

# Leadership of allied health professions in trusts: what exists and what matters

An evaluation summary and self-assessment for trust boards

June 2018

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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# Foreword

This document shares findings from a project that NHS Improvement commissioned to evaluate current leadership arrangements for allied health professions (AHPs) in trusts in England. We initiated the project in response to requests from directors of nursing for guidance about developing AHP leadership in their organisations. We wanted to establish the evidence base to inform our responses.

AHPs are the third largest workforce in the NHS. They practise in most clinical pathways and work across organisational boundaries at all stages of the pathway, providing solution-focused, goal-centred care to support patients' independence and autonomy. There has never before been such a need to harness their potential for transforming healthcare. However, their contributions to outcomes are often poorly understood, resulting in missed opportunities for their collective potential to support the transformation of health and care.

Successful outcomes will depend on effective leadership at all levels and across all AHPs. This quote from the evaluation report captures the nature of the challenge and, we suspect, will sound familiar to many readers:

“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. The need for AHP leadership generally is not well understood nor is the need for representation of AHPs in operational matters”.

AHPs, like all clinical professions, will be most effective in delivering and improving healthcare if there is sufficient strategic, professional, clinical and operational leadership to maximise their contribution to quality and productivity. This document will help trust boards self-assess their current AHP leadership arrangements, identify gaps and risks and identify opportunities.

We will support you to take action where current arrangements are insufficient, so that trusts optimise their AHP workforce and the unique contribution they offer to quality, productivity and system sustainability.



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# Introduction

There is widespread agreement that it is essential for the NHS to develop leadership and improvement capabilities to protect and improve services in the short term and for the next 20 years.<sup>1,2</sup> *AHPs into action*<sup>3</sup> outlined the specific transformative potential of AHPs in health, care and the wider system, recognising that “AHPs can lead change”. AHPs are identified as effective leaders who have diverse skills that are vital at a senior decision-making level.

The focus for this small and rapid review was on leadership for the 14 professions regarded as AHPs by NHS England: art therapists, drama therapists, music therapists, chiropodists/podiatrists, dietitians, occupational therapists, operating department practitioners, orthoptists, osteopaths, prosthetists and orthotists, paramedics, physiotherapists, diagnostic and therapeutic radiographers, speech and language therapists.

The evaluation indicates that AHP leaders face challenges in common with leaders across health and social care. Some specific historical and structural contexts have created ambiguity about the concept of AHP leadership. Preliminary indications suggest the presence of senior leadership can support AHPs’ visibility, influence and contribution to trusts’ services. This may seem obvious, but the proportion of trusts with such senior leadership is small. Some AHPs are already in posts providing strategic leadership for AHPs and the wider health and social care system, engaging staff in improvement to deliver quality and productivity benefits. But more needs to be done to promote AHP development in leadership and to sustain existing leaders.

It is not possible to set out a single model of AHP leadership. However, evidence indicates that senior AHP leadership has quantifiable quality benefits for trusts that have established senior AHP leadership roles.

<sup>1</sup> *Five year forward view*, NHS England 2014 <https://www.england.nhs.uk/five-year-forward-view/>

<sup>2</sup> *Developing people – improving care*, NHS Improvement 2016  
<https://improvement.nhs.uk/resources/developing-people-improving-care/>

<sup>3</sup> NHS England 2017 <https://www.england.nhs.uk/ahp/ahps-into-action/>

## What trust boards should consider

Trusts looking to strengthen leadership arrangements and subsequent benefits should consider:

- **Appointing a senior AHP with a strategic focus** – senior roles are by their nature more strategic, focused on relationships, influencing and engagement. This is a quick win that can focus on unlocking AHPs' potential within the trust. Consider constructing the postholder's portfolio to align AHP skills with the trusts' priorities. It is important to consider proximity to the trust board.
- **Harnessing the AHP workforce's potential for system redesign** – identifying the AHP workforce's transformative potential; implementing new care pathways to improve quality and productivity; building workforce competence and capability to realise the benefits.
- **Demonstrating AHPs' value** – historical fragmentation and low participation need radical change. Senior roles can demonstrate that the professions are valued and board business is communicated to and from AHPs to deliver trust priorities. These roles can enable talent management and succession planning, with AHPs actively engaged in trust and system-wide initiatives. A strategic focus on demonstrating value according to the triple aim (better care for individuals, better health for the population and lower cost through improvement).

## Structure of this document

We found AHP leadership arrangements vary widely across NHS providers in England. We present our findings in six sections, according to the Warwick 6 C Leadership Framework.<sup>4</sup> Each section is intended to guide thinking and analysis of strengths and gaps in AHP leadership in trusts, and summarise the evaluation's findings.

The full evaluation is available on our website.<sup>5</sup>

<sup>4</sup> Hartley J, Benington J (2011) Recent trends in leadership: thinking and action in the public and voluntary service sectors. King's Fund.

<sup>5</sup> <https://improvement.nhs.uk/resources/leadership-allied-health-professions-trusts-what-exists-and-what-matters>

# Our findings

## AHP leadership concepts

**Can the board easily identify its strategic and professional AHP leader?**

**Does the board have a shared understanding of the range of professions referred to as AHPs?**

AHP leadership concepts vary widely, reflecting the ways in which AHPs are defined and understood. In some trusts, AHPs include professions beyond the 14 recognised by NHS England, such as psychologists, psychotherapists, biomedical scientists and social workers. The terms ‘therapies’ and ‘AHPs’ are used inconsistently and often interchangeably, or to differentiate subgroups of AHPs.

Structures and arrangements vary widely. This is reflected in the array of job titles for the most senior AHP lead (41 titles across 43 job descriptions), meaning in most cases there is not a readily identifiable ‘go-to’ AHP leader as in other professions — for example, the director of nursing (DoN).

Job descriptions and specifications are inconsistent, and include instances where AHP leadership roles are open only to a subset of AHP professions. Some posts combine nursing and AHP titles, but these posts are not always open to AHPs. However, there is evidence that AHPs are providing leadership in posts with high levels of influence such as chief executive or chief operating officer.

Board-level accountability for AHP matters is ultimately and almost always via the DoN/chief nurse. However, the scale of the nursing agenda may leave the DoN feeling unable to adequately represent AHPs at board level.

## Leadership contexts

**Have you reviewed your AHP leadership model and are you satisfied with its fitness for purpose for your current organisational context?**

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

There is a sense that the contribution of AHPs is becoming more recognised. For example, sustainability and transformation partnerships and integrated care systems offer new opportunities for AHP leaders to be at the table, influencing and shaping the agenda and harnessing AHPs' potential.

## Characteristics of AHP leaders

**Comparing your most senior AHP leader to the typology below, are you confident that your arrangements match your requirements?**

**Does your broader AHP leadership structure deliver effective leadership for all strategic, professional, clinical and operational matters?**

Our findings indicate that the presence of AHP seniority – indicated by higher-banded posts – increases AHP visibility, and can act as an enabler by opening doors and providing credibility with senior leaders and trust boards.

Importantly, our findings indicate that the most senior roles influence the AHP workforce and increase its engagement in improving services. This is significant, given the correlation between improvement, quality and productivity, as well as the staff retention benefits that come from staff taking part in improvement activity.

AHP leadership posts occur at Agenda for Change (AfC) bands 8a and above, with most reported at AfC Band 8c and some senior posts established at bands 8d and 9. Our evaluation did not provide a rationale to explain this degree of variation.

We summarise the evaluation's most prominent findings in Table 1 below.

**Table 1: Preliminary indicators for an AHP leadership typology**

Leadership typology	Relationship with trust board	Typical AfC bands	Relationship with metrics			
			Visibility/influence with trust board	Communication of AHP business to trust board	AHP perceptions of contribution to trust improvement	Evidence of nationally recognised AHP exemplars
Uniprofessional – eg profession-specific leads	Distant	<b>8a, 8b</b>	Low	Uncertainty	Low	Limited
Uniprofessional – eg profession-specific leads with voluntary or bolted-on AHP representation	Process-driven					
Partial multiprofessional	Varied intermediate  Process-driven  Increased emphasis on relationships	<b>8c</b>	Variable	Improved confidence	Strengthened	Good (most)
Overarching multiprofessional	Close  Predicated around senior relationships	<b>8c, 8d</b>	Improved	Mostly confident	Strengthened	Good (most)
Strategic overarching multiprofessional	Close or direct  Predicated around relationships	<b>8d, 9</b>	Good	Mostly confident	Strongest	Good

## AHP leadership capabilities

**Do you have an appreciation of the benefits offered by AHP leaders who have experienced a varied career portfolio?**

**Do you have a structured approach to talent management and do you enable AHPs to access diverse opportunities for development?**

**Does your AHP leadership structure enable AHP leadership capabilities to be used to best effect for systems leadership and transformation?**

Senior AHP leaders offer skills that add value and strengthen overall trust leadership capability. They demonstrate a strategic appreciation of the wider health and social care system, often gained from a diverse portfolio of health and social care career experiences. They can work with and influence high-level trust decision-makers, mapping and demonstrating the impact of factors at trust and national level that affect service delivery. They demonstrate an ability to connect with and represent diverse AHP professional identities and interests, and have a track record in health and social care delivery and innovation.

Leaders we interviewed referred to the transferrable skills AHPs bring to senior leadership roles. Those in the most senior posts had supplemented their experience in their own profession, often spending time in less traditional AHP roles and/or outside their profession. While some had actively sought career development in this way, others found themselves in posts less deliberately. Either way, AHP leaders judged such experiences to be highly valuable in career progression because of the wider health and social care service delivery insights they developed in such roles. They regard an ability to see a wider health and social care system perspective as crucial. There is a sense among AHPs that they have begun to find a voice but now need to use it to articulate where and how their contribution can be made to matter in the system as a whole.

AHP leaders felt that interdisciplinary and interagency learning opportunities would be the most effective way to develop AHPs' leadership competency.

## AHP leadership challenges

**Do you have sufficient senior AHP leadership capacity to effectively and sustainably address clinical, operational, professional and strategic priorities?**

**Where leadership posts currently specify a particular clinical background, is there an opportunity to broaden the scope of professions listed to increase diversity and access to a wider pool of talent?**

**Are you able to demonstrate the quality and productivity impact of your AHPs?**

As with nursing and medicine, AHP leadership must represent a variety of professional identities, cultures and practice traditions – and diverse professions too.

Postholders at Band 8c reported a tension between balancing operational challenges and delivering strategic and transformation objectives, with the former taking precedence. Where they were the organisation's most senior AHP leader, this diminished the AHP workforce's transformative potential and could minimise trusts' perceptions of their ability to contribute to strategic transformation agendas. Individuals reported considerable burden of expectation in these roles, describing their ambition to provide robust representation and leadership to all the AHP professions. However, the structure of professional leadership supporting them was often weak, resulting in the strategic agenda becoming less of a priority.

Culturally established traditional perceptions of professional identity may perpetuate preferences for uniprofessional leadership and representation, convoluting communication between AHPs and trust boards. There is a risk some AHP groups are inadvertently overlooked, with their impact hard to detect, diluted or unrealised. Uniprofessional and AHP leadership are not mutually exclusive; a key benefit of senior AHP leadership is to ensure the constituent professions have voice and influence.

The system is based on recognising the impact of traditional care models that may be task-focused and have an immediate effect. AHP impact may be more distant: for example, AHPs' contribution to an acute care pathway may have most impact in the community or social care stage of a patient journey. This distance from impact may limit AHP confidence in current national productivity and quality metrics. However, the AHP Operational Productivity Programme may increase their confidence. It is helping trusts to measure and benchmark their productivity, optimise their AHP workforce and access the Model Hospital to compare performance metrics with peers and identify unwarranted variation.

Traditional role specifications sometimes exclude AHPs from applying for posts, creating a poverty of opportunity for AHP leadership progression and limiting the talent pool that will contribute to organisational success.

The variation and complexity of AHP leadership arrangements results in fragmentation. Often there is not a readily identifiable 'go-to' AHP leader, as there is for other professions such as nursing and medicine. Fragmented leadership may dilute AHP visibility, influence and impact. There is a suggestion that visibility and influence may become even more vulnerable when trusts reconfigure.

## AHP leadership consequences

**Do your current leadership arrangements drive and enable delivery of AHPs' contributions to improvements for hard-to-solve productivity, efficiency and quality challenges?**

We examined the effectiveness of formal AHP leadership against qualitative and quantitative metrics. We found that AHP leaders in senior posts from 8c and above had increased effectiveness.

There are a number of indicators of the benefits senior AHP leaders bring:

- where traditional approaches have been applied to service quality, efficiency and productivity challenges without improvements, AHPs may offer service and patient benefits through alternative, new models of service delivery

- improving visibility and influence between trust boards and their AHP workforce, and vice versa, to fulfil organisational and system objectives
- improving the extent to which AHPs perceive they can contribute to trust and service improvement.

We asked AHP leaders for their views on the most significant benefits of robust senior AHP leadership in trusts. Clear themes emerged around enabling transformation by redesigning pathways and the workforce. These views reinforce our evaluation and make a strong case for AHPs having more opportunity to contribute to system redesign to meet quality, productivity and sustainability challenges.

# Appendix 1: Background, context and design of the evaluation

## The evaluation questions

Recognising that AHP leadership varied around the country, we commissioned Kingston University Enterprise Ltd to develop insights into two key issues regarding AHPs' leadership across the NHS in England:

1. What organisational leadership governance structures exist for AHP service provision, and what is their impact on 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 AHP's career?

## Defining AHPs

The project concentrated on leadership for the 14 professions regarded as AHPs by NHS England: art therapists, drama therapists, music therapists, chiropodists/podiatrists, dietitians, occupational therapists, operating department practitioners, orthoptists, osteopaths, prosthetists and orthotists, paramedics, physiotherapists, diagnostic and therapeutic radiographers, speech and language therapists. Professions other than these are referred to collectively as non-AHP in the evaluation.

## Leadership focus

The evaluation focused on formal professional AHP leadership: established senior leadership positions aligned to higher Agenda for Change bandings (8 and above).

This was not to ignore that leadership occurs at all levels but to provide specific insights relating to senior strategic leadership for AHPs.

## Engagement and design of evaluation

The evaluation comprised a survey, interviews and analysis of job descriptions. A range of quantitative and qualitative metrics were used to gather facts, opinions and experiences to address the questions. We gathered 124 responses from 95 trusts to a survey distributed to 233 directors of nursing, representing a return rate of 41%, and 10 purposive interviews were conducted with senior AHP leaders.

## Quality assurance from key stakeholders

Summary findings were shared with over 120 AHP leaders at NHS Improvement-led regional events in May 2018. They provided assurance that the findings reflected their experience in their regions and trusts. We asked for views on the quality and/or productivity benefits if trusts had sufficient leadership structures to achieve operational, clinical and strategic priorities. Participants were also asked to inform the direction for future AHP leadership development opportunities and programmes.

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