Inequitable barriers and opportunities for leadership and professional development, identified by early-career to mid-career allied health professionals

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ABSTRACT

Introduction Interprofessional leadership is essential to sustain the National Health Service (NHS) in pressured times, which should include the NHS's third largest clinical workforce in England: allied health professionals (AHPs) (AHPs as defined by NHS England: Art therapists; Dramatherapists; Music therapists; Dietitians; Occupational therapists; Operating department practitioners; Orthoptists; Osteopaths; Paramedics; Physiotherapists; Podiatrists, Prosthetists and Orthotists; Radiographers; Speech and language therapists). Therefore, a feasibility study was undertaken, to explore the views of AHPs working in early to mid-career positions, regarding the barriers and opportunities they encounter, in both leadership and career development.

Methods Twenty-seven participants, representing 8 of the 14 AHP professions across England, were interviewed across 10 focus groups.

Results Thematic analysis (TA) generated four themes, including the barriers and opportunities for AHP leadership development and career progression. Further TA identified three overarching themes: equitable and interprofessional leadership development; an equitable and structured AHP career pathway; and having AHP leaders at a strategical and/or very senior level. These overarching themes were subsumed under the umbrella category: equity of opportunity and voice. The AHPs, who were interviewed, reported inequitable access to both career and leadership development, compared with other professions, such as nurses, doctors and pharmacists.

Discussion Further work is needed to ensure that interprofessional representation, within senior leadership levels, includes AHPs; which the data suggests would directly benefit all AHPs' leadership and career development. Recommendations for organisations to facilitate leadership and career development were developed from the TA and at a system-wide level. Further research would be beneficial to gather the views of the six AHP professions not interviewed in this study and from other organisations, such as independent practice. However, this feasibility study does attempt to represent the voices of AHPs, which can be lacking in both organisations and research.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ National Health Service (NHS) England and NHS Improvement considered the foundation skills, knowledge and experience that early-career allied health professionals (AHPs) have, and identified how staff members could develop from mid-career to senior levels.

WHAT THIS STUDY ADDS

⇒ This study focusses on AHPs who identify themselves to be in early to mid-career positions and their views on the barriers and opportunities for leadership and career development.

⇒ The study highlighted that many AHPs do not receive consistent leadership development and some encounter barriers in their career pathway; an inequity compared with other healthcare professions, such as nurses, doctors and pharmacists.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Organisational and system-wide recommendations were developed to facilitate AHP leadership and career development. Further research is needed to examine if the themes and recommendations are consistent for all individual AHP professions, AHP departments and across the health and social care system.

INTRODUCTION

The health and social care system is facing multiple challenges, including an ageing population, workforce shortages and financial constraints.[1] Effective leadership can help tackle these challenges by improving the care quality, staff well-being and organisational effectiveness.[2] Moreover, the National Health Service (NHS) recognises the need for interprofessional healthcare leadership, with the NHS's[3] Interim NHS People Plan stating a vision for fostering 'systems-based, cross-sector, multiprofessional leadership' (p. 15). Furthermore, the NHS's[4] People Plan 2020/2021 states the importance of all staff having a voice, alongside distributed leadership. However, collectively, very senior leaders in healthcare tend not to represent the diversity of the general population.[5] Professional diversity at senior leadership levels should also be considered as a component for effective leadership, so that the entire NHS workforce is used to its full potential[6 7] and this inequity is avoided.

Collectively, allied health professionals (AHPs) are the third largest clinical NHS workforce in England[8] and, therefore, need to be part of an interprofessional leadership approach. AHP leadership can positively impact on clients, employees and the healthcare system,[9] adding value clinically and through contributions to service improvement.[10] AHP qualities include being person-centred,

innovating beyond traditional pathways and authentically challenging.[11] However, systematic literature reviews identify a paucity of literature on AHP leadership development.[12 13] Furthermore, AHPs are categorised differently across countries,[14] which complicates drawing comparisons across the available literature. Within NHS trusts, NHS England and NHS Improvement[11] document a dearth of AHP leaders within senior leadership positions and at board level. The authors do not specify the exact numbers of senior AHP leaders, potentially because these figures are not recorded by national NHS arm's-length bodies. Therefore, it is difficult to monitor the progression of diversity, including of very senior leaders. Although mandatory monitoring does not necessarily lead to rapid improvements, for instance, with the gender pay gap,[15] it can highlight the areas that need addressing.

The reasons that AHPs are less represented in senior leadership positions may be inferred from numerous factors. Historically, the NHS's senior leadership has been composed of non-clinical, medical, and nursing management.[7] Trust boards or executive directors require only a registered doctor/dentist and a nurse/midwife from clinical professions. Additionally, AHPs lack a structured career pathway compared with doctors and nurses,[16] with doctors' and dentists' lengthy training programmes usually including quality improvement (QI) and leadership skill development. NHS England and NHS Improvement[17] devised organisational actions to increase senior AHP leadership roles, documenting the organisational benefits of established AHP directors within trusts. Since this study was completed in 2021, there have been further publications on developing Chief AHPs,[18] guidance on how to integrate AHPs into the Integrated Care Systems,[19] and paramedic leadership development.[20] However, it is unclear that the status quo has changed significantly at senior or board level and the COVID-19 pandemic may have impeded progress.

Therefore, a feasibility study was undertaken to investigate AHP leadership, by drawing on the views and real-life experiences of AHPs, across England, through focus groups (FGs). The study's aims were:

- To establish the barriers and opportunities to career development, faced by AHPs seeking to move onto middle or senior leadership positions.
- To reveal the priority placed on leadership development by AHP employees, at early to mid-career positions.
- To identify how organisations can facilitate AHP leadership development.

METHODS

The sampling was purposive, with the study advertised through the FutureNHS Collaboration Platform and three professional bodies confirmed dissemination. The inclusion criteria were:

- A member of 1/14 AHP professions, as defined by NHS England.[11]
- AHPs who identified themselves to be in early to mid-career positions, usually in keeping with NHS Agenda for Change (AfC) bandings 5–7.
- Located in England.
- Working within NHS Trusts, council-led organisations, independent practices, and/or governmental arm's-length bodies.

The qualitative data, taken from the participants' perspectives, was gathered by 10 virtual FGs in June 2021, lasting 40–55 min. The FGs were directed by a topic guide (as shown in online supplemental appendix A), shared prior to the FG, which had been formed using a deductive theoretical approach, based on the literature. Then the qualitative data was analysed using thematic analysis (TA). Box 1 provides detail of the process of TA.

Box 1 The process of thematic analysis (TA) in this study (using Braun & Clarke's[26] method)

1. Familiarisation with the data, through attending and then listening to the recordings, documenting pertinent comments and transcribing relevant quotes verbatim. Quotes were then checked with individuals, to maintain the intended meaning and confidentiality.
2. Generation of the initial semantic codes. Firstly, through deductive TA, a theoretical approach based on the topic guide and the literature review's finding, and then through inductive TA, drawing from the raw data. Semantic codes created the initial subthemes.
3. Generation of the initial themes.
4. Review and refinement of the themes. Latent codes generated the overarching themes and umbrella categories.
5. Definition and naming of the themes.
6. Creation of the final analysis.

RESULTS

Nine out of 33 participants did not attend, with three rearranging, resulting in an 18% non-attendance rate (see online supplemental appendix B for the range of participants across professions and banding). As the 27 participants self-selected their FG time, the range of participants attending each FG ranged between 2 and 5 participants, with a median of 2.5. One band 5 AfC banding (or equivalent), 11 band 6s and 15 band 7s attended. Table 1 provides an overview of the themes, overarching themes and the umbrella category. Each theme will be explored in more detail; where relevant, the number of participants who referred to a theme or subtheme is stated in brackets.

Theme 1: leadership qualities across seniorities and specialisms

AHPs, regardless of banding, understood the difference between management and leadership, and considered themselves to be leaders; furthermore, participants (n=7) identified non-registered staff as leaders. Participants (n=11) stated the importance of varying levels of seniority within clinical leadership; for example, informal leadership appropriate to the participant's banding. Other leadership roles identified were clinical lead/specialist, strategical/change project leader, research leader and managerial leader.

Table 1 The generated themes from this study

Umbrella category	Equity of opportunity and voice
Overarching themes	1. Equitable and interprofessional leadership development. 2. Equitable and structured AHP career pathway. 3. AHP leaders at a strategical and/or very senior level.
Themes	1. Leadership qualities across seniorities and specialisms. 2. The importance of leadership development. 3. The barriers to AHP leadership development and career progression. 4. The opportunities for AHP leadership development and career progression.

AHP, allied health professional.

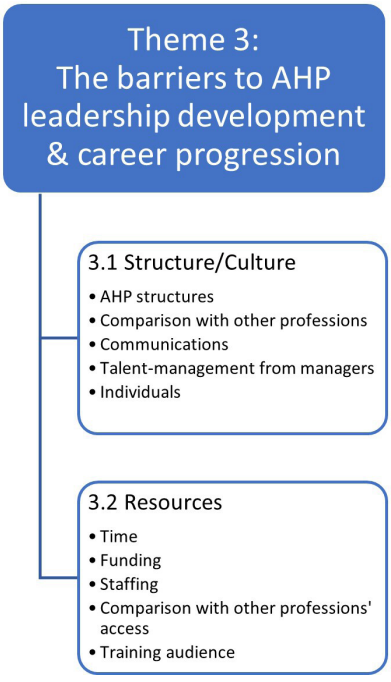

Figure 1 Theme 3. AHP, allied health professional.

When defining leadership, participants listed a range of attributes for leaders, with participants (n=4) recognising a role in inspiring others by modelling the right behaviours. One participant described how a leader should be adaptable, which was supported by participants describing different attributes depending on the situation. For instance, participants (n=9) recognised an assertive and/or directive role, with one participant giving the example of ensuring that clinical guidelines are followed, other participants (n=7) described a coaching role and another participant described an advocacy role, ensuring that everyone's voices are heard and empowering team members to make changes.

Theme 2: the importance of leadership development

Leadership development was cited as important for clinical leadership. The benefits included: at a system-level, to be enabled to improve the overall quality of services and patient experience, in line with person-centred care; at a team-level, when leading a team or colleagues; and at a personal level, for individual development, recruitment and/or retention and to create a stepping-stone in career development. It could be postulated that participants implicitly felt that leadership development was as important as clinical skills development, with one explicitly stating this and other participants (n=9) stating that leadership development should be incorporated across all roles, including students and non-registered staff members. However, two participants felt that leadership development should be voluntary.

Theme 3: the barriers to AHP leadership development and career progression

Figure 1 lists the subthemes from theme 3.

Structure/culture

AHP structures

Participants (n=3) referenced a lack of standardisation between bands 6–8b, based on responsibilities and/or funding, within and across organisations. Participants (n=3) noted the lack of development posts, with two participants reporting that AfC had not delivered on the promise of development posts across bandings.

Different organisations reportedly had different expectations regarding leadership, which sometimes impacted on transferring between organisations. For instance, two participants felt that the NHS offered more opportunities than in privately-contracted NHS services or council sectors, and one reported more opportunity in independent practice. Participants (n=4) flagged difficulties progressing to higher bandings in smaller professions, departments or organisations. However, in other small departments, two participants reported easier access to opportunities or progression. One participant reported working in smaller organisations was advantageous, due to networking opportunities.

Comparison with other professions

Lack of progression within professions was discussed, with participants (n=22) reporting a lack of opportunity to clinically progress to more senior roles, with some participants remaining in the same band 6/7 role between 7 and 20 years. Contributing factors included a lack of positions and/or turnover, with participants (n=8) reporting that to progress they would need to unwillingly move into managerial roles.

Numerous factors reportedly contributed to the lack of progression within organisations: participants (n=6) contrasted the hierarchical organisational structure, which preferences other professions, to the lack of AHP career structure. Two participants felt that organisations preferred AHPs to work in clinical areas over managerial positions, to maximise workforce capacity. Participants (n=4) reported that other professions, such as nurses, had more access to secondments and opportunities for promotion. Participants (n=14) reported that other professions lacked an understanding of an AHP's role and the training involved and/or did not recognise that AHPs could take on more senior or clinically specialist roles. Many participants highlighted that roles, job titles and personal specifications were advertised solely for other professions, such as nursing and pharmacy, including roles that represented the AHP workforce. Alternatively, some positions were open for AHPs to apply to, but this eligibility was not transparent. Participants (n=11) noted the lack of professional diversity in senior leadership roles, including the absence of an AHP lead/director, which one participant felt should be mandatory.

Communications

Participants (n=8) reported their organisations and/or managers did not disseminate opportunities.

Talent-management from managers

Many participants reported that mangers did not offer talent management. Two participants reported that managers did not expect band 5–6 participants to lead, therefore, did not release them or give them designated non-clinical time for leadership development. Participants (n=3) reported managers expected band 5–7 participants to lead, but without any formal training. For instance, one more senior participant was asked to justify how a free and short course was relevant to their role. If training was offered, participants reported it was not always responsive to the learner, rather it was a one-size-fits-all approach, felt to be at a relatively low-level. Two participants gave the example of managers routinely offering only the Leadership Academy Edward Jenner programme (a foundation leadership programme

open to health and social care staff in England). Another participant gave the example of managers not actively encouraging accredited or MSc modules, even though senior roles expect this academic level. If participants did attend relevant training, participants (n=6) reported that managers did not create the opportunity to translate theory-based knowledge into practice. Two participants felt that on-the-job training was generally lacking. Participants (n=7) reported their manager did not ensure mentoring and one participant reported a lack of supervision.

Two participants noted that accessing leadership training was reliant on who a person's appraiser was or complicated due to having two line managers. Participants (n=4) reported their manager lacked an understanding of their clinical role, and therefore did not understand the skill set required or the priorities for personal development. Participants (n=5) reported that managers blocked development, because they were hierarchical, did not prioritise development and/or showed preferential treatment. For instance, one participant felt their managers saw them as threatening if they developed themselves. Participants (n=4) reported a lack of commitment by managers to service development or changes, with one participant reporting that junior team members were not allowed ownership of projects and that success with projects was not recognised or celebrated.

Participants (n=3) felt managers were not creative with vacant roles, leading to a lack of leadership opportunities, development posts and/or job share roles. Participants (n=4) flagged an inequity for employees who were unable to be flexible for fixed-time/full-time positions or secondments, with the expectation to either forgo their permanent position or their managers declining to release them.

Individuals

Participants (n=9) recognised that some individuals, particularly themselves, were proactive, by choice or through necessity. Other participants offered reasons why employees may not wish to develop or progress. Participants (n=3) reported downgrading their banding, to achieve a better working quality of life, with two preferring to focus on their clinical specialty, which was at a lower banding than managerial opportunities. Female participants (n=3) reported caring commitments and/or working part-time restricted their ability to spend personal time on development or commute to progress their careers. Participants (n=2) recognised that employees at the early stages of their career may wish to embed into their clinical career first. One participant reported that they would access leadership development after embedding in their new role and establishing their development needs.

Resources

Time

Participants reported studying in their own personal time. Participants (n=13) reported a lack of time for leadership development, due to a busy clinical role or large management role. Two participants reported their managers expected employees to complete leadership development in their personal time.

Funding

Participants (n=9) reported that accessing funding for training was difficult, with some self-funding.

Staffing

Participants (n=5) reported leadership development was curtailed because services were short-staffed and/or they were not able to obtain backfill or it was complicated to organise. One participant noted that these difficulties affected their ability to focus during training.

Comparison with other professions' access

Participants noted an inequity in access to resources compared with other professional groups. Participants (n=7) noted that doctors and nurses may have the opportunity to access fully-funded leadership courses or dedicated development time, such as doctors accessing 'supporting professional activity' time. Participants (n=5) noted that nurses and doctors may have access to research/leadership/practice development departments. Two reported that priority for accessing training was often given to nurses over AHPs, citing the offer to become Advanced Clinical Practitioners. Participants reported a lack of consistency between the opportunities afforded to different AHP departments, within the same organisation.

Training audience

Participants (n=8) recognised the need for interprofessional leadership programmes. However, they reported that training courses were often tailored towards other professions, for example, doctors, nurses or occasionally larger AHP professions, such as physiotherapists and occupational therapists. National leadership programmes open to health and social care staff in England, such as the Mary Seacole programme (for first-time leaders), were felt to be designed for the work experiences of nursing. Two participants noted that courses were targeted at operational managers.

Theme 4: the opportunities for AHP leadership development and career progression

Participants (n=20) explicitly stated that they felt supported by their managers, either past or present. However, the majority of participants cited accessing a limited range of development opportunities, primarily: accessing in-house and external training; managers advertising opportunities; and/or training opportunities being identified at appraisals or supervision. The participants suggested ideas that either none or only a few had experienced personally. However, some participants (n=3) felt that managers needed to achieve a balance between talent managing all staff members against solely advertising the opportunities, since not every employee wishes to develop.

Participants from two organisations felt that the situation had changed positively for AHP senior leadership over the last few years; however, the conversation often returned to the barriers. Many participants wished that organisations enabled them to pursue a specific career of their choice, including in research, strategy and QI. Notably, two participants felt that unstructured job roles and career structures could offer flexibility with leadership and career development.

Summary

Table 2 includes selected quotes for each theme. Each FG had some commonality, particularly with the main themes. However, the subthemes identified and the personalised examples were more variable, which may have been related to professional experience; for instance, those groups with more band 7 and experienced band 6 participants were more likely to mention their organisation's structure/culture, irrespective of profession. The variability of perspective expressed by FG participants, regarding the subthemes and the examples given, may indicate an absence of group-think.

Table 2 Selected quotes (further quotes in the online supplemental file)

Theme 1: leadership qualities across seniorities and specialisms	***Band 7 Physiotherapist:*** *Leadership has changed massively over the last 10–15 years… you can't lead by bullying anymore… it's… about motivating people and coaching rather than bullying people into doing their role… inspiring others to work as a team to achieve good results rather than being a task-orientated person.* ***Band 7 Speech and Language Therapist:*** *…all members of the workforce… can display leadership skills and qualities…*
Theme 2: the importance of leadership development	***Band 7 Dietitian:*** *The more staff that access leadership courses the better it is for the team…* ***Band 7 Occupational Therapist:*** *…in the future, …the new graduates will need different skills… So if we expose them to leadership in an early stage of their career pathway that's really beneficial.*
Theme 3: the barriers to AHP leadership development and career progression	**3.1 Structure/culture** **3.2 Resources**
3.1.1: AHP structures	***Band 6 Orthoptist:*** *When AfC came in, the run through post was supposed to be set in stone but that disappeared within a few years, which was frustrating. People have to move to get their progression… we could have done with a band 6… but there were barriers of funding.*
3.1.2: comparison with other professions	***Band 7 Dietitian:*** *As AHPs…we have to fight incredibly hard and shout incredibly loud… to ever get anywhere… with leadership training, leadership positions and within research and this is vastly different to nurses or doctors.* ***Band 6 Occupational Therapist:*** *If the trust is not even providing that chief AHP post, it makes you feel a bit disheartened…* ***Band 6 Orthoptist:*** *We are not equated to other professions. An 8a AHP needs to be a manager whereas you can be an 8a clinical nurse specialist… Nurses are given far more opportunities…* ***Band 7 Orthotist:*** *The …senior leadership roles… are not AHPs by background so they understand the career pathway of doctors and nurses and how to progress them into more senior roles… but there's never been an AHP in that… role.* ***Band 7 Therapeutic Radiographer:*** *I was a band 6 for 11 years and had a master's but there was no band 7 post available… We are led by a Chief Nurse, who would send out emails titled nursing & midwifery so AHPs felt like an afterthought.*
3.1.3: talent-management from managers	***Band 5 Occupational Therapist:*** *The Edward Jenner programme is offered as standard to all clinical staff… which can feel like a tick box exercise from my management… there's not necessarily any thought behind it…* ***Band 6 Occupational Therapist:*** *If I applied to a leadership course, I would be questioned as to why I wanted to do that… they would be arguing what benefit would it give for the patients on a day-to-day level.*
3.2.1: time	***Band 7 Dietitian:*** *… your time is purely clinical as you are there to dredge through the patient numbers… we don't necessarily have enough staff to cover the service. So… to do QI or to progress your leadership skills is done in your own time.*
3.2.4: comparison with other professions' access	***Band 7 Dietitian:*** *…I was completely shocked by the amount of time [doctors] have written into their job plans purely for their own CPD [continuing professional development]… why aren't we at an equal level of having those training opportunities and protected time to progress our skills…?* ***Band 7 Occupational Therapist:*** *AHPs don't have ring-fenced money and time – I know doctors have to have a certain amount of opportunities to fulfil their registration requirements with a pot of money alongside it – so then for AHPs it comes down to the trust you are working for.*
3.2.5: training audience	***Band 7 Occupational Therapist:*** *…I do feel sometimes we are a bit of an afterthought.*
Theme 4: the opportunities for AHP leadership development and career progression	***Band 7 Speech & Language Therapist:*** *[Managers are] really keen for people to take up leadership opportunities, they promote them and there are lots of good opportunities internally.*
Overarching Theme 1: equitable and interprofessional leadership development	***Band 7 Occupational Therapist:*** *…we get a bit forgotten about – maybe it's because we are so many smaller professions lumped into one big group… because everything always comes back to nursing and medicine… although we are the 3rd largest part of the workforce it feels like we are a second class citizen in a way… The opportunities are not always there.*
Overarching Theme 2: equitable and structured AHP career pathway	***Band 7 Occupational Therapist:*** *We have quite a large practice development team… and they are creating opportunities for nurses to experience different roles and areas. Are they doing that for AHPs? No they are not! So why are we being excluded from that?… They are not thinking about how they can support AHP's to extend their scope and roles – they are just keeping us pigeon-holed in our profession. That's not fair – we are limited in our ability to move into more senior roles… so there's often a glass ceiling…*
Overarching Theme 3: AHP leaders at a strategical and/or very senior level	***Band 7 Dietitian:*** *If you don't have [AHPs] at the higher levels, you don't get that seat at the table, then AHPs are never represented and you completely get forgotten about as you haven't got people shouting for you. Who is going to take all those AHP concerns to senior levels about how we need more staff or when we've done a great job.*
Umbrella Category: equity of opportunity and voice	***Band 7 Occupational Therapist:*** *AHPs need to be given more of a voice. We are starting to find more of our own voices because we are feeling more frustrated and wanting change and wanting those opportunities and we can see other professions going off and doing great things and we are thinking well we can do that too and why aren't we a part of this, we need to be included so we are standing up for ourselves perhaps more than we have done in the past.*

AHP, allied health professional.

DISCUSSION

All participants identified the importance of leadership and career development. For those individual AHPs who had been developed, they reported feeling valued by their organisation and able to contribute to high-quality care. Despite the vision of interprofessional working,[3] all participants reported a historical or current negative organisational culture for AHPs and an inequity of opportunity, compared with other professionals. Oxtoby[21] discusses the reluctance of some doctors to engage in management. In contrast, Boyce and Jackway[22] assert that AHPs face an access gap, reflected in the views of this study's participants wishing that interprofessional leadership was the norm, based on organisational need, rather than profession. However, NHS executive leaders report that AHPs can be reluctant to move to very senior roles, sometimes due to the AHP's strong professional identity, and their concerns about losing values and credibility.[17]

Participants wishing to become a clinical leader and/or an operational manager, within their own profession, faced barriers, which became more apparent when seeking to move into strategic leadership, or leading a multiprofessional team or ward. The most frequent barriers were noted to be: a lack of opportunity, time and/or funding to progress; a lack of visible senior AHP leadership and actual positions; and a lack of recognition

Table 3 Comparison of recommendations from this study with recommendations from NHS England and Improvement[11] and Lloyd *et al*[24]

Recommendations from this study	NHS England and Improvement[11]	Lloyd *et al*[24]
General		
Regular communication or promotion of opportunities, with encouragement	N	Y
Changes to preregistration training	Y	N
Talent management and resources		
Equitable time, funding, staffing	N	Y
Departmental training needs analysis/framework	N	N
Job plans for protected development time	Involvement in planning rather than implementing	N
On-the-job training, *eg, QI projects/audits*	Y	Y
Formal development: in-house training	Y	Y
Formal development: external training	Y	Y
Non-medical prescribing courses	N	N
Widening types of training accessed, *eg, MSc modules/research/role play*	Y (MSc modules, research)	Y (research)
Improving the quality of training offered, *eg, having a varied offer and making it responsive to the learner*	N	N
Formal shadowing, mentoring and coaching	Y	Y (shadowing, mentoring)
Development posts between bandings	Mentions leadership (not clinical) development posts	N
Increased equity to and frequency of secondments/opportunities	Suggests secondment to a professional/arm's-length bodies	Y
Effective appraisals	Recognises this as standard	Y
Regular and effective supervision, reviewing appraisal and career objectives	Recognises the lack of protected time for this	Y
Facilitated networks/links	Y	Y
Structural and cultural change to organisations		
Parity with other professionals' leadership and career progression, *eg, generic professional titles, increased senior AHP leadership posts, research/leadership/practice development departments, learning environment leads, placement expansion facilitators*	Y except not placement expansion facilitators	Y

AHP, allied health professional; NHS, National Health Service; QI, quality improvement .

that AHPs can take on other roles. The reticence to include AHPs into multidisciplinary team leadership has been highlighted by quotes from the Nursing and Midwifery Council, although the Chief Nurse of NHS England supports recruitment of AHPs into these particular positions.[23]

This study suggests that any progress made, since the relevant NHS England publications,[1 10 11 17] has not significantly impacted on those AHPs at early to mid-career levels. Furthermore, the study supports the need for targeted action by the system to actively invest and promote leadership development throughout an AHP's career, informing the current talent pipelines for AHPs across Health and Social Care. This will help create a career pipeline for AHPs moving into more senior positions, in both operational management and strategic leadership, in order to diversify the professional groups leading the health and social care system. Leadership and career development can be achieved through a wide range of activities, as identified by the participants involved (see 'Recommendations from participants' below).

Recommendations from participants

Even though the FG participants were mixed in terms of professions, organisations and locality, the TA showed a relative homogeneity within and between each group, in terms of their opinions and experiences on the main themes. Therefore, it seems reasonable to assume that, if the six other professions were interviewed, AHPs' views may remain relatively homogenous.

Table 3 lists the recommendations for facilitating AHP leadership and career development, drawn from themes 3 (barriers) and 4 (opportunities), which the participants had experienced or would like to receive. Between one and nine participants, with a mean of 3.2, made each suggestion. The top three suggestions were: structural and cultural change to organisations; formal shadowing, mentoring and coaching; and supervision. Table 3 also compares the participants' suggestions to two other publications: NHS England and NHS Improvement[11] and Lloyd *et al*[24] although Lloyd *et al* focusses on workplace learning for clinical and professional skills, and not leadership per se, in Australia. The participants in this study identified novel ways of development not suggested by NHS England and NHS Improvement, which may reflect senior leaders expecting that these suggestions are offered as standard.

System-wide recommendations

Evaluative research would be beneficial to establish the extent of which the recent NHS England publications have influenced the AHP leadership landscape. Furthermore, the lack of AHP voice at senior levels needs to be addressed at a system-wide level. Organisations should consider creating a visibility and representation strategy, which could incorporate the following: sharing and translating best practice, for instance, from other established AHP leads or directors; implementing reverse mentoring, where very senior leaders are mentored by more junior AHPs around their role and value; and improving access to existing leadership programmes for interprofessional applicants. One example of a successful multidisciplinary leadership programme is the Future Leaders Programme, Postgraduate Medical and Dental Education, Health Education England - Yorkshire and the Humber

(HEE YH). Furthermore, the Leadership Academy has historically offered programmes targeting black and minority ethnic groups, so could consider explicitly advertising funded places for other underrepresented groups, including AHPs. Finally, existing and upcoming AHP leaders, who are adding value to organisations, could be showcased through existing networks, for instance, the Integrated Care System and social media.

The study's limitations

The FGs represented all NHS regions in England. However, only 15 NHS trusts and 1 council-led organisation were represented. Only 27 participants from 8 of the 14 professions participated. The missing professions were paramedics, who are the fourth largest AHP profession, operating department practitioners (6th/14 in terms of size), osteopaths (9th/14 in size) and all three of the arts therapies (collectively, 12th/14 in size). Band 5 professionals were only represented by one participant. Participants were volunteers from varying sizes of professions, departments or trusts; therefore, past experiences and existing work culture may have impacted on their views, alongside pre-existing interests. The researcher is an AHP herself, which may have created bias in the questions posed and the interpretation, with only collated themes and recommendations, alongside individual quotes, member-checked. Finally, due to the qualitative nature of the FGs and the population size, the results cannot be generalised to the whole AHP population. Furthermore, the devised recommendations may not align to what organisations can practically offer, which was not further analysed.

Conclusion

The study highlighted that the NHS's third largest clinical workforce in England, AHPs, do not receive consistent leadership development and many encounter barriers in their career pathway, which presents as an inequity compared with other healthcare professions, such as nurses, doctors and pharmacists. Furthermore, the data suggests that very senior AHP leadership would directly benefit all AHPs' leadership and career development. The recommendations identify concrete examples of how organisations can help develop individuals. Further research is needed to examine if the themes and recommendations are consistent for each AHP profession, and AHP departments across the health and social care system,[25] including independent practice. However, this feasibility study does attempt to represent the voices of AHPs, which can be lacking in both organisations and research.

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