Allied Health Professionals (AHPs) and management

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1. Background
By virtue of their characteristics as professions, AHPs offer scope for exploring aspects of clinician management in a range of settings which have been neglected by clinician manager research. This research will therefore add significantly to our understanding of how clinician managers operate. For AHPs in managerial roles in a range of health and social care settings, we wish to investigate the following, which relate directly to the themes identified in the call for proposals:

1. Their lived experience and how they make sense of their role(s). Do they experience the same role conflicts that have been identified for nurse and medical managers?
2. What identities do they construct (both for themselves and others), and how do these compare with those of medical and nurse managers? (How) do these identities vary between junior, middle and senior managers?
3. What career narratives do they construct? What factors do they perceive as promoting or restraining their engagement in management and their career progression?
4. What narratives do they offer regarding their relationships as managers with members of their own profession, and with other professions and managerial staff groups? What strategies do they employ for managing them? How do they vary between junior, middle and senior managers? How do these compare with those that have been found for medical and nurse managers?
5. What narratives do they construct regarding their relationships with other sectors (such as education or social services) with whom they interact in a managerial capacity? What are their strategies for managing these relationships?
6. What narratives do they construct regarding the relationship between central policy imperatives and local needs? What strategies do they use to mediate these? How do they vary between junior, middle and senior managers? How do these compare with those that have been identified among medical and nurse managers?
7. How might the promoters of engagement identified under 3 above be increased and the barriers to it reduced?

2 Need.
The English NHS employs almost 70,000 AHPs (Information Centre, 2007). Like other health professionals, they are increasingly being required to work more flexibly, promote change and develop extended roles which cross professional and organisational boundaries (McPherson et al, 2007; DH, 2000; Allied Health Professions Federation, 2005). They are also being actively encouraged to engage with service and role redesign in order to increase capacity and improve service delivery. In line with the current policy emphasis on clinical leadership in the NHS (Darzi, 2008), developing AHP leadership capacity has been identified as a priority by the Chief Health Professions Officer (DH, 2007). Despite this, for a variety of reasons, AHPs lag behind medicine and nursing in terms of their involvement in management. Their relative underdevelopment thus represents a significantly under-exploited managerial resource for the NHS. More generally, they are massively under-researched by comparison with those other professions. A number of features make AHPs challenging but also potentially extremely fruitful for clinician-manager research. The most striking of these is their heterogeneity as a group of professions. They differ along a number of dimensions:

1. In terms of size, they range from physiotherapists (c. 20,000), and occupational therapists (c.17,000), through speech and language therapists (just under 7,000), down to arts therapists (at just 700).
2. These differences in size are correlated (although not consistently) with significant
variations in professional organisation, power, status and public visibility. All of these might be expected to be relevant not just to opportunities for involvement in management but also to the kind of narratives that individual AHP clinician-managers might be able to construct, and to the success of their storytelling.

3. Their professional ethos, education and practice vary in terms of the extent to which they conform to the biomedical paradigm, with radiographers and physiotherapists at one extreme, and arts therapists at the other.

4. The complexity of the task of inter-professional boundary management that they are exposed to also varies. For example, radiographers operate largely (if not exclusively) in the context of a (generally subordinate) relationship with a single profession (Radiology/Medical Physics/Oncology). By contrast, physiotherapy, occupational therapy and speech and language therapy interface with a much wider range of health professionals as a consequence of their involvement in multi-professional stroke recovery pathways, say.

5. The extent of inter-sectoral boundary management that AHPs are required to negotiate. Thus, occupational therapy and speech and language therapy are expected to operate (and potentially manage) across important sectoral boundaries, such as social care (OT and SLT), housing (OT) and education (SLT). By contrast, radiographers' and paramedics' practice is effectively confined to clinical settings.

6. Finally, the variety of organisational contexts in which they operate creates the potential to identify and explore management arrangements that diverge from the 'industry standard' doctor-nurse-lay manager triumvirate.

3 Methods

a. Setting In depth case studies will be carried out in a purposively sampled maximum variation sample (up to six) of NHS sites in London, South East Coast, South Central and Eastern regions.

b. Design We propose to adopt a narrative approach to understanding the experience of AHPs in managerial roles in health and social care settings, that is, to understand them through the stories that they tell, both as tellers of stories and as the objects of the stories they tell (Homo narrans narratur). The history of the narrative tradition in research on organisations has been summarised by Bruner (2002), but builds on theoretical and methodological contributions from (among others) Gabriel (2000) and Boje (2001). It maintains that our understanding of the world is built up through the creation and exchange of narratives, which serve to construct social order, and give substance to organisational culture. However, we produce these narratives not solely for others, but also for ourselves - as means of creating (and recreating) our identities and making sense of our lives. To date, there have been few examples of narrative research in health care settings, but those that have been carried out (e.g. Curry and Brown, 2003; Iedema et al, 2003; Bate et al, 2008) confirm its potential as a methodology for exploring the identities of managers in health and social care settings (Beech and Sims, 2008). Within this overall approach we will follow a phased, multi-method and flexible research design, in which the outcomes of earlier phases will inform the research agenda and the detailed design of later stages. As far as is possible within the constraints of the project, our design will be longitudinal, contextual and processual.

c. Data collection We will employ a variety of data collection methods:

1. In-depth interviews of AHP managers and selected members of their networks;
2. Systematic observations made in a range of settings while 'shadowing' AHP managers in the course of their official duties over a period of time. These will include formal meetings and less formal interactions;
3. Analysis of relevant documentation.

d. Data analysis All of the above data sources will be transcribed, and subjected to systematic and iterative inductive content analysis using the constant comparative method. We are confident that, in combination, they will generate rich and in-depth data for the
understanding ('thick description') of the issues we are seeking to explore. From these materials, for each of the case studies, we will prepare a draft narrative, which will be fed back to participants for validation (or modification), feedback and comment, and in order to stimulate further reflection and discussion. Individual case study narratives will then be combined into a series of draft meta-narratives, which incorporate key themes and the relationships between them. These will also be fed back to study participants for final validation, refinement or modification.

4. Contribution to existing research
This research into AHP clinician managers will
1. add substantially to our understanding of an under-researched component of the health and social care workforce and its experience of and engagement with management;
2. develop our understanding of the experience of clinician managers more generally;
3. explore the potential of narrative research as a tool for NHS management research;
4. identify capacity, organisational, skills and other barriers to AHPs’ (and by extension other clinicians’) engagement with management, as well as examples of good practice in promoting it;
5. identify priorities and actionable recommendations to improve AHP (and other clinicians’) engagement with management.

5. Plan of investigation
We propose a three-phase study design. Findings from earlier phases will inform the detailed design of later ones.

Phase 1. Key stakeholder interviews
In-depth interviews with key policy makers, officials and others will establish the context of the project.

Phase 2. Case studies
Detailed case studies at up to 6 sites will involve a variety of data collection methods:
1. In-depth interviews of AHP managers and selected colleagues;
2. Systematic observations of meetings and other interactions made while 'shadowing' AHP managers in the course of their official duties over a period of time;
3. Analysis of relevant documentation.

Phase 3. Policy Delphi
We will present findings from the case studies to a panel of experts, for them to discuss in a structured fashion and identify recommendations for policy, practice and future research.

6. Service users/public involvement
The research is concerned with the experience of service providers (AHP clinician managers) and their interactions with other service providers. Service users are not involved although they may be present in some of the settings where we will be collecting data. Service provider stakeholders have been involved in a variety of ways at different stages of the project. In the development phase we consulted extensively with the Chief Health Professions Officer's Office and with Regional AHP Advisors. Project delivery has been designed to maximise stakeholder involvement throughout. In Phases 1 and 3, key stakeholder interviews and the policy Delphi will enable senior members of the AHP policy and management communities to shape the research agenda and influence its impact on policy and practice. In Phase 2 our data collection methods will entail constant and systematic exposure to communities of AHP (and other clinical and non-clinical) communities of practice. We will appoint a Project Advisory Board, drawn from relevant DH, NHS and professional bodies, to advise on strategy and to consult on specific issues.

The project forms part of a wider programme of active involvement in fostering AHP engagement with management. City University's Centre for AHP Research (CAHPR) has recently launched an inter-professional postgraduate programme in Clinical Leadership for AHPs, and also possesses an extensive network of contacts and good working relationships with a wide range of national and regional stakeholders, including DH, NHS and professional bodies.
7. References

This protocol refers to independent research commissioned by the National Institute for Health Research (NIHR). Any views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the SDO programme or the Department of Health.