

## Allied Health Professions Leadership in Academia:

Opportunities,  
challenges  
and current  
positioning



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Dr Marc Griffiths, Acting Dean, Faculty of  
Health and Applied Sciences, University of  
the West of England, Bristol

Dr Vivien Gibbs, Head of Department of  
Allied Health Professions, Faculty of Health  
and Applied Sciences, University of the West  
of England, Bristol

# Contents

Foreword	4
Abstract	5
Introduction	6
Background	7
Research Methodology	8
Data Analysis	10
Discussion	11
Conclusions	17
Key Recommendations	18
References	20
Appendix 1	22
Appendix 2	24
Appendix 3	25
Appendix 4	26

## Thanks and biographies

With grateful thanks to Beverley Harden, National AHP Lead and Health Education England who commissioned and supported this work to develop greater understanding of the opportunities and challenges faced by AHP leaders within the HEI sector. The recommendations aim to improve access to HEI sector leadership development and mentorship, to better value diversity within leadership and to liberate the full talent and contribution of Allied Health Professionals to the system. Together with the Council of Deans for Health, HEE is committed to improving the support to AHPs, to ensure AHPs are better supported to transition strongly from expert clinical and research roles into HEI sector leadership, and to continue to advance their leadership careers within academia.

### Dr Marc Griffiths

*Acting Dean, Faculty of Health and Applied Sciences, University of the West of England, Bristol*



Dr Marc Griffiths is currently the Acting Dean of the Faculty of Health and Applied Sciences at the University of the West of England (UWE), Bristol. Marc is a HCPC registered Diagnostic Radiographer with over twenty-two years of clinical and academic experience and has a research track record in nuclear medicine, hybrid imaging, workforce development, mentorship, leadership and advanced practice. Marc is a Principal Fellow of the Higher Education Academy, a Fellow of the Leadership Foundation, a member of the Approval and Accreditation Board at the Society and College of Radiographers and a partner at the Health and Care Professions Council. His professional background has involved working in clinical, commercial and academic environments and he has a particular focus on the impact of new technology on the patient experience. Marc's previous positions include Head of Department for Allied Health Professions at UWE, Bristol and working closely with Health Education England on the development of new professional pathways, namely in Paramedic Science and Physician Associates.

### Dr Vivien Gibbs

*Head of Department of Allied Health Professions, Faculty of Health and Applied Sciences, University of the West of England, Bristol*



Dr Vivien Gibbs is Head of the Department of Allied Health Professions in the Faculty of Health and Applied Sciences. This Department offers a diverse range of programmes, including Physiotherapy, Occupational Therapy, Paramedic Science, Diagnostic Imaging, Radiotherapy & Oncology, Medical Ultrasound, Sport Rehabilitation, Nuclear Medicine, Optometry and Physician Associate Studies. Vivien originally qualified as a Radiographer and went on to specialise in Medical Ultrasound. Vivien is a committee member of the Consortium for the Accreditation of Sonographic Education (CASE), a role which involves advising and approving UK Ultrasound programmes to confirm they meet minimum standards for training the sonography workforce. She is a member of the Fitness to Practise Panel for the Health & Care Professions Council (HCPC). And is also currently Vice President for Education and Research for the annual UK Radiological Congress.

## Foreword



One of my key priorities since I became Chair of the Council of Deans of Health has been to ensure that we are a truly UK-wide and multi-professional organisation. With some professions being larger than others and with government and regulatory agendas focusing heavily on nursing, this is not always an easy task.

The Council is not an organisation that represents healthcare professionals, who happen to work in academia. We are rather a membership organisation of senior academics representing the higher education sector, healthcare being the subject matter. I am committed to continue to reiterate this message to governments, our partners and key stakeholders we interact with. With that in mind, our focus as a membership organisation should be on discussing strategic academic issues across all professions. This is often the case although I can recognise instances whereby debates can be skewed towards a particular profession, which at times is required.

One would expect that healthcare academics have the same opportunities to hold senior roles than any other academic colleague and that within healthcare, all professions would have the same access to senior roles such as Dean, Pro Vice Chancellor and Vice Chancellor. I regret to observe that this is not always the case and there is more we need to do to see a greater proportion of allied health professionals in senior governance and leadership posts in universities. At the Council we are focused on getting the data and evidence on how many roles are currently held by academic AHPs versus other healthcare professionals through our staff academic census. Once we have that evidence, we will be in a strong position to focus our attention on understanding the status quo and agree what changes we need to consider.

The research findings in this publication offer us all an opportunity to reflect on what we need to do differently to support more AHPs and other healthcare professionals and enable them to be more visible in senior roles in academic leadership. I can imagine that not all the examples in this publication will resonate with everyone as every academic's experience is different and unique. There are however some loud and clear messages here for individuals, associations, governments and our of course our Council.

During my career as an academic and now Pro Vice Chancellor and in my role as Chair of the Council I have come across many impressive AHPs with strong leadership skills. Whether this was in research through the Research Excellence Framework (REF), where AHPs do really well in terms of impact or in other roles, I know that AHPs excel in the leadership whichever role they decide to take on. I look forward to discussing with our members how we can continue to observe excellence in AHP academic leadership now and in the future.

**Professor Brian Webster-Henderson**

*Chair, Council of Deans of Health*

# Abstract

## Introduction

The aim of this research was to gain a deeper understanding of the perceptions of key stakeholders in relation to the current extent of Allied Health Professionals (AHPs) in leadership roles within academia. The researchers undertook an exploration of the potential barriers, challenges and opportunities that exist for AHPs to undertake leadership roles within higher education and used the findings to offer recommendations for the future.

## Background

Whilst it is acknowledged that the number of AHP academic staff is significantly smaller than other professions such as nursing, it is generally recognised that a lower percentage of AHPs are appointed to significant leadership roles within academia. This is particularly noticeable in posts associated with governance, policy and decision making. This project focused specifically on the reasons why this may be the case and aimed to identify opportunities for future development models.

## Method

Purposive sampling took place to ensure a diverse sample of stakeholders, and the inclusion of the most appropriate participants with different experiences, backgrounds and roles, thereby ensuring a range of perspectives would be obtained. A total of twenty semi-structured interviews were conducted and the data analysed using thematic analysis in order to explore the initial findings and create core themes.

## Findings

Several themes emerged from the study, the primary ones relating to lack of confidence, a lack of motivation amongst AHPs to aspire to senior leadership roles, with a preference instead to focus on gaining clinical and research expertise rather than leadership skills. In addition, fewer opportunities appear to exist for AHPs to progress into senior leadership roles outside of the AHP sphere, due to a number of reasons which are explored in more depth in this report, but the key issue was an inability to break through existing structures within academia. It was noted that AHPs probably have much to learn from our nursing colleagues in how to move into strategic leadership roles within academia.

## Conclusion

A number of recommendations have been made to ensure that AHPs attain the ambition, the confidence, the skills and the opportunities required for them to be able to move into senior leadership roles in the future.

Whilst it is recognised that the findings from this study may not resonate with all AHPs, the comments and the themes represent the lived experiences of the interviewed participants. Further work is therefore needed to establish whether the issues raised here are specific to AHPs, or are shared by other academic groups, and hence of wider relevance.

The findings from this study will be used to apply for a subsequent grant application for a future project. Current research in the area is limited, and further information is required to establish what challenges are faced by AHPs when progressing through their careers.

# Introduction

In April 2018, Health Education England commissioned the University of the West of England (UWE), Bristol to undertake a primary research study evaluating the current scope of Allied Health Professional (AHP) leadership within higher education (HE).

Whilst it is recognised that the number of academic AHPs is significantly smaller than other professions such as academic nurses, it is widely acknowledged anecdotally that a lower number of AHPs are appointed to significant leadership roles within academia. This is particularly noticeable in posts associated with governance, policy and decision making. This project therefore was designed to explore the reasons why this may be the case, as well as identify opportunities for future development models.

It is becoming increasingly important to ensure that strong AHP leadership is evident within the HE sector. The increasing opportunities and challenges opening up in the education sector in relation to the impact of the move to tuition fees and student loans in England; the impact of REF 2021 criteria on AHP research capacity; the potential impact of the Augar Post-18 Education and Funding Review; and the increasing volatility of the HE sector, all contribute to the increasing importance for health disciplines to work more strategically with external stakeholders at a high level. Creating future educational curricula that embeds a stronger culture of leadership will also help develop confidence to actively seek new opportunities for AHPs.

## Aims of the project:

1. To gain a deeper understanding of the perceptions of key stakeholders in relation to the current position of AHP leadership within academia.
2. To explore the potential barriers, challenges and opportunities that exist for AHPs to undertake leadership roles within higher education
3. To use the findings to maximise developmental opportunities for individuals to reach senior positions in order to realise their full potential

## Background

In the UK, new university lecturers with nursing, midwifery and allied health profession backgrounds are generally appointed after establishing themselves as expert clinicians with associated practices and identities. They find the mid-career transition to their higher education roles challenging. They generally enjoy the challenge, feel well supported and are highly motivated by nurturing new practitioners. However, they see teaching as a priority and it takes up much of their time and energy. They experience underlying pressure to complete a doctorate and be research active, and often do not see strong pathways into leadership roles. In addition, they may experience reluctance to let go of their prior identity and credibility as a clinical practitioner and try to retain their clinical skills. Despite this, it seems that nursing colleagues are able to do this more willingly as they appear to more frequently take on leadership roles. It appears therefore that AHPs may have much to learn from their nursing colleagues, and this study is an attempt to explore some of those factors (1-2).

There has been a strong move since the late 1980s by the Government to reduce the medical dominance by doctors in the clinical environment. The mainly Thatcher-driven determination to reduce the power of doctors had a significant impact on nurses who received encouragement and incentives to move into management hierarchy away from patriarchal medical dominance (3). This process however, did not extend to AHPs and, as a result, these departments became subsumed under nursing colleagues who were recruited to Board level leadership roles. Currently statute requires foundation trusts to have both a medical director and a director of nursing. As a result, very few AHPs have ever achieved Board level roles. This mind-set appears to have transferred into the academic world with very few AHPs appointed to senior leadership roles within Higher Education Institutions (HEIs). When undertaking a literature review on the subject, a dearth of literature was noted.

The Chief Allied Health Professions Officer (CAHPO) in England has recently published the results of a large national research project *AHPs into Action: Using AHPs to transform health, care and wellbeing*. This has had a huge impact on inspiring AHPs and clinical managers to think differently about how clinical services are offered. The CAHPO has succeeded in raising the profile of AHPs and provided them with the confidence to shape new models of care. This research project into AHP leadership in academia was designed to link to '*AHPs into Action*' and further explore the extension and progressive development of the AHP role specifically within academia. This was an important platform to build on in terms of creating the appropriate interview questions and create a sense of initial understanding from senior educational leaders who attended the Council of Deans of Health (CoDH) Summit meeting in May 2018.



# Research Methodology

A qualitative approach was used to investigate the perceptions of key stakeholders, which focused on AHP academics working within higher education or a professional body. As the context of the research study was leadership, the structure and design of the methodology and interview questions did not explore AHP research positioning and it is acknowledged that this is strong across many AHP disciplines (especially physiotherapy).

To explore this subject, a constructivist Grounded Theory methodology was used, which is considered to be particularly useful where there are complex relationships and professional situations. It aims to uncover new or poorly understood values and generates new theory from these (4-5).

Ethical considerations were paramount throughout the research process. The research team were guided by ethical principles and Institutional ethical approval was obtained for the study from the UWE Ethics Committee in April 2018. Confidentiality and anonymity of the respondents was deemed to be paramount and the researchers ensured that individuals could respond fully without being identified or linked to their institution. Participants were informed that quotations may be used as examples but would not be attributable to individuals. They were also informed that they would be free to withdraw from the study at any time.

Purposive sampling took place across the membership of CoDH, and professional bodies. CoDH facilitated contacts with their members for potential inclusion in the study. The AHP professional bodies were all contacted and several professional bodies [Chartered Society of Physiotherapy (CSP), College of Operating Department Practitioners (CoODP), Royal College of Occupational Therapists (RCOT), Society and College of Radiographers (SCoR), British and Irish Orthoptic Society (B&IOS), British Association of Music Therapy (BAMT)] identified a named representative to be interviewed for the study. Participants included AHPs from a variety of backgrounds plus two non-AHPs who work within an AHP environment.

The inclusion criteria for participants related to having some knowledge of, or experience of, working as an AHP in the HEI environment. Purposive sampling ensured a diverse sample with the inclusion of the

most appropriate participants (4) with a range of different experiences, backgrounds and roles, thereby ensuring a range of perspectives. Representation across England, Scotland and Wales was undertaken through the interviews and attempts were made to recruit participants from Northern Ireland, but this was not possible. The majority of interviews were from participants based in England, however the professional experiences of some participants drew upon time spent in other parts of the United Kingdom.

Clinical AHP practitioners were excluded from this research study from a participation perspective, however previous clinical experience from participants did reference time spent within clinical practice. This was inevitable and helped to shape some of the emergent themes within the research study.

A discovery phase was initially undertaken and further details are presented in the next section of this report.

Individuals were invited to participate in the investigation via a letter or email, which included an information sheet and a consent form. The information sheet (see appendix 1) was made available providing details about the purpose and nature of the investigation, making it explicit that there was no compulsion for the individual to participate. A consent form (see appendix 2) was provided for all participants to sign, in order to demonstrate their agreement to take part in the study and for the interviews to be recorded.

Each interview was semi-structured, supported by a framework which acted as a guide for an informal conversation between researcher and participant, and also guided the analysis. This method of qualitative interviewing is recognised as an effective method of obtaining reliable views and information from participants (6). Semi-structured interviews were created using guidance questions (appendix 3) were designed, to gain an understanding of individual views on the current position of AHP leadership within academia, and any observations on the barriers, challenges and opportunities that exist for AHPs. Closed questions were used to explore respondents' biography and professional backgrounds. Open-ended questions asked about areas such as their experiences, the support they had been given, their personal professional development, and their views on the issues. Within



these broad areas they were prompted for strengths, opportunities, constraints, their perspectives on formal and informal support for leadership development, and any areas for potential further development.

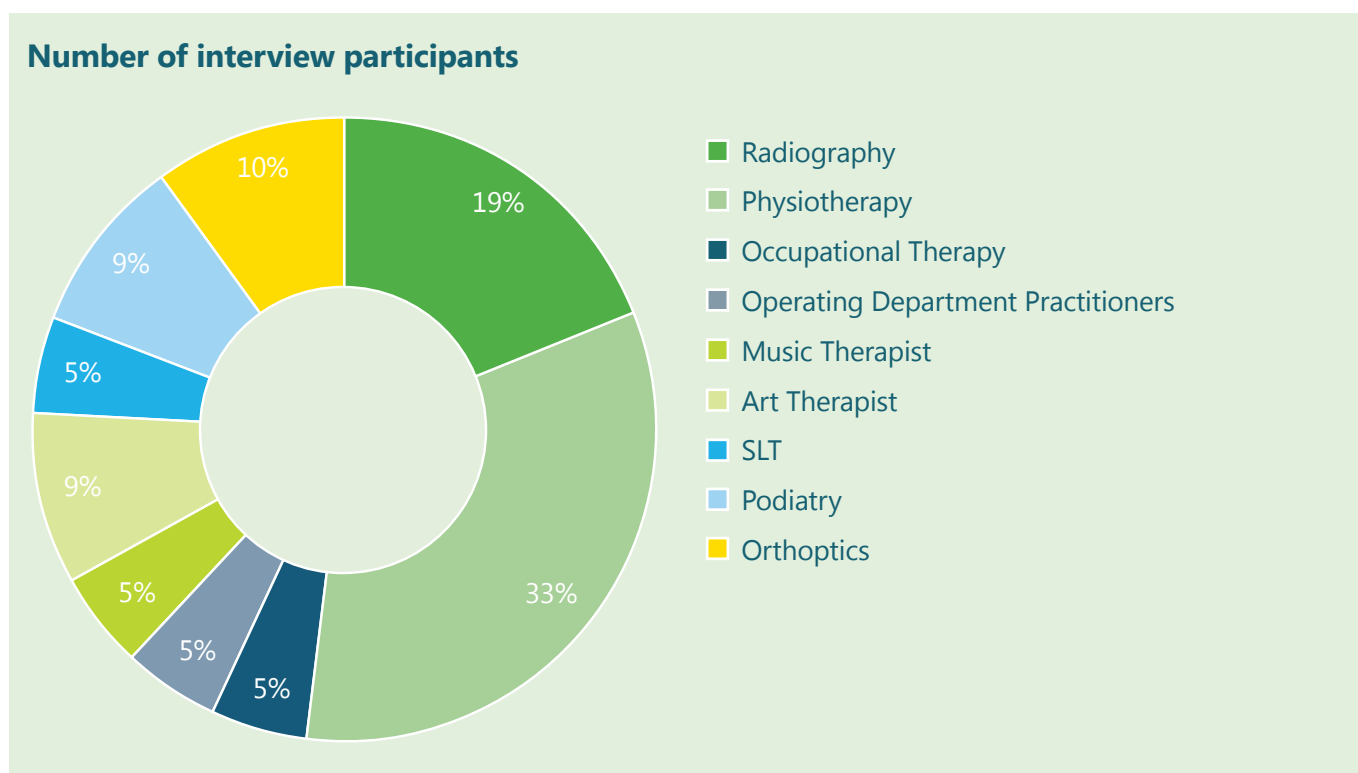
The interviews were conducted via telephone, using a digital dictaphone recorder. Written consent was received for all interviews. All data was collected anonymously and stored securely. A research assistant was used to transcribe the interviews. This individual was aware of the importance of anonymity and confidentiality of the contents of the interviews and was asked to sign a confidentiality agreement before involvement. All data was stored securely on an encrypted external storage device, in accordance with the University's data protection policy. Once publication of the research findings has occurred, all interview data was deleted in accordance with General Data Protection Requirements (GDPR).

Six interviews were initially undertaken via telephone; findings and emergent themes from these were disseminated at a discussion workshop in May 2018 at the CoDH Summit, to highlight key themes and initial findings. A further fifteen interviews were undertaken,

which spanned representation from Russell Group universities, the University Alliance and a number of professional bodies.

A further workshop was held at the CoDH Summit in May 2019 to present the themes arising from the project. Whilst some delegates in the room could not relate to the views being presented regarding the challenges experienced by the participants in this study, conversely, many did identify with them. The value of mentorship/coaching and confidence building was a theme where there was general agreement that this needs to be further explored. A shortage of suitable role models and mentors were recognised by AHPs although, interestingly, not by those involved in research. Some felt that the challenges associated with moving into leadership roles is wider than just AHP and is experienced across the healthcare sector generally.

Representation of professional groups within the AHPs is highlighted in **figure one** and it is acknowledged that two professions (physiotherapy and radiography) contribute to over fifty percent of the participants that were interviewed.



**Figure one** – Representation of different AHP groups that were interviewed

# Data Analysis

## Data Analysis

During the research, although discussions and responses were wide-ranging, several common themes began to emerge. The broad range of comments from participants that arose from the interviews, were reviewed by the researchers by defining subject content of the data, and then coded according to their content. As the codes were accumulated, they were then sorted into five themes. This resulted in a transfer of the descriptive data, summarising the responses into a more interpretative approach to help understand the data.

The data was analysed using a thematic analysis approach to understand the findings and a complete open coding method was used initially to identify anything and everything of interest from the transcripts (7). These were coded with a word or brief phrase that captured the essence of interest and all relevant codes assigned to each point of interest (8-11). Focused coding was then utilised to develop

tentative categories and theory testing as the research progressed. Memo writing was implemented from the early stages of the data analysis and conducted concurrently to allow ideas and theory building to occur (11) as well as providing an audit trail (12). Memo writing has been described as the intermediate stage between data coding and theoretical analysis (10). This allowed ideas, thoughts and challenges to be captured (10,13-15) as well as forcing questioning to increase the rigour and credibility of the research and emergent theory (13, 16). The process also allowed any gaps to be identified which were explored in later data collection (10). Initial codes and associated categories were checked by a second person to ensure these were unbiased.

All the points raised by participants were finally identified as fitting into one of five themes. The comments have been synthesised and outlined in appendix 4 of this report.

## Discussion

An initial discovery phase took place in May 2018, with a scoping exercise being conducted at the CoDH Summit in May 2018.

Three key themes that emerged from the discovery phase were:

**Comment #1:** AHPs are swept away in the nursing and midwifery voice, especially in terms of issues relating to recruitment, retention etc. Senior leadership opportunities are difficult to come by for AHPs in academic environments.

**Comment #2:** Potential for AHPs to transform services (e.g. placed based care/integrated care) in practice – e.g. Greater Manchester’s devolution care model.

**Comment #3:** Limited opportunity for AHP involvement in strategic development / policy making/governance creation.

The discovery phase was an essential component of this research project, exploring the impact of the AHPs into Action strategy within the higher education environment. Post discovery phase, the final interview questions were defined and an initial appreciation was obtained of the positioning within a cluster of AHP leaders from various HEIs across the United Kingdom.

From discussions and interviews with participants, a picture began to emerge that AHPs frequently benchmark themselves against nursing colleagues. This is probably understandable given the close working proximity of these professions within both the healthcare and the HE sectors. This is reflected in the themes that emerged from data analysis.

Five primary themes were identified from the interviews undertaken:

### Themes:

1. The hierarchical structure of the nursing profession provides them with the inspiration/aspiration to ‘climb the ladder’ to senior roles. In contrast, there are a limited number of AHP role models in leadership positions and no established mentoring scheme.
2. AHPs tend to focus on increasing their clinical specialist and/or research skills and aspire to become leaders in their clinical/research specialty areas, rather than more general leadership roles. Opportunities do exist but sometimes AHPs do not pursue them due to lack of confidence, negative perceptions of leadership, shortage of training opportunities and fear of losing their professional identity.
3. Traditional historical perspectives and legislation still exist which affects the dominance of nursing, resulting in the voice of AHPs being restricted. Currently statute requires that nurses have representatives at NHS Board level whereas AHPs do not. This provides nurses with a stronger voice and high-level connections; nurses in HEIs therefore have more readily available access to contacts in these senior NHS positions. This gives them a wider perspective of the landscape and increased political acuity.
4. AHPs are a group of disparate professions and have apparent differences amongst themselves. It is often difficult to have one voice or avoid competing with each other in terms of skills and capabilities of staff. The professional bodies often encourage this ‘protectionist’ approach.
5. Healthcare is a relatively new area in HEIs and in some organisations, particularly the Russell Group universities, there is often scepticism about the relevance of nursing and AHP healthcare education within the university setting.

## Exploring each of these themes individually:

**Theme #1: The hierarchical structure of the nursing profession provides them with the inspiration/aspiration to 'climb the ladder' to senior roles. In contrast, there are a limited number of AHP role models in leadership positions and no established mentoring scheme**

AHPs' absence of voice at clinical board level results in them not being part of the executive team and therefore they tend to rise to no higher than divisional level. This results in a lack of role models and mentors to enable them to progress. Without having many AHPs currently in senior roles, it is difficult to provide aspirational mentors who inspire other people and provide networking opportunities. The requirement for increased mentoring opportunities and the shortage of AHP role models were mentioned frequently by participants. A network and register of AHP mentors were suggested as a possible way forward and a stronger inclusion of leadership attributes at pre-registration level would also be required in order to develop the next generation of AHP leaders (**figure two**).

In the NHS the nursing workforce is very large and needs to be managed appropriately, with formal structures in place. Nurses were therefore perceived as always working in team structures and relying on hierarchy to manage these structures. As a result, they view progressing up the hierarchy as something to be aspired to and valued. In contrast AHPs often fail to seize the opportunities when they arise, as they do not view this as desirable career progression. This is similar in academia as well and there is a need for a whole system approach to mentorship across the HE environment to create an impact upon the expectation, mindset and motivation of all healthcare professionals working within higher education

The nursing profession's focus on hierarchy rules and policies was mentioned by several participants. However, it was acknowledged that this bureaucracy does serve the function of creating structures that enable people to develop and progress as leaders. The contrast was highlighted between the NMC's validation process requiring nurses to attend a minimum number of hours of training (which hospitals pay for in order to retain registered staff), and the HCPC's more moderate stance in requirements for education. This results in AHPs having to fund their own training and development and carry it out in their own time due to its non-mandated requirement.

**Theme #2: AHPs tend to focus on increasing their clinical specialist and / or research skills and aspire to become leaders in their clinical / research specialty areas, rather than more general leadership roles. Opportunities do exist but typically AHPs do not pursue them due to lack of confidence, negative perceptions of leadership, shortage of training opportunities and fear of losing their professional identity.**

Several participants stated that AHPs, when they first qualify, aim to become highly competent practitioners with excellent clinical skills and therefore do not value or develop leadership skills. They also viewed leadership roles as something that would distance them from their profession, clinical and/or research activities and original professional identity.

Those AHPs that take opportunities to become leaders (typically through informal/organic support networks) found it challenging to 'acclimatise' to their new roles without appropriate formal support/development and felt they are often blocked from further developing their roles in areas such as research. This potentially creates an environment where AHPs are not represented as strongly as their nursing counterparts in senior academic leadership roles.



**Figure two – Positioning of mentorship within a career pathway**

Nursing and medical programmes normally embed leadership, autonomy and confidence within pre-registration curricula. Conversely, some AHPs have not had that culture of being given the concept of leadership all the way through their careers. AHP programmes tend to focus more on clinical and research skills, often neglecting to instil leadership characteristics from an early point. This can result not just in a lack of confidence but also an absence of aspiration. The AHP's lack of confidence, and preference to stay within their 'comfort zone', was a concern for many. The perception seemed to be that this was linked to a shortage of role models, unclear career structure as an academic leader and a resulting absence of aspiration.

**Interview participant comment:** *'AHPs I work with usually prefer the safety of an environment in which they have knowledge of and feel comfortable in, that's their clinical or research areas where they have already built up expertise and recognition'*

In general participants felt well supported when first entering the HEI environment as new lecturers. In a smaller number of cases lecturers felt formal support was weak and some felt isolated in their workplace.

**Interview participant comment:** *'Are we looking at a shortage of AHPs in leadership positions or a lack of an AHP voice in HEIs because, even when reaching leadership positions, AHPs fail to focus on strategic issues affecting AHPs so the AHP voice is still not heard'*

Often the workplace experiences of new AHP lecturers appear to encourage them to hold on to their identity as a credible clinical practitioner, despite the inherent contradiction that this is no longer a realistic position due to their new workplace setting. In this area of the new lecturers' experiences Wenger's (2) emphasis on the connection between practice and identity is significant. He describes how individuals moving from healthcare settings often do not strongly focus on building new identities as higher education teachers,

researchers or leaders within their professional field. This may additionally lead to a lack of understanding of the hierarchy of their new organisation and a consequential failure to engage with the process of moving through the system. Being able to transition between types of environments where a range of skills are required is important in order to ensure agility and flexibility of approach. Leaders need to feel confident in these environments and promote collaborative ways of working within unfamiliar hybrid models of engagement.

One participant commented that AHPs may develop an 'isolationist' mentality when they move into a HEI role and this could affect their willingness to become involved with the issues of other professions. Further analysis of this participant's transcript identified the lack of cohesion within AHPs, a lack of confidence and an inability to contribute to new developments as reasons why an isolationist mentality develops. This will inevitably affect not only their interest in applying for a wider leadership role, but also their suitability and preparedness for these roles.

Several participants commented that when AHPs move into academia they have to either take the leadership / management route or a research route, and many are attracted to the latter for a number of reasons; they may see this as more intellectually stimulating and/or as more professionally prestigious to achieve success as a researcher. Whilst it could be viewed that this will equally apply to nurses, comments from participants suggested that nurses do not seem to share this perspective. Also, AHPs may view leadership posts as vulnerable positions, particularly as much of the HEI sector is moving towards rotational posts. Individuals could therefore be in these roles for a maximum of five years and then would have to revert to a lower status role. This would mean having to put their entire research remit completely on hold. It would then be challenging to return to that and start again at a later point. AHPs are therefore less likely to take on leadership and management roles if they feel it is going to inhibit their potential for having a research career and promotion to chair.

**Theme #3: Traditional historical perspectives and legislation still exist which affects the dominance of nursing, resulting in the voice of AHPs being restricted. Currently statute requires that nurses have representatives at NHS Board level whereas AHPs do not. This provides nurses with a stronger voice and high-level connections; nurses in HEIs therefore have more readily available access to contacts in these senior NHS positions. This gives them a wider perspective of the landscape and increased political acuity.**

Whilst it was recognised that AHPs need to be selected on grounds of merit, it was generally felt that greater equal opportunities needed to exist. The requirement exists for greater acknowledgement of the suitability for AHPs as potential candidates for senior leadership roles, rather than the general assumption that leaders should originate from a nursing background.

**Interview participant comment:** *'Where AHPs are selected on academic merit in research roles, they have been seen to do well'*

The historical perspective was viewed as a major factor which advantages nurses, particularly in relation to nurses having representatives at NHS Board level whilst AHPs generally do not. Currently statute requires foundation trusts particularly, although not necessarily trusts that haven't reached foundation status, to have both a medical director and a director of nursing. In order to change this primary legislation, there would need to be ministerial intervention, but this is unlikely to be imminent with the current workload faced by parliament in relation to Brexit. Rather than creating a director of allied health on the board, a preferable solution would be for non-medical board leadership posts to be open to any registered nurse, healthcare scientist or allied health professional. The selection process should focus on the competence of the individual rather than professional background. This would have the added advantage of providing opportunities for diverse roles and perspectives to be part of strategic leadership decision making.

This clinical leadership advantage for nurses was perceived as extending into the academic environment. When they start in academia, nurses may invariably have more influential networks with access to senior nurses in clinical positions. They may also have more leadership experience themselves and an awareness that aspirations to leadership roles are a professional norm. This will undoubtedly affect their ability to access strategic discussions with senior leaders and therefore they will have a strategic voice themselves, enabling them to be able to progress within their own academic leadership development. One participant highlighted that in Scotland the chief hospital nurse will only communicate with a nursing dean. Faculties therefore are heavily weighted towards ensuring the role of dean is held by a nurse.

There are currently over 690,000 registered nurses on various parts of the NMC register (17) and 329,000 registered with the Health and Care Professions Council (HCPC) (18). Of those registered with the HCPC, approximately 171,000 are AHPs (as the register also includes healthcare scientists and social workers), so clearly with these numbers there are more available nurses. Nonetheless, there was strong feeling from those interviewed that there are disproportionately high numbers of nurses in senior leadership roles in HEI organisations. It was felt that these senior academics roles should be appointed to in terms of merit and should be open to all regardless of the relative number that are represented in the workforce.

Recent work has been undertaken looking at the qualitative state of play of leadership in clinical organisations. The document *Developing People – Improving Care* from NHS Improvement (19) is a national framework to guide local, regional and national action on developing NHS-funded staff. This issues very clear guidance to chairs and chief executives to really examine their current stance, and then take note of best practice and evidence that we have, in order to support them in their decision-making around looking at their leadership. This is potentially an area that probably needs to translate to the Council of Deans of Health in terms of thinking about leadership within the academic context also.



CoDH was viewed by several interview participants as being rather 'nursing focused,' with nursing related issues tending to dominate in discussions. The Florence Nightingale Foundation scholarship programme has also traditionally been available only for nurses to develop the leadership skills to progress to a role of dean. There is no similar programme for AHPs.

**CoDH Open Forum (Discovery Phase) comment:**

*Clinically, AHPs are typically represented by the Director of Nursing. Some would like to change this title to the Director of Nursing, Midwifery and Allied Health Professions for the benefit of the public and increased visibility for AHPs*

The Council of Deans of Health are beginning to address the issue of AHP leadership more widely. In 2017 the Council, in collaboration with the Burdett Trust for Nursing, introduced the Student Leadership Programme (#150Leaders) for pre-registration healthcare students. The programme is open to nursing, midwifery and AHP students and is designed to encourage individuals yet to qualify to feel the importance of leadership at every level. This is crucial to the future development of educational leadership roles within AHPs, as one interviewee commented:

**Interview Participant comments:** *They (AHPs) don't have enough role models to base those leadership roles on.*

AHPs lack confidence, prefer to stay in their 'comfort zone', lack role models and aspiration

In addition, CoDH has recently put together a number of initiatives to enhance AHP academic visibility. These include hosting specific policy sessions for AHPs, networking events with AHP members only, specific AHP policy work (such as vulnerable professions recruitment) and roundtable discussions with AHP professional bodies. These opportunities have the potential to have a positive impact on the role of AHP leadership.

Another point raised frequently by participants was that, nursing programmes tend to be very large programmes within universities, and therefore large income generators. This will undoubtedly provide them with a stronger voice and will facilitate their ability to ensure more focus, more resources, and more importance generally is attached to these.

One area of concern for some participants was the 'Double speak' which often occurs where, although publicly acknowledging the issue of lack of AHP opportunities and a desire to rectify this, privately this is not followed through with any real conviction. Kegan and Lahey (20) highlight the real reasons why people will not change and this is typically associated with having big assumptions around what change could look like and how a person can instigate small but significant change.

**Theme #4: AHPs are a group of disparate professions and have apparent differences amongst themselves. It is often difficult to have one voice or avoid competing with each other in terms of skills and capabilities of staff. The professional bodies often encourage this 'protectionist' approach.**

AHPs are currently a group of 14 very different professions with often little in common. The only feature that links them generally seems to be perceived as the fact that they are not nurses or doctors. Generally, people understand what nurses and doctors are, but they have less confidence knowing what the other smaller professions might do, or what skills they possess. As a result, they may focus on nursing when making strategic decisions or selecting individuals for posts.

The role of professional bodies was mentioned as perhaps being a 'disabler' for uniting AHPs. They tend to, understandably, be protectionists for their own individual body of professionals and perhaps need to look at focusing differently on how to enhance opportunities for AHPs in general, both for clinical and academic environments, in order to drive the agenda forward.



It was recognized that grouping together of the professions provided a stronger voice and an increased profile. This was seen as a positive enabler to create more connections with senior decision makers. However, the complexities associated with the different professions means that AHPs often cannot agree what leadership means for them as a group at the core dimension. In order to truly speak with one voice, we need first to learn how to join up the 14 professions. It was acknowledged that the professional bodies actively encourage the individual profession focus as this is part of their remit. However, they perhaps have a role here to promote AHPs rather than their profession specific focus, which could risk diluting the overall identity of AHPs.

Whilst evidence of collaborative work has been happening at a strategic level via the AHP Federation (AHPF) in terms of pursuing equitable leadership opportunities for AHPs, perhaps the issue here is that this work has focussed primarily on clinical practice rather than academic leadership. There may also be a lack of awareness of the breadth of work professional bodies do on members' behalf, and perhaps this needs more explicit communication.

Several people within this research commented that with the prominent role of the Chief Allied Health Professions Officer, plus growing numbers of AHPs in leadership positions in Health Education England, this has raised the profile and created more awareness of AHP professionals generally. This in turn will potentially have an effect on academic leadership because AHPs will start to have more impact. However, a number of AHP leaders have also reported concerns around the sustainability of the AHPs into Action strategy, especially with a number of established AHP leaders within HEIs about to retire in the next 3-5 years.

**CoDH Open Forum (Discovery Phase) comment:**

*AHPs into action is currently successful in raising the profile, however, there is a concern about the succession plan and if it is sustainable*

Several HEIs have recently been involved in setting up new schools of medical education, which is a heavily established and dominant profession, and this may shift the balance for AHPs again in the future. Whether this will result in stronger links and other professional alliances remains to be seen, and potentially other inequalities may arise. It was considered that it will

always be difficult for the AHP voice to be influential when income generated in HEIs is much less than other professional areas.

It was suggested that perhaps people outside of healthcare with a lack of understanding of the role of an AHP should be interviewed in a future project, to explore the views of non-AHPs and nurses to determine their views and insights into relevant issues.

**Theme #5: Healthcare is a relatively new area in HEIs and in some areas, particularly the Russell Group universities, are often sceptical about the relevance of healthcare education within the university setting, or the ability of these healthcare individuals to transfer their skills.**

Several participants mentioned the fact that healthcare does not have equal standing in terms of academic rigor of the training programmes. There is a perception that in some areas, particularly the Russell Group universities, there is scepticism about the relevance and 'intellectual hierarchy' that AHPs and nurses did not tend to have in terms of the same research credibility as other disciplines (e.g. medicine). The career trajectory of these healthcare individuals meant that they would generally aim to complete several years in clinical roles before moving into an academic career. This then led to them entering academia and research at a later stage in their careers. They will therefore have to focus on achieving postgraduate qualifications and building up a research profile before they can consider moving into a strategic leadership role.

There is perhaps an approach needed by HEIs to facilitate a move by healthcare professionals into academia at an earlier stage in their careers. Suggestions were made that greater use of clinical academic careers should be encouraged, perhaps even at graduate stage, to ensure individuals have time to develop the appropriate skills and experience needed to progress into leadership roles within HEI.

Note was also made that one of the biggest challenges for AHPs moving into leadership roles is demonstrating transferability. They are often seen externally as possessing a narrow skillset and this limits their ability to transfer into other fields or move into roles with a wider, more strategic focus. Further research exploring with those AHPs who have made the transition successfully into senior leadership roles would be potentially enlightening.

## Conclusions

There was general consensus amongst participants that there are larger numbers of nurses compared with AHPs within academic senior leadership roles, even when taking into consideration the larger pool of nurses that there is to draw from compared with AHPs. The reasons for this were considered to be multifactorial, but primarily related to an absence of aspiration or desire to move into leadership roles by AHPs due to a focus on acquiring skills in clinical and research expertise. There was also an awareness of a lack of confidence, a shortage of role models, and limited understanding of HEI structures and opportunities available for an AHP to aspire to a strategic leadership position. It became apparent during this research that AHPs have much to learn from their nursing colleagues in how to aspire and achieve senior leadership positions.

Historical perceptions and current legislation were seen as facilitating the dominance of nursing and resulting in the voice of AHPs being restricted in comparison. Nurses have representatives at NHS Board level whereas AHPs do not, and this provides nurses with a stronger voice and high-level connections; nurses in HEIs therefore have more readily available access to contacts in these senior NHS positions. This gives them a wider perspective of the landscape and increased political acuity.

The hierarchical structure of the nursing profession was noted as providing them with the aspiration and the opportunities to rise to senior roles. Many successful nursing role models exist in senior leadership role, and these roles were seen as highly desirable. In contrast, there was acknowledged to be a limited number of AHPs in leadership positions who could act as role models, and no established mentoring scheme to get them there.

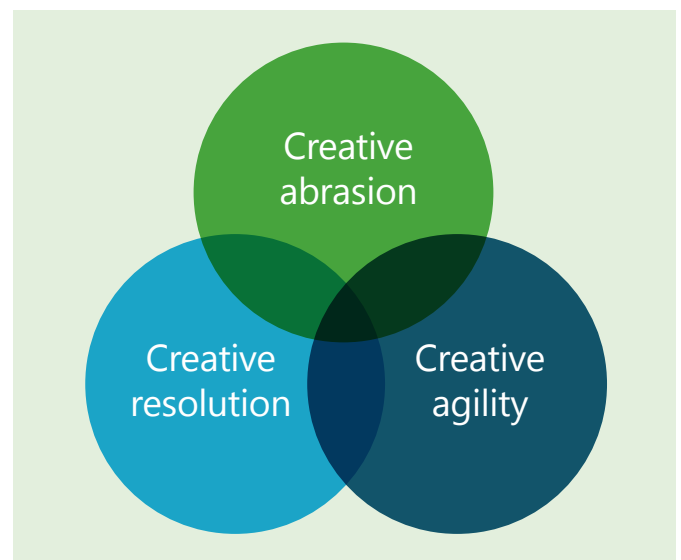
Whilst it is recognised that the findings from this study may not resonate with all AHPs, the comments and themes represent the lived experiences of the interviewed participants. Further work is therefore needed to establish whether the issues raised here are specific to AHPs or are shared by other academic groups and hence of wider relevance.

## Key recommendations

### Recommendations for the higher education sector, CoDH and AHP academics

- There is a greater need to embed leadership skills in pre-registration education programmes, providing students with inspiration to aspire to leadership roles. Current AHP programme leaders should facilitate students to feel that they are important, and to aspire to achieve senior leadership roles. There is a duty and obligation by the current educational and clinical workforce to help student and graduate AHPs to increase their confidence by embedding leadership in the core curriculum. The professional bodies need to own a stronger role in developing the aspiration to move into leadership, without having to sacrifice a research or clinical career and in doing so promote the importance of leadership careers in HEIs. This could be undertaken via case study or enquiry-based learning approach.
- Design a toolkit for AHPs for leadership within education. This would need to be HEI specific and to address areas relating to HEI needs. As part of this, a national health specific mentoring/ shadowing scheme could be developed which is not necessarily restricted to professions or institutions. This could incorporate education experiential learning, provide partnership talent management, and a self-directed but supported leadership engagement programme. It is important for AHPs to improve networking abilities, the strategic HEI environment and support others through mentorship at all levels throughout the organisation. We need to work with colleagues to explore what AHPs can do to further this particular agenda in a multi-professional sense and ensure we can learn from our nursing and midwifery colleagues. CoDH could potentially be the mechanism for this with their trans-institutional/trans-professional position. It would be beneficial to explore the feasibility of working with someone such as the Chief Allied Health Professions Officer, to link in to the *AHPs Into Action* in order to develop a national project to raise the awareness of the importance of leadership: *AHPs into Leadership*.
- Facilitate clinical-academic pathways and encourage graduates to consider this approach to ensure they move into an educational role at an early stage in their careers when they can develop the appropriate skills and experience. This work would also include making sure that new lecturers had a clear understanding of the hierarchies within HEIs and the confidence to engage with colleagues at multiple levels.

Academic communities have a responsibility to ensure the conditions for creativity exist, including support for the development of domain-relevant skills, creativity-relevant processes and motivation (23). This approach will better connect the individual and the organisation, thus creating the right intrinsic environment for creative working and confidence building. This can be achieved through three key capabilities, as described by Cook (2014 (24) in **figure three**.



**Figure three – Creating the right type of intrinsic environment for leadership to flourish through core capabilities (24)**

The recent findings from the CoDH report *#150Leaders: Fostering Student Leadership* (25) highlights how students can be motivated as leaders at the start of their higher education experience, thus creating the conditions for creativity to thrive. This is especially important for future co-creation models of education, interdisciplinary working and future graduate outcomes. This approach will also better support AHPs who will work across different work environments and cultures in their graduate roles.

- Promote equal opportunities within the context of higher education, in term of applications for leadership roles. Raising awareness that all health professions should be able to apply for leadership roles and successful recruitment is based upon merit, knowledge and experience. Talent management, mentorship and professional development should be available to everyone and support for tomorrow's leaders. There is an urgency associated with reframing of AHP leadership roles within HEI environments.

### Recommendations for AHP professional bodies

- Professional bodies need to be viewed as a resource that individuals and teams can draw on to support more strategic approaches to leadership development e.g. advocating for AHP leadership roles/capacity and strategic engagement with senior HEI representatives, whilst recognising this needs to align with institutions' priorities. They could potentially help to build leadership capacity and more actively contribute to developing leadership capacity within existing teams e.g. building on the kinds of initiatives developed with members in clinical practice.

### Recommendations for public bodies, government and HEE

- Establish a leadership programme for AHPs in education, e.g. through the #150Leaders route. This could potentially link with the NHS Academy, the Leadership Foundation and the Higher Education Academy (now Advance HE). This could incorporate e.g. high level AHP senior leaders' seminars to provide inspiration from VCs and Deputy VCs who are AHPs by background, to discuss their experiences and backgrounds. As part of this, structured online networking and mentoring opportunities could be created.
- Creation of an Advanced Educator programme within HEIs. This approach could offer a clear pathway for academic leaders who are AHPs and align with frameworks offered by organisations such as Advance HE. This could connect with the development of the Virtual ACP Academy through Health Education England (22) will create consistency and fairness across professional domains and provide opportunities for HEIs to further promote the role of AHPs as leaders.

### Potential further areas for research

The findings from this study will be used to apply for subsequent grant applications for future research. Current research in the area is limited, and further information is required to establish what challenges are faced by AHPs when progressing through their careers.

- Include other professions in any future research project to obtain the external perspective, ensuring there is a 360 degree coverage of the opportunities and challenges facing healthcare leaders in higher education.
- Undertake evaluation of a programme of capability building to explore pre/post statistics in a longitudinal study.
- A national conference exploring AHP leadership within higher education and the creation of a 'tribrid role' which brings in clinical, academic and research perspectives, but focuses on capacity building for future generations of AHPs with core leadership qualities.
- Investigate the international perspective to explore whether we can learn from AHPs in other countries. Primary research from Australia conducted by Boyce and Jackway (2016) also highlight the barriers and challenges being faced by AHPs and future research could further explore the opportunities for international collaboration on AHP leadership within higher education. Different models of patient care undoubtedly create opportunities to understand how leadership evolves and how it is implemented within core teaching, learning and research.

#### Dr Marc Griffiths (Project Lead)

*Acting Dean  
Faculty of Health and Applied Sciences  
University of the West of England Bristol*

#### Dr Vivien Gibbs (co-researcher)

*Head of Department of Allied Health Professions  
Faculty of Health and Applied Sciences  
University of the West of England Bristol*

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# Appendix 1

## Research Project: AHP Leadership in Academia: Opportunities, challenges and current position

### Information Sheet for participant interviews

Your participation is voluntary but we hope you will share our view of the importance of this work and agree to participate. If you have concerns not dealt with by the information provided here, please contact Dr Marc Griffiths by email: marc.griffiths@uwe.ac.uk or phone 0117 3288488

### Why have I been asked to take part?

You have been asked to take part in this project because of your experience and position as an Allied Health Professional working in Higher Education or a Professional/Regulatory Body.

### Do I have to take part?

No. Your participation is entirely voluntary. If you do decide to take part in the project you will still be able to withdraw at any time up to three weeks after completion of the interview. In this case, no information you have given us up to that point will be kept and used. To leave the project, all you need to do is e-mail or telephone Marc Griffiths (contact details above). However, your views are very valuable, so we hope that you will want to take part.

### Interviews with the researcher

Marc Griffiths or Dr Vivien Gibbs (co-researcher) will contact you to invite you to take part in an interview which can be either talking to the researcher face-to-face, or over the telephone, whichever is more convenient. The interview will take about 30 minutes and may be audio-recorded so the interviewer can concentrate on listening to you, and also have a record of what you said so that nothing is missed. During the interview, the researcher will ask you a series of open ended questions relating to the research

### What is the purpose of the interview?

1. To understand the current perception of AHPs in leadership positions within academic/higher education
2. To understand the potential barriers/challenges and opportunities that exist for AHPs to undertake leadership roles within academia/higher education

### Is the information I provide confidential?

We are interested in creating a general understanding of participants' experiences. Individuals will not be named in any presentation of the data. The researcher will remove any identifiable material from the data. Quotations may be used as examples but will not be attributable to individuals.

### How long will the interview take?

About 30 minutes.

### What will happen to the findings from the project?

The initial findings will be presented at the Council of Deans of Health meeting in May 2018. At this meeting members will comment on the presentation, and these comments will inform the final report.

It is planned that the final report and findings will be published in a professional journal to share the results more widely, and presented at a future national conference and used to help shape future mentorship and development opportunities for AHPs.

### What will happen if I agree to participate in the research?

You will receive an email from Marc Griffiths or Vivien Gibbs. He/She will arrange a time to meet with you, or telephone you, to carry out the interview.

### What should I do if I want to take part in the project?

If you wish to take part in the project, please fill in the enclosed form and post it or mail it to Marc Griffiths at the address below.



### **Can I agree to the interview, but refuse to be taped?**

Yes, written notes will be taken during the interview.

### **What will happen if I decide to withdraw from the project?**

If you decide to withdraw from the project after signing the consent form, you will only need to contact Marc Griffiths to tell him of your change of decision. Any information already given by you in the interview will then not be used. There will be no negative implications for you if you do decide to withdraw.

### **Who has reviewed the project?**

This project has been approved by the ethics sub-committee of the Faculty of Health and Applied Sciences, UWE

### **Can I talk to someone afterwards about the issues raised by the interviewer?**

If you would like to talk further about any of the issues raised in your interview,, you can contact Marc Griffiths [marc.griffiths@uwe.ac.uk](mailto:marc.griffiths@uwe.ac.uk) or Viv Gibbs [Vivien.gibbs@uwe.ac.uk](mailto:Vivien.gibbs@uwe.ac.uk) at any time.

Thank you for your time and support of this important project

### **Dr Marc Griffiths Principal Investigator**

Tel: 0117 3288488

Email: [marc.griffiths@uwe.ac.uk](mailto:marc.griffiths@uwe.ac.uk)

Postal Address:

### **Dr Marc Griffiths**

Room 2A08, Frenchay Campus  
Faculty of Health and Applied Sciences  
University of the West of England, Bristol  
Coldharbour Lane  
Bristol  
BS16 1QY

# Appendix 2

## Consent form

**Title of project:**

**AHP Leadership in Academia: Opportunities, challenges and current position**

*Please initial each box if you agree*

I understand that my participation is entirely voluntary, and I am free to withdraw at any time up to three weeks after completion of the interview, without giving any reason.

I confirm that I have read and understood the Participant Information Sheet and I agree to take part in the study

I give consent for the interview to be recorded. I understand that the information will be stored securely on an encrypted external storage device in accordance with the University's Data Protection policy, and that all interview data will be deleted in accordance with GDPR requirements once publication of the data report has occurred

I understand that anonymized quotes from the interview may be used in publications, presentations and reports.

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Researcher's signature: \_\_\_\_\_

## Appendix 3

### Research Project: AHP Leadership in Academia: Opportunities, challenges and current position

#### Interview questions:

- What is your professional background and how long have you been qualified in your specific profession?
  - What attracted you to a role within academia/professional/regulatory body?
  - What opportunities exist within your current workplace for progression/development specifically relate to AHPs?
  - How were you supported in your development as a leader?
  - How heavily are AHPs involved in policy making/workforce development in HEIs?
  - How does this fit with AHPs in to action?
  - In your view, is there a disproportionately low number of AHPs in senior leadership roles (compared with nurses) within the Higher Education sector?
  - If so do you have a view as to why this is may be the case?
  - What are the challenges that AHPs face when trying to progress to senior leadership roles in HEIs
- Does any current evidence suggest there is an issue with a lack of AHPs in leadership roles within HEIs?
  - Why do so many nursing colleagues reach senior leadership roles in HEIs?
  - Is there a connection between the two (i.e. nurses in HEIs have stronger professional/political connections to senior nurses at Board level in Trusts providing them with access to strategic decision makers)?
  - Is there a sufficient level of mentorship/leadership development (incl. strategic decision making, policy development, governance etc) for AHPs within Higher Education? If not, what could be done to enhance this?
  - Any other comments/opinions?

# Appendix 4

## Quotations

**1. The hierarchical structure and the sheer size of the nursing profession provides them with the aspiration and the opportunities to 'climb the ladder' to senior roles. In contrast, there is a limited number of AHPs role models in leadership positions and no established mentoring scheme.**

- I think because they always work in team structures and hierarchy, they are much more like hierarchical animals and to be higher up the hierarchy is something that is more valued. To be seen to be the boss has more kudos to it to nurses than it does to AHPs. So, I think there is an element of the opportunities not being there and when the opportunities are there, AHPs are not wanting to step into them either.
- There are a lot of senior nurses in leadership positions in the NHS. That's a little bit of a role model isn't it
- Nurses are more likely to be running departments which contain large numbers of nursing students, which of course brings in a lot of money for the universities.
- In the NHS the nursing workforce is very big and therefore I think that workforce needs to be managed. They are there because they are a large number and they need that structure in place to manage it. I think that's much the same in academia as well.
- I get torn between smiling about nursing as a profession in terms of its almost obsession with hierarchy rules and policy that at times, it drives me mad, but also thinking because they have those things they are able to do things like create structures that enable people to progress in leader. For instance, the NMC's validation process requires people to attend so many hours of training. The hospitals therefore have to pay for training for their nurses otherwise they won't be registered.
- They (AHPs) don't have enough role models to base those leadership roles on
- It's important for us to improve our networking and our support through mentorship at all levels.
- In contrast to medicine and nursing we are still streets behind. Do we need to do a bit of internalisation upon ourselves and does that mean we need to start retro fitting or looking back over our undergraduate curriculum to start redeveloping things there to make leaders of the future
- It is difficult to get that AHP voice even though they have invited us there, the nursing predominates because that's where the bulk of the money, contracts and experience has gone.
- If there aren't many AHPs in senior roles, how do you then provide aspirational mentors who inspire other people and provide network. It is tricky as it is kind of chicken and egg. I do think we could have a network of AHP mentors and do something about it ourselves.
- I'm a little bit concerned by professional bodies. They tend to be, I'm sure they're not but a little bit inward looking and stuck at a level lower than where they ought to be because they don't have the leaders out there in academia who actually drive the agenda forward.
- I think developmental opportunities, those leadership development programmes, that sort of thing would be enormously helpful and networks, networking opportunities to hook up with other people of similar kinds of backgrounds.
- One of the things I think is having leadership development throughout. It was only when we merged with the nurses that the nurses were talking about leadership as something that you teach undergraduates, why would you teach them? They are not leaders, they are undergraduates. They haven't even qualified yet, how can they be a leader? So, the idea that you would teach them leadership as a concept very early in the career rather than something that you became after 10 years was strange to me.

- They (nurses) have pretty large student numbers which generates a lot of staff. They do get staff working together. To be honest I think in the NHS, it is all about doctors and nurses, there are a lot of nurses and they do reach very senior positions in the NHS, well paid salaries etc. I think there's then expectations from nurses in academia who have those same expectations and aspirations.
  - Nursing colleagues tend to outrank AHPs when applying for leadership roles. The interviewee sees the healthcare hierarchy as:
    - 1) Doctors
    - 2) Nurses
    - 3) AHPs
  - It is absolutely the kind of thing the Council of Deans of Health should be doing and they are well positioned to do it because of their trans-institutional position (*discussing mentorship*).
  - I don't think there is enough mentorship. There's no formal mentorship.
- 2. AHPs tend to focus on increasing their clinical specialist and/or research skills and aspire to become leaders in their clinical/research specialty areas, rather than more general leadership roles. Opportunities do exist but AHPs do not pursue them due to lack of confidence, negative perceptions of leadership, shortage of training opportunities and fear of losing their professional identity.**
- AHPs have to understand that we each (as separate professions) have different starting points in our undergraduate curriculum in terms of leadership, autonomy and confidence. Other professions (e.g. nursing) seem to do this better and more directly. We (as in AHPs) need to ensure our future AHP workforce has leadership instilled from an early point, along with the confidence around autonomy.'
  - There is a difference between management development (things like performance management, managing change, negotiating) and leadership development.
  - We value highly competent physiotherapy hands on patient related skills and the people who develop leadership that would be seen as clinical leadership. We wouldn't necessarily value the leadership that might be across a whole department because then you've stepped away from the clinical bit
  - It (VC role) wouldn't be something that I would have wanted to do because it would take me away from profession and my own research activities.
  - Our current vice-chancellor of the university is a nurse by background. If you look at her profile you can see that she has moved around from university to university. Obviously, her goal in life is to get to a vice-chancellor position which is what she has done. I'm not sure how many of us in allied health professions want to be in those positions.
  - I think that for AHPs you either take the leadership management route or you take a research route.
  - AHPs lack confidence, prefer to stay in their 'comfort zone', lack role models and aspiration.
  - I do hear a lot of, both clinically and academics, that they don't want to move away from their profession
  - Leadership should be embedded from the day that they (students) arrive for their programme of study. If you look at medicine, it is instilled that confidence.
  - I think there is something about the personality of AHPs that tends to make them more individual players and not necessarily seeing leadership as a thing they want to do or even that they value. Possibly because they haven't had good leadership
  - It is something about positive confidence. It's not about being aggressive or chippy in any way.
  - I guess you could argue there are structural things that don't give people the confidence they need, in terms of the opportunities or whether it is something to do with training and our place in services. That's quite a generalisation but, I think that's a factor.

- Part of the problem, maybe, is because people go into an AHP department because you really love doing that job. If you go into management, then you suddenly have to stop doing that job and you have to manage nurses. You go in because you love the patients, you love the challenge or the research in that particular topic and then you go into management and actually, you spend your life doing rotas and budgets and that sort of thing.
  - People have already adopted a culture which says leadership and management is not that big a deal, it is not really worth having, by the time they come in higher education.
  - I know we concentrate on leadership programmes through the Leadership Academy, the King's Fund, things previously like the Florence Nightingale Foundation, which are multi-professional and also there are some uni-professional but there isn't anything for me exclusively that then focuses on that trajectory of leadership within an academic and the university sphere.
  - My mentor is very keen on coaching and mentorship, so she sent me on a leadership course, which at the time I didn't see that I was a leader. You tend not to. You tend to think I'm a researcher or I'm a clinician because I didn't really see that the leadership role was more important.
  - I don't know if we are very good at leadership development generally.
- 3. Historical perceptions and legislation still exist which affects the dominance of nursing, resulting in the voice/visibility of AHPs being restricted. Nurses have representatives at NHS Board level whereas AHPs do not. This provides nurses with a stronger voice and high-level connections; nurses in HEIs therefore have more readily available access to contacts in these senior NHS positions. This gives them a wider perspective of the landscape and increased political acuity**
- One of the things that I did wanted to do was the Council of Deans of Health aspiring deans programme, which is offered by the Florence Nightingale Foundation and of course the big stumbling block was that I wasn't a nurse. I understand now that they are revising that, so that you could do it if you are an allied health professional.
  - The CoDH has a Florence Nightingale scholarship programme for nurses to build future leaders which I was told quite clearly was not open to AHPs to apply for
  - The CoDH tends to be very nursing focused. When I've attended, which is only on a small number of occasions, the nursing related issues have been dominant in discussion
  - I think there is a historical perspective here and clearly, without changing statute, because statute requires foundation trusts particularly, not necessarily trusts that haven't reached foundation status, to have both a medical director and a director of nursing, and that is required in statute. To change that, ministerially, I'm not saying there isn't the will to do it, but of course finding parliamentary time to make any material change to primary legislation, quite frankly with Brexit is not going to happen.
  - For me, it is not about the uni-profession silo, as it were at board level, because I think to have a director of allied health on the board, you are just creating another silo and for me that non-medical board leadership post should be open to whether you're a registered nurse, health care scientist or an allied health professional. Again, it is about competence of the individual
  - It feels as if we are all trying to play catch up with Suzanne with AHPs into action. It all seems to be very successful in creating a brand around AHPs that the rest of us aren't framed around and its particular true within HEIs. I don't think AHPs have that much visibility
  - We need to be there on merit but the opportunities need to be available and we need to be recognised as potential candidates for senior leadership roles rather than it be the assumption that it'll need to be from a nursing background
  - AHPs into action does recognise leadership as part of the aim but primarily it's focused on extending clinical roles
  - Yes, nurses are better connected than AHPs and this will affect their ability to access strategy level people and therefore have a strategic voice.

- Nurses when they start in academia, they may well be better networked because they've got access to senior nurses in clinical positions. I think it is important that you have a diverse voice around that strategic table. We're not just focusing on a particular model, so to have someone coming in and challenging the nursing view of the world and to say there are other ways to do things and have you thought about doing something like this, has got to be beneficial.
- Certainly, in Scotland, the chief hospital nurse will only deal with a nursing dean. So, if you don't have a dean who is a nurse then you are stuck. Yes, you can take your dean along that is not a nurse but I think there is a pressure to have somebody leading who is nurse and therefore it has perpetuated down.
- If AHPs wanted to go into education type roles where they might be working with HEIs and externals, I think it's more likely that they would struggle in some of those roles. If it had anything to do with nursing, there may well be people within the system who would say 'you're not a nurse, what would you know'. I think this persists externally.
- Nurses have got contacts at Board level within the trust which can help them to rise within the HEI because they're better connected, they've got director of nursing who they are friends with who sit on board level. I suppose I'm thinking that gives them more influence and power because of who they're connected to
- The problem for the AHPs is they have no voice at board level so very few AHPs will be at a board level as part of the executive team. So, they are not at executive team level, they maybe at a divisional level. So, there are no role models to get them there.
- New types of institutions will be getting involved with medical education, which is a heavily established provision, and this may alter the balance again. Whether stronger links and profession groups will emerge in institutions as a result, I'm not sure, and that probably won't be hugely helpful because probably other inequalities will arise.
- There tends to be a lot of 'Double speak' – people talk the talk but don't walk it – they're saying it but not doing.
- After an interview the feedback that I got was I'd done a really good job, this is awful because this is in my memory and it may or may not be 100% accurate but the feedback as I recall it from the agency was that there was another candidate who was 'quite good' and was a nurse so she had been offered the position.
- My experiences are limited to just a few institutions, but I think there is a situation where perhaps AHPs in many institutions are not that far up the management chain and therefore I think their voices are diluted to a certain extent as they're perhaps not getting their views through to the right level.
- They (the NHS) have a network of nurses, so if you didn't have a director of nursing you wouldn't have another way into that organisation. It immediately gives the nurses an advantage which they make full use of, they're brilliant at doing it.
- My experience is that actually, it is not brilliantly linked up. You've got intermediate organisations, like clinical research networks, so I think it is easier for senior nursing staff that are in senior management roles to get onto those regional groups and panels.
- So, the most bizarre example for me is that there has to be a director of nursing for the ambulance service. These are paramedics. They are allied health professions yet there's a director of nursing at the top. There's never been a bigger disconnect in the way of something as structured than that as far as I'm concerned. It's legislation as far as I understand it, it seems to be mandated.



### **4. AHPs are a group of disparate professions and have apparent differences amongst themselves. It is often difficult to have one voice or avoid competing with each other. As a result, the public understanding of AHPs tends to be low**

- It is good for us all to be together, but I think we are a complex group and need to get more visualisation of the AHPs and our importance as individual professions as well as a group of allied health professions.
  - How do we go forward if the 16 professions within AHP can't agree between them what leadership looks like at the core dimension.
  - The more voice we have and the more profile we have then there's likely to be more connections with more senior roles I think.
  - I think the term AHPs doesn't necessarily help us that much.
  - People outside of healthcare don't understand what an AHP is. I'm hopeful you are actually going to be asking these questions of non-AHP and nurses and if that's not the brief, at some point I think a similar branch of questions needs to be asked of other professions about how they see AHPs. I think that might be in itself quite revealing.
  - To be honest I think in the NHS, it is all about doctors and nurses, there are a lot of nurses and they do reach very senior positions in the NHS, well paid salaries etc. I think there's then expectations from nurses in academia who have those same expectations and aspirations.
  - What we haven't learnt how to do is how do you join up 16 professions, speak as one voice and then you've got some balance against nursing and medicine. They will always take the air time unless you can find a way to say there is a purpose here for us all.
  - You would expect to find that leaders are more likely to emerge from the areas of physiotherapy and occupational therapy rather than podiatry and say radiography because of the way we tend to operate. What draws us to those professions in the first place probably impacts on that. There's a whole piece of work around socialisation of your own discipline.
- I think because it is such a small profession and because we tend not to accept more than maximum of 14 students on the training programme, Universities very often find, certainly the arts therapies, music therapy and dramatherapy, it is not cost effective. I think from that perspective it can become quite a challenge. Constantly showing that you are contributing to the vision to the life of a higher education institution.
  - The only thing I do feel is that greater research would strengthen AHPs as a whole. Some areas are quite good in research, but others are not.
  - We're (AHPs) still a little bit behind in terms of research activity and I think particularly in radiography. We've got our research strategy in place, but I feel a step behind some of the other AHPs but we're also a big step behind people like biomedical sciences.

### **5. Healthcare is a relatively new area in HEIs and in some areas, particularly the Russell Group universities, are often sceptical about the relevance of healthcare education within the university setting, or the ability of these healthcare individuals to transfer their skills.**

- I think there is more opportunity in the non-Russell Group universities than there are in the Russell Group universities for that sort of profile for both AHPs and nurses.
- Healthcare professionals (AHPs and Nursing) tend to enter academia later in life and therefore have to focus on achieving postgrad qualifications and building up a research profile before they can consider moving into a strategic leadership role.
- Healthcare is a relatively new area in HEIs and in some areas, particularly the Russell Group unis, they tend to be considered to be intellectually inferior or more of a technical college degree programme
- I think the biggest challenge for AHPs getting into leadership roles is demonstrating transferability.
- The teams based in Russell Group, sometimes their influencing ability nationally might be more powerful because they have a stronger voice than an institution from different division groups with different profiles.

- If I went to a Russell Group university, in my head I would have difficulty being credible in that environment because I don't have a research profile that is strong enough.
- People were more interested in 'what's your academic credibility' and of course, professions were playing catch up against an establishment that didn't really want them there in the first place.
- If you go back 25-30 years, most of the AHPs and nursing sat either in FE or in colleges of NHS schools. Therefore, they sat outside of the university sector. Most of them ran nationally approved programmes and national examinations. So, there was a hierarchy within the professions and there was usually a college structure that meant that examiners would move around and see what was going on.



**For further information contact:**

**Council of Deans of Health**

Woburn House  
20 Tavistock Square  
London WC1H 9HD  
0207 419 5520

[www.councilofdeans.org.uk](http://www.councilofdeans.org.uk)

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