

Investing in chief allied health professionals: insights from trust executives

A guide to reviewing AHP leadership for trust boards and clinicians

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Foreword

This guide offers insights into the benefits of the chief allied health professional (AHP) role, based on discussions with trust board executives who have established such posts in their own organisations. It builds on our 2018 publication, *Leadership of allied health professions in trusts in England: what exists and what matters*.¹ That report revealed wide variation in the way AHPs are led across the NHS in England. But it found that in the small number of trusts that had introduced a chief AHP with strategic responsibility, improvement activity markedly benefited and AHPs had a higher profile.

Since then, the number of trusts with chief AHPs has continued to grow, demonstrating an appetite from the system for such roles. However, significant system-wide barriers remain to creating them. Our follow-up project sought to better understand these roles through honest insights from trust executives. They overwhelmingly recognised that once chief AHP leadership is in place, the value and contribution of the workforce is immediate. One who took part summed up this recognition:

“I feel like I may have spent 20 years not appreciating what the AHP workforce can contribute.”

AHPs are the NHS’s third largest clinical workforce. Their practice is integral to most clinical pathways. They work across organisational boundaries, providing solution-focused, goal-centred care to support patients’ independence. As the NHS Long Term Plan² notes, there has never been such a need to harness the AHP workforce’s potential for transforming healthcare. Successful outcomes will depend on effective leadership at all levels and across the entire AHP workforce – but without dedicated strategic AHP leadership, these outcomes will not be truly recognised.

Professionally diverse senior leadership teams are better equipped to meet the challenges the NHS faces and the Long Term Plan’s ambitions. To benefit from the transformative potential of the AHP workforce and its unique contribution to quality, productivity and system sustainability, trusts must make chief AHP leadership a priority and challenge the barriers to it.

¹ <https://improvement.nhs.uk/resources/leadership-allied-health-professions-trusts-what-exists-and-what-matters/>

² <https://www.england.nhs.uk/long-term-plan/>

We will support you to take action where current AHP leadership arrangements are insufficient. We hope you find the insights in this document useful in shaping your own organisation's thinking.



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Introduction

The NHS Long Term Plan highlights the importance of visible senior clinical leadership in enabling and assuring the delivery of high quality care, both within organisations and in the new system architecture. It also highlights the importance of realising the transformative potential of the AHP workforce, as described in *AHPs into action*,¹ the national AHP framework.

Board members told us that having a chief AHP in post had raised the profile of the AHP workforce, increasing its engagement and therefore its contribution to trust priorities. But they recognised the need for further work to challenge the system-wide, taken-for-granted practices that historically may have limited or concealed AHPs' strategic contributions to health and social care.

“Clinicians from all professional backgrounds have a lot to offer as senior leaders. Supporting these talented people, who are already working in our organisations, to make the most of their potential is an opportunity too important to neglect.”²

Dido Harding, Chair, NHS Improvement

Our work reveals wide variation in AHP leadership structures. Despite quantifiable benefits for patients, organisations and the wider system from having a chief AHP, historical practices and gaps often present challenges to realising these benefits.

Such challenges, and the factors driving implementation of these roles, are subject to local priorities and contexts. However, we found common themes and similarities. We also found organisations tackling this opportunity, and its subsequent challenges, in innovative ways.

This guide contains:

Key questions for trust boards and senior leaders to consider about the potential benefits and common barriers to developing AHP leadership capacity and capability throughout the organisation and system. In considering these questions, trust board executives will gain

¹ <https://www.england.nhs.uk/ahp/ahps-into-action/>

² <https://improvement.nhs.uk/resources/clinical-leadership-framework-action/>

new perspectives and find new opportunities for benefit. These questions appear throughout the guide.

Insights from trust board executives describing how they are benefiting from dedicated chief AHP leadership, as well as the perceived challenges. Our aim is to give board members, and current and aspiring AHP leaders, ideas about how they can start reviewing their AHP leadership capacity and capability.

Executive board members' insights appear in these sections:

- Factors driving development of chief AHP roles
- Impact of chief AHP leadership roles
- Challenges and barriers.

Each section is intended to guide thinking and suggest actions for trusts to strengthen AHP leadership structures.

Key recommendations

Trust boards looking to strengthen AHP leadership arrangements and realise subsequent benefits should:

1. **Appoint a substantive chief AHP with a strategic focus.** A growing body of evidence recognises and supports the need for diverse clinical leadership. This guide reaffirms that need. If trust boards and integrated care systems are to recognise and realise the AHP workforce's transformative potential, chief AHP leadership roles must be established as the norm, to engage and provide dedicated strategic leadership for the third largest clinical workforce in the NHS.
2. **Challenge historical practices on traditional roles.** As healthcare policy develops, innovative and transformative approaches to the workforce are needed to meet the growing and changing demands of healthcare. As delivery models evolve, so do the roles, becoming more about the skills and competencies required to meet patient need. Despite this, many roles traditionally held by a designated profession, which could be held by an AHP, are ringfenced. AHPs are prevented from applying, restricting valuable leadership development opportunities for the AHP workforce – and this prevents the right skills being in the right place at the right time for patients. A chief AHP role will help challenge historical professional silos and support the organisation to identify opportunities for a richer skill mix, focusing recruitment on the skills and competencies to best meet patient need.
3. **Review governance arrangements.** The AHP workforce is historically fragmented, reducing visibility and engagement. We ask trusts to use the chief AHP role to reduce this fragmentation and bring the workforce together, to work in a safe, governed and productive way, in line with the National Quality Board's recommendations in *Developing workforce safeguards*,¹ as well as the key lines of enquiry in the Care Quality Commission's (CQC) well-led framework.²
4. **Recognise the AHP contribution.** Despite being the NHS's third largest clinical workforce, AHPs' potential is little understood – as demonstrated by fragmentation

¹ <https://improvement.nhs.uk/resources/developing-workforce-safeguards/>

² <https://improvement.nhs.uk/resources/well-led-framework/>

and disengagement. A chief AHP will help provide visibility and voice, ensuring the AHP contribution to trust priorities is not overlooked.

5. **AHP leadership development and career pathways.** AHPs have a poorly defined leadership development pathway and often find they hit an operational management 'ceiling'. They are often overlooked for senior strategic roles, due to their low profile and lack of opportunity to gain the necessary skills and experience because roles are ringfenced. A chief AHP role will enable talent management, succession and development planning, creating a workforce fit for the future and the diverse clinical leadership the system needs.

Our findings

Factors driving development and review of AHP leadership

Executives identified some common features.

- **Recognition of AHP value** – despite a general awareness of AHPs within a trust, their potential contribution to its success is often poorly understood by the board. National work such as *AHPs into action* (2016) and *Leadership of allied health professions in trusts in England: what exists and what matters* (2018) drew attention to AHP-led initiatives and innovation, which prompted trusts to reappraise the value of AHPs.

“I feel like I may have spent 20 years not appreciating what the AHPs can contribute.”

“An AHP leadership post should not be an option. All trusts need someone senior with oversight of AHPs, who is an AHP.”

“As the chief nurse, I recognised the need for an AHP in the senior leadership team. It’s been an incremental development, which began by bringing an AHP-equivalent to matrons’ meetings and then to board forums. When a deputy chief nurse post became vacant we changed it to a chief AHP.”

- **Structure and visibility** – executives felt the AHP workforce had struggled with visibility. They described this as being in the board’s ‘blind-spot’ at times. Reviewing AHP leadership capacity often arose from trust-wide restructures and staff feedback. Several directors of nursing explained that the opportunity arose from assessing their own portfolio and recognising that a chief AHP was vital for robust board assurance and the AHP workforce’s visibility, through strategic leadership.

“Examining the scope of my own portfolio, I realised it was not possible to cover it all.”

“There are difficulties of visibility for non-nursing and non-medical professions such as AHPs.”

“We need to give AHPs equal voice compared with nurses and medics.”

- **Rethinking existing leadership posts** – for some, the decision to establish a chief AHP arose through the opportunity a vacancy presented or by radically rethinking posts traditionally held by a nurse. Importantly, any decisions to change a post were not about substitution but driven by AHPs having the right skill set to fulfil the role and in turn meet the trust’s priorities.

“Difficulty recruiting to nursing vacancies has been a prompt to look at ways in which AHPs may be used more effectively, not as nurse substitutes but because the AHP brings the right skill set. This has not only filled a vacancy, but in turn provided AHP leadership opportunities.”

“Challenge taken-for-granted practice, traditional structures, job descriptions which restrict applicants to certain professions. Why wouldn't we have other professions in these roles? I have two deputies and one is an AHP.”

- **Governance structures** – AHPs were recognised as a collection of smaller professions, often practising in relative isolation from other AHPs across trusts as well as being part of different directorates or care groups. This fragmentation and isolation, in the context of existing traditional structures, were a cause for concern. For some, this raised questions about effective governance of the AHP workforce and AHPs’ ability to contribute to and influence decision-making. Appointing a trust-wide chief AHP providing strategic leadership addressed these concerns. It also contributed to meeting the recommendations in *Developing workforce safeguards* and CQC’s trust-level expectations for the workforce – ensuring safe, sustainable, productive and effective workforce planning.

“AHPs are managed in lots of different ways across the trust. It’s important to have someone with dedicated professional oversight of all the pockets of AHPs and to ensure the board doesn’t lose sight of the AHP contribution. The AHP lead advises me and keeps abreast of the national agenda.”

“Trust structure means many of the larger groups of AHPs are managed in the operational area where they contribute. The chief AHP is important in ensuring these groups are professionally led, not lost in operational structures. Heard.”

Key questions for trust boards

- Do any of these factors sound familiar to you?
- What is your understanding of the governance arrangements for the AHP workforce in your trust, and could you show they accord with CQC’s ‘well-led’ domain and meet the recommendations in *Developing workforce safeguards*?
- Does the board understand the range of professions referred to as AHPs within your trust?
- Who is championing the AHP workforce at board level?
- Are job descriptions and personal specifications of leadership roles reviewed, to ensure no unnecessary ringfencing?
- How are you developing teams that value the importance of professional diversity?

Impact of chief AHP leadership roles

Strategic chief AHP leadership has quantifiable benefits for the patient, organisation and wider system.¹ Trust executives were keen to tell us about the impact they had seen since creating the role and, where it was still recent, the benefits they anticipated.

- **AHP workforce visibility and voice** – without exception, the AHP workforce’s visibility and voice were reported as greatly improved by the introduction of a chief AHP. A ‘place at the table’ through visible AHP leadership can clearly articulate the workforce’s value and contribution.

“We now have nurses, AHPs and midwives around the table for every forum.”

¹ <https://improvement.nhs.uk/resources/leadership-allied-health-professions-trusts-what-exists-and-what-matters/>

“AHPs often have the answers – they really have the answers. Get AHPs at the centre of wards, units, teams! I’m wholly persuaded of the contribution of AHPs and that these professionals need visible AHP leadership.”

- **AHP workforce optimisation** – having a chief AHP markedly improved AHP deployment across the trust, ensuring the right skills were in the right place at the right time. Having a voice at senior decision-making forums ensured that AHPs were factored in to pathway business planning from the outset. Consequently, executives told us there was a noticeable increase in innovative AHP-led care models, which were overtly linked to tangible benefits such as recruiting and retaining AHPs in previously hard-to-fill posts.

“There’s been a noticeable impact on recruitment and retention. Since we appointed the AHP lead, our occupational therapy vacancies have been almost zero. The AHP lead has been innovative in linking hard-to-fill posts with projects and career development opportunities.”

“The chief AHP has a seat in operational performance forums so we can ensure AHPs are factored in to business planning. It ensures predicted activity or productivity gains from service and consultant developments are realised because AHPs have not been overlooked.”

- **Wider productivity gains** – a chief AHP with strategic oversight provides key information for executive board members on AHP matters and performance and – importantly – keeps them abreast of national AHP initiatives and policy. Executives who previously had to communicate with, or indeed line-manage, a range of individual AHP professional leads, saved time. In addition to such immediate productivity gains, the single point of contact with the chief AHP led to more consistent communication between the board and the AHP workforce.

“Having overarching AHP leadership ensures the director of nursing is suitably briefed and appraised of AHP matters, priorities and national initiatives.”

“It’s been time-saving for me as the chief nurse, as I am meeting with one overarching lead and not multiple individual meetings with each professional lead. I think that reduces confusion between professions.”

- **AHP innovation and improvement** – our 2018 AHP leadership evaluation found that the existence in a trust of a chief AHP at Band 9 or 8d correlates positively with workforce engagement and contribution to improvement activity. Executives reaffirmed this finding. They greatly valued being able to view enduring system challenges through the person-centred focus of the AHP workforce. Specific improvements were reported in both trust and national performance measures, including workforce, patient safety, quality, productivity and patient flow.

“With a chief AHP leader in post we are seeing more involvement of AHPs in improvement and innovation work, such as our therapy-led ward. I’m confident this AHP involvement has contributed to a reduction in length of stay.”

“We’ve seen improvements in early discharge, rapid response, user satisfaction, patient-reported outcome measures and reduced length of stay.”

- **Staff engagement** – before any of these positive impacts could be realised, executives stressed that the chief AHP’s primary function should be to engage a probably fragmented and previously overlooked part of the workforce: without this, there would be no impact. They stressed the need for patience to enable tangible, measurable change in the future.

“For any board thinking about developing AHP leadership, I’d say not to be unsettled about what impact can or cannot be proved in the first instance but to focus on engagement. Without engagement there will be no impact.”

“The (prior) absence of senior AHP leadership has meant the newly established post has a lot of remedial work to do. I think realistically it is going to take time, to be confident about all the benefits the post delivers.”

Key questions for trust boards

- Have you appointed a chief AHP with strategic and professional oversight of the AHP workforce, to provide voice and visibility to the board?
- Is the AHP workforce engaged and measuring its productivity: ie using the *AHP job planning: best practice guidance*?¹
- Do AHPs have a 'place at the table' at senior operational forums: ie to discuss planning and quality?
- Does the board fully understand the AHP workforce within your trust and the value it adds to trust priorities?
- Are AHP performance measures reported to the board?

Challenges and barriers

Developing a new role may entail challenges to traditional and taken-for-granted practices, as well as finding funding in an already difficult financial climate. However, board members shared some other key challenges to expect when developing AHP leadership roles.

- **Role purpose: strategic, operational or both** – where chief AHP roles had been established, executives said this was in response to trust priorities and the need for strategic leadership to provide a collective voice and visibility for AHPs in the trust. As trust priorities vary, executives expressed differing views about whether a chief AHP role should be purely strategic or also operational. Where it was both, executives suggested it should be acknowledged that operational issues tended to divert leaders' attention away from strategy, vision and innovation. In some instances, the strategy and operations aspects mirrored those of other professional groups' senior leadership roles, ensuring and signalling equity for AHPs in the trust's senior leadership structures.

“Principally I see the AHP leadership role as strategic across the trust.”

¹ <https://improvement.nhs.uk/resources/allied-health-professionals-job-planning-best-practice-guide/>

“The AHP leadership role has been established as a purely strategic role, mirroring the organisation’s corporate nursing leadership structures and roles, thus reflecting the leadership philosophy and culture of the organisation.”

“Operational demands tend to take priority, and the potential for strategic gain in the organisation is lost.”

- **AHP leadership development and career pathways** – many board executives told us they had encountered an unexpected struggle when attempting to recruit to the newly developed post, observing gaps in strategic leadership experience. This prompted recognition that AHP career paths are generally poorly defined compared to nursing and medical colleagues. Traditionally, many job descriptions and person specifications for roles providing leadership development specify Nursing and Midwifery Council registration, preventing AHPs from applying. This lack of defined leadership development opportunities may be leading to a gap in strategic and wider-system experiential learning in AHP career development.

“Currently there is difficulty finding the AHPs to fill these leadership roles because they have not been given the opportunity or do not feel permitted to try. We need to move from roles being linked to professions and rather roles/person specifications being linked to skill set.”

“Leadership is mapped out as an option from the outset for nurses but not AHPs. Student nurses are given more responsibility than AHP students, so they are stretched and understand the wider system sooner.”

Executives were keen to highlight they had tackled this by introducing AHP talent management schemes and encouraging senior leaders to review job descriptions and personal specifications to reflect the skills and competencies required rather than the profession traditionally appointed; they were fearful that if they did not, they would lose talented professionals. They are also encouraging and seeking out opportunities for the workforce, both locally and nationally.

“There’s a mid-career permafrost for AHPs. There’s nowhere for them to progress to, so we lose them from the workforce.”

- **Talent management** – it was apparent that executives play an essential part, not only in identifying a need for an AHP leadership role but in subsequently mentoring, championing and supporting promising, potential and aspiring AHP leaders, including those who perhaps did not have leadership on their career radar. This talent management is essential, not only for current chief AHPs but for succession planning. Encouraging AHPs to apply for opportunities that will stretch them should be a priority for all trusts if we are to have a supply of clinical leaders for the future.

“I recognise we need to build a cohort of AHP leaders across the trust.”

“I encouraged the person who is now my AHP lead to take a deputy director role. She was reluctant to take it, but she gained vital operational leadership insight and experiences.”

“I’m spotting Band 5 and 6 AHPs who are rising stars who should be harnessed and developed. There’s a national gap in terms of smaller professions such as midwifery and AHPs in the leadership talent pool.

- **Professional identity** – AHPs have a strong professional identity, often becoming highly specialist in their clinical field. When leadership opportunities arise, AHPs can be cautious about stepping away from their clinical roles. Loss of professional identity, threats to values and credibility, and ‘a step into the unfamiliar or unknown’ could all be concerns for clinicians moving into leadership and management roles. Promoting leadership as part of the clinical career can help overcome some of these assumptions, as well as enabling senior leaders to ‘keep in touch’ with the point of patient care. This may lead to greater willingness to move into leadership positions.

“AHPs don’t always consider leadership roles. We need to make sure they feel they have permission to apply for leadership positions.”

“AHPs have been overlooked. They are cautious about stepping out of clinical roles, and there’s a need to create development pathways for AHPs which are equivalent to nursing.”

- **Diverse clinical leadership** – innovative and transformative approaches to workforce are needed to meet the growing and changing demands of healthcare. This requires the emergence of innovative and integrated multiprofessional practices, which may not have featured in traditional career pathways. Executives engaging with this agenda have recognised the AHP workforce’s potential contribution and the associated need for senior AHP leadership. However, they acknowledged this is not happening across the whole system, conceding that some colleagues do not share their perspective on professional leadership diversity. It is important that trusts share their learning from the impact of these posts, to reassure – if that is what is required – other parts of the system.

“Not all my colleagues or senior nurses within the trust felt that there needs to be senior AHP leadership. I had to make the case, champion it.”

“Initially there was some push-back from the board but now that impact is being recognised, they are fully committed.”

“It might be a leap of faith for some less experienced senior leaders (board members) to consider revising job descriptions and person specifications to open up to other professions. It requires a cultural shift – professional, individual and organisational. There is scope for mentoring organisations who are not yet taking this leap of faith.”

Key questions for trust boards

- Who is championing the chief AHP role and need for professional leadership diversity, to be better equipped to face the challenges facing the NHS?
- Are job descriptions and person specifications designed for leadership roles (at all levels) traditionally limited to a profession? Does this need to be the case? Could the skills and experience of AHPs meet the delivery requirements of the role?

- Are AHPs included and engaged in your talent management and succession planning, so they have a range of opportunities to build their operational and strategic leadership skills: ie secondments, shadowing, coaching and mentoring?
- Are AHPs encouraged and given the time/space to access local or national leadership development programmes, such as the NHS Leadership Academy?
- Are individuals given adequate time to keep up professional registration and guided in how to do this?
- Relinquishing professional identity, and threats to values and credibility, could be concerns for clinicians moving into leadership and management. Is leadership promoted as part of the clinical career, to overcome these assumptions?

Conclusions

The insights that board executives provided for this guide draw attention to system-wide, traditional practices that may have limited or concealed the AHP workforce's strategic contributions to health and care and to trust success. Chief AHP leadership can transform an organisation and system by providing an engaged, productive and visible workforce that can contribute actively to trust and system priorities.

It is essential that trusts recognise that a sustained cultural shift is needed to remove outdated practices. By thinking differently about how the system provides development and manages talent, we will maximise the contribution of the NHS's third largest clinical workforce and ensure we make the most of the talent we have, from all professional backgrounds.

Recruiting for the skills required rather than from a specific profession will enable trusts to provide the integrated, multiprofessional working essential for transformative patient-centred care. It will also provide opportunity for AHPs to develop the skills and experience to become valuable members of the senior leadership team.

Simon Stevens, NHS CEO, said: "We must do more to unleash the energy, insight and brilliance of AHPs".¹ But to truly realise this, we must have chief AHP leadership in place as the norm.

We want this guide to help you and your organisation consider the need, impact and implementation challenges associated with AHP leadership necessary to address the health and care challenges of the future.

¹ <https://www.youtube.com/watch?v=QtN8QX85gzY&feature=youtu.be>

Next steps

The next steps for your organisation will depend on how far you have implemented AHP leadership, but we would recommend you:

- consider the key questions in each section above
- appoint a chief AHP with strategic and professional oversight of your entire AHP workforce
- email us at nhsi.ahpteam@nhs.net to discuss the support we can offer you in reviewing AHP leadership structures within your organisation
- engage your AHP workforce by running multiprofessional meetings or focus groups to explore current AHP leadership arrangements and what the future should look like
- if you have a chief AHP, consider sharing best practice about the factors that drive this role and its impact, as well as your learning so far, with other organisations.

We recognise there is no ‘best practice’ model of AHP leadership, so we are keen to hear about your experiences (nhsi.ahpteam@nhs.net) – about what works and what does not – so that we can work together to make the most of the value AHPs bring to the workforce.

Appendix 1: Project design

Two main sources of data were used to gather detailed insights from board executives in trusts where a strategic chief AHP role had been established:

- review of free text comments from 124 responses to the survey of 233 directors of nursing in NHS trusts (December 2017)
- telephone interviews with a purposive sample of executive board members including directors of nursing, medical directors and chief executives (October to December 2018).

Appendix 2: Key contributors

This guide was created by:

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