to reflect on the impact of the LHIP 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 was selected, drawing on initial needs analysis data.

Data analysis

Qualitative data were analysed using a thematic analysis framework. 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 use of soft systems methodology (Checkland and Scholes, 1999).

Key emergent messages

This section builds on Alimo-Metcalfe and Lawler's (2001) reference to the shortfalls of the health improvement economy, and places this in the context of the development and evaluation of the LHIP. The following paragraphs are therefore expressed in terms of the needs identified prior to, and during the course of, the programme, and the ways in which they have been addressed.

Needs acknowledged from the outset of the programme
The need for a multi-organisational cohort. In accordance with emerging literature on leadership, the first need to be acknowledged by the programme organisers was that of creating a regional workforce of health improvement leaders. In the early part of the programme, many participants reported appreciating that they were with "strangers", i.e. not their immediate work colleagues, and this allowed them to shift their focus away from current organisational issues and/or difficulties. However, towards the latter part of the programme, with a view to trying to apply their learning in their organisations, a few participants reflected on the impact of being the only organisational representative within the programme, and began re-evaluating their place within their organisational hierarchy.

In relation to this, some participants commented on the strong health service focus of the programme content, a feature reflected in the recruitment balance. This created a context in which it was difficult to capture the interface between the NHS and other agencies/organisations. However, a growing cohesion between participants was observed across the lifespan of the programme. This facilitated discussion and debates relating to roles and organisations and by the mid point of the LHIP, participants were reflecting on the knowledge/expertise/practice that could be, but was not always, exchanged within partnership working. In spite of this, some participants highlighted the difficulties in carrying over effective partnerships between disparate practices.

Needs emerging through programme participation
The need for time out of practice. A substantial number of people commented that in addition to the learning experience, attending the LHIP was also important "time out" for them, representing time away from their day-to-day activities, thinking processes and pressures. This was time when they were being developed and nurtured and where, as participants, they were 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. At the same time, there was a strong sense that, for some, the LHIP had to stand alone, as they reported that they did not have time outside of the events to capitalise on their learning. This may have been affected by the state of turbulence for many programme participants from the NHS, caused by massive organisational restructuring.

The need for learning opportunities to be maximised. Grasping the learning potential of the LHIP was one particular concern. Participants feared a sense of wastefulness, that they were allowing knowledge and opportunity to slip through their fingers. Many participants expressed concern that they would not fully integrate the learning into their knowledge base and repertoire. This may have been avoided somewhat if participants had more fully appreciated at the outset that they were not expected to engage with all the information to the same degree. Cognisant of the breadth of the

public health endeavour, the LHIP offered a wide menu of development opportunities, from which participants were expected to draw on in various degrees, depending on their individual circumstances. From the organisers' point of view, LHIP enrolees were sufficiently senior and mature individuals and therefore able to make such judgements for themselves. The balancing of competing priorities is however acknowledged as a challenging task.

The need to cascade programme learning. Participants reported enthusiasm for sharing the learning from the LHIP with their local organisations and rolling out the learning into their local contexts. Strategies, routes and processes to do so were addressed and enhanced during the LHIP. However, the weight of cultural, political, organisational and financial barriers to change was still felt by many participants. They reflected on how to make change happen in old, archaic systems and how to delegate tasks in order to free themselves from the "doing", to engage with leadership. Both participants and organisers commented on the unease employers can feel towards leaders with strong transformational style within an organisation, thereby emphasising the need for support, system awareness and political astuteness. As they developed these skills, 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. By the end of the programme, a shift could be observed, from a model where participants were concerned about cascading their LHIP learning within their organisation, with a potential impact on other regional organisations, to a model where they had become more literate in terms of cross-organisational working.

Needs addressed by the programme

Many positive outcomes were reported by participants. These related both to new aspects of health improvement leadership development and to the "speeding up" of development processes already underway. Participants reported an increased capacity for self-reflection, an energising effect, an increased political astuteness and confidence as leaders, enhanced strategic thinking abilities, greater awareness of health improvement tools and an enhanced evidence base for practice. Participants reported to have expanded their health improvement and public health vocabulary, and could now use approved language and package their interventions in a more effective way. By the end of the programme, participants evidenced a greater understanding of the systems in which they, and their co-participants, were working.

Participants' feedback on the programme. The overriding feedback was that people were highly appreciative of the quality of the content of the programme, in particular, its relevance, currency, flexibility and responsiveness to participant feedback, as well as its one-year time span. This latter aspect allowed participants to become part of a cohort, to develop networks and relationships, to revisit issues, and generally facilitate a cumulative approach to learning and development. Many participants commented that the relationships and networks enabled by the programme were its greatest asset.

Participants valued having the leading experts on an issue/policy/theory delivering at the events. These speakers generated great enthusiasm and a sense of looking forward to the next event. Participants liked the level of timely and relevant information they received, and the table-top discussion sessions.

Discussions of public health policies and targets, and the complexity of "local" translation of the "global", generated reflection on prevalent discourses and the implications on health improvement leadership practice. By the end of the programme, participants reported that they were more ready to take risks, and particularly valued hearing from other people's experiences in testing the boundaries of practice.

Although the LHIP had proved effective for participants as a relatively "stand alone" activity, a number of people, largely on reflection as the programme progressed, wondered if they perhaps should have committed themselves to engage more with the programme learning in between events. 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 due to lack of personal preparation. At the same time, participants were very appreciative of the flexibility regarding their level of engagement and optional extra curricular activities that were offered to them.

Although there was an overwhelming acknowledgement of experiencing health improvement leadership development as a consequence of attending the LHIP, many participants found it difficult to articulate the specifics of their development process. Lack of engagement in individual needs analysis and development reflection was perhaps influential here. In particular, many participants appeared not to make maximum use of the framework in the early part of the LHIP. However, there was a definite sense that the framework was used more actively by more participants as the programme progressed, and to good effect. Examples of this included participants addressing elements of the framework deemed not relevant to them in the early stages of the programme, and writing action plans both for them as individuals and for their organisations that were guided by the LHIP framework.

There was an overwhelming desire that the LHIP, in some format, should continue to support the application of leadership for health improvement into practice. Encouraged and supported by the programme providers, participants completed the LHIP with a sense that the dynamism generated might be maintained.

Discussion and conclusion
Echoing the results from the evaluation of other leadership programmes, for example that reported by Watson (2006), the LHIP has achieved success. In this discussion, we explore and offer some explanations for this achievement, attempt to highlight the specific attributes of this approach to health improvement leadership development, and clarify health improvement leadership development issues.

The LHIP approach
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 – both 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 education. It seems reasonable to conclude, therefore, that the LHIP has gone some

significant way to addressing McAreavey *et al.*'s (2001) challenge of delineating what effective public health leadership is.

The issue of linear thinking
In slight contrast with the existing literature, for example Watson (2006), in which organisational impact of such programmes has been studied in a linear manner in a search for causal relationships, the LHIP and its evaluation have highlighted the possibility of studying organisational impact in a non-linear, non-static and evolving way. This fosters a conceptualisation of health improvement leadership development as an iterative process, which is contingent upon, but can also thrive against, 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. Participants were facilitated to apply whole system thinking, so that health improvement could ensue at a later stage. They therefore manoeuvred change in a way that might make subsequent health improvement leadership happen in a favourable climate.

Challenges
The evaluation identified six interconnected paradoxes related to the development and delivery of the LHIP. It is suggested that discussion and debate around these key challenges would support and sustain the development of future programmes:

(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 which was in keeping with the scope and range of public health activity itself.

(2) *Current reality versus vision and ambition* – 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 a new programme is rooted in current practice reality, or whether it seeks to work with vision and ambition.

(3) *A two dimensional participation paradox* – The programme was underpinned by two paradoxes resulting from the mix of participants: promoting health improvement as a central idea meant that NHS members were more likely to feel keen to engage in the programme than their non-NHS peers, who might not have seen themselves as having a direct and explicit role in health improvement; and embracing the idea of leadership as a democratic and hierarchically uniformly held responsibility meant that participants could not all be expected to be 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 reflected the LHIP's visionary stance.

(4) *Practice versus principle paradox* – 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 the engagement in health improvement is conceptualised as a journey, this relates to the participants and their organisations' ability to conceptualise health improvement in a way that was both in line with the national policy direction, and that could also resonate with the organisational context.

(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 NHS reorganisation, it could prove particularly challenging to identify organisational learning needs which could stand the test of time.

(6) *The paradox of time* – The final paradox relates to the time frame of the programme. In contemporary public health/health improvement development, people are often looking for "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 and that it needed a time frame of this duration to allow strong networks and relationships to emerge from within the group.

As a consequence, of the LHIP experience, health improvement had become every participant's business. For those who joined the programme already very much "signed-up" to the concept, it expanded their understanding of what health improvement leadership meant for them and their organisations. For those who entered the programme unsure, or perhaps even sceptical, of what health improvement leadership meant for them as individuals and for their organisation, it became much more firmly appreciated as part of their business. The other dimension of being "everyone's business" 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.

Adapting Alimo-Metcalfe and Lawlers' (2001) question of "what is the leadership economy lacking", the LHIP set a considerable challenge for the evaluation. However, analysis of the learning outcomes identified that the health improvement leadership "economy" had been lacking in a number of ways. These included: political astuteness; policy awareness and engagement; self confidence with respect to 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. Many of the participants initially engaged with the LHIP in anticipation of "finding solutions" to their current problems and issues. Although the LHIP did enable participants to do so, it also facilitated a refinement of this desire by assisting in developing an ability more clearly to define situations and, as appropriate, instigate immediate or

longer term interventions. As the LHIP was about health improvement principles for practice, current reality and vision and ambition, it facilitated development of a mindset geared to theoretical insight, the need for quick fixes and straight answers was relativised.

The LHIP developed a creative and innovative approach to leadership development. It included a range of learning style opportunities, such as master classes, key note inspirational speakers, debates, action learning, experiential sharing, day and residential attendance. Future applications of a creative, dynamic and innovative programme such as the LHIP 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 the 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 pathways potential that the LHIP offers. Its value may, however, extend beyond the programme to provide a template for ongoing development and sustainability. The LHIP framework has now been adopted by NHS Health Scotland in an attempt to develop a leadership programme aimed a "middle management" level, using a model of dispersed leadership. South Central Strategic Health Authority are also in the process of developing a multi-organisational leadership programme using the LHIP framework and associated learning from the evaluation.

Finally, what the LHIP has demonstrated above all else is the need for leadership development within public health which has either been limited, seen as too NHS focused, or simply absent altogether. There is a supreme paradox here since public health policy has in some respects never been higher on the political and health policy agendas. Rarely a day or week goes by without there being some public health headline in the media. Yet, the leadership challenge for the most part remains to be met in public health both inside, and more especially beyond, the NHS. We have suggested that public health is everybody's business by which we mean not only that it embraces a number of different professions and organisations, many of whom would not immediately regard themselves as "doing" public health, but also that it must include chief executives, directors of finance, and other members of corporate boards. The LHIP is a start but it has only succeeded in scratching the surface of what needs to be done to equip the wider public health workforce with the relevant skills and insights. There is much still to be done although hopefully the LHIP has charted a clear direction to follow and one which, according to the evaluation, is valued and welcomed.

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Further reading

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