Leading Improvement for Health and Well-being
Programme Evaluation

Workforce and Education, NHS South Central
Public Health Development Programmes

July 2010

Joanna Chapman-Andrews, Camilla Leach, Viv Speller

Towards a healthier future...
Contents

Summary 3

1. Introduction 6

2. Aims, objectives and scope of the evaluation 7

3. Programme aim, structure and resources 9
   3.1 Learning Events 9
   3.2 Workshop sessions 9
   3.3 Online resources 10
   3.4 Academic accreditation 10
   3.5 Participant recruitment 10

4. Evaluation findings 10
   4.1 Recruitment 10
   4.2 Programme attendance 11
   4.3 Networking and partnerships 11
   4.4 Joint ventures 14
   4.5 Learning events – content, structure and approach 16
   4.6 Methodology workshops 18
   4.7 Academic accreditation and support 19
   4.8 Personal development and organisational development 19

5. Conclusions 20

6. Next steps 20
Summary

Background

In 2008 Public Health Development organised for a multi-agency review of leadership education and training across the South Central region to determine, to what extent, leadership for health improvement comprised a part of these programmes. The review was prompted by a growing number of government reports and White Papers between 2002 and 2008 highlighting the need for inter-agency working if health inequalities and the promotion of health and well-being are to be effectively addressed.¹ The review found that whilst many of these programmes examined personal leadership development and leadership as a part of service improvement, none focused on leadership for health and well-being. This confirmed the intention of NHS Education South Central (NESC) Public Health Development and its Professional Advisory Group to commission and pilot a multi-agency programme - Leading Improvement for Health and Well-being. The tender to deliver the programme was awarded to the Improvement Foundation (IF).

Leading Improvement for Health and Well-being

The programme had three aims:
- To develop local leadership capacity in relation to service and quality improvement;
- To deliver health and well-being improvement reform on the ground across South Central;
- To develop effective partnerships across organisational boundaries and build strong local networks.

Invitations for 60 participants were issued across South Central to those working in health and social care including, the emergency services, local government and the third sector. The programme was intended for those working at a strategic level; chief Executives, associate directors and other senior members of staff. The programme started in January 2009 and ran for 12 months. It comprised five learning events and two methodology workshops. The programme included keynote speakers from the public, private and voluntary sectors who had worked across local, national and international arenas. Speakers were selected because of their extensive experience and knowledge of leadership skills, successful partnership working, knowledge of service improvement and the implementation of health and well-being reform.

Evaluation

Recruitment to the programme was high with participants selected from many sectors; however, participants from health organisations predominated comprising two thirds of the cohort. Whilst participant reactions to the programme were mixed, none questioned either the aims of the programme or its overall curriculum. The level at which participants were working within their organisations had a wider spread, between strategic and operational, than was originally intended. At times this led to participants from both groups feeling disengaged from elements of the programme. This might have been addressed by dividing the cohort for certain tasks.

Partnership Working

Issues surrounding successful partnership working proved to be a key area of interest for all participants. As the programme progressed, differing organisational cultures, languages, ways of operating, financial year ends etc., and the barriers that these can pose to the ability of partners to work together to address health inequalities were highlighted. Since 2007 organisations have been required to conduct Joint Strategic Needs Assessments, however despite this and the existence of Local Strategic Partnerships, many issues still remain. Participants would have liked more time to address ways in which these issues can be overcome. They would have liked speakers to focus more on how organisational barriers were overcome, what type of leadership they needed to exercise in that situation – the actual ‘nuts and bolts’ required. Participants requested more time within the programme to reflect on the content of the presentations and consider how these ideas might or might not be implemented in their own organisations.

Participants appreciated the opportunities provided by the programme to network, to share and to learn from each other’s organisations. They commented on the importance of physically meeting together and the benefits that could result. New partnerships were formed as a result of contacts made on the programme. For example, one of the emergency services and a mental health trust are now working together to review and redesign psychological services for staff. The programme provided a non-formal venue for the discussion of seemingly intractable problems and how these could begin to be resolved.

Methodology Workshops

These sessions were well received and, many reported that they had gained the most in these more practical sessions. This was in contrast to comments from several senior level staff who had previously critiqued the main programme for having too great a focus on operational rather than strategic content. The workshops were reported as being the most interactive sessions; they provided the opportunity for deep discussion, exchange of knowledge and experience in a safe environment. The smaller size of these sessions may have produced the right environment for this type of learning to take place. Participants felt that a greater use could have been made of their peers and the ‘experience in the room’ throughout the whole programme.

Personal Development

Most participants have come away from the programme with something that has prompted them to think differently about how they operate in their own organisation and how they approach health and well-being. Some feel it will take time for new skills and knowledge gained to be evidenced in the way work is undertaken and delivered in their own organisations.

Conclusions

This evaluation found that there was a great desire amongst all the organisations represented on the programme to gain knowledge, cross organisational barriers and find ways in which they could arrive at successful and effective partnership working. There was a strong sense of a common purpose between the organisations - the need to create efficient systems, with a greater focus on health and well-being and illness prevention but, at times, participants declared a lack of knowledge of how this could be achieved whilst at the same time meeting requirements to reach their own organisational targets.

The experience of participants relayed on this programme has highlighted that there are occasions when organisations do not have a full understanding of how each works, what level of support they can offer each other and consequently misconceptions arise. Whilst the LIH&WB programme has begun to address the need for greater knowledge and understanding of partnership working, participants indicated that some would like assistance in taking further the work that began as a result of involvement in this programme. It appears important, for breaking down organisational barriers and to overcome the differing organisational language and cultures that exist, that participants are brought together in a multi-agency programme to learn. The benefits of physically coming together for networking, for exchanging ideas, sharing knowledge and peer group learning was expressed very clearly by the participants.
With the impending changes in the structure of public health services, with more engagement with and ownership by local authorities anticipated in the forthcoming Public Health White Paper, the lessons from the LIH&WB programme are all the more important. The programme has demonstrated that, even at very senior levels, there is limited understanding across sectors of organisational structures, decision making processes, financial commitments and ways of sharing information. Understanding each others’ language and organisational culture, building relationships, trust and commitment will all be increasingly vital. The evaluation has also given a number of suggestions of practical changes that could be made to learning and development opportunities to meet these challenges. It is clear that leadership skills will be key in delivering improved health and well-being in the new systems, but as one respondent observed, this should be a new form of leadership for the future; “Which isn’t about knowing yourself but about how you can impact and be a good leader in promoting change and how you can be a good leader in developing systems”. 
1. Introduction

Workforce and Education, formerly NHS Education South Central (NESC) is part of South Central Strategic Health Authority (SC SHA) which covers the counties of Oxfordshire, Buckinghamshire, Berkshire, Hampshire and the Isle of Wight. NESC was established with the purpose of creating learning and development opportunities, realising potential and achieving excellence for all. This programme was established within the Public Health Development programme which formed part of the Innovation and Development directorate. The emphasis on training, education and partnership working is an important component of SC SHA’s ability to achieve its long term aspirations of improving the health of its population by reducing health inequalities and promoting health and well-being as a means of ill health prevention.2

In 2008, as part of NESC, Public Health Development organised a review to be undertaken across a number of organisations to ascertain the provision of leadership training and education for those in the South Central region with a responsibility for leading on health and well-being 3 and to determine the extent to which leadership for health improvement comprised a part of these programmes. The call for the review was prompted by discussion within the Professional Advisory Group (PAG) for the Programme and a growing number of government reports and White Papers between 2002 and 2008 that highlighted the need for interagency working if health inequalities and the promotion of health and well-being4 were to be effectively addressed. The need for successful partnership working has, since 2007, been made more pressing by the statutory obligations on organisations to undertake Joint Strategic Needs Analysis (JSNA) to achieve the commissioning and provision of services that will serve their local communities in response to evidence based needs. The NESC review likewise concurred that the promotion of health and well-being and the reduction of health inequalities cannot be achieved by working in organisational silos; success is dependent upon inter- and intra- organisational working. Organisations with a responsibility for promoting health and well-being as part of their work, and examined as part of the review, included the NHS, Local Authorities, the Emergency Services, Social Care, and the Third Sector.

The NESC review found that whilst there were a number of regional and national leadership initiatives in place for these organisations that addressed personal leadership development and leadership as a part of service improvement, there were none with a focus on leading improvement for health and well-being. An outcome of the review was a decision by Public Health Development and the PAG to pilot a training and education programme for leadership and service improvement in health and well-being as a multi-sector programme, with the aim of building and creating networks capable of adopting a whole systems approach to the delivery of health and well-being targets. A tender document for the provision of a leadership programme – Leading Improvement for Health and Well Being (LIH&W) was issued by the SHA/Public Health Development and a bid was accepted from the Improvement Foundation (IF). The IF was considered to have demonstrated extensive experience of running multi-agency improvement programmes and, more particularly, of running similar leadership for health improvement programmes that had previously been externally evaluated by Northumbria University.5

---

2 ‘Shaping the Future’, http://www.nesc.nhs.uk/pdf/100314_Shaping_the_Future_Workforce_Strategy_


Underpinning the Improvement Foundation’s programme was a model, developed by Catherine Hannaway, David Hunter and Paul Plsek, that adopted a tripartite approach to leadership development and comprised three intersecting domains:

- Leadership;
- Health and well-being improvement systems;
- Improvement knowledge and skills.

Whilst these three domains remained central to the programme, space was available within the model to incorporate the local requirements of SC SHA. Particularly important for SC SHA was a focus on the development of multi-agency partnership working and how to apply national policy for health and well-being in the local context.

The PAG met for the duration of the programme, either in person or via conference calls, together with members of the Improvement Foundation’s delivery team to monitor progress of the programme, and consider how ongoing participant evaluations could be used to inform and shape future sessions. For example, early evaluations indicated the participants’ desire for more networking time and sharing of local best practice. This was noted by the Improvement Foundation Team and made a formal part of the agenda for subsequent programme learning events.

2. Aims, objectives and scope of evaluation

The aims of the evaluation were:

- To assess the development of leadership thinking and practice amongst participants in the context of the educational programme.
- To determine the development of leadership capacity in relation to service and quality improvement for health and well-being across South Central SHA.
- To assess the development of participants’ capacity in leading Health and Well being initiatives within and across South Central SHA and its partner organisations.

The evaluation of the programme comprised three main parts and considered:

- Outcomes
- Processes
- Context

The evaluation drew on mixed-methods data collection strategies, including pre- and post-programme sampling. The data sources used to provide the evaluative evidence for the aims of the project were varied, with the aim of generating detailed evidence. An interpretive approach to data analysis was taken, which sought to identify common themes across the data sources and provide a context for the findings.

The data generated by the respondents have been considered in the context of Kirkpatrick’s four levels of evaluation, which identify different ways of capturing change:

---


Level 1: Reaction – how participants react to a programme;
Level 2: Learning – what participants learn from a programme;
Level 3: Behaviour – whether what was learned has been transferred to their practice;
Level 4: Results – whether changes in practice lead to tangible results.

The sources of the data were:

- Session evaluation forms: from each session
- Leadership Competency self-rating: pre/post
- Partnership Competency self-rating: pre/post
- Service Improvement projects: from participants
- Participant observation
- Semi-structured interviews with a cross section of participants selected by organization, levels of responsibility and geographical location.
- Other documentary evidence, e.g. programme handbooks, presentations, online resources, programme documentation and correspondence.

A key aim of this programme was to foster successful multi-agency partnership working. Therefore, a major focus for this evaluation has been to probe participant views and determine to what extent the LIH&WB programme has enabled them to improve their partnership working and what, if any, further learning needs they may have in this area.

To avoid duplication of data and to lessen evaluation requirements from participants, data between NESC and the IF were, as far as possible, shared. The IF maintained participant attendance records, collated evaluation responses from programme events, listed and monitored participants’ service improvement projects and monitored their self assessment scores for personal leadership development and levels of partnership working. The NESC evaluator was responsible for conducting semi-structured interviews to explore participants’ perceptions of the programme and the design and delivery of entry and exit questionnaires. All interviews were recorded and transcribed verbatim. Informed consent was obtained from participants prior to interview and all responses were subsequently anonymised. NHS ethics approval was not required for this report as it forms part of a service evaluation. All data has been stored in accordance with the 1998 Data Protection Act.

**Evaluation limitations**

Whilst the Improvement Foundation and NESC were agreed on the need to share data for the purposes of evaluation, due to unforeseen circumstances, this proved impossible to achieve. At the end of January 2010 the Improvement Foundation abruptly ceased to trade. Staff were made redundant within 48 hours and found that they were unable to save or access data stored on the Foundation’s website. Consequently not all data collected for this evaluation was able to be accessed and used.

Prior to this, most of the IF’s Learning Event evaluations, along with key summary data, for example Workshop and Learning Event attendance figures, had been shared. Missing for our purposes therefore are the pre- and post- programme leadership scores to determine personal leadership development and the scores to assess levels of partnership working. Neither is it possible to view any participant’s write up or evaluation of their service improvement projects. However, data is available to show the participants’ original project proposals and the teams within which these projects were being undertaken.

Some elements of the evaluation have, as a consequence, had to rely more heavily, therefore, on information provided by the questionnaires and interviews. As the interviews are based on responses from (19) 33% of the cohort, whilst significant, they cannot be assumed to be representative of the cohort as a whole.
3. Programme aim, structure and resources

The primary aims of the programme were to:

- develop local leadership capacity in relation to service and quality improvement;
- deliver health and well-being improvement reform on the ground across South Central;
- develop effective partnerships across organisational boundaries and strong local networks. 

The programme ran for 12 months and comprised five Learning Events, held at approximately two monthly intervals, augmented by two, one day methodology workshops. The first and last Learning Events were two day residential sessions; the remainder were one day events. Participant attendance at the Learning Events was advertised as essential, attendance at the methodology days was optional. Venues were chosen, as far as possible, from those that had worked to minimise their carbon footprint and in locations accessible by public transport. Venues were selected from across the South Central Region with the intention of inviting local Directors of Public Health to “host” the start of each event and enabling equity of total travelling distances by the end of the programme for participants.

3.1 Learning Events

The Learning Events included keynote speakers from the public, private and voluntary sectors who had worked across local, national and international arenas. The speakers were selected because of their extensive experience and knowledge of leadership skills, successful partnership working, knowledge of service improvement and the implementation of health and well-being reform. The agenda for each Learning Event also included participant debate, showcasing best practice from local projects, and opportunities for peer networking.

3.2 Workshop Sessions:

The two one-day methodology sessions, held in the North and the South of the region, were designed to deliver identical content and run by two trainers external to the IF’s team. Both trainers had personal experience of leadership and change management in addition to knowledge of, and training in, the delivery of leadership training, personal development techniques and service improvement methodologies. The workshops were structured around small groups and functioned in part as action learning sets. Topics covered in these sessions included: development of an awareness of self, engaging others, effective communication, project management skills, skills for successful partnership working, change management and the implementation of service improvement methodologies. Participants were introduced to Plan Do Study Act cycles (PDSA), process mapping, gap analysis, measurements to determine improvement and change, as well as Honey and Mumford’s learning styles and Myers-Briggs Personality Type Indicators (MBTI). At the request of participants, the LIH&WB programme was extended to include the opportunity for individual MBTI assessments and a subsequent interactive session on the use and application of MBTI – Valuing the Difference.

An essential part of the LIH&WB programme was the undertaking of a service improvement project (SIP) related to each of the participant’s area of work. The methodology workshops provided the space whereby the design and delivery of projects could be explored and trainer and peer group support given.

Participants were offered support to undergo and receive feedback from 360 degree assessments. However, the IF team report that this option was taken up by few of the participants. A telephone coaching session with a member of the IF team was also made available for participants. Ongoing coaching sessions were not a feature of this programme.

3.3 Online Resources:

All Learning Event and workshop presentations were posted for participants on a password protected site, hosted and managed by the IF. Further resources, including additional reports, journal articles and web links to other sites of programme interest were placed on the site. Online assessments and questionnaires were

---

8 As stated on letter of invitation, October 2008.
provided for the participants to complete, enabling them to monitor and reflect upon their personal leadership development, approaches to partnership working and the progress of their SIP as they moved through the programme.

3.4 Academic accreditation
Participants were able to register with Teeside University for M Level accreditation (30 points) for work undertaken as part of the LH&WB programme. Points could be used for progression to a full Masters degree with Teeside or accrued for transfer to academic study elsewhere. Academic support and online resources were provided by the University, with personal tutorials available at the programme Learning Events, if booked in advance. The tutor could also be contacted via phone and email.

3.5 Participant Recruitment
Programme invitations distributed across the South Central region stated that this was a high level programme aimed at Chief Executives and other key senior officers (Associate Directors or Heads of Department) in organisations which have a part to play in reducing health inequalities and the promotion of health and well-being across the South Central region. Invitations were signed by South Central’s Regional Director of Public Health, and endorsed by the Government Office of the South East (GOSE), NHS South Central and The Improvement and Development Agency (iDeA). The programme was advertised as a multi-sector programme aimed at making a significant contribution to developing mutually supportive relationships across organisational boundaries to achieve sustainable improvements in addressing health inequalities and the promotion of health and well being. Recognising that it is often difficult for people who have participated in off-site leadership training, to implement service improvement and organisational changes upon return to their own organisations, this programme encouraged participants to apply in teams. It was hoped that if participants had a nexus of support within their organisations the delivery of service improvement and change might be more easily realised. All participants were required to submit applications giving clear reasons for their wish to join the programme and how they anticipated it would help them in achieving their organisation’s health and well-being goals. Each application was required to be endorsed by a high level member of staff, preferably the participant’s CEO. Programme fees were funded by NHS South Central, travel and accommodations costs were funded by the participants.

4. Evaluation Findings

4.1 Recruitment
Recruitment to the programme was high with places available for 60 participants. Initially the programme was oversubscribed, eight participants resigned between the launch event in November and the first Learning Event in January 2009, the reasons for which were not given. However, their initial applications show that of this number six withdrawals were from Heads of divisions, CEO’s, Area Directors and Assistant Directors. It would have been helpful for the programme to know their reasons for withdrawal. Of the 60 participants who began the programme a further two withdrew due to change of job location and maternity leave. Whilst participants included those from Local Government, the Emergency Services and the Voluntary sector, these groups formed just under a third - 32% of the total cohort. The majority came from a health background such as the: the NHS, Public Health, the Health Protection Agency, and Health and Social Care. Participants from all organisations were keen to learn from each other and stated they would have liked there to have been a more even spread of the organisations in attendance. At times those from Local Government, the Voluntary Sector, or the Emergency Services felt they did not have enough of a voice and were not large enough in number to have contributed as much as they would have liked to the programme.
It was noted by participants that there was little black or minority ethnic representation amongst the cohort. If the programme were to be run again thought may need to be given as to how a more balanced representation of organisations and participants could be achieved.

---

http://centres.exeter.ac.uk/cls/documents/LSWreport2.pdf
Whilst the programme was advertised for those working at a strategic level, observations were made by some participants that there was a wide spread of levels of responsibility amongst the cohort. It was felt that this may have necessitated the programme having to address two levels of need simultaneously - content for those employed at strategic level and content for those working at an operational level. Some wondered if this led to a lack of coherence in the programme – having to cater for a wider spread of need. Additionally, the differing types and size of the organisations represented meant that parity of roles between organisations could not always be guaranteed, thereby affecting the levels at which participants were working and possibly their differing expectations for the programme. One suggestion to the IF to address this was that the cohort could have been divided into two groups.

4.2 Programme attendance
Attendance at four of the five Learning Events totalled 70% or above. Attendance at Learning Event 4 in September registered 45%. It is not possible to state conclusively why the numbers dropped for this event but the high percentage of participants working in areas directly related to health may have been affected by the emergence of swine flu. This became an increasing national concern for the UK from April 2009 onwards. The Improvement Foundation reported that several participants found their work now involved increased duties as a result of swine flu which seriously compromised their engagement with the LiH&WB programme both in terms of attendance at the learning events and their delivery of work based service improvement projects. 18 participants attended three of the Learning Events, 16 participants attended four events and 18 participants attended all five Learning Events. In total, 90% of the participants attended over half the Learning Events. The optional workshop sessions were attended by 64% of participants for Workshop 1 and 50% for Workshop 2. Therefore the perception by some interviewees that numbers dropped dramatically during the course of the programme are not borne out by the attendance registers.

4.3 Networking and Partnerships
The programme focus on the development of partnership working and the opportunity to network, learn from peers and develop a whole systems approach to addressing health improvement was a key attraction for many of the participants in applying. This was highlighted consistently by participants in their initial applications, session evaluations and exit interviews.

<table>
<thead>
<tr>
<th>I wanted the opportunity to see how other public and voluntary sectors lead, manage change, make partnerships work, problem solve and to network with individuals (Emergency Services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>We both work in Acute Care and we’re both very silo focused. We haven’t enough time to—we struggle talking about medicine and surgery, never mind with the outside world, so I was really looking forward to meeting with people from Local Councils and PCTs and things. And, yes, taking a bit more of a partnership approach and a bit more of a broad look at health… (Health)</td>
</tr>
<tr>
<td>[Attracted]... because of the opportunity to look specifically into health and Well-being and because it was multi-agency. So, it was an opportunity to hear about leadership from the perspective of some of the partners that we work with because I think that would be really helpful in knowing how to work with them more effectively. (Health)</td>
</tr>
<tr>
<td>Because Mental Health Trusts seem to be quite isolated in some ways; they don’t seem to necessarily find out about a lot of the initiatives that are happening in mainstream practice...there are no formal arrangements, as such, for partnership working between our Trust and other organisations around physical health and well-being...so to cut a long story short, that was one of the big appeals of joining this course was it was an opportunity to look at some of these partnerships and find out more about work that was happening and how we might link in. (Health)</td>
</tr>
<tr>
<td>What I actually found attractive was to be able to work in a multi-disciplinary team so that I could spread my knowledge about things outside the normal NHS that I would get involved with Local Government. There was a person on the course like X who runs a Supporting People project at a County level. There were all sorts of—I knew there was going to be a mix on that course. (Local Authority)</td>
</tr>
</tbody>
</table>
The idea that I might learn something new about leading partnerships and in settings where agendas are different and work with a slightly different focus from my normal approach. (Health and Social Care)

The programme was successful for several in creating completely new working relationships and enabling greater understanding of the logistics that need to be addressed in achieving successful partnerships. Participants mentioned being able to have conversations about ‘wicked issues’ in a non-formal setting and sharing ideas on how these could be resolved. The importance of developing personal relationships in order to achieve change was stressed.

...I would say especially with X from Social Services because, although we know in theory that our organisations work together, some of the conversations we had about the frustrations of that and the reality of that, were really very useful, just as background political information on what’s going on. (Health)

Understanding that there are differences in budget setting processes and timing, and all that sort of thing between organisations is useful. (Health)

...before you can engage with partnership working, you need to know more about what you’re engaging with and how you engage...I think it did make me think about people’s organisations and how they were structured differently and how their decision-making structures were different from ours. And their ability or lack of ability to commit resources was different, so yes, it did make me think about the partnerships. (Local Government)

It’s been easy for me in the past to say, ‘***** NHS, they’re all a load of pen-pushers creating extra work for me’, and I think that I’ve got a greater understanding now, of what they in turn are having to contend with. This makes me more sympathetic to them. But, also once you know that, you know how and when and what to talk to them about. So, if I want to go to them with a funding application or I want to talk to them about how a project’s progressing, I can understand what some of their trigger points are and talk in the same language. (Voluntary Sector)

...it comes down partly to personalities and relationships because you’ve got to get by. You’ve got to get innovative Chief Excs who both trust each other, who respect each other, in the sense of their own management abilities, and we drop the ‘them’ and ‘us’ and we get on with achieving an improvement for the population. (Health)

Input from a partnership could take several forms. Sometimes partners did not require financial input but instead wanted to share and learn from a partner’s specialist knowledge. In one instance a relationship, formed between one of the emergency services and a mental health trust as a result of contact made through the programme, has now progressed to the stage of formal tendering. The project is to review and change the current provision of psychological support provided to staff. Other participants too have been able to learn from and utilise the experience of others.

...we’re now in a position where we’re going to move to a formal contractual process – I just happened to be sat down with X from a Mental Health Trust...and it was just interesting that he put me in touch with the right people...with making that link they were able to reflect our thinking; were able to tell us whether it was reasonable; whether it was do-able; what the cost implications were; what other opportunities were available to us.

Until I met them, I didn’t know anything about the Government initiative, IAPTS, the Increased Access to Psychological Treatment Services; didn’t know about that, that’s something we can look into. (Emergency Services)
Well, we landed up trying to talk about information and being able to swap information across organisations... (Local Authority)

Because I’m already working very closely with the Fire Service in Oxfordshire...I was able then to get in touch with those particular firemen from Hampshire and let them know what we’re doing in terms of sharing data from the emergency department with our Community Safety Partnership. So, hopefully, I was able to help them take things forward in Hampshire, because we’re a bit ahead of them on that one...so that was a useful link I think. (Health)

I’ve networked well, for example, today, and between the last two sessions, I’ve got together with the people from X around Health and Well-being posts within Occupational Health because we want to get that funded at our Trust and share job descriptions, and X is going to share some evidence and cost-effective business case research, really, to demonstrate the benefits of creating more support within Occupational Health. (Health)

Through contacts made on the course we are looking at possibly developing some form of older people health trainers.

I’ve now got some really good links with Public Health...See them as my support for bringing in health and well-being. DPH for X now wants to work more closely with us. (Health)

Whilst successful entrées into partnership working were initiated as a direct result of the programme, participants still felt that this was an area where more work was needed and where greater use could have been made of the experience and knowledge of the IF team and the programme cohort – ‘the experience in the room’. The issue of differing organisational cultures and language as a barrier to partnership working were mentioned frequently by participants. One reflected that the term ‘Health and Well-being’ was not of itself a constant but was interpreted according to the focus of the organisation using it, illustrating the necessity to ensure that there is a full understanding between partners before the commencement of a joint venture. Some programme speakers also, inadvertently, through their own presentations demonstrated how barriers can arise and how these issues can impact. Despite a key focus of the programme being partnership working and the increased development of a whole systems approach to health improvement, at times, the language used by speakers and the approach taken, led to some participants experiencing feelings of separation and exclusion. The programme was critiqued for having too great an NHS bias. Longstanding NHS staff reported that at times even they were unable to comprehend the acronyms and NHS jargon. Likewise, when content more pertinent to Local Government was under discussion the barrier swung the other way. Consequently participants requested more help breaking down cultural and language barriers to ensure a greater chance of creating successful partnerships.

It was billed as cross agency but it wasn’t really. So many times speakers had to apologise because of yet another health example being given. I don’t think the course was thought through. (Voluntary Sector)

I think a strong criticism I have is that there was a lot of use of Health Service words that even I didn’t know. I felt that people outside the NHS would struggle even more...I thought it was too heavily an NHS focus, given that it was a multi-agency programme...if it was multi-agency we needed to use less jargon. (Health)

It’s just hard sometimes to make the link back to what you’re actually doing at work on a day-to-day basis...because I don’t work in Public Health...it was quite hard to keep up with acronyms and the paradigms and things, that people were talking about. And then to be able to apply that back to actually what it means on a day-to-day basis in terms of delivering health care. (Health)

At the last event there was a lady there who was the Director of Public Health in X who said to us ‘Are you getting anything out of this?’ And I said, ‘Not really’. You try—after the first couple of days, you really try and think about things laterally and it was becoming more and more difficult...People on that table were
very kind to us and kept telling us all the jargon, I know our service is full of jargon but there were some acronyms there that I couldn’t work out...it’s almost like, if you’re getting people from other agencies, you want a jargon buster on the back of the form each time...Some you could actually work out but others were just completely bizarre and very specialised within Health. (Emergency Services)

The very last session talked about place-shaping. Place-shaping is very familiar ground to Local Authorities but it was a different language to the NHS and, suddenly, it was something that had engaged us – that we knew about – but it really made me think just what different worlds the two organisations – the NHS and the District Councils and County Councils live in. And there are certain people from those two sets of organisations that interact through Local Strategic Partnerships but the vast majority of those organisations have nothing to do with these joint agendas. (Local Government)

4.4 Joint Ventures
Participants mentioned frustrations they had previously experienced at their difficulties in working with wider partnership initiatives to address health inequalities because of an inability to find a way to link this work with requirements to meet their own organisational targets. It was hoped that the LIH&WB programme might provide either the knowledge or skills to overcome these obstacles. One participant noted:

The challenge is always how to effectively lead an agenda when some of your leadership is explicit; other is non-explicit, where actually it requires everyone to be signed up to an agenda but, actually, most people are signed up to multiple agendas. And, so it’s charting a course though what can get very muddled, very confused, very distracted because there are so many other strands of work going on. (Public Health)

Whilst the Learning Events showcased successful local projects, participants reported that they would have liked to have heard more about the process or journey that the presenters went through before reaching their endpoint. How did they manage organisational and geographical barriers? What type of leadership did they exercise in order to overcome problems and reach a successful conclusion? A Director of Public Health (DPH) reported feeling that discussions at the Learning Events did not go deep enough. One multi-agency project team, formed as a result of joining the programme felt that the failure of their project, as originally intended, exemplified the problems they encountered in joint ventures. The team included those working in Health, Local Government, the Voluntary Sector and the Emergency Services. Interviewed individually, with the opportunity to speak freely, team members made the following observations:

We were trying to get a [County] wide project —it was the Director of Public Health for X, who was also on the course, who was very keen that we had—that we used this as an opportunity to do a large partnership project which involved everybody from the area who was on the course...we recognised that probably all of us were targeting similar households and that, actually, probably there were many different people from different organisations all going into the same household. So, the idea was that we looked at streamlining that, at using actually, X [Emergency Service] as almost a first point of contact who could address a wide number of health issues and health problems, themselves by first going in and knowing where to signpost people if they highlighted an issue.

...I think, probably, it didn’t tick boxes for everybody within the group, so there was difficulty with everybody feeling engaged. For example, X [Voluntary Sector] covers an area that, as a Trust, we don’t cover...for me it didn’t fit particularly well with my work programme; I couldn’t very easily see a link to my role.

...I felt it would have been good to have more time committed within the course to do some of the thinking...and it was quite ironic—I can remember reflecting afterwards that we’d had presentations during the morning from people about partnership working and the challenges of partnership working...but I think we all forgot about what we’d just been learning about in the morning...perhaps if we’d pulled some of that learning into some of the discussion...we could have used that as quite a nice learning exercise. (Project Team Member 1)

I think we start too many partnerships up locally and regionally where, okay, there may be a project in mind but the first thing is let’s start with the Steering Group. But then, often, as has happened with our group, is nobody’s
prepared to take the leadership role because it involves more work, it might involve some financial input into it. Because, every member of the partnership is up to their eyeballs in work already and the incentive for them to deliver on the project is not high enough to enable them to do that.

I think the partnership thing was difficult because you had a lot of people there at different levels – management levels, if you want to put it that way. I think if everybody had been Heads of Service or senior management or whatever, it might have been easier to have formed those business bonds. But you had some people who were—you had the strategists and you had the operational people mixed in...And I think that it was probably complicated by those different tiers of management, there, plus the fact that, of course, some people turned up and some people didn’t turn up on odd occasions so you lost the continuity. (Project Team member 2 – Voluntary Sector)

 Tried to form a partnership with X County Council and it got too big...we wanted another agency to take the lead but we just couldn’t get one to do it and that’s the disappointing thing about it.

Language was a problem, obviously, in the beginning—But I think we all started to ask ‘Just stop there will you? Can you just explain what that is?...I think we all started to recognise that we could share information quite easily. And then—I think it’s—when they went back to their day jobs, they were all too busy and nothing ever came of it again; it was waiting for the next instruction to go.

And we thought we had everybody on board and then there were one or two who said ‘Well no this won’t achieve what I want to achieve...And that’s what you sometimes find in partnership working; if somebody’s not comfortable, they won’t commit. Bearing in mind that this could have been something that could have been delivered and actually processed and brought through and now been delivered today but it wasn’t the focus of their attention. (Project Team member 3 – Emergency Services)

We started off with a joint project which was an absolute disaster; it was supposed to be across the Emergency Services, a Voluntary Sector, a Trust, ourselves and it was just unworkable the group was too big. And we’ve landed up with two of us doing—looking at some issues: one looking from a County end and one looking from a District end. So, we’re doing two completely separate write-ups about a very similar issue. (Project Team member 4 – Local Government)

A reflection of one team member was that it would have been helpful to have received facilitation from the programme team to see how theory delivered as part of the Learning Events could have been applied and a successful project outcome achieved.

In contrast, another multi-agency project team working in a smaller geographical area was able to cross organisational barriers enabling the team to work collaboratively. However, it must be noted that this project did not, at this stage, conflict with existing organisational targets. The team acknowledge that without participation on LIH&WB programme the project is unlikely to have been started. The project aimed to raise understanding amongst local leaders of the importance for each organisation in working together towards the goal of improving the health and well-being of their population and the part that each organisation could contribute. This was considered particularly important for those who, traditionally do not see that they have a part to play in this area:

Politically, we’ve got people who think health and well-being is not on their radar.... this was about us trying to find that common agenda of Public Health and if we hadn’t, if I personally hadn’t done this,[the LIH&WB Programme] then I wouldn’t have met colleagues from the PCT on this subject. We would have been talking to ourselves a lot and we would have left it to the people who have got the name Director of Public Health or Head of Health Improvement in the City Council. So, we wouldn’t have met other colleagues like X, like Y, others who are equally engaged in the PCT, not necessarily mainstream Health and Well-being but... (Local Government)
For this team, the project arose from discussions generated, in part, by their reactions to speakers at the programme Learning Events. As their own awareness around leading improvement for health and well-being grew, they wanted to raise awareness among others, particularly their local leaders. ‘I see where that comes into housing now, I see where that comes into children, I see where that comes in fire and rescue...’ They realised that the impact of their work in this area may not be immediately visible but are hopeful that it will become so.

‘...we have to accept, don’t we; we won’t see necessarily the impact of what we’ve done until maybe some time down the road. There might be this Eureka moment that the leader suddenly says ‘Oh, and health...’ and some health and well-being statement goes right to the forefront of his political statement or agenda. And we’ll say, ‘Oh, maybe we fed that in, in terms of our own leadership’.

The presentation given by this team at the end of the programme generated much enthusiasm amongst their peers. The team were frank in their discussion of the problems that they had encountered. The project had not been straightforward. As a result of early findings original plans had changed and the project was not completed but ongoing. The team talked about the difficulties of finding time for the project and the importance of the support that they provided for each other to keep it going. Feedback from the audience was that they would like to know how the work progresses.

Both multi-agency teams acknowledged the role of the LIH&WB programme for stimulating their thinking, and prompting them to look for new approaches to joint working at both strategic and operational level. The increased importance of joint working is highlighted in South Central SHA’s workforce strategy ‘Shaping the Future’, which stresses the necessity, especially given the current financial climate, to deliver improved and more efficient services by working together across all agencies to develop a workforce capable of meeting the health and well-being needs of the local population. This document states that South Central will work with service providers to improve integrated working by removing the barriers between health, social care, the third sector, community and primary care that may hinder the development of local policies and contracts.  

Whilst the LIH&WB programme included sessions on the challenges of partnership working, the experiences of LIH&WB participants indicate that further work and assistance is still required to help South Central achieve its aims for joint working.

4.5 Learning Events - content, structure and approach
Responses to questions surrounding the content, structure and approach of the programme often reflected the participant’s own level of working within their organisation and as a consequence their particular needs. As mentioned above, those who were working at a strategic level would have liked greater discussion of government initiatives. One participant commented:

‘I’m working at Director Level and I suppose I wanted a bit more challenge around policy, strategic influencing...I probably got more when we had input from opinion leaders or policy people. I think xx’s input was useful; because he can really poke around with what’s going on, what does that mean in practice’. Another senior level participant noted ‘I guess we were expecting it to focus on many of the very senior level and real challenges about making change happen in partnership working. It got there; it touched on lots of stuff but...’

Others, less senior, or more operational in their roles, found the programme too academic and gained inspiration from the showcasing of local projects which perhaps resonated with their own work. With the wide spread of working levels within the cohort it would, however, be hard for the IF team to achieve accord amongst all participants for the totality of the programme. Participants did appreciate being introduced to new ideas, for example, the opportunity to discuss the import of the Marmot Review across organisations.

---

10 NHS South Central ‘Shaping the Future...Workforce’, http://www.nesc.nhs.uk/pdf/100314_Shaping_the_Future_Workforce_Strategy_Draft_15.pdf, p.31
Some presenters were able to speak across organisational divides, negotiate language barriers and resonate with a wide cross section of the participants. Particularly noted were Jim Easton, Beverly Alimo Metcalfe and Paul Plsek. Paul Plsek’s session on Creative Leadership was cited by some as inspirational and should have formed the start, rather than the end of the programme.

[Paul Plsek] He was just so inspirational. Walked away from that session thinking, I wish I’d heard a lot of this a long time ago. So, taking in ideas from other industries; saying about looking at the fast food industry and seeing how they actually work their system; looking at the flu clinic in the Virginia Mason in Seattle, seeing that it was a drive-in clinic, that just opened up all sorts of possibilities, to me, which I’ve gone away and thought about. And I feel that they are practical things that I could take along to the Trust and say, right, okay, we don’t need to have this big structure; we can do this, and do this very easily. He was incredibly inspirational.

The agenda for each Learning Event listed objectives for the event but these were not always observed by participants in the content of the day. One participant commented that there was not enough of a reference back to the model that had introduced the programme, that whilst each of the three domains had been separately addressed, little focus had been given by any of the speakers to the model’s points of intersection and perhaps speakers should have been better briefed on this. Some commented they would like to have left with clear outcomes that could be transposed to their own working environment. There was a feeling that each of the events could have stood alone as an independent study day. There was a lack of coherence between one event and the next. The following comments came from staff working at a senior level in Public Health and a PCT.

Yes, I think there have been some really good pieces in the course but I think the other thing is trying to look ahead to see what was coming next. Sometimes the – I know the agendas came out in good time; it wasn’t obvious where the next level you were going would take the course, I think, from one month to the next; it wasn’t obvious to me.

I think it would have been helpful to have a product at the end of the day. To take a scenario and work through a scenario with some input at the beginning and say, ‘Right at the end of the day, what you are going to have —? ’ So you can actually take away how you are going to re-brand, re-launch a Local Strategic Partnership.

I think being able to come away from a session, feeling as though you had tools that you could readily use, you might argue they were already there – perhaps we couldn’t see the wood for the trees – but certainly on the last session we went to with PP, I certainly came away with the handouts from his PowerPoint and have started to use those in other presentations because I had tools to use, and that would have been nice to have been able to do every time really.

...the agenda should have been around the biggest challenges and, then, some tools and paradigms we’re working within, and then doing the business in days, the theory of planning and then being equipped at the end of the day is to take it out and start using in practice.

The programme has not been critiqued in terms of its aims or the topics chosen for the Learning Events but suggestions have been made for changes to the structure of the days. It was felt that some of the sessions were too crammed and too rushed. Participants wanted more time for reflection, time to consider how the topic might impact on their own working environment.

Comments were made that there was a large amount of professional experience amongst the programme participants themselves that was not ‘tapped into’. Participants noted that in some fields people did not need to work in partnership to meet their targets but that their working could be enhanced if they did at least talk to others. Participants stated that at times, they realised others in the programme only had a shallow understanding of what their organisation did and it was through talking at joint learning events that this could be changed.
I thought there were some good things to learn, from frankly, what other people had done. There was, it struck me, that certainly from the world of Health Improvement, Public Health initiatives, a huge amount that’s done that’s experimented with and lots of very practical lessons to learn. But actually finding a way through the evidence base is complex. And it struck me that there were bound to be people knocking around the network across South Central who had useful things to contribute in terms of things done, things that didn’t work, things that did work, that would be useful to learn from. (Local Government)

...you can get very comfortable in your own area of work and believing that you know what you’re doing and the way forward but, actually, there are very different ways of doing things, and I think talking to people from other types of organisations just reminds you of that. (Health)

Some participants expressed the view that they had not mixed or talked as much as they would have liked with the other participants. Suggestions to overcome this have included more ‘free’ time in the programme, the programme to become totally residential, the IF to be responsible for setting the groups for table work, sessions to be more evenly divided between outside speakers and learning sets and for the days to have a theme e.g. smoking, alcohol, safeguarding children and each participant to share how their organisation could contribute and work with others in these areas.

4.6 Methodology Workshops
These sessions concentrated on operational tools and service improvement methodologies and were the sessions that drew the most enthusiastic responses from participants including those working at a senior level. The delivery by the trainers, the curricula and the mode of delivery were all highly spoken of. One interviewee, working at a strategic level, when asked about the contradictions contained in their responses between criticisms of the programme for focussing too much on operational rather than strategic issues, and their enthusiasm for the methodology workshops, thought that this may have been because in the workshops they found information with which they were familiar and consequently they felt on more of an equal footing with the other participants. At the Learning Events the large size of the cohort and the dominance of the NHS in terms of language and examples, meant that coming from a non health background this participant felt excluded for much of the time. In the workshops the improvement tools provided a focus and points of discussion that were able to cross organisational boundaries. As the groups were smaller, participants said they found it was an opportunity to engage with others at a deeper level. Participants received support from the trainers and their peers in how service improvement methodologies could be applied in their own work. They discussed approaches that had already been tested in their own organisations and shared the successes and failures of these with the group. The participants provided evidence that almost immediately, knowledge and tools gained from these workshops was being transferred into practice (Kirkpatrick Level 3) and cascaded to others in their work environment.

But then I would say the last two sessions – the one at Milton Hill and the one where we did the Myers Briggs stuff, the Myers Briggs was quite an interesting one because that was the first time that I felt that there was any real bonding between the people in the room, in that they all felt that they were getting to know each other and had some sort of common purpose. And that’s when it really perked up for me, and I got to know people more in that day at Winchester and then Milton Hill than I had in all the sessions beforehand. (Senior level participant)

I ran a big workshop on the use of resources at the beginning of November with the Audit Commission with people from the County Council and the PCT to look at what’s happening on these. And I’ve used some of the techniques that I had talked about to map out what we’d been doing, to present some of it...I’ve consciously used some of those methods to help—partly to present evidence and information but also to ask people questions and gain engagement...I was slightly surprised that those workshops happened three or four or five events into the programme. (Senior level participant)
Future courses should consider carefully how, irrespective of the size of the cohort, a feeling of cohesion and a sense of belonging can be created amongst the participants. Particularly important if the advantages of the sharing of knowledge and the benefits to be gained from peer group learning are not to be lost.

4.7 Academic Accreditation and Support
The availability of the tutor and the support provided by her was well received and appreciated by the 15 participants who chose to take up this option. They reported that the tutor was proactive in contacting them each time new material was added to the University website and in making herself available to give tutorials at the Learning Events. The blended learning approach of both face to face and telephone contact combined with e-learning was positively received. For some there was a difficulty in finding an operational project that they as someone working at a strategic level could undertake, normally this type of work would have been passed to other members of their team. There was also a difficulty in aligning projects with academic submission dates. The time required to pass project proposals through internal committees before work could begin, or the reality of the time required to implement and deliver a project, meant that some found it impossible to complete and write up in time for the academic submission dates and extensions had to be requested. In all instances where this was the case the University was able to accommodate.

4.8 Personal Development and Organisational Development
Whilst participants have, at times, negatively critiqued elements of the programme, or made suggestions for improvements should it be run again, on further questioning nearly all who responded have indicated ways in which they have personally gained or found something to take back to their organisations. There was an appreciation of the soft skills – communication, working with others, personal insight. An awareness that leadership does not necessarily have to be leading from the front – quiet leadership can be just as effective. Service improvement methodologies and a variety of project management tools are already being cascaded by participants to teams in their own organisations. Discussion of the Marmot review led one participant to have this as a focus for a study day in their organisation, and as a consequence they were prompted to submit a response to the review. Another has commissioned the Improvement Foundation to run a leadership programme for their staff. The programme has created, for one team, an awareness of the importance of a whole systems approach and they are now looking at the whole patient journey, the people and organisations involved before the patient arrives in the Trust and how they can work together. Some participants have reported increased self confidence in leading and setting organisational direction. One team is working on raising the profile of public health and exercising influence in an area where public health is not usually given consideration.

The programme has caused us to go our way to make contact, yes especially around planning, to actually draw planning people in to the meetings...to get involved in their processes...often planners can be very focused on getting a planning application turned around in eight weeks rather than the health and well-being effects of their planning policies. And, so, as a result of that we’ve got planning people in to the meetings and had some frank discussions. And, I think, from their point of view there’s been a recognition that they’ve not really considered these aspects before; it’s drawn them into looking up some of the NHS publications on planning and public health and created a new area of interest for them...I think it’s about saying, ‘We can help you with this’, this isn’t something you have to go away and research. All the knowledge is in this room, we can do it for you.

My project that I’ve done through the programme is around pay management...and so I’ve done that piece of work but there’s another wider piece of work to do now, around redesigning the service so that it meets the needs of patients and it meets commissioners’ needs, so that it fits with some of the other services that have been provided in the community. And—the approach we’ve taken to that is very much to get everybody around the table that’s involved across the spectrum of care and to work together to come up with some kind of outcome. And it’s—the way we’re tackling it is to look at it from a ‘what’s ideal for the patient’ type of view, rather than, ‘how does that fit with the current structure of the organisations that we’ve got’ approach.

...two days after we got back from that workshop I had to chair a meeting where, for the first time ever in a partnership meeting, I had to take something to the vote because there was conflict in the room...and already I was thinking, oh, I’ve learnt such a lot about that, I need to make sure I’ve learnt it all properly. This is where
the learning starts...people said, afterwards that I’d chaired it well and we had got to a resolution, but I want to embed that learning for myself and I think one way to do that would be to share it with the team and actually, then, help them to learn it as well.

So, whilst I’ve been a bit critical of the programme—what it’s made me realise is that [our] staff who, for the very few...get identified to do leadership training, it’s one per region, you’re not going to get very far with that. What it reflected was that, actually, I shall try and get some money to run something for a cohort of consultants based on this kind of model of leadership development. Which isn’t about knowing yourself but about how you can impact and be a good leader in promoting change and how you can be a good leader in developing systems. So, I’ve gone out and actually secured money and now commissioned a programme...and I want to test it out to see what it can offer the region.

5. Conclusions

In April 2009, soon after the start of the LIH&WB programme, the government launched the Comprehensive Area Assessment (CAA) \(^\text{11}\) which requires Councils to examine on an annual basis how well they are working together with other public bodies to meet the needs of the people they serve, and for a report of the findings to be made publicly available. This, in the view of the SC SHA Public Health Development Team, in conjunction with South Central’s publication of ‘Shaping the Future’ and the need to achieve financial efficiency through strategic commissioning and greater development of joint services, added greater weight to their initiative of piloting an inter-agency leadership programme with a focus on partnership working for health and well-being.

This evaluation has found that there was a great desire amongst all the organisations represented in the programme to gain knowledge, cross organisational barriers and find ways in which they could arrive at successful and effective partnership working. There was a strong sense of a common purpose between the organisations - the need to create efficient systems, with a greater focus on health and well-being and illness prevention but, at times, participants declared a lack of knowledge of how this could be achieved whilst at the same time meeting requirements to reach their own organisational targets.

The experience of participants relayed on this programme has highlighted that there are occasions when organisations do not have a full understanding of how each works, what level of support they can offer each other and consequently misconceptions arise. Whilst the LIH&WB programme has begun to address the need for greater knowledge and understanding of partnership working, participation responses indicate that some would like assistance in taking further work that has begun as a result of involvement in this programme. It appears important, for breaking down organisational barriers and to overcome the differing organisational language and cultures that exist, that participants are brought together in a multi-agency programme to learn. The benefits of physically coming together for networking for exchanging ideas, sharing knowledge and peer group learning was expressed very clearly by the participants.

6. Next Steps

- Thought now needs to be given to how these needs can be addressed within the current financial restraints and with the proposed changes in the structure of public health services.

- With more engagement with, and ownership by, Local Authorities anticipated in the forthcoming Public Health White Paper, the lessons from the LIH&WB programme are all the more important.

\(^\text{11}\) For further information on the CAA see Audit Commission: [http://www.audit-commission.gov.uk/localgov/audit/CAA/Pages/default.aspx](http://www.audit-commission.gov.uk/localgov/audit/CAA/Pages/default.aspx) (date accessed 29th February 2010)
• The programme has demonstrated that, even at very senior levels, there is limited understanding across organisations of: organisational structures, decision making processes, financial commitments and ways of sharing information.

• Understanding each others’ language and organisational culture, building relationships, trust and commitment will all be increasingly vital; this evaluation has shown that ways to do this may include small multi-sectoral groups working together to achieve an outcome in common.

• The evaluation has also given a number of suggestions of practical changes that could be made to learning and development opportunities to meet these challenges.

• It is clear that leadership skills will be key in delivering improved health and well-being in the new systems, but as one respondent stated, this should be a new form of leadership for the future “Which isn’t about knowing yourself but about how you can impact and be a good leader in promoting change and how you can be a good leader in developing systems”.

• It may be that a short term investment to meet the development needs of staff described in this report could result in long term savings in terms of improved whole systems working in the future.

--oOo--

Distribution:
All participants
All Directors of Public Health, NHS commissioning organisations
Regional Director of Public Health, SC SHA
Liz Steel, Head of Public Health, SC SHA
Members of Professional Advisory Group for Programme
IDeA, Trevor Hopkins
South East Employers, Progress through Partnerships, Peter Johnson
Catherine Hannaway, formerly Improvement Foundation
Nick Goulder, Director Hampshire & Isle of Wight local government Association
Geoff Howsego, Hampshire Fire Service
Jean Bradlow, DPH Hampshire (at time of Programme initiation)
John Acres, PH specialist training Programme Director, Wessex
Premila Webster, Specialist PH Training Programme Director, Oxford
Peter Lees & Merrill Bate, Leadership SC SHA
Nicky Priest & Steve Fairman, Service Improvement SC SHA
Post graduate Deans, Wessex & Oxford Deaneries
Allan Jolly, Workforce & Education, SC SHA
Fleur Kitsell, Workforce & Education SC SHA
Jenny Wright, Supporting Public Health
Seamus Watson SE Coast, for information
Sylvia Beacham, SE Coast, for information

Comments are welcome to: phdevelopment@southcentral.nhs.uk