# Current thinking on Leadership and Physiotherapy Practice

Contents

# 1   EXECUTIVE SUMMARY

The Chartered Society of Physiotherapists (CSP) is undertaking project work on leadership and commissioned this report on current thinking. The report is based on literature and in-depth interviews with three physiotherapy leaders.

Leadership as opposed to 'leaders' is becoming important in healthcare due to the transformational changes needed to meet increasing demand and the integration of services. There are many ways of leading, with both policy and the literature suggesting healthcare requires leadership that can work across both professional and organisational boundaries, that is distributed leadership and systems leadership. There is a need for leadership development, with current thinking suggesting that development is more effective where there are learning opportunities that support learning from experience, embracing both self-awareness in the individual through structured reflection and collective sense making through to collaborative activities.

There is very limited research on leadership in physiotherapy. Traditional structures and roles have resulted in the medical dominance in leadership in healthcare, but this is changing with opportunities for physiotherapists to move into strategic leadership roles. In common with the wider society, there may be fewer women taking up leadership roles and this needs to be evaluated and addressed. There are examples of physiotherapists working successfully in new roles using distributed and systems leadership, but there is a need for more. Interviewees consulted as part of this report expressed a concern that clinical leadership and research evidence is not being used effectively in service re-design. Key to systems leadership is a focus on patient care and ensuring that everyone works together proactively.

Developing leadership capacity needs a strong focus to meet current healthcare needs. Evidence suggests that education and development opportunities for leadership, needs review in prequalification education.  The CSP is developing its support for leadership and it is suggested that actions should value leadership, signpost leadership to members and consider different options for leadership development within the profession.

# 2 INTRODUCTION

This report documents the current thinking on leadership and specifically leadership within the physiotherapy profession. It is based on key reviews and literature, enriched with personal stories from current practitioners.  It has been commissioned by the CSP to inform project work on leadership and will form the basis for a short engagement tool for physiotherapists.

The report is presented in three sections:

- Leadership in Healthcare - a literature based overview of current thinking
- Leadership and Physiotherapy Practice - based on literature, interviews and a CSP survey
- Enhancing leadership capacity - options for consideration going forward.

It draws on interviews from three physiotherapy leaders who were chosen to cover clinical, managerial, academic, research and management roles.  Brief vignettes of these individuals and interview questions are provided in appendix A.

# 3 LEADERSHIP IN HEALTHCARE

## 3.1 WHAT IS LEADERSHIP AND WHY IS IT IMPORTANT?

Leadership is defined by the King's Fund Commission as "the art of motivating a group of people to achieve a common goal." (1). There are many different concepts and theoretical perspectives of leadership. Current thinking is that leadership is more than the competencies, behaviours and values of the leader and is relational (2) and socially constructed[1] (3). Leadership is created through a complex interplay between the leader and the context in which they find themselves, expressed through relationships both formal and informal, across and within organisational boundaries (2, 4-6).

This progression in thinking is summarised in the diagram below.

**Leadership as 'leaders'**
- Focussed on qualities, competency, skills behaviours and attributes of an individual

**Leadership as situated in a context**
- Responding and being defined by the situation and context

**Leadership as relational and constructed**
- Socially constructed through complex interactions between people and the context in which leadership is being created

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[1] Social constructivism emphasises how meaning and understanding  is created through social interaction and discourse

Hence leadership is no longer seen as not purely being the domain of leaders, but the process of debate, challenge and persuasion (2) that involves everyone at every level. In his 2015 review, Rose (7) focussed on NHS Trust management and bringing talent into those roles but acknowledged that leadership qualities needed to be celebrated across "all disciplines and job grades". So everyone working in healthcare needs to motivate and work with others whether other health professionals, carers, relatives or volunteers (1).

Leadership remains a topical issue (8),  not least because of the perennial question of the differences between leadership and management (2). Leadership is viewed as 'doing the right thing' and management as 'doing the thing right' so management is seen more as the application of learned ways of doing, whereas leadership is around tackling the new (5). In steady unchanging times good management is needed to ensure efficient and effective use of resources but in the current healthcare sector where there is rapid change, multiple pressures to manage increasing demand, with limited resources, leadership is key (9).  The tragic failures of leadership and management such as those at Bristol Royal Infirmary and Mid Staffordshire NHS Foundation Trust – the latter detailed in the Francis report (10) – have created a sense of urgency to address leadership in healthcare (1). In addition the level of vacancies in senior leadership positions suggest that there is a need for more effective talent management (11). Leadership for innovation and new ways of working needs to be developed to meet current challenges.

## 3.2   WHAT IS THE CURRENT THINKING ON LEADERSHIP IN HEALTHCARE?

There have been several recent reports and reviews produced by the King's Fund on leadership in the NHS (1, 4, 11-13). In addition, in 2015 the Rose review (7) was published. This report focussed on Trust leadership and involved extensive stakeholder consultation.

**Qualities of leadership**

Much of the literature that considers qualities of leadership tends to focus on the individual leader and their qualities, characteristics and behaviours, even though current thinking suggests this view is simplistic  (12). Although leadership is viewed more collectively, there continues to be an interest in the qualities of leadership.

The qualities that the Rose review (7) suggests that Trust leaders  should possess include:

- driving transformational change
- taking bold decisions
- developing large-scale change management
- having strategic and commercial skills
- the ability to lead in a networked or group structure are becoming more important

To some extent these qualities are seen in all clinicians who need to facilitate behavioural change, take clinical decisions, participate in changing and developing services, market and promote their profession and create influence within a healthcare team. These 'business skills' have many similarities to clinical practice although the subject of analysis for leadership is the organisation rather than the patient (9).

Timmons (13), in his recent report for the King's Fund, interviewed leaders who were working across systems using a distributed form of leadership. Participants discussed the important qualities of building alliances, engaging staff, persuasion, giving away ownership, not taking the credit, consistency of purpose yet flexibility. One interviewee described leadership as "being comfortable with chaos" and none of the participants thought leadership was easy. In addition, there is a growing trend for hybrid roles where leadership, clinical and managerial skills are needed (3), and where the use of soft power as opposed to command and control in dealing with 'wicked problems' (5) is essential.

Self-awareness is a key factor in leadership and Emotional Intelligence (EI) (14, 15), which is the ability to be aware of one's emotions, perceive those of others and recognise the impact on thinking and behaviour, is highly valued in healthcare leadership (16). It has been shown to be a major contributor to effective leadership (15) and features strongly in the nursing literature on leadership. Authentic leadership (17) where an individual is self-aware and honest within their relationships, is considered an alternative way of viewing leadership rather than a set list of desirable qualities.

Leadership is generally presented in a positive way in the healthcare literature however it is suggested that there is a 'dark side' with a number of pitfalls (18). Ingratiation theory suggests individuals lower in status tend to over affirm and agree with those in higher positions to an exaggerated extent. This is sometimes described as 'being surrounded by yes people'. There is a need for a leader to seek out critical feedback (19) so that they do not succumb to an overestimation of their leadership abilities - 'hubris'. This is more likely where leadership is centralised in a powerful leader. In addition there are critics of the whole notion of leadership. Checkland (20) challenges the rhetoric on clinical leadership as simply 'new branding', in much the same way that administration became management, we now have leadership.

**Multiple ways of leading**
There are numerous styles and models of leadership that have been described in the literature over the years. Style tends to relate to the description of leadership as embodied in a leader and a model tends to embrace both the individual and/or the context to a greater extent. The context relates both to the people factors such as culture and working relationships, and the organisational context be that for example, location or sector. However, the relationship is not binary. Examples focussed on the 'leader' i.e. style, include:

- Commanding - leads with use of power
- Heroic - a charismatic leader who takes risks
- Traditional - a leader with positional power.

Leadership that recognises the interaction with others i.e. model includes:

- Visionary - creates a vision and inspires others
- Democratic - faciliates democracy and listens to the people
- Servant-follower - leads to serve followers (21).

Leadership models that embrace a more current view of leadership are:

- Distributed leadership
- Systems leadership.

Transformational leadership is associated both with individual leadership style and as a collective model.

The key models espoused in the current healthcare literature will be outlined below.

**Heroic leadership**
The historical perspective of much of the early literature saw leadership as embodied in an individual who heroically leads their followers, often using positional power. This was rejected by the King's Fund review (1) as healthcare leadership involves "multiple actors… working collaboratively… across organisational and professional boundaries" (1). However it is mentioned here as Careau et al (22) found in their review of health education programmes that a 'traditional' model of leadership focussed on a 'leader' was the most commonly taught.

**Transformational leadership**
In response to the "adapt or die" message (7) created by the current challenges in healthcare, there is a growing interest in innovation and transformational leadership, as doing things in the same way in the future will not be affordable (23). Bureaucracies do not support transformational leadership well and Rose suggests that leadership in the NHS is sometimes characterised more by a culture of avoiding failure rather than driving for successful innovation (7). It has been suggested that the growth of healthcare being provided by social enterprises, charities and private organisations may provide opportunities for transformational leadership (24). Others have suggested similarities in transformational leadership and heroic leadership as both focus on a key individual (3), after all the focus of the Rose report was about getting the 'right' leaders into the NHS. However, the idea that changing a leader will be sufficient to change the system is viewed by some as 'fantasy' (4).

**Distributed / shared leadership**
The theory of distributed leadership (often also called shared leadership in healthcare literature) where empowerment of others leads to shared responsibilities can be exhibited in a number of ways: spontaneously - where individuals come together to undertake a particular task or project, intuitively - where it is developed over time and becomes encompassed by a relationship, or institutionalised - where organisational structures are designed to facilitate collaboration between individuals (25).

Bolden (26) in his review of the conceptual and empirical literature on distributed leadership found that there was much diversity in the interpretation of distributed leadership and that there were different hybrid configurations in practice. Distributed leadership is focussed on empowering people across the system (8) and across organisational boundaries (27).

Given that leadership in healthcare requires relationships across interconnected clinical fields and managerial roles, it can be seen as shared and distributed across the system (1, 4, 28) so:
- within organisations 'from the board to the ward'
- across disciplines
- across organisations into social care, local government, the voluntary sector and the wide variety of other agencies.

Distributed leadership has become a key strand of policy in the NHS (8) and the King's Fund report argues that "leadership of the 21st century health system needed to be 'shared, distributed and adaptive'"(1). It differs from traditional forms in that responsibilities are dispersed and is seen by some to offer a way forward to the clinical-managerial divide and the complexity of healthcare (4). It requires an understanding of leadership practices and organisational interventions rather than a simple and traditional leader-follower relationship (4) . It also requires staff involvement at multiple levels. There is a strong evidence base that staff engagement has benefits for both the individuals and the organisations (29) which supports the wider adoption of distributed leadership.

Implementing distributed leadership is not easy because of the historical hierarchical structures in healthcare. Rose highlights 'the triumvirate' of disciplines, which he describes as Nurses, Doctors and General Managers who do not share and understand each other's priorities (7), or what Martin et al describe as values (8). Martin et al drew on qualitative data from three health care organisations that were implementing distributed leadership and found between individuals there were very different perceptions of power and understandings of location within the structure and values. Some participants felt that power remained outside of the clinical group and remained external and hierarchical in that they had to follow policy or respond to commissioner demands. Both clinicians and managers suggested their influence was limited, with the perception that they had lots of responsibility and no power. The divide between managers and clinical leaders remained evident and were in many cases reinforced through social group discourse, with clinicians getting involved in management seen as going to the 'dark side'. They suggested that there was a need for more radically distributed leadership so that high-status group members could challenge thinking which could impact on the entrenched views of 'others' on whom was projected both agency (ability to take action) and blame.

Perhaps what is reflected in this study is that some participants had a traditional view of leadership, whereas leadership that crosses traditional structures needs to lead through influence and collaboration (13). To encourage these relationships, support and development is needed. A case study where a form of distributed leadership was supported by leadership development had more positive outcomes (30), resulting in an improved service for both patients and greater staff satisfaction.

For distributed leadership to have impact, and for the theoretical advantages to be realised, high-trust relationships need to be created across the professional tribes and the clinical and managerial divide. There is also a need for stability to form these relationships (13), so frequent restructuring for example, will disrupt these relationships and take time to reform.

**Systems leadership**
Systems leadership is a more radical form of distributed leadership extended to leadership across systems and silos that are seen as barriers to effective working (11) and focusing on complex change using systems thinking (31). Recent reviews (12, 13) suggest that there is a compelling case for leadership across systems and boundaries both within and between organisations. Everyone is involved in the responsibility of achieving success, with leadership as a collective responsibility of teams (13). Given the agenda of integration of health and social care it has become "less of a 'nice to have' and more of a 'must have' (13). This changes the question from developing 'leaders' to how to develop 'leadership' in the system (2). There is empirical evidence to support leadership as a key mechanism in inter-professional teams (32). Based on the literature and case studies, Goss (31) suggests systems leadership is a mind-set not a skill and identifies six dimensions of systems leadership:

- feeling – about having strong personal values
- perceiving – about listening, observing and understanding
- thinking – about intellectual rigour in analysis and synthesis
- relating – the conditions that enable and support others
- doing – behaving in ways that lead to change
- being – personal qualities that support distributed leadership.

The move to clinical commissioning groups (CCGs) was intended to encourage the radical system changes and redesigning of services. Initial research based on data from six CCGs suggests that where there are examples of this significant large-scale transformation, it has required collaboration often at a CCG level and at present there are many groups that have yet to implement the transformative, radical reforms envisaged by national policy (33). Transformational change had been facilitated where structures had changed with the integration of health and social care and the use of multi-disciplinary teams.  However, tensions were noted between collaboration through relationship-building and the competition that contracting leads to, and some 'leaders' did not share the radical ambitions of the policy makers.

**NHS model of leadership**

There are a number of leadership models / frameworks specifically linked to healthcare (12). These principally take a competency approach:

- NHS Leadership Framework
- Medical Leadership Competency
- Clinical Leadership Competency Framework
- Healthcare Leadership Model, NHS Leadership Academy (34).

The most recent of these is the Healthcare Leadership Model produced by the NHS Leadership Academy in collaboration with the Open University and the Hay group. It supersedes the NHS leadership framework and was developed from an evidence based review of the literature (35) and consultation with key stakeholders. The leadership model describes nine dimensions of leadership behaviour, (inspiring, shared purpose, leading with care, evaluating information, connecting our service, sharing the vision, engaging the team, holding to account, developing capability and influencing for results), with a four-point scale from 'essential' through to 'proficient' and 'strong' through to 'exemplary'. They suggest that these are not job or role related.

This model emphasises the concept of greater self-awareness leading to more effective behaviours that will in turn lead to better team working and hence more effective patient care. The model is designed to be updated as the needs in healthcare change so that these behaviours are historically situated in the present and relevant to current practice needs. Although focussed on the individual, it incorporates relational factors both with others, e.g. engaging with the team and the organisational, or system context, e.g. evaluating information.

## 3.3   HOW CAN LEADERSHIP CAPACITY BE DEVELOPED?

Despite the conclusion of the King's Fund review (1) that leadership development was a priority for every NHS organisation, Rose (7) found that leadership training was fragmented with several institutions responsible for leadership including the NHS leadership Academy, Health Education England, and the NHS staff college. The majority of these leadership development programmes have been based on competency models  and should be available for all disciplines and at all levels (12).

There is debate as to whether centralised leadership development is the answer as leadership development needs to be embedded in practice and requires conversations and learning with people who share that context  (2, 4). In this way, the development becomes focussed on the roles, relationships, challenges and practices within the specific setting.  This reflects the view of leadership as more than the 'leader', and fits with the concept of situated learning (36).

The development of individual capital will not automatically lead to social capital (2). Edmonstone conceptually compared two different forms of leadership development, the NHS Leadership Academy (UK) based on academic Masters courses with the practice based programmes provided by the Scottish National Leadership unit. The latter courses use coaching, mentoring, action learning[2], with some master classes. These are long programmes with interventions over 18 months. The suggestion is made that practice based courses that enable practitioners to reflect on their lived experiences of leadership, are more reflective of the development of understanding of leadership within a complex dynamic system, than programmes designed to develop personal attributes.

A review published by the King's Fund in February 2015 (12) on leadership development highlighted some key points. These include:

- The research literature shows that there is no single method that is most effective for leadership development
- Good leadership development is context specific
- Most development focusses on a 'gap' analysis of need in individuals
- There are numerous competency frameworks within healthcare although there is little evidence that the use of competency frameworks leads to improved leader effectiveness
- Clinicians in health services often have non-managerial backgrounds and are often ill prepared for leadership roles and require more support than might be the case in other organisations
- Several studies in the grey literature have identified the benefits of leadership development for individuals
- There is clear evidence of the link between leadership and a range of important outcomes within health services, including patient satisfaction, patient mortality, organisational financial performance, staff well-being, engagement, turnover and absenteeism, and overall quality of care.

The Royal College of Nursing Clinical Leadership Programme (CLP), which started in 1995 is cited by this review as a positive example of a development programme that research shows can impact on nurses' transformational leadership competencies (37).  Other recent reviews (4, 12) suggest that supported experience is the most valuable factor with an emphasis on interventions that facilitate learning from that experience, although there is no clear evidence of a single method being most effective. Change requires a recognition of leadership as a collective practice with even those individuals who do not see themselves as leaders being able to see what needs doing and able to work with others to do it (4).  Interventions in leadership programmes often include 360 feedback tools, supported experience, job rotation, action learning, mentoring and coaching. The King's Fund review suggests the factors outlined by Yukl (38) should be considered. In summary he suggests clear learning objectives, to ensure content is meaningful and sequenced, teaching using mixed methods, with intervals to enable active practice with timely feedback.

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[2] Action learning is a structured facilitation technique undertaken in groups, where each individual outlines an issue and the rest of the group asks questions. There are many modifications including eavesdropping where the individual listens in to a conversation about their issue. An alternative approach is feedforward where group members give suggestions.

A case study at Lancashire Care Foundation Trust demonstrated the implementation of a leadership development programme specific to the organisation and involving all staff levels. They used multiple methods of Appreciative Inquiry, Generative Conversations, and Action Research as well as more traditional tools such as 360 degree feedback, to develop what they describe as appreciative leadership (30). This programme had strong leadership from the Chief Executive Officer, was situated within a trust and had external funding (a million pounds over three years). Evaluation suggested positive outcomes both for the organisation and staff.

Practice based mentoring is supported also by a review on talent management (11). This suggests that talent management through mentoring supports those in leadership positions and those in the pipeline. Massie suggests:

- Identification of the leadership required
- Deploying talent across boundaries through supporting and creating opportunities for successful deployment
- Succession planning.

This review highlighted the importance given to creating leadership opportunities as it reinforces the need for supported experience.  For the development of systems leadership there needs to be supported personal reflection e.g. coaching and opportunities for collaborative sense making, e.g. action learning (31).

To conclude, the current thinking suggests that effective leadership development is provided by an interplay between content, practical workplace experience and interventions that enable learning from that experience (4). Ideally this should be undertaken collaboratively with those in the systems in which they want to create change. Interventions that enable self-reflection e.g. coaching, 360-degree appraisal and collaborative sense making, e.g. action learning and appreciative inquiry are also advocated.


## 3.4   SUMMARY OF LEADERSHIP IN HEALTHCARE

In summary this section shows that current thinking suggests:

- There is a growing emphasis on 'leadership' as opposed to 'leaders'.
- Leadership in healthcare is viewed as socially constructed through a complex interplay of relationships in a context and the interactions between these.
- There is a need for leadership for innovation and change to address the current challenges in healthcare.
- There are a number of competency frameworks for leadership, the NHS Healthcare Framework is the most recent, although there is limited evidence that the use of competency frameworks leads to improved effectiveness of leaders.
- There are many ways of leading, with both policy and the literature suggesting healthcare requires leadership that can work across both professional and organisational boundaries, i.e. distributed and systems leadership.
- For distributed and systems leadership there needs to be an understanding of leadership that goes beyond individual leaders in senior positions and embraces all levels of staff.
- Although leadership development has little evidence to support a best method, current thinking is that development is more effective where there are learning opportunities that support learning from experience, embracing both self-awareness in the individual through structured reflection and collective sense making through collaborative activities.

# 4 LEADERSHIP AND PHYSIOTHERAPY PRACTICE

Currently there is very limited specific literature on leadership within the Physiotherapy profession, making it "not currently possible to perform a systematic review of this topic" (9). It should be noted that the interpretation in some of the studies presented is of leadership as an individual 'leader' who is generally viewed as having a more senior organisational position. To provide more information for this report, three leaders were interviewed (indicated below as 1, 2, 3 with direct quotes highlighted (in italics and blue font), and findings from a survey carried out by the CSP (39) were used.

**Interviewee 1**
Consultant and clinical lead for a specific area of practice managing all care of the patients, managing an interdisciplinary team of therapists, both hospital based and community based.  The interviewee was also responsible for service development, teaching and research within this area. This role has developed with changing organisations (integration) and changes to the role.

**Interviewee 2**
Therapy service manager for therapists across two sites in secondary care. This was a Trust wide role leading on a strategic area and with a clinical caseload. There have been recent changes in the organisational structure.

**Interviewee 3**
University academic primarily involved in research activity but also postgraduate teaching, working both in the NHS and privately, with scope of practice that includes strategic leadership.

## 4.1 LEADERSHIP QUALITIES IN PHYSIOTHERAPY

The relationship between 'business skills' and clinical problem solving is explored by McGowan and Stokes (9) who suggest that these skills have many similarities. Desveaux and Verrier (40) carried out a quantitative, cross-sectional study with physical therapists in Canada, using a Web-based questionnaire on 15 leadership characteristics. They found that the top three characteristics physical therapists identified as important for leadership were communication, professionalism, and credibility but participants were focussed in their specific workplace environments.

The three interviewees who were consulted for this report had continued some clinical work.  It was suggested by the two interviewees managing teams that this was essential for their credibility. One interviewee suggested that obtaining her doctorate had helped her credibility with medical colleagues and noted – "*the [positive] comments I got from doctors when I got my doctorate*" 2.

Chan et al (41) in their online survey of Canadian physical therapists found that the key difference between leaders and what they term 'non-leaders' was that leaders were significantly more likely to possess the 'achiever' strength as measured by the Clifton Strengths Finder. However, there was a substantial overlap with non-leaders for other strengths. They support the view of McGowan and Stokes (9) that there is overlap in the skills identified for leadership and those of clinical practice, for example the strategic strength 'being able to quickly spot the relevant patterns and issues' and the concept of clinical reasoning to make decisions on patient care.

The relationship of leadership qualities to the context or environment in which one is leading is supported by several studies. A study that compared academics and managers found that both had the primary characteristics of 'learner' and 'achiever' (42). Academics secondary strengths were 'empathy' and 'intellection', whereas managers were 'harmony' and 'connectedness'. In a study comparing Canadian and Irish physiotherapists via a survey (43) participants were asked the importance of 15 characteristics in the workplace, healthcare system and society. There were cultural differences with Canadians valuing 'communication', 'professionalism' and 'credibility', whereas in Ireland although 'communication' and 'professionalism' were the top two, the third was dependent on context, for the workplace it was 'motivate', for healthcare 'active management' and for society it was 'empathy'. The most commonly cited characteristic in the CSP survey (39) was communication and listening skills. These studies suggest key qualities for leadership in physiotherapy, leaders are those that support the development of interaction with others, e.g. communication and, personal growth and development, e.g. learner.

The three interviewees' supported the qualities identified in the literature in particular the importance of communication and learning. For example, for communication one interviewee said: *"relationships are the key… staff and patients …fundamentally underneath that …unless people understand how to interact with each other, nothing works well."* Leadership is helping others to *"make sense of where they are in the big picture, that they have some responsibility for the whole thing, each of us plays a part"* 2. Another interviewee thought that it was important to appreciate *"the softer aspect of leadership"* and *"as a whole team we make up for each other's gaps"* to *"appreciate the different skills that different people bring that not everyone has to be the same"* 1. The three interviewees expressed at interview a modern concept of leadership which empresses supporting others in development and learning: *"Leadership only works when it is not dictatorial sometimes getting support for a suggestion, sometimes it is about finding a person and supporting them…a good leader… knowing someone else is better than you and doing what you can to support that person… it is collaborative"*.3. So qualities to be valued for leadership are identified both in the literature and by the three interviewees as those focused around interaction such as communication and listening and those focussed around learning for example supporting others in their development. Qualities that should be part of professional practice.

## 4.2   ROLES AND STRUCTURES

Clinically every trust has a clinical director and a chief nurse but representation at a board level for therapists is rare. As Rose points out, strategically the key leadership relationships in the NHS are between the Chief Executive, the Clinical Director and Chief Nurse (7). Desveaux and Verrier (40) suggests that to advocate Physiotherapy and its value there is a need to build leadership capacity and positions across the healthcare system. The three interviewees all had roles in which they had strategic responsibilities and their roles crossed different boundaries, including across a trust and leading a service across primary and secondary care. They were all what could be described as hybrid roles, in two cases leading inter-professional teams. These roles had been emergent, in two out of the three cases they had been created to some extent around the individual and in the third was developing with time into an even wider, more strategic role.

The development of clinical leadership roles in the UK such as consultant and extended scope practitioners is forging the way in clinical leadership. As one interviewee said: *"Some of the leadership initiatives that have let my profession evolve the way it has, have been exceptional, a lot of the rest of the world looks towards this country and says wow!"*3. However, the interviewees had experience of senior managers deciding on treatment pathways and staffing structures that was not always evidence based, so *"clinicians [were] not involved in the big table"*, with short term decision making *"not looking at the downstream tsunami"* 3. That the Rose review (7) barely mentions allied health professionals (AHPs) suggests AHPS need to develop a stronger leadership voice at a strategic level and in health systems design.

Structures within the health services are changing from traditional uni-disciplinary silos to integration across disciplines with interdisciplinary teams. A realist synthesis (32) focussed on inter-professional healthcare teams stated leadership as one of the four key mechanisms contributing to these teams' effective operation. Some teams had shared leadership although a key challenge was the traditional hierarchy with medics often being viewed by both themselves and the team as the leaders although this was not always the case.

The finding that medical power may influence leadership in healthcare was also expressed by the interviewees, who also noted that this varied in different hospital settings, this latter point has not been recognised in the literature but was mentioned spontaneously by all three interviewees. They found greater resistance to therapy leadership in teaching hospitals due to the medical 'power'. In the general hospital you: *"could challenge the medics … could challenge the nurses"* 2. *"General hospitals the power is much more equal … in some teaching hospitals that power is not equal… doctors think they have more knowledge … are more superior"* 2. *"Because we work in an area that doesn't have a big teaching hospital there's very much a collaborative approach across professions and the doctors have been so supportive, I look at other places and I can see it is still very medically dominated". 1* The third interviewee after years of working in a teaching hospital had *"moved to a non-teaching hospital [as] much easier to implement change" 3.* This variance between hospitals is not documented in the research literature and would warrant further investigation.

In some areas of health care, inter-professional teams are well established. A study of three paediatric teams in the Greater London area found that overall there was a positive response to their multi-disciplinary teams, including the leadership (44). There was some variance at a team level with two teams suggesting staff felt they could challenge and express opinions but in the other team there was a diversity of views around the ability to express opinions and be heard.  One interviewee consulted for this report who was leading a multi professional service in an integrated organisation (Health and Social Care) saw herself as *"ultimately responsible for the patent care…"* 1 in her area. Although not necessarily directly managing all of the staff, e.g. nurses, that wasn't perceived as a barrier *"Leadership (is) about influencing people, what we need to do for the whole service"*1. Although the interviewee had initially experienced some inter-professional rivalry in the new role, "people *waiting for it to fail … some people not very supportive… other professions …some senior nurses"1* this had dissipated with time and by achieving outcomes.

For physiotherapists moving into these strategic roles, changes in both mind set and structures will be required. These changes are being adopted as seen on the CSP works website (http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works) and in the roles of the three interviewees. For example, Lisa Horne's clinical leadership has led to a transformation of musculoskeletal services across the systems of primary and secondary care (45). For physiotherapists to be able to apply successfully for newly created and often 'hybrid' leadership roles, they need to see themselves in these roles (46). A concern has been expressed by some participants in a survey of physiotherapists (46) that these roles might become dominated by other professions, but the experience of two interviewees in this report was that physiotherapists were often leading on inter-professional teams and taking up these roles: *"Physiotherapists are not backwards at coming forward"* 1.

Leadership takes place in a context and with society as a whole there is a gender gap in senior leadership roles (47) - the so called 'glass ceiling'. Gender and leadership is discussed by Mc Gowan and Stokes (9) who suggest gender may be a barrier for women to achieve senior leadership roles despite being a largely female profession. The paper found that 59 of the 106 member organisations of WCPT had male leaders although they also congratulated the CSP on their appointment of a female Chief Executive. There is very limited work in this area in physiotherapy, Chan (41) found no difference in gender in the strengths identified in Canadian physical therapy leaders, other than the 'achiever' strength associated with leadership was more present in females. In a study in Canada, male gender was associated with being a self-declared leader (43). For colleagues working in academia, gender has been found to be a significant factor in the representation in senior roles in universities (48). Gender was not mentioned as a barrier by any of the interviewees.

## 4.3 LEADING ON PATIENT CARE ACROSS SYSTEMS AND PROFESSIONS

A study (49) carried out in Scotland using the Multifactorial Leadership Questionnaire (MLQ) focused on AHPs found that physiotherapists had greater transformational leadership behaviours than some other AHPs, notably radiographers and podiatrists. Both seniority of grade and prior leadership training also positively influenced transformational behaviours. A survey of 69 physiotherapists on leadership in Saudi Arabia showed that leadership was positive for both job satisfaction and the leadership style, with participants self-reporting their leadership style to be more transformational or transactional (50). This suggests that physiotherapists may be well placed to lead the changes required in the current health care transformation.

In healthcare system, there is a tension between the development and focus on technical (clinical) skills and leadership skills (11), with a need for clinicians to move into leadership positions (11, 51) and lead on delivery of healthcare (52). One of the interviewees for the report was already leading a highly integrated service using data across the system to continue to develop effectiveness of the service. A concern was expressed by two of the interviewees around the need for a stronger approach to using evidence based practice to develop rigorous patient care pathways and justify physiotherapy. Studies have shown that there is a need for leadership in the utilisation of evidence based practice (EBP) (53), with a growing recognition that contextual factors of leadership and culture are critical to successfully implementing EBP. In order to ensure excellence and quality in physiotherapy services, leadership and management is required not just high level clinical skills (54).

All three interviewees expressed concern about service re-design and the need for physiotherapists to be proactive in leadership in this process. Two of the interviewees were very concerned that despite *"an overwhelming wealth of research evidence"* 3 services were being designed by senior managers with insufficient input from clinicians. One interviewee described how they had designed an evidence based pathway that had been researched and evaluated by health economists and focus groups which showed it was less expensive and had better patient satisfaction than the alternative surgical procedure. However, it was not implemented in the teaching hospital because the trust could charge more per intervention for surgery than it could for a physiotherapy intervention. There was frustration from the interviewees that *"because of the hierarchy of professions"* that at times it seemed that the systems did not support *"putting the patient first"* and that staff needed to remember *"we are not here for ourselves"*3.

A case study on distributed leadership by Boak et al. (55), examined physiotherapy provision in a musculoskeletal physiotherapy service at Salford Royal NHS Foundation Trust. This was focussed on operational outcomes including waiting lists. The service was restructured from a traditional model to a distributed leadership model with clear responsibilities being devolved to specialist teams. Authors suggested that this resulted in enhanced communication, development of treatment protocols, and after 10 months was reinforced by specific team leadership roles and use of data to involve teams in operational decision making. Outcomes were:

- Initial fall in waiting times of 32% with ongoing gains
- Maintenance of high patient satisfaction in 'family and friends test'
- Very positive staff feedback in two structured evaluations including the benefits of working together.

There are several key points worth noting in this case study. Relationships developed and were formed over time, so that after the initial restructuring, there was an emergence of team leaders which then became embedded with the new roles. The complexity of the structures and the shared leadership gave some responsibilities to the teams, but some responsibilities were retained by the managers. Teams were expected to decide on their own ways of working.

Desveaux and Verrier (40) found that physiotherapists tended not to look beyond their immediate environment, they suggested that for physiotherapists to have impact across the systems of healthcare, they need to recognise leadership roles and opportunities beyond their immediate work environment. The extent to which physiotherapists are prepared for and taking up distributed leadership roles is an important area, if distributed leadership is the future of leadership in healthcare.

There are many individual examples of physiotherapists leading areas of practice and taking a distributed and systems approach, although in the literature this is in the main reported in terms of patient outcomes rather than leadership. Examples described by the three interviewees were integrating patient pathways, using evidenced based practice, integrating different professions and organisations. It can be seen in the vignette below that the interviewees were embracing a modern interpretation of leadership.

Interviewee 1
This interviewee who was leading a theory led service was clear that the key focus was around the patient and *"making sure right things happen at the right time…what data tells us …what developments can we make…. why are we doing it this way…challenging"*.
It was about collective working rather than individuals - *"it's not just about me is it, there are loads of people who do loads of great stuff, we listen to each other"* with *"sharing across the team"*.
A systems approach was described *"what do we want to achieve her? Integration around the patient pathway…is this what the patient wants?"* They saw the role of the leader as *"Communicating to people what the vision is… bringing people back to what is important"*.

Interviewee 2
This interview was leading a multi-professional service across two sites. In the leadership literature there is documented the importance of leaders having a vision and being able to take their followers with them and this was supported: *"We need to have a vision, we need to know how we are going to try and achieve that vision and we need to understand that we need to work together for that vision."* They suggested that everyone needed to recognise that they had a part to play - *"what is your responsibility in this organisation… that the patients are the priority not you"* and escalate action up to the leaders as required and know that if they did this *"something will happen"* and *"you deliver"*.
Thus taking a systems approach related ultimately around forming relationships with others *"when it comes down to it, it is much more about relationships… Staff need to be nurtured … trained and feel that they can do their jobs competently"*.
A key obstacle to this they felt was peoples' inability to work collectively - *"biggest problem is people's egos"* 2. They expressed concern that this respect was essential for true patient focussed care - *"Patient centred and everyone respecting everyone else"*.

Interviewee 3
Although interviewee 3 had worked in a traditional physiotherapy service they still described distributed leadership. It was important to *"identify key people in each area"* and empower them and at times *"recognising that you might have an idea but you might not be the best person to lead"* and *"the only way to be a leader is to engage everyone in that project... find the right person who can"*. There was an emphasis on team working in their practice of leadership *"making sure teams are accessing appropriate research information… to inform clinical practice [and]...trying to plug the gaps"*.
This interviewee identified that in their experience within the profession there were barriers to systems leadership between different roles of managers, academics and clinicians: **"Lack of relationships between the clinical and academic world… huge divide between clinical and academic"** with in some cases *"managerial decisions not related to clinical evidence"*. For this interviewee the key test was the family and friends test: *"would I be satisfied if my mother, wife or children received this"*.

## 4.4 LEADERSHIP DEVELOPMENT PRE-QUALIFICATION

Considering entry qualification education there are a number of concerns identified in the literature related to the teaching of leadership. The task force set up by the WCPT to examine the skills and knowledge that physical therapists should have in the area of Leadership, Administration, Management and Professionalism (LAMP) recommended that these skills should be developed and embedded in all phases of a student's development.

The introduction of inter-professional learning should be providing an opportunity for students to explore a more collaborative understanding of leadership, however review evidence (22) suggests this is not the case. Careau et al review of health literature focussed on the ability of health education programmes to teach collaborative leadership. Of the articles reviewed, only 40% formally identified models of leadership. These included traditional leadership (20%), transformational leadership (11.6%), clinical leadership (4.8%), and the lowest of all was collaborative leadership (3.2%). The most identified competences were inter-professional communication, knowledge on how to work in teams and across disciplines and financial knowledge. The most common form of measuring the impact of programmes was on learner skills changes (56.0%) with only 6.8% of the articles reviewed assessing impact on patient-centred outcomes and 3.6% on system change. This is supported by a study of occupational therapy students (56) that found the leadership styles most preferred were considerate (focused around comfortable work environments) and spirited (inspirational), least preferred were direct and systematic. In addition a survey of Irish physiotherapists suggested there needed to be more on leadership in undergraduate training (46).

Inter-professional education could be seen as an opportunity for developing collaborative leadership skills. A systematic review  for the effectiveness of university-based inter-professional education (57) found positive evidence for developing  inter-professional collaboration but insufficient evidence  on the  teaching of communication skills. To achieve collaborative behaviours and the development of peer coaching skills requires careful facilitation going beyond simply co-locating students in a room, and this is discussed in an evidenced based review by Ladyshewsky (58). Furthermore, in a study (undertaken in 1999)  in three paediatric teams, 12 out of 17 respondents said that they had had little or no teaching on teamwork during their training (44).

In translating education to the clinical setting,  a study in Australia (59) explored the difficulties in achieving collaborative leadership teaching that then leads to an impact in the clinical setting. Again there is a recognition that changes in organisational structures are required to enable shared leadership. In a realist synthesis (32) clear leadership was associated with team innovation and effectiveness in both the quantitative and qualitative studies reviewed. The leaders exhibited many positive factors but team leaders were noted to be lacking in chairmanship or facilitation skills, communication and listening, and coaching ability. There is a need to develop collaborative leaders to navigate the complex health systems and future challenges, but review  evidence (22) suggests this may not be adequately addressed in current education programmes.

There is a tension in educating students in leadership between the role models of managers/ leaders they might experience currently in practice with traditional structures, and an understanding of leadership as to what it needs to be for systems change. As one interviewee put it, *"leadership used to be what the doctor said, what the chief physio said …evolved to be not such a top down…more group, more consensus"*3 now it was *"less dictatorial but of course a mixture"*3. There was recognition by physiotherapists in a survey in Ireland that some managers were not leaders and had not had sufficient development to enable them to be leaders (46). Those in the CSP survey (39) considered that students were the 'shining diamond'. Students need to be taught current thinking on leadership and for it to be given sufficient emphasis in the curriculum.

## 4.5   DEVELOPING LEADERS IN PRACTICE

There is little literature describing how physiotherapists view leadership development or why they become leaders. For physiotherapists to be motivated towards learning leadership they need to view it as key to their professional practice.

**Formal education and training**

Some universities are already exploring how they can more overtly address the leadership agenda. A study using focus groups explored concepts of leadership with multidisciplinary stakeholders (60), exploring development post qualification. Interestingly some participants did not necessarily appreciate leadership as a professional skill required by graduates. The value of learning in a multi-disciplinary way with good role modelling in practice was identified as a key factor for students to develop the essential leadership skills. They suggested that the teaching of leadership should be "re-badged" and incorporated more overtly within all programmes. In contrast a survey of Irish physiotherapists found that respondents recognised the importance of leadership and would like more opportunities to develop leadership skills (46). As found in the King's Fund review studies, physiotherapy clinicians in Ireland are arriving in leadership roles having not received any formal or informal training (46). Some of the influential leaders in the CSP survey (39) had been developed through their roles as stewards or representatives that had increased their confidence to undertake such positions.

All of the interviewees had undertaken more formal education largely focussed around clinical development, although two had some specific leadership development in an academic environment. The *"academic pathway [was] really important"* 2, for both knowledge and self-awareness. The knowledge was around processes, capacity, outcomes and management issues learning about *"making things happen"* 1. The self-awareness was *"really important for me in my thinking and me understanding the way I think…. self-awareness taught me a lot about myself"* 2. They were continuing learning with one interviewee using *"TED talks by a whole variety of experts and geniuses, inspirational books and podcasts"* 3 to keep exploring and developing.

**Self- awareness**

Although not specifically focussed on physiotherapy, a study using a qualitative phenomenological methodology with 10 occupational therapists (61) found that the drivers to take up leadership roles were: to influence the profession or care delivery, a need for personal or career development, and a need for change. The study strongly suggested the mentor approach should be supported given its practical and outcome driven focus. They suggest three ways to support leadership development:

- Leadership in curriculum
- Professional leadership development
- A culture of mentorship.

In a study of paediatric teams (44), therapists recommended workshops to improve their skills of communication and enhance their self- awareness. It has already been suggested that for relationships to be formed there needs to be stability.  The effective inter-disciplinary teams described in this study may reflect that 10 of the respondents (58%) had been working in community paediatric teams for more than seven years and hence were part of much more stable groups. So there is a need for development opportunities but also some stability for relationships to develop. Stability can lead to building of relationships and enable the forming of a community of practice around leadership (61) as a way of building leadership capacity.

All of the interviewees demonstrated self-awareness and spontaneously offered perceived personal weaknesses and gave examples of working with others to use each other's strengths and to *"leave your own ego at the door"*2. There are a number of interventions that can support self-awareness including 360 degree tools, psychometric tools, coaching and mentoring and these tools are usually core to a leadership programme.  Two of the interviewees had experienced the use of 360 degree tools and one had used something similar. They had had positive experiences of personal development, on the 360 - *"it was amazing… really well done…with supported feedback by a mentor…someone there to talk it through"*2. This was a 360 with facilitator feedback. The *"psychometrics started to give me insight into my behaviour and other people's behaviour…being able to reflect on this"* 1*.*  One interviewee had sought out coaching from their human resources department for support over a specific issue. All the interviewees were reflective as one interviewee suggested, it is *"not just about courses, it's all just one big educational activity just coming to work"*1.

**Multiple roles and opportunities for experiential learning**
All three interviewees currently had multiple roles and had been in a number of different roles in their careers including in two cases working in different countries. Chan et al  (41) found that those they characterised as leaders often had multiple roles and suggest that leaders tend to seek opportunities for professional growth and engage in social networks conducive to further leadership development. This is supported by the survey of Irish physiotherapists (46) where respondents suggested that experiential learning and in particular mentoring and role modelling were important. Obviously different roles will result in exposure to more role models. In the CSP survey (39) the majority of the strategic influencers described their varied experiences as the reason why they felt confident to be physiotherapy leaders.

One interviewee described how they had been given a leadership role early in their career and had experienced experiential learning and had been given the opportunity to *"do things differently"* 2. There is a tension about getting experience through different roles and the stability to form relationships. Two of the interviewees had been in many different roles but in a similar location so had managed to experience different roles whilst maintaining relationships and developing trust – *"group who worked together for a long time [so] trust each other"2.*

**Role models**
Role modelling is a key way people learn about how to 'be'  a leader (46). All of the interviewees mentioned role models both within and outside the profession, *"I could see a different way of being" "I was so in awe of her"*2, *"inspirational people...bosses, colleagues, friends"*3. In some cases reflecting on leaders whose style they thought was not optimal was also helpful in thinking about why they did not like how leadership was being practiced, so *"identifying bad and trying to avoid it"* 3. One interviewee commented on how having been empowered in one role, they then moved into a role where they were less valued for being proactive and not encouraged to take things forward and found this frustrating and demotivating. It was noted that there were *"Lots of good role models around"* 1, and one interviewee had visited and shadowed leaders as a way of gaining greater opportunities to see different role models.  They also recognised that they too were role models for others and had taken in part in mentoring themselves as mentors.

## 4.6 CHALLENGES OF LEADERSHIP GOING FORWARD

The three interviewees were asked about their views of leadership for the future. Key themes were the pace of change, the need to have a voice but work with the change and the need for physiotherapists to take on the challenges and roles.

There was a perception that the pace of change as unrelenting - *"So much happening all of the time"* and there was potential to get *"exhausted and drained"* with the constant challenges and the "drive to keep on cutting back"2. It was recognised that there were *"huge challenges for the future model of care…trying to meet the needs of a really complex aging population"* 1 and that it was about *"working out what the population needs … need to map out challenge"*1. A concern was expressed that at times it was *"overwhelming"*2 even with redesign, it was not possible to meet the need, although the need for transformational change was clear to the interviewees.

In ensuring physiotherapy has a role in the future of healthcare they identified as a key factor *"how we manage managers"*1. A concern was expressed that service redesigns were often taking place ignoring clinical evidence. These were either led by management consultants or led by medics with the need for nurses and AHPs within the redesigned service being given limited attention - *"as long as you have got the doctor"*2. So you needed to both *"defend what you do"*2 using evidence and also accept that due to pressures you may need to *"do things in a different way"*2 as the resources were just not there. Using the evidence base was seen by the interviewees as essential as *"unless you can defend what you do we cannot get staff"* 2 and that *"clinicians have amazing evidence"*3. Within this the patient must be central and in some cases this was just *"rhetoric"* and *"patient centred care… it is not about you as a clinician…everyone talks about it but we are still not doing it"*2 To undertake this challenge there needed to be *"good intelligence, vision to take this forward, inspiring people it can be different, enabling people to make a sustainable change"*1. But ultimately we may have to face that *"we are not able to meet this need … we can do it differently … but we need a really up front conversation about what is going to be provided"*1 and *"we may need to drop doing some things"*3 where the evidence base was not available.

There was a concern that with cutbacks the opportunities for leadership roles such as consultant physiotherapy roles were diminishing and that with *"changes being imposed …so many incredible people are looking to move out of the profession"*3, and staff were just *"trying to juggle too much"*2. Again the issue of medical dominance in teaching hospitals was described and this has a greater impact than in other settings where a more *"pragmatic approach"*1 and *"innovative"*1 practices were being developed due to a less medically dominated environment. The key was to focus on the patients' needs and then the profession. For example, a post that was currently going to be open to AHPs had raised the question *"keep bring back what does this role need to do [it] so then who can do it? If a nurse could do it then it should be open to them…"*1 So rather than say, this needs a physiotherapist, review the tasks and then decide which professions could undertake the role. It was recognised that in each trust there was a *'re- inventing the wheel'* 3 developing pathways. It was suggested that perhaps this was an area where a professional body could provide support so all of the effort went into national pathways.

In meeting these challenges leaders will have a tough job *"bringing people with you"1.*

## 4.7 THE ROLE OF PROFESSIONAL BODIES IN DEVELOPING LEADERSHIP

There is a perception that some other professions are more focused on leadership development (40). As mentioned previously, the Royal Collage of Nursing has had a leadership development programme since 1995. That nursing has dominated the study of leadership aspiration and development is recognised by other AHPs (61), who are also exploring the importance of leadership to their professional standing, with key memorial lectures focused on leadership (62). In contrast to this two of the interviewees for this report thought that in their experience, physiotherapists were very active in taking up leadership roles - *"I don't perceive that there are less physios in leadership roles than other professions quite the reverse…I don't see evidence that physiotherapists are failing to take up leadership roles"*. [1] However others suggest physiotherapy leaders of the present and future still need to be supported, encouraged and nurtured (63).

There is a growing recognition by professions that there is a need for clinicians to be engaged in leadership and it is no longer an optional extra but a necessity (51), and that professional bodies need to address the issue of leadership capacity (40). Some physiotherapy professional bodies in other countries have more professional body provision for leadership development than currently provided in the UK (9). McGowan and Stokes (9) reviewed five countries' professional physiotherapy bodies leadership development activities. These included mentoring, workshops, seminars, symposia, study days and personal development plans. Some professional bodies had their own development programmes for leadership. In addition, many organisations had specific interest groups focussed around leadership although in some cases the membership of these was restricted to specific job roles.

Some physiotherapists in Ireland have criticised current leaders, the lack of training opportunities, and the emphasis being on clinical skills (46). The implication of distributed leadership is that it requires "therapists at all levels … to take on leadership responsibilities and thus will require leadership training" (9). The extent to which this is the responsibility of a professional body needs to be considered, however with the direction towards inter-professional structures and working, service redesign, hybrid roles and distributed leadership, it could be considered important to have leadership development across professional boundaries to ensure physiotherapists can participate fully in future healthcare services.

The interviewees for this report thought that leadership provision for the profession was "*quite piecemeal*"[2] and although "*we absolutely value leadership … not sure the leaders are doing enough… to listen to those that they are leading*"[3]. The support tended to be "*bits and pieces*"[2] for example in Frontline. That there was a need for publicity to show that "*it was important*"[2] and that there was "*a crying need for a Joyce Williams[3] figure*"[2], the CSP should be "*shouting loud that we need really good leadership*"[2].

However given the nature of distributed leadership, one interviewee felt that uni-disciplinary leadership development might not be the best way forward: "*I am not sure how much of the leadership stuff is uni-professional anyway …I don't think the CSP has a role to develop a leadership programme ….leadership is much broader than purely physiotherapy ….personally I would have not gone anywhere near anything just physiotherapy related, too constrained*" [1]. It should be noted however that the three interviewees had been successful in progressing to leadership positions in the current system, so they had sought out opportunities and development for themselves. It may be that there are other 'potential' leaders who need more support to be successful.

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[3] Joyce Williams a physiotherapist who championed a business approach to practice in particular around capacity and monitoring activity, running a number of events for physiotherapists

What the three interviewees suggested was that the CSP should be providing more orientation to leadership through resources and *"inspiring stories"* so the *"CSP should champion the skills needed"*[1] and provide *"career pathways"*[2] and suggest or propose *"opportunities for development"*[2]. It was *"very unstructured at the moment"*[2]. A suggestion from the CSP survey (39) was for a self-assessment form and signposting to courses. The profession needs to provide a *"clear vision of what we are as a profession...what do people require to achieve for that vision… right infrastructure, be that training or mentorship"*[3]. There was a view that it perhaps *"falls to organisations to talent spot"* and individual's responsibility to seek out development having identified their needs. However it was recognised that *"sometimes people don't understand all of the opportunities, sometimes people think it needs to be a taught course and don't appreciate experiential learning"* [1] This was highlighted in the CSP survey (39) as some respondents requested a programme or course.

It was also felt that there was a role for the CSP to provide more leadership across systems in providing evidence based pathways and information, as currently *"things aren't joined up"*[3]. This could then inform service redesign and show leadership across the profession: *"There are so many areas we could be addressing, lack of joined up thinking between clinical, managerial, research"*.[3] To help get the *"stakeholders around the table"* and *"translate evidence in creative ways to improve healthcare"*[3]. This is supported by a finding of the CSP survey (39) that one identified problem was that the CSP didn't have a business development service. It was suggested that it was a waste for everyone to be doing this individually when it could be undertaken at a national level so that *"everyone can go to the CSP for a care pathway… for a patient information leaflet …branded CSP"*.[3]

## 4.8 Summary of leadership and Physiotherapy practice

In summary:

- There is very limited research evidence to draw upon that is specific to physiotherapy.
- Physiotherapists recognise leadership qualities that support interaction, relationship building and personal growth.
- Traditional structures and roles are potential barriers for physiotherapists moving into strategic leadership roles.
- New roles are being developed and physiotherapists need to be inspired and given support to move into these roles.
- There is a perception that in some organisations there remains a medical dominance in clinical leadership.
- In common with the wider society, there may be fewer female physiotherapists taking up leadership roles although there is currently limited knowledge on this.
- There are examples of physiotherapists working successfully in new roles and applying distributed leadership and systems leadership, but there is a need for more.
- There is a concern that clinical leadership and research evidence is not being used effectively in service re-design.
- Key to systems leadership is a focus on patient care and ensuring that everyone works together proactively.
- The research in healthcare including a literature review suggests that undergraduates are in the main being taught a traditional view of leadership and that leadership may not be sufficiently explicit in the curriculum.
- Opportunities for formal development were considered worthwhile.
- Self-awareness was considered a key component of leadership and tools such as 360 and psychometrics were valued to support this.

- Having the opportunity to experience different roles was supportive of leadership development.
- Roles models were inspirational and demonstrated how leadership could 'be'.
- There was a recognition that leadership was going to be essential moving forwards especially systems leadership to re-design services to meet the challenges of increasing demand and limited resources.
- It was essential for physiotherapy leaders to be a strong 'voice' based on research evidence.
- Current managers / leaders may need development if they are to provide leadership for the changes in healthcare that are required.
- Professional bodies are exploring their role in leadership development with some providing more than others.
- Professional bodies are uniquely positioned to develop systems leadership at a national level.

## 5 CONCLUSION

There is an overriding need for leadership in healthcare at the current time. Distributed and systems leadership are required to ensure effective use of resources and provide excellence in care. Research on physiotherapy and leadership is limited. The CSP has an opportunity to show that it values leadership and to provide support and development for its members.

# 6 APPENDIX

Interviews

Three interviews were carried out with individuals being selected to try to cover as many different aspects as possible. All three interviewees had multiple responsibilities and roles. Two were female and one was male. Collectively their experience included a variety of:

- Sectors
  - o Secondary (teaching hospitals and non-teaching hospitals), Primary, University and Private practice.
- Areas of clinical practice
  - o Musculoskeletal, Neurology, and Respiratory
- Roles
  - o Managerial, Clinical, Academic, Research and Private Practitioner.

**Interviewee 1**
Consultant and clinical lead for a specific area of practice managing all care of the patients, managing an interdisciplinary team of therapists, both hospital based and community based. The interviewee was also responsible for service development, teaching and research within this area. This role has developed with changing organisations (integration) and changes to the role.

**Interviewee 2**
Therapy service manager for therapists across two sites in secondary care. This was a Trust wide role leading on a strategic area and with a clinical caseload. There have been recent changes in the organisational structure.

**Interviewee 3**
University academic primarily involved in research activity but also postgraduate teaching, working both in the NHS and privately, with scope of practice that includes strategic leadership.

**Interview Format:**
**About you:**

1. Tell me about your current work roles

2. What does leadership look like in in your current practice?

3. Thinking about your career development up until the current point what has helped you develop your leadership?

Triggers to check

- Education
- Training
- Mentoring
- Coaching
- 360 degree
- Other
- Inspiration role models

4. What is your current understanding of leadership and has that changed from when you first joined the profession?
5. Based on your own experience are there any facilitators or barriers to Physiotherapists taking up leadership positions?

**Healthcare:**
6. What do you see as the challenges of leadership in healthcare now?
7. What leadership qualities do you think healthcare currently needs?

**Physiotherapy profession:**
8. How do we as a profession value leadership?
   Is there anything you think needs to change or develop?

9. How do we as a profession identify and nurture future leaders?
   Is there anything you think needs to change or develop?

10. What do you see as the professional bodies' role in fostering leadership in the profession?
    Is there anything you think needs to change or develop?

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