Abstract:

Objective: The aim of the present study was to investigate the opinions and perceptions of senior allied health (AH) leaders in relation to AH leadership, governance and organisation from an Australian public health perspective. The target group was the New South Wales (NSW) Health AH directors or advisors, the most senior public AH professionals in NSW.

Methods: The study was conducted over a 6-month period in 2014–15 and comprised two parts: (1) data collection through a 46-question online survey that sought the views of AH leaders about the field of AH in NSW; and (2) two confirmatory focus groups with members of the NSW Health AH Directors Committee.

Results: The online questionnaire generated novel information about the field of AH in the public sector of NSW, including the current organisation, governance and culture of AH. Focus group participants explored key findings in greater depth, including the effects of AH on and value of AH to the health system as a whole, as well as the attributes and competencies required by AH leaders. Participants identified the need to build and grow their influence, to more clearly demonstrate AH's contribution and to realign efforts towards more strategic issues influencing governance, performance, professional standards and advocacy. This entailed broadening the vision and scope of AH Directors as well as across discipline leaders.

Conclusion: The results provide new information about Australian AH leadership, governance, culture and organisation, and highlight potential priorities for future leadership activities.

What is known about this topic? Although leadership is considered an essential element in the provision of high-quality health care, leadership across AH remains under examined.

What does this paper add? There is a paucity of literature pertaining to AH leadership nationally and internationally. This paper describes the issues affecting AH leaders and leadership in NSW, as reported by senior AH leaders.

What are the implications for practitioners? This study identifies key elements related to AH leadership and governance. Health systems and services can use this information to implement strategies that enhance AH leadership capability.

Introduction

Allied Health (AH) clinicians are tertiary qualified health professionals who use their knowledge and skills to restore and or maintain the optimal psychological, cognitive, physical, sensory and social function of patients.[1-4] They are expected to have a range of professional and organisational competencies [5] and to play a significant role in the delivery of health care. [6]

Although there is evidence that AH professionals are said to be well positioned to lead health system change, [6, 7] they remain under-represented in these roles due to a range of organisational issues. For example, AH clinicians are more likely to have to manage diverse professional teams requiring a multiplicity of deliverables.[8] Their leadership trajectories (either within a discipline or in AH more broadly) can be hampered due to a lack of clearly defined paths, support services and processes, [9] with the very organisational structures within which they are located still evolving.[8] Recent decades have seen notable improvements in the status and training of AH professionals [8, 12, 13] yet many still report feeling powerless to affect the healthcare system compared with their clinical colleagues. [9]

Research into AH leadership in Australia remains limited. [6, 8, 10, 11] This study sought to examine current AH leadership roles and functions, organisational and governance structures, and the attitudes and "culture" of AH, as viewed from the perspective of the senior AH leadership across the largest Australian jurisdiction, as a way of identifying current enablers and barriers to AH leadership.

Methods

The New South Wales (NSW) public health system is organised into 15 local health districts (LHD), as well as three specialist networks (SN) (justice health and forensic mental health, paediatric services, St Vincent's Health). [14] Participants included NSW Health Advisors and Directors of Allied Health (DAH) with an organisation-wide role in a NSW LHD or SN. DAHs are the most senior AH leaders within NSW public healthcare organisations.

The study was completed over a six month period in 2014-2015 and consisted of two parts: 1) completion of a voluntary on-line survey, and 2) two confirmatory focus groups which explored thematic results from the survey. Study participants were given written information about the project and each provided signed consent.

Part 1: The NSW Allied Health Leadership Survey

The NSW AH leadership online survey was developed by the authors based on peer-reviewed [14,16] and grey literature such as the SESLHD Nurse Engagement Scale. Their direct knowledge of the AH field and the study aims also informed the survey design. The survey consisted of 46 questions, grouped into eight categories (Table 1). There were 33 open and 11 closed questions, with two questions presented as Likert scales using one (strongly disagree) to five (strongly agree) ratings. Three of the questions had sub-parts, for example the 'Self-Assessment' question had nine statements which respondents were asked to rate using a Likert scale.

Background and demographics	Personal and professional strengths and opportunities
Allied health organisational structure	Leadership
Allied health leader self-assessment	Allied health culture
Functions of Allied Health Directors	Allied health attitudes

Table 1: Survey topic areas

The survey was piloted by two former AH Directors whose feedback resulted in a number of adjustments being made to the questionnaire. Their data were not included in the final results.

The study involved all of the DAHs across the LHD/SN's in NSW except one rural LHD (n=17). Online surveys were sent to participants in June-July 2014 with a 100% return rate by September 2014. Once collected, the results were interrogated using the framework of eight topic areas (Table 1). QSR NVivo 10 software was used to capture the analysis.

Part 2: The NSW Allied Health Leadership Focus Groups

Once data from the survey had been collected and analysed, DAHs or their senior delegates were invited to be involved in one of two one-hour focus groups. One focus group was held in December 2014 with face-to-face (n=8) and teleconferenced (n=2) participants whereas the second was held in January 2015 via a teleconference (n=3). Of the 17 organisations participating in the study, eight metropolitan LHDs, three rural LHDs and two SNs were represented in the focus groups. Of these, three participants were new to the study, not having participated in the online survey.

The focus groups were facilitated by the first author (PB) and were conducted to confirm that survey topics and findings represented current views. They also operated to explore several elements of the survey in greater depth, including DAH influence and value, important tasks for DAHs, and core DAH attributes and competencies. During the focus group process, a small number of additional topics and perspectives were identified and discussed by participants.

All verbal responses from participants made during the focus groups were recorded and transcribed verbatim. Material from the two groups were analysed thematically using NVivo 10.

Ethics

Ethics approval for this study was obtained from the UNSW and South Eastern Sydney Local Health District Ethics Committees. Site Specific Assessment (SSA) ethics approval was obtained from 17 LHDs and SNs. One LHD declined SSA approval and was thus excluded from the study.

Results

The results of both the survey and the focus groups are presented concurrently. We commence with a description of the background and demographics of the participants, whose leadership covers approximately 95% of all public AH services in NSW. We then discuss the key themes identified in

the analysis, including AH organisational structures, personal leadership skills, functions and competencies, strengths, opportunities, influence and culture.

Background and demographics

Of the 17 of 18 NSW public health organisations which participated in the survey, 88% of respondents (n=15) were Executive Directors or DAH. 24% (n=4) were fulltime DAH and 76% (n=13) were part-time. Nine DAHs had roles that were strategic only (having no line management of AH services) and eight DAHs (47%) had roles that encompassed both strategic and operational (line management) elements.

Of the respondents, 88% (n=15) had worked 19 years or more since graduation, with 76% (n=13) working 10 years or more for NSW Health. Many had been in a senior discipline role such as Physiotherapy Manager prior to being the DAH (n=14, 82%). Most had worked in the DAH role for less than five years (n=13). Fourteen respondents (82%) had post-graduate qualifications. All had received leadership training and 12 (71%) held formal leadership or management qualifications.

Allied health organisational structure

Australian organisational AH governance structures have been described previously by Boyce [15, 16] Boyce proposed four primary models of AH structures: unit dispersal, classical medical, division of AH; and integrated decentralisation/Matrix. [15]

Seven respondents had were part of matrix model structures (combination of management and team based structures), four were in divisions of AH (with either a rotating Chair of AH with profession-based departments, or a DAH in a stand-alone AH division), one state-wide entity had a unit dispersal model (with individual AH disciplines dispersed across clinical units or teams). Five of the LHD/SNs had structures that were a mixture of models. No entity used a classic medical model (where individual AH disciplines are organised in departments reporting to a medical director).

Approximately 80% of AH across NSW were organised in discipline-based departments (such as speech pathology) and 20% in multidisciplinary teams (such as Aged Care Assessment Teams). Most (82%) of NSW AH staff report to another AH practitioner. From an operational perspective, Allied Health Manager positions formed part of reporting structures in 14 LHD/SNs. Senior organisation-wide discipline leadership roles such as Principal Psychologist or Podiatry Advisor were in 10 LHD/SNs.

At the organisation's Executive level, all but one entity had a DAH or equivalent in their senior Executive structure. At the time of the study, all DAHs reported to the Chief Executive or Director of Operations.

Focus group participants considered AH as non-homogenous, diverse and relatively small in relation to other clinical groups in Australia, with an identity that had changed significantly within the participants' working lifetime. For some, these changes had increased both the opportunities available to, and the need for AH leaders to keep evolving their individual and collective competency. For others, "allied health" was still an emerging and disparate group, notably lacking in organisational power.

AH leader self-assessment

A series of self-assessment survey questions were posed to the DAHs using a Likert Scale of one to five. High mean scores (> 4) were found for questions relating to respondents' confidence in the DAH role and their feelings of being skilled and valued as AH workers. The lowest mean score (3) was reported in relation to the issue of resources, with many respondents (n=8, 47 %) either disagreeing or strongly disagreeing that they were adequately resourced. DAHs also reported that they did not have sufficient delegation to undertake their roles (n=5 disagree/strongly disagree).

Functions and competencies of Allied Health Directors / Advisors

The important tasks for DAH's positions were to provide strategic direction and focus and to be a point of influence for AH at the Executive level. DAHs had key roles in ensuring high standards in the provision of professional practice standards and measures, in leadership, and in workforce services (initiatives, planning, and recruitment).

DAHs reported that they spent most of their time in: administration (meetings, phone-calls and correspondence); innovation and strategic planning; workforce services; and professional and clinical governance. In contrast, DAHs would like to allocate more time to: strategic planning for improved and innovative AH service models; workforce redesign; and capacity building for AH.

AH roles were thought, by focus group participants, to function within a complex environment created by the range of disciplines within, and the challenges faced by, AH. Professional diversity was considered the defining feature of AH. At a macro level this speaks to the multidisciplinary construct which is AH, and at a micro level to the range skills brought to healthcare by each DAH, including leadership, financial management, adaptability, communication, and setting priorities.

In taking on a leadership role, the DAHs undertook a complex transition not only from clinician to manager [17] but also shifting from a discipline specific perspective, to one capable of encompassing all of the challenges and concerns of the wider field. This included managing multiple professions and professionals and harmonising their organisational and professional efforts.

> *"[Because of our specialisation] … clinicians and department heads have difficulty realigning themselves with a change of service or directions of the organisations."DAH-12*

Personal and professional strengths and opportunities

Survey respondents thought AH took a consultative and collaborative approach to their professional interactions, and to use this approach to create, build and manage diverse teams. They were said to

have particular strengths in strategic thinking and planning, strong personal values (including integrity), and strong communication skills.

At the same time participants felt that those within the AH field needed to 'state their worth' more clearly and to better describe their contribution to health systems as a whole. While the focus group felt that an overall cultural shift was emerging, Executive support for and inclusion of AH in key decision making varied across LHD/SNs. This situation was perceived to have an impact on their capacity to contribute to, and have influence on, their organisations.

> *"I've certainly seen in some particular instances where allied health are becoming far more integral in organisational structures in terms of Executives and others where they're completely ignored."DAH-7*

Part of the reason for the cultural shift was the complex, changing operating environment of healthcare. The transformation of models of clinical care, ongoing workforce reform (eg AH Assistants), and rapid advances in technology, were all thought to require new approaches to the delivery and leadership of AH services, including: the need for seven-day clinical service provision; further exploring AH's contribution to person-centred care; and the involvement of AH in new and emerging initiatives, such as integrated care.

Leadership and Influence

DAH's were able to clearly describe the attributes of effective AH leaders. These included:

- strong communication and listening skills

- the ability to set a clear vision or direction

- being innovative

- showing authenticity and integrity

- being accountable

A successful AH leader was someone who was inspiring, visionary, effective and engaging. This required: self-awareness; strong relationships; a commitment to personal growth; technical skills; being willing to work hard; taking managed risks; and exploring opportunities.. All the DAHs who participated in this study had taken personal responsibility for developing their leadership skills, using a variety of strategies such as engaging mentors, undertaking formal study, setting personal goals, and investing in personal development.

One gap noted by the participants was the need to increase DAHs' influence within the health system, particularly by increasing their individual and collective political acumen. DAHs felt they needed to better utilise their role in executive teams to expand their focus beyond AH. Participants suggested that a way to strengthen AH capacity and capability was the development of a state-wide and tailored leadership training, mentoring and coaching program for DAHs. Underpinning these strategies was the call for more research into AH and into developing and strengthening the fields' collective capacity.

Allied health culture

All participants were asked about the defining feature of AH. This was described as: *patient-focussed professionals who worked in teams to provide high quality healthcare.* Its culture is: *holistic, person-centred, team-based and inclusive.* AH professionals were considered to be: *a diverse group with a breadth of skills and a commitment to learn, as well as collaborators who were open, honest and had integrity*, with their greatest strength that they *were able to view the whole person (patient) across all environments*.

Discussion

AH Directors are considered, and consider themselves, leaders in NSW who provide vision, direction and leadership across AH services. Results and thematic analysis from an on-line questionnaire and focus groups generated information about the perceptions and insights of these leaders. Findings

expose a range of complexities and multifaceted challenges for this group, including managing diverse multidisciplinary teams within the context of ongoing organisational change. These same challenges highlight opportunities for AH leaders across the system.

Results illustrated that organisational and governance structures for AH in NSW have shifted over time. [15] AH clinicians predominantly report to other AH practitioners, and senior discipline and AH leader positions exist in many LHDs/SNs. This appears to have come about since AH director roles were systematically appointed across the NSW health system following Garling's 2008 The Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals Report. [18]

Garling's report made 139 recommendations aimed at improving the NSW healthcare system, including one in relation to the appointment of AH leadership roles in NSW public healthcare organisations. [18, 19] This was supported by NSW Health [20] and, as a result, a number of LHD/SNs appointed DAH's for the first time thereby strengthening the AH leadership group in NSW.

This study confirmed that DAHs are increasingly included in their organisation's Executive team. This potentially increases AH's opportunity for influence and growth across the health system and for the utilisation of their knowledge to drive clinical innovation and service delivery improvement. However, ongoing challenges remain in relation to the variable acceptance and utilisation of DAH roles across NSW, along with the persistent tension regarding how AH positions itself in relation to its' more historically and organisationally cohesive clinical colleagues. To address this, AH as a professional cohort could build their organisational role and agility and take greater responsibility for the changes in areas such as multidisciplinary practice and integrated care, which are currently in demand across health systems.

The study also highlighted the DAH's current focus of energies relate largely to administrative and operational tasks. To release more time for strategic clinical, workforce and capacity-building endeavours, wider systemic recognition of the full range of DAH capabilities is required.

Other areas of development identified for DAHs included building influence and demonstrating value as a leadership group by better engaging with the current healthcare system. One element of this was the need to be more proactive and vocal in relation to the contribution of AH to the provision of care. Using their strengths in effective communication, negotiation and strategy, DAHs should realign efforts towards more strategic issues influencing governance, performance, professional standards and advocacy. However, this strategy raises questions such as whether the strengths of AH professionals, developed for the clinical context, will be as effective in the executive suite. To facilitate this transition, specific leadership training may be required, which builds on, rather than replicates, existing AH expertise.

Discipline leaders were considered essential in driving system-level change for AH and for building a collaborative culture. The focus groups in particular noted the importance of broadening the vision and scope for discipline leaders alongside those managing across AH services. Leadership development that fosters collective thinking and openness to change may also benefit discipline groups.

Although experienced clinicians, many DAHs had been in their roles for a relatively short time. Contextualised leadership support through mechanisms such as training, coaching and mentoring provided early in their role would assist the development of transformational and adaptive leadership skills. [21-23]

A system-wide approach to AH leadership development would extend the skills and foster the conditions for senior AH personnel to be efficacious, efficient and high-performing. This in turn

would enable AH to optimise their potential contribution to safe, effective and high quality patient care.

Conclusion

The present study provides new insights about contemporary AH leadership, governance, culture and organisation from an Australian perspective, and could enhance current understanding of the key perceptions and priorities of AH leaders in NSW. The results of this study may be used to better understand and contextualise the complexities of AH leadership in NSW, and to evaluate the effectiveness of the current AH leadership roles as well as to determine priorities for future activities.

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