Allied Health Professions’ Leadership in NHS Trusts in England
Understanding what exists and what matters

Report to Dr Joanne Fillingham
NHS Improvement Clinical Director for AHPs and Deputy Chief Allied Health Professions Officer
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- Link aspiring leaders with mentors and role models .......................................................... 45

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- There was an employer focus on succession planning, talent spotting ............................. 45

- There were recognisable routes for AHP progression ....................................................... 45

- AHPs were supported, championed and encouraged ......................................................... 45

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Glossary of Terms and Abbreviations

AFC: Agenda for Change. NHS pay scales
AHP: Allied Health Professional(s)
Band: AFC pay band. A higher number denotes a higher pay point
CEO: Chief Executive Officer
COO: Chief Operating Officer
CQC: Care Quality Commission
DoN: Director of Nursing
HCPC: Health and Care Professions’ Council
NHSE: NHS England
STP: Sustainability and Transformation Partnership
Executive Summary

This report sets out findings in relation to two key questions:

1. What organisational leadership governance structures exist for Allied Health Professional (AHP) service provision and what is the impact of them for the quality and productivity of care delivery in NHS provider organisations in England?

2. What are the characteristics, key skills and attributes, of effective AHP leaders, and how are these gained through professional development during an AHPs career?

The findings are based on data collected between December 2017 and March 2018 in relation to AHP leadership arrangements across NHS provider Trusts in England.

The report is structured into four main sections:

- Section 1: Background and Project Design
- Section 2: Findings
- Section 3: Synthesis of Findings: Concepts, Context, Characteristics, Capability, Challenges, Consequences
- Section 4: Recommendations and Next Steps

The focus in this project has been on formal AHP leadership; senior roles established to provide leadership across AHPs employed in NHS provider Trusts.

A combination of survey, interviews, documents and extant national metrics were used to gather the range of facts, opinions and experiences required to address these questions. A total of 124 responses from 95 Trusts were gathered from a bespoke survey distributed to 233 Directors of Nursing (DoNs) in the NHS in England. Additionally 10 purposive interviews were conducted with senior AHP leaders. To ensure that learning from each part informed subsequent inquiry and that findings could be integrated iteratively as the project progressed, the two areas were addressed in parallel using mixed methods.

Key findings

Overall, AHP leadership has been found to vary widely across the NHS in England.

To provide a structure to support thinking about this variation and associated implications, the findings from this project have been synthesised in relation to the Warwick 6C Leadership Framework.¹ For this report the 6Cs have been considered first in terms of Concepts, Contexts, Characteristics, Capabilities, Challenges and finally, Consequences.

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AHP Leadership Concepts

- AHP leadership concepts vary widely reflecting the variety of ways in which AHPs are defined and understood. In some provider Trusts the understanding of AHPs extends to professions beyond the 14 NHSE/HCPC registered AHP professions, for example to include psychologists, psychotherapists, biomedical scientists, social workers.
- There are limited examples of established, unified senior AHP leadership across NHS Trusts in England.
- There is some evidence of a declared lack of confidence from AHPs that leaders from one AHP background can adequately represent another AHP profession at a senior level.
- The project has also identified AHPs who lead in the NHS in England; holding roles including CEO, COO and Clinical Directors.

AHP Leadership Contexts

- In common with other aspects of health and social care, AHP leadership is influenced by local and national factors.
- Historical and traditional practice contexts appear to influence how AHP leadership is structured but the relative influences of different contextual factors cannot be readily isolated.
- There is a sense that the contribution of AHPs is becoming more recognised.

Characteristics of AHP Leadership

- AHP leadership posts occur at Agenda for Change (AFC) bands 8a and above and most reported at AFC band 8c
- Some senior posts are established at AFC band 8d and 9
- AHP leaders have a range of AHP and non-AHP professional backgrounds
- There is some indication that higher banded posts increase AHP visibility, influence and the engagement of the AHP workforce in improving services.
- As a non-mandated post, most AHP leadership ultimately reports into DoNs either directly or indirectly.
- Characteristics of AHP leadership posts have informed a preliminary typology of AHP leadership which is presented in Section 3 and Appendix 6.

AHP Leadership Capabilities

AHP leaders present with:

- A strategic appreciation of the wider health and social care system often gained from a diverse portfolio of health and social care career experiences.
- The ability to work with and influence high level Trust decision makers; mapping and demonstrating impact in relation to Trust and national service delivery drivers
- The ability to connect with and represent a wide range of diverse AHP professional identities and interests.
- A proven track record in health and social care delivery and innovation.
AHP Leadership Challenges

- AHP leadership requires representation of diverse professions with a variety of professional identities, cultures and practice traditions.
- The system is predicated to recognise the impact of traditional models of care which may be more task focused and more immediate. AHP impact may be more distant, for example AHP contribution in an acute care pathway may have added impact in a community or social care element of a patient journey.
- Traditional role specifications sometimes exclude AHPs from applying for posts. creating a poverty of opportunity for AHP leadership progression.
- Complex AHP leadership arrangements result in fragmentation. In many cases there is not a readily identifiable ‘go-to’ AHP leader as is the case for other professions, for example Director of Nursing.
- Culturally established traditional perceptions of professional identity may serve to perpetuate preferences for uni-professional leadership and representation resulting in more convoluted arrangements for communication between AHPs and Trust Boards. There is a risk some AHP groups get inadvertently overlooked and that AHP impact is at best hard to detect and at worst diluted or unrealised. This potential fragmentation of the AHP voice and associated loss of visibility appears to provide a strong case for unified, collective AHP leadership.

AHP Leadership Consequences

The project provides first steps in understanding what has emerged as a complex and varied AHP leadership landscape. Preliminary indicators of the benefits of senior AHP leadership have been identified as:

- Improving visibility and influence between Trust Boards and their AHP workforce, and vice versa.
- Opportunities associated with increased visibility and influence to propose new models of care which capitalise on the AHP contribution to hard-to-solve productivity, efficiency and quality challenges.
- Improving the extent to which AHPs perceive they are able to contribute to Trust and service improvement.
- Where traditional approaches have already been applied to address service quality, efficiency and productivity challenges without delivering the aspired to improvements, AHPs may offer service and patient benefits through alternative, new models of service delivery.

Summary and next steps

Currently there are varied arrangements for AHP leadership. A best solution or configuration for AHP leadership has not been identified, although there are some preliminary indicators that establishing formal AHP leadership at 8c and above can enhance AHP influence and make the AHP contribution more visible. There is a sense of increased recognition of the contribution of AHPs which provides a rationale for developing greater clarity and reducing complexity around AHP leadership solutions so as to capitalise on this recognition. There are already AHPs of high calibre providing leadership for AHPs and the wider health and social care system. There is more to be done to facilitate AHP development in leadership and to sustain existing leaders.
The evidenced insights gathered through this project can now inform the development of best practice in AHP leadership, sharpen the focus on AHP impact across the NHS system and guide future AHP leadership development across the NHS in England.

The report closes with suggestions for future AHP leadership development drawn from the insights gathered during the project.
Section 1:
Background and Project Design
1.1 Background and context

This report sets out the findings from a project commissioned in November 2017 by the NHS Improvement Clinical Director for AHPs and Deputy Chief Allied Health Professions Officer Dr Joanne Fillingham. The project was initially prompted by approaches from Directors of Nursing (DoNs) to the NHS Improvement Clinical Director for AHPs, seeking guidance about the development of AHP leadership in NHS provider organisations in England. Recognising that there was variation in AHP leadership nationally, the aim of the project was to develop insights into two key questions regarding allied health professions’ leadership across the NHS in England:

1. What organisational leadership governance structures exist for AHP service provision and what is the impact of them for the quality and productivity of care delivery in NHS provider organisations in England?
2. What are the characteristics, key skills and attributes, of effective AHP leaders, and how are these gained through professional development during an AHPs career?

The project was conducted between November 2017 and March 2018 by Kingston University Enterprise Limited (KUEL). The KUEL project team consisted of academic staff from the Faculty of Health, Social Care and Education, Kingston and St George’s University of London. In delivering this project, the KUEL project team have worked closely with NHS Improvement Clinical Director for AHPs’ Clinical Fellow, Caroline Poole and a project steering group. A combination of survey, interviews, documents and extant national metrics were used to gather the range of facts, opinions and experiences required to address these questions. To ensure that learning from each part informed subsequent inquiry and that findings could be integrated iteratively as the project progressed, the two areas were addressed in parallel using mixed methods.

The report provides a snapshot of current, established AHP leadership structures across the NHS in England. It describes the scope and purpose of current AHP leadership roles and provides some insights into the potential impact of such roles. This is combined with an indication of the profile of current AHP leaders and the professional development pathways which have led AHPs to take up such posts.

1.1.2 What is meant by AHP Leadership?

The following assumptions and considerations were agreed with NHS Improvement ahead of the project:

AHPs

For the purposes of the project, the focus was on leadership for the 14 professions regarded as AHPs by NHS England: art therapists, dramatherapists, music therapists, chiropodists/podiatrists, dietitians, occupational therapists, operating department practitioners, orthoptists, osteopaths, prosthetists and orthotists, paramedics, physiotherapists, diagnostic radiographers, therapeutic radiographers, speech and language therapists. Professions other than these 14 will be referred to collectively in the report as non-AHP.
**Leadership**

The focus of the project has been on formal professional AHP leadership in the NHS in England; established senior leadership positions aligned to higher Agenda for Change (AFC) job bandings. While it was not known at the outset of the project what bandings such posts might be assigned, drawing on soft intelligence held by NHS Improvement, it was assumed that formal AHP leadership positions were likely to be at band 8 and above. This decision to focus on formal leadership is not to ignore that leadership occurs at all levels in an organisation or to overlook the role of clinical leadership, but to provide insights in particular regarding requests from Directors of Nursing (DoN), for guidance in developing senior strategic leadership for AHPs.

**1.2 Project Design:**

The project was designed to address the areas of focus as comprehensively as possible within a short timeframe and to deliver sufficient, evidenced insights to inform and resource future AHP leadership initiatives for optimum benefit. There was a focus on two interconnected areas of inquiry as set out in the original brief from NHS Improvement:

**Mapping organisational AHP leadership structures and correlating with impact.**

a. What exists in terms of formal AHP leadership in England? – identification of metrics that will capture the structures, levels and roles that exist.

b. What are the implications of different organisational structures? – identification of metrics to quantify the impact, quality and productivity of care delivery, in relation to the structures?

**Effective AHP leadership.**

c. Identifying the characteristics of effective AHP leadership and how these have been facilitated to develop in the AHP workforce?

d. What is it about the career journeys of effective AHP leaders that serve successful AHP leaders in delivering their roles?

Full details of the project design, data collection and analysis can be found in Appendix 1. A combination of survey (Appendix 2), interviews (Topic Guide Appendix 3), documents such as job descriptions and extant national quantitative and qualitative metrics, (for example, Model Hospital, NHS Staff Survey, nationally recognised AHP practice exemplars) were used to gather the range of facts, opinions and experiences required to address these questions. A total of 124 responses from 95 Trusts were gathered from a bespoke survey distributed to 233 Directors of Nursing (DoNs) in the NHS in England. Additionally 10 purposive interviews were conducted with senior AHP leaders. The profile of interviewees is summarised in Table 1:
The professional groups of those interviewed included representation from speech and language therapy, physiotherapy, occupational therapy, radiography (diagnostic), paramedic and psychology. Provider types included those from Acute Non-Specialist, Acute Specialist, Ambulance, Mental Health and Integrated Acute and Community. Of those interviewed, there were 8 females and 2 males. While this is a very small purposive sample, it should not be regarded as diminishing the findings.2

To ensure that learning from each part informed subsequent inquiry and that findings could be integrated iteratively as the project progressed, the two areas were addressed in parallel using mixed methods. Adopting this approach minimised duplication and replication of effort thus maximising project efficiency.

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2 Guest et al (2006) retrospectively reviewed their own qualitative research concluded that no new research themes were discovered beyond 12 interviews and that having completed 6 interviews, most of the themes could be identified, even though they had pressed on until 60 interviews were gathered. Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82
Section 2

Findings:

- Profile of survey responses
- AHP Leadership: What exists?
- AHP Leadership: What’s the impact?
- AHP Leaders: Characteristics and Careers
2.1 Profile of Survey Responses

2.1.1 Trust response profile:
A total of 124 survey returns were received. After screening for duplicate returns (multiple completed surveys from the same provider Trust) a total of 95 separate provider organisations responded, representing a return rate of 41%. Returns were received from across the different types of provider organisations and are summarised below in Figure 1.

![Responding Trusts Types](image)

*Figure 1 Survey Returns by Provider Types as indicated*

2.1.2 Individual respondent profile:
It was not always the DoN who completed and returned the survey, (see Figures 2 and 3 below). While the biggest single professional group of respondents are nurses, the survey appears to have been disseminated to AHP colleagues in around half of cases and overall responses are from those with a non-nurse professional background.
Figure 2 Designations of Survey Respondents, (including duplicate returns)

Figure 3 Professional backgrounds of survey respondents (including duplicate returns)
2.1.3 Representation of AHPs in workforce for respondent Trusts:
Across the surveyed Trusts, all AHP professional groups were represented either as direct Trust employees or through other arrangements, as set out below in Figure 4. The focus in the project has been on the leadership arrangements for AHPs directly employed by Trusts.

![Numbers of Trusts employing AHPs Directly or Indirectly](image)

**Figure 4 Numbers of Trusts employing AHPs Directly or Indirectly**

2.2 AHP Leadership: What exists?
The primary sources of evidence used to address this question were:

- survey returns
- collated job descriptions, person specifications and organisational charts
- interviews

The AFC grade for the most senior leadership post was not provided by all survey respondents. Follow up emails were sent to Trusts where this was the case. A total of 67 leadership posts were ultimately identified. Twenty eight remained unknown by the data inclusion cut off date.

2.2.1 Identifying structures and levels of AHP leadership posts by Trust type
The pattern of AHP leadership by AFC Band across provider types are indicated in Figure 5 below:
Where reported, senior AHP leadership posts are established between bands 8a (lowest) and band 9 (highest). Posts at 8c are most frequently reported. Band 9 posts (highest) are only reported in Mental Health Trusts and Specialist Acute Trusts. Free text from surveys provides further insights about less formal AHP leadership arrangements, as in this Trust where the highest declared AHP banding was 8a:

*The AHP Lead who was nominated by his peers is serving a 3 year tenure period. It promotes leadership development within the Trust and enables turnover & therefore opportunities. The individual in post could be voted to stay in post for another period by his peers. There is a responsibility payment and monthly meetings with the DON to support this initiative.*

or examples of AHPs finding a work around to ensure peer support and a collective voice:

*AHP leadership currently functions based on professional lines e.g therapists meet as a group of senior therapists. Work is currently underway to create a trust-wide AHP network which will include all AHP groups and bridge the gaps between senior leads and the more junior staff. Plans are underway to create and establish an AHP collaborative learning network to enhance career development, organisational learning and improve retention.*

And in some instances there is a sense of dissatisfaction:

*Leadership for AHPs across the organisation is patchy and relies heavily on senior positions which are all part-time. It also relies on having a director of Nursing and professions who has an understanding of AHPs, as there is no direct route to the board. This is a post that can only...*
be filled by a Nurse. Most AHPs in the Trust are generically managed and there is poor profession specific representation as other professionals struggle to recognise the diversity and complexity of AHP leadership due to the number of different professions. The need for AHP leadership generally is not well understood nor is the need for representation of AHPs in operational matters.

2.2.2 Patterns of AHP leadership and Size of AHP Workforce
Where AFC band was known for the most senior AHP leadership, a comparison was made to the size of the AHP workforce where available from Model Hospital data. AHP workforce size has been matched to Model Hospital Quartiles (Q1-Q4) where Q1 is the smallest workforce and Q4 the largest. While this is a useful way to look for a trend, it should also be noted that there may be Trusts with similar sized AHP workforce at quartile boundaries and this metric is a headcount revealing nothing about the characteristics of the AHP workforce. The pattern is illustrated in Figure 6:

![Size of Workforce and Leadership Band](image)

Figure 6 Numbers of AHP Leaders at Band 8a to 9 by size of Trust’s AHP Workforce

2.2.3 Leadership Job Profiles: Insights from Job Descriptions
Drawing on the job descriptions gathered through the survey and other sources, 43 job descriptions, declared by the source as the Trust’s most senior AHP leader, were analysed. The sample included job descriptions from acute specialist, acute non-specialist, mental health and community Trusts. The spread of bandings was as follows:

- Band 9 (n=6)
- Band 8d (n=4)
- Band 8c (n=19)
- Band 8b (n=12)
- Band 8a (n=2)

There is a lack of consistency of job titles at all bandings. Over the 43 job descriptions examined, only 2 job titles were repeated (Associate Director for Therapy Services and AHP Lead, Head of Therapy.
meaning a total of 41 different job titles were identified. A full list of job titles is provided in Appendix 5.

For consistency, the job purpose/summary section was selected from each of the job descriptions from which to gather an overarching profile of the characteristics from each band. This broad sweep approach to the job description analysis was adopted in order to capture the main characteristics and identify any consistencies or common features within and across the bands. It is important to note that a level of interpretation of the meaning of the job description characteristics was necessary in the process and that a more in depth examination of the job descriptions and person specifications might give further detail of the leadership expectations.

Common characteristics identified from the job purpose/summary are clustered to reflect how often they featured for band of post. For ease of presentation these are displayed as high, mid or low frequency across each band in Table 2:

<table>
<thead>
<tr>
<th>Job description characteristics</th>
<th>Frequency of occurrence across job descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional leadership (informing executive team and chief nurse of AHP issues), advising corporate committees</td>
<td>9  8d  8c  8b  8a</td>
</tr>
<tr>
<td>Corporate representation (internal/external stakeholders), includes Trust on call rota.</td>
<td>Mid  Mid  Mid  Low  High</td>
</tr>
<tr>
<td>Governance e.g. risk management, patient safety</td>
<td>High  Low  High  High  High</td>
</tr>
<tr>
<td>Strategic direction, delivery of the divisional and Trust strategic objectives, policy</td>
<td>High  High  High  High  High</td>
</tr>
<tr>
<td>Deputising for other senior staff (e.g. senior management)</td>
<td>High  High  High</td>
</tr>
<tr>
<td>AHP protected role – only open to AHPs</td>
<td>Low</td>
</tr>
<tr>
<td>Professional guidance (advice/expertise on all professional nursing &amp; AHP /clinical issues) implementing national guidance</td>
<td>Mid  Mid  Mid  High  High</td>
</tr>
<tr>
<td>Clinical leadership - e.g. visibility, role model</td>
<td>High  High  High</td>
</tr>
<tr>
<td>Multi professional representation</td>
<td>High  High  High</td>
</tr>
<tr>
<td>Uni-professional representation</td>
<td>Mid</td>
</tr>
<tr>
<td>Quality agenda and indicators, monitoring</td>
<td>High  High  High</td>
</tr>
<tr>
<td>Service effectiveness</td>
<td>High</td>
</tr>
<tr>
<td>Business planning, developing therapy services</td>
<td>Mid  Low  Low</td>
</tr>
<tr>
<td>Resource management, financial/budget responsibility, workforce planning (recruitment and retention)</td>
<td>High  High  High  Mid</td>
</tr>
<tr>
<td>Line management e.g. performance management</td>
<td>Low  High</td>
</tr>
<tr>
<td>Inspirational leadership, motivate staff</td>
<td>Mid</td>
</tr>
<tr>
<td>Operational management (day to day) e.g. complaints management</td>
<td>Low  High  High  High  High</td>
</tr>
<tr>
<td>Transformation, modernising service, service improvement, innovation, change agent</td>
<td>Mid  Low  High</td>
</tr>
<tr>
<td>Accountable for AHPs: whole organisation</td>
<td>Mid  High</td>
</tr>
<tr>
<td>Research and development/education/teaching/mentoring of peers</td>
<td>Low  Mid</td>
</tr>
<tr>
<td>Patient Experience, Co-production</td>
<td>Low  Low  Low  Mid</td>
</tr>
</tbody>
</table>

Table 2 Most frequently occurring characteristics from AHP leader job descriptions by band
Analysis of the job descriptions reveals a mixed pattern of characteristics for AHP leadership roles. For higher bandings (9 and 8d) there is stronger emphasis on strategic leadership activities and for lower bandings (8a and 8b) the AHP leadership components may be combined with more operational management activities and or clinical practice. Posts at 8c may combine elements of both the strategic organisational leadership roles in addition to continuing with a high level of operational management. The more senior bandings have responsibilities for representing multiple AHP professional groups in contrast to the lower bandings which appear to include a number of uni-professional roles. In these instances it seems that the roles with a uni-professional emphasis then have a “bolt on” leadership role which may or may not be remunerated according to the formality of the arrangement. While 8a and 8b roles may have a developmental remit for the post holder with a view to the step up to a more strategic leadership role from 8c and above, this is not clearly signalled in the available data.

The overall mixed characteristics and diverse expectations of the AHP leadership roles and apparent interchangeability of some titles and terms such as ‘AHP Lead’ and ‘Therapies Lead’ creates a lack of clarity about the AHP Leadership identity.

The pattern of reporting for AHP leadership posts is illustrated in Table 3 below. There was insufficient access to organisational charts linked to every job description to verify seniority. Loose seniority rankings have been suggested by inference, although it is recognised that it is not possible to confirm either status or influence confidently. In at least one instance, the role of chief nurse was combined with a governance role. In another, while the job description stated a report to the CEO, the accompanying survey return indicated that as of April 2018, the report would be to the DoN and for this reason the post was recorded as reporting to the DoN not the CEO.

<table>
<thead>
<tr>
<th>Posts reported to (loosely ranked by assumed seniority)</th>
<th>Frequency of occurrence in Job Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Director of Nursing/Chief Nurse</td>
<td>2</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td></td>
</tr>
<tr>
<td>Executive Director, Quality and Safety</td>
<td></td>
</tr>
<tr>
<td>Deputy Chief Operating Officer</td>
<td>1</td>
</tr>
<tr>
<td>Deputy Director of Operations</td>
<td>1</td>
</tr>
<tr>
<td>Assistant Clinical Director</td>
<td></td>
</tr>
<tr>
<td>Assistant Director of Operations</td>
<td></td>
</tr>
<tr>
<td>Clinical Support Divisional Manager</td>
<td></td>
</tr>
<tr>
<td>General Manager</td>
<td>1</td>
</tr>
<tr>
<td>Divisional Chief Operating Officer</td>
<td></td>
</tr>
<tr>
<td>Department Chief Operating Officer</td>
<td></td>
</tr>
<tr>
<td>Divisional Director</td>
<td>3</td>
</tr>
<tr>
<td>Clinical Director</td>
<td>1</td>
</tr>
<tr>
<td>Directorate Manager</td>
<td></td>
</tr>
<tr>
<td>Designated Line Manager</td>
<td>1</td>
</tr>
<tr>
<td>Associate Director of Operations</td>
<td></td>
</tr>
<tr>
<td>Consultant Prosthetist</td>
<td>1</td>
</tr>
<tr>
<td>Associate Director of Nursing and AHPs</td>
<td></td>
</tr>
<tr>
<td>Directorate AHP Lead for Therapies</td>
<td></td>
</tr>
</tbody>
</table>

Table 3 Patterns of reporting for AHP leaders by AHP leader post band
The reporting structure within the job descriptions identify that the DoN is a consistent reporting mechanisms across all bandings from 9 to 8a. In the absence of organisational charts it is impossible to assess with certainty but there is some indication that:

- At band 9 and 8d, reporting mechanisms are to more senior Trust staff implying post holders are communicating more directly at Executive Board level. This matches with reports from the senior AHP leaders interviewed about relationships between a direct reporting line and the AHP voice being heard at Board level.
- From band 8c, although still often reporting to the DoN, there are more varied reporting arrangements including Divisional and Department level reporting. This is again consistent with interviews where 8c leaders have reported having some difficulty having their voice heard at board.
- At Band 8b and 8a, the line of reporting extends further from the Executive Board to roles such as Associate Director and Line Managers reflecting the more operational characteristics identified in the job descriptions. This matches the interviews and survey free-text where lower banding leadership levels (8a and 8b) have indicated more uncertainty about how their voice is communicated to board and back. Potentially there are a greater number of layers or complexity between their role and the board.
- Posts at 8a and 8b are more likely to feature a clinical component.

The reporting patterns identified via analysis of the available job descriptions should also be considered in conjunction with the patterns identified in the analysis of communication between Trust Boards and AHPs which are presented below in section 2.2.4 and later in 2.3.4.

The job description analysis aimed to obtain an overview across those job descriptions available and across the AHP leadership banding. It is recognised that the type of organisation, organisational structures, management titles and roles will vary between Trusts. While it is not known for every survey respondent Trust, there is evidence that AHPs of varying professional backgrounds hold senior leadership roles. Predictably those from the largest AHP professional groups, i.e. physiotherapists, occupational therapists, radiographers were more often reported to hold these roles and in addition some senior AHP leadership roles have been found to be held by non-AHP professionals such as clinical psychologists.

Research and Development was minimally identified within the job descriptions, appearing most within those at Band 8c.

In summary the job description analysis demonstrates:

- AHP leadership is established at bands 8a and above
- Band 8b and 8c posts have been most often reported
- AHP leadership post titles lack consistency.
- Posts which are more highly banded have greater strategic components in the job description
- Posts which are more highly banded have few reporting steps between the post holder and Trust board
- Reporting to the board is often, ultimately or directly via a Chief Nurse or DoN
2.2.4 Mechanisms for Communication flow between Trust Boards and AHPs

In addition to the information gained from the job descriptions about who AHP leaders report to, further insights were gathered from survey respondents who were asked to describe how the Trust Board communicates with AHPs and separately to describe how AHP matters are communicated with the Trust Board. Responses were in the form of free text and were grouped into categories of communication methods. As with the job description analysis, some interpretation was required. Figures 7 and 8 illustrate the dominant patterns of communication between Trust Boards and AHPs as described by survey respondents. These mechanisms for communication are further considered in relation to impact in Section 2.3.

Communications from the Trust Board to AHPs

The following categories were identified from survey free text describing communications from the Trust Board to AHPs:

- Organisational Structures e.g. Trust Divisions, care groups, cascade
- Operational Processes and mechanisms, e.g. Team Brief, team meetings, intranet, cascade
- AHP specific mechanisms – AHP staff forum, Therapies, AHP /Therapies Strategic Senior Leadership Role e.g. Director of AHPs or Therapies
- Operational process with enhanced visibility e.g. Trust Executive Committee, CEO contact, CEO Briefing, board to ward events
- Meeting chaired by e.g. DoN
- Face-to-face one-to one, DoN
- Meeting chaired by another senior manager or Director, e.g. strategic board, Director of Professions
- Face-to-face one-to one other senior management team or executive
- Respondent describes fragmentation, ambiguity, variation or complexity
- Informal networks
- Relationships with Non-Executive Directors
- Joint nursing, midwifery and AHP board
- Limited survey detail
Respondents indicate that Trust Boards often communicate with AHPs through organisational structures such as line management and divisional structures or using established operational communications processes such as Team Briefing. The data indicate that DoNs have a central role in the communication between a Trust’s Board and AHPs whether through forums chaired by the DoN or through one-to-one meetings between AHP leaders and the DoN, to whom most AHP leaders report.

**Communication of AHP matters to the Trust Board**

The following categories were identified from survey free text describing communication of AHP matters to the board:

- Organisational structures, e.g. reverse cascades, line management
- Escalation processes, governance processes
- Via DoN or deputy
- Via Executive other than nursing
- AHP/Therapy Route or mechanism
- Clinical Reference Groups or advisory group, senate
- Forum with CEO visibility
- Respondent doesn’t know or uncertain or not satisfied No direct board report
- Reported variations
- Present to Board - Papers to board
- staff stories, patient stories, board to ward visits
- Non Executive Director
Comments relative to how AHP matters are communicated to the Trust Board again reveal a strong position for DoNs as a conduit for AHP matters to Trust Boards. In responding to this question, some survey respondents focused on governance and escalation processes.

2.2.5 Wider AHP leadership context

While the focus for the project was on overarching formal leadership for AHPs, the project also sought to gain insights into the wider context of AHP leadership. For this reason, the survey asked respondents to describe:

- leadership for individual professional groups
- AHPs who are leaders; other senior leadership roles within the Trust, which were held by an AHP

**Leadership for individual professions**

The survey data revealed the following pattern, with individual professional leadership concentrated at AFC Band 8a and 8b:

- Band 6 (n=13)
- Band 7 (n=81)
- Band 8a (n=265)
- Band 8b (n=196)
- Band 8c (n=72)
- Band 8d (n=6)

The data suggests, there are a number of 8d uni-professional leadership posts but a closer scrutiny of responses to this question cast some doubt on the consistency of responses across the data set on review of responses it is possible that where a Trust employs just one member of a particular AHP
group there is no uni-disciplinary leader as such. As a result, the line management for that professional may be to an 8d multiprofessional AHP lead. For example, if a Trust only employs only one podiatrist, it cannot be discerned from the survey return whether the podiatry post is at 8d or whether the podiatrist reports to an AHP lead at 8d. In view of this uncertainty about the reporting and as the main focus of the project is to examine AHP leadership across the professions, the data for uni-professions has not been analysed or reported further.

Leaders of AHPs or AHPs who are leaders?
Data from surveys and from interviewees indicate that AHPs are providing leadership in Trusts beyond roles with a specific AHP leadership remit. The interview data provided insights about the contribution of wider leadership experiences to AHP leader career development, (see section 2.4.2 for further discussion)

AHPs who are leaders
In 97 of the 124 surveys returned examples were provided of AHPs holding posts with wider leadership scope. Respondents did not provide information about the bands of these posts. The posts described included:

- CEOs with AHP professional background
- Chief Operating Officer
- Clinical Director
- Director roles: Director of Operations, Director of Governance, Divisional Director, Clinical Director
- Associate Director and Deputy Director
- Deputy Chief Operating Officer
- Non-Executive Director
- Ward managers, Matron
- Service managers who are AHPs with or without responsibilities for AHPs
- General Managers who are AHPs with or without responsibilities for AHPs
- Corporate management roles e.g. Patient Safety Manager

Areas of corporate responsibility which featured for the senior roles reported to be held by an AHP included:

- Quality, Governance, Quality Improvement, Patient Experience, Risk, Safeguarding, Occupational Health, Human Resources, Data Quality, Performance, Training and Development

The professional background of post holders was not always specified but where this is stated senior leadership positions are held by AHPs with various professional backgrounds:

- Art Therapy, Dietetics, Drama Therapy, Music Therapy, Occupational Therapy, Orthotics, Paramedic, Physiotherapy, Podiatry, Radiography – therapeutic and diagnostic, Speech and Language Therapy,

Additionally, the responses indicated that other professions are regarded as AHPs in some Trusts. These include:

- Biomedical Scientist, Pharmacist, Psychologist

27 respondents either indicated that there were no AHPs in wider leadership roles or that the respondent was not aware of any such cases and 15 respondents skipped the question.
**Further insights about AHPs who lead:**

Further insights have been provided by free text comments and from interviews. There is a mixed picture about the extent to which broader leadership roles are open to AHPs. Some survey respondents have suggested that operational posts are open to all professions while others have made comments that such posts are unlikely to be filled by an AHP as illustrated in these two survey comments:

*Operational posts are open to anyone. I held the learning from incidents and Trust-wide clinical audit lead post for 6 years before moving into my current role*

*There are no AHP’s in generic leadership positions above a band 6*

It is not clear from survey free text comments whether variation in the presence and/or visibility of AHPs in such leadership positions is because person specifications for the roles preclude AHPs from applying or whether there are assumptions that AHPs will not apply:

*A deputy divisional manager (8b) is a PT by background but has just handed in her notice as she is retiring. It is unlikely to be filled by an AHP*

*No specific roles for AHPs most governance roles etc. occupied by nurses.*

Survey respondents do present some insights that influencing factors may include the relationship of posts to clinical activity or professional identify:

*Community operational managers (no clinical caseload) two physio, one OT, one podiatrist*

*These roles do exist but it has been very challenging to get AHP’s to lead these roles broadly especially those working in community health settings as they are very clinically focussed leaving little time for other responsibilities*

*Several leaders with AHP backgrounds but not actively on the HCPC register*

### 2.2.6 Summarising what formal AHP leadership structures exist in NHS providers in England

The data gathered indicate:

- There is variation in the extent to which formal AHP leadership is established in provider organisations
- Senior leadership posts are most often reported at AFC band 8c
- AHP leadership at band 8c is established across a range of provider Trusts
- The highest AFC banded AHP leadership posts are reported at AFC bands 9 and 8d
- AHP leadership posts at bands 9 and 8d are reported in Acute Specialist and in Mental Health provider Trusts
- There is a vast array of AHP leadership role titles.
• Reporting route to Trust Board appears more direct where the most senior leadership roles exist. At band 8b and 8a the reporting routes have more levels between their roles and the Board than the higher leadership roles.

• A range of AHP professions are represented at senior leadership levels, and appears to reflect the size of the professional group representation. For example, physiotherapy, radiography and occupational therapy leadership roles occur more often than speech and language therapists.

• Some senior AHP leadership roles are held by professions other than the 14 HCPC/NHSE AHPs professions, e.g. clinical psychologists

• Bandings of 8b and 8a have more operational management and/or clinical role within their job descriptions where the strategic leadership element of the role appears as a “bolt on”.

• Bandings of 8d and 9 are more highly strategic in their job descriptions with less operational management.

• Bandings at 8c present with more even distribution of both strategic and operational expectations in their job descriptions.

• Around two thirds of respondents have indicated that AHPs also hold wider leadership roles in NHS Trusts. In some cases these are very senior roles, including Chief Executive.

2.3 AHP Leadership: What is the impact?

Patterns of AHP leadership have been considered with reference to a combination of both quantitative and qualitative evidence to establish any implications associated with different AHP organisational structures.

2.3.1 Relationship between AHP Leadership and AHP staff retention

Using Model Hospital data for staff retention and where the bands of senior AHP leadership posts are known, the relationship between AHP leadership banding and AHP workforce retention rates has been examined, see Figure 9.
While the numbers of returns are small, there is a stronger relationship between better staff retention and leadership at Band 8c posts and below. It is possible that the patterns in retention rates are influenced by other factors such as geography or size of workforce rather than providing any clear indicator about senior AHP leadership. The relationships between AHP leadership, size of workforce and staff retention may warrant further exploration.

2.3.2 AHP Leadership and Trust CQC ratings

While it is acknowledged that there is less focus on AHP practice specifically in CQC ratings, it was agreed with the steering group that given the visibility of CQC rating nationally, it would be of interest to establish whether there is a relationship between Trusts reporting established senior AHP leadership and CQC ratings. Figure 10 illustrates this relationship where CQC ratings were available and where the AHP Leadership arrangements were known. While the numbers are small, Figure 11 additionally illustrates the percentage relationships between CQC ratings for each AHP leadership band.
The relationship between Trusts reporting established senior AHP leadership and those Trusts rated as well-led by CQC are illustrated below in Figure 12 and the percentage relationships between CQC well-led ratings for each AHP leadership band are shown in Figure 13:
Rather than identifying clear indicators from these relationships there are further questions regarding the ways in which AHP contributions to provider Trusts are reflected in CQC inspection reports and for AHP leaders and Trust Boards to explore how AHP contributions can support quality improvements which are in turn reflected in CQC assessments. Might it be that as more AHP leadership posts are established, so this is reflected in CQC scores and might well-led Trusts be leading the way in recognising the potential benefits of more focused and formal leadership for AHPs?
2.3.3 Relationship between AHP Leadership and AHP perceptions of contribution to improvement at work

The mean percentage scores for contribution to improvement across AHP professions reported in the NHS Staff survey were considered in relation to the presence of senior AHP Leadership in these Trusts. This is illustrated in Figure 14:

Overall AHPs report high levels of contribution to improvement and the data indicate that this may be enhanced for AHPs who have more senior AHP leadership.

2.3.4 AHP Communication to and from Trust Boards

In Section 2.2 survey responses about how Trust Boards communicated with the AHP workforce and how AHP matters were communicated back to the Board were reported. Responses were free text and categories of communication methods were summarised. In this section the patterns are re-examined in relation to the seniority of AHP leadership where this is known.

AHP Leadership Seniority and Patterns of Communication from AHPs to Trust Boards

The patterns of communication methods were compared for Trusts with AHP leadership above 8d, those at 8c, (the most frequent senior leadership band reported) and those below 8c and are illustrated below in Figure 15.
These findings indicate:

- more direct communication between AHPs and Trust Board where there is leadership at 8c and above.
- a central role for DoN and communication between AHPs and DoN at all levels of AHP leadership
- less dependence on operational process and organisational structures for communication from the Trust Board to AHPs where there is leadership at 8c or above
- the presence of AHP leadership at 8c or above appears to eliminate reports of uncertainty and or dissatisfaction with the communication of AHP matters to the Trust Board.

**2.3.5 Additional insights about communication between Trust Boards and AHPs**

Further insights have been drawn from interviews and supplementary data sources.

AHP leaders who were interviewed referred to the use of social media as a mechanism for increasing AHP visibility and signalling to Trust leaders where AHPs were making an impact, for example by including the Trust's twitter handle or that of key leaders in posts about AHP activity and impact.

The deliberate focus in this project on senior leadership perspectives is acknowledged as a possible limitation and that future work directed at the experiences of lead AHPs would enrich understanding. A comment from one interviewee about confidence in AHP visibility highlights this as the participant referred to a mismatch between structural mechanisms for communication to and from the board.
and operational reality, suggesting she was only 50% certain the communication to/from her board works. Another commented that while her reporting line was directly to the Board, this did not always protect time with board-level report and the actual experience was that the AHP leader’s meetings were subject to deprioritisation. Another suggested that the communication links to Board were “a hard slog” and success depended on the individuals’ persistent efforts and relationship building. In difficult circumstances, medical and nursing concerns were often prioritised and the potential for AHPs to be part of the solution missed. Free text comments from surveys further support a sense of dissatisfaction either with the mechanisms or with the sort of information that comes from and goes back to the board:

Arrangements have changed over the years regularly with different models, we are about to start a consultation which will look at the leadership and reporting mechanism but as a smaller part of the workforce we do feel that we are not utilised or involved in the direction of services. The senior management role has a huge remit and not often appreciates the skills on offer for AHP and we feel undervalued.

Cascaded via Matrons - not always successfully - nurse lead / focus

There is a lack of representation of AHPs at board level and frequently the nursing agenda is so large that AHP concerns are not considered.

Most information for AHPs filters via directorates and teams. Much of the information is not AHP specific. AHPs are often treated as generic workers so information is generic. It is difficult to know if AHP specific information is given to the AHP lead from the director of Nursing or whether it would be registered as such.

At 0.1 wte it is hard to gain that. It is largely a nominal post that looks good on an organisational chart. As we have the memorandum of understanding with the acute Trust and they have leads who are fulltime and have a background in their area of work it is hard to feel that we are adequately represented at any senior level discussion.

It is important to note that while the centrality of the mandated DoN role is a source of frustration for some respondents, it is not consistently the case and in some instances is seen as a crucial enabler of AHP visibility, as is the case in the free text response from this Trust where the lead AHP is at Band 8C:

The Trust values its AHPs and has invested in and protected professional leadership arrangements. There is still room for improvement, and the new AHP strategy will address the need for career pathways and AHP consultant roles. We have just invested in a pilot project to grow AHP consultants through a Staff Empowerment program to strengthen involvement in R&D/QI at Band 7 level. We also ensure that AHP achievements are profiled at board level, and where possible, nationally through NHS Improvement and the CAPHO. Our Trust AHP Lead role is unique within our wider system and she hopes to work more closely with her colleagues in other Trusts to address some of the issues (e.g. workforce). The reporting line to the DoN is crucial and brings opportunities for collaboration with Nursing.
In addition, an interviewee also identified her confidence in this relationship describing it as historically good. The relationship with DoN had further evolved to the point where the collaboration led to the first joint AHP and Nursing Conference.

2.3.6 Evidence of nationally recognised AHP practice exemplars in relation to Senior AHP Leadership

Twenty case studies were found from AHPs into Action, CAHPO awards 2017 and NICE 2015-February 2018 which could be linked to survey respondent Trusts, of which fifteen were Trusts where the level of AHP senior leadership was declared. Figure 16 below show the pattern of exemplars in relation to AHP leadership bandings:

The numbers are again small but there is some indication that Trusts where formal, substantive AHP leadership is established, have more nationally recognised AHP exemplar practice.

2.3.7 Additional insights from AHPs about AHP leadership:

Qualitative insights about the impact of senior leadership posts have been gained from project survey comments, project interviews, AHPs into Action raw data from NHS Improvement and @WeAHP Twitter Chat transcripts.

**AHP Status:**

Themes gathered from interview data provide some additional insights into the impact of formal AHP leadership. Interviewees acknowledge that the AFC band of a post may not be the key factor but that having a highly banded AHP leader can:
• Act as an enabler – gets a seat at the influencing table
• Serves to support AHP visibility (internal and external to the employing Trust)
• Creates equality for AHPs in the NHS leadership hierarchy
• Puts AHPs on the radar of key influencers, e.g. DoNs
• Means the AHP leadership workforce is equally remunerated at leadership levels
• Empowers AHP leaders by reinforcing a professional identity for AHPs within a traditional NHS hierarchy of professional identities

Interview participants also referred to the relationship between position and influence and for some a lack of status was related to feeling unable to influence. Interview data also indicates that impact is perceived to be greater when there is AHP leadership representation where it is perceived to matter most, for example by being visible to mandated board positions such as the DoN.

**AHP Leadership track-record, influence and visibility**

Examples from interviews indicating an increase in AHP visibility associated with the establishment of a formal AHP leader in the Trust involved the launch of a Trust AHP strategy and holding a celebration event which for the first time was a joint AHP and nursing venture.

For some interviewees, even those with highly banded leadership roles, while the band of the post might get the leader to the right place to influence, ultimately it is a proven track record of delivery in relation to factors such as Trust priorities and more recently Sustainability and Transformation Partnership (STP) plans is what matters. AHP leaders spoke about the roles they had representing the organisation and the AHP contribution, for example as the member of an STP advisory board. Interviews indicate that demonstrating AHP impact at a more macro level may require an AHP leap of faith and that this is where visionary AHP leadership may be required in terms of providing challenge not only to traditional systems’ working but also for traditional AHP working; so impact that matters to Trusts and the wider health and social care system may need to be differentiated from traditional AHP measurement of outcome. One interviewee indicated that the current metrics such as recruitment and retention measures give a limited insight into the impact of AHP leadership and suggested that success of an organisation and AHP leadership are entwined. Demonstrating impact in ways that matter to Trust Boards is cited by some leaders as a necessary step in giving senior Trust leaders and decision-makers confidence to turn to AHPs in ways that may be regarded as less traditional. Examples of this snowballing of AHP influence included Trusts deciding to open up posts traditionally held by medical or nursing colleagues to applicants from AHP backgrounds. These insights perhaps suggest that influencing mandated positions by seeing things from the Board’s perspective can be a powerful mechanism for increasing AHP visibility.

**Influence of Service Status**

There is some indication that for services where traditional approaches have already been applied to address service quality, efficiency and productivity challenges without delivering the aspired to improvements, this provides an opportunity to fill, what one interviewee described as a ‘quality improvement vacuum’. In essence, it provides the opening for AHPs to offer alternative, new models of service delivery. As described above, this can have a snowball effect for AHP contribution to service improvement as it provides tangible evidence of the potential for AHPs to be part of the Trust solution to longstanding service delivery challenges.
AHP leadership and efficiency
Interviewees have referred to efficiency of AHP-wide leadership in relation to decision-making processes because there is a ‘go-to’ AHP with sight of all pockets of AHP activity across the Trust. Senior AHP leadership was perceived to increase the degree of confidence across the AHP workforce. Participants also referred to productivity gains through mobilising un-realised AHP potential and through reducing duplication and replication ranging from practice consistency to consistency across job descriptions or streamlining representation at Trust forums.

AHP leaders as advocate and role model
Some leaders characterised themselves variously as a buffer/filter/barrier/facilitator between the Trust board and workforce or practice interface. It may be possible to detect this empirically in staff survey responses for Trusts where such leaders are in post. The possible effects of an AHP leadership role model do seem to be detected in the staff survey scores for example relating to AHP contribution to service improvement. Interviewees referred to supporting AHPs in non-traditional roles by mobilising, energising and enthusing their workforce but also referred to leadership spread and cascades of influence, not only strategically but also clinically, culturally and pastorally. The relationship with retention rates do not fully support this and it is important to note that the focus of this project has been at the senior leadership end of the hierarchy; those who lead. Future work could look to gather opinions from those who are led.

Barriers and Challenges for AHP Leadership
Drawing on the free text in surveys, interviews and other data sources, a number of barriers and challenges are identified. These barriers and challenges can be clustered into the following categories:

- Professional identity/professional alignment
- Cultural practices and behaviours

Professional identity and professional alignment
Variation in AHP leadership has been widely observed in this project. This variation includes how AHP leadership posts are specified, what band the post is graded at and the scope of the post including whether the AHP leader leads all or some of the AHPs in the Trust, who can hold the post and whether there are professions included in the scope beyond the 14 HCPC registered professions. For example, the scope of some senior AHP leadership roles has been found to extend to psychologists and psychotherapists and in some cases the senior leadership role is held by a psychologist. In some Trusts the job description may state it is an AHP leader and then include a person specification that extends only to a subset of these professions. This variation can be partly linked to issues of professional identity and professional alignment. There is also some indication in the free text

   Our AHP lead (SALT) is switched on, does listen and has many useful skills and qualities but lacks the knowledge of PT and community rehab.

In addition to professional identity factors, interview data also suggests such differentiation can be attributed to factors of tradition and pathway, including those of historical budgeting. Differences may be linked to the nature of Trust provision, for example in the survey data there are a number of
acute provider instances where arrangements appear to be managed in different business delivery divisions or units, such as this:

*AHPs are not managed collectively in the Trust; Therapies and radiology are managed as part of Clinical Support Services, Prosthetics are managed within the Surgical Directorate, Orthoptists are managed within the hospital site where the service is based and ODPs are managed as part of Theatres.*

There are signs that culturally established traditional perceptions of professional identity may serve to perpetuate preferences for uni-professional leadership and representation, however where this is the case the arrangements for communication between AHPs and Trust Boards seem more convoluted. It becomes easy to see how such arrangements may result in some AHP groups being inadvertently overlooked and that AHP impact is at best hard to detect and at worst diluted or unrealised. This potential fragmentation of the AHP voice and associated loss of visibility appears to provide a strong case for unified, collective AHP leadership. Interview data which refers to evolving professions and the mix of professional philosophies illustrates that overarching, collective AHP leadership will not be without its own challenges. In part due to inter-AHP professional dynamics, there is some sense that energy is being expended influencing and persuading within the AHP envelope and might be better collectively directed to key and mandated Trust leaders and decision makers. This sentiment is clearly articulated in these comments drawn from raw data gathered through crowd sourcing to inform the AHPs into Action publication:

**Comment 1:** Need to remember that different AHPs exist for a reason, OTs aren’t physio’s who aren’t dieticians. We all have different skills and need leaders that understand this and embrace our differences. Please don’t turn AHPs into an amorphous blob

**Response:** A comment on a theme in these comments - I don’t understand what you mean by an amorphous blob”. Brain surgeons aren’t obstetricians who aren’t gastroenterologists, but they sure are doctors! And that is why they are powerful - because they talk and march with one voice at the highest level of leadership (managerial/strategic) whilst appreciating and supporting the contribution of the various specialties/professions that constitute the blob (block) at the clinical level. Until professions/professionals understand that until they strongly commit to the overarching concept of allied health there can be no roles at higher levels. High level roles aren’t about representing professions and professional interests, they are about contributing to the organisation in terms of developing new ways of working to help meet organisational objectives consistent with improving quality and safety of care. Sometimes that means saying NO to old ways of doing things and calling out profession-centred behaviour that is not client centred. That is leadership.

**Cultural Practices and Behaviours**

Survey respondents and interview participants have referred to a dominant national narrative around the roles of doctors and nurses which extends to leadership. Respondents acknowledge that while this is an understandable narrative associated with the more established histories of some professions, there is a call for Trusts to establish roles and the related job descriptions with increased focus on the required leadership skill set rather than clinical professional backgrounds as a way to shift
the balance away from taken-for-granted, default management and leadership structures. In the context of traditional leadership structures, interviewees in particular have referred to poverty of development opportunity leading to an imbalance of professional perspectives at higher levels of influence and decision making. At present, as one interviewee suggested, there are more senior posts where the exclusion of AHPs is the default, making opening leadership up to AHPs an exceptional inclusion. Some have questioned whether one such opportunity would be for deputy DoN and Allied Health posts to be open to AHPs as well as nursing. One example of this type was reported where the most senior AHP held an 8c Divisional Director of Nursing and Allied Heath post.

The dominant narrative described is important not just in terms of opportunities for AHP leaders to be in positions of sufficient influence to demonstrate AHP impact for Trusts but more importantly for the wider health and social care system, as is the STP aspiration. Interviewees have referred to AHPs as recognising and balancing the relative influences of local and national priorities while acknowledging the impact for patients. AHP impact may extend beyond the provider organisation and be detected in the wider system including extensive public health, social benefits and support for self-management with a focus on well-being which ultimate reduce system dependencies. While the whole system is evolving to recognise this spread of influence at least one interviewee shared concerns that with nationally collated metrics predicated around traditional models, these do not always demonstrate the extent of AHP impacts in ways that matter to decision-makers.

**Enablers**

Among the enablers identified in the interview and free text data are that an overarching AHP leader can provide:

- Collective voice
- A Community of Practice
- Visibility to board, with reference made by some to making good relationships with key executives and the DoN
- Capitalising on serendipitous communication with key influencers by being in the right places for this to occur
- Established AHP leadership as a signal from the Trust that AHPs are valued
- Using local intelligence/data as a driver for change and innovation
- Showcasing success

There is some sense that AHPs are mobilised and recognising their potential but are not always articulating this in ways that make sense to Boards and decision makers. Furthermore, where there are multiple ways in which AHPs relate to each other and to the Board, it may become difficult for key and consistent AHP messages to be heard where they will make a difference.

**2.3.8 Summarising the impact of formal AHP leadership:**

The data gathered indicate:

- The presence of a senior AHP leader may influence AHP contribution to improvement at work
- AHP leadership at band 8c and above increases AHP certainty about communication with the Trust board
- AHPs and AHP leaders use social media to showcase AHP impact with Trust boards
Nationally recognised AHP practice exemplars are found where there is senior AHP leadership at 8c and above.

There is some suggestion that the status associated with more senior AHP leadership banded posts increases visibility and influence.

AHP leaders suggest a track-record enhances influence and visibility.

Overarching AHP leadership may improve efficiency by reducing fragmentation.

AHP leaders advocate for their AHP staff and provide a role model for future AHP leaders.

In common with other health and social care leaders there are barriers and challenges though the issue of diverse AHP professional identity and alignment may be a source of challenge for AHP leadership impact.

2.4 AHP Leaders: Characteristics and Career Paths

The findings in this section draw predominately on interview data.

2.4.1 Identifying the characteristics of effective AHP leadership:

The following characteristics have been identified from the interviews:

- Connectedness with workforce, with board, with wider system
- Visibility – to workforce and to senior leaders
- Influential
- Credible – has a track-record of delivery
- Advocate
- Creativity
- Challenging taken for granted practice
- Looking ahead
- Responsive and solution orientated – innovative
- Focus on exploring possibilities
- Balancing local and national priorities
- Linking AHP business to the wider trust or system
- Strategic
- Ambitious – for service and professions
- A self-starter – being proactive
- Fallible

The need to move beyond individual professions’ concerns and map AHP business to Trust and national priorities was highlighted by interviewees.

AHP leaders holding posts at 8c and lower were identified for interviews in relation to an AHP practice exemplar. There is some indication in their accounts, consistent with the job description analysis, that leaders at 8c and lower are juggling multiple contrasting leadership roles; clinical, operational and strategic. Where this is the case, there is some indication that day-to-day clinical and operational concerns are necessarily prioritised ahead of strategic leadership.
2.4.2 Facilitating AHP Leadership development: insights from AHP leader career paths.

Career development paths vary for these leaders but there are some common features. A frequent feature is that the path to AHP leader was not always meticulously planned and often the leaders spoke about the role of serendipity; acting into a role which they would not have contemplated applying for and realising that they could do it and enjoyed it. Others referred to being championed or supported by another colleague to take on a leadership role, not always by another AHP. Where talent has been spotted in the AHP as a leader by someone outside of AHPs, e.g. a nurse leader, there is some indication that this has helped to endorse the AHP in that leadership role, especially if the role is not traditionally held by an AHP. Others have indicated that the presence of AHPs in positions of higher influence can have a snowballing effect to further facilitate AHPs being considered for roles previously and traditionally held by nursing colleagues. In one case, an interviewee had been motivated to take on her senior leadership position because she was fearful of someone else she knew doing so.

While not everyone describes a clear career development plan the AHP leaders spoken to present as proactive in seeking both development and support opportunities. This includes taking roles which are not directly related to AHP business. Examples include roles such as a ward manager, general manager, roles in service development and director of operations roles. For those who have done so, such roles are regarded as valuable in developing insights and experiences in the wider health and care system. AHPs with this sort of wider experience described how such roles helped them to develop insights into the transferrable skills they possessed as AHPs and to have opportunities to use their AHP skills in novel contexts.

Most have engaged in some form of post-registration education. For some this was described not as providing especially different operational insights but in providing a framework on which to make sense of being a manager or leader. More important for others was the credibility and influence associated with having a track record as an influencer, enabler and innovator.

While AHP leaders present as ambitious, this is more clearly detected in their ambition for the professions, services, their workforce and ultimately patients. In the end, some suggest that realising this ambition was not possible without the status of a senior leadership role and the associated influence described earlier.

2.4.3 What does it feel like to be a senior AHP leader?

Interviewees additionally provided insights into what it feels like to hold these positions. Post holders indicate the perceived responsibility of holding these roles and of perhaps being the first AHP to have this level of seniority in the Trust. Having broken with tradition to take on such roles some declared they were selective about disclosure of professional identity. For this and other reasons, for some the role has also brought some professional isolation and a sense of not knowing where to get professional support at this level. The need for a role for AHP leadership networks is mentioned and would be welcomed.

Some acknowledge that the level of responsibility comes with some personal investment and cost, a need to weigh up the challenges of work-life balancing and a sense of leadership burden. Commenting
on colleagues who were perceived as capable of stepping up to more senior leadership roles, interviewees sometimes attributed declining promotions to ‘leadership reticence’ but more probably because of perceived operational management burden. Some have referred to the frustrations associated with a mismatch between their aspirations for the role and the actuality. In the words of one interviewee, she feels weary of flag-waving.

However, even those who have referred to the ‘hard slog’, most spoke, often for well over an hour, with enthusiasm and energy about being where they wanted to be to effect change and gain satisfaction from being able to influence.

2.4.4 Developing future AHP Leaders

Asked about how future AHP leaders might be developed and the current AHP leaders sustained, interviewees referred to the need for programmes and mechanisms which:

- Recognise the different educational influences in the different professions and the mix of professional philosophies and identities
- Link aspiring leaders with mentors and role models
- Prepare and support existing leaders to be mentors and role models
- Explore the Influence of structure compared with the influence of the leader
- Recognise the current evolution of professions
- Help potential leaders and employers to focus on leadership skill set not clinical background
- Are multiprofessional not uniprofessional and move beyond traditional professional identity
- Encourage and support AHPs to step out of a sector/profession
- Includes a mixture of both formal and informal learning activities
- Includes vicarious learning experiences; learning from and working with others
- Support the development of knowledge of self

Within the system, interviewees have suggested that AHP leadership development would be enhanced if:

- There was an employer focus on succession planning, talent spotting
- There were recognisable routes for AHP progression
- AHPs were supported, championed and encouraged

Additional suggestions include the use of:

- Informal sponsors or mentors or buddies – inside or outside Trusts, with different leadership experience and/or someone who model the possibilities. However emphasis was placed on mentor quality and that position alone is not enough.
- The value of networks and peer support
- The value of secondments in providing wider perspective and for validation, testing the water, developing on the job/in the job confidence
- Ensuring patient experience remains in leaders’ sights
While there was some indication that the variety and diversity of AHP professions may warrant development approaches that are specific to AHPs, others were clear that this was not necessary. There was uncertainty about the quality and usefulness of traditional leadership development from some and that future programme need more emphasis on possibility and expanding horizons including practical experiences to do this so that potential AHP leaders get breadth and variety of experience.

It was suggested by some that leadership development should begin in pre-registration training and that there is a role for preceptorship and supervision.

2.4.5 Summarising Characteristics and Career Paths

- AHP leaders demonstrate ambition for services and professions they lead.
- AHP visibility in wider senior leadership positions can lead to AHPs being considered for roles previously and traditionally held by nursing colleagues.
- AHP leaders have engaged in a range of development opportunities including formal leadership training opportunities. There are mixed views about relative values of focused AHP leadership and AHP engagement in broader, cross-profession leadership development opportunities. Some have commented that the design and content of some leadership development opportunities reflects traditional models and is therefore less useful.
- AHPs leaders highlight the value of experiential development and many have described a move into a general or operational role facilitates AHP leadership career development.
- AHP mobility into non-traditional AHP senior leadership roles is facilitated when AHP post holders have a recognised and proven track record within the organisation in such roles, whether leading AHPs or in a more corporate leadership role.
- There is some sense of the burden of AHP leadership and of a sense of isolation; most have referred to the potential value of a senior AHP leadership network and would welcome such a development.
Section 3

Synthesis of Findings
3.1 Overview of findings
The findings from this project have been synthesised in relation to the Warwick 6C Leadership Framework. The 6cs of the framework has been set out with Concepts, Contexts, Characteristics and Capabilities considered first followed by Challenges and Consequences.

3.2 AHP Leadership Concepts
This section considers what the project findings contribute to the understanding of the concept of senior AHP leadership.

The project has revealed a mixed picture of formal AHP leadership concepts in relation to person, position and process. A fundamental influence relates to the ways in which AHPs are defined and understood. Some respondents have included professions beyond the 14 NHSE/HCPC registered AHP professions, for example psychologists, psychotherapists, biomedical scientists, social workers.

The understanding of the concept of AHP is inconsistent within and outside of the AHP cluster. This is reflected in concepts of AHP leadership in a variety of ways:

- There are limited examples of established, unified senior AHP leadership within Trusts.
- AHP leadership is sometimes a bolt-on or proportion of a wider substantive role.
- There are leadership structures which reflect traditional AHP and other professional identities.
- There is inconsistent use of the words Therapies and AHPs: sometimes used interchangeably and in other cases to differentiate sub-groups of AHP.
- There is some evidence of a declared lack of confidence that leaders from one AHP background can adequately represent another AHP profession at a senior level.
- For some, clinical credibility may be seen as a pre-requisite for AHP Leaders and for others it is about leadership skills which transcend professions and clinical boundaries.
- The scope of AHP leadership posts is sometimes extended to include professions beyond the 14 NHSE/HCPC recognised AHP professions. Post holders are not always from one of the 14 professions.
- The variety of structures and arrangements are reflected in a wide array of job titles meaning that in most cases there is not a readily identifiable ‘go-to’ AHP leader as is the case for other professions, for example DoN.
- There is inconsistency in the job descriptions and specifications. There are instances which are described as Director of AHPs which then invite applications from a subset of the professions such as therapies.
- There are posts which combined nursing and AHP titles but it is not always clear if these posts are open to AHPs to apply for.
- In addition to those who lead AHPs, there is evidence of AHPs who lead including those in post with high levels of influence such as CEO or COO.

3.3 AHP Leadership Contexts
This section considers what the project findings contribute to the understanding of the wider environment in which senior AHP leadership is established and operates.

Contexts can be considered at a local and more macro level. Many of the macro contexts which include national policy, political, social and economic factors apply more widely to leaders across the health and social care system. Others may be more specific to the AHPs such as regulatory and
profession-wide factors, including the guidance from individual professional bodies and individual, traditional AHP profession identities.

There is a sense that the contribution of AHPs is becoming more recognised. This is an evolving picture which is reflected in survey, interview and supplementary data. As one Chief Nurse survey respondent describes:

*AHPs play a central role in our Trust, but we still have work to do* …

The relative influences of different contextual factors cannot be readily isolated. For example, where there are multiple AHP leadership solutions within a given Trust, it is not possible to discern whether this arises for historical reasons, reasons of financial flow, care pathway reasons or professional identity factors. The range of contextual influences identified in this project include:

- References to national AHP policy and guidance such as AHPs into Action.
- Reference to the value of increased visibility for AHPs nationally signalled by and promoted by a Chief Allied Health Professions’ Officer and associated roles becoming established
- Senior AHP leaders identifying the need for AHP impact to be mapped to Trust, local and national policy drivers such as Trust objectives and STP local commissioning priorities
- Traditional and/or mandated leadership structures; the default position of Directors of Nursing as a conduit between AHPs and Trust Boards
- Financial constraints: respondents have referred to feeling the need to protect what has been established in AHP provision. Others have indicated that informal or voluntary AHP leadership arrangements have been established in the absence of resources for a substantive role

Local contextual influences and considerations include:

- Local Trust configurations
- Traditional Trust hierarchies
- The focus of the Trust’s main business (Ambulance, Mental Health etc)
- Leadership Stasis leaders and seniors in positions for many years which can limit progression /succession

### 3.4 Characteristics of AHP Leaders

This section summarises what roles and resources are available to leaders and how leadership roles vary.

The characteristics of formal AHP leadership supported by the data gathered for this project provide an informed snapshot of current arrangements in the NHS in England:

- AHP leadership posts occur at AFC bands 8a and above.
- Most AHP leadership has been reported at AFC band 8c
- Some senior posts are established at AFC band 8d and 9
- AHP leaders have a range of AHP and non-AHP professional backgrounds
- There is some indication that higher banded posts increase AHP visibility, influence and the engagement of the AHP workforce in improving services
• As a non-mandated post, most AHP leadership ultimately reports to DoNs either directly or indirectly.

By exploring existing AHP leadership configurations in relation to quantitative and qualitative metrics it is possible to propose a preliminary typology which is summarised in Table 4 below and set out in more detail in Appendix 6. This is presented as a possible first informed step to appreciate what might be valuable in AHP leadership configurations and the possible associated impact. It is a distillation of the most prominent findings in this project but is necessarily oversimplification snap shot of the actual national position of AHP leadership. It is proposed in recognition that there may not be a one-size fits all solution to AHP leadership however working towards a more refined typology may support Trusts and AHP leaders to identify the component that are required and valuable in their Trust’s context. It is acknowledged that there will be more work to do in this regard, perhaps exploring this preliminary typology with wider AHP and Trust leadership audiences to further refine. AHP leadership has been found to be varied and established at varying levels of seniority; and there is a spectrum of influence and of authority. There is some indication that seniority, as evidenced by the AFC band applied to the leadership post, can act as an enabler; opening doors, providing credibility with senior leaders and Trust Boards. Track record, as described elsewhere, is regarded as more important than AFC band for others.

3.5 AHP Leadership Capabilities
In this section the contribution of the project to understanding the skills and abilities which can help an AHP leader to be effective are summarised.

In addition to the leadership capabilities that might be expected across the system, senior AHP leaders appear to benefit from:

• A strategic appreciation of the wider health and social care system often gained from a diverse portfolio of health and social care career experiences.
• The ability to work with and influence high level Trust decision makers.
• The ability to connect with and represent a wide range of diverse AHP professional identities and interests.
• The ability to map AHP potential and contribution to Trust and national service delivery drivers.
• An awareness of the need to demonstrate impact in relation to Trust and national service delivery drivers
• A proven track record in health and social care delivery and innovation
<table>
<thead>
<tr>
<th>Leadership typology</th>
<th>Relationship with Trust Board</th>
<th>Typical AFC Bands</th>
<th>Relationship with Metrics</th>
<th>Evidence of Nationally Recognised AHP exemplars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uni-professional – e.g. profession-specific leads</td>
<td>Distant Process-driven</td>
<td>8a, 8b</td>
<td>Low</td>
<td>Uncertainty</td>
</tr>
<tr>
<td>Uni-professional – e.g. profession-specific leads with voluntary or bolt/on AHP representation</td>
<td>Varied intermediate Process-driven Increased emphasis on relationships</td>
<td>8c</td>
<td>Variable</td>
<td>Improved Confidence</td>
</tr>
<tr>
<td>Partial Multi-professional</td>
<td>Varied intermediate Process-driven Increased emphasis on relationships</td>
<td>8c</td>
<td>Variable</td>
<td>Improved Confidence</td>
</tr>
<tr>
<td>Overarching Multi-professional</td>
<td>Close Predicated around senior relationships</td>
<td>8c, 8d</td>
<td>Improved</td>
<td>Mostly Confident</td>
</tr>
<tr>
<td>Strategic Overarching Multi-professional</td>
<td>Close or Direct Predicated around relationships</td>
<td>8d, 9</td>
<td>Good</td>
<td>Mostly Confident</td>
</tr>
</tbody>
</table>

Table 4 Preliminary indicators for an AHP Leadership Typology
Leaders who were interviewed referred to the transferrable skills which AHPs bring to senior leadership roles. Those holding the most senior posts have often spent time in less traditional AHP roles and/or outside of their profession. While some have actively sought career development in this way others found themselves in posts less purposively. Either way, such experiences are judged to have been highly valuable in career progression because of the wider health and social care service delivery insights that are developed through such roles. The ability to see a wider health and social care system perspective is regarded as crucial. There is some sense that AHPs have begun to find a voice but that they now need to use that voice to articulate where and how the AHP contribution can be made to matter in the system as a whole; shout, but shout wisely.

There was no discernible mention of the role of research for the highest levels of AHP leaders.

3.6 AHP Leadership Challenges
In this section the key challenges, purposes and/or aims of senior AHP leadership are summarised.

AHP leadership faces challenges in common with other NHS leaders which include finances and rising demand. Some challenges may be more specific to AHP leadership at macro, local and individual levels:

- AHP leadership requires representation of diverse professions with a variety of professional identities, cultures and practice traditions
- The system is predicated to recognise the impact of traditional models of care which may be more task focused and more immediate. AHP impact may be more distant, for example AHP contribution in an acute care pathway may have greatest impact in a community or social care element of a patient journey. This distance from impact concern may limit AHP confidence in current national productivity and quality metrics. The current work of the Model Hospital project to engage AHPs in the shaping of future metrics may go some way to increasing confidence.
- Traditional role specifications sometimes exclude AHPs from applying for posts. Such default professional exclusions create a poverty of opportunity for AHPs to develop the necessary wider health and social care capabilities required for successful AHP leadership. This is also encountered within AHP provision, for example where applications for a newly established AHP lead post was limited to a subset of dietetics and therapy professions.
- Traditional person specification exclusions are regarded as having career progression implications; limiting AHP role models at senior levels and constraining the breadth of AHP career experiences. Where leaders have suggested some AHP colleagues are reluctant to step up the lack of role models and opportunities is cited as a possible explanation and is linked by some to a call for more formal AHP leadership networks.
- The variation and complexity of AHP leadership arrangements results in fragmented leadership arrangement and means that in many cases there is not a readily identifiable ‘go-to’ AHP leader as is the case for other professions, for example Director of Nursing.
- Fragmented leadership may dilute AHP visibility and influence. Some free-text survey comment suggest visibility and influence vulnerabilities may be exacerbated at times of Trust reconfigurations.
Even where there are close links and reporting lines to senior executives this is not without challenge because meetings can get deprioritised. The reasons for variation and complexity are not readily isolated but this may represent an area for future attention and focus in AHP leadership development. Culturally established traditional perceptions of professional identity may serve to perpetuate preferences for uni-professional leadership and representation resulting in more convoluted arrangements for communication between AHPs and Trust Boards. There is a risk some AHP groups get inadvertently overlooked and that AHP impact is at best hard to detect and at worst diluted or unrealised. This potential fragmentation of the AHP voice and associated loss of visibility appears to provide a strong case for unified, collective AHP leadership.

3.7 AHP Leadership Consequences

Consequences considers how can we tell whether leadership is effective? The effectiveness of formal AHP leadership was examined by a combination of qualitative and quantitative metrics. The increased effectiveness of AHP leaders in posts from 8c and above were identified. There is a varied picture and this project should be regarded as initial understandings of what has emerged as a complex picture. However, indicators of the benefits senior AHP leaders bring can be summarised as:

- Improving visibility and influence between Trust Boards and their AHP workforce, and vice versa. There are perceived and evidenced visibility and influence benefits linked to increasing AHP leadership seniority and status.
- Reducing uncertainty for AHPs about how their contribution to the Trust is communicated to Board.
- Improving the extent to which AHPs perceive they are able to contribute to Trust and service improvement.
- Where traditional approaches have already been applied to address service quality, efficiency and productivity challenges without delivering the aspired to improvements, AHPs may offer service and patient benefits through alternative, new models of service delivery.

There is further supporting evidence for these benefits in the existence of nationally recognised AHP practice exemplars.

The search for evidence of AHP leadership impact is currently limited by:

- Limited focus on AHPs in national inspections such as CQC.
- Limits in confidence about current national AHP metrics. This is due to national and local variation in AHP service configurations and a focus on traditional delivery models. AHP impact may take effect elsewhere in the pathway or in the context of innovative (non-traditional) models of care.

3.8 Summary

This small and rapid review of AHP leadership in the context of a constantly evolving health and social care landscape has indicated that AHP leaders face challenges in common with leaders across health and social care. There are some specific contexts both historical and structural which have created some ambiguity regarding the concept of AHP leadership. While cautious not to over-interpret, there is however some preliminary evidence that the presence of senior leadership can support the visibility,
influence and contribution of AHPs to Trust services. There are already AHP of high calibre providing leadership for AHPs and the wider health and social care system. There is more to be done to facilitate AHP development in leadership and to sustain existing leaders.
Section 4:

Recommendations and Next Steps
4. Recommendations and next steps

4.1 Areas for further focus:
The findings from this project provide an informed platform from which to plan future work to develop and sustain AHP leadership. Future work may include:

- Refining a typology for AHP leadership configurations
- Exploring how AHP leaders can work effectively with mandated decision-makers and influencers, e.g. DoN. How can AHP leaders be supported to influence and work with mandated, traditional Board structures and dominant service delivery narratives?
- Exploring metrics which reflect AHP impact with greater fidelity; looking at whole systems impact and impact at distance from the AHP intervention.
- Explore where this work fits in the bigger AHP picture – AHPs into Action, AHP Mandate, Workforce Planning and AHP education
- Gather insights which have not been possible in this ‘first steps’ project. For example, interviews have focused on the perceptions of senior leadership and there is a case for examining the experiences of those who are led.
- Exploring how AHP leadership supports AHP professions to map traditional AHP evidence and outcomes to Trust and national priorities to more consistently demonstrate nationally relevant impact across the system and for patients?
- If traditional service redesign has not delivered and challenges remain, how can AHP leaders influence Trust decision makers to actively engage AHPs to address the ‘quality improvement vacuum’?
- The higher banded posts were not always in Trusts with the most favourable CQC ratings. However, the review of hard metrics provided some indication that senior AHP leadership may influence AHP staff perceptions of contribution to improvement and that for Trusts where such posts are established. There is also some indication that there are more nationally recognised AHP practice exemplars. It may be that investment in AHP leadership will have greatest impact for Trusts which have improvement challenges and where AHPs can engage in addressing the ‘quality improvement vacuum’.

4.2 How can insights from this project support the development of AHP leadership posts?
It is not yet possible to declare that there is a single best model of AHP leadership. There are some indicators that senior AHP leadership has quantifiable and quality benefits for Trusts where senior AHP leadership roles have been established. Trusts looking to establish such posts may wish to consider:

- Establishing an AHP leadership post might not seem like a priority for some Trusts, especially where there are wider service improvement challenges. However the data suggests the presence of a senior AHP leader may deliver improved AHP contribution to improvement and help to address service improvement challenges where traditional solutions have not delivered.
- Consider who the AHPs are in the Trust and who will be led and represented by this AHP leader.
• Understand any challenges linked to bringing AHPs with diverse professional identity and purpose together under a leadership post. Acknowledge possible challenges and continue to review and monitor them in conjunction with the AHP leader.

• Have clarity of purpose about the focus of leadership. Consider whether it is realistic for one post to hold clinical, operational and strategic focus; and if so how will these be balanced.

• Consider how Board business will be communicated to AHPs and how AHP matters will be represented at the Board; close proximity of AHP leadership to Trust Boards improves influence, visibility and contribution to service improvement.

• Consider how and where the AHP workforce could contribute to the delivery of key Trust targets and commissioning intentions, (for example Sustainability and Transformation Partnership (STP) plans) for patient care

• Consider how a formal AHP leader can develop and engage the AHP workforce to contribute to the delivery of key Trust targets and STP aspirations for patient care

• Design the AHP leadership post to have accountability and responsibility that will ensure AHP visibility at board level to facilitate engaging AHPs where they can make the best contribution to Trust objectives and patient care

• Think about AHP leadership impact in terms of demonstrating impact for the Trust objectives and patient care to the AHP leadership; how will these be evidenced and reviewed through both data and stories?

• While it should be acknowledge that it is not all about the band of leadership post, bear in mind that posts above 8C seem to demonstrate greater AHP contribution to improvement. Trusts may want to signal the value of AHP contribution and will want a high calibre leader who has the authority to bring together and represent all the AHPs in the Trust with one voice, much like a traditional and mandated Director of Nursing role would do.

• Develop and foster AHP leaders. Consider opportunities for AHPs to gain valuable wider systems AHP leadership experience in roles which may not be traditionally open to AHPs. When such posts become vacant, be prepared to challenge why an AHP could not fill the position. Build roles and job descriptions around skills and not professions.
Appendices
Appendix 1

See also Appendices 2-4 for details of survey questions, interview topic guide and additional data source @WeAHP Twitter Chats

Project Design

The project was designed to address the areas of focus as comprehensively as possible within a short timeframe and to deliver sufficient, evidenced insights to inform and resource future AHP leadership initiatives for optimum benefit. There was a focus on two interconnected areas of inquiry as set out in the original brief from NHS Improvement:

Mapping organisational AHP leadership structures and correlating with impact.

a What exists in terms of formal AHP leadership in England? – identification of metrics that will capture the structures, levels and roles that exist.

b What are the implications of different organisational structures? – identification of metrics to quantify the impact, quality and productivity of care delivery, in relation to the structures?

Effective AHP leadership.

c Identifying the characteristics of effective AHP leadership and how these have been facilitated to develop in the AHP workforce?

d What is it about the career journeys of effective AHP leaders that serve successful AHP leaders in delivering their roles?

A combination of survey, interviews, documents and extant national metrics were used to gather the range of facts, opinions and experiences required to address these questions. To ensure that learning from each part informed subsequent inquiry and that findings could be integrated iteratively as the project progressed, the two areas were addressed in parallel using mixed methods. Adopting this approach minimised duplication and replication of effort thus maximising project efficiency.

Data Sources and Collection:

As AHPs are an active and engaged community of health and social care professionals, the potential sources of data for this inquiry are extensive and varied. KUEL worked in consultation with the steering group to agree a data set from which to optimise insights into the questions posed within the scale of the project. Data sources were selected to maximise:

- representation from all 14 AHP professions
- comprehensive description of established AHP leadership arrangements
- understanding about AHP leadership arrangements in different provider organisations
- exploration of AHP leadership arrangements with reference to nationally collected productivity and quality metrics
- insights into AHP leadership characteristics

Guided by these criteria the following data sources were used
Bespoke survey of 233 provider DoNs in England
- Purposive interviews with formal AHP leadership post holders
- NHS Improvement nationally collated metrics: Model Hospital, Care Quality Commission, NHS Staff Survey
- Job Descriptions, Person Specifications, Organisational Charts for established AHP leadership posts gathered via survey, NHS jobs, NHS Improvement
- CVs from most senior AHP leadership post holders requested in interviews
- AHP practice exemplars: AHPs into Action Case Studies, Chief Allied Health Professions’ Officer Awards, NICE AHP exemplars³
- Feedback from project steering group
- Supplementary data including selected transcripts from @WeAHPs Twitter Chats and data relating to leadership from AHPs into Action crowd sourcing (provided by NHS Improvement)

Survey data was collected in December 2017 and interviews conducted in February 2018. As analysis progressed and gaps in data identified, follow-up emails were sent to survey respondents who had indicated they would be willing to be contacted. The final cut off for receipt of data to be included in the project was 14.03.18.

Survey
In the first phase of the research a survey was constructed for circulation to all Directors of Nursing (DoNs) across the NHS in England. The rationale for a survey distributed to DoNs was agreed with the steering group and reflects:

- the origins of the project prompted by requests from DoNs for guidance about developing AHP leadership roles
- the mandated role of DoN for NHS provider Trusts⁴

The main purpose of the survey was to gather data to map organisational AHP leadership structures by establishing a snapshot of what currently exists.

Survey Design and Administration
The survey consisted of 22 questions. Respondents were asked to report on:

- the range of AHPs employed directly and indirectly in the Trust
- the leadership arrangements for individual and collective AHP groups
- how communication took place between the Trust board and AHPs
- how AHP matters were brought to the attention of the board
- whether any wider leadership roles were held by someone with an AHP background

Respondents were also asked to provide a job description, person specification and organisational chart for the most senior AHP leadership post established in the Trust.

The survey was created using an online survey solution SurveyMonkey\(^5\). In the week before the survey was launched, an announcement was made through the NHS Improvement provider bulletin providing a brief overview of the project and its aims. The online link to the survey was embedded in an email to each DoN which was sent directly from NHS Improvement Clinical Director for AHPs and Deputy Chief Allied Health Professions Officer, Dr Joanne Fillingham. The survey remained available on line for two weeks from 08.12.17 to 22.12.17.

Survey Analysis
In the first instance survey analysis was used to:

- identify data gaps for further follow-up
- inform the design of the interview phase
- inform the purposive sampling for interviews

Free text responses were coded for themes.

Interviews
Interviews were used to provide supplementary insights into Trust AHP leadership arrangements and to develop an understanding of the characteristics of effective AHP leadership, the ways in which these characteristics have been facilitated to develop and examples of the elements of post holders’ career journeys which support successful AHP leaders in delivering their roles.

Interviews and Purposive Sampling
Following preliminary analysis of surveys and in consultation with the steering group purposive sampling was adopted using the following inclusion criteria:

- Formal substantive AHP leadership post holder at Agenda for Change (AFC) 8D or above (identified from survey)
- Survey respondent who may not be at 8D or above but has nationally recognised exemplar (AHPs into Action, CAHPO Award winner)
- Survey indicates willingness to participate further in evaluation

26 potential participants were identified who met the purposive criteria. 10 participants, able to provide a telephone interview in the available timescale were consented to take part as described below, (see also Project Governance below in this appendix). Telephone interviews were conducted by AHP academics working in the School of Allied Health, Midwifery and Social Care, Kingston and St George’s University of London between 12.02.18 and 06.03.18. Interviewers used a pre-prepared topic guide, (Appendix 3) to ensure key areas of focus were addressed with each participant.

\(^5\) [https://www.surveymonkey.co.uk/](https://www.surveymonkey.co.uk/)
Participants were asked to provide a Curriculum Vitae following the interview and a job description if not already available from the survey. Interviews were audio recorded but not transcribed verbatim.

The professional groups of those interviewed included representation from speech and language therapy, physiotherapy, occupational therapy, radiography (diagnostic), paramedic and psychology. Provider types included those from Acute Non-Specialist, Acute Specialist, Ambulance, Mental Health and Integrated Acute and Community. Of those interviewed, there were 8 females and 2 males.

Interview Analysis
Interview notes and audio were analysed for themes.

Additional Documentary Data
Additional documents included:

- job descriptions gathered from survey respondents, NHS Improvement and NHS jobs (n = 40 from Bands 8a to 9)
- Anonymised AHP Leader’s CVs (3 willing to share at interview)
- @WeAHP Twitter chat transcriptions (10 Chats selected)
- AHPs into Action crowd sourced information provided by NHS Improvement

Quantitative Metrics
To support the evaluation of AHP leadership impact an extensive list of possible nationally collated qualitative metrics was identified in discussion with the steering group. Data sources included Model Hospital, NHS Staff Survey, Friends and Family Test, NHS Safety Thermometer and NHS National Reporting and Learning System. Guided by the steering group, challenges were identified as reporting requirements for Trust types are not consistent. Further guided by the NHS Improvement data team an NHS Improvement data subset for all survey respondent Trusts was requested. Following selective screening of data a final short data set was agreed with the steering group which was available for all survey respondent Trusts and could be used in conjunction with the qualitative metrics detailed below to support the evaluation of AHP leadership arrangements within the scope of the project:

- Staff retention rates (Source: NHS Improvement)
- Trust CQC ratings (Source: NHS Improvement)
- CQC Well-led ratings (Source: NHS Improvement)
- Staff survey AHP perceptions of contribution to quality improvement (Source: NHS Improvement)

Qualitative Metrics
Qualitative metrics selected to support AHP leadership impact evaluation were:

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Evidence of nationally recognised AHP practice exemplars (Sources: AHPs into Action, CAHPO awards 2017, NICE 2015-February 2018)

AHP perceptions (Source: Project survey comments, Project interviews, AHPs into Action raw data from NHS Improvement and @WeAHP Twitter Chat transcripts)

From 54 AHPs into Action case studies, 13 could be matched to survey respondent Trusts. Two of the five Chief Allied Health Professions’ Officer Awards in 2017 were from Trusts who responded to the survey. Of the 24 NICE AHP practice exemplars from 2015 to February 2018 reviewed, five were from survey respondent Trusts.

Addressing Data Gaps
Where possible data gaps and omissions identified during data analysis were addressed. For example where survey responses needed clarification, such as the banding of the most senior AHP in the organisation, individuals who had agreed in the survey to be contacted again received a follow up email requesting clarification.

Synthesis of Findings
The Warwick 6C Leadership Framework was used to support the synthesis of findings. The framework provides six dimensions in relation to thinking and practice about leadership:

- **Concepts** – what do we mean when we talk about leadership?
- **Characteristics** – what roles and resources are available to leaders and how do leadership roles vary?
- **Contexts** – what do leaders need to be aware of in the wider environment?
- **Challenges** – what are the key challenges, purposes or aims of leadership?
- **Capabilities** – what skills and abilities help a leader to be effective?
- **Consequences** – how can we tell whether leadership is effective?

These dimensions have been used by Hartley and her team to review published healthcare leadership literature and have informed publications and reports on public sector leadership trends.

Project Governance
Throughout the project, KUEL worked closely with the NHS Improvement Clinical Director of AHPs’ Clinical Fellow. The project further benefitted from the insights of a steering group which was convened specifically for the purposes of the project and chaired by the Clinical Fellow. The steering group membership included a NHS Improvement nursing Clinical Fellow and practice colleagues with firsthand AHP leadership experience and insight. The steering group met monthly throughout the project and where questions arose between meetings these were addressed through email correspondence. There were weekly progress calls throughout the project between KUEL and the NHS

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7 There is a separate @WeParamedics Community. Review of the archived @WeParamedics chats did not identified chat transcripts with a focus on AHP leadership for inclusion.
Improvement Clinical Director for AHPs’ Clinical Fellow. The following project decisions were assured by the steering group:

- Final project plan
- Decision to direct survey to DoNs
- Survey design
- Purposive interview strategy
- Selection of productivity and quality metrics
- Review of project report

Using the NHS HRA decision tool the project was judged to be an evaluation of current practice for which ethical approval is not required. However, the project team conducted the work in compliance with the University’s Guide to Good Research Practice and with the University’s ethics and data handling procedures. All data was handled in the strictest confidence. All aspects of this project, including case examples, were conducted with anonymised data. Secure, password protected data management tools and processes were used to store, handle and interrogate data throughout. At the end of the project all gathered in the project will be transferred to NHS Improvement to inform future work related to AHP leadership. Survey and interview participants were provided with information about the purpose of the study, data handling, ownership and confidentiality. Survey recipients were informed that receipt of a completed survey was regarded as implied consent and interview participants were required to provide written consent ahead of interviews.

Project Design Limitations
This is a small scale delivered in a short timescale which limits scope and depth of findings. However the short timescale is positive in providing a real-time snapshot of current AHP leadership in the NHS in England; something that will be evolving in the context of a dynamic health and social care landscape. The project therefore offers an important opportunity to provide informed focus for future work aimed at developing AHP leadership capacity and capability.

A further concern shared acknowledged by the project team and steering group was that the timing of the project during the winter period might limit engagement with the project. In the context of a widely publicised challenging winter period in 2017/18 there has been a good level of engagement with the project and wide representation from Trusts and professions.

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8 The Health Research Authority Decision Tool is a publicly available tool designed to help decision making about whether a project is evaluation or research [http://www.hra-decisiontools.org.uk/research/](http://www.hra-decisiontools.org.uk/research/)
Appendix 2

Survey Content

The Allied Health Professions (AHPs), are a diverse group of professions, managed and led in a variety of ways across the NHS in England. There is no current consensus regarding the most effective leadership structures for these professions. This short survey is part of a systematic approach to professional leadership development and talent management across NHS Improvement’s Nursing Directorate. The survey seeks to establish a snapshot of current senior professional leadership for AHPs for each NHS Trust in England, recognising arrangements will vary from Trust to Trust.

The project is commissioned from Kingston and St George’s University of London by NHS Improvement. To facilitate data analysis, completed surveys will be gathered via the University’s password-protected Survey Monkey account. The project team will conduct the work in compliance with the University’s Guide to Good Research Practice. At the end of the project the data will be transferred to NHS Improvement. Returned, completed surveys will imply consent to use survey data for the purposes of the current project. It is expected that a summary report will be produced on completion of the project in late spring of 2018.

This survey will be open from 8th December to 22nd December 2017. The completion of the survey should take 10-15 minutes.

Thank you for taking the time to contribute to this data collection exercise. We appreciate that you may not have responses to every question, but please do complete the questionnaire as fully as possible.

Please click on OK to commence the survey.

1. Please give the name of your Trust
2. Which type of Trust describes your organisation?
   - Acute Non-Specialist Trust
   - Acute Specialist Trust
   - Ambulance Trust
   - Mental Health Trust
   - Community Trust
   - Other (please specify)
3. Please give name of individual completing this survey
4. Please give designation of the person completing this survey
5. What is the professional background of the person completing this survey?
6. Please indicate which AHPs are directly employed in your Trust
   (14 NHSE/HCPC AHP professions listed)
7. Please indicate which AHPs you have access to though are not directly employed by your organisation
   (14 NHSE/HCPC AHP professions listed)
8. How are AHPs led in your Trust?
   The primary focus of this survey is to understand leadership for AHPs directly employed by your Trust.
   Please indicate which of these directly employed AHPs have a profession specific lead. Where there is a professional lead, please use the matrix to indicate the band of the lead post, e.g. head of dietetics, Band 6
   (Grid provided for answers bands 6+ for each AHP profession)
9. Who do the Heads of Profession from Question 8 report to? Please indicate if these heads of profession report differently e.g. Head of Speech and Language Therapy reports to Chief Therapist but Head of Radiography reports to Director of Nursing.
   Free text
10. Can you tell us about any other senior AHP leadership roles for AHPs directly employed in your Trust? For example Paramedic, Clinical Director reports to the Board
11. Can you share a Job Description for the most senior AHP leadership role or roles in your Trust?
   Please attach relevant document or if preferred email as an attachment (contact details at end of survey)

12. Can you share a Person Specification for the most senior AHP leadership role or roles in your Trust?
   Please attach relevant document or if preferred email as an attachment (contact details at end of survey)

13. Please describe how AHPs get information from the Board/Senior Leadership Team

14. Please describe how AHP matters get communicated to the Board/Senior Leadership Team

15. Is there collective leadership for a group of professions within your Trust that you have not already described? E.g. Physio, OT and Speech/Language Therapy led as a group. You may include groups which include non-AHPs e.g. Physio, OT, Speech, psychotherapists led as a group
   Please describe the groups and who leads them in the box provided.

16. Is there anything further you would want to describe about the AHP leadership arrangements for your Trust? Please describe the arrangement here:

17. Are you able to provide an organisational chart (weblink if publicly available) which illustrates the AHP leadership arrangement and relationship with the Trust Board?
   Upload organisational chart or if you prefer email attachment, contact details below

18. Are there any other senior leadership roles held by a colleague with an AHP background? For example a Clinical Governance and Audit Lead who is an AHP. Please use the comment box to state the role and the AHP professional background for such posts if these exist in your Trust.

19. Do any board members have an AHP background? If so please state AHP profession and Board position.

20. Is there any other information which you consider will be useful in helping us to understand the AHP leadership structure in your Trust?

21. Are you willing to be contacted by the team conducting the evaluation? If so please confirm your email:

22. Is there anyone else in your Trust who it might be useful to talk to about AHP leadership?
   Please provide contact details.

If you have any questions regarding the survey, please contact Liz Treadwell, Project Lead

e.treadwell@sgul.kingston.ac.uk
Appendix 3

Indicative Interview Topic Guide

Part 1: Understanding more about leadership arrangements

- Influence of structure and or business of the organisation (Trust) on ways AHPs are led
- Variation in AHP leadership posts
  - History of post? How/why developed? Specific drivers?
  - If multiprofessional - how are profession specific concerns addressed?
- How is AHP voice is heard (or not heard) at Board level in your Trust?
- Board positions which are held by an AHP e.g. a Director of Transformation who is a radiographer - impact of the presence or absence of AHPs in board positions?
- What difference formalised AHP leadership role make?
- What factors influence quality of service delivered by AHPs?
- Influence of AHP leadership structures impacts and outcomes? Are there outcomes or metrics you think we should consider that might show this?
- Evidence of AHP strategy linked to Organisation clinical and operational strategy? – how are AHPs involved?
- Anything else it is useful for us to know about AHP leadership?
- Any key documents which we might not have considered or areas of the Trust’s website where we should look for further information?

Part 2: Other aspects of impact such as exemplars and case studies demonstrating the contribution of AHPs

- Encourage discussion about exemplar if one has been identified in purposive sampling – what was AHP leadership role?
- Others? Including locally /nationally recognised?

Part 3: Characteristics of AHP leaders and the influence of AHP leaders’ career paths

- Can you tell us a bit about your career path?
- What prompted you to apply for your current post?
- What are the main knowledge – skills -attributes required to be an AHP leader?
- What experiences have been important in your leadership development?
- Can you tell us about any leadership development you have undertaken? What have you found most useful?
- Do you have any formal/informal arrangements for peer support/network in your role?
- What have been the turning points light bulb moments in your development as an AHP leader?
- If you were designing a leadership programme for AHPs what would you want see in the programme?
- Do you think there is enough access to leadership development for AHPs? Should there be focused development for AHP leadership? And why?
- Where do you see your career going next?
- Is there anything else you think it would be useful for us to understand about AHP leadership and leaders?
## Appendix 4

### Twitter Chat Transcripts used as supplementary data source

<table>
<thead>
<tr>
<th>Title</th>
<th>Date</th>
<th>Number of Contributors</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHPs: today, tomorrow and us</td>
<td>March 2015</td>
<td>87</td>
</tr>
<tr>
<td>Integration: me, you and us</td>
<td>April 2015</td>
<td>51</td>
</tr>
<tr>
<td>The importance of leadership for me, for you, and for us</td>
<td>June 2015</td>
<td>61</td>
</tr>
<tr>
<td>Mastering the public health impact of our work</td>
<td>March 2016</td>
<td>116 (multi-community chat)</td>
</tr>
<tr>
<td>Making our practice the best practice: Everyday Evidence</td>
<td>July 2016</td>
<td>48</td>
</tr>
<tr>
<td>Maximising our productivity: who, what, why and how?</td>
<td>August 2016</td>
<td>33</td>
</tr>
<tr>
<td>Influencing in times of change</td>
<td>November 2016</td>
<td>23</td>
</tr>
<tr>
<td>#AHPsintoAction: taking forward the AHP mandate for change</td>
<td>February 2017</td>
<td>37</td>
</tr>
<tr>
<td>Expanding horizons: leading across boundaries</td>
<td>March 2017</td>
<td>44</td>
</tr>
<tr>
<td>Evidencing the quality and productivity of AHPs' care</td>
<td>July 2017</td>
<td>31</td>
</tr>
</tbody>
</table>
Appendix 5

AHP Leadership job titles from supplied job descriptions

Posts at band 9
- Director of Allied Health Professionals
- Director of Quality Performance
- Head of Therapies (Clinical Director)
- Chief of Therapies, Rehabilitation and Allied Clinical services
- Director of Therapies
- Director of Rehabilitation & Therapies and Laboratory Medicine

Posts at band 8D
- Professional lead for Allied Health Professionals and Health Care Scientists
- Clinical Director of Therapies and Directorate Manager for Therapies, Orthotics and PLIMS, and Trust Lead for AHPs. General Manager for Rheumatology, Pain Management, Psychology and Integrated MSK service
- Chief Allied Health Professional and Head of Therapies
- Chief Allied Health Professional (AHP)

Posts at band 8C
- Head of Therapy Services x2
- Head of Children's Therapies/deputy Associate Clinical Director
- Associate Director of Governance
- Rehabilitation Services Manager
- Head of Therapies
- Trust Wide Strategic Recovery & Allied Health Professions Lead
- Health Professions Lead
- Radiotherapy Manager
- Divisional Assistant Director of Nursing & Allied Health Professionals
- Strategic Lead for Occupational Therapy/Allied Health Professions
- Radiotherapy Manager and Professional Head of Therapy Radiography
- Therapies Manager
- Radiology Manager
- Associate Director for Therapy Services and AHP Lead x2
- Associate Chief Allied Health Professional (AHP)
- Clinical Lead -Therapies and Rehabilitation Medicine
- Strategic Lead for Allied Health Professions
- Divisional Director of Support Services (Clinical and Non-Clinical)

Posts at Band 8B
- Head of Allied Health Professions (AHPs) and Healthy Lifestyles
- Head of services
- AHP Directorate Manager
- Head of Therapy
- Lead Allied Health Professional
- Professional Head of Occupational Therapy Services and Arts Therapy
• Chief Dietitian
• Lead Allied Health Professional
• Trust AHP Professional Lead and Recovery Services Advisor
• Assistant Service Lead
• Head Orthoptist
• Head of Nursing and Allied Health Professions (AHPs)

**Posts at 8A**
• Professional lead for allied health professionals
• Integrated Governance Lead – Therapies Directorate
## Preliminary Typology of AHP Leadership

<table>
<thead>
<tr>
<th>Leadership typology</th>
<th>Relationship with Trust Board</th>
<th>Typical AFC Bands</th>
<th>Relationship with Metrics</th>
</tr>
</thead>
</table>
| **Uni-professional** – e.g. profession-specific leads. Retains strong clinical and operational components | **Distant** – for example reports to divisional director or general manager before a Chief Nurse or Director of Nursing Predicated around *process* – e.g. team brief | 8a, 8b           | • Sense of **low visibility** with Trust Board and **low influence**.  
• **Uncertainty** about how AHP business is communicated to Board  
• **Lower** AHP perceptions of contribution to Trust improvement  
• **Limited evidence** of nationally recognised AHP Practice exemplars |
| **Uni-professional** – e.g. profession-specific leads with voluntary or bolt/on responsibility for some or all AHP representation. The AHP representation is not the main purpose. Retains clinical and operational responsibilities | **Distant** – for example reports to divisional director or general manager before a Chief Nurse or Director of Nursing though may have seat at some Director of Nursing or senior level forums Predicated around *process* – e.g. team brief | 8a, 8b           | • Sense of **low visibility** with Trust Board and **low influence**.  
• **Uncertainty** about how AHP business is communicated to Board  
• **Lower** AHP perceptions of contribution to Trust improvement  
• **Limited evidence** of nationally recognised AHP practice exemplars |
| **Partial Multiprofessional** – e.g. leads a cluster of AHP professions. May be one of a number of such posts in Trust e.g. Head of Therapies and Head of Diagnostics or may be a corporate role (Divisional Director) with AHP or professional leadership as part of portfolio. May retain some clinical focus | **Varied intermediate** – tends to have intermediate reports before Chief Nurse or Director of Nursing though may have seat at some Director of Nursing or senior level forums Predicated around *process* – e.g. team brief Increased emphasis on relationships | 8c                | • **Variable visibility and influence** with Trust Board  
• **Improved confidence** in communication of AHP business to Board  
• **Strengthened** AHP perceptions of contribution to Trust improvement  
• **Good evidence** of nationally recognised AHP practice exemplars |
| Overarching Multiprofessional – e.g. representation for all or most AHP professions in Trust. May retain some operational focus. Increased strategic focus | Close – tends to have more direct reports Chief Nurse, Director of Nursing or other executive team member. Has seat at executive forums. Predicated around relationships with senior Trust decision makers | 8c, 8d | • Improved visibility and influence with Trust Board.  
• Mostly confident about communication of AHP business to Board  
• Strengthened AHP perceptions of contribution to Trust improvement  
• Good evidence of nationally recognised AHP practice exemplars |
|---|---|---|---|
| Strategic Overarching Multiprofessional – e.g. representation for all AHP professions in Trust. More strategic focus | Close or Direct – tends to have more direct reports Chief Nurse, Director of Nursing or other executive team member. May have one-to-one meetings with CEO. Has seat at executive forums. Predicated around relationships with senior Trust decision makers | 8d, 9 | • Good visibility and influence with Trust Board.  
• Mostly confident about communication of AHP business to Board  
• Strongest AHP perceptions of contribution to Trust improvement  
• Evidence of nationally recognised AHP practice exemplars |