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Realist evaluation of allied health management in Queensland: what works, in which contexts and why

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Abstract

Objective. Allied health structures and leadership positions vary throughout Australia and New Zealand in their design and implementation. It is not clear which organisational factors support allied health leaders and professionals to enhance clinical outcomes. The aim of this project was to identify key organisational contexts and corresponding mechanisms that influenced effective outcomes for allied health professionals.

Methods. A qualitative realist evaluation was chosen to describe key aspects of allied health organisational structures, identify positive outcomes and describe how context and processes are operationalised to influence outcomes for the allied health workforce and the populations they serve.

Results. A purposive sample of nine allied health leaders, five executives and 49 allied health professionals were interviewed individually and in focus groups, representing nine Queensland Health services. Marked differences exist in the title and focus of senior allied health leaders' roles. The use of a qualitative realist evaluation methodology enabled identification of the mechanisms that work to achieve effective and efficient outcomes, within specific contexts.

Conclusions. The initial middle range theory of allied health organisational structures in Queensland was supported and extended to better understand which contexts were important and which key mechanisms were activated to achieve effective outcomes. Executive allied health leadership roles enable allied health leaders to use their influence in organisational planning and decision-making to ensure allied health professionals deliver successful patient care services. Professional governance systems embed the management and support of the clinical workforce most efficiently within professional disciplines. With consistent data management systems, allied health professional staff can be integrated within clinical teams that provide high-quality care. Interprofessional learning opportunities can enhance collaborative teamwork and, when allied health professionals are supported to understand and use research, they can deliver positive patient and business outcomes for the health service.

What is known about the topic? A collective allied health organisational structure encourages engagement of allied health professionals within healthcare organisations. Organisational structures commonly include management and leadership strategies and service delivery models. Allied health leaders in Queensland work across a range of senior management levels to ensure adequate resources for sufficient suitably skilled professional staff to meet patient needs.

What does this paper add? Literature to date has described how allied health professionals operate within organisational structures. This paper examines key aspects of allied health management, governance and leadership, together with mechanisms that support allied health professionals to deliver effective clinical and business outcomes for their local community.

What are the implications for practitioners? Health service executives and allied health leaders should consider supporting executive allied health leadership roles to influence strategic planning and decision-making, as well as to deliver outcomes that are important to the health service. When allied health leaders implement integrated professional and operational governance systems, executives described allied health professionals as influential in supporting team-based models of care that add value to the business and improve outcomes for patients. When allied health leaders use consistent data management, executives reinforced the benefit of aligning activity data with financial costs to monitor, recognise and reimburse appropriate clinical interventions for patients. When allied health leaders support allied health workforce capability through educational and research opportunities, clinicians can use research to inform their clinical practice.

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Introduction

In Australia and New Zealand there has been strong interest in allied health models and structures, resulting in a variety of titles of senior positions and organisational structures. Since the 1990s, there has been significant research describing and analysing allied health workforce structures for their ability to support and position allied health professionals to meet consumer health needs.^{1,2} Concurrently, it is acknowledged that pure models of organisational structure are rarely implemented in complex healthcare systems, nor can they ameliorate intergroup politics and competition.³ The Mason review of Australian Government health workforce programs highlighted that allied health leadership positions were important to integrate allied health services in order to drive innovation around new service delivery models.⁴ However, there is limited analysis of differential outcomes of different allied health leadership and management structures, and it is not clear which aspects or organisational factors support allied health leadership.

In Queensland Health, allied health structures vary in how they are designed and aligned to published models.¹ The aim of the present study was to better understand which aspects of organisational context influence allied health outcomes, and through which mechanisms this occurs. For this project, 'allied health' referred to the range of individual professions that are neither nursing nor medicine. Given there are slight variations to professions included across some health services, we accepted all professions who are recognised as 'allied health' within Queensland.

Methods

A qualitative realist evaluation was chosen to guide the design of this research project.⁵ Realist evaluations seek to provide a theoretically consistent account of social programs by explaining what works, in what contexts and why. It is recognised that knowledge and actions have social and historical antecedents, so that in complex situations aspects of the local context interact in different ways to generate outcomes. A realist evaluation commonly explores how changes are influenced by people acting (or not) in specific conditions and attempts to explain how, in a specific context, particular mechanisms support certain outcomes. These context, mechanism, outcome (CMO) propositions offer plausible explanations for local and broader interpretation.

A realist evaluation begins with a shared explanation of how things happen and works to refine and test components of that explanation. At the start of this project, a steering committee of senior allied health leaders agreed that a collective allied health organisational structure was important to support and position individual professions in order to lead to greater engagement of allied health professionals within a healthcare organisation. There was agreement that organisational structures provide the environmental context in which allied health managers and leaders plan and deliver team-based services to meet the needs of local consumers. Allied health and professional leaders were described as functioning across a range of senior management levels to ensure sufficient resources for appropriate numbers of suitably skilled professional staff.

For this research project, we described the context in which allied health organisational structures and leaders operated in a sample of Queensland hospital and health services. From this sample, we focussed on identifying key mechanisms that support effective allied health management, governance and leadership. We then developed CMO propositions to explain how specific context and processes are operationalised to influence clinical and business outcomes for the allied health workforce and their patient populations. It is expected that these key propositions may be interpreted in health services beyond Queensland.

Sample

A steering committee of senior allied health leaders from Queensland Health was engaged across the project lifecycle to inform the research design and to clarify and test CMO propositions. Purposive sampling was used to ensure allied health leaders were from diverse geographical regions, professional backgrounds and organisational structures. Initial email contact was made with the most senior allied health leader in each of 10 Queensland hospital and health services. Interested participants were provided with information about the research project and given time to consider their involvement before deciding to participate.

Data collection

A written questionnaire was distributed to the most senior allied health leader at each participating site to gain demographic and organisational information. Semistructured one-on-one interviews were conducted with the most senior allied health leader within each participating health service and their executive line manager. Focus groups were conducted with an invited group of allied health professionals in the same health service.

Interviews and focus groups were audio recorded and transcribed by a professional transcription service. The interviewer also took notes and kept a reflective journal for the purposes of data referencing.

Data analysis

All transcripts were reviewed and coded against narrative themes to identify the range of unique management and organisational contexts. Data analysis was designed to identify unique combinations of context and mechanisms that enabled specific clinical and business outcomes. Core outcomes were described by participants as relating to improved operational and clinical indicators around the provision of quality and efficient health care. Key mechanisms were identified as processes through which an aspect of the context generated outcomes. Preliminary CMO configurations were developed by comparing the ways in which specific mechanisms operated in different contexts to achieve (or not) similar outcomes. These CMOs were discussed and refined through multiple sessions of collaborative analysis, including discussion with the steering committee, until they could offer plausible explanations for and beyond the specific local context in which they were developed.

Often, one CMO configuration was observed to have a flow-on effect that could be linked to a new configuration so that over time the outcome of one particular context became the starting context for different mechanisms to generate additional

outcomes. This ripple effect between sequential CMOs occurring has been reported previously.⁶

Ethics review

This research study received ethics approval from the Gold Coast Hospital and Health Service Human Research and Ethics Committee (HREC/16/QGC/289). Site-specific approvals were obtained for all participating sites.

Results

Nine hospital and health services participated in this study (three metropolitan, three regional, one statewide, one rural and one rural/remote health service). This represented three large (>1000), three medium (500–1000) and three small (<500) allied health workforces.

The most senior allied health leader was interviewed in all nine sites. Their professional backgrounds included five different allied health professions (speech pathology, occupational therapy, physiotherapy, psychology and medical imaging) and their length of time in the role ranged from 1 to 10 years. Members of the executive team were available for interview at five sites, with a total of five interviewed. Focus groups were held at eight sites. In total, 49 allied health professionals from junior to senior staff levels across more than 10 different professions participated in focus groups. The allied health professionals had been working in their professions from 8 months to 38 years.

Narrative summary

A narrative summary describes the key contextual features and outcomes of allied health organisational structures from the three stakeholder groups (executives, allied health leaders, allied health professionals) and synthesises the shared meaning. Participants' quotes are included and italicised to illustrate key points.

Contextual features of allied health organisational structures

Marked differences exist in the title and focus of senior allied health leaders' roles. Five leaders were working as Executive Directors of Allied Health, reporting directly to the Chief Executive. Three leaders were working as Directors of Allied Health and one was an Allied Health Lead, with all four reporting to Executive Directors.

Five allied health leaders reported having stable organisational structures, three leaders reported being involved in a current restructure and one described a restructure within the past year. There was a common response that restructures were seen as disruptive because of changes in roles and reporting arrangements, as well as reduced communication:

I think that when there is senior leadership instability what suffers is the future thinking. . . also it affects the discretionary effort at all levels of staff. (Executive)

Six allied health leaders reported having offices near other executives and one was planning to move nearer to their executive colleagues. This was reported to positively make a difference through opportunistic conversations and better visibility:

It's been fantastic, the corridor conversations. . . I think that, seeing everyone every day, you build really good relationships, strong relationships. You just have informal chats all the time. (Allied Health Leader)

Allied health outcomes

There was consistency between executives and allied health leaders that the greatest successes for allied health were building a cohesive allied health team, contributing to innovative service models and in enacting clear allied health governance, plans and strategies. Allied health leaders were noted by all stakeholder groups to use influencing leadership strategies, namely advocacy and respect across the allied health professions:

I think the culture of respect between the professional groups has really facilitated it. . . levels of trust have been able to be established between medical and allied health groups. (Executive)

Allied health leaders described aligning allied health with health service objectives and providing input on strategic directions. Their professionalism, positivity, consistency, persistence, resilience and flexibility was noted by allied health staff.

Thematic analysis of CMO configurations

This realist evaluation facilitates deeper and confidential comparison across different settings to better understand the mechanisms triggered by the different contexts within Queensland. The explanations of the way different mechanisms work are summarised in four key propositional CMOs for consideration of their applicability to broader national and international organisational contexts.

Strategic contribution through allied health executive roles

Perspectives from all stakeholders were consistent that allied health executive positions are an important contextual feature of healthcare organisations that promote effective influence and strategic contribution between allied health professions and the health service:

. . . having an executive director of allied health role in the organisational structure at a leadership level now in a permanent capacity is really important for the staff. (Allied Health Leader)

Allied health leaders in executive roles used key mechanisms of influence to build relationships, maintain effective communication and develop partnerships within the organisation in a manner similar to medical and nursing executive peers. The context of allied health representation within the executive was seen to have cumulative and flow-on effects. Over time, the executive allied health leaders became involved in executive level strategic planning and decision-making. As they implemented strategy, they delivered results that were important to the health service. Executives reported that this built trust and a positive allied health reputation within the organisation:

...understanding the bigger picture and being able to align their work priorities to the bigger picture, and being able to take decisions. (Executive)

Where organisational structures were stable, there was opportunity for processes and practices that support the governance, development and delivery of allied health services to establish and embed. Allied health leadership roles were defined not only on paper, but also through the actions, relationships and outputs of the leader in the role over time. With appropriate authority and autonomy, allied health leaders were able to develop and implement long-term plans. In the context where plans and strategies were successfully implemented, the allied health workforce felt supported and had capability to deliver quality services:

If we are to position ourselves for that future, then we have to take very seriously the allied health workforce, the value-add it provides to patients, an understanding that... it adds to that diversity of thinking at the executive table, the diversity of opportunity across streams. (Executive)

Where allied health executive positions had not been embedded at the executive level, there were greater challenges to effectiveness. Allied health leaders were not included in planning and they had reduced autonomy to implement strategy. In some cases, patients did not receive allied health services and there were no opportunities to identify benefits from allied health intervention:

You're seeing documents being produced with no allied health input which affects the whole service delivery from management down to...the services patients are receiving. (Allied Health Professional)

Integrated professional and operational governance

An integrated but explicit model of allied health governance is able to separate and promote interaction between professional and operational responsibilities in complex healthcare organisations. Hospital executives commonly described a matrix system where professions allocated staff from a variety of disciplines to deliver the optimum range of clinical services:

...if you think of a matrix – the service delivery arm of an organisation is holding one of the professions within it and then allocating staff out...they provide the workforce... [and] the governance around that. (Executive)

Systems of professional governance are another important context for allied health. Professional governance relies on accountable systems for managing and supporting a clinical workforce, usually within a defined profession. Responsibilities were commonly described by allied health leaders as follows: staff recruitment, orientation and allocation; leave management, registration and credentialing; professional development; and workforce planning. Executives commented that professional governance was recognised as a basic building block for ensuring that the right staff, with appropriate support, have suitable skills to deliver safe and high-quality clinical care.

Further, professions need to ensure the supply chains are in place from universities to ensure that clinical staff have suitable career paths to deliver the appropriate models of care required by their operational managers. Professional leaders need to ensure that clinicians are sufficiently educated and credentialed to work to full or extended scope of practice. Respect for each professional's role, scope of practice and contribution can follow.

On balance, both executives and allied health leaders described the strongest and most efficient models of professional governance as being when professional leaders operationally managed their own professional workforces. Executives described a good professional governance framework as providing professions with the acknowledgement and freedom to manage their own workforce while also being accountable for staff to work effectively within the operational framework. Allied health leaders reported positively that when they operationally managed their staff, there were efficiencies in the delivery of professional governance. Having independent budgets allowed significant internal redesign, which enhanced clinical service delivery. In contrast, when allied health professionals were managed by other professions, professional leaders were often required to resolve problems:

...when there's a problem, they've recruited someone who's not registered...or they've put someone on the wrong pay point...then it's an issue for allied health [to resolve]. (Allied Health Leader)

Strong professional governance was seen as an important context for effective operational management of clinical teams. Executives described a range of operational functions that, when allied health staff were included, promoted better service delivery, such as clinical prioritisation, resource allocation, integrated models of care, empowered clinician managers and delegated decision-making. Most commonly, executives described operational managers defining what and how services should be delivered and setting and measuring performance targets. The most effective models of care included an integrated or coordinated allied health component that specified inclusion of the most appropriate professional groups. When an allied health governance framework was functioning well, allied health professionals were positioned at the right stage of the patient journey to demonstrate their worth at every level:

...if we talked about this is a cohort of patients that we feel we could do better for. What can we all offer? Actually talk about a model of care that is patient-centred and then we pick the services we need based on the patient. (Allied Health Professional)

These challenges informed the final set of mechanisms that sustained integrated clinical service teams. Health service executives were clear that there needed to be consistent and transparent business rules for decision-making and planning between both operational and professional governance systems:

...we simply recognise the professional side and the operational side, and we come to an agreement on how we're going to deliver services operationally within the

business rules, but taking on board the professional requirements of that workforce so that we're safe and we've got quality, we meet all the legislative requirements. (Executive)

Allied health leaders described having detailed responsibility matrices as well as clear business rules. Several described service-level agreements and memoranda of understanding that detail the number of allied health staff from different professional groups that are working within specific clinical areas:

[The memorandum of understanding] describes how we will provide annual leave, emergent leave relief. . . how we manage the workforce as well provide the learning professionally. . . it gives clinical service lines reassurance that they will get X number of FTE [full-time equivalents]. (Allied Health Leader)

Further, having a single point of accountability for allied health governance was seen as important:

. . . obviously all of the allied health professionals are involved in supporting patients in the [clinical] service. But rather than having each one of them talking individually, we had one person who. . . took the lead in addressing the issues. (Executive)

There was recognition that allied health professionals understood the uniqueness of different professions and could best identify which particular professions delivered services that enhanced patient care. Allied health leaders were able to recognise and advocate for the components of care that are unique to specific allied health professions in order to add value for the business and patient care. This enabled them to ensure clinical services were coordinated across specialties and professions. Executives described allied health leaders as being influential in supporting the delivery of new models of care that added value to the business and improved outcomes for patients, often through a team-based delivery of care.

Consistent data management

The way in which allied health professionals understand and use data about their activity and financial performance is another important context that affects the outcome of allied health effectiveness. Executives acknowledged that service managers should know which allied health professionals are delivering clinical interventions to support their patients. Allied health leaders described the importance of being able to attribute professional staff to specific clinical areas to understand the basic patterns of service delivery. They described the need to be consistent across all allied health professions while respecting clinical diversity. Allied health leaders recognised the need to ensure that clinicians formally capture clinical data, which are then included in routine organisational reporting metrics. An outcome of this mechanism is that clinical teams have transparent data to substantiate professional clinical activity.

When professional activity data are integrated in clinical services, through routine reporting another set of mechanisms can operate. Allied health leaders described using activity data in combination with financial data to understand trends. Allied health leaders developed business rules to create and coordinate

dashboards for discussion at business meetings. These dashboards commonly provided visibility of professionals, skill mix, quality metrics and budget performance:

. . . we actually get that feedback from management on a yearly basis to show trends over time, workload demands within each area, what we are achieving, what we could achieve better. (Allied Health Professional)

This mechanism of aligning activity and financial data enabled the outcome of appropriate financial reimbursement for each profession. Executives reinforced the benefit of aligning activity data with financial costs because it enabled business processes to monitor, recognise and reimburse activity appropriately. However, some executives recognised that this was not often achieved in allied health:

. . . it's not very transparent. It's not clear to us who has been funded to do what. . . it's quite difficult to say. . . where does our service stop and the next service start. (Executive)

With accurate and transparent professional data, another set of mechanisms was observed to occur. Health service executives described allied health professions using their activity data to inform strategic decisions. Allied health leaders described ways they were using data to demonstrate added business value from their clinical involvement in innovative patient care models. Project management and business planning processes required accurate clinical and financial data. Executives were most concerned about data that reflected allied health as a group of professions, but this required professional directors to consistently combine accurate numbers and costs for contributing professional staff. The outcomes reported by executives were to maximise and build the capacity of the allied health workforce to contribute to enhancing patient care.

These mechanisms were not consistently reported in all participating health services. Reporting data upwards to the executive was not consistent across all sites, and as a consequence there was limited visibility for some organisations of allied health's contributions. Allied health leaders reported that their information systems were inadequate to support service line managers, describing them as not sufficiently agile and connected. Further, activity did not always capture the complexity of patient care required.

Workforce capability

The size and capacity of the allied health workforce varies greatly between health services and is another important contextual factor for allied health success. This context functions differently in well-staffed metropolitan health services and is reported as a challenge for rural and remote health services. Allied health leaders recognised that structures to promote career progression are important to retain allied health professionals within health services. Without appropriate career progression opportunities, younger clinicians tend to leave for other more attractive opportunities. Another two mechanisms were described in some but not all health services as potentially contributing to the outcome of staff retention: education and research.

An important context for education of allied health staff was identified as the professional support for technical competence. Technical skills are an important part of every profession's contribution to patient care. Professions traditionally have structures and systems in place to ensure clinical staff are well educated. Professional leaders were seen as key to valuing and supporting education and professional development for students and staff:

...profession specific technical training is well bedded down in terms of competencies or capabilities through supervision and performance improvement plans. (Allied Health Leader)

The mechanism of interprofessional education was seen as a logical extension by some allied health leaders to drive better collaborative work, because professionals have learned together, from each other and improved their mutual understanding and respect of each other. Allied health leaders described creating common initiatives around new graduates learning together, developing peer supervision models and interprofessional leadership, capability and mentoring programs. Some clinical service groups also provided specific team-based continuing professional development and educational opportunities.

Early mechanisms to build research included systems to build individual clinicians' capability through mentoring relationships, university partnerships and dedicated research fellow positions:

...we've looked at partnerships with our university partners to actually start activity. (Allied Health Leader)

The combination of strategies varied between organisations, and allied health leaders described matching appropriate strategies for clinicians' interest and maturity around research. Showcasing successful research projects and rewarding clinician researchers were also seen as positive strategies. It was acknowledged by allied health leaders that they needed to support the clinicians who have the skills to do research:

...one of the ways which we've done research capacity building is through the annual research week. (Allied Health Leader)

The allied health leaders of research-active organisations described a set of strategies they used to engage broadly across the professions to understand and use research to improve their clinical practice. As researchers were willing to share their experiences and learning, this continued to build research capacity. From entry level, they wanted to ensure all clinicians are able to be informed research consumers. They could then identify and share clinical questions with their research-active colleagues, who could generate new research to address these knowledge gaps. Further, engagement of allied health professionals in interdisciplinary research leads to the highly desirable outcome of using research to inform clinical practice:

I think the research arm that we've actually spent time in developing has been very effective, both from a profile but also from establishing evidence-based practice and then

being able to implement that practice. (Allied Health Professional)

Where there was not a strategic plan for research, dedicated research roles or systems to support allied health research, research activity was lower. Allied health professionals at these sites reported gaps in time, support and resources to engage in research, and subsequently were reluctant to engage in research activity.

Discussion

This research project presents a comprehensive investigation of the perceptions of hospital executives, allied health leaders and staff to confirm key contextual aspects of allied health management structures, processes and practice that influence governance and the delivery of allied health services in Queensland. This realist evaluation identified four aspects of organisational context that have the potential to affect effective allied health management more broadly: allied health leaders in executive roles, integrated professional and operational governance, consistent data management systems and workforce capability strategies.

Allied health leaders in executive roles can build positive relationships with other medical and nursing executives. They can influence organisational planning and decision-making to ensure allied health professionals deliver successful patient care services. Delivering results builds a positive reputation, which generates trust from other executives and further opportunities to demonstrate allied health quality in innovative models of care. These mechanisms are reinforced when allied health leaders are located in close proximity to their executive colleagues and when organisations have stable structures.

An integrated and explicit model is required to distinguish professional governance and operational responsibilities. Professional governance systems embed the management and support of the clinical workforce most efficiently within professional disciplines. Operational management systems define how clinical services should be delivered, monitored and measured. Consistent business rules and strategies are required to set and manage expectations between allied health professions and clinical service managers so that appropriate professional staff are integrated within clinical teams to provide high-quality care. Credible, skilled and respected allied health leaders are required to enact these systems.

Effective and consistent data management systems support allied health leaders to attribute professional staff to clinical areas and align clinical activity with financial costs in order to plan, implement and evaluate clinical service delivery. Allied health leaders require business and strategic skills to build integrated service delivery models with appropriate staffing profiles to meet patient needs.

The allied health workforce is a capable one, where educational and learning opportunities are initially provided within disciplines to build technical capabilities. Career development and progression opportunities are required to engage and retain staff. When interprofessional learning opportunities are provided, collaborative work between professionals is enhanced. Building research capability is also important for staff retention and for quality service provision. When allied health leaders

support and celebrate research success, they can motivate staff to understand and use research, which, in turn, can improve clinical practice. Ultimately, this can have a reinforcing effect on staff retention and delivering positive patient and business outcomes for the health service.

Within Australia and internationally, an aging population, increased burden of chronic disease and rising health care costs present a challenge to governments and health services. Allied health professionals have an important and increasing role in delivering health services, particularly in areas of aging, chronic diseases and disability. Promoting models that support high-quality, efficient service delivery is of interest to health professionals, planners, executives and the public. These four key sequential patterns of CMO configurations align closely with aspects of the extant literature and are likely to offer relevant insights to health services beyond Queensland. Strong representation of allied health at senior and executive levels is well supported as a strategy to promote allied health's contribution and influence in team-based service planning.¹ Executive allied health roles were acknowledged to provide expert allied health advice in areas of strategy, planning, quality and safety.⁷ The visibility of effective leaders is also key.⁸ Clearly defined professional leadership structures are recommended to deliver high-quality clinical care in interdisciplinary teams.² An internal matrix management system has been recommended to support professional management while being responsive to the operational needs of clinical service units. Allied health packages of care have described integrated service requirements for all allied health disciplines.¹ Further, it has been recognised that allied health services with allocated budget for operational and service delivery responsibilities managed and implemented strategy effectively and efficiently.⁷ Professions that provided clinical support, education, supervision and engagement in research promoted a sustainable, skilled and capable allied health workforce.⁷

Limitations

There are local limitations to this report in that the mechanisms that support effective allied health management, governance and leadership have been described by allied health leaders and professionals and a small group of Queensland executives. This evaluation was designed as a snapshot in one context to help deepen understanding in this context and beyond. CMO configurations were explained positively to demonstrate how contexts triggered unique mechanisms to produce specific outcomes. However, their sequential implementation varied across Queensland for reasons that we could not fully elucidate. It is expected that variation will occur in the implementation of CMOs across national and international health services, which have different allied health leadership styles and priorities.

Considerations for future research and practice

Further research to develop and validate these propositions is recommended in other health services to confirm our proposed plausible explanatory propositions and begin to elucidate the causal web of conditions. Future research could also identify alternative mechanisms that may be activated in different

organisational and cultural contexts where allied health leaders are achieving positive business and clinical outcomes.

Allied health leaders are recommended to critically review each of these four CMO propositions in relation to the context of their own health service and to investigate whether they can activate similar mechanisms to achieve positive business and clinical outcomes. Health executives and policy makers are encouraged to reflect on the extent to which they can create positive contexts and conditions for allied health leaders to activate some of the mechanisms identified.

Conclusion

This study provides a comprehensive report of how key contextual components of organisational structure facilitate management mechanisms and generate positive clinical and business outcomes for the allied health workforce and the patient population it serves. Four aspects of organisational context were identified as having the greatest potential and impact for effective allied health management: allied health leaders in executive roles, integrated professional and operational governance, consistent data management systems and workforce capability strategies. A detailed explanation of underlying mechanisms is offered for each context to suggest plausible propositions that may function in healthcare organisations, nationally and internationally.

Executive allied health leadership roles enable allied health leaders to use their influence in organisational planning and decision making to ensure allied health professionals deliver successful patient care services. Professional governance systems embed the management and support of the clinical workforce most efficiently within professional disciplines. When they are integrated with operational management systems, using consistent business rules and strategies, allied health professional staff are integrated within clinical teams that provide high-quality care. Career development and progression opportunities are required to engage and retain staff. Interprofessional learning opportunities can enhance collaborative teamwork and, when allied health professionals are supported to understand and use research, they can deliver positive patient and organisational outcomes for the health service.

Competing interests

All authors report that they have no conflicts of interest.

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