Strategies for allied health leadership development : enhancing quality, safety and productivity

Final Report

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EXECUTIVE SUMMARY

Overview

Delivering on quality, safety and productivity is fundamental for public health services. Organisational and systems improvements and outcomes rely on effective leadership. This report is the result of work commissioned by Victoria's Chief Allied Health Officer Department of Health and Human Services (DHHS) in 2015 to identify evidence informed models of leadership development) for allied health professionals (AHP). Featured in the report are strategies to strengthen AHP leadership-readiness in the Victorian public health context.

Methods

Data collection was completed in two parts: 1) A rapid review of relevant literature was conducted on approaches, practices, programs, structures and processes supporting Allied Health leadership development within the health sector, along with a review of the grey literature; and 2) Feedback was sought on the findings from Victorian Allied Health Directors and Managers.

Key results

From the literature review transformational leadership (Bass & Riggio, 2006) emerged as the most effective model for AHP LD (Leggat & Balding, 2013; McKee *et al*., 2011; Wylie & Gallagher, 2009; Gellis, 2001).

Collaborative/ Shared/ Distributive leadership models (Leggat & Balding, 2013 and Lingard *et al*., 2012) were highlighted, along with evidence published by the National Health Service (NHS) on the importance of collective leadership (West *el al*, 2015).

All of the articles included in the review referenced the importance of organisational support and collaborative work environments. Lingard, Fleming Carroll, Rashotte and Tallett (2012) found that collaborative approaches to leadership may be challenging for multidisciplinary teams embedded in traditional health care systems that reinforce the idea that "physicians sit at the top" of the hierarchy (p. 1762).

Findings clarified that Allied Health leadership development requires support at three strategic levels - system, organisational and individual. Four target groups for AHP leadership development emerged, reflecting different career stages. They were: undergraduate and early career professionals; emerging Allied Health leaders (senior clinician level); growing Allied Health leaders (new discipline managers moving from operational to strategic roles), and established leaders.

Leadership training early in professional careers was identified as important (Wylie and Gallagher, 2009; Long et al., 2011). Growing leaders (moving from operational to strategic) were seen to be the highest priority for formal Allied Health leadership development by key stakeholders in this review.

Across the four AHP career levels highlighted for leadership development, based on comparative qualitative analysis, consistent themes emerged regarding required competencies and key leadership development strategies. These included strengthening understanding of policy and regulatory influences, mentoring (Eckert *et al.,* 2014; Bamberg and Layman, 2004), formal training and experiential/action learning, with a collaborative focus. The report outlines various leadership development approaches according to AHP career level.

The literature on individual level strategies for leadership development is outlined. However system level strategies and organisational reform will be required to move an Allied Health leadership development agenda forward. Hence organisational and hierarchical barriers will need to be addressed to meet the challenges of implementing effective, collaborative leadership approaches.

Based on the findings of this study, the report makes a number of recommendations to progress Allied Health leadership development in the Victorian public health context.

Recommendations

Recommendation 1: Adopt a strategic and transformational approach to building collaborative, multidisciplinary and inclusive leadership development opportunities for AHP.

Collaboration is encouraged between DHHS, academic institutions, professional bodies and the Victorian Allied Health Leaders Council (VAHLC) and medical, nursing and Allied Health clinicians and leaders to progress future plans for Allied Health leadership development. Governance arrangements should be set in place to drive implementation.

Recommendation 2: Expand AHP representation in existing leadership and clinical improvement initiatives within organisations and monitor progress and outcomes.

Recommendation 3: Promote organisational and structural reform to strengthen Allied Health leadership development and deliver equity of opportunity.

Recommendation 4: Expand access to tailored and varied leadership development opportunities for AHP, drawing on strategies outlined in the report.

Recommendation 5: Consider resourcing implications of the proposed strategies.

Recommendation 6: Identify future research directions.

Conclusion

Clinical engagement is essential in driving quality, safety and productivity in health care. AHPs contribute significantly to the health care sector. In future, leadership development opportunities for AHP need to be addressed across the identified levels of practice. The vision for clinician engagement in health care reform, which underpins the AHP leadership development strategy outlined in this report, must emphasise collaborative approaches – across Allied Health disciplines and working closely with medicine and nursing – and conceptualise a model of distributive leadership (Leggat & Balding, 2013, p.312). This vision will need to be driven and implementation strategies trialled and evaluated.

INTRODUCTION

Clinical leadership is at the forefront of healthcare reforms globally. It is therefore imperative that effective, evidence informed models of leadership development are considered for all health professions including Allied Health , as a matter of strategic priority.

In June 2015 Victoria's Chief Allied Health Officer DHHS, developed an innovative project to ensure that AH contributes to leadership readiness in an industry right direction.

This initiative was remarkably timely given the Travis Review (2015) which highlighted that new approaches are needed in Victoria to optimise health system performance. The final report identified the need for a more systematic approach to using innovation to achieve increased health service capacity and improve patient outcomes. System-wide innovation requires clinical engagement:

"The term 'clinical' has been chosen carefully to be inclusive of all health professionals….innovation usually involves the whole health care team…….it is important that clinical engagement involves all who must change – doctors, nurses, allied health practitioners, ancillary services personnel and administrators" (p. 71).

In light of current and future health care challenges and reliance on clinical engagement to drive reform and innovation, effective leadership development strategies are required to ensure that Allied Health as a key part of the clinical workforce, is leadership-ready.

The purpose of this report is to outline the findings of the study undertaken, identify possible strategies for Allied Health leadership development and to make recommendations for consideration by the Chief Allied Health Officer.

BACKGROUND

AHPs play a key role in the delivery of high quality health care throughout the health, community and private sector within an Australian and international context. Together with doctors and nurses, AHPs are widely regarded as one of the three pillars of the health workforce both domestically and internationally (AHPA, 2015).

According to Allied Health Professions Australia (AHPA), there are approximately 120,000 Allied Health professionals delivering in excess of 200 million health services annually (AHPA, 2015). They comprise approximately 26 per cent of the Australian healthcare workforce. Despite their numerical significance, the contribution and value of these professions to improved health outcomes remains poorly represented in health policy, leadership and organisational reform contexts (Philip, 2015).

AHPs are autonomous practitioners who work collaboratively as part of effective teams alongside doctors, nurses and midwives to provide quality person-centered care. Allied Health contributes strongly to an integrated approach to health care across the continuum of care. Operating across a broad range of disciplines, from physiotherapists and pharmacists to radiographers, dieticians and medical scientists, AHPs are qualified to support and enable diagnosis of health conditions for people of all ages and deliver direct patient care, rehabilitation, treatment, diagnostics and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive and social functions and wellbeing. AHPs contribute to the health system through:

- the oversight and delivery of interventions to promote safety and quality in clinical care linked to organisational and financial performance and outcomes
- improving the quality of the health service, patient experience and improvements that benefit service users
- patient care across the continuum, linking hospital and community services
- responding to the complex needs through integrated inter-disciplinary pathways
- education and research

The importance of high-level leadership positions in health services through visible Allied Health governance structures are a trend that has become embedded in health services since the 1990s in Australia (Boyce 2001). High performing Allied Health leadership has been identified in planning and policy forums as crucial to service innovation and the quality of decision-making:

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, 2013, p 23-24).

Similarly, Wylie & Gallagher (2009) in their study of transformational leadership behaviours in the AHP have argued that the challenge to reform traditional models of care depends upon an allied health "leadership revolution" to achieve "effective clinical leadership at all levels" of the health system (pp: 65-6).

AIM

To identify Allied Health leadership development strategies for possible implementation within the Victorian public health context.

OBJECTIVES

1. To conduct a rapid evidence review of relevant literature on models, practices, programs, structures and processes supporting Allied Health leadership within the health sector
2. To seek high level Allied Health stakeholder feedback on the findings

3. To critically analyse key themes and findings to identify:
   - opportunities for Allied Health leadership development ;
   - strategies likely to result in organisational and systems improvement outcomes, if so adopted, adapted and/or implemented
4. To make recommendations regarding possible future directions for Allied Health leadership development.

METHODOLOGY

Two phases were adopted for the project:

Part 1: A rapid systematic review of the peer reviewed and grey literature was utilised with an exhaustive search of relevant databases and other online and organisational resources.

Part 2: Focus groups were held with leaders in the Allied Health field across Victoria. The verbatim recordings of the group discussions were subject to comparative qualitative analysis.

Part 1: Literature Review

Search Strategy and Eligibility

A standard systematic review approach was utilised however the methodology was modified to accommodate a rapid response. Eligible studies were located by systematically searching the electronic databases PsycINFO, CINAHL, Medline, SocIndex and Web of Science using the key search terms derived from 'allied health' and leadership. Relevant grey literature, government reports and policy documents were also located using a web-based search focused on literature specific to allied health leadership in context to the health sector (National Health Services [NHS], The King's Fund, Department of Health, The Victorian Quality Council and Health Workforce Australia).

Inclusion/Exclusion Criteria

Given the desired focus on recent, evidence-based literature, only peer-reviewed articles and grey literature from the past fifteen years (2000-2015) were included. Initial database searches highlighted the scarcity of research specific to an Australian context. International literature from contexts similar to Australia (USA, Canada, and the UK) was therefore included.

Moreover, whilst this paper focused on leadership development for AHP within the health sector, peer-reviewed articles discussing Allied Health leadership development within the educational sector (i.e. leadership models utilised by Deans of Allied Health Programs) were also included. Figure 1 provides an overview of the inclusion and exclusion criteria used the search strategy.

Figure 1. Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Papers focusing on AHP	Papers specific to professions other than AHP
Papers discussing leadership models/ development/ strategies/ programs or processes	Papers not specific to the health sector
Papers in English language	Papers published before 2000

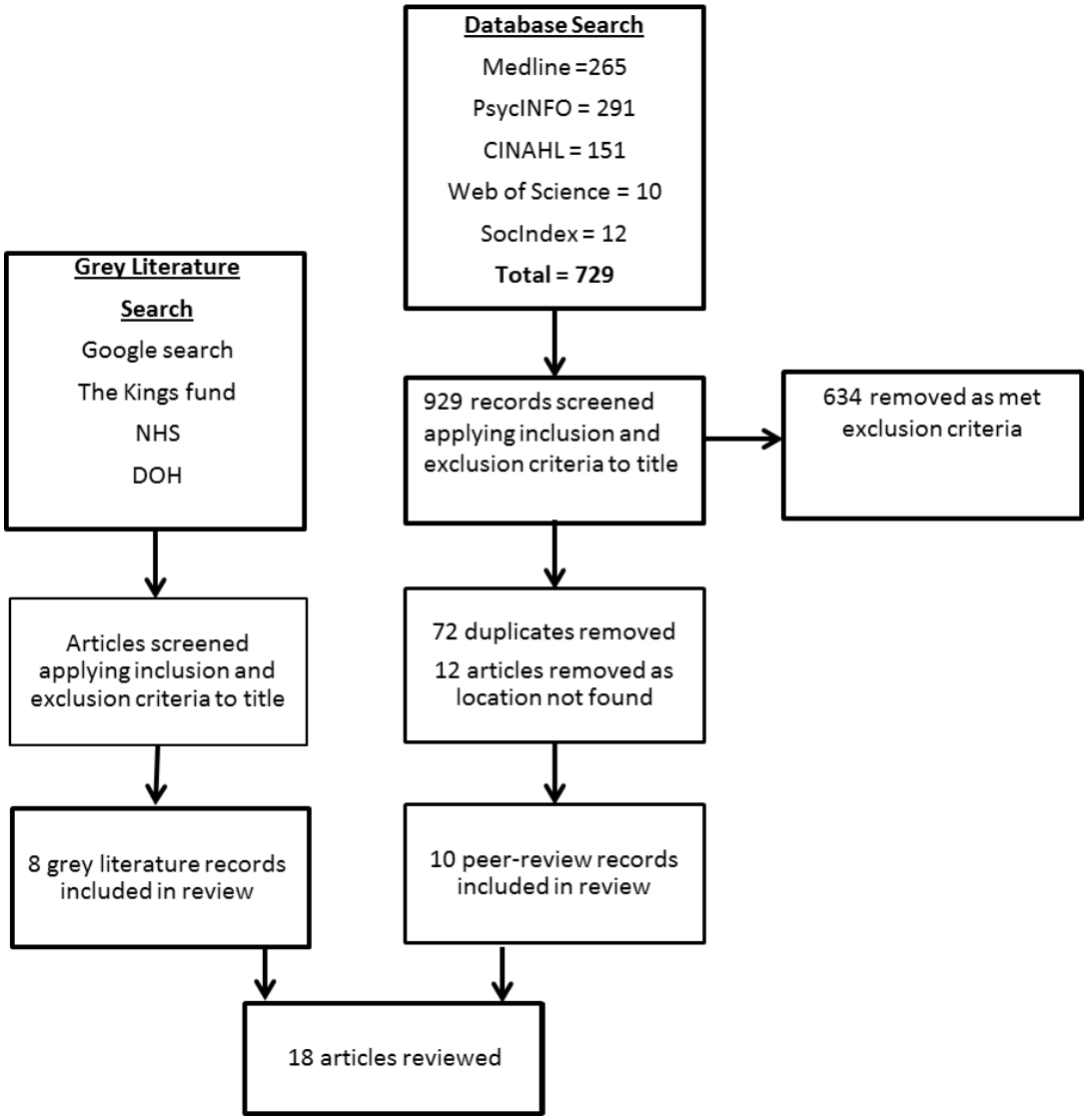
Analysis

The rapid review considered the evidence and information derived from the peer-reviewed articles in detail. Data was extracted into tables. To integrate the differing types of literature included in this review (peer-reviewed and grey literature) thematic analysis was utilised.

RESULTS

Figure 2: Article Extraction, represents the article extraction process, following the application of the inclusion and exclusion criteria, the removal of duplicates and the removal of articles that could not be located. Data from 18 reviewed articles was charted into Table 1. Data Summary Table (See Appendix A), outlining the type of study and method, year, authors, country, source of publication, aims/purpose of study, leadership approach/model utilised in study and main findings

Figure 2. Article Extraction



Study Characteristics

The charting process highlighted that peer-reviewed research specific to Allied Health leadership within the health sector has predominately been conducted in the USA (n=4), followed by the UK (n=3), Canada (n=2) and Australia (n=1). Seven of the ten articles focused on multiple AH professions or health clinicians broadly whilst two focused specifically on the social work profession (Gellis, 2001) and one on occupational therapy (Fleming-Castaldy & Patro, 2012).

Most of studies included in this review were found to have a relatively small sample size ranging across studies from 10 participants (Cullen, 2013) to 753 participants (Wylie & Gallagher, 2009). The three studies with the largest sample size (753, 187 and 178 participants respectively) all focused on transformational leadership models. The methodological strength (of having a larger sample group) and strength of evidence of these studies was therefore found to exceed the other studies included in this review.

Types of Leadership Models

Various paradigms have been developed throughout the international literature in relation to effective leadership models within the health sector. The peer-reviewed articles included in this review focused predominately on six different models. Four articles focused on transformational leadership, two on shared/ distributive/ collaborative leadership, whilst the others discussed the Leadership Challenge Model, Social Change Model, the Bolman and Deal frames or the Servant and Partner Leadership model.

Whilst the peer-reviewed literature focused on the above models, other frameworks were also referenced, including Servant and Partner Leadership (Cullen, 2013), Authentic Leadership (Walumba et al. 2008), Ethical Leadership (Brown et al. 2005), Empowering Leadership (Arnold et al, 2000), Congruent Leadership (Stanley, 2008) and Transactional Leadership (Bass, 1990) (Wylie, 2011).

The behaviours and characteristics of each of the identified models are outlined in detail in Table 1. Data Summary Table (See Appendix A). A brief summary of the four main models follows in Table 2.

Table 2. Evidence Informed Leadership Models Identified

Dates and authors	Model	Key Elements
Leggat, S., & Balding, C. (2013) **McKee, M., Driscoll, C., Kelloway, K., & Kelley, E. (2011)** **Wylie, D., & Gallagher, H. (2009)** **Gellis, Z. (2001)**	**Transformational Leadership (Bass, 1990)**	The key characteristics of transformational leadership are: Idealised Influence (attribute/perceived charisma and behavioural charisma); Inspirational Motivation; Intellectual Stimulation; and Individualised Consideration.
Leggat, S., & Balding, C. (2013) **Lingard, L., et al (2012)**	**Shared/ Distributive/ Collective Leadership**	Leadership as the property of a group or network of interacting individuals; expertise distributed across many; boundaries of leadership shifts among members
Fleming-Castaldy, R., & Patro, J. (2012)	**Leadership Challenge Model (Kouzes & Posner, 2002)**	The key characteristics are: Willingness to challenge the system and the process; Inspiring a shared vision and organisational direction through consistent dialogue; Enabling others to act/empowerment; creating a sense of teamwork; Modelling the way;

		Encouraging the heart/faith in followers' abilities
Sasnett, B., & Clay, M. (2008)	**Bolman and Deal (Bolman & Deal, 1991)**	Emphasis is on Structural frame (policies, data analysis, the bottom line, accountability for results); Human resource frame (relationships, facilitation, empowerment); Political frame (coalition building, persuasion, negotiation networking); Symbolic frame (culture, values, beliefs, team spirit); Multiple frames used.

Grey literature

The grey literature search revealed a scant amount of literature pertaining specifically to the AHP. Whilst there is a substantial body of evidence in the international scholarship pertaining to clinical leadership or leadership within the health sector broadly, many of the articles did not specify if they were referring to Allied Health, nursing or medical professionals. Articles specific to leadership development within the health sector and were included.

Key Findings and Outcomes

The following subsections include key findings from both the peer-reviewed and grey literature.

Organisational Factors

All of the articles included in this review referenced the importance of organisational support and collaborative work environments. Lingard, Fleming Carroll, Rashotte and Tallett (2012) found that collaborative approaches to leadership may be challenging for multidisciplinary teams embedded in traditional health care systems that reinforce the idea that "physicians sit at the top" of the hierarchy (p. 1762).

Similarly, hierarchical and interdisciplinary team constraints were also identified by Leggat and Balding (2013) as participants in their study of 28 clinical managers indicating that the cultures of the individual disciplines presented a barrier to clinical leadership in their organisation. Participants from this study suggested that without organisational expectations about how health professionals should work in teams, clinical leaders would continue to face barriers to improvements in efforts (Leggat & Balding, 2013, p.318).

Issues relating to role clarity, accountability, security and sustainability were also addressed as key organisational factors impacting clinical leadership (Leggat & Balding, 2013). Clinical leadership was not perceived by these participants to be about developing leadership skills in individuals, but about ensuring "health care organisations were equipped to conceptualise a model of distributive leadership." (Leggat & Balding, 2013, p.312). The

findings from research suggest that without an appropriately structured and supportive organisation, clinical leadership will not be achieved.

Individual Factors

Individual factors and personal traits associated with effective leadership were frequently discussed throughout both the peer-reviewed and grey literature. The Healthcare Leadership Model (2013) developed by the National Health Service (NHS) Leadership Academy outlines nine dimensions of leadership behaviour specific to individuals. These dimensions include:

1. Inspiring shared purpose (valuing a service ethos, curious about how to improve services and patient care and behaving in a way that reflects the values of the NHS)
2. Leading with care (having the essential personal qualities for leaders in health and social care, understanding the unique qualities and needs of a team and providing a caring, safe environment to enable everyone to do their jobs effectively)
3. Evaluating information (seeking out varied information, using information to generate new ideas and making evidence based decisions)
4. Connecting our service (understanding how health and social care services fit together)
5. Sharing the vision (communicating a compelling and credible vision of the future)
6. Engaging the team (involving individuals and demonstrating that their contributions and ideas are valued)
7. Holding to account (agreeing clear performance goals and quality indicators and providing balanced feedback)
8. Developing capability (building capability to enable people to meet future challenges and acting as a role model for personal development)
9. Influencing for results (deciding how to have a positive impact on other people, building relationships that recognise other's passions and collaboration) (adapted from NHS, 2013).

Similarly, the Health LEADS Australia Framework (2013) outlines five core characteristics effective leaders should possess, including:

1. Leads oneself (self-aware, seeks opportunities for personal development and has strength of character)
2. Engages others (values diversity and models of cultural responsiveness, communicates with honesty and respect, strengthens consumers, colleagues and others)
3. Achieves outcomes (influences and communicates the direction, is focused and goal orientated, evaluates progress and is responsible for results).
4. Drives innovation (champions the need for innovation and improvement, builds support for change and positively contributes to spreading innovative practice)
5. Shapes systems (understands and applies systems thinking, engages and partners with consumers and communities and builds alliances) (HWA, 2013, p. 7-9)

In addition to the hierarchical and positional leadership skills discussed in both the Health LEADS Australia Framework (HWA, 2013) and the Healthcare Leadership Model (NHS, 2013),

Wylie (2011) contends that there are numerous core personal leadership behaviours that can be practised by all AHPs regardless of their organisational rank or job description. This is also reflected in Fleming-Castaldy and Patro's (2012) study of occupational therapists, which found that the participants possessed distinct qualities that contributed to their success as leaders. This finding is similar to Stewart's (2007) observation that there are certain characteristic traits that occupational therapy practitioners hold which best suit them for leadership positions. (Fleming-Castaldy & Patro, 2012, p.195).

Similarly, Leggat and Balding's (2013) study found that clinical managers identified that emotional intelligence; resilience, self-awareness and understanding of other clinical disciplines were seen as the essential factors for clinical leaders (p. 319).

In contrast, West *et al* (2015) contends that only a few studies have rigorously tested the assumption that personality traits and competencies have a causal impact on leader effectiveness. The authors claim that for at least some personality traits and competencies, it is not clear which comes first, being in a leadership position or possessing the trait or competency in question (West *et al,* 2015).

System levers for leadership development

The importance of leadership development was consistently referenced throughout the literature. Various articles made reference to experiential experience being regarded as more valuable than formal professional development sessions. Bamberg & Layman's (2004) study found that most respondents (60%) indicated that they thought the professional experience they received from their positions held more benefit in their leadership development than the formal programs, workshops, and activities they had completed (p. 119).

In contrast, Wylie and Gallagher's (2009) study of transformational leadership skills across different AHP found that professionals who had received leadership training reported significantly higher aggregated transformational leadership scores than those without. According to Wylie and Gallagher (2009), "these findings support previous research (Kouzes & Posner, 1988) that demonstrated transformational leadership and self-awareness are more evident in those who had participated in a leadership development program." (p. 71).

Mentorship, organisational support and external stakeholder support were also identified as an effective means of LD. More than half of the respondents from Bamberg and Layman's study (2004) indicated that they had been mentored on their way to becoming a dean or director of allied health. Eckert, West, Altman, Steward and Pasmore (2014) also identify coaching, mentoring and feedback as core aspects that should be used in the delivery of a leadership development strategy within the healthcare sector. In regards to external stakeholder support, national agencies, professional associations and academic institutions play an important role in supporting allied health leadership development (Garrubba, Harris & Melder, 2011).

Likewise, the Victorian Quality Council (2005) publication, *Developing the clinical leadership role in clinical governance,* contends that organisational support is crucial to leadership development. According to the authors, "health care organisations should assist clinicians

who wish to take on a leadership role to identify their strengths and interests and build on these to develop an appropriate leadership role. This approach spreads the leadership load and encourages a team approach to safety and quality improvement, with different leaders contributing in their specific expertise." (VQC, 2005, p. 5).

Another area of leadership development that was a significant finding throughout the literature was early intervention of leadership training in graduates and junior staff. According to Wylie and Gallagher (2009), if AHP clinical leadership at all levels is to become a reality, high numbers of new AHP graduates need to be targeted with leadership development programs early in their professional careers, before professional normalisation renders them resistant to change (p. 72). Wylie and Gallagher contend that the "elements within transformational leadership must therefore be made clear to junior staff or students at an early stage in their career both in terms of didactic experience and experiential learning." (p. 72).

Similarly, Long *et al* (2011) found that the quality of supervision, the on-the-job professional socialisation, the relevance and breadth of knowledge and skills required, as well as the workload, are all important factors which influence the ability of junior staff and trainees to develop as leaders in the future (p.116).

Part 2: Exploratory Study

This study also drew on the expertise of the field. All Allied Health Directors and Managers and leaders from across Victoria were invited per email by the Chief Allied Health Advisor to attend a workshop in December 2015 to review and comment on the results of the literature and grey literature reviews.

Methods

Using focus group methods n = 14 participants joined members of the two literature review project working groups from the University of Melbourne, Monash University, St Vincent's Hospital Melbourne (SVHM), Monash Health and private industry. Comparative qualitative analysis was undertaken of the literature reviews, the grey literature findings and the workshop feedback. The strength of themes was identified and the project working groups collaborated on the strategies and recommendations outlined in the Recommendations.

Focus Group Questions

Informed by the analysis of the literature reviews, feedback was canvassed on three questions.

1. How do we develop leaders in Allied Health?
2. What are the system levers necessary to ensure the sustainability of Allied Health leadership development
3. What type of Allied Health leaders do we need?

Focus Group Responses

It is important to note that workshop participants were resoundingly positive about the influence of Allied Health leaders, highlighting a number of successful outcomes from leadership at a local and state level. The uptake of advance practice roles in elective surgery has resulted in cost savings for organisations and a reduction in waiting lists. In emergency departments and diagnostic services advanced practice roles have ensured that patients are promptly triaged, treated and provided with the best care. Feedback was given about Allied Health's ability to provide perspectives on patient needs across the continuum of care and to provide innovative solutions that transcend hospital walls. A summary of responses to the focus group questions follows.

1. How do we develop Allied Health leaders?

Workshop participants described a number of key influences on their own leadership development and a variety of evidence based approaches to building talent in their teams. Whilst participants' leadership journeys differed, the important role of a mentor or coach came through strongly. Mentors were responsible for identifying talent in aspiring leaders and supporting their development. All workshop participants identified that they had a mentor and many reported a strong obligation to provide mentoring in their organisations.

In addition to mentoring, a number of practical leadership development methods emerged. These experiences were designed to build a repertoire of skills and abilities and were relatively cost neutral. They included additional responsibilities to build practical experience ranging from job rotations, deputising, project management roles, to chairing working groups and committees.

Feedback included importance of formal training approaches alongside practical opportunities. Formal learning provides basic foundational knowledge and skills required by leaders in core areas such as financial skills, human resource management and communication featuring in most course content. It appeared that many health services run some form of formal leadership training in-house. Tertiary education institutions and the many post graduate leadership training programmes were also highly valued. Many of the directors and managers of Allied Health had either obtained a post-graduate business qualification or were pursuing business training. No one qualification was reported to be superior, yet it was unanimous that knowledge of the financial and funding context was essential for leaders at any level in health. Ultimately a mix of formal and informal training was proposed as the best approach to developing leaders and there was commitment to supporting the recommendations of the project working group.

2. What are the system levers necessary to ensure the sustainability of Allied Health leadership development?

It was acknowledged that considerable effort is needed to set up leadership initiatives and to maintain the effort in health settings when compared to business environments. System

levers were defined as factors within the health system that can influence the set up and sustainability of leadership training. Collated themes from the workshop identified four categories of levers: government, universities, organisational human resource departments and professional bodies.

Mirroring findings in the grey literature, some participants affirmed that AHP leadership development should begin at an undergraduate level and also targeted to the early years of professional practice. Given that leadership is a curriculum subject for medical students at an undergraduate level, similarly it was felt that this could be considered for others including AHP.

Participants provided feedback that workforce leadership development is often contingent on the interest and support of supervisors and senior executives. Had neither of these supports been in place, many of those present said that their leadership journeys would have been very different and decidedly more complicated.

Participants emphasised the importance of internal and external mechanisms for leadership development. Leadership or workforce development features highly on health services' strategic plans and there are also a number of leadership programs auspiced by the DHHS. Equity of access for AHP was viewed as desirable.

The importance of measuring attainment in relation to leadership skills was highlighted. It was suggested that position descriptions should quantify leadership expectations of staff at different levels. Regular performance reviews should include a review on leadership, reinforcing the role of leadership in clinical care, teamwork and in other areas.

The contribution of regulatory and professional bodies to changing perspectives regarding AHP leadership development was raised. Several participants felt that professional bodies need to collaborate to develop the AHP leadership agenda and review opportunities and role statements for to expand opportunities for an AHP contribution.

3. What type of allied health leaders do we need?

Responses included that Allied Health leaders needed to be individuals with a mix of expert technical/clinical skills as well as key behavioural traits. They need a solid understanding of the influences on health care from all levels – organisational, community and professional - as well as understanding health policy and regulatory influences. The importance of transcending professional groups and taking a broad view of health was noted. Responses highlighted that a focus on patient care, quality of care, safety, productivity and other outcomes was essential. In addition to clinical competencies, leaders needed proficient communication, collaborative/teamwork skills and problem solving skills.

In discussion about the type of leaders needed, four levels of Allied Health leadership development focus were identified:

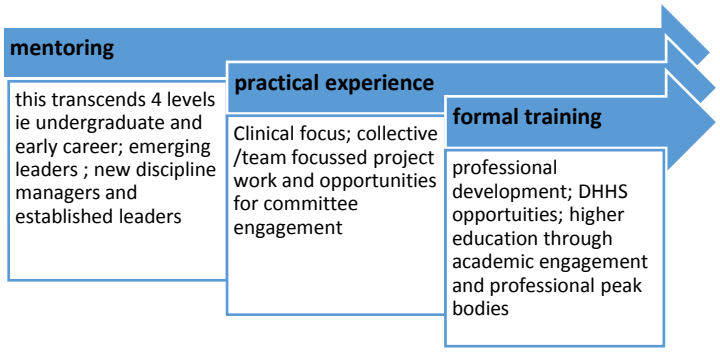
- Undergraduate and early career professionals

- Emerging Allied Health leaders (senior clinician level)
- Growing Allied Health leaders (discipline managers -moving from operational to strategic leadership thinking)
- Established leaders

It was noted that currently senior health service personnel have access to a large number of leadership development opportunities within their organisation and externally. Programs such as Health LEADS run by the DHHS offer executive leaders in-depth training with mentor support. The DHHS Leadership and Organisational Improvement Team runs a number of programs – for example *Leaders in Conversation* series, *Leadership, Innovation, Networks and Knowledge (LINK) in Health* programs, Clinical Leadership in Quality and Safety (CLiQS).

To advance healthcare reform and innovation, it was considered that AHP leadership development efforts, needed to move to new approaches and identify areas for priority action. The thematic analysis focused on emerging AHP leaders as a sensible and strategic investment. This group generally does not have ready access to leadership training. There was consensus, given that this group has key clinical responsibilities, they should be the highest priority for new AHP leadership development endeavours going forward. Key leadership development processes emerged from the comparative qualitative analysis which need to be emphasised – mentoring, practical experience and formal training. (See Figure 3 below).

Figure 3: Key LD processes from the comparative qualitative analysis



In developing a framework for AHP LD going forward, these processes are incorporated into suggested strategies and levels of Allied Health leadership development focus in the Recommendations section below.

DISCUSSION

What is the value to the health organisation of developing Allied Health leaders?

As a core pillar of the health sector, Allied Health contributes significantly to improved patient outcomes. According to the Centre for Workforce Intelligence (2013) making better use of AHPs improves outcomes for service users as well as the organisation and makes better use of finite resources (p. 11). Within an Australian context, a seminal paper

published by South Australia Health (2015) found that Allied Health is the smallest and most economical professional workforce in South Australia. Moreover a skill mix of AHPs adds value and improves outcomes across care pathways (CFWI, 2013), particularly by extending the multidisciplinary team's capacity for holistic planning and decision-making (Cullen, 2013).

Whilst there is limited evidence-based research to date pertaining to the value Allied Health leaders will contribute to the health sector, it is a growing area of interest throughout the international community. Given the significant contribution these professions currently make to the sector together with the ever-changing needs of service-users, it is imperative that organisations and leadership roles undergo significant reform.

What are effective models for developing allied health leaders in health organisations?

Whilst various leadership models have been discussed throughout this review, transformational and collaborative/ shared/distributive leadership received the most support throughout international scholarship as the most effective models in the health care sector.

Transformational leadership is one of the most studied theories of leadership in recent times (McKee, Driscoll, Kelloway & Kelley, 2011), particularly as it has been studied extensively in nursing (Bowles & Bowles, 2000; Stordeur, Vandenberghe & D'hoore, 2000; McDaniel & Wolf, 1992). According to Wylie and Gallagher (2009), one of the established advantages of adopting this model is that there are a number of robustly validated tools that would enable more rigorous measures to be taken.

Moreover, transformational leadership in particular has been positively associated with many positive individual and organisational outcomes, including employee psychological wellbeing (Arnold et al, 2007; McKee, Driscoll, Kelloway & Kelley, 2011). This finding is significant as recent research has shown that supervisor behavior has a greater effect on employee mental wellbeing than many other factors including stress, life and work events (Gilbreath and Benson, 2004; McKee, Driscoll, Kelloway & Kelley, 2011). Gellis' (2001) study found that the higher the rating of the social work manager as transformational, the increased desire of social workers to engage in activities requested by their leader, even though the demands went beyond what was expected of them (p. 24).

The research also revealed that some AHPs (namely radiography and podiatry) may require significantly more support than others in terms of developing transformational leaders (Wylie & Gallagher, 2009). Tailoring training programs to the specific needs of each profession is therefore critical to effective learning, engagement and leadership empowerment.

Shared / collaborative models of leadership were strongly supported throughout the research. Much of the available evidence, particularly that published by the NHS, highlights the importance of collective leadership and advocates a balance between individual skill enhancement and organisational capacity building (West *el al*, 2015, p. 3). According to West *et al* (2015) collective leadership culture is "characterised by shared leadership where there is still a formal hierarchy but the ebb and flow of power is situationally dependent on

who has the expertise at each moment. Research evidence suggests this is valuable, particularly at team level." (p. 3).

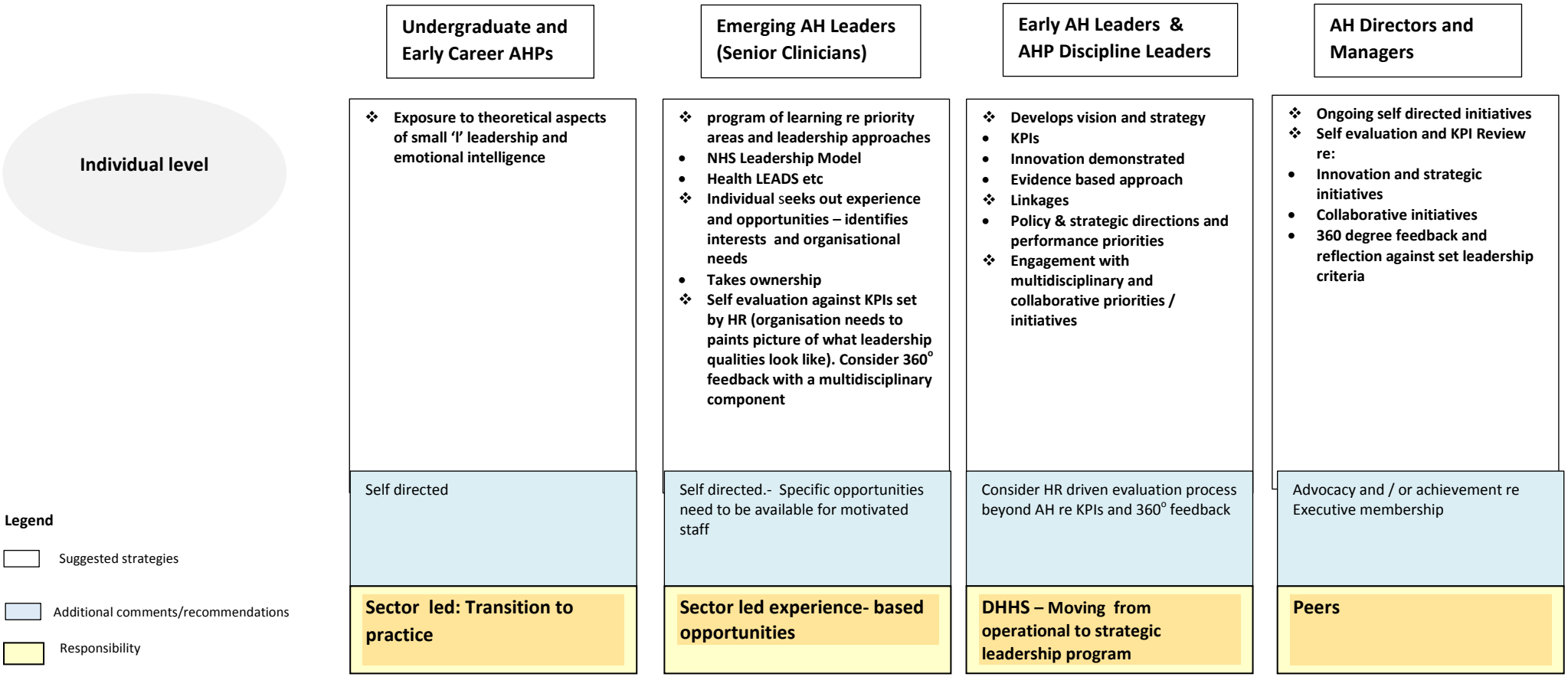
Whilst there is a convincing body of literature supporting the use of shared / collaborative models of leadership throughout the health sector, research conducted by Lingard *et al* (2012) revealed challenges of implementing effective collaborative leadership models due to organisational and hierarchical barriers. Lingard *et al's* (2012) study revealed that collaborative approaches within multidisciplinary teams are not effective if professionals are working within a hierarchical health care system. According to authors, "a collaborative approach to leadership may be challenging for inter-professional teams embedded in the traditional health care system that reinforce the idea that physicians sit at the top of the hierarchy." (p. 1762). The need for organisational and system reform, particularly in regards to the traditional medical model hierarchy, as well as supporting the development of leaders across all levels of professions, is subsequently crucial.

RECOMMENDATIONS

Based on the main findings of this study, the final part of this report suggests firstly, a framework which outlines strategies for Allied Health leadership development going forward, and secondly, a set of specific recommendations for consideration.

Figure 4: Suggested strategies for allied health leadership development

Figure 4: Suggested strategies for allied health leadership development cont.



Specific recommendations

Envisioning the future: The vision for clinician engagement in health care reform, which underpins an AHP leadership development strategy, must emphasise collaborative approaches – across Allied Health disciplines and working closely with medicine and nursing. This vision will need to be driven and implementation strategies trialled and evaluated. Key recommendations to progress this are:

Recommendation 1*:* Adopt a strategic and transformational approach to build collaborative, multidisciplinary and inclusive leadership development opportunities for AHP.

Collaboration between DHHS, academic institutions, and professional Allied Health bodies, including the Victorian Allied Health Leaders Council (VAHLC), and medical, nursing leadership bodies should be considered to progress future plans. Governance arrangements should be set in place to drive implementation.

Recommendation 2: Expand AHP representation in existing leadership and clinical improvement initiatives within organisations and monitor progress and outcomes.

It is important to address existing barriers to Allied Health leadership development , such as traditional hierarchies and structural arrangements, organisational development. The role of the Chief Allied Health Officer affords opportunities to raise awareness, communicate, set expectations and require progress and outcomes reporting from health services across Victoria.

Recommendation 3: Promote organisational structural reform to strengthen AH leadership opportunities and deliver equity of opportunity.

The involvement of Allied Health leaders and clinicians in strategy and policy as well as reform and decision-making is imperative to the engagement and empowerment of these professions. It is recommended that equity considerations drive reform and that Allied Health leaders are represented in positional leadership opportunities and executive decision-making bodies within organisations.

Recommendation 4: Expand access to tailored and varied leadership development opportunities for AHP, drawing on strategies outlined in the report.

Tailored leadership development programs targeted to four key AHP career levels have been identified. Emerging Leaders (Senior Clinicians) are identified as a priority group for sector based experiential activity with Early AHP Leaders (Discipline Managers) identified as the priority focus for Department of Health and Human Services led intervention. Early intervention in leadership development is needed for health students and early career AHP (Wylie and Gallagher, 2009).

Organisational support and encouragement of AHP involvement in system redesign and development, mentoring and training opportunities are pivotal elements of leadership development for AHP.

Recommendation 5: Consider resourcing implications of the proposed strategies.

This review supports the Victorian Quality Council's (2005) recommendation that allocation of resources to provide internal and external training must be matched, where possible, with resources to backfill staff (p. 8). Further, opportunities for new initiatives including scholarship offers via the office of the Chief Allied Health Officer and other key entities should be considered.

Recommendation 6: Identify future research directions.

The report recommends ongoing organisational and systemic support of research pertaining to the value of Allied Health leadership development within the health sector, transformational leadership in AHP and other leadership development and training models. Evidence-informed practice has gained significance throughout the health sector, hence the body of research relating to Allied Health leadership development must continue to be developed.

CONCLUSION

As health care organisational reform and clinical leadership are currently at the forefront of international scholarship, it is imperative that Allied Health professionals are provided with effective leadership development opportunities and positional leadership roles throughout the health sector. The international literature pertaining to Allied Health leadership development within the health sector highlighted the growing need for continued research and organisational reform within this area of practice. Whilst significant progress has been made across the Australian allied health sector over the last two decades, there remains significant organisational and structural reform required to develop transformational leaders, collaborative approaches and leadership development opportunities across all levels of Allied Health.

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APPENDIX A : Table 1. Data Summary Table

Study Number	Author(s) and Date	Source of Publication	Country	Type of Study	Aims/ Purpose	Approach/model/ program utilized or recommended	Participants	Main Findings/ Results
1.	Bamberg, R., & Layman, E. (2004)	Journal of Allied Health	USA	Research Paper – Quantitative Survey	To determine the frequency of use of various approaches for leadership development in the context of preparing for the role as lead administrator for a unit of Allied Health.	Most frequently listed programs were Harvard University's Management Development Program, regional allied health deans groups and institutional leadership programs.	75 deans and directors of Allied Health in ASAHP member institutions participated (39 women and 36 men participated).	For allied health leadership development, the most important leadership competencies are strategic planning and forecasting, having a vision and team or collaboration building. Mentorship was also identified as an important.
2.	Long, W., Lobley, K., Spurgeon, P., Clark, J., Balderson, S., & Lonetto, TM. (2011)	The International Journal of Clinical Leadership	UK	Research Paper	To build leadership capability among the clinical professions, and assess readiness to embed leadership competencies into undergraduate, postgraduate training and continuing professional development.	The Clinical Leadership Competency Framework (CLCF).	97 individuals from a mix of the clinical professions within the healthcare sector.	Recognition across the clinical professions that leadership capacity building is crucial. The CLCF was seen to be an effective tool in leadership development.
3.	Leggat, S., & Balding, C. (2013)	Journal of Health Organization and Manageme	Australia	Research Paper – Qualitative Study	To present the results of a qualitative study with clinicians and clinician managers to gather opinions on the	High Performance Work Systems (HPWS), Distributive Leadership and Transformational	28 clinicians and clinician managers participated (21 females and 7	The findings suggest that organisation structure and support are essential for clinical leadership development.

		nt			appropriate content of an educational initiative being planned to improve clinical leadership.	Leadership	males).	Organisational factors, consistent with the components of HPWS, are needed to support clinical leaders. Health care organisations also needed to be equipped to conceptualise and support a model of distributive leadership.
4.	McKee, M., Driscoll, C., Kelloway, K., & Kelley, E. (2011)	Journal of Management, Spirituality & Religion	Canada	Research Paper	To explore the relationship between transformational leadership, workplace spirituality and wellbeing in health care workers.	Transformational leadership	178 health care workers from community health settings (89% were female)	Results suggest that leaders influence individual wellbeing through their ability to enhance employee's sense of community in the workplace.
5.	Wylie, D., & Gallagher, H. (2009)	Journal of Allied Health	Scotland	Research Paper	To explore transformational leadership behaviour profiles within the six largest allied health profession groups in Scotland to determine the influence of factors such as seniority of grade, locus of employment and/or leadership training.	Transformational Leadership – Multifactorial Leadership Questionnaire was utilised in study methodology.	753 allied health professionals from four Health board areas across Scotland (92.3% of participants identified as female).	Results identified significant differences in transformational leadership between allied health professions, indicating that some professional groups are inherently advantaged in embracing the modernisation agenda.

6.	Gellis, Z. (2001)	Social Work Research	USA	Research Paper	To evaluate empirically a model that delineates two types of leadership processes - transformational and transactional - within social work practice.	Multifactorial Leadership Questionnaire was utilised in the study methodology.	187 clinical social workers employed in hospitals (86% identified as female).	Results indicated that all five transformational factors and one transactional factor were significantly correlated with leader outcomes of effectiveness, satisfaction, extra effort.
7.	Fleming-Castaldy, R., & Patro, J. (2012)	Occupational Therapy in Health Care	USA	Research Paper	To increase knowledge regarding occupational therapy leadership by examining the leadership characteristics of occupational therapy managers.	Leadership Challenge Model – Leadership Practices Inventory (LPI) measure was utilised in methodology.	53 occupational therapy managers (77% identified as female)	Results demonstrate that the five characteristics from the Leadership Challenge Model are reflected in the practice of occupational therapy leaders.
8.	Cullen, A. (2013)	British Journal of Social Work	UK	Research Paper	To explore suggested similarities between social work practice and the recently developed model of 'servant and partner' leadership within a specialist palliative care setting.	Servant and Partner Leadership	10 multidisciplinary team participants and a service coordinator.	Results suggest that social workers in a palliative care setting exercise leadership reflective of the 'servant and partnership' leadership model.
9.	Lingard, L., et al (2012)	Academic Medicine	Canada	Research Paper – Case Study	To better understand the role of physician leadership by exploring how five	Collaborative leadership	46 health care providers	Inter-professional teams agreed about the importance of collaborative leadership

					inter-professional health care teams perceived and demonstrated leadership in their daily practice.			however the evidence indicated actual enactment of collaborative leadership was a challenge. Participating physicians indicated their teams functioned non-hierarchically. However results revealed hierarchy behaviours persisted.
10.	Sasnett, B., & Clay, M. (2008)	Journal of Interprofessional Care	USA	Literature Review	To review several applications of the Bolman and Deal Leadership Model within academic health care and the aggregate recommendations for leaders of health care discipline based on collective findings.	Bolman and Deal Leadership Model (BLDM)	Six Occupational Therapy, Nursing, Radiation Therapy, Medical Residency, Quentin Burdick and Health Information Management studies were discussed in context of BDLM.	Human Resource frameworks emerged as the most prevalent frame used by leaders across all six studies.

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