Allied Health Leaders: Australian Public Sector Health Boards and Top Management Teams

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Abbreviations:

AAHF: Australian Allied Health Forum
AHLANZ: Allied Health Leaders of Australia and New Zealand
AHAP: Allied Health Professions Australia (Federation of allied health professions)
AHLN - online: Allied Health Leaders Network online (via AHPA)
AICD: Australian Institute of Company Directors
CAHO: Chief Allied Health Officer
DCS: Director of Clinical Services
E/DAH: Executive/Director of Allied Health
E/DMS: Executive/Director of Medical Services
E/DONMW: Executive/Director of Nursing / Midwifery
ICHPO: International Chief Health Profession Officers (International Chief Allied Health Advisors)
IOM: Institute of Medicine
NAHAC: National Allied Health Advisors Committee (Chief Allied Health Advisors in jurisdictions)
TMT: Top Management Team. Tier 1 & 2 where Tier 1 is Chief Executive Officer (CEO)
Vic (Major):   Organisations with ≥ 100 hospital beds.
Vic (Minor):   Organisations with <100 hospital beds.

A Note on Allied Health:

There are numerous definitions of 'Allied Health' internationally[1-4][1] and within Australia.[2] Australian jurisdictions do not have an agreed definition of members of Allied Health as each includes different professions depending on the local policy context. The definitions are largely similar in terms of constituent professions that are regarded as therapies[2]. There are greater differences in the inclusion of scientific and newly emerging workforces. Membership of Allied Health includes regulated, self-regulated and un-regulated occupational classifications. Websites of each jurisdiction should be consulted for precise definitions and approaches.

This report adopts the following positions to orientate readers to 'Allied Health':

1. The accurate, if inelegant, approach that Allied Health does not include graduates of medical, dentistry or nursing and midwifery training;
2. That in the Australian context, Allied Health consists of the professionally/scientifically qualified (≥ AQF 7[3]) in an allied health field, together with their cognate technical, assistant and support worker roles, and
3. The first author's findings that 'Allied Health' is an identity, not a definition. Allied Health is not a federation of professions, it is the synergy that is released from the cooperation of those that gather as Allied Health; it is more than the sum of the parts [5-7].

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[1] In 2012, ICHPO's 17 member countries agreed a definition but did not specify the member professions due to inter-country variation.
[2] See page 33-34 of reference # 2: Department of Health & Human Services and (J. Buchanan & D. Law) (2016). Appendix 3; International Variations in Definitions of the Allied Health Workforce.
[3] The Australian Qualifications Framework (AQF) is the national policy for regulated qualifications in Australian education and training. AQF Level 7 Bachelor Degree. See http://www.aqf.edu.au/aqf/in-detail/aqf-levels/

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1. Executive Summary

The allied health workforce is important to health and social outcomes across the continuum of care within the physical health, mental health, disability, aged care, education, justice/corrections, human services, public health, rehabilitation and self-care sectors. Once characterised as 'just the jam between the bread-and-butter roles of nursing and medicine'(Marks, 1999 p. 169)[8] allied health has emerged as an equal partner with other health professions in the pursuit of health reform[7, 9-12].

Whilst the contribution of allied health at the service level is increasingly well described[12-20][4], much less is known about allied health's contribution to leadership and decision-making at the executive and Board levels of health service delivery agencies.

Health professionals have been urged to increase their involvement in the planning, management and leadership of health service delivery organisations as a strategy to improve decision-making, clinical governance and patient safety[21-25].

The purpose of this report is to map allied health leadership on the Top Management Teams (TMTs) and Boards of public sector health service delivery organisations in Australia. Thus, this report presents an evidence-based snapshot of allied health in leadership positions in Australia during 2015.

A further goal was to undertake a comparative analysis of medical, nursing/midwifery and allied health professions. The motivation is not to launch claims for equity with medicine and nursing / midwifery, but to explore where allied health could add value to system performance and the quality and safety of patient care.

Despite the importance of the allied health workforce[5], the results show allied health remains distant from, and un/under-represented on, sites of decision-making where it could make a positive difference to system performance, service quality and patient safety. Allied health is starting from a low base with 3.4% (36.5/1061) of Australian TMT positions being a named allied health position (10.4% medicine and 9.3% nursing / midwifery). Of all national Board members with known qualifications, 6.3% (N=63.5/1015)[6] have an allied health qualification (15.4% medicine and 8.1% nursing / midwifery).

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[4] Two infographics (2016) from the UK explain the role and value of allied health: Allied Health Professionals-Who We Are and Healthcare Scientists in the NHS. Source: Mister Munro http://www.mistermunro.co.uk/animation/ An infographic from Victoria (Department of Health & Human Services, Office of the Chief Allied Health Advisor) is expected to be available later in 2016.

[5] Allied Health is Australia's second largest health workforce after registered nurses and midwives. Note that many publications on Australia's health workforce count only the 14 health professions registered under the Australian Health Professions Regulation Agency framework (https://www.ahpra.gov.au/);leaving many thousands of allied health professionals unaccounted for in calculations.

[6] Allied health qualified Board members as a percentage of all Board members is 5.5% (63.5/1145).

Amongst the Australian states and territories, Victoria has a unique position in this study due to its large number of public sector health service delivery agencies; almost two-thirds of the total Australian sample of 130 organisations. Victorian data was segmented between larger centres [Vic (Major)[7]] and smaller regional and rural settings [Vic (Minor)] to evaluate and contrast the leadership context in each setting. The intra-Victorian analysis provided useful insights into differences in allied health executive and Board level participation in more rural areas.

Key findings[8] of the investigation are:

1. Approximately a quarter of Australian **TMTs** (34/129 organisations) have named profession leadership positions for all three health profession workforces.

2. Allied health is significantly under-represented in health service Tier 2 **TMT** named positions compared to those available for the medical and nursing/midwifery workforces. Nationally, there were approximately three times as many named medical and nursing /midwifery director positions on TMTs as there were allied health positions.

3. Victoria's situation is less favourable than the national position for named allied health positions on the **TMT**. There are 5.5 and 7.5 times more TMT positions for named nursing/midwifery and medicine leadership positions respectively than for allied health.

4. Seven of the 129 (5.4%) organisations had no named leadership positions on the **TMT** for any of the health profession workforces. All were from Vic (Minor).

5. The Victorian segment Vic (Minor) had a very low level of named allied health leadership positions on the **TMT** (2 from 55 organisations); however they have the highest number and percentage of Board members with an allied health qualification of any jurisdiction.

6. Ten of the 129 (7.8%) **Chief Executive Officers** had an allied health qualification. Six of the ten positions came from the Vic (Minor) segment.

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[7] Vic (Major) was defined as organisations with ≥ 100 hospital beds; Vic (Minor) < 100 beds. Vic (Major) had 24 organisations in the TMT and Boards study. Vic (Minor) had 55 organisations in the TMT study and 56 in the Boards study.

[8] Data was obtained from 1061 members of 129 TMTs and 1015 of 1145 Board members from 130 organisations.

Experience of TMT-level operational and strategic leadership is an important developmental platform and stepping stone for allied health leaders aspiring to CEO positions. The leadership capability of allied health remains 'un-tapped' and 'under-exploited' without experience at TMT level[9, 26].

7. Nationally, approximately 30% (302/1015) of **Board** members with known backgrounds have a health qualification. Looking at the type of qualification 15.4% (156/1015) have a medical qualification, 8.1% (82.5/1015) have a nursing/midwifery qualification and 6.3% (63.5/1015) have an allied health qualification. The Australian results for Board members with a health professional qualification are similar to those from to a recent study on NHS England acute hospitals[27].

    Of the 302 Australian Board members with a health qualification, 51.7% have a medical qualification, 27.3% have a nursing/midwifery qualification and 21% have an allied health qualification.

    Victoria does not reflect the medical dominance evident in the national context. Of the Victorian Board members with a health qualification (N=98), they were evenly spread with close to a third each being in medicine, nursing/midwifery and allied health (34, 30 and 34 members respectively).

    The results for Victoria as a whole are somewhat misleading as there are striking differences between Vic (Major) and Vic (Minor). Vic (Major) closely reflects the national situation with 54.8% medical, 26.2% nursing/midwifery and 19.0% allied health qualifications. Conversely, in Vic (Minor) allied health and medicine are reversed with medicine having 19.6% of health qualifications, allied health 46.4% and nursing/midwifery having 33.9%.

Overall the study of the TMTs and Boards show that allied health has small numbers in both arenas, and that with the exception of Boards in Vic (Minor), their numbers are significantly fewer than those occupied by medicine and nursing/midwifery. Thus, the "problem" is both of low absolute numbers and low proportion relative to other health professions.

If, as a growing body of research suggests [21, 28-32], clinician leaders are a valuable resource on Boards and TMTs, should not the second largest, and the most complex workforce about which we know the least, also be contributing their expertise to the important business of health? Writing in relation to Australian medical clinicians, Dickinson et al. (2016)[31] have described an 'engagement gap'. In the case of allied health clinician leaders our findings indicate that the issue is not so much an engagement gap as it is an '**access gap**'.

These findings suggest several questions that need to be addressed:

1. Why is allied health not part of the **TMT** in 92 of the 129 public sector health service delivery organisations in Australia?[9]

   > If Vic (Minor) is removed from the sample there are 39 out of 74 organisations nationally with no named allied health position on the TMT.

2. Why is allied health not part of the **TMT** in 70 of the 79 public sector health service delivery organisations in Victoria? [17 of the 24 Vic (Major) sites and 53 of the 55 Vic (Minor) sites]

3. What strategies could address the institutional / structural deficit and individual leadership capacity levels in terms of **TMT** membership?

4. Each jurisdiction dictates a specific framework for membership of **Boards**. In open-call jurisdictions, what strategies can be used to increase the pool of high quality Board-ready allied health qualified applicants?

5. Biographies of many allied health qualified **Board** members suggest a tenuous on-going connection with allied health, particularly for those outside large urban centres. Are strategies needed to re/connect current (and potential) allied health qualified Board members with allied health networks and priority issues?

Targeted strategies, including 'springboard accelerator' approaches, are required to increase named allied health positions on TMTs and Board-ready allied health professionals. Current political directives In Australia to achieve gender balance on public sector Boards maybe an opportunity to increase allied health Board representation due to allied health's overwhelming female workforce profile[33, 34].

The discussion on 'Building Allied Health Executive Leadership Capacity' in section 7 includes suggested work programs to increase allied health professionals attaining leadership roles.

- Allied Health may benefit from positioning themselves within a framework similar to the MAGNET program for nursing which demonstrates the relationship between nurse leadership and system performance.
- For TMTs, the creation of a *Chief Allied Health Officer* role (not position) is proposed as a possible solution when a Director of Allied Health position is not feasible.
- Several strategies are proposed to and identify potential sources of candidates and increase allied health qualified Board-ready candidates; including candidates for

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[9] Nationally, 19 of 129 organisation's TMT have no named medical leadership positions and 30 of 129 have no named nursing / midwifery leadership position.

those health service organisations with ambitions for Academic Health Science
Centre status.

Allied health needs a stronger focus on leaders, leadership and leading. This is particularly
important given the tendency in a multi-jurisdiction context for initiatives to be fragmented
and local, rather than nationally agreed and co-ordinated.

It may be time to revisit the attempt in 2011 to form a National Allied Health Leaders group
which directly draws on, and represents, Executive/Directors of Allied Health; a group who
are currently absent from the national peak body Australian Allied Health Forum. It is the
Executive/Directors of Allied Health who are organisationally responsible for managing,
leading or supervising Australia's allied health workforce in public sector health service
delivery organisations; a workforce of tens of thousands.

Whilst research on medical and nursing leaders has been evident over several decades[35,
36], allied health leaders have rarely been studied systematically or beyond occasional
interest in individual professions [11, 26, 37, 38][10]. This report seeks to address this gap,
and provide authoritative data on the relative position of the most understudied workforce
group: allied health.

This research is a national study of Australia's 130 public sector health service delivery
organisations. Data collection was obtained from all government jurisdictions and 89-99%
of the sample, depending on the specific research question. There are several sources of
innovation in the research:

1. Few studies look at both the TMT and the Board level together to obtain a more
   nuanced understanding of these two important levels of governance;
2. This is the first systematic national study focused on allied health leaders and
   leadership at the executive TMT level and at Board level, and
3. This is the first study of its kind to undertake comparative analysis of the three major
   health profession workforces: medicine, nursing/midwifery and allied health at TMT
   and Board level.

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[10] Trish Bradd (NSW) has a paper from her PhD research currently under review; 'Allied health leadership in
NSW - A study of perceptions and priorities of allied health leaders'

2. Introduction: The Allied Health Leadership Context

2.1 Allied health: critical partners in health care delivery

The Allied health workforce is the second largest clinical workforce in the health sector. A key characteristic of allied health is the diversity of distinct professions that constitute the workforce[39]. Allied health works in partnership with the medical and nursing/midwifery professions and support workers to deliver health outcomes across the spectrum of community, primary and acute care settings.

The size of the three health profession workforces in Australia in descending order are:

Nursing and midwifery (registered nurses and midwives)[11] 270,879

Allied Health (practicing professionals)[12]   120,000

Medicine (registered medical practitioners)[13]   85,510

Australia has a large investment in allied health given the size of the workforce[40]. Analysis of serial census data from the Australian Bureau of Statistics shows growth rates in allied health have exceeded the medical and nursing workforces and population growth[41-45].

2.2 Advocacy for inclusion in health services executive-level roles

Twenty-five years ago the Institute of Medicine (USA) called for greater attention to allied health leadership and stronger links between allied health and the central administration of health organisations[46]. The IOM argued for greater support for allied health leadership as an important strategy for improving clinical and organisational decision-making, service delivery, workforce management and the relationship with nursing and medical services.

In the UK during the late 1970s and 1980s a body of research-based work (Jaques, Tolliday & Kinston) examined the place of allied health (therapy professions) in the health services hierarchy[47]. In 1992, Øvretveit, building on this work, published a definitive text that established the Director of Therapy Services/Division of Therapy Services[48] in

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[11] Australian Institute of Health & Welfare (2014) http://www.aihw.gov.au/workforce/nursing-and-midwifery/who-are-they/ (accessed 30 March 2016)

[12] Allied Health Professions Australia (AHPA) www.ahpa.com.au (accessed 30 March 2016). Includes non-AHPRA registered allied health professions/als

[13] Australian Institute of Health & Welfare (2014) http://www.aihw.gov.au/workforce/medical/ (accessed 30 March 2016)

organisational designs in UK hospitals and health services[14]. More recently, a major NIHR SDO funded study of allied health in management roles observed 'AHPs have lagged behind medicine and nursing in terms of their involvement in management. Their relative underdevelopment thus represents a significantly under-exploited managerial resource for the NHS'[26].

Australia was beginning to explore enhanced allied health leadership in public sector health services in the late 1980s[49-51], but without the driving force of a longitudinal research program or an influential organisation such as the IOM behind it. The Australian experience could more properly be described as a fragmented, bottom-up locally driven endeavour[52-54]. The first tranche of hospital based Director of Allied Health positions[15] began to appear in the late 1980s, and in New Zealand a decade later[55].

Despite the advocacy of the Institute of Medicine, allied health positions at top leadership levels have not been widely achieved in American hospitals and health services[16]. Irwin Epstein, Professor of Applied Social Work Research, City University of New York, a frequent visitor to Australia, noted that allied health in the USA was more 'siloed than allied'.

> Highly developed in Australia ['the concept of "allied health"'], it is rarely used in my experience in hospitals and health settings in the US. Siloed more than allied, health professions in the US are too often competitive and cut off from each other. Even multi-disciplinary team members know little of what other team members do[57].

The position of allied health (therapy and sciences) organisational leadership is quite variable in the UK today. Scotland and Wales have maintained leadership positions in most health services[58, 59]. In England many of the therapy leadership positions described by Øvretveit have been eliminated [60, 61]. Issues of strategic visibility, new models of care, scope of practice and the quality of care have occupied professional association's policy interest more so than workforce structure, organisation and governance[14, 58, 62].

In Australia allied health models continue to be firmly established, although their precise form has transformed and matured over the past 25 years[5, 54, 63]. Despite their continuing success, a national review of health workforce programs (Mason Review 2013)

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[14] See examples such as *Bath Therapy Agency* and the *Basildon and Thurrock District Professional Services Division* in Øvretveit, J. (1992). Therapy Services: Organisation, Management and Autonomy. Switzerland, Harwood Academic Publishers, p. 60.

[15] In the Australian (and New Zealand) context 'allied health' is conceptualised as greater than the sum of the parts (member professions) and a 'profession community' in its own right[7.   Boyce, R.A. (2006). Emerging from the shadow of medicine: allied health as a "profession community" subculture. Health Sociology Review *15*, 520-534.]

[16] Named 'allied health' program leadership positions have a long history in American academic institutions. In comparison, they are relatively new in Australia and the UK. [56.   Hanavan, F.V. (1981). The Education of an Allied Health Administrator: Introduction of a New Order. In Review of Allied Health Education, (Volume 4), J. Hamburg, ed. (Lexington, Kentucky: University Press of Kentucky), pp. 96-114.]

concluded that much more needed to be done to harness the contribution of allied health leadership to system reform and service renewal[64]. Mason's work drew a clear link between supporting leadership /management positions and the capacity to drive innovation, new service delivery models, input into policy and collaborative interprofessional practice.

> Inspirational leadership in allied health is required to move services from traditional service delivery to innovative interdisciplinary approaches …. Allied health leadership and management positions are important as they provide allied health disciplines with a "voice" in policy decision making as well as impetus to continue to work towards integrating allied health services into core health service delivery (Mason, pp 23-24).

The following section will briefly explore empirical studies on Australian allied health organisational governance in greater detail. This will aid in understanding the impact of significant changes in the organisational design of public sector health service delivery organisations and the implications for where allied health leadership positions sit in those organisations. As organisations have changed their institutional form over time, so too have the allied health professions had to adapt to resituate themselves into new contexts.

2.3 Shifts in allied health leadership levels & institutional organisational structure

Governance structures in Australian public sector health services have given more prominence to allied health leadership since the late 1980s with the introduction of a new role, the '*Director of Allied Health*', as part of '*Division of Allied Health'* organisational units. Not all the new Director of Allied Health positions were included on the Top Management Team of the organisation. The minutes of the inaugural 1993 meeting of Australian Directors of Allied Health[17] showed that of the 19 organisations present at the meeting, 6 reported directly to the CEO (ie. in a tier 2 position)[51][18]. Nine reported to a medical director. Five of the 19 were in appointed positions that were fully funded. Of the 14 remaining positions, 6 had no funding for their position and 8 had partial funding. Seven had full operational and budgetary responsibility for the Division.

A national survey (94% participation rate; sample size of 107 organisations) in the late 1990s showed that the Division of Allied Health had become the dominant organisational model in Australia compared to other new approaches such as program management (divisionalisation, patient care departments, service streams)[54]. Forty-one Directors of Allied Health were identified in the 1999 study; an increase since the inaugural Directors of Allied Health meeting 6 years earlier.

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[17] This meeting included job titles such as Director, Co-ordinator and Chair of Allied Health.

[18] Anecdotal data presented at the meeting showed 33 hospitals had implemented versions of a distinct allied health structure under the leadership of an allied health professional in a representative or appointed position. This included informal positions titled 'Chair of Allied Health'.

In essence the development of the Division of Allied Health model was a shift from direct medical management and supervision to one of allied health self-management. Traditional pre-1990s models of allied health in which profession-based departments reported to a medical director[65] were still strongly represented in the 1999 study (56 of 107 sites). However, they were largely limited to smaller sized hospitals and those in rural and regional areas. Informal Co-ordinator and Chair positions were common in these settings.

2.4 Current allied health leadership: growth and complexity

A replication study was conducted 15 years later in 2014 (97% participation rate). Analysis showed that whilst 'allied health' models with explicit leadership positions were still predominant, there was a greater complexity and diversity in the organisational approaches[63]. These changes reflected the development of larger health service organisations based on multi-campus / network / area / district models throughout the states and territories.

A key change observed in the 2014 study was the creation of a new position; the *Executive Director of Allied Health,* associated with large networked health services. The largest networked organisations had close to two thousand allied health staff across multiple sites, and included acute care, sub-acute, community, aged care and mental health service sectors. Depending on the organisation, the Executive Director could have full operational responsibility for all allied health resources; a purely strategic role; or a mix of the two roles.

The merged networked entities often struggled to develop a coherent service delivery and management structure for allied health at a whole-of-organisation level[63]. In particular it was noted that the admitted services side of the organisation may have one approach to allied health organisation, whilst sub-acute, community-based and mental health services may have another governance approach. Where multiple organisational models for allied health exist within the one organisation, allied health leaders remarked upon the fragmentation of services and the lack of clear single point accountability to drive change and quality standards.

Rural and remote allied health professionals benefited from the establishment of larger regionally-based organisations which were able to aggregate the allied health workforce under a single allied health leadership position[66]. No organisations with allied health departments reporting to an executive-level medical director (the universal model up to the late 1980s) were identified in the 2014 study[66]. Fifteen years earlier in the 1999 study[19] there had been 56 examples of this type of allied health governance structure.

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[19] This study was confined to public sector health services delivery organisations with ≥ 100 beds.

Seventy-one Director of Allied Health positions (variously named) were identified in the 2014 replication study[63]; building on the 33 reported in 1993 and 41 in 1999[20]. The 71 positions throughout Australia arose from 148 organisations in the study sample (48%). These were the most senior named allied health positions in the organisation.

The 71 national positions do not represent the total Director of Allied Health positions in Australia, as large multi-site, multi-division health services may have an Executive Director of Allied Health with several more Directors of Allied Health embedded in different areas of the organisation in an associate or assistant director role. All 71 senior allied health positions were funded (appointed) positions with the exception of 5 rotating Chairs in one jurisdiction[21].

2.5 New frontiers in allied health leadership: TMTs and Boards

The cumulative body of two decades of research described above (1991-2014)[5, 7, 51-54, 63, 66] has confirmed that distinct allied health organisational models and leadership positions remain prevalent in Australia. Despite the widespread acceptance of allied health governance models, and the growth in Executive/Director of Allied Health positions, little is known about their comparative position vis-a-vis medical and nursing leadership positions at the executive level of organisational management (TMT).

Although prior work has looked at health professionals at Board level in Australia, this work has largely been devoted to medicine and or nursing[36, 67]. No prior work has mapped the presence of allied health on Australian Boards, nor undertaken a comparative analysis of the three major health professional workforce groups.

After addressing the methodology deployed in the research, we address the results for Top Management Teams in section 4 and the results for Boards in section 5 before presenting consolidated key findings in section 6.

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[20] These positions were not Directors of individual professions e.g. physiotherapy or dietetics. In the Australian context an Executive/Director of Allied Health leads multiple allied health professions.

[21] Chairs of Allied Health were common in the inaugural phase of establishing recognisable allied health entities in the 1980s. Demands for single point accountability, authoritative leadership at the strategic level and strong operational and financial performance paved the way for appointed positions in most jurisdictions7.   Boyce, R.A. (2006). Emerging from the shadow of medicine: allied health as a "profession community" subculture. Health Sociology Review *15*, 520-534.

3. Methodology

A cross-sectional national study of public sector health service delivery organisations was undertaken (2015) to map designated/named health leadership positions (medical, nursing/midwifery or allied health) on TMTs. The TMT was defined as Tier 1 and Tier 2 positions where Tier 1 was the Chief Executive Officer (CEO). The study also examined models of profession representation on TMTs to determine the nature and frequency of different approaches. A concurrent study examined the background of Board members to identify those with qualifications from the health professions (medical, nursing/midwifery, and allied health).

The sample for both studies was public sector health service delivery organisations. Health department web sites of each jurisdiction were consulted to assemble the sample. One hundred and thirty organisations were identified from the six states and two territory jurisdictions. The level of analysis was at the highest organisational unit, for example at the level of Metro North Hospital and Health Services in Queensland rather than constituent services such as The Prince Charles Hospital or Royal Brisbane & Women's Hospital. Similarly in Victoria, analysis was at the level of Northern Health, not at Northern Hospital or Craigieburn Health Service.

TMT data was collected from public health service documents such as annual reports and websites. There was great diversity in the amount of detail available between and within the jurisdictions. Some states issued a single state-level report with minimal governance information on individual health services; others had uniform report formats across services. Board membership was identified from institutional sources or government websites such as Public Boards Victoria (http://www.publicboards.vic.gov.au/). Where data sources were in conflict (most commonly between the website and annual report) the administrative officer servicing the Board and TMT was consulted for clarification. Professional social network sites were utilised to identify qualifications and positions when other avenues failed. Qualifications were inferred from listed academic post nominals e.g. 'B.Soc.Wk', or from comments in a biography, 'spent 20 years as a nurse' or other strong evidence of a clinical background.

Across the two studies data was available for 89-99% of the sample, depending on the specific research question. Data was obtained from 129 of the 130 organisations for the TMT study. A small number of dual roles were identified in the TMT study eg. CEO and Director of Nursing or Director of Nursing and Allied Health. In these cases 0.5 was allocated to each professional group. There were 1061 positions (including the CEO positions) in the TMTs study of 129 organisations. In the Boards study, there were 1145 members from 130 organisations nationally. Of those, qualifications were known for 1015 Board members. Of the 130 for whom data was not available, 114 were from Vic (Minor).

3.1 A note on Boards

For comparative purposes with other international contexts it should be noted that Australian public sector health service delivery organisations do not generally use a mixed model of executive and non-executive members on Boards[22] (e.g. as found in NHS Foundation Trusts). Australian jurisdictions typically constitute health service Boards with non-executive members. Practicing health professionals on Boards typically do not come from their own institution. Each jurisdiction dictates the parameters of Board function and membership type. See for example, the new Western Australian legislative reforms from the Health Service Act 2016 which mandated between 6 - 10 Board members. Each Board is required to have at least three health professionals (two currently practising).[23]

3.2 A note on Victoria

Victoria is over-represented in the two studies with almost two-thirds of the sample from Victorian organisations (80/130 sites). The larger number of organisations is due to a policy commitment to local governance, particularly in rural areas where more stand-alone centres are evident[68]. Of the 1061 members of Top Management Teams, 496 (47%) were from Victoria. Of the 1145 Board members, 683 (60%) were from Victoria.

The Victorian data was subjected to additional analysis to explore and compare the larger urban/regional centres Vic (Major) and smaller regional/ rural centres Vic (Minor). One hundred or more hospital beds was the criteria for placing the health service in the Vic (Major) group. Health services with fewer than 100 beds were allocated to the Vic (Minor) group. The MyHospitals website was used to allocate health services to a group (http://www.myhospitals.gov.au/). Of the Victorian sites, 24 were in the Vic (Major) group and 56 in the Vic (Minor) group. It is noteworthy that many of the Vic (Minor) health service organisations had less than 10 patient care hospital beds.

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[22] http://www.companydirectors.com.au/director-resource-centre/publications/the-boardroom-report/back-volumes/volume-12-2014/volume-12-issue-14/the-differences-between-executive-and-non-executive-directors (Accessed 9 August 2016)

[23] http://ww2.health.wa.gov.au/About-us/Interim-Health-Service-Board (Accessed 9 August 2016)

4. Top Management Teams and Allied Health

The aim of the study on Top Management Teams was to identify the proportion of designated/named medical, nursing/midwifery and allied health positions at the executive level of management; Tier 1 and 2, where Tier 1 was the CEO.

Common terminology of the named positions is Executive/Director of Medical Services (E/DMS), Executive/Director of Nursing and Midwifery (E/DON/MW) and Executive/Director of Allied Health (E/DAH). The positions may have operational control over the workforce, or be purely strategic without operational responsibilities or a mix of roles in large multi-site networks. Where all three profession leader positions are in place in the one organisation, each may have a differing split in operational and strategic responsibilities depending on the workplace context.

The analysis focuses on two aspects of allied health representation on TMTs:

1. Identification of named health profession leadership positions
2. Type of profession representation models

The study of organisational profession representation models sought to classify the TMTs and determine the frequency of different approaches.

4.1 Named health profession leadership positions on the TMT

Table 1 below shows summary national and Victorian data for the number (and per cent) of named medical, nursing/midwifery and allied health positions at TMT level. The national data shows there were approximately three times as many designated medical and nursing director positions on TMTs as there are allied health positions.

The situation in Victoria is less favourable for allied health compared to the national position. Victorian results showed there were 5.5 and 7.5 times more TMT positions for named nursing and medicine positions respectively compared to allied health. When the data is segregated into Vic (Major) and Vic (Minor) the relative position between the two sectors is stark.   Eleven per cent of the 79 Victorian sites had an allied health position on TMT; this was comprised of 27% for Vic (Major) and 4% for Vic (Minor).

Table 1 TMT: Named Health Profession Positions – Selected Jurisdictions

Jurisdiction (N = number of sites)	Medical Director	Nursing / MW Director	Allied Health Director
National (N=129)	110.5 (86%)	99 (77%)	36.5 (28%)
Victoria (N=79)	63.5 (80%)	49 (62%)	8.5 (11%)
Vic (Major) (N=24)	25 (100%)	17.5 (73%)	6.5 (27%)
Vic (Minor) (N=55)	38.5 (70%)	31.5 (57%)	2.0 (4%)

Notes:
- *Total TMT members nationally: 1061 from 129 organisations*
- *Vic (Major) was defined as organisations with ≥ 100 beds; Vic (Minor) < 100 beds.*
- *Data is based on the titles/named positions for Allied Health, Medicine and Nursing/Midwifery,*
- *Incumbents in 'Other' TMT positions with health qualifications are outside the scope of this study.*
- *Where a position was shared eg Director of Nursing and Allied Health 0.5 was allocated to each profession. A small number of organisations had two named position for one profession on the TMT.*
- *Care is required in interpreting named nursing positions in Vic (Minor). CEOs with nursing qualifications may not have a named nursing position on the TMT. Further, new positions being implemented (Directors of Clinical Services (DCS)) were often 'reserved' for nursing qualified candidates but were not formally named positions for nursing despite clear accountability for nursing workforce and standards. DCS positions were not counted as named positions.*

Source: Adapted from Boyce, R. A. and P. T. Jackway (2015). From Bedside to Boards: Allied Health Leadership. 11th National Allied Health Conference. Crown Conference Centre, Melbourne (http://www.nahc.com.au/papers/nahc2015abstract00568.pdf)[69].

Figures 1-5 below show a further breakdown of the results graphically. Figure 1 is the national data set, Figure 2 is Victoria (total) and Figure 3 is NSW. Figure 4 and 5 are Vic (Minor) and Vic (Major) respectively. Of the eight government jurisdictions, only South Australia, Tasmania and ACT had a 100 per cent access rate for allied health to the TMT, however they only accounted for 9 of the 129 sites[24].

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[24] In 2016 *Tasmania* shifted from three regions to a single state-wide Tasmanian Health Service. At the time of writing, it was unclear if Allied Health would be included on the TMT. It was suggested that a position named 'Nursing and Allied Health' was likely to be included, however, allied health qualified and experienced applicants appeared to be excluded from applying for the position.

Named Positions on TMT: National

N = 129 sites
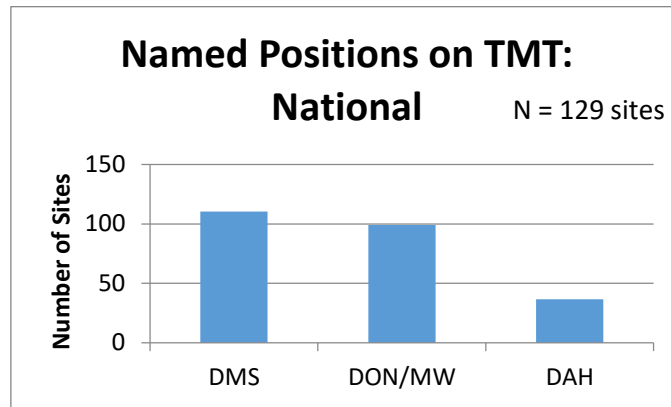
Figure 1 Named Positions on the TMT: National

Named Positions on TMT: Victoria (Total)

N =79 sites
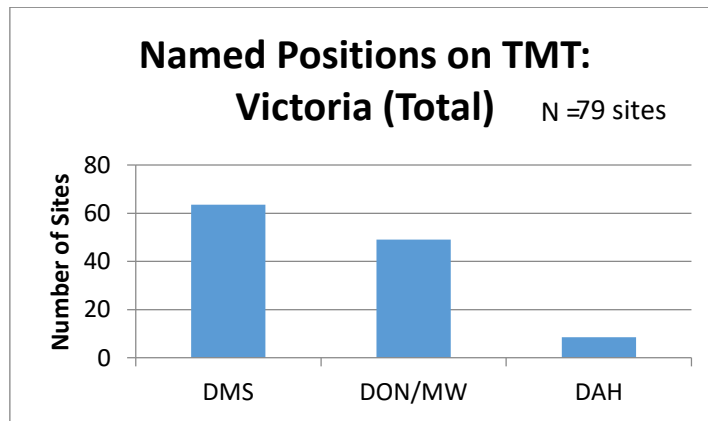
Figure 2 Named Positions on the TMT: Victoria (total)

Named Positions on TMT: NSW

N = 18 sites
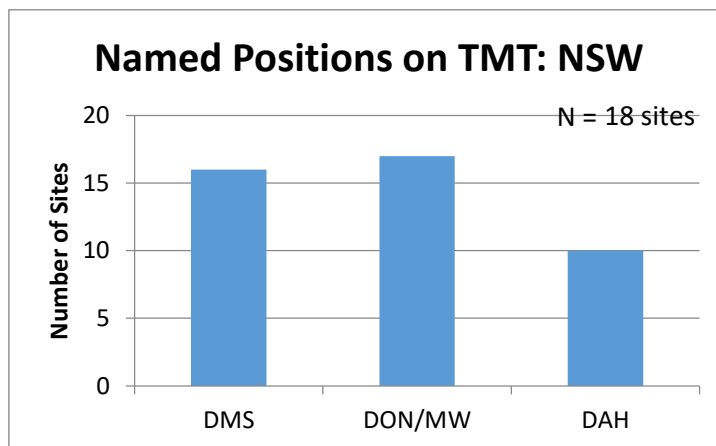
Figure 3 Named Positions on the TMT: NSW

TMT data is shown for NSW (18 organisations, see Figure. 3) to provide further comparative analysis for the Victorian result. NSW has 16 named medical positions, 17 named nursing/midwifery positions and 10 named allied health positions on the TMT. Queensland data (17 organisations) is not shown in a Figure; however it has a similar pattern to NSW

with 18 positions[25] for each of medicine and nursing/midwifery and 7 positions for allied health. Western Australia data (not shown in a Figure) was more mixed with 5 organisations having 3 named medical positions and 5 for nursing/midwifery and 1 for allied health[26].

The Victoria data is over-represented in the national study. It accounts for almost two-thirds of the sample due to the numerous very small health service delivery organisations in that State; a feature markedly different to other jurisdictions. In the very smallest Victorian organisations it was not unusual for the allied health staff to number less than five positions or to employ sessional staff from the private sector rather than their own staff. These very small numbers of staff severely limited a viable allied health governance model being implemented with TMT representation.

The breakdown of the Victorian data into Vic (Major)[27] and Vic (Minor) illustrates the difference between the two settings.
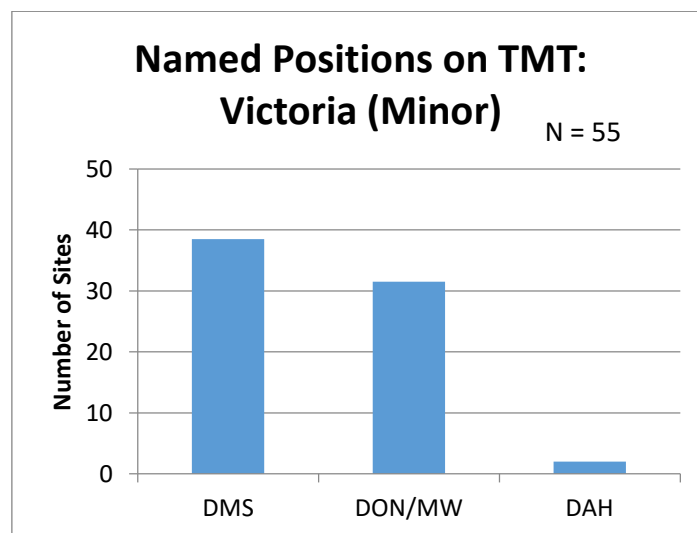
Figure 4 Named Positions on the TMT: Vic (Minor)

Figure 4 Vic (Minor) shows 2 of 55 organisations had a named allied health position on the TMT, whilst 38.5 and 31.5 positions on the TMT were identified for medicine and nursing/midwifery respectively. Of interest is that Vic (Minor) has 6 of the 10 CEOs in Australia with and allied health background.

[25] Two organisations had more than one named position for a profession on the TMT explaining why the total positions exceed the number of organisations.

[26] Western Australia's two TMTs that had no named medical positions each had a 'Director of Clinical Services' position that appeared to be held by medically qualified personnel. As they were not named medical positions they were counted as 'Other'.

[27] *Vic (Major) was defined as organisations with ≥ 100 hospital beds; Vic (Minor) < 100 beds.*

Notable too, was the new position of Director of Clinical Services (DCS) in Vic (Minor); a
position that appeared to be 'reserved' for nurses and which often specified accountability
for nursing standards and workforce. The DCS position appeared to represent a
replacement for the Director of Nursing named position. However as the DCS was not
named as a nursing position in its title it was not included as a nursing position in the study.
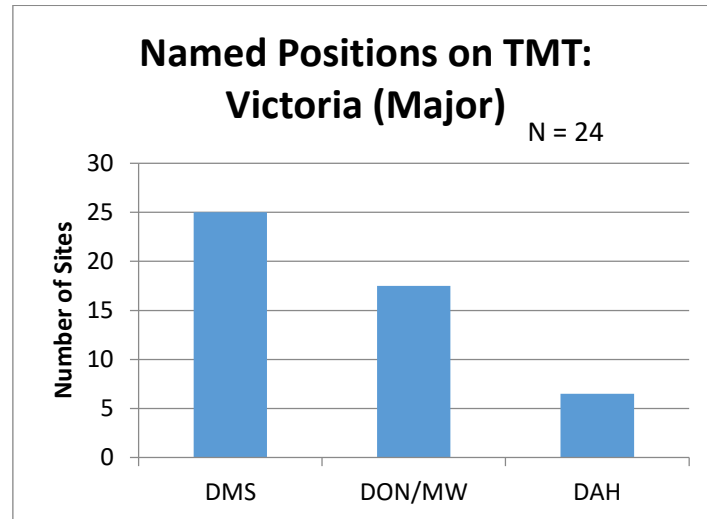
Figure 5 Named Positions on the TMT: Vic (Major)

In contrast, Figure 5 of Vic (Major) shows 6.5 of 24 organisations report a named allied
health position on the TMT, whilst 25 and 17.5 positions on the TMT were identified for
medicine and nursing respectively.

The Vic (Major) result is best compared with the NSW cohort (see Figure 3) and Queensland,
as all sites in the three cohorts are public sector health service delivery organisations with ≥
100 beds. As seen in the bar charts, NSW (Figure 3) has 10 designated allied health positions
on the TMT from its 18 sites. Queensland has 7 designated allied health positions on the
TMT from its 17 sites. Excluding Victoria data, there are 28 allied health positions in 50
organisations, therefore with 24 sites in Vic (Major) we might have expected in the vicinity
of 13 positions on the TMT rather than the 6.5 that were observed.

4.2 Profession representation models – type and frequency

An aim of the study was to classify the TMTs in terms of models of profession
representation and to calculate the frequency of the different approaches. The study
identified three TMT profession representation models:

1. A 'full' model where all three professional groups had named positions
2. A 'partial' model where one or two professional groups had named positions
3. A 'non-professional' model with no named positions on the TMT.

Table 2 below shows the frequency for each of the three profession representation models for the 129 Australian sites.

Table 2 TMT: Profession Representation Models & Frequency - Jurisdictions

Jurisdiction	Full Profession Representation Model	Partial Profession Representation Model	No Profession Representation Model
National (N=129)	34 (26%)	88 (68%)	7 (6%)
National – Vic (Minor)(N=74)	32 (43%)	42 (57%)	0 (0%)
Victoria (N=79)	8 (10%)	64 (81%)	7 (9%)
Vic (Major) (N=24)	6 (25%)	18 (75%)	0 (0%)
Vic (Minor) (N=55)	2 (4%)	46 (83%)	7 (13%)
NSW (N= 18)	9 (50%)	9 (50%)	0 (0%)
Queensland (N=17)	7 (40%)	10 (60%)	0 (0%)
South Australia (N= 5)	5 (100%)	0 (0%)	0 (0%)
Western Australia (N= 5)	(0%)	5 (100%)	0 (0%)
Tasmania (N= 3)	3 (100%)	0 (0%)	0 (0%)
Northern Territory (N=1)	1 (100%)	0 (0%)	0 (0%)
ACT (N=1)	1 (100%)	0 (0%)	0 (0%)

Notes:

- *Vic (Major) was defined as organisations with ≥ 100 hospital beds; Vic (Minor) < 100 beds.*

Nationally, thirty-four (26%) of the 129 sites in the study had designated TMT leadership positions for all three health professions (allied health, nursing/midwifery and medicine). We have noted above that South Australia, Tasmania and ACT had all sites (9 in total) operating full profession representation models. At the other end of the scale 7 (6%) sites had no designated TMT positions for any health profession leader positions. All 7 sites were from the Vic (Minor) group. Eighty-eight organisations (68%) had a partial model with either one or two named health profession positions on the TMT.

If Vic (Minor) is removed from the national data set, we see 32 of 74 sites (43%) have a full profession representation model and the remaining 42 sites (57%) have adopted a partial profession representation model on the TMT.

In terms of full profession representation TMT models, Vic (Major), NSW and Queensland were 25%, 50% and 40% respectively. Partial profession representation models were 75%, 50% and 60% respectively for Vic (Major), NSW and Queensland.

In the following sections we look more closely at the 'partial' profession representation model to identify how many had a sole named position and which, if any, profession was dominant in the sole role (see section 4.3.1). The focus then turns to those partial models where two of the three profession leadership positions are named (see section 4.3.2).

4.3 Partial profession representation models on the TMT

Table 3 below shows a breakdown of national TMTs by frequency of profession representation model type. The 'partial' model is further segmented to show the frequency of those with one member and those with two members (See Tables 4 and 5 below).

Table 3 TMT: Type of Profession Representation Model – National Frequency

Type of Profession Representation Model (TMTs)	Number of Named Professions	Number of Sites N=129
Full Profession Representation	3	34
Partial Profession Representation	2	53
Partial Profession Representation	1	35
No Profession Representation	0	7

4.3.1 Sole position partial profession representation models on the TMT

Table 3 above showed that 35 of 129 organisations had one named health profession leader position on the TMT. Table 4 below shows a breakdown of sole named positions by profession. In no case was allied health a sole named position. Medicine with two-thirds of the sole TMT positions (24 of 35 positions) was the dominant profession. Nursing/midwifery had 11 sole named positions.

Further analysis of Victoria showed that the sole named profession leader representation model was the most prevalent in the Vic (Minor) cohort where it accounted for three quarters of all cases nationally (26 of 35 cases).

Table 4 TMT: Partial Profession Representation Models – Sole Positions by Profession

Jurisdiction (N = number of sites)	Medical Position Only	Nursing / MW Position Only	Allied Health Position Only
National (N=129)	24	11	0
Victoria (N=79)	22	9	0
Vic (Major) (N=24)	5	0	0
Vic (Minor) (N=55)	17	9	0

Notes:
- *Where a position was shared e.g. Director of Nursing and Allied Health, a named position was allocated to each professional stream. A small number of organisations had two named positions for one profession on the TMT; these were treated as one position for calculations in the Table.*
- *Vic (Major) was defined as organisations with ≥ 100 hospital beds; Vic (Minor) < 100 beds.*
- *Care is required in interpreting named nursing positions in Vic (Minor). CEOs with nursing qualifications may not have a named nursing position on the TMT. Further, new positions being implemented (Directors of Clinical Services (DCS)) were often 'reserved' for nursing qualified candidates but were not formally named positions for nursing despite clear accountability for nursing workforce and standards. DCS positions were not counted as named profession positions.*

An important analytical caveat to this part of the study is that a sole health profession leadership position on the TMT did not necessarily imply governance over the other health profession workforces.

4.3.2 Two-member partial profession representation models on TMT

Two-member partial profession representation models were the most numerous in the national cohort (53/129 sites, 41%). Table 5 below shows the national and Victorian results. Ninety-four per cent of all two profession leaders in the partial model consisted of a medical and nursing/midwifery member.

Table 5 TMT: Partial Profession Representation Models – Two Positions by Profession

Jurisdiction (N = number of sites)	Medicine & Nursing Positions	Medical & Allied Health Positions	Nursing / MW & Allied Health Positions
National (N=129)	50	1	2
Victoria (N=79)	32	1	0
Vic (Major) (N=24)	12	1	0
Vic (Minor) (N=55)	20	0	0

Notes:
- *Vic (Major) was defined as organisations with ≥ 100 hospital beds; Vic (Minor) < 100 beds.*

5. Board Members and Allied Health

There are 1145 Board members of Australia's 130 public sector health service delivery organisations. Background qualifications are known for 1015 members (89%). Of the 11% (130) for whom qualifications are not known, 88% (114) are from 13 Boards in the Vic (Minor) cohort.

Some jurisdictions tightly prescribe the type of backgrounds required to fill Board positions. Where one or two positions are designated as health practitioner positions, the jurisdiction is likely to include no members with allied health qualifications. It was also observed that the smaller the number of places on the Board, the less likely it was that Board members had an allied health background.

5.1 Board members with health qualifications

Table 6 below shows the percentage of all Board members (N=1145) with health qualifications for the Australian and Victorian cohorts. Approximately a quarter (26.4%) of Board members nationally had a health professional qualification. The scope of the study did not include the practice status of Board members with health qualifications.

Table 6 Board Members: Health and Non-Health Qualifications

Jurisdiction	Health Qualification (%)	Non-Health Qualifications (%)	Unknown (%)
National (N=1145, 130 Boards)	26.4	62.2	11.4
Victoria (N=683, 80 Boards)	14.3	69.0	16.7
Vic (Major) (N=198, 24 Boards)	21.2	78.8	0
Vic (Minor) (N=485, 56 Boards)	11.5	65.0	23.5

Notes:
- *Total Board members nationally: N = 1145.*
- *Vic (Major) was defined as organisations with ≥ 100 hospital beds; Vic (Minor) < 100 beds.*
- *Background of 130 members are unknown (11.4%); 114 are from 13 Boards in Vic (Minor).*

Victoria has 62% of Australia's public sector health service delivery Boards due to the large number of organisations in the Vic (Minor) segment. Vic (Minor)'s 56 organisations constitute 70% of Victoria's Boards and 43% of all those in Australia.

Of Victoria's Board members 14.3% possessed health qualifications. Vic (Major) and Vic (Minor) were 21% and 11.5% respectively. If Vic (Minor) is removed from the national data set, 37% of the remaining Board members in Australia have a health qualification, 60% have no health qualifications and 3% are unknown. See Appendix 1 for additional calculations on Boards that are not discussed in detail here.

5.2 Medical, nursing/midwifery and allied health qualifications

In Table 7 below, all Board members with health qualifications (N=302) are examined in terms of their specific qualifications in medicine, nursing/midwifery and allied health.

Table 7 Health Qualified Board Members by Professional Background

Jurisdiction	Medicine (%)	Nursing /MW (%)	Allied Health (%)
National (N=302 with Health Qual)	51.7	27.3	21.0
Victoria (N=98 with Health Qual)	34.7	30.6	34.7
Vic (Major) (N=42 with Health Qual)	54.8	26.2	19.0
Vic (Minor) (N=56 with Health Qual)	19.6	33.9	46.4

Notes:
- *Total Board members nationally with a health qualification: N =302.*
- *Nationally there were 63.5 Board members with an allied health background (5.5% of <u>all 1145</u> Board members and 6.3% of the 1015 Board members with <u>known qualifications</u>). The '0.5' of 63.5 arises from a Board member having dual qualifications, for example, nursing and occupational therapy or social work. Dual qualifications were assigned a half for each profession.*

Australian Boards have low levels of members with allied health and nursing/midwifery qualifications compared to members with medical qualifications. There are close to 2.5 times the members with medical qualifications (51.7%) compared to allied health (21%).

In Victoria, the results for Vic (Major) are similar to the national situation with 19% and 21% respectively having allied health qualifications. However, Vic (Minor) is very different with 46.4% of members with a health qualification coming from allied health compared to 19.6% for medicine and 33.9% from nursing /midwifery.

Victoria provides 53.5% (34 positions) of Board members in Australia with an allied health background. Of the 34 Victorian allied health qualified positions, 26 (74.5%) come from the Vic (Minor) cohort. Of the allied health qualified Board members (63.5 positions) in Australia, 40.9% (26 positions) are from Vic (Minor).

5.3 Board members and allied health qualifications – which professions?

Nationally there are 63.5 Board members with allied health qualifications. Twenty-six come from Vic (Minor) and a further 8 from Vic (Major). NSW accounted for 14.5 positions, Queensland 11, Western Australia 3 and ACT had 1 member with an allied health qualification.

Table 8 below shows a breakdown of Board members with an allied health qualification by profession. Allied health qualified Board member in Australia came from eleven different professions. In Victoria, allied health qualified Board member came from nine different professions.

Table 8 Board Members: Allied Health Qualifications by Profession

Jurisdiction	Allied Health Profession Qualifications (Number of Board Members)										
	Phar	PT	Psy	OT	MLS	SWC	Diet	SP	Opto	Para	BEng
National Total	15	15	7	7.5	6	6	1	1	1	2	2
National – Vic (Minor)	6	11	7	4.5	6	1	1	0	0	0	0
Victoria	10	7	2	4	0	5	0	1	1	2	2
Vic (Major)	1	3	2	1	0	0	0	0	0	0	0
Vic (Minor)	9	4	0	3	0	5	0	1	1	2	2

Notes:
- *Total Board members nationally with an allied health qualification: N = 63.5.*
- *Vic (Major) was defined as organisations with ≥ 100 hospital beds; Vic(Minor) < 100 beds.*
- *Counselling is included with Social Work (SWC)*
- *Key: Phar = Pharmacy; PT = Physiotherapy; Psy = Psychology; OT = Occupational Therapy; MLS = Medical Laboratory Science; SWC= Social Work & Counselling; Diet = Dietetics; SP = Speech Pathology; Opto = Optometry; Para = Paramedical/Emergency; BEng = Biomedical Engineering.*
- *6 of 6 MLS are from Queensland, 5 of 6 Psychology are from NSW*

Nationally, Pharmacy and Physiotherapy were the most numerous allied health qualifications with each contributing 15 positions to the 63.5 total. Occupational Therapy, Psychology, Medical Laboratory Science and Social Work/Counselling recorded 6 - 7.5 members each. The remaining 7 positions were from Dietetics, Speech Pathology, Optometry and Other Sciences.

Victoria had a total of 34 Board members with an Allied Health background (8 Vic (Major) and 26 Vic (Minor)). Ten of the 34 were from the pharmacy profession and 7 from Physiotherapy; nine and four respectively from the Vic (Minor) cohort. The remaining member backgrounds were Social work/counselling and Occupational Therapy (3-5 members) and Speech Pathology, Optometry and 4 from Other Sciences.

Different jurisdictions range between 0 – 34 members with Victoria having the highest number at 34 and South Australia, Tasmania and the Northern Territory having no Board members with allied health qualifications.

6. Key Findings – Allied Health and Executive Leadership

The overarching goal of this research was to map the position of allied health on the most senior leadership settings in public sector health service delivery organisations. A second goal was to undertake a comparative analysis with the position of the medical and nursing / midwifery professions.

There are seven major findings about allied health membership of Top Management Teams and Boards in Australia's public sector health service delivery organisations:

1. Approximately a quarter of Australian **TMTs** (34 organisations) have named profession leadership positions for all three health profession workforces.

2. Allied health is significantly under-represented in health service Tier 2 **TMT** named positions compared to those available for the medical and nursing/midwifery workforces. Nationally, there were approximately three times as many named medical and nursing /midwifery director positions on TMTs as there were allied health positions.

3. Victoria's situation is less favourable than the national position for named allied health positions on the **TMT**.

   Victoria has 5.5 and 7.5 times more TMT positions for named nursing/midwifery and medicine leadership positions respectively compared to allied health.

   Of the 129 TMTs throughout Australia, 34 (26%) were using a 'full profession representation' model that included named leadership positions for all three of the health profession workforces. The position in Victoria was less favourable at 14.3%. Vic (Major) reported 21.2% as 'full profession representation' models and Vic (Minor) 11.5%.

4. Seven of the 129 (5.4%) organisations had no named leadership positions on the **TMT** for any of the health profession workforces. All were from Vic (Minor).

   Of the 88 Australian organisations using a 'partial profession representation' model, only 3 (3.4%) included a named allied health leadership position on the TMT. Of Victoria's 64 'partial profession representation' TMT models, only one (1.6%) had a named allied health leadership position on the TMT.

5. The Victorian segment Vic (Minor) is unique compared to other jurisdictions, it recorded the:

   - *Lowest* level of named allied health membership of **TMTs** (2 from 55) (Table 1);

- *Highest* level of **CEOs** with an allied health background (6 of 10); and
- *Highest* number and percentage of **Board** members with an allied health qualification (Table 7).

6. Ten of the 129 (7.8%) **Chief Executive Officers** in the TMT study had an allied health qualification. Six of the ten positions came from the Vic (Minor) segment.

   Experience of TMT-level operational and strategic leadership is an important developmental platform and stepping stone for allied health leaders aspiring to CEO positions. The leadership capability of allied health remains 'un-tapped' and 'under-exploited' without experience at TMT level[9, 26].

7. Nationally, approximately 30% (N = 302) of **Board** members with known backgrounds (N=1015) have a health qualification. Looking at the type of qualification 15.4% % (156/1015) have a medical qualification, 8.1% (82.5/1015) have a nursing/midwifery qualification and 6.3% (63.5/1015) have an allied health qualification. The Australian results for Board members with a health professional qualification are similar to a recent study on NHS England acute hospitals[27].

   Of the 302 Australian Board members with a health qualification, 51.7% have a medical qualification, 27.3% have a nursing/midwifery qualification and 21% have an allied health qualification.

   Victoria does not reflect the medical dominance evident in the national context. Of the Victorian Board members with a health qualification (N=98), they were evenly spread with close to a third each being in medicine, nursing/midwifery and allied health (34, 30 and 34 members respectively).

   The results for Victoria as a whole are somewhat misleading as there are striking differences between Vic (Major) and Vic (Minor). Vic (Major) closely reflects the national situation with 54.8% medical, 26.2% nursing/midwifery and 19.0% allied health qualifications. Conversely, in Vic (Minor) allied health and medicine are reversed with medicine having 19.6% of health qualifications, allied health 46.4% and nursing/midwifery having 33.9%.

7. Building Allied Health Executive Leadership Capacity

Allied health is starting from a low base with 3.4% of all **Australian TMT** positions (36.5/1061) being a named allied health position (10.4% medicine and 9.3% nursing / midwifery). Of all **national Board** members with known qualifications (N=1015), 6.3% (N=63.5) have an allied health qualification (15.4% medicine and 8.1% nursing / midwifery).

As outlined in section 6 on Key Findings, **Victoria**'s position is less favourable than the national situation for named allied health positions on the **TMT**; 0.8% (8.5/1061) of all Australian TMT positions are named allied health positions from Victoria (6.0% for medicine and 4.6% nursing/midwifery). Expressed in terms of **all Victorian TMT** positions (N=683), the results are 1.7% of all Victorian TMT positions are named allied health positions (12.8% medicine and 9.9% nursing/midwifery).

Of all **Victorian Board** member positions with known qualifications (N=569), 5.7% were allied health, 5.7% medicine and 5.0% nursing/midwifery. This apparent equality of outcomes across the professions hides major differences within the larger and small organisational settings.

As discussed earlier, **Victoria** dominates the results as it has close to two-thirds of all organisations in the national data pool. The two cohorts Vic (Minor) and Vic (Major) have different distribution patterns within each of the TMT and the Boards arms of the study. For example (from Table 7), in **Vic (Major)** Board members with medical qualifications are close to 3 times more prevalent than members with allied health qualifications. Conversely, in **Vic (Minor)** it is allied health (46.4% of those with health qualifications) that is the most numerous, with medicine (19.6%) very poorly represented compared to Vic (Major) (54.8%).

Overall the studies of the TMT and Boards show that allied health has small numbers in both arenas and that with the exception of Boards in Vic (Minor) their numbers are significantly fewer than those occupied by medicine and nursing/midwifery. Thus, the "problem" is one of low absolute numbers and low proportion relative to other health professions.

If, as a growing body of research suggests [21, 28-32], clinician leaders are a valuable resource on Boards and TMTs, then should not the second largest, and the most complex workforce about which we know the least, also be contributing their expertise to the important business of health?

The findings suggest several questions that need to be addressed:

1. Why is allied health not part of the **TMT** in 92 of the 129 public sector health service delivery organisations in Australia?[28]

    > If Vic (Minor) is removed from the sample there are 39 out of 74 organisations nationally with no named allied health position on the TMT.

2. Why is allied health not part of the **TMT** in 70 of the 79 public sector health service delivery organisations in Victoria? [17 of the 24 Vic (Major) sites and 53 of the 55 Vic (Minor) sites]

3. What strategies could address the institutional / structural deficit and individual leadership capacity levels in terms of **TMT** membership?

4. Each jurisdiction dictates a specific framework for membership of **Boards**. In open-call jurisdictions, what strategies can be used to increase the pool of high quality Board-ready allied health qualified applicants?

5. Biographies of many allied health qualified **Board** members suggest a tenuous on-going connection with allied health, particularly for those outside large urban centres. Are strategies needed to re/connect current (and potential) allied health qualified Board members with allied health networks and priority issues?

It is outside the scope of this report to definitively address the questions posed above; however in the following section some suggested first-steps are proffered commencing with the notion of allied health as an under-utilised source of management and leadership expertise. This is followed by focusing on strategies at TMT level and then Boards before concluding with a discussion of limitations of the current study and opportunities for further research in section 8.

7.1 Allied health clinician leaders as an under-exploited resource

Petchey et al. (2013, p.19), researching in the context of the NHS (England), has described the involvement of allied health clinician leaders compared to that of medicine and nursing:

> AHPs have lagged behind medicine and nursing in terms of their involvement in management. Their relative underdevelopment thus represents a significantly under-exploited managerial resource for the NHS[26].

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[28] Nationally, 19 of 129 organisation's TMT have no named medical leadership positions and 30 of 129 have no named nursing / midwifery leadership position.

An on-line workshop conducted by NHS England (April-July 2016) to consider how allied health could transform the health service if it was used effectively, ranked Board level positions for allied health as a highly supported issue. The workshop involved 1360 people making 10,000 contributions[29]. The first comment to propose more Board members as a mechanism for greater effectiveness of allied health said:

> AHP representation at Board level: There should be greater AHP representation at board level; otherwise the focus in healthcare will always be nursing, midwifery and medical.
> https://ahp.clevertogether.com/en/login - Accessed 6/5/2016.

In Australia, there has been little focus on allied health qualified members on Boards. Conversely, a key objective since the 1990s has been to secure senior allied health leadership positions in health services[54, 70]. The focus shifted to their hierarchical position relative to the TMT[71]. Allied health's preferred governance model was for a consolidated Division under a Director of Allied Health reporting to the CEO[6, 7]. A cognate portfolio is sometimes added to the Director's role to broaden organisational responsibilities, for example Director of Community and Allied Health or Director of Allied Health and Rehabilitation[30]. Anecdotally, some allied health leaders have pursued an alternative pathway via a clinical operations or clinical governance management route to the TMT outside the classic 'allied health' pathway.

The pathways described above are perceived as viable pipelines to attaining Director of Clinical Services, Chief Operating Officer or CEO positions for senior allied health leaders. Currently there are 10 allied health qualified CEOs from the pool of 130 organisations (7.7%).

What can be deduced from observing incumbent career paths is that allied health leaders have a unique trajectory from the time they enter the health workforce until they achieve executive level leadership roles. Typically, allied health leaders move from a uni-professional leadership mode to a more demanding multi-disciplinary leadership role.

A focal difference with leaders from the medical and nursing/midwifery professions is the allied health experience of <u>managing and leading</u> the large number of distinct professions that constitute allied health; in some workplaces these can number up to 40 different

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[29] When the on-line workshop (sponsored by the Office of the Chief Allied Health Professions Officer, NHS England) closed in July 2016, the input data had risen to 1931 people with 16,000 contributions. Primarily targeted at allied health professionals, the workshop was open to other professions and the community.

[30] Discussions from the workshop series: (1) Boyce, R.A. (2013) 'Organisational Models for Sustainable Futures', *Allied Health: Governance and Leadership Workshop,* Health Department Victoria, Nov 1st. (2) Boyce, R.A. (2013) 'Risk-Proofing Allied Health: Evaluating and Comparing Organisational Designs', *Allied Health: Governance and Leadership Workshop,* Health Department Victoria, Nov 1st. (3) Boyce, R.A. (2013) 'Allied Health Leadership & Management Development', *Allied Health: Governance and Leadership Workshop,* Health Department Victoria, Nov 1st (Convener for all sessions: Kathleen Philip).

professional and assistant or support worker classifications. The ability to develop a single united allied health 'voice', whilst supporting individual profession identity, is a critical success factor of the Director of Allied Health role. It is akin to the shift from managing a 'tribe' to leading a 'nation' that was discussed by Blayney & Fitz (1990, p. 8) [72-74].

This report has focused on Tier 1 and 2 positions on the TMT and on Boards. Earlier we noted that 92 of the 129 public sector health service delivery organisations in Australia did not have an allied health leader position on the TMT. The review of public documents for this study (organisational structures) showed that the majority of these 92 organisations had an allied health leader at the Tier 3 position, with some at Tier 4, and a very few at Tier 5 or outsourced allied health on contracted sessions. In the following section we briefly look at possible strategies for achieving TMT representation before looking more closely at Boards.

7.2 Strategies for TMTs

Recent Australian publications about clinician engagement by Bonais et al. (2012)[22] and specifically about medical engagement by Dickinson et al. (2016)[31] and the AMA[24, 75, 76], and a White Paper from the Australian College of Nursing (2015)[36] outlining the contribution of nursing leadership to the health care system, suggest that allied health should be directing effort to similar issues.

Dickinson and colleagues refer to an *'engagement gap'* in regards to greater medical involvement. In allied health's case we could construct the issue as an *'access gap'*, given the results of the current study. Anecdotally[31], there is no suggestion that allied health are reluctant leaders at the level of the TMT[11] or that there is a disconnect between 'elites' in allied health and the 'rank and file' as Dickinson et al. describe in their analysis of medical engagement issues.   Rather, for allied health, they wish to more fully engage at all levels of the health system and its organisations[20].

There are several arguments that can be advanced to support claims for an allied health leader position on the TMT. They include:

1. Value-based arguments in which allied health demonstrates how involvement in corporate level planning and decision-making would enhance deliberations and outcomes[77];

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[31] Discussions from the workshop series: Boyce, R.A. (2013) 'Allied Health Leadership & Management Development', *Allied Health: Governance and Leadership Workshop,* Health Department Victoria, Nov 1st (Convener for all sessions: Kathleen Philip).

2. Assembling evidence of economic and service impact[2, 19] in terms of workforce reform, and the significant knowledge that allied health has in leading critical organisational areas that effect health outcomes and activity-based funding models such as:

   - preventable hospitalisation;
   - chronic disease management / long term conditions;
   - care of older persons;
   - early intervention rehabilitation;
   - integration across the primary care interface; e.g. rapid assessment clinics, and
   - realigning the internal allied health workforce skill mix between professionals and assistants, and so on

3. The advantages of a mechanism (TMT position) for single point accountability, clinical governance, cost management and effective deployment of the workforce.

Three work programs could have an influential effect on building the positive regard for universal allied health involvement on the TMT:

1. A seminal document based around the arguments above directed to Chief Executives and Board members of health service delivery organisations.

   There have been several publications from the UK that provide a platform for advancing allied health's contribution to the health system that can provide models for Australian endeavours [13, 14, 62, 78]. The on-line workshop conducted by NHS England (see section 7.1) provides a breakthrough approach for work to occur across the Australian jurisdictions.

   The most comprehensive Australian document which demonstrates how involvement in corporate level planning and decision-making would be enhanced is the NSW Directors of Allied Health (2013) *Consensus Statement on Principles Underpinning Allied Health Governance in Local Health Districts / Specialty Networks*[77]. The consensus statement is included in Appendix 2. It provides seven principles on which governance decisions about allied health inclusion in the TMT can be argued; linking structural integrity, active leadership and service impact. A principles-based approach complimented by case examples, could be the basis of a broader, evidence-based, national process for demonstrating the value-contribution of allied health leaders on the TMT.

2. An Annual Australian Allied Health Report (*Better Health Through Allied Health*) which has two sections:
   a. A retrospective *Performance Analysis* outlining achievements in the past year.
   b. A prospective *Innovation Outlook* detailing work programs and priorities to be undertaken in the forthcoming year.

   Such an endeavour might reasonably be overseen by the National Allied Health Advisors Committee (NAHAC) working with the Directors of Allied Health from the jurisdictions.

3. An ambitious long-term program of research akin to the nursing MAGNET program[79]to identify *'allied health-sensitive patient outcomes'* and *'allied health-sensitive organisational outcomes'*. An allied health aligned program is not inconceivable.

7.2.1 Directors of Allied Health and Chief Allied Health Officers

In some settings Allied Health Tier 2 TMT positions might be difficult to justify due to the small size of the organisation, or an unwillingness to increase the number of reports to the CEO. There are three strategies that can be used to mitigate these problems:

1. A *Director of Allied Health* position can be shared with one or more neighbour organisations and sit on the TMT. This approach was observed in the study cohort for a small number of Director of Medicine positions.

2. In smaller organisations where the operational role of a Director of Allied Health is not sustainable, an alternative strategy is to create a *Chief Allied Health Officer (CAHO)* role (not a position) in conjunction with a pre-existing senior allied health professional. The *Chief Allied Health Officer* is responsible for professional governance of allied health and acts in an advisory role to the CEO. The CAHO is part of the TMT without necessarily being a direct report to the CEO.

3. Allied health qualified personnel may be on the TMT in another capacity such as executive-level operations, clinical governance or research/education positions. It may be a viable option to create a CAHO role in the terms described above and add it as a portfolio responsibility to an allied health qualified member of the TMT. The CAHO role provides the single point accountability in terms of professional governance and corporate advice.

7.3 Strategies for Boards

Nationally, 29.8% of all Australian Board members for whom qualifications were known (N=1015)[32] had a health qualification (15.4% doctors, 8.1% nurses and 6.3% allied health). The results showed that some jurisdictions have no Board members with an allied health background.

There is broad agreement between the Australian results and those reported in a study of the English NHS. Veronesi et al. (2015, p. 1037) mapped clinical qualifications of Board members of the acute hospital sector in the English NHS over 2005-2009 and reported that 'on average, 25.6 per cent of the board directors had a clinical background (13.7 per cent doctor directors, and 12.1 per cent nurse or other allied health professions directors)[27][33].

Victorian results, based on Board members with known qualifications (N=569), were 17.2% with health qualifications; Vic (Major) 21.2% and Vic (Minor) 11.5%. Table 7, which analysed Victorian Board members with health qualifications (N=98), showed Vic (Major) significantly favouring those with medical qualifications (54.8%) whilst in Vic (Minor) it was allied health which was the dominant professional group (46.4%).

Current political directives to increase gender balance on public sector Boards [33, 34] may present an opportunity to increase allied health Board representation given the dominant female gender of the allied health professions[80, 81].

Victoria provides the greatest opportunities for expanding allied health member numbers because they have the greatest number of Boards; 80 of the 130 (61.5%). Further, these Boards contain 683 members that constitute 59.7% of the national pool. Of the 683 Victorian Board members 98 were identified with a health qualification (14.3%), 34 from allied health (5%).

Vic (Minor) had 56 Boards with 485 members; 26 with an allied health qualification. Vic (Major) had 24 Boards with 198 members; 8 with allied health qualifications. The comparative position of Vic (Major) is highlighted by looking at NSW and Queensland as in all three cases the health organisations have over 100 beds, the criteria for Vic (Major) vis Vic (Minor). Vic (Major) has a similar number of Board members to NSW at 198 and 199 respectively; with NSW having 14.5 allied health qualified Board members compared to 8 in Vic (Major). Queensland is the jurisdiction with the next most Board members; 17 Boards with 140 Board members, of whom 11 are allied health qualified.

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[32] This equates to 26.4% of the total Australian sample i.e. N=1145 (including 130 for whom qualifications are not known).

[33] Veronesi et al. also reported 'Clinicians were CEOs in 19.5 per cent of the cases and chairs of the board in only 7 per cent. These percentages did not change significantly over time.' Note that NHS England typically uses a mix of executive and non-executive directors on Boards.

The small number of Boards in jurisdictions such as the ACT, Northern Territory, Tasmania, South Australia and Western Australia could realistically provide only a small number of opportunities given the paucity of organisations. These five jurisdictions account for 16 Boards from the pool of 130 (12.3%) and 123 Board members (range 9-42) from the national pool of 1145 (10.7 %). In 2015 the Boards of these five jurisdictions contained only 4 allied health qualified members between them. Northern Territory, Tasmania and South Australia had no members with an allied health qualification.

Public sector health service delivery Boards may be categorised according to their local context and characteristics. Three basic types are shown below; each will seek, and attract, different kinds of candidates:

1. Large, high reputation, research active centres with ambitions for Academic Health Science Centre status;
2. Larger regional organisations servicing multiple communities, and
3. Smaller community-oriented organisations embedded in regional / rural areas.

Of the three organisational types, research active health services seeking Academic Health Science Centre status are likely to have the most specific member profile requirements. Allied health qualified Board-ready candidates with high impact research/academic accomplishments including high value collaborative and leadership networks would be potential contenders for Board positions. Additional value is achieved where such candidates have interprofessional research and practice experience rather than uni-professional.

Allied health needs to develop an easily accessible, experienced and Board-ready cohort of potential appointees. Board candidates (for any jurisdiction) might be drawn from sources such as:

- Allied health-focused businesses in the private sector / private practice;
- Tier 2 and 3 Directors of Allied Health from neighbouring public sector health organisations;
- A small cohort of Tier 2 and 3 Directors of Allied Health in private sector health services delivery organisations;
- Allied health qualified senior public servants and practitioners with interprofessional experience from other cognate sectors eg. human services, rehabilitation, disability sector and aged care;
- Senior managerial staff from Primary Health Networks with allied health backgrounds, and
- Senior university academics/researchers from allied health disciplines with experience in interprofessional contexts

Allied health is able to assemble Board-ready candidates through acquiring Australian Institute of Company Director (AICD) credentials and gaining experience in smaller, community-based or not-for-profit organisations. However, it is the issue of easy access to candidates for a Board looking to make appointments that is the most difficult issue. Individual candidates may respond to calls for Board members from the jurisdictions, but there is no easily accessible organised listing of allied health Board-ready candidates for Boards to peruse.

A strategic work program to target issues of access, experience and capacity is a key piece of work that needs to be undertaken to accelerate allied health qualified candidates to Boards.

The final section of this Report brings together some concluding remarks on building a stronger focus on allied health leaders and explores some potential next steps. Limitations and difficulties of conducting TMT and Board level studies are addressed and future research is suggested.

8. Concluding Comments, Study Limitations and Future Research

This study has focused on the highest echelons of public sector health service delivery organisations: Top Management Teams and Boards. An impetus for the study was to map the contribution allied health qualified personnel make at both levels and embed it in a comparative study with medicine and nursing / midwifery. No prior studies have looked specifically at the contribution of allied health leaders at TMT and Board level, nor undertaken such a comparative analysis at a national level.

Health care involves three primary workforces: medicine, nursing / midwifery and allied health – all complex and unique in their own right – none more so than allied health with its multiple diverse professional, scientific, technical and assistant occupational categories. Despite the importance of the allied health workforce to the achievement of health outcomes and health system reform, it remains distant and un/under-represented from the sites of decision-making where it could make a positive difference to system performance, service quality and patient safety.

8.1 A greater focus on leaders

The importance of allied health is easily overlooked without a focus on leaders, leadership and leading. Support for leadership capacity building is somewhat fragmented and piecemeal in Australia with no overarching national allied health leaders group that actively draws on, or represents, the expertise of the Executive/Directors of Allied Health[34]. The disconnect of the Executive/Directors of Allied Health is problematic as these are the leaders that are directly responsible for managing, leading or supervising Australia's allied health workforce in the 130 public sector health service delivery organisations; a workforce of tens of thousands. These leaders belong to no single allied health profession. A 2014 national study (Boyce and Wiseman) of organisational structures in public sector health services identified 71 Executive/Director of Allied Health leadership positions with backgrounds from eight different allied health professions[66].

Attempts to create the member-based Allied Health Leaders of Australia and New Zealand (AHLANZ) following the 3rd National Allied Health Managers Conference in Launceston 2011 have stalled. In an unrelated development, an Allied Health Leaders Network (AHLN-online) was created in late 2014. Its goal is to be an online networking and information-sharing vehicle for members of selected professions; however utilisation rates are believed to be

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[34] Most jurisdictions have meetings of their Directors of Allied Health but these lack the formal governance arrangements that are hallmarks of professional associations.

low[35]. AHLN-online is not available to all allied health professionals nor does it have a targeted role in capacity building.

The Australian Allied Health Forum (AAHF), formed in 2013, is a collaborative of representatives from allied health organisations who work together on issues of national importance to the allied health professions and the Australian public. AAHF comprises four national allied health associations/networks[36], none of which directly capture the corpus of Executive/Directors of Allied Health as members. The AAHF 2016 'Strategic Plan for the Allied Health Sector - Better Utilisation, Better Health Outcomes'[40] makes no mention of the importance of developing leaders and leadership to shape, support and deliver the reform agenda.

The Australian nursing profession accords leaders and leadership a strong priority in influencing system and organisational performance[35, 36]. Daly et al.'s (2014, p.80) discussion of nursing and the importance of clinical leadership in hospitals noted the nexus between global, national and local leadership initiatives:

> Globally, the International Council of Nurses identifies leadership as one of the major considerations underpinning their activities and has established a Global Nursing Leadership Institute as a vehicle for these activities. In addition to this global approach, local initiatives to enhance clinical leadership have been developed and implemented in a number of countries[23].

The International Chief (Allied) Health Profession Officers (ICHPO)[37] network formed in 2008 has been exploring a Commonwealth Federation/Global Alliance of Allied Health linking with allied health groups who are not discipline specific; however there is no timetable for this proposal[38].

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[35] AHLN-online is only available to allied health professionals who are members of the professional associations that constitute Allied Health Professions Australia (AHPA). Many Executive/Directors of Allied Health chose to cancel memberships of their professional association when they take up Director of Allied Health roles that lead multiple professions.

[36] AAHF members are Allied Health Professions Australia (AHPA), Indigenous Allied Health Australia (IAHA), National Allied Health Advisors Committee (NAHAC) and Services for Rural and Remote Allied Health (SARRAH). The AAHF meets regularly with the Federal Chief Allied Health Advisor.

[37] ICHPO members at June 2015 are Australia, Belgium, Canada, Denmark, England, Hong Kong (SAR), Malaysia, Malta, Namibia, New Zealand, Northern Ireland, Scotland, Singapore, Slovenia, South Africa, Southern Ireland and Wales. http://www.gehealthcarefinnamore.com/images/VDAH/ICHPO.pdf (Viewed 23 August 2016)

[38] Various allied health professions have international organisations, for example, World Confederation for Physical Therapy or International Confederation of Dietetic Associations, however as discipline specific uni-professional groups these are not 'Allied Health' organisations in the terms we are using in this study (see introductory note on allied health on page 4).

8.2 Next steps

In terms of next steps, several strategies might be considered:

1. Revisit the need to establish a national allied health leaders group that:
   a. Is not discipline specific;
   b. Is based on personal membership;
   c. Is inclusive of all sectors of practice;
   d. Encompasses the Exec/Director of Allied Health, and
   e. Joins the Australian Allied Health Forum

2. Develop a framework, strategies and action plan for leadership capacity development to achieve greater allied health presence at the TMT and Board level of public sector health service delivery organisations.

3. Set membership targets for TMTs and Boards and undertake annual or bi-annual measurement of progress.

As this Report focuses on the public sector, a feasible approach might be for NAHAC (National Allied Health Advisors Committee) to develop a draft national framework and strategy and then conduct workshops with allied health leaders at the 12th National Allied Health Conference in mid-2017 (Sydney) to reach an inclusive definitive plan. The plan could include funded 'Springboard Accelerator' opportunities to hasten the developmental process.

The capacity building and reporting functions referred to above could eventually be a function of the National Allied Health Leaders group as per point one above. In the implementation phase, supportive networks could be established with groups such as the Australian Institute of Company Directors[39] and Women on Boards[40] in order to build the experience of aspirants to Board roles. Similarly for aspirants to TMTs, Chief Executive Officer or Chief Operating Officer roles, working with the Australasian College of Health Service Management[41], Australian Institute of Management[42] and Chief Executive Women[43] could be considered.

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[39] Australian Institute of Company Directors http://aicd.companydirectors.com.au/
[40] Women on Boards https://www.womenonboards.net/en-AU/Home
[41] Australasian College of Health Services Management https://www.achsm.org.au/
[42] Australian Institute of Management http://www.aim.com.au/
[43] Chief Executive Women   http://cew.org.au/

8.3 Limitations of the study

This study used public documents (mainly annual reports and websites) to compile data on over 2000 members of TMTs and Boards in Australia's 130 public sector health service delivery organisations. Similarly to Veronesi et al.'s (2015) study of Boards in the English NHS[27], the absence of a central repository of governance arrangements at individual sites (Boards and TMTs) hampered the progress of the study. Victoria's Public Boards website (http://www.publicboards.vic.gov.au/) was an exception but only listed names. Many institutional documents and websites listed only names and no biographies of TMT and Board members, whilst others gave expansive details including all qualifications, job experience and community roles.

Data availability on TMTs was entirely dependent on the policy of the state or territory regarding requirements for individual agencies to publish annual reports. Jurisdictions such as NSW, where individual agency reports were recently replaced with a single state level annual report were particularly problematic due to the absence of detail on local level governance. Other jurisdictions such as Queensland had a mandated reporting framework for each health service that included governance arrangements. Health service websites were often at odds with the information in the Annual Report. Where information could not be reconciled, the administrative officer servicing the Board and TMT was consulted for clarification. Despite these barriers, a high rate of participation was achieved with 129 of 130 organisations in the TMT study and 1015 of 1145 (88.6%) Board members included across 117 of the 130 Boards (90%).

The literature on health professionals in management or Board roles lacks clarity and uniformity as to what constitutes a 'clinician' leader. There may be country-specific interpretations that treat the word 'clinician' as reserved for medical staff, whilst in other contexts (such as Australia) a clinician can relate to any health professional group. The literature is dominated by studies of single professions, especially medical clinician leaders, and less frequently nursing clinician leaders. It is rare for studies on TMTs and Boards to examine allied health in any depth.

8.4 Future research

An interesting question would be to determine the relative contribution on system performance of profession leader positions from different backgrounds. A challenge for future research will be whether it is possible to separate the institutional effect of medical clinicians on TMTs or Boards when a nursing and an allied health clinician leader is also included on the TMT.   How can differential impacts be measured? Other questions of interest focus on the type of profession representation model. What effect do the different TMT profession representation models have on institutional performance? For example,

does a health service with a full profession representation TMT model (medicine, nursing and allied health) out-perform other representation types, including TMTs with no named profession leaders? These considerations are complicated by the presence of other health-qualified members on the TMT not in 'named' profession positions. The professional background of the CEO and gender dynamics on Boards and TMT are other factors to consider.

Earlier discussion in this report has proposed several potential programs of work that could be undertaken to advance greater inclusion of allied health on TMTs and Boards. The motivation is to validate the contribution of allied health to system performance and the quality and safety of patient care in terms of allied health's impact as a workforce, and more broadly as part of the clinical partnership with medicine, nursing and midwifery.

The following investigations would deepen and advance our understanding of allied health in senior management and leadership roles:

1. Studies of organisations where allied health is a TMT Tier 2 position to explore with CEOs and other Tier 2 appointees what they value about the allied health leader role [5-7][44].

2. Studies of organisations where only medicine and or nursing/midwifery have named positions on the TMT to explore why an allied health position is not included/valued;

3. Comparative studies of institutional performance between those organisations with, and without, a named allied health leader on the TMT.

4. Mapping career path trajectories of current Executive/Director of Allied Health appointees;

5. Mapping career path trajectories of current allied health qualified Operations Manager appointees;

6. Mapping career path trajectories of current allied health qualified Chief Executive Officers;

7. Identification of the background of all members of TMTs to ascertain the true level of health profession qualified personnel on TMTs and in CEO roles;

8. Analysis of the allied health gender split at TMT and Board level;

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[44] The value of allied health in senior executive roles at the TMT level was explored in these publications from 20 and 10 years ago. A future study could compare views with those in the 1996 PhD data files.

9. Compiling and testing probable allied health-sensitive organisational outcomes and allied health-sensitive patient care outcomes similar to the nursing MAGNET program to demonstrate the relationship between allied health leadership and system performance and quality and safety of patient care;

10. Investment in leadership capacity building 'springboard accelerator' strategies and subsequent evaluation of the investment : outcome result, and

11. Collection of data as per the current study on an annual or bi-annual basis to allow longitudinal analysis.

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9. Appendix 1. Additional Board Data

Of the total Board members in Australia (N=1145):

- 5.5% have an allied health qualification;
- 7.2% have a nursing/midwifery qualification, and
- 13.6% have a medical qualification.

If Vic (Minor)'s 485 Board members are removed from the national data set (N=660) the proportion of health qualifications rises to:

- 5.7% for allied health;
- 9.6% for nursing/midwifery, and
- 22% for medicine.

Reanalysing the national data in terms of the total Australian Board members for whom qualifications are known (N=1015) the results are:

- 6.3% for allied health;
- 8.1% for nursing/midwifery, and
- 15.4% for medicine.

For Victoria (Major + Minor) (N=596 from 67 Boards)[45] with known health qualifications:

- 5.7% were allied health;
- 5.0% were nursing/midwifery, and
- 5.7% were from medicine.

Within Victoria, the two cohorts Vic (Major) and Vic (Minor) are similar for nursing/midwifery but strikingly different for medicine.

Vic (Major)'s Board members with known health qualifications (N=198):

- 4.0% were allied health;
- 5.5% nursing/midwifery, and
- 23.5% and medicine

Vic (Minor) Board members with known health qualifications (N=371):

- 7.0% were allied health;
- 5.1% were nursing/midwifery, and
- 3% were medicine

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[45] Of the 683 total Victorian Board members, the qualifications of 114 from 13 Boards (all Vic(Minor)) were not known, leaving 596 with known qualifications from 67 Boards (24 in Vic (Major) and 43 in Vic (Minor)).

10. Appendix 2. Consensus Statement - Governance: NSW Allied Health Directors[46]

CONSENSUS STATEMENT: PRINCIPLES UNDERPINNING ALLIED HEALTH GOVERNANCE IN LOCAL HEALTH DISTRICTS / SPECIALTY NETWORKS (July 2013)[77]

The focus of this paper is on Local Health Districts and Specialty Networks with the principles outlined in this document applicable to all services and sectors, including primary care, paediatric and aged care services. Integration of allied health governance and clinical service delivery across the multiple proposed sectors should be considered, particularly in regional, rural and remote locations.

Introduction

The NSW Allied Health Directors have endorsed the following set of principles underpinning allied health governance. It is believed that organisational models for allied health can be developed from these principles within Local Hospital Districts (LHDs) and Specialty Networks (SN) as well as across clinical service networks as required. These will be complementary to local service delivery and community need.

The primary goal of a well-conceived organisational structure is to maximise the quality and safety of health care delivery by strengthening clinical governance and risk management, capturing resource efficiencies, and enhancing the professional development of employees (Boyce 2001).

The NSW Ministry of Health (MOH) (2011a, 2011b) has highlighted devolved and localised decision making involving local clinicians as a key driver of improved patient care across the NSW health system. In releasing its revised governance framework, the MOH specified LHD/SNs as owners of services and called for increased clinician leadership, engagement and support (MOH 2011b). Clinician-driven change was also a key recommendation outlined in the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (Garling 2008; Skinner et al 2009).

Organisational structures which enable professional autonomy and a strong sense of identity can lead to greater innovation, better teamwork, enhanced flexibility and greater efficiency and effectiveness (Braithwaite et al 2005; Nugus et al 2010; Rodwell et al 2009; Rowe & Boyce 2009). This, in turn, leads to better patient care.

These principles have been developed in accordance with this goal.

NSW Health Allied Health Professions:

Allied health care professionals have a range of education, specific skills and competencies (Mueller & Neads, 2005). Twenty-three allied health disciplines are identified as allied health in NSW,

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[46] This consensus document was developed by Directors of Allied Health as guidance for developing services and governance structures; it is not an endorsed NSW Health document.

including the professions of audiology, art therapy, counsellor, dietetics, diversional therapy, exercise physiology, genetics counselling, medical radiation science (includes radiography, radiation therapy, nuclear medical technology), music therapy, occupational therapy, orthoptics, orthotics / prosthetics, physiotherapy, psychology, pharmacy, child life therapy, speech pathology, social work, sexual assault work and welfare work (MOH 2012).

For reporting purposes, reference to allied health professions relates to these categories of employees. Additionally, working in collaboratively with Allied Health Professionals are a range of assistant workers with an increasing focus on Certificate qualified assistant workers such as pharmacy technicians, physiotherapy assistants and dietetic assistants to name a few.

It is commonly accepted that the core allied health professions are nutrition and dietetics, occupational therapy, orthotics, physiotherapy, podiatry, psychology, pharmacy, speech pathology and social work. In addition, the professions of audiology, orthoptics, diversional therapy, and play and life therapy are commonly considered to be part of allied health, however it is acknowledged that these profession services are not widespread. With the context of LHD/SNs consideration should be given in relation to whether radiography and other imaging services are professionally aligned with Allied Health or operationally organised as a separate unit.

Since the Health reform process was undertaken in 2011, there is now a Director of Allied Health position at Tier Two in reporting to the Chief Executive in most LHDs/SN.

Organisation and Governance

Governance refers to the facilitation of systematic and integrated approaches to ensuring standards of clinical responsibility and accountability in order to improve safety and quality, thereby optimising patient care (Braithwaite & Travaglia 2008).

Organisation of allied health professions into clinical streams for operational purposes may vary. The final decision as to which professions to include under the banner of allied health rests with each LHD/SN. Allied Health governance functions apply to both operational and professional structures.

Governance frameworks must include the assistant workforce, and consideration of the nongraduate workforce (such as non-graduate welfare, non- graduate counsellors) is required. In some circumstances, any health professional who provides a direct health intervention to a client and who is not a doctor or a nurse is considered to be an allied health professional.

PRINCIPLES

Principle One: Executive Allied Health Director position

The role of Executive Allied Health Director is a professional advisory role for the LHD/ SN. The Ministry of Health has recommended LHD/ SNs to place this role at the Tier 2 level as the expectation of the role is to provide a direct reporting relationship to the CE.

The position would include, but not be limited to, the following functions:

- To provide expert advice to the Chief Executive, other district/ speciality network executives and managers on strategic Allied Health issues;

- To provide input from an Allied Health perspective into issues of planning, and quality and safety programs within the LHD/ SN;
- To function as the principal reference point for advice on policy development within the LHD/ SN relevant to the Allied Health workforce;
- To participate as a member of the Executive team in leadership of the LHD/ SN;
- Conduct regular forums (or similar consultation processes) with all allied health clinicians to ensure that allied health clinicians are kept aware of all health systems and clinical practice improvements and enhancements and to enable clinicians to provide timely feedback to the LHD/ SN Chief Executive on such matters.

Principle Two: Allied Health Streams/Division/Networks

Allied health governance is at its strongest and most effective when allied health operates as an integrated group. This grouping can take various forms including an allied health stream, division or network. The Executive Director Allied Health position should be responsible for leadership of this group. By having allied health grouped together, significant gains can be made in areas such as:

- allied health strategic and service delivery planning, which is most effective when acute, subacute, post acute and primary health care are addressed as a whole;
- workforce planning, by ensuring that workforce is distributed in an equitable manner according to client, service and organisational needs;
- workforce development, including current and projected workforce needs and workforce profiles.
- contingency planning to enhance the continuity of service delivery in periods of unscheduled absence or protracted vacancy while recruitment processes are undertaken;
- supervision, by ensuring that all allied health clinicians have a supervisor who can support them in their client service delivery and their ongoing professional development;
- overseeing quality and safety, through the implementation of a quality framework that includes clinical indicator collection and benchmarking, the development of evidence based protocols and guidelines, routine audits and, where indicated, a system for root cause analyses;
- credentialing and competency assessment, by ensuring that a methodology is in place to monitor that allied health clinicians have an acceptable and safe level of clinical expertise.

At the LHD/SN level this can be best achieved through the development of allied health clinical streams or networks, where they do not currently exist.

Principle Three: Allied Health Leadership and Governance Positions

Allied health governance can only be achieved when leadership positions for allied health are present at all key operational levels. These levels can include:

- Cross profession 'integrating' positions to ensure clarity of strategic direction, coordinated planning, effective governance for allied health services, and cross profession collaboration at the relevant level of the LHD/SN. These positions include: - leadership and strategic responsibility for all allied health services across a LHD/SN through an executive (Tier 2) Allied Health Director position; - allied health manager

positions providing allied health leadership across an entire cluster; - allied health manager positions providing allied health leadership within larger facilities.

- Positions across the LHD/SN providing professional leadership and governance for each profession, such as a Social Work Director for District X. These positions are responsible for the clinical governance of the respective profession across the LHD/SN, the establishment and monitoring of specific discipline professional standards, patient safety issues with a professional aspect and the development and monitoring of key clinical performance indicators.
- Senior allied health clinical positions providing professional leadership and clinical governance for each allied health profession within each clinical stream, cluster, and facility. For example, there could be positions which manage senior occupational therapists in aged care, in mental health, in community health, in hospital X and in cluster X. The specific positions would be allocated in a way to compliment the area clinical structure.

To be effective, these leadership functions require:

- an appropriate resource base to allow the incumbent to perform the duties assigned to the role
- a clearly defined job description that articulates the role, responsibilities, accountabilities and expectations of the positions
- clear and efficient reporting lines for all staff categories
- a capacity for flexibility to respond in a complimentary way to the dynamic nature of organisational and clinical service delivery changes over time

Principle Four: Equity and Access to Allied Health Services

As a general principle, health consumers should have equal access to allied health services no matter where they live within a LHD or SN.

In addition, consumers should be given consistency in service standards. This is best achieved through the implementation of standard evidence based clinical protocols and guidelines, coupled with a competency assessment framework. Allied health leaders are best placed to ensure such clinical governance is managed effectively and uniformly.

Principle Five: Allied Health Resource Management

In order to maximise the ability to manage workforce distribution across a LHD/SN, the budget for allied health services is best located within the Allied Health grouping, within the applicable service structures. This enhances corporate and clinical governance, efficiencies for economy of scale, and enables appropriate evidence based resource distribution. Inequities in workforce distribution caused through such things as population change, staff leave, and the introduction of new models of practice can best be managed when an organisational approach is taken to resource management.

Principle Six: Allied Health Representation

Allied health forms one of the three main clinical workforces, along with nursing and medicine. In a 2012 NSW Ministry of Health snapshot, the three main categories of clinical workforce was listed

allied health professionals, medical, and nursing / midwifery positions. Allied Health Professionals are recognised as a core workforce within the mainstream of hospital and health service provision. As such it is imperative that allied health representation exists on key clinical and operational committees. These include:

- on the LHD/SN executive;
- on LHD/SN advisory councils;
- on Medicare Local executives;
- on relevant clinical stream services executives, such as aged care, child and adolescent and
- on regional management groups, and
- local lead clinician groups on all relevant clinical committees or working parties.

The establishment of an allied health structure within LHD/SNs should consider the interface of allied health clinical services across clinical streams and LHD/SN executive structures, the need for allied health representation on key committees / forums in the planning of clinical services and the importance of developing a culture of collaboration within and across LHD/SNs.

Principle Seven: Workforce Development

Discipline specific clinical support, education and supervision are essential to the maintenance of a skilled allied health workforce. Allied health services need to be arranged to ensure adequate and ongoing clinical supervision and support for all allied health practitioners employed by a LHD/SN. This will ensure lines of professional accountability and facilitate strong systems of safety and clinical governance.

In order to enhance the recruitment and retention of allied health employees, it is imperative that appropriate clinical support and training are offered. This includes access to professional support and supervision as well as continuing professional development opportunities. The budget for such endeavours should be prioritised as a key to strengthening workforce development. Such opportunities include:

- clinical education provided in-house;
- externally provided clinical education for the development of specialist skills;
- conference leave and funding;
- partnerships or links with universities for clinical placements, ongoing staff education and research, and
- support for internal research.

Leadership across allied health professions is critical to the implementation of workforce redesign and in ensuring responsiveness to clinical service innovation. In order to ensure that allied health maintains the ability to reconfigure workforce profiles, maximise utilisation of clinical specialists and educators and ensure establishment of new roles meet patient and service needs, delegated authority to review workforce and services in collaboration with other managers is a necessity.

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