identified enablers and barriers may serve as impetus for refining existing leadership programs and developing targeted interventions to address systemic challenges, so as to improve the experiences of patients. Furthermore, the identified contextual factors underscore the necessity of fostering an empowering environment that enhances clinical leadership effectiveness, aligning with the NHS's commitment to continuous improvement in patient care. We hope to provide additional insights that deepen our understanding of the complex relationship between clinical leadership and patient experience as the study advances through the Delphi process.

4 DEVELOPMENT OF A MEDICAL LEADERSHIP PROGRAMME: UNCOVERING NEEDS USING A QUALITATIVE APPROACH

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Introduction Leadership is key to the delivery of excellent, person-centred care by engaged, empowered teams. Ensuring essential leadership behaviours and skills are promoted and developed is fundamental in shaping organisational culture

In 2018, NHS Tayside instituted a clinically led model of management. Whilst traditional medical training focusses on the development of clinical skills to treat individual patients, the delivery of high-quality care for populations requires a knowledge of systems thinking, change management and team management skills. The acquisition of these skills is often 'on the job' whilst in a leadership role.

Our goal as a health board is to assist medical staff in the development of leadership qualities and management skills throughout the medical career; from undergraduate through to consultant and career grade staff with bespoke formal training available. In doing so we hope to demonstrate that medical leadership roles are viewed as both valued and attractive posts within the Board.

Aims and objectives of the research project or activity To identify and understand the development needs of both current and aspiring medical leaders of NHS Tayside to establish recommendations for the development of a tailored programme that addresses these needs.

We identified the following required actions:

1. Consultation with existing leaders
2. Examine existing training in other Health Boards
3. Review existing frameworks for practice

Our key questions to leaders were:

- What knowledge, skills and attitudes do doctors within NHS Tayside need to excel in Medical Management positions?
- What experience and support is required by doctors to develop the skills needed to lead teams in a complex system and support the delivery of high-quality patient care?

Method or approach Semi-Structured interviews were performed, exploring our key questions with a purposeful sample of current, recent and aspiring leaders within NHS Tayside. Participants were provided with information regarding scope of the project and data consent, they were then invited to book an interview. Participants were identified from medical, nursing and senior management teams across different leadership levels.

Interviews were carried out on 'Teams' by three interviewers using open ended questions developed as prompts. Transcripts were recorded and two of the interviewers analysed them, using Atlas.ti, an AI-driven coding system to identify emerging themes through qualitative analysis.

In combination a search was undertaken of existing National resources relating to medical leadership development and practice.

Finally, communication via the network of Scottish Clinical Leadership Fellows explored formal training opportunities that existed within other Scottish Health Boards.

Findings 1. Results of Consultation with Leaders

We had engagement from across the medical, nursing and professional manager lines at numerous career levels in total 30 respondents were interviewed.

Emerging qualitative codes included:

- Communication and relationships
- Dealing with uncertainty
- Generic challenges of leadership
- Professional development
- Strategy and decision making
- Self-awareness
- Supportiveness

The common themes which were identified in interviews could broadly be grouped into; preparation for the role, facilitators to who assist leaders, skills needed for the role and barriers to achieving objectives.

2. Existing Frameworks for Practice

There are numerous frameworks which provide a structure for thinking about leadership practice in healthcare. These models come from professional bodies such as the GMC, Faculty for Medical Leadership and Management and the Royal Colleges and cover broadly similar themes.

3. Existing Training in Other Health Boards

Communication via the SCLF network suggested that only a few formal structured medical leadership programmes at a Health Board level are currently being delivered. One example which had recently been implemented offered a structured educational programme to support the learning needs of medical consultants within the first 5 years of their career.

Key messages Reflecting on the qualitative analysis and learning from existing resources, there would appear to be five areas that should be the focus for improvement.

1. Role clarity

- Ensure existence of job description for all medical leadership roles with clear objectives
- Structured handover from previous incumbents

2. Individual Support

Develop mechanisms to encourage access to:

- Coaching
- Mentoring
- Peer support
- Return to face-to-face meetings
- Maximising appraisal process
- Self-assessment

3. Leadership Skills

- Managing diverse teams
- Conflict resolution
- Development of a just culture
- Communication in difficult circumstances

4. Change Management Skills

- Service Design
- Developing change ideas
- Human Factors and Ergonomics
- Improvement science

5. Management Procedures

- Formal training in management procedures, for example:
- HR policies
- Finance

Many elements of this programme already exist and require improved signposting. Differentiating between essential and desirable elements will help to provide a programme that is valuable and can be delivered in a realistic timeframe for the individual.

5 INEQUITABLE BARRIERS & OPPORTUNITIES FOR LEADERSHIP & CAREER DEVELOPMENT FOR EARLY- TO MID-CAREER ALLIED HEALTH PROFESSIONALS

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10.1136/leader-2024-FMLM.5

Introduction Interprofessional leadership is the vision of NHS and essential to sustain the NHS in pressured times. Furthermore, the Messenger Review (2022) states that collaborative and inclusive leadership is fundamental for high-quality patient care. The study focused on Allied Health Professionals (AHPs), which is an umbrella term for 14 distinct professions who represent the third largest clinical workforce in the NHS in England. A literature review indicated that AHPs are underrepresented in senior leadership positions; the causes of which are likely multi-factorial. Historically, the NHS's senior leadership has primarily comprised of non-clinical, medical, and nursing management, due to the legal requirements for Trust boards. Furthermore, the lack of leadership development and career infrastructure for AHPs, at early to mid-career levels, likely results in a lack of a talent pipeline for diverse senior leadership. The impact is an inequity in opportunity and voice compared to other healthcare professions, such as nurses and doctors.

Aims and objectives of the research project or activity This study interviewed AHPs, who identified themselves to be at early to mid-career levels. The study's aims were: to establish the barriers and opportunities to leadership and 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. The study attempted to represent the voices of AHPs, which can be lacking in both organisations and research.

Method or approach The sampling was purposive. The inclusion criteria were being a member of one of the 14 AHP professions, who identified themselves to be in early- to mid-career positions, in England. Focus groups (FGs) were undertaken with 27 participants, representing 8 of the 14 AHP professions, in June 2021. The FGs were directed by a topic guide, developed using a deductive theoretical approach, based on the literature, and shared prior to the FG. The qualitative data from the FGs was analysed using thematic analysis (TA). This involved generation of initial semantic codes, using a theoretical approach: deductive TA, based on the topic guide, and then inductive TA, drawn from the raw data. The participants represented all seven NHS England regions, which provided geographical representation. However, the results cannot be generalised to the whole AHP population, due to the qualitative nature of the FGs and the population size.

Findings The TA generated 4 themes: leadership qualities across seniorities and specialisms; the importance of leadership development; the barriers to AHP leadership development and career progression; and the opportunities for AHP leadership development and career progression. Further TA identified 3 overarching themes: equitable and interprofessional leadership development; an equitable and structured AHP career pathway; and having AHP leadership at a strategic and/or very senior level. These overarching themes were subsumed under the umbrella category: equity of opportunity and voice.

The individual AHPs, who had been developed, reported feeling valued by their organisation and able to contribute to high-quality care. However, despite the vision of interprofessional working, all participants reported a historical or current negative organisational culture for AHPs and an inequity of opportunity, compared to other professionals. This inequity of access to structured leadership and career development impacts on both individual AHPs and the diversity of leadership within organisations. Organisational recommendations were developed to facilitate all AHPs' leadership and career development, and to address the lack of AHPs' voice at senior levels.

Key messages Compared to other professional groups, AHPs are not offered an equitable leadership and career development. Therefore, further work is needed to ensure interprofessional representation, within senior leadership levels, to ensure diversity of thought. Senior leaders should be mindful of these organisational structural barriers, when developing new policy and strategies aimed at developing and retaining their workforce.

The results significantly add to a neglected area of research and are relevant when considering the NHS Long Term Workforce Plan. The CAHPO's AHPs Strategy for England 2022–2027 commits to AHPs championing and promoting diverse and inclusive leadership, as an enabler to achieve its areas of focus. This study suggests that the strategy's recommendations are not yet making an impact in practice or influencing the AHP leadership landscape. A longitudinal study in 5 years' time could interview the same professionals from this study and/or a new group to determine the system changes.

6 HOW DO DOCTORS ON BOARDS INFLUENCE PERFORMANCE? THE CASE OF NHS TRUSTS

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Introduction Healthcare organisations around the world are under increasing pressure to improve their productivity and quality of care, while achieving financial viability. In response, policy makers have argued for greater investment to support the development of clinical leadership at all levels. There is now a significant body of evidence demonstrating the positive impact of the increased participation of doctors on hospital