



Enabling Allied Health Clinicians Into Health Systems
Leadership: 'less about the profession, and more about the
person'

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Abstract

Health and disability systems are complex phenomena, enduring constant multi-level change and strategic shifts in priorities (Ayeleke et al., 2018). Leading these systems requires a breadth and depth of knowledge to foster innovation within a diverse workforce delivering an array of services (Mutonyi et al., 2024). The traditional focus of diagnostic-centric, facility-based systems for service delivery is increasingly misaligned with the emerging paradigm shift towards a consumer-focused, community-based health journey (Mather et al., 2018). Effective health systems leadership is key to the success of health organisations, and the enabling characteristics of leadership have been well documented (Sihame & Moyosolu, 2021). Allied health clinicians exemplify these effective characteristics, qualities and perspectives (Bradd et al., 2017; Mizzi & Marshall, 2024; NHS England and NHS Improvement, 2019a; Wylie & Gallagher, 2009). Yet, the health system's design will falter if health system leadership relies on positional authority and a medico-centric perspective for achieving outcomes (Edmonstone, 2019). Enabling allied health clinicians to assume health systems leadership roles is crucial for a sustainable health system.

Using Interpretive Description, founded on Social Constructionism, this research sought to understand how allied health clinicians are enabled to step into health systems leadership roles. This applied health research had three objectives: explore allied health clinicians' experiences of stepping into health systems leadership roles; identify influential elements; and develop recommendations to support and enable their leadership progression.

The literature review contextualised the study within existing research, highlighting a paucity of research on allied health clinicians in health systems leadership roles, particularly in Aotearoa New Zealand. This empirical qualitative study, conducted through online interviews with 19 participants, provided new insights. Analysis and synthesis of data, in conjunction with relevant literature, led to the development of four themes. These themes were: *The Leader Within*, *Navigating the Next Step*, *Overcoming Bias* and *At the Mercy of Infrastructure*. From those themes nine recommendations were made for change to practice.

This research found allied health clinicians are enabled into health systems leadership roles when their leadership identity is validated; they have equitable access to leadership development; and their environments endorse their value, creating a culture that enables them to thrive. Nine recommendations advocate for the integration of these enabling factors into policy; clear leadership career guidance for competent practice; and the shift of system perspectives through mechanisms with broad national influence. This study recommends stakeholders across the health system work together to validate, develop and endorse allied health systems leaders.

The identification of elements which promote health systems leadership as a visible, viable and legitimate career pathway for allied health clinicians in Aotearoa New Zealand, contributes new knowledge. The

findings offer insights into a culture of systemic bias where the environment limits their inclusion as health systems leaders. The recommendations have implications for allied health clinicians in practice, for leadership development policy and for health systems leadership culture. By reframing expectations for health systems leadership, this research challenges operational and behavioural legacies and underscores how health systems leadership diversity enhances health system sustainability.

Keywords:

health systems leadership, allied health, equity, health paradigm, health system, systemic bias

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Attestation of Authorship

This Thesis has been digitally submitted, and certain elements within it are best viewed in digital format. In Chapter 4 there are several figures included to illustrate process and the overall image of the figures communicates more about the process than the detail of the content. Some figures have been duplicated into the Appendices in A3 format to enable a clearer view.

The artificial intelligence (AI) software, Copilot (Microsoft 365, 2025) and Grammarly (Grammarly, 2025) have been used as tools to critique and refine the grammar and punctuation of this Thesis.

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgments), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Rebecca George

Co-Authored Works Arising from the Doctoral Thesis

Contributor role detail is aligned to the Contributor Roles Taxonomy (Allen et al., 2019).

Student and Supervisor Approvals

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Ethical Approval

Auckland University of Technology Ethics Committee (AUTEC) granted ethical approval for this research study on 11 October 2021.

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‘we are all in this together without exception’

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Glossary of Key Terms

| | |
|--|--|
| Allied health clinician | ‘Allied Health Professions are a distinct group of health professionals who apply their expertise to prevent disease transmission, diagnose, treat and rehabilitate people of all ages and all specialties. Together with a range of technical and support staff they may deliver direct patient care, rehabilitation, treatment, diagnostics and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive and social functions.’ (Department of Allied Health, 2020) Examples include occupational therapy, social work and dietetics. |
| Allied Health Professions Collective | ‘The allied health workforce is made up of health professionals who are not part of the medical, dental or nursing professions. There are at least 43 professions that are classed as Allied Health professions in New Zealand. Allied health professionals are autonomous practitioners who work in a variety of health care settings and often work in multidisciplinary teams.’ (Manatū Hauora – Ministry of Health, 2019) |
| Consumer | A person who has used, is currently using, or may potentially use health services, or is a carer for a patient. (Te Tāhū Hauora – Health Quality and Safety Commission, 2021) |
| District health boards (DHBs) and Health New Zealand (Health NZ) | In 2022 Aotearoa New Zealand initiated an extensive reform of the public health system. This transformation merged 21 operational health districts to centralise under a single operational entity called Health NZ. This transformation continues in 2025 as the changes embed systemwide (Health New Zealand – Te Whatu Ora, 2022). |
| Health system governance | The processes, structures and institutions that are in place to oversee and manage a country’s healthcare system. (World Health Organisation, 2024) |
| Health systems leadership | ‘Leadership within and across organisational and geopolitical boundaries, beyond individual professional disciplines, involving a range of organisational and stakeholder cultures, often without direct managerial control of resources and working on issues of mutual concern that cannot be addressed by any one person or agency.’ (Edmonstone, 2020) |
| Interprofessional practice | A complex and multifaceted way of working in a relational context, where team spirit outweighs narrow professional interests (Flood et al., 2022). |
| Patient | A person who is receiving care from a health service organisation (Australian Commission on Safety and Quality in Health Care, 2024) |
| Rangitira | To be a leader, a rangatira, is to excel at weaving people together, to encourage or inspire others to go on a journey together, to exercise agency, and to light the way toward a world in which all flourish.’ (Spiller et al., 2020, p. 522) |
| Te Aka Whai Ora – Māori Health Authority | Te Aka Whai Ora – The Māori Health Authority was created in July 2022 and disestablished on 30 June 2024. It was established to share responsibility for decision making, planning and delivery of health services to improve the wellbeing of whānau. Supporting Te Tiriti partnerships throughout the system (Health New Zealand – Te Whatu Ora, 2025). |
| Tuakana-teina relationship | A relationship that is an integral part of traditional Māori society and provides a model for buddy systems; ‘an older or more expert tuakana (brother, sister or cousin) helps and guides a younger or less expert teina (originally a younger sibling or cousin of the same gender).’ The tuakana-teina roles may be reversed at any time in a mutual exchange of teaching and learning. (Te Kete Ipurangi, 2025) |
| Whānau | Extended family, delivery, to give birth, genus (Ryan, 2012) |

Abbreviations

| | |
|-----------|---|
| AHP | Allied health profession |
| CAHPO | Chief Allied Health Professions Officer |
| CG | Clinical Governance |
| DHB | District health board |
| Health NZ | Health New Zealand |
| HQSC | Health Quality & Safety Commission |
| MECA | Multi-Employer Collective Agreements |
| NGO | Non-governmental organisation |
| NHS | National Health Service |
| RTA | Reflexive thematic analysis |
| SOP | Standard operating procedure |
| UK | United Kingdom |

Chapter 1 Introduction, Background and Rationale

1.1 Introduction

Developing effective health systems leadership is essential to the strategic design, resourcing and delivery of healthcare systems and services (Rasa, 2019). Recruiting health workforce personnel into health systems leadership roles is an established legacy of practice (Mousa et al., 2023). Globally, it has been noted health systems leadership roles have typically been fulfilled by medical and nursing professions (Boyce & Jackway, 2017; Eddison et al., 2023). Allied health systems leaders have the capability to improve consumer outcomes, contribute value, and directly impact health systems (NHS England and NHS Improvement, 2019b). However, there is growing evidence of the underrepresentation of allied health leaders in health systems leadership roles and a paucity of empirical research addressing health systems leadership by allied health clinicians (Colesby, 2024; Eddison et al., 2023; Mizzi & Marshall, 2024). This research study aims to address this gap by exploring how allied health clinicians are enabled to step into health systems leadership roles.

1.2 Personal Positioning

My personal journey as an allied health clinician in Aotearoa New Zealand inspired me to complete this research. Navigating into and through health systems leadership roles has been a mix of positive and negative experiences, shaping my leadership identity and instilling a drive to support and encourage fellow allied health clinicians to pursue similar roles.

During my undergraduate studies in occupational therapy there was little to no teaching provided on leadership within health systems. After graduating, the healthcare organisations I worked for provided opportunities for leadership training with an operational focus, but there was no clear pathway for progressive strategic leadership. The leadership teaching I encountered was oriented to workforce management, with a focus on one's own clinical workforce or on the allied health collective of professions. There was no indication that allied health clinicians could lead across nursing or medical professions. With limited exposure to health systems leadership and secondment opportunities, I had to be highly motivated to identify and pursue leadership career progression opportunities.

When health systems leadership roles were advertised, allied health clinicians were not typically encouraged to apply. Further, once I had successfully achieved a health systems leadership role, there was no guarantee of consistent inclusion within strategic decision-making work streams. It took patience and persistence to achieve a seat and be heard at the leadership table, and to be recognised as a valuable contributor for strategic decisions. I have experienced profession-based bias from colleagues, exclusion from leadership recruitment processes, and disempowerment in strategic decision-making forums. These challenges have influenced my career choices and given visibility to the career limitations that allied health

clinicians are subject to. Despite these limitations and a frequent sense of powerlessness, I have attained health systems leadership roles through persistent determination, relational engagement and a fundamental belief that capability supersedes clinical profession. I believe that successful health systems leadership as a clinician is not predicated on being a doctor or a nurse.

It has become increasingly important to me to inspire allied health clinicians to pursue health systems leadership roles. Initiating positive change within the health system would benefit the design and delivery of services and enable allied health clinicians to demonstrate their capability as effective leaders. This research study aims to establish a baseline of evidence to support and enable allied health clinicians to lead health systems within Aotearoa New Zealand. Consistent with Interpretive Description (my selected methodology), Chapter 3 provides further reflections on my personal positioning and theoretical 'baggage' (Thorne, 2016, p. 60).

1.3 Research Rationale and Significance

1.3.1 Clinicians as Health Systems Leaders

Health systems are complex phenomena under increasing pressures. They are adaptive, multifaceted environments that require a breadth and depth of competent and capable leadership (Dalton et al., 2021; Stolarek et al., 2022; Wojtak & Goldhar, 2019). Health systems leaders need to be cognisant of workforce professional cultures, able to influence strategically, comfortable working with difference, inclusive in approach and driven by participation rather than performance (Edmonstone, 2019; Want et al., 2019).

Systems leadership is an approach to delivering leadership for complex organisational environments (Edmonstone, 2019). Health systems leadership takes a broad, inclusive view of achieving successful health outcomes using the full diversity of resource available. This approach to leadership suggests a capability for perceiving the complexity of solutions to be achieved by considering factors beyond the professional lens of one's own clinical background. The following quotation illustrates how health systems leadership focuses on the capability for inclusion, humility and compassion:

It is about the way people need to behave when they face large, complex, difficult and seemingly intractable wicked problems; where they need to juggle the multiple uncertainties which they face; where no one person or organisation can find or organise a way forward on their own; where everyone is grappling with how to make the existing resources meet the demand which is outstripping them; and where the way forward, therefore, lies in involving as many people's energies, ideas and talents and expertise as possible. (Edmonstone, 2019, p. 26)

The ability to effectively lead multiple professional groups has never been more critical. Successfully led collaboration is essential as health organisations across Aotearoa New Zealand look to align their service design with Pae Ora (Healthy Futures) Act (New Zealand Government, 2022) and the 2022 health reforms

(Health New Zealand – Te Whatu Ora, 2022). This approach to leadership differs significantly in its requirements from the traditional approach of legacy leadership. This traditional approach focuses on, and frequently specifies, the recruitment of medical and nursing professions for health systems leadership roles. Contemporary health systems leadership is not about the profession, symbolic power, position or hierarchical authority of approach. The more contemporary approach required for health systems leadership is about relationships, diversity of perspective and embracing uncertainty (Edmonstone, 2019; Jackson et al., 2021; Mizzi & Marshall, 2024; Ogden et al., 2021).

Since Florence Nightingale's influential impact in leading change and shaping global health practice, international health systems leadership has continued to evolve (Nightingale, 1999). However, progress has not always been smooth, and the evolution has not always been for the better. Aotearoa New Zealand's health and disability system, nominally focussed on universal health coverage, initially took on a non-clinical management-led model (Quin, 2009). In the 1990s, a period of neoliberal¹ government brought changes that further shifted focus away from clinically-led service design, policy and provision across the health sector towards management-led organisation and funding structures (Gauld, 2009). The changes were designed to improve health outcomes, 'increase accountability and efficiency and to reduce escalating health expenditure' (Quin, 2009, p. 2). Where neoliberalism promoted management rather than clinical leadership, disadvantages emerged for specific populations, for example, those experiencing disability. The management focus on a free market rather than a right to health meant that people without long-term disability were less expensive to provide services to. This focus created and perpetuated a health system and leadership that delivers inequitable health outcomes and a society that disempowers those with high and complex health needs (Sakellariou & Rotarou, 2017). The leadership of health systems has focused on achieving fiscal efficiencies by meeting acute health needs and systemising short-term health issues. The positive intentions of contemporary health organisations and the existing Government regarding the current reforms are, therefore, shaped by neoliberalism, influencing existing strategic aims for the future.

In response to disengagement between public health management and clinicians in Aotearoa New Zealand, a Ministerial Task Group for New Zealand's Government completed a review of clinical leadership (Ministerial Task Group on Clinical Leadership, 2009). This important review determined that clinicians were key drivers of better health services and called for more clinicians to be involved in leadership. However, a focus on doctors and nurses implied they were considered the principal clinical leaders, overlooking other health professions. The emphasis on these professions in a publicly available government

¹ Neoliberalism comprises two notions – 'neo' meaning new and 'liberal' meaning free from government intervention. The neoliberal agenda of health care reform includes cost cutting for efficiency, decentralizing to the local or regional levels rather than the national levels, and setting health care up as a private good for sale rather than a public good paid for with tax dollars. McGregor, S. (2008). Neoliberalism and health care. *International Journal of Consumer Studies*, 25, 82–89. <https://doi.org/10.1111/j.1470-6431.2001.00183.x>

report highlights an existing workforce hierarchy (Nancarrow & Borthwick, 2021). This emphasis is perpetuated in popular media, with mainstream news interviews and social media highlighting the medical and nursing leadership of health systems today. Literature affirms that the medical and nursing professions remain dominant in health systems leadership and governance roles in Aotearoa New Zealand and around the globe (Boyce & Jackway, 2017; Fennell, 2021; Mizzi & Marshall, 2024; Te Whatu Ora – Health New Zealand, 2023). This predominance has had an enduring influence, and continues to shape a medico-centric leadership perspective for Aotearoa New Zealand’s health and disability system.

Despite this professional dominance in leadership, recent literature advocates that all health professions have an essential role in leading, developing and improving health and disability services (Scott et al., 2018). In 2020, Aotearoa New Zealand’s health and Disability System Review reported that the current inherited health and disability system with its ‘types of regulation, professional silos, provider-based system, and highly medical model will not meet future needs’ (Health and Disability System Review, 2020, p. 183). This conclusion echoes previous calls for a cohesive approach to leadership of organisational service provision and the systematic and transparent development of emerging leaders (Ministerial Task Group on Clinical Leadership, 2009). There is an increasing call for recruiting the right person (Gordon et al., 2015) and enabling a greater diversity of professions into leadership (Te Whatu Ora – Health New Zealand, 2023) rather than focusing on their clinical profession. The evidenced need for diverse, equitable and inclusive leadership is not new. Yet, these consistent calls for leadership development within health strategies have not yet been effectively translated into leadership practice or development for Aotearoa New Zealand.

1.3.2 Allied Health Systems Leaders

Research investigating allied health and leadership has typically focused on profession-specific leadership styles, behaviours or related outcomes (Isaacs et al., 2021; McGowan et al., 2018a). Other literature identifies the allied health workforce as a broad range of clinicians who may fulfil health systems leadership roles across services and professions, but require development and access to roles (NHS England and NHS Improvement, 2019b; Wylie & Gallagher, 2009). It may be hard for a single allied health profession and its smaller workforce to gain traction, given the dominance of their medical and nursing peers in leadership. Regardless of profession, an underrepresentation of allied health clinicians in health systems leadership roles is evident across health systems. This situation exists in conjunction with a paucity of literature addressing health systems leadership by allied health clinicians (Bradd et al., 2018b; Cumming et al., 2021; Dalton et al., 2021). It is, therefore, important to consider reframing the focus of allied health leadership research towards the collective allied health workforce. A broader inclusion would encompass a greater pool of workforce talent and help to raise the profile of the capability of those who are not in the nursing or medical professions. Engaging with the allied health workforce, rather than a single profession focus,

emphasises the contribution this broad pool of talent could make in influencing the design and shape of health systems as health systems leaders.

Some allied health clinicians do occupy health systems leadership positions within the global health system. There are national roles for the allied health workforce in the United Kingdom (UK), Australia and Aotearoa New Zealand. The inaugural Chief Allied Health Professions Officer (CAHPO) role for Manatū Hauora – Ministry of Health, Aotearoa New Zealand was created in February 2019. This role established consistent visibility of the allied health workforce for the whole health and disability system, alongside the already existing chief nursing and medical roles within the Ministry of Health. The subsequent 2024 appointment of the role of National Chief Allied Health, Scientific and Technical Officer for Health NZ, also provided the public health system with certainty of allied health representation (Health New Zealand – Te Whatu Ora, 2024). Both appointments at a national level have been important milestones in raising the profile of allied health clinicians into senior health systems leadership roles for Aotearoa New Zealand. However, these roles typically span across but remain limited to the allied health workforce. There remains a dearth of allied health clinicians visibly occupying health systems leadership roles that lead across the entire health workforce, spanning geopolitical boundaries and organisational cultures.

Globally, it is recognised that allied health clinicians remain underrepresented in senior and executive health systems leadership roles (Boyce & Jackway, 2017; Mizzi & Marshall, 2024). Research has identified that progression to senior leadership roles within health systems was rarely promoted as a legitimate career pathway (Dalton et al., 2021). In the UK, literature indicated that the skills and competencies required for leadership were unknown, disparity existed between professions for opportunities of experience, and the tension between clinical regulation and leadership accountability was a limiting factor (Faculty of Medical Leadership and Management, 2018). In Australia, research identifying the lack of allied health clinicians in senior leadership has emphasised the need to support equitable inclusion and to facilitate effective service design for contemporary health needs (Boyce & Jackway, 2017; Bradd et al., 2017; Bradd et al., 2018b; Dalton et al., 2021). There is growing recognition that the current approach to health systems leadership development is inequitable and exclusive.

International literature continues to endorse allied health clinicians for health systems leadership roles (Boyce & Jackway, 2017; Eddison et al., 2023; Mizzi & Marshall, 2024; NHS England, 2022). There is evidence of systems leadership attributes and philosophy e.g. inclusive interdisciplinary perspectives, embedded within allied health clinical training and models of practice (Bradd et al., 2018a). These philosophies inform allied health theoretical frameworks, and promote the use of the biopsychosocial model of care to complement their capability for systems thinking (Fry, 2009; New Zealand Institute of Economic Research, 2021). The Aotearoa New Zealand Government has argued that clinical involvement in leadership roles is critical to the success of population health outcomes and integral to health system

design (Ministerial Task Group on Clinical Leadership, 2009). However, as evidenced by the health reform strategy (Te Whatu Ora – Health New Zealand, 2023), there remains a lack of clear, evidence-based, coordinated and progressive leadership pathways for allied health clinicians.

Allied health clinicians are well positioned to effectively fulfil the broader health systems leadership roles. Allied health clinicians are known to be innovative, think outside of the traditional models, and be responsive and able to adapt to a range of changing population and organisational contexts (Nancarrow & Borthwick, 2021). Using interprofessional practice, they view consumer needs through a biopsychosocial lens that extends beyond the diagnosis to identify which services would improve outcomes (New Zealand Institute of Economic Research, 2021). The allied health workforce uses the influence and practice of collaboration to engage, treat and lead services, and there is a wealth of evidence demonstrating the impact of inclusive and equitable teamwork on health system outcomes (Manatū Hauora – Ministry of Health, 2023a; O'Donovan et al., 2021; Ogamba & Nwaberiegwu, 2020). These skills and capabilities meet health and disability system needs (Akhtar et al., 2016; Gauld, 2017; Ministerial Task Group on Clinical Leadership, 2009; NHS England, 2022; Suckling et al., 2015). The allied health clinician's experience of interprofessional practice, their understanding of multiple professional cultures and their orientation to systems thinking emphasise their potential and capability for working with complexity, multiple stakeholders and across a range of boundaries (New Zealand Institute of Economic Research, 2021).

Since 2010, a significant international health paradigm shift is underway in the approach to health system models and strategic delivery. Where once facilities, service providers, and managers were the sole focus of planning and funding, health and disability systems now advocate for a 'whole of system' view and consumer-centric approach (Health New Zealand – Te Whatu Ora & Māori Health Authority – Te Aka Whai Ora, 2022). As the shift towards this paradigm occurs, it is critical to develop the right people with the right skills and values to lead it (Health and Disability System Review, 2020). The existing Government in Aotearoa New Zealand looks to improve health and disability system leadership via innovation, workforce flexibility, and resource management. The future health system requires diverse clinical leadership to engage the health workforce, and provide systems thinking at all levels of strategic decision-making. This diversity needs to be contextual to Aotearoa New Zealand and inclusive of membership across our marginalised populations (Manatū Hauora – Ministry of Health, 2020a). Arguably, the initial future leadership development focus would benefit from including all workforce members who align with consumer-centric, community-focused services. If Aotearoa New Zealand's health system wants to radically change its perspective, and adopt a preventative population-tailored health system, it needs leadership that can provide this perspective. Such leaders would have an inclusive approach to health and wellbeing embedded within their systems thinking (Edmonstone, 2019; Wojtak & Goldhar, 2019). It is argued that allied health clinicians are well-placed to provide this essential leadership with their biopsychosocial lens, future-focused competency requirements and inclusive approach to person-centric service delivery

(Markham, 2015; Mizzi & Marshall, 2024; New Zealand Institute of Economic Research, 2021; NHS England, 2022; Wylie & Gallagher, 2009).

After nursing, the allied health profession's collective is the second-largest health workforce in Aotearoa New Zealand. Examples of allied health professions include physiotherapy, occupational therapy, radiography, social work and dietetics (see Appendix B for a full list). According to Central Region's Technical Advisory Services Limited (2020), 12,683 allied health clinicians were employed across Aotearoa New Zealand (including Scientific and Technical staff), compared to 5,781 senior medical officers employed by district health boards across the same population. Further, Allied Health Aotearoa New Zealand (2017) reported 30,000 allied health personnel from at least 43 different professions nationwide. These figures suggest the greater proportion of allied health workforce operates outside of Health New Zealand (Health NZ) employment, working within primary care and community services for private and non-governmental health organisations.

There is little data regarding allied health clinicians occupying health systems leadership roles in Aotearoa New Zealand. In 2021, 21 Directors of Allied Health were occupying roles on District Health Board executive leadership teams. In 2024, in the midst of health reform, these figures remained in flux. These senior and executive roles held by allied health clinicians involving the leadership of multiple professions across services, sectors, and geopolitical boundaries, are examples of health system leadership roles. They typically differ from medical and nursing executive roles because of the multiple professions they support and hold responsibility for. Where health leadership roles focus on a specific profession across services, they do not engage with the full scope of health systems leadership. Health systems leadership roles may be situated in quality improvement, health and safety, data and digital or aspects of health systems that strategically lead work across geopolitical boundaries, and across all professions and service sectors.

Anecdotal evidence points to a lack of visible allied health clinicians in health systems leadership roles across private, public, and non-governmental health organisations (NGOs). However, there is limited data on the demography and profession of those currently occupying health systems leadership roles. This makes it hard to define the scope, location, role type, or profession of allied health clinicians holding health systems leadership roles in Aotearoa New Zealand, limiting the public profile of allied health clinicians within health systems leadership roles. Colleagues, the public and the allied health workforce, remain unaware of allied health clinicians in health systems leadership roles.

As Aotearoa New Zealand's 2021 health reforms progress, ensuring effective health systems leadership has been at the forefront of implementing the organisational and workforce change. The uncertainty created by the public system's transition from regional to centralised operations has emphasised the opportunity to refresh the health system's leadership approach. The Health Systems Review (Health and Disability System Review, 2020) and Te Pae Tata Interim New Zealand Health Plan (Te Pae Tata) (2022) identified the priority

for developing an inclusive leadership and culture. This priority was emphasised as a key part of their strategies for putting people and whānau (families) at the heart of health. Within Te Pae Tata, Health New Zealand – Te Whatu Ora and Māori Health Authority – Te Aka Whai Ora (2022)² committed to establishing a Pae Ora Leadership Institute to develop existing and future leaders in health.

The National Health Workforce Plan (2023) then confirmed there would be a focus on establishing and developing the leadership institute for the whole workforce. There was a brief mention of allied health professions within their discussion, but the national initiatives for explicit leadership development pathways were specified only for the Nursing, Midwifery, Māori and Pacifica workforce. The narrow focus of the National Health Workforce Plan (2023) contrasted markedly with the direction for health system design expressed in the Te Pae Tata Interim New Zealand Health Plan (2022). The plan identified the need to align with the emergent international health paradigm. Where this emergent health paradigm focuses on timely, consumer-centric, community-focused services it moves away from the conventional facility, system flow, and efficiencies motivated orientation (Hayata, 2023; Health New Zealand – Te Whatu Ora & Māori Health Authority – Te Aka Whai Ora, 2022; van den Broek-Altenburg & Atherly, 2025).

The development and recruitment of allied health clinicians into health systems leadership roles is not identified as a strategic priority for the existing health system in Aotearoa New Zealand. Indications of inclusion for allied health clinicians are rather gestures of intention without proof of action. Allied health clinicians suggest there is danger in sitting back and letting others lead because it allows those who may not appreciate the breadth and depth of their potential to define them (Fry, 2009). To enable allied health clinicians to step into these roles and contribute to an inclusive and diverse leadership culture in Aotearoa New Zealand's health system, clear pathways for allied health staff to assume health systems leadership roles are needed (Manatū Hauora – Ministry of Health, 2020a; Mizzi & Marshall, 2024). This research is required to explore allied health clinicians' experiences of progressing into health systems leadership roles; to understand what these enabling pathways are and how they support allied health clinicians on their health systems leadership journey. This new knowledge is relevant for public and private health organisations, the Ministry of Health, senior allied health leaders, and the allied health workforce. The research outcomes will inform national and organisational strategic initiatives for health systems leadership development and career pathways. The findings will further inform organisational governance forums, tertiary institutes, professional bodies and senior health systems leaders, and leadership policies and processes. New knowledge about allied health clinicians in health systems leadership roles will raise the profile of the allied health clinicians' capability as health systems leaders. It will serve as a call for the system to review their health systems leadership in alignment with the evidence presented.

² The Māori Health Authority – Te Aka Whai Ora was disestablished on 30 June 2024.

1.4 Research Question, Aim and Objectives

This research sought to understand how allied health clinicians are enabled to step into health systems leadership roles. The following research question was posed to fulfil this research aim:

How are Allied Health Clinicians Enabled to Step into Health Systems Leadership Roles?

Three objectives were developed to investigate allied health clinicians' experiences:

1. Explore and identify a breadth of enabling experiences
2. Develop an understanding of what and why those experiences were meaningful
3. Develop recommendations for change that will support and encourage allied health clinicians into health systems leadership roles

This research study was underpinned by Social Constructionism and applied Interpretive Description as the theoretical framework. This philosophical foundation and theoretical framework scaffolded the study's exploration of participant experience. The disciplinary relevance of Interpretive Description helped manage the theoretical baggage brought into the study, enriching the interpretation and analysis (Crotty, 1998; Thorne, 2016). An appreciative inquiry lens was used to shape the interviews and provide a strengths-based approach to analysis (Whitney & Cooperrider, 2012). Data was analysed using reflexive thematic analysis (Braun & Clarke, 2022). This methodological approach helped to produce a wealth of rich data, facilitated the development of novel findings and enabled the development of recommendations for practice.

1.5 Structure of Thesis

This thesis has seven chapters and includes two manuscripts published during the research process. This chapter has provided an introduction to this research and thesis. Chapter 2 includes a literature review presented in two parts. The first part is the initial review of existing literature completed and published as a manuscript. The second part is an updated review completed to ensure all relevant literature was considered. Chapter 3 provides an overview of the methodology for this research. It includes the second published manuscript and provides a reflective account of the philosophical positioning and methodology chosen to frame this research study. Chapter 4 describes the methods, and critiques the tools, strategies, and techniques used to engage with and complete the research process. The value of reflexive practice is emphasised, and the methods employed to sustain rigour are discussed. The four themes were developed from analysis of the data and are presented in Chapter 5. Chapter 6 presents a synthesis of the findings, discussed within the context of existing research. The strengths and limitations of this research and how they have shaped the study's outcomes are also discussed. Finally, Chapter 7 combines the findings and discussion into nine recommendations focusing on the implications for Aotearoa New Zealand's health system's design, policy and practice. This final chapter identifies new knowledge developed, explores future

research directions, and draws the knowledge produced through this research together to conclude this thesis.

With only minor amendments for APA style alignment, the published manuscripts are presented as submitted for publication, and as a result, some repetition of information may occur within the chapters. Where a manuscript is included, it will be positioned between an introduction and chapter summary to provide coherence, emphasise key outcomes, and segue into the next chapter. The referencing format has been standardised using the APA style, and a comprehensive single reference list is provided at the end, followed by the appendices. The main academic writing style is in the third person, but transitions will occur between the third and first person, where there is a need to reflect a more personal tone of communication. When this transition occurs, it will be identified to the reader for seamless progression.

1.6 Chapter Summary

This research study examines the topic of allied health clinicians fulfilling health systems leadership roles in Aotearoa New Zealand. In this introductory chapter I have articulated my personal and professional motivations for undertaking this research. I have provided a contextual understanding of health systems leadership, focused on the current landscape for allied health clinicians in health systems leadership roles. I have communicated the rationale and significance of the study, highlighting the potential impact of its findings. The study's objectives and background information have shaped the research question: "How are Allied Health Clinicians Enabled to Step into Health Systems Leadership Roles?". With this foundational context, a literature review is presented in Chapter 2.

Chapter 2 Literature Review

2.1 Introduction

This research study seeks to contribute new insights to the fields of health systems leadership and allied health leadership development. The purpose of this literature review is to position this research within existing evidence and literature. Consistent with Interpretive Description (Thorne, 2016), the existing evidence base forms part of the study's theoretical framework. Thorne (2016) emphasises the role of existing disciplinary knowledge in informing and shaping a study's design. Health professional and researcher roles have similar requirements; both have a professional and ethical responsibility to deliver evidence-based outcomes. The ability to use and apply a synthesis of evidence to sustain the quality and safety of their practice is essential (Aveyard, 2023). Therefore, it is critical to articulate the knowledge base on which a study is premised so that new insights are clearly identifiable.

This chapter is set out in two parts. The first part comprises a published manuscript of the first Literature Review, which synthesised international and national evidence exploring allied health clinicians and health systems leadership, published after 2013 to the end of 2020 (further justification of these timeframes are included below). Due to a paucity of relevant research, a small number of key papers published before 2013 were included. These key papers orient to important aspects of allied health systems leadership which were not addressed in more recent publications. The second part includes a more recent literature review, synthesising updated evidence and information published between 2021 and 2024. To retain coherence through this chapter, both reviews synthesise literature under three subheadings, including **Health Leadership Frameworks, Current State** and **Enablers and Barriers**. These subheadings helped to focus the review, creating an evidence-based picture of the current positioning of allied health clinicians amidst health systems leadership nationally and internationally. The Chapter concludes with a summary which draws together findings from both reviews and provides key learnings for consideration.

2.2 Manuscript 1

An initial literature review was conducted and submitted for publication in 2020. This first narrative literature review was published in the Australasian Journal of Health Services Management (2021). It is included below as it was published, with minor amendments to the table layout and citations to align with the APA referencing style.

George, R. K., & Webster, K. (2021). The future of allied health leadership in New Zealand-Aotearoa: A literature review. *Asia Pacific Journal of Health Management*, 16(2), 16–27.

<https://doi.org/10.24083/apjhm.v16i2.743>

2.2.1 Abstract

BACKGROUND: The allied health, scientific and technical (allied health) workforce is the second largest workforce in New Zealand, providing diagnostic, therapeutic and preventative services. Increasingly, consumers present with complex conditions requiring multi-professional integrated services, and a legacy of profession-focused leadership development is being challenged (Akhtar et al., 2016). Future health and disability systems require leaders prepared to lead complex services, less focussed on their professional background and more on understanding their interprofessional services (Health and Disability System Review, 2020; Mickan et al., 2019). The allied health workforce is well placed to lead these systems, providing interprofessional experience, a biopsychosocial lens and collaborative models of practice.

AIM: To provide an understanding of the literature and research available that addresses the leadership of healthcare services by allied health clinicians.

METHODOLOGY: An initial database review was completed using a systematic approach across CINAHL complete, EBSCO Business, Medline, and EBSCO Health databases from March 2020 to September 2020. An expanded search used Google Scholar and NZ, UK and Australian-based government websites to access institutional documents, such as policies, reviews and reports.

RESULTS: The review identified an emerging pool of research on allied health leadership in Australia and the UK but a paucity of literature on allied health leadership in New Zealand. Three themes were identified and explored within the article: health leadership frameworks, current state and barriers and enablers identified.

CONCLUSIONS: Literature advocates for a broader scope of clinicians into strategic leadership roles. Despite evidence of strategic allied health roles in New Zealand, there remains a dearth of literature on allied health leadership. To foster and sustain the development of allied health leaders in New Zealand, it is important to understand the enablers that impact this process.

KEYWORDS: allied health, leadership, health system, disability, New Zealand, Aotearoa

2.2.2 Introduction

Healthcare is known for its complexity, its workforce diversity and ongoing financial challenges. It also continually presents more adaptive requirements than we can implement solutions to resolve. A health workforce looks to the health and disability system leadership to provide vision, direction and clarity (Marinelli-Poole et al., 2011; Markham, 2015; Swanwick & McKimm, 2011). Establishing effective leadership in healthcare across services, systems and the workforce, is key to supporting the provision of high-quality treatment, optimal results and the ongoing development of consumer-focused services (Bradd

et al., 2017; Gauld & Horsburgh, 2015a; McGowan et al., 2018a; Swanwick & McKimm, 2011). As healthcare continues to evolve in response to population diversity, digital technology development and health needs, it is suggested the recruitment of the most effective leadership possible is a logical objective.

New Zealand's allied health, scientific and technical collective of professions is a significant proportion of the health workforce. According to District Health Boards (DHBs) in New Zealand (Central Region's Technical Advisory Services Limited, 2020) the employed workforce number is 12,683. This compares with 5,781 Senior Medical Officers and 30,355 Nurses. Allied Health Aotearoa New Zealand (Allied Health Aotearoa New Zealand, 2017) reports that the allied health collective across both public and private sectors comprises more than 30,000 clinical professionals across 43 different professions, providing diagnostic, preventative and rehabilitative services. This makes allied health the second largest workforce in public health in New Zealand.

This article presents a review of the literature addressing leadership by allied health clinicians within the context of health and disability services internationally, regionally and locally in New Zealand. The themes identified include health leadership frameworks, current state and the barriers and enablers to allied health leadership.

2.2.3 Literature Search Method

A narrative literature review using a systematic approach to searching was undertaken to identify relevant literature on healthcare services leadership by allied health clinicians, seeking to gain an overview of the current state of research and empirical evidence available (Green et al., 2006). The search utilised electronic databases between March 2020 to September 2020, specifically: CINAHL Complete (Cumulative Index to Nursing and Allied Health Literature), EBSCO Business; Medline; and EBSCO Health databases. Search terms used were, health*, lead*, manage*, (multiprofessional or multidisciplinary), and (NZ, New Zealand or Aotearoa). Terms were used in combination and with the 'AND' Boolean. Database searches were initially limited to English-only citations published after 2013 to ensure relevancy and utilise the most recent research available. Peer-reviewed literature that addressed leadership methods, processes, case studies, frameworks and theory development were included. Conference papers, books and book chapters on allied health leadership were excluded, as were papers focused on disciplines whose context of practice was external to the public health and disability system, such as sports training or coaching. Due to a lack of research literature available using these parameters, key papers prior to 2013 were included and Google Scholar and NZ, UK and Australian based government websites provided access to relevant institutional documents, such as policies, reviews and reports.

EndnoteX9 software was used to manage the exclusion of duplicates and refine management of the references by keyword tagging and categorisation. Microsoft Excel provided the platform for data

synthesis, utilising the headings of author, theme, year, title, topic, methodology, findings, argument, and limitations to find emergent themes, commonalities and differences. The use of coding and identifying direct quotes enabled the researcher to synthesise the literature available according to their outcomes or perspectives. This supported the development of the key thematic areas addressed within existing evidence and an overall understanding of the current context of allied health leadership. The total number of articles found $n = 21$ is summarised in Table 1.

Table 1*A Summary of the Literature*

| Author (Year) | Country | Title | Topic | Findings |
|---|-------------|---|---|---|
| Boyce and Jackway (2017) | Australia | Allied Health Leaders: Australian Public Health Boards and Top Management Teams | Overview of allied health leadership positioning | AH is underrepresented on top management teams. AH only make up a quarter of the board positions. |
| Bradd et al. (2018a) | Australia | AH Leadership in NSW: a study of perceptions and priorities of AH leaders | Views and perceptions of AH leadership | Identified need to build and grow influence, demonstrate AH contribution, focus efforts on governance, performance, standards and advocacy. To increase scope of AH directors and across profession leaders. |
| Edmonstone (2013) | England | What is wrong with NHS leadership development? | Leader development vs leadership development | Principles outlined for leadership development |
| Edmonstone (2020) | England | Beyond healthcare leadership? The imperative for health and social care systems | Health and social care systems leadership | Health and social care as a system rather than separate organisations, developed through systems leadership. Leadership not individual leaders. |
| Faculty of Medical Leadership and Management (2018) | England | Review Report: Barriers and enablers for Clinicians moving into senior leadership roles | Clinical Leadership | Progression to leadership roles rarely promoted as legitimate career pathways. Skills and competencies required were not always clearly known. Need to identify and develop leadership talent. Lack of data about backgrounds and qualifications of senior NHS leaders. |
| Forsyth and Mason (2017) | England | Shared leadership and group identification in healthcare: the leadership beliefs of clinicians working in interprofessional teams | The leadership beliefs of clinicians in interprofessional teams - are they associated with professional or team identities. | No difference between professions about beliefs in shared leadership. Group identification link to clinician's leadership beliefs. |
| Fry (2009) | New Zealand | Social Work clinical leadership in allied health | Clinical leadership in social work in allied health in NZ | There are challenges and opportunities to use and develop skills and knowledge and practice to provide ah with unity and direction |

| Author (Year) | Country | Title | Topic | Findings |
|-------------------------------|--------------------------|--|---|--|
| Garman et al. (2020) | United States of America | Bridging Worldviews: Toward a common model of leadership across the health professions. | Revising and validating an interprofessional leadership competency model | Competencies all met the criteria for validity, 85% of the competencies also mapped to 5 other professional leadership models. Revised model is able to provide a common language framework for interdisciplinary leadership development |
| Gifford et al. (2018) | Canada | Managerial leadership for research use in nursing and allied health care professions: a systematic review | The association between leadership behaviours and nurse and AHPs use of research | Managers performed a diverse range of leadership behaviours - change oriented, relation oriented, and task oriented. Most common was support for the change. |
| Gordon et al. (2015) | United Kingdom | Dimensions, discourses and differences: trainees conceptualising health care leadership and followership | What does leadership and followership mean to medical trainees working in today's interprofessional health care workplace | dominance of individualistic discourse (hierarchy, personality and individual behaviours), context heavily influenced trainee's conceptualisations. |
| Marinelli-Poole et al. (2011) | New Zealand | New Zealand Health Leadership | The comparison of two different approaches to leadership development used in District Health Boards | Two distinct models of approach - no quantifiable outcomes demonstrated. |
| Markham (2015) | Australia | Allied Health: leaders in health care reform | The potential for allied health workforce to demonstrate leadership in healthcare reform | Health care challenges can be met by allied health workforce actively and effectively. |
| McGowan et al. (2018b) | Ireland | Leadership capabilities of physiotherapy leaders in Ireland: Part 2. Clinical Specialists and Advanced Physiotherapy Practitioners | Do Clinical Specialists and Advanced Physiotherapy Practitioners identify with leadership capability | Sample identified capabilities associated with all four domains. Predominance of skills in the human resource frame. Less in political and symbolic frames - same as physio managers |
| McGowan et al. (2018a) | Ireland | Leadership capabilities of physiotherapy leaders in Ireland: Part 1. Physiotherapy Managers | Do Physio managers identify with leadership capabilities across the four domains of the Bolman and Deal framework | Sample identified capabilities associated with all four domains. Predominance of skills in the structural and human resource frames. Symbolic frame was underused, fewer examples evidencing communication of vision, demonstrating passion and facilitating positive workforce culture. |

| Author (Year) | Country | Title | Topic | Findings |
|----------------------------|--------------------------|---|--|---|
| McGrath et al. (2019) | United States of America | Intentional interprofessional leadership in maternal and child health | Description of interprofessional training programme, evaluation and implications | Self-reported outcomes and in-depth focus on self, team and wider community |
| McKeever and Brown (2019) | Australia | What are the client, organisational and employee related outcomes of high quality leadership in the Allied Health professions? A Scoping Review | Qualitative outcomes as a result of high-quality leadership | 35 articles. Lack of viable AH research. 4 styles of leadership prevalent, traits of an effective leader identified, specific examples of outcomes relating to client, organisation and employee when leadership is effective. |
| Mickan et al. (2019) | Australia | Realist evaluation of allied health management in Queensland: what works, in which contexts and why. | Which key organisational contexts and mechanisms influenced outcomes for Allied Health Professionals | Identification of mechanisms that work to achieve effective and efficient outcomes |
| Orton and Hocking (2017) | New Zealand | Clinical Governance: Implications for occupational therapists in Aotearoa New Zealand | Exploring the impact of NZ's Clinical Governance (CG) framework on Occupational Therapy practice in NZ. | CG is poorly understood, CG gives therapists responsibility for quality improvement. Expectations for clients to take responsibility may not be achievable by all. OTs need to consider how to respond to CG. CG requires leadership - but due to poor understanding leadership may not be fulfilled. |
| Scott et al. (2018) | Canada | Building Healthcare Leadership Capacity: Strategy, Insights and Reflections | Review and overview of the Dorothy Wylie Health Leaders Institute, Canada. | Leadership is crucial to the success of complex healthcare. |
| Smith et al. (2018) | England | Leadership in interprofessional health and social care teams: a literature review | A review examining how leaders of interprofessional teams are functioning and synthesis identifying factors that contribute to good leadership practice. | Limited literature. 28 papers. 12 domains identified. |
| Wylie and Gallagher (2009) | Australia | Transformational Leadership Behaviours in Allied Health Professions | An evaluation of self-perceived leadership profiles across different Allied Health professions | Significant differences in transformational leadership behaviours between individual AH professions. Radiographers and Podiatrists scored consistently lower, seniority of grade influenced scores, prior training influenced scores. |

2.2.4 Health Leadership Frameworks

Until July 2022 there are 21 District Health Boards (DHBs) in Aotearoa New Zealand who have a variety of roles at their executive board level (Department of Prime Minister and Cabinet, 2021). These are led by clinical and non-clinical leaders whose perspective spans clinical and operational systems. Each DHB autonomously creates and shapes their leadership and governance structure according to the perceived need (Minister of Health, 2000). In 2016, the refreshed Aotearoa New Zealand Health Strategy was published providing clear direction to ensuring 'Value and high performance, Te whāinga hua me te tika o ngā mahi' of the health system performing as 'One team, Kotahi te tīma.' The theme 'One team' focuses on building leadership, talent and diversity within the workforce. Reducing fragmentation of services and fostering collaboration are key elements to improving timely service provision, access to services and reducing duplication of resource (Ministry of Health, 2016). However, the refreshed strategy only partially achieved the outcomes it sought. A lack of coordinated leadership development across the health and disability workforce emphasised the need to develop leaders early and create deliberate career pathways (Health and Disability System Review, 2020).

A key aspect of healthcare governance is the empowerment of clinicians into leadership roles. In 2009, The Ministerial Task Group Report 'In Good Hands: Transforming Clinical Governance in New Zealand' (Ministerial Task Group on Clinical Leadership) was published outlining the transformative changes required to the leadership of clinicians as well as identifying the need to nurture clinicians into roles to lead. The Task Group reported 'healthcare that has competent, diffuse, transformational, shared leadership is safe, effective, resource efficient and economical' (Ministerial Task Group on Clinical Leadership, 2009). However, the implementation of their recommendations on clinical governance has not been without its challenges. Orton and Hocking (2017) reported that each DHB was left to interpret the recommendations in their own way and develop their own frameworks. This evidence contradicts the intention of a united and shared vision for a standardised approach to clinical governance.

Exploring the implications of clinical governance for occupational therapists in NZ, Orton and Hocking (2017) affirmed the benefit it has on quality improvement and service reform and concluded that the proposed advantages that clinical governance brings to the development of leadership and the healthcare system in NZ present opportunities but only when it is fully understood. It is suggested we continue to lack a coherent and easily implemented leadership framework for healthcare and disability services in NZ. While there is evidence of DHBs working hard to implement localised leadership development and training courses, they don't have a single framework to reference for consistent and quality assured competency requirements (Marinelli-Poole et al., 2011). Garman et al. (2020) suggests that the use of a universal framework or model provides neutral territory for developing programmes. He goes on to claim there are indeed 'more similarities than differences in the leadership development challenges' faced by health

systems within a nation (p.9). Although this claim is supported by Marinelli-Poole et al. (2011) their case study included only two DHBs in NZ, a sample too small to confirm the claim across NZ healthcare organisations.

Evidence demonstrates that ineffective leadership leads to poor patient outcomes and is associated with inadequately performing healthcare services (Mianda & Voce, 2017). The drive therefore for successful outcomes and positive high-performance measures within healthcare systems has seen a diverse number of healthcare service leadership models and provision frameworks across Aotearoa New Zealand and Australia. Modern healthcare is delivered from within a team-based framework utilising a breadth of skills across professions and a focus on positive healthcare experience, which emphasises the critical elements of consumer engagement and consumer centred care (Markham, 2015; Ministry of Health, 2016). Examples of leadership programmes developed for the Aotearoa New Zealand health service include; The Leading Excellence in Health Care Programme and Xcelr8 (Marinelli-Poole et al., 2011), i3 Health Leadership (i3 Institute for Innovation and Improvement, 2021) and HELM – Hub for the Essentials of Leadership and Management (HealthLearn, 2021).

In a world where our populations are presenting with more complex conditions, they typically require an approach that has a broader perspective rather than solely a diagnostic focus. According to McKeever and Brown (2019) ‘any professional group can improve the quality scores for health services not just medical and nursing.’ There is a growing emphasis on interprofessional health teams to lead cohesively to meet the needs of the consumer (Health and Disability System Review, 2020; McGrath et al., 2019). In order to facilitate effective interprofessional service delivery it requires leadership with an understanding across agencies and professions involved. Evidence suggests that allied health clinicians achieve successful outcomes where they have a systems leadership role. Improved patient outcomes, reduction in wait list volumes for medical and surgical interventions and the provision of high-quality outcomes are proven results of allied health clinician led services and clinics (Markham, 2015; Micken et al., 2019)

A growing number of institutes around the world are developing health leadership competency frameworks. This is in response to the growing evidence that effective leadership is crucial to a healthcare organisations success in meeting the increasingly complex challenges of a population’s health needs. In the United Kingdom’s (UK) National Health Service (NHS) report ‘High Quality Care for All’, Darzi (2008) affirms that leadership is a mechanism for change and will enhance the quality of provision to patients where the opportunities are taken up. Leadership is a central component to supporting patients towards optimal clinical outcomes and the accurate assessment of leadership performance plays a vital role in the development and improvement of leadership for healthcare organisations (Garman et al., 2020; Hui-Gek et al., 2016; Scott et al., 2018).

In his research of the conceptualisation of health care leadership by medical trainees, Gordon et al. (2015) argues that the individualistic, profession-based leadership model is out of date in its capacity to respond to contemporary healthcare. Where context and educational influence play important roles in leadership conceptualisation, it is now proposed that development of health leadership is more effective than leader development within the healthcare context (Edmonstone, 2013, 2020). Therefore, the individualistic and profession-based leadership model of development is likely to 'self-perpetuate' within an individualistic workplace culture (Gordon et al., 2015, p. 1260). Where an individualistic profession focus perpetuates siloed leadership programmes, competency in interprofessional leadership cannot be gained (Akhtar et al., 2016). Knowledge and awareness of the interplay between professions is key to leading the contemporary healthcare system and services provided. Leadership in this context is therefore required to not only acknowledge the contributing professions but their culture, identity and unique skill mix (Mickan et al., 2019).

Leadership across multiple professional groups has never been more critical. As our Aotearoa New Zealand health organisations and governance structures look to their service design, effectively led collaboration is essential (Garman et al., 2020). The NHS Improvement (2019) report 'Clinical Leadership – a framework for action' emphasises 'collaborative and compassionate' leadership as one of the requirements to meet contemporary healthcare challenges (p.2). Leadership requires good communication and consultation skills to manage diverse teams. Interprofessional leadership can be demanding since it does not rely on the professional credibility as a locus of authority (Smith et al., 2018). Recommended leadership competencies extend beyond operational skills to inherent values, behaviours and relationships. Garman et al. (2020) argues that where a leadership model does not include them it reflects a potential 'blind spot' (P.7). Therefore, where a specialised and technical focus is required for clinical skills a more board perspective and pan-profession orientation is required for leadership. With growing evidence that the future of healthcare reform lies in leadership of interprofessional team's, literature argues it is a disadvantage to staff that their opportunities for leadership and development are not based on an interprofessional model of leadership (Boyce, 2014; Garman et al., 2020). There is recognition in the literature that leadership in healthcare transcends professions, Bradd et al. (2018a) report that allied health staff are well positioned to lead healthcare reform premised on a culture that focuses on being 'holistic, person centred, team based and inclusive.' According to Mickan et al. (2019) allied health leaders understand the uniqueness of different professions, able to enhance patient care through the delivery of appropriate models of care.

2.2.5 Current State

Comparative to the wealth of literature on health leadership premised on medical and nursing professions, there is a paucity of literature on allied health leadership in contemporary healthcare (Bradd et al., 2018a; Gifford et al., 2018; McGowan et al., 2018b; McKeever & Brown, 2019; McNabb, 2009; Wylie & Gallagher,

2009). Typically, where research has been conducted on leadership by allied health clinicians it is typically focused on the leadership of a single profession, and addresses a single profession's leadership style, behaviours or related outcomes (Bradd et al., 2017) Since 2017, Australia and the United Kingdom (UK) have begun to address allied health leadership across professional boundaries. Taking a broader view in their leadership research both Bradd et al. (2017); (2018a) and Boyce and Jackway (2017) have researched the leadership experience and capacity of allied health professions across multiple professions. While in the UK, the NHS Improvement forum has recently published reports addressing the current state of Allied Health leadership and designed a framework to support leadership development (NHS Improvement, 2018, 2019) The NHS Improvement (2018) research collated information from allied health leaders leading allied health professions as well as those in senior leadership they reported to. It provided new information on the lack of organisational governance infrastructure supporting allied health services and the impact it had on delivery and productivity. The study also had a second focus on the 'characteristics, key skills and attributes of effective AHP leaders' and how they had been gained (p.15). Despite this progress little is understood about the barriers or enablers to allied health staff progressing into systems leadership roles.

As evidenced by the literature, Australia and the UK have made significant progress into the allied health leadership research field (Boyce & Jackway, 2017; Bradd et al., 2018a, 2018b; NHS Improvement, 2018). It is argued that one of their key drivers for research is the lack of established and unified allied health leadership roles (NHS Improvement, 2018). Conversely, in NZ there are strategic allied health leadership roles at every DHB executive board level but a lack of evidence to support the efficacy and impact of the existing allied health leadership. This absence of evidence exists across leadership capability and the requirements for development of future leaders. While the gap in research exists, it is a challenge to understand how to support the leadership of healthcare by allied health professionals and increase their potential for impact at the strategic and health reform level. There are many avenues of research available and key drivers include the current transformational shift in healthcare towards cohesive and integrated services, the recent appointment of a chief allied health professions officer and the predominance of non-allied health staff in governance roles (Health and Disability System Review, 2020).

Wylie and Gallagher (2009) argued that it is vital that allied Health professions develop leaders to fulfil their potential by seizing opportunities presented in the redesign of health care services. They suggested that having the leadership capacity would support allied health leaders in contributing to the services most in need of reform and improvement. This is affirmed by the Australian study of allied health leadership perceptions by Bradd et al. (2018a) which reports not only is there under-representation of allied health professions in health system change roles but that allied health leaders feel 'powerless to affect health system change compared to their colleagues'(p.2).

There is a lack of empirical evidence regarding the added value of allied health leadership is clear but what there is identifies a connection between successful health outcomes and effective allied health leadership (Bradd et al., 2017; McKeever & Brown, 2019). According to Markham (2015) allied health is 'front seat' to lead changes in health system using leadership, workforce model changes and a focus on prevention and early intervention. Mickan et al. (2019)'s study reported executives described allied health leaders as 'influential' in the development of new models of care, using collaborative models of service delivery 'adding value' to business and improved outcomes for consumers.

2.2.6 Barriers and Enablers

According to Orton and Hocking (2017) allied health professionals may not always take leadership opportunities due to a lack of recognition of their own potential. The context in which they practice may also influence their perceptions of leadership. Wylie and Gallagher (2009) studied the transformational behaviours in allied health leaders and identified that if new allied Health professional graduates do not receive leadership development training the context in which they practice is likely to make them resistant to change. Conversely Bradd et al. (2018b) identify that there is success in improving outcomes for healthcare when allied health leadership training is provided, without stipulating timing of provision. Regardless of when the training is provided it is evident that training and development is effective in creating leadership capability (Scott et al., 2018). Consideration of context also includes organisational culture. If allied health leadership is not supported within the organisational culture then there can be a negative impact on organisational performance (Mannion et al., 2005)

A key report published in the UK by the Faculty of Medical Leadership and Management (2018) identifies a dominance of medical and nursing professionals in leadership roles. This finding aligns with a previous study for Aotearoa New Zealand published by Gauld and Horsburgh (2015b). The Faculty of Medical Leadership and Management (2018) made key recommendations to support the increase of clinicians into senior leadership roles, drawing on leadership across 'all relevant clinical professions' (p. 8). While the recommendations were inclusive the study sample was not and the majority of views were provided by medical and nursing staff, limiting the generalisability of their findings. An indication that medical leaders can be more easily identified, is substantiated by Gordon et al. (2015) who reported in his research that participating trainee doctors saw their role as one which should be taking the lead.

Literature identifies that context and education play significant roles in how leadership is perceived, this suggests that leadership culture change is associated closely with training (Gordon et al., 2015, p. 1260). Training is required to develop the insights and tools to lead effectively in 'volatile, uncertain, complex and ambiguous situations' (Impact International, 2012; Scott et al., 2018, p. 11). Considering context, a lack of professional partnership and interprofessional engagement undermine the ability to contribute to strategic and operational elements of health care planning and service provision (Gauld & Horsburgh, 2015b). All

clinicians, including allied health professions need to be viewed as equals rather than through a hierarchical perspective. Where recruitment is specified to a profession, rightly or wrongly, it does not allow for the employment of the most appropriate person and could lead to the inequity of opportunities for staff to lead. This in turn can lead to allied health professionals feeling disempowered in comparison to their colleagues (Bradd et al., 2018a).

2.2.7 Conclusion

The international literature affirms expanding the scope of clinicians in systems leadership roles (Faculty of Medical Leadership and Management, 2018). The allied health workforce are called to step forward and lead, that they may be understood and use their valued skills to help shape Aotearoa New Zealand's health and disability system (Fry, 2009). While Aotearoa New Zealand supports allied health clinicians in health systems leadership roles, there remains an inequitable representation across the health and disability system. Contextualised research is required in order to understand what factors, enable or limit allied health clinicians stepping into health systems leadership roles. These research findings could be used to inform the Ministry of Health, senior allied health leaders, health organisations and the allied health community. The information could be used to develop frameworks and policy that will support, develop and sustain allied health clinicians leading across the health and disability system.

2.3 Literature Review Update 2021–2024

2.3.1 Introduction

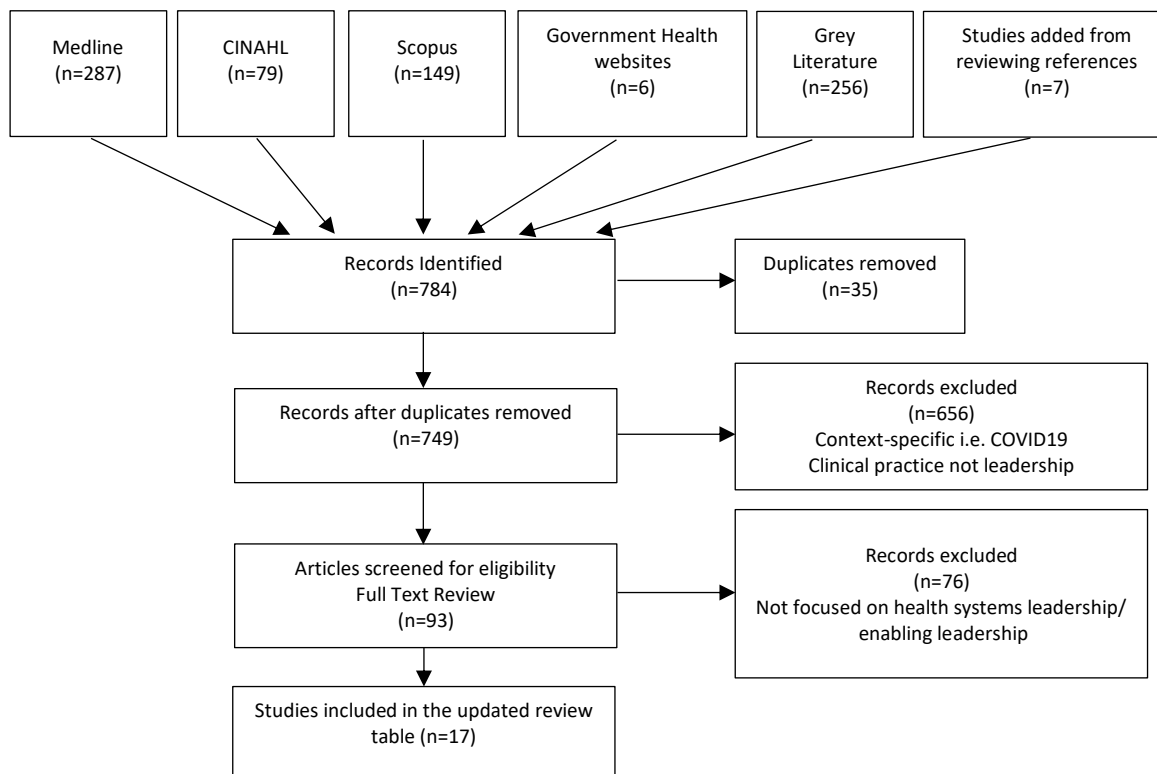
This literature update includes research and information identified between the beginning of 2021 and 2024. The structure of this updated review aligns with the first review and the literature will be discussed using the same subheadings of *Health Leadership Frameworks, Current State, and Enablers and Barriers*. The Chapter Summary will draw findings from both reviews together and synthesise key learnings for discussion later in the thesis.

2.3.2 Literature Search Method

The approach taken to review, screen, and select the updated literature aligns with the review methods of the first review. A systematic approach was taken to searching for literature focussing on allied health leadership and its position within the broader health leadership literary field. Seeking to understand the prevalence, scope, and tone of research and literature, the updated search utilised the same electronic databases but limited the search to papers published between January 2021 and July 2024. Databases included CINAHL Complete (Cumulative Index to Nursing and Allied Health Literature), EBSCO Business, Medline, EBSCO Health databases and Scopus. Additional Grey literature was sought using Google Scholar, The Kings Fund and Government health websites (see Figure 1).

Search terms used were health*, lead*, manage*, (multi-professional or multidisciplinary), and (NZ, New Zealand or Aotearoa). Terms were used in combination using the 'AND' Boolean. Database searches were limited to English-only citations published from January 2021 to identify new evidence published since the earlier search. Peer-reviewed and grey literature that addressed leadership methods, policy, case studies, frameworks and theory development were considered. Conference papers, books and book chapters on health systems leadership were excluded from the review. Two papers, which preceded 2021 and hadn't been previously identified were identified through the screening of citation lists and selected for inclusion. Papers were eligible for inclusion if they discussed leadership in health services by the allied health collective of professions in alignment with Edmonstone (2020) definition of health systems leadership. National and international grey literature which discussed health systems leadership was also screened for eligibility. Papers that focused solely on nursing or medicine or on disciplines whose context of practice was external to the public health and disability system, such as sports training or coaching, were excluded. Literature that did not apply leadership insights to practice was also excluded. Literature that did not meet the inclusion criteria was identified from in-depth reading of the text. Grounded in the applied definition of health systems leadership from Edmonstone (2020), each text received a critical review with a subjective and informed 'insider' lens. Leaning on Page et al. (2021) and the updated PRISMA approach, Figure 1 provides an overview of the systematic approach taken in this additional Literature Review.

Figure 1
Flow Diagram Outlining Systematic Approach to Literature Search



The advent of the global pandemic in 2021 and the surge in awareness of the need for effective leadership of complex health service delivery prompted a wealth of published literature discussing a diverse range of health leadership issues. These papers discussed specific pandemic factors impacting health leadership and how the workforce had responded to, or been impacted by, the pandemic rather than discussing sustainable health systems leadership. Completing the updated literature search identified the number of government documents focused on health systems leadership, and particularly allied health leadership, published since the first search had markedly increased. Table 2 provides an overview of the articles included in this updated literature review, including purpose and findings relevant to this doctoral research.

Table 2*A Summary of the Updated Literature*

| Author (Year) | Country | Title | Purpose | Findings |
|---|-----------|---|--|--|
| Australian Healthcare and Hospitals Association (AHHA) (2022) | Australia | Allied Health Leadership and Advancing Practice Framework 2022 | A framework and model to guide the training of the allied health workforce of Queensland in the non-clinical skills expected for career progression. | With an intra-allied health professions focus it gave four reasons for a leadership framework and identified four milestones of leadership - leads self, leads others, leads innovations and leads systems. Each was associated with a role phase, a focus and training content. Self assessment tools are provided for establishing a baseline and evaluating progress. Leads systems role phase has breadth of scope across professional boundaries, stakeholders, services and sectors. This framework provides an enabling mechanism to support clinicians' progression into and through leadership. It standardises an approach to understanding the scope of leadership skill set in practice. |
| Colesby (2024) | England | How are Allied Health Professionals represented at board level in NHS Trusts in the West Midlands? | Establish and explore the representation of AHPs at NHS Trust board level. | A statistically significant underrepresentation of allied health professionals at trust board level across the West Midlands. Limited by inclusion criteria but recognises the implications of these findings impacting workforce health and safety and informing accurate operational assessments. |
| Dalton et al. (2021) | Australia | Leading health reform: a critical review of 'leadership' within allied health competency standards | Analysis of where and how 18 allied health disciplines align with the Australian health LEADS framework. | Health leadership was not easily discernible within the allied health practice standards that were studied. Only two professions out of 18 reviewed, specified leadership and defined it, most references to leadership were vague and unclear. The study strongly contended that leadership is essential at all health system levels, leadership frameworks can guide leadership development and support professional competency standards to achieve clarity and promote leadership identity for allied health professionals. The study called for the reinstatement of a national health leadership framework across all professional groups. |
| Eddison et al. (2023) | England | Exploration of the Representation of the Allied Health Professions in Senior Leadership Positions in the UK National Health Service | An exploration of allied health leadership roles across NHS Trusts and health boards in the UK. | Research identified gaps in Exec Board policy and legislation, senior AHP positions should be open to all AH professionals along with opportunities for and access to training and development, early career pathways would enable development initiation earlier than existing practice. Lack of visible role models contributes to reduced sense of identity. Practices that prevent AHPs from harnessing their leadership ability need to be removed. |

| Author (Year) | Country | Title | Purpose | Findings |
|----------------------|--------------------------|---|---|--|
| George et al. (2021) | Aotearoa New Zealand | Allied Health: Leading Digital and Data Driven Health and Disability Services. | A Position Statement asserting four needs of digital, and data driven services by allied health professionals. | The position statement acknowledged the value of Allied health, scientific and technical professions in Aotearoa New Zealand, identifying their capacity for leadership, collaboration, healthcare reform and improved digital and data competency. The statement highlights the potential for the professions to lead in designing and shaping the future health and disability system to meet population need. They assert that leadership, collaboration, service evolution and digital and data capabilities are essential for enabling a competent workforce and delivery of contemporary services. |
| Koh et al. (2022) | Singapore | The hard truth about soft skills: Exploring the association between leadership competency and career advancement of allied health professionals | An ecological, cross-sectional study investigating how organisations could engage with their employees in career progression to everyone's benefit. | Employee engagement impacts organisational performance, career advancement is a determinant, leadership competency is factor influencing career advancement. Organisations need to engage with workforce on career advancement to retain talented and productive individuals. Use of the AHEAD tool identified association between some leadership competencies and the perception of career advancement. Competency evidence included mentoring, academic attainment, relationships as social capital, leveraging networks. Study found AHPs require a myriad of skills and soft skills play an equally if not greater role in effective leadership than hard skills. |
| Kutz (2004) | United States of America | Necessity of leadership development in allied health education programs | A Literature Review addressing the integration of leadership development within educational programs. | The promotion of Allied health professions has long been debated and advancing their value is proving difficult without the necessary leadership skills. The review found that the Coalition of Allied Health Leadership who connects and informs leaders has five relevant goals that are worth considering as leadership competencies for allied health clinicians. These five goals include - mentoring skills, relationships, change management, self-knowledge and how leadership relates to AHP practice. The study strongly promoted leadership development as separate and distinct from management training. Where AHPs step into leadership roles it can only enhance the credibility of AHPs in the eyes of the community and their colleagues. |
| Lindsay (2022) | England | Innovation, exploration and a whole lot of learning through an online programme of Allied Health Professional development. | Action research study delivering leadership development training for allied health clinicians. | The study found that transparency and open communication in online training enabled the effective delivery of leadership development. The training resulted in a broader understanding of health systems leadership, validation of their leadership skill set, empowerment for their 'voice' and enabled participants to identify and experience influence as leaders. |

| Author (Year) | Country | Title | Purpose | Findings |
|--|----------------------|--|---|---|
| Manatū Hauora – Ministry of Health (2023b) | Aotearoa New Zealand | Clinical Leadership in Manatū Hauora | A document defining and outlining the value of Clinical Leadership in the context of Manatū Hauora | The document promotes clinical leadership for strong collaboration and the integration of clinical leaders throughout Manatū Hauora. The document articulates a definition of clinical leadership because of a series of interviews and a scoping literature review. Very little literature was found nationally or globally addressing an agreed definition of clinical leadership within government organisations. Four principles were developed: Collaborative leadership, System quality, Enacting Te Tiriti, Capability building. These principles focus on clinical safety and delivery as well as interdisciplinary collaboration and strengthening of leadership capability. |
| Manatū Hauora – Ministry of Health (2024b) | Aotearoa New Zealand | Hauora Haumi Allied Health Report. | To collate information about 14 Allied Health Professions in Aotearoa New Zealand that identifies their current population benefit for achieving Pae Ora, the issues preventing their contributions, and with additional data, foster greater understanding of these professions. | 14 allied health professions provided an outline of their profession, pathways to registration, workforce data and the benefits of a highly enabled profession. The executive summary lists the shared opportunities and barriers identified across the professions. They included enabling full scope of practice, delivering culturally safe practice, improving training pathways. Barriers identified included loss of experienced professionals, focus on biomedical models of care, lack of understanding by public and wider sector. |
| Manatū Hauora – Ministry of Health (2021) | Aotearoa New Zealand | Allied Health Business Plan 2021-2023 | A strategic business plan detailing the aim, goals and actions for the Chief Allied Health Professions Officer. | The report details the five challenges facing allied health workforce in Aotearoa New Zealand and acknowledges the role of the Chief AHP Officer as providing clinical governance. The business plan includes specific mention of leadership and key enabling actions to build frameworks to support allied health leadership. In alignment to the Ministry of Health's driver of 'Strengthen System Leadership', it states the aim of 'developing allied health leadership in the broad sector.' This aim outlines actions of - providing secondments at the Ministry, delivering services that demonstrate leadership, and publishing a generic allied health career framework. |
| Martin et al. (2021) | Australia | Gender balance in pharmacy leadership: Are we making progress? | Analysis of Australian pharmacy organisations data from their board/committees/council's historical membership. | Gender disparity continues to exist despite prevalence of women in the professional discipline of pharmacy. Diversity is known to deliver organisational benefits and therefore should receive additional focus time and resources to build greater diversity within leadership teams. The analysis found that Australian pharmacy associations/regulators were on track to reach a 50/50 balance for gender membership in 2029. The study asserted that diversity in leadership shouldn't just focus on gender but include |

| Author (Year) | Country | Title | Purpose | Findings |
|---|----------------------|---|---|--|
| | | | | consideration of race, ethnicity, sexual orientation and age. |
| Mizzi and Marshall (2024) | England | Inequitable Barriers and Opportunities for Leadership and Professional Development, Identified by Early-Career to Mid-Career Allied Health Professionals | A feasibility study explored the views of allied health clinicians regarding barriers and enablers to both leadership and career development. | Research resulted in three overarching themes - equitable and interprofessional leadership development, an equitable and structured AHP career pathway, having AHP leaders at a strategic and/or very senior level. Umbrella category across all three of Equity of Opportunity and Voice. Four themes discussed - leadership qualities across seniorities and specialisms / the importance of leadership development / barriers to AHP leadership development and career progression / Opportunities for AHP leadership development and career progression. |
| New Zealand Institute of Economic Research (2021) | Aotearoa New Zealand | Hidden in Plain Sight | A report that identifies, demonstrates and advocates for the value that allied health professionals provide to the health services in Aotearoa New Zealand. | The report calls for greater inclusion of allied health practitioners across a consumer-centric system design, an approach to governance not based on professional hierarchy, and for funding equitable inclusion in collaborative service design. While it does not explicitly mention leadership. The actions detailed and recommendations made, indicate the need for allied health clinicians to participate in systems leadership decision making and service design for implementation. The report strongly advocates for the Aotearoa New Zealand health system executive/decision makers and governance personnel to recognise the value of what allied health professions can deliver for the benefit of all. |
| NHS England (2023) | England | Paramedic Leadership in Ambulance Trusts in England - Understanding the Synergies and Differences with Other Allied Health Professions' Leadership and Leadership Development | A study into the state of leadership development within the paramedic profession and it's alignment with AHPs for professional growth, credibility and service development. | The study found that there is inclusion and alignment with the existing broader AHP leadership situations. Current state of paramedicine aligns with lack of diversity, not recognising leadership potential and few embedded leadership roles. Leadership development needs to start at undergrad training, and include strategic whole systems thinking, the use of mentoring and champions, establishing relationships, and developing perspectives beyond paramedicine and beyond health. |
| NHS England and NHS Improvement (2022) | England | Allied Health Professionals within Integrated Care Systems - Guidance for Executives and Senior Leaders | Strategic report providing practical guidance for identifying, recognising and using AHPs in Integrated Care services. | This report seeks to emphasise and signal the value and benefits of AHP leadership. It recommends identifying senior AHP leadership of the AHP workforce and if not available to establish AHP leadership resource to support the planning and delivery of services. The report strongly advocates for AHP representation within the design and decision making of infrastructure when developing services. It acknowledges the need for data to extend their evidence base and recommends support for AHPs to develop through their careers in leadership and improvement capacity and capability. |

| Author (Year) | Country | Title | Purpose | Findings |
|--|--------------------------|---|---|---|
| Te Tāhū Hauora – Health Quality and Safety Commission (2024) | Aotearoa New Zealand | Clinical Governance Framework - Collaborating for Quality (DRAFT) | A framework and model to guide the health workforce in how to implement and enable Clinical Governance in New Zealand | This is a review and refresh of the Clinical Governance Framework used by the Health Quality and Safety Commission for Aotearoa New Zealand. Leadership is a 'system driver' - stated to have an important role in influencing the quality of health services and enabling the workforce. Leadership actions are operational for implementation and monitoring progress. |
| Te Whatu Ora – Health New Zealand (2023) | Aotearoa New Zealand | Health Workforce Plan 2023-24 | Interim strategic plan to support and enable the health workforce in Aotearoa New Zealand | Current state of workforce described and focus concerns identified. 6 Action areas set out for implementation. The sixth was 'growing our future leaders' with intention to 'invest and develop.' It identifies that AHPs are 'key to emergent models of care' and need to be included in leadership development for a system that needs 'diverse leaders.' It proposes a leadership institute with a focus to promote Māori and Pacifica leadership development and for those who have not traditionally had access 'i.e. allied health professions.' |
| Wiedman (2023) | United States of America | Physical therapists' professional role identity in the clinician to leader transition | A study exploring the space of professional identity when physical therapy clinicians move into leadership roles. | This study focused on the experiences of physical therapists in the space of professional identity when moving into a leadership role. The research study's six themes identified that participants recognised a non-clinical skill set that benefitted their transition even though it was uncomfortable. They found value in relationships, autonomy and connecting leadership with their profession. They also found that their professional identity was informed by their discipline identity, expanding their scope of practice but remaining connected. Findings refuted perceptions that leadership is separate to clinical practice. The study argued for the integration of leadership skills as part of professional practice. |

2.3.3 Health Leadership Frameworks

Since 2021, documentation on health leadership frameworks has primarily included grey literature produced by government bodies and health organisations. These reports place different degrees of emphasis on the allied health workforce. Some discuss them directly (Australian Healthcare and Hospitals Association (AHHA), 2022), and others only allude to the broader health workforce (Te Tāhū Hauora – Health Quality and Safety Commission, 2024). However, all the reports are relevant to allied health professions, advocating for leadership roles in support of the health system, workforce, and consumers.

There were distinct differences across the literature regarding the perceived leadership futures of allied health clinicians. The authors either took a passive position in tone and language, setting allied health clinicians outside the existing leadership structures or were more active, using assertive language to demonstrate the existing allied health leadership and capabilities of allied health clinicians. NHS England and NHS Improvement (2022) published a guide for health system executives and senior leaders on allied health involvement in newly formed Integrated Care Services. Building on a previous publication (NHS Improvement, 2018), the guide re-emphasised the benefits of recognising and using allied health clinicians in leadership, highlighting the improvement in healthcare achieved by recruiting allied health clinicians into health systems leadership roles. The tone implied that this leadership level continued to be aspirational for the allied health workforce despite prior literature evidencing their existence at those leadership levels (see section 2.2.5). Similar positions were conveyed within *The AHP Strategy for England: AHPs Deliver* (NHS England, 2022) and the *Allied Health Leadership and Advancing Practice Framework 2022* (Australian Healthcare and Hospitals Association (AHHA), 2022). Both inferred that allied health clinicians had the potential to lead, using future focussed language such as ‘can’ and ‘will.’ These pieces of literature conveyed the perspective that the allied health workforce viewed itself as predominantly outside of the health systems leadership sphere. In contrast, the *Allied Health: Leading Digital and Data Driven Health and Disability Services* position statement (George et al., 2021) called for leadership frameworks to support allied health clinicians in pursuing leadership development beyond a clinical focus and into a health systems perspective. It emphasised a contemporary need for leadership career advancement, arguing that allied health clinicians are well positioned to lead. The rhetoric around the place of allied health clinicians in health systems leadership has the potential to impact how they are viewed by allied health clinicians themselves, and by others. For example, the passive approach can be disabling, positioning allied health clinicians as outsiders asking for a way in. In contrast, the more active use of language and recognition of leadership in place has the potential to empower allied health clinicians to identify with their capability and ambitions.

There was a clear absence of guidance on systems leadership for allied health clinicians beyond the clinical scope and beyond leadership of the allied health collective. Extending the role of allied health clinicians into

health systems leadership including oversight of systems also relevant to medical and nursing professions was not openly encouraged. Literature that provided guidance and practical direction for clinicians typically provided it up to systems leadership across multiple allied health professions and no further. The literature search revealed only one allied health focused leadership framework published since 2021; The Australian Healthcare and Hospitals Association (AHHA) (2022) report, *Allied Health Leadership and Advancing Practice Framework 2022*. The Australian framework draws on the LEADS framework out of Canada (Dickson & Tholl, 2014), and was written to guide training of the allied health workforce in Queensland. It delivers a training model for the non-clinical skills allied health professionals are expected to possess to advance their clinical services. Despite the progressive milestones and use of system terminology, the pitch of the framework is for intra-allied health leadership development. It reflects a similar pitch to the NHS England and NHS Improvement (2019a) report, *Developing allied health professional leaders: a guide for trust boards and clinicians*. The AHHA (2022) report expresses a restrictive approach and limits the identification of value and transferability of systems leadership from extending beyond the allied health professions. It does not encourage allied health clinicians to consider broad system-wide roles that would benefit from their capabilities. This is a narrow perspective which implies allied health clinicians do not, or cannot, apply their capability for systems leadership beyond the allied health workforce.

This perspective that allied health clinicians can only lead health systems effectively across other allied health professions appears in several contemporary government published documents (Manatū Hauora – Ministry of Health, 2023b; NHS England, 2022; NHS England and NHS Improvement, 2022). These documents are founded on research-based evidence and written in response to strategic implementations affecting the health system infrastructure. *The AHP Strategy for England: AHPs Deliver* (NHS England, 2022) calls for diverse allied health leadership, using future based language and a focus on the allied health collective of professions. It is argued that allied health clinicians in leadership 'can transform an organisation and system by focusing the engaged, productive and visible AHP workforce on system priorities.' (p. 17). The document read as a reactive response to the publication of important strategic changes in health system infrastructure. The NHS report's tone, language and tense conflicted within itself. It argued defensively for the inclusion and promotion of competent and capable allied health clinicians as systems leaders and, at the same time, communicated strong evidence of existing competent health systems leadership across boundaries, professions and sectors. The reports did not appear to build on the existing credibility of allied health clinicians as delivering systems leadership or exert confidence in their competence beyond the allied health workforce as strategic leaders across the health system.

A similar message about leadership can be interpreted from the *Clinical Leadership in Manatū Hauora* report (Manatū Hauora – Ministry of Health, 2023b). This report was published soon after the health reform programme restructured the health workforce across previous organisational boundaries in 2022, addressing the role and scope of clinical leadership within government organisations, specifically the re-

structured Manatū Hauora. Manatū Hauora is the chief strategic advisory body and steward of the health and disability system in Aotearoa New Zealand; (Manatū Hauora – Ministry of Health, 2023b). The peak roles for clinical leadership who help to provide this stewardship are the Chief Nursing Officer, Chief Medical Officer and the Chief Allied Health Officer (Manatū Hauora – Ministry of Health, 2024a). Following a literature review for clinical leadership they found no single agreed definition. Therefore, using their own definition, they determined clinical leadership in regards of systems thinking with strategic, policy and regulatory expertise while retaining a clinical focus and assurance of clinical practice capability (Manatū Hauora – Ministry of Health, 2023b). The document outcomes assert the value and position of strategic, clinically-based professional advisors for the professions they represent. In the case of the Chief Allied Health Professions Officer, this includes interprofessional, strategic systems thinking to strategically encompass a collective of professions. Despite evidence of health systems' scope and expertise, the report missed a critical opportunity to highlight their competence as health systems leaders.

Te Tāhū Hauora – Health Quality and Safety Commission (2024) (HQSC) also delivers a mixed message about leadership for the broader health system. Despite contemporary evidence for the impact of leadership on outcomes, the national framework for delivering quality and safe services minimised systems leadership in favour of an operational approach. *The Clinical Governance Framework – Draft* provides a refined definition of Clinical Governance:

the sector and organisational approach through which health services are responsive to their communities' health needs, creating a culture and environment in which clinical excellence and continuous quality improvement can flourish. (p. 6)

Clinical governance was described as a practical outworking of the system, an 'approach' to be undertaken by all those working for the health system. The HQSC called it 'a culture of participatory leadership' but conversely described leadership as a 'system driver' (pp. 6, 18). The document appears to identify leadership as a system driver without articulating how that approach aligns with systems thinking or strategic planning. HQSC focused its leadership guidance on using an operational approach by setting priorities, shaping culture, supporting the workforce, and addressing problems. It did not specify an interprofessional perspective as necessary in delivering leadership, yet described health service complexity as a risk where it is not possible to make sense of any single part of the system without understanding its relationships and interactions with the 'wider system' (p. 9). This view of risk aligns with expanding health systems leadership beyond the clinical scope. This document, which purports to be a strategic and governance approach to health services, appears to miss the opportunity to emphasise the importance of health systems leaders as key quality and safety enablers.

One meagre indication of an expanded allied health leadership potential was the joint position statement between the Ministry of Health and the National Allied Health Informatics Group in Aotearoa New Zealand.

This report highlighted the potential for allied health clinicians to lead within the emerging field of data and digital health (George et al., 2021). It contended allied health clinicians leading digital and data-driven services within the health system are critical to enabling the workforce to contribute to and participate in the digital evolution of health services. The position statement identifies leadership as one of the four pillars of need. It argues for existing allied health leaders to advocate for and proactively create capable clinical informatics leadership roles to support and increase further leadership capacity (George et al., 2021).

This collection of literature indicates a set of parameters to which the allied health clinician can regard their career advancement. The majority identifies allied health clinicians as predominantly capable of providing health systems leadership within and across the scope of allied health professions and clinical practice. This information and knowledge has the potential to influence the allied health workforce identity. It could constrain their aspirations of leadership to the clinical scope and limit their view of options for extending their ambitions of health systems leadership across the full scope of the health system. Undervaluing the breadth and depth of capability that allied health clinicians can bring to health systems leadership has the potential to negatively influence the broader workforce's and public's perspective.

It became apparent across the literature that professional standards have a key role in shaping leadership aspirations and setting the context for investment in leadership development. Professional standards typically exist within a symbiotic relationship between professional regulation, training curricula and organisational expectations for ongoing professional development. Dalton et al. (2021) looked at allied health practice competency requirements relevant to leadership within the Australian allied health workforce professional standards. While these standards are specific to Australia, the findings provide insights into the influence of professional standards on enabling (or not) allied health clinicians into leadership roles. Dalton et al. (2021) found that health leadership was not easily recognisable in the standards, and as a result, the leadership contributions made by allied health clinicians to directional changes within or across the health system reform may be overlooked. Finding meagre mention of leadership infers a lack of alignment between professional standards and contemporary leadership needs. Dalton et al. (2021) suggested that a lack of professional standards for leadership development perpetuates the underrepresentation of allied health in leadership roles. They argue allied health clinicians are an important leadership resource and underutilised within system reform. An example of this is found within *The National Health Workforce Plan (The Plan)* (Te Whatu Ora – Health New Zealand, 2023).

The reform and centralisation of the public health and disability system in Aotearoa New Zealand delivered an opportunity to engage with the standardisation of leadership development. *The Plan* referred to medical and nursing as 'foundational workforces' a marked contrast to the naming and detail provided of only six of the 43 Allied Health Professions across Aotearoa New Zealand within the entire document. These six

professions included: Anaesthetic technicians, Sonographers, Pharmacists, Radiation Therapists, Dental/oral health therapists and Clinical/cardiac physiologists. These professions were identified in association with being vulnerable to workforce shortages and reliant on overseas training. Six action areas were the focus of *The Plan*, the last being 'Growing our Future Leaders', because the system needs 'diverse leaders' (Te Whatu Ora – Health New Zealand, 2023, p. 12). *The Plan's* action point for this was to 'Invest and Develop', and they proposed a Leadership Institute. The investment focus of the 'next generation of clinical leaders' to be in the Māori and Pacifica nursing and midwifery workforce (Te Whatu Ora – Health New Zealand, 2023, p. 76). The Leadership Institute is described as intentionally inclusive. *The Plan* argues for equitable access and enablement of the workforce across professions into the Leadership Institute, acknowledging a lack of options previously available for allied health clinicians to pursue leadership (Te Whatu Ora – Health New Zealand, 2023, p. 77). While *The Plan's* actions appear positive and inclusive for allied health clinicians, the published narrative infers a lack of knowledge and understanding about the strategic value of allied health clinicians for the future of health systems leadership. The opportunity to engage in the standardisation of leadership development is taken but the lack of insight potentially undermines equitable investment beyond *The Plan's* 2023-2024 timeline.

The implementation of an international future focused and inclusive health workforce leadership framework supporting all professions already exists (Dickson & Tholl, 2014; NHS South East Leadership Academy, 2024). The benefits of an inclusive standardised framework reach beyond organisational employment. The use of such a contemporary leadership framework to align professional leadership standards with could promote competency alignment and support changes to undergraduate curriculum to equip staff for future leadership. Dalton et al. (2021) emphasises this point arguing that for allied health clinicians to play their optimal role in health system reform, innovation and change, the standards that guide the allied health professions must explicitly reflect health leadership competencies. The alignment would be critical in preparing allied health graduates and support the existing allied health workforce to engage with systems leadership. Establishing professional leadership standards, achieved through competencies, subsequently supports the integration of leadership development for those competencies within standardised training, particularly within undergraduate training programmes. Consequently, the inclusion of leadership competencies within professional standards to recognise, validate and provide scope for allied health clinicians to progress into leadership supports them in establishing a leadership identity.

This leadership identity is endorsed by the *Allied Health Business Plan* (Manatū Hauora – Ministry of Health, 2021) which set out and defined a direction of work to be delivered to advance the allied health, scientific and technical workforce. This report aligns key drivers for developing allied health leadership in the broad sector with the Ministry of Health's own published intention for strengthening system leadership. This deliberate alignment positions the *Allied Health Business Plan* with the Ministry of Health's governance

perspective on leadership, emphasising the actions for leadership development. There appears to be a shift in momentum towards a more inclusive approach to leadership development in Aotearoa New Zealand and for promoting allied health leadership by Manatū Hauora – Ministry of Health (2021) and Te Whatu Ora – Health New Zealand (2023). Their stated intention to develop allied health leadership and create an inclusive Leadership Institute has established a nationally accountable benchmark for enabling allied health leadership.

The literature discussed has provided valuable insights into the extent to which national and global health systems have recognised and supported allied health clinicians in leadership roles through their strategic planning. The use of the future tense in the language that evidences value in allied health clinicians occupying leadership roles conveys the position of outsiders to the leadership field. This perspective does not give a sense of leadership presence, but rather conveys a perpetual aspiration of leadership. Where guidance is provided on systems leadership development, the literature infers that the allied health clinician's leadership ambition is limited to their clinical scope of expertise across the allied health collective of professions. Literature identified the value of integrating leadership as part of the professional regulatory standards and practice competencies, yet the generalisability of specifics is constrained by the differences between international professional standards and training regulations. Despite the need to address these issues, there continues to be a paucity of literature detailing contemporary leadership frameworks for allied health clinicians to use and enable their career advancement.

2.3.4 Current State

Several articles shared commonalities about the current state of allied health leadership. There was consensus on the value and efficacy of having allied health clinicians in leadership and a common thread of limited access to leadership development with a focus on the allied health workforce rather than broad strategic systems leadership, an underrepresentation of allied health clinicians in health systems leadership roles and poor leadership culture (Dalton et al., 2021; Eddison et al., 2023; Kutz, 2004; Mizzi & Marshall, 2024). Compared to other health professions, very little is known about the current state of allied health clinicians in health systems leadership roles, particularly in Aotearoa New Zealand. There was minimal research associated with this topic uncovered in this review, and this doctoral study is the first to focus on understanding how allied health clinicians are enabled to step into health systems leadership roles in Aotearoa New Zealand.

Literature contends that allied health clinicians approach their work with an interprofessional perspective, aligned to the contemporary health paradigm for providing consumer-centric care closer to home (Eddison et al., 2023; New Zealand Institute of Economic Research, 2021). They are endorsed for bringing a holistic approach to health and well-being, focused on preventative intervention to enable consumers to live well and integrate into their communities (Mizzi & Marshall, 2024; NHS England, 2022). This interprofessional,

cross boundary approach to work is known to be embedded during undergraduate education. Documents produced by allied health senior leaders set out arguments for greater recognition of the benefits these professional perspectives bring to the health system (New Zealand Institute of Economic Research, 2021; NHS England and NHS Improvement, 2022). Yet there is consistent indication from health organisations that they do not recognise this. Aotearoa New Zealand's *Health Workforce Plan* (Te Whatu Ora – Health New Zealand, 2023), conveys a marked lack of understanding of the allied health workforce. It suggests allied health clinicians will be required to learn about interprofessional practice and change their models of care. It recommends allied health clinicians need 'new approaches to training – including interdisciplinary models which reflect the way we want these professionals to work in the future' (p. 56).

This view contrasts sharply with an earlier evidence-based public report, *Hidden in Plain Sight* (New Zealand Institute of Economic Research, 2021). This document was commissioned by Allied Health Aotearoa New Zealand, a partnership that suggests motive to publish an independent review of the allied health workforce as a means to objectively identify value and impact of allied health services. The report highlighted services and systems which underutilised the potential of allied health clinicians within their existing interprofessional models of practice. It highlighted primary care, data provision and referral limitations as opportunities for creating positive change (New Zealand Institute of Economic Research, 2021, p. 29). The report detailed the economic benefits of the biopsychosocial approach for the design and delivery of health services in Aotearoa New Zealand. Research illustrated the value and impact of allied health clinicians on sustaining consumers within the community, reducing demand on acute health services and integrating with existing systems. It emphasised the alignment allied health clinicians have with the emergent health paradigm, identifying opportunities to influence the design of contemporary health systems towards consumer focused and timely data driven services.

National literature indicated health organisations are uninformed of the advantages of the embedded interprofessional approach allied health clinicians provide the organisations they work for and the broader national health system. Despite the availability of evidence-based literature it was evident that government documents needed to utilise existing research to inform strategic health workforce plans. The differing views about the allied health workforce and their value in Aotearoa New Zealand will likely impact strategic workforce investment. This was emphasised by key initiatives in *The National Health Workforce Plan 2023-24* which prioritised particular professions, such as nursing for leadership development (Te Whatu Ora – Health New Zealand, 2023). A lack of understanding about the value of allied health clinicians and subsequent decisions made about investment and leadership development may perpetuate the support for only some professions in leadership roles rather than recognising the enhanced value of allied health clinicians as health systems leaders.

The lack of investment into allied health systems leadership development is identified by several allied health studies addressing leadership standards, barriers to career advancement and leadership education (Dalton et al., 2021; Mizzi & Marshall, 2024; NHS England, 2023). A UK Paramedic study identified that training and development did not commence early enough in professional careers and recommended that leadership should be a core pillar of practice and integrated in pre-registration training programmes (NHS England, 2023). This study also reported close alignment with the needs and benefits of the allied health leadership work in the NHS, emphasising early-career leadership exposure. In Aotearoa New Zealand, there was recognition that a lack of leadership opportunities limit allied health clinicians in their pursuit of health systems leadership roles (Te Whatu Ora – Health New Zealand, 2023, p. 20). As noted above, the *National Health Workforce Plan 2023-24* states an intention to create a Leadership Institute for the purpose of including professionals who have traditionally had few clinical leadership pathways to pursue (Te Whatu Ora – Health New Zealand, 2023). In alignment with the NHS, a health Leadership Institute may work to mitigate the lack of access to leadership development for allied health clinicians (Manatū Hauora – Ministry of Health, 2024b). Further, a Leadership Institute will likely only serve the existing public system workforce and leave a considerable proportion of the national allied health workforce navigating inconsistent access. National and international literature suggested the need to incorporate leadership skillsets into education programmes, develop clear career pathways to support professional growth and intentionally cultivate leadership potential (Dalton et al., 2021; Manatū Hauora – Ministry of Health, 2024b; Mizzi & Marshall, 2024). Literature suggests an intentional approach to undergraduate education, standardised expectations for graduate access and funding, and the formal framing of leadership career pathways is used do address the current inconsistency within leadership development.

As indicated in section 2.3.3 there is evidence of literature focusing allied health clinicians on leadership across allied health professions rather than promoting strategic systems leadership across the whole system and workforce. This perspective is reflected in a report on the current state of fourteen allied health professions in Aotearoa New Zealand (Manatū Hauora – Ministry of Health, 2024b). These fourteen professions included: Audiology, Clinical physiology, Dietetics, Medical imaging and radiation therapy, Medical laboratory science, Occupational therapy, Paramedicine, Pharmacy, Physiotherapy, Podiatry, Psychology, Social work, Sonography and Speech language therapy. The report highlighted the health and wellbeing benefits of what could be achieved by highly enabled allied health clinicians delivering their full impact and value (Manatū Hauora – Ministry of Health, 2024b). Information not previously collated about these professions emphasised the opportunities and barriers the professions experienced in providing their services. The report also incorporated the views of a wide range of allied health stakeholders who contributed for each profession.

Within the report a word search found 'leadership' mentioned 26 times across six professions. Leadership was frequently indicated as an operational opportunity to enable the development of the workforce, and

the lack of leadership opportunities or pathway was consistently identified as a barrier to professional development (Manatū Hauora – Ministry of Health, 2024b). The professions argued that despite having translatable skillsets, career pathways and roles for health systems leadership were not easily identifiable or accessible. There was clear evidence that many professions believed occupying leadership roles was a key enabler for developing their professions and advancing their careers. Notwithstanding the broad consultation and diverse contributions, leadership was not explicitly mentioned within the executive summary. By not identifying leadership as a key opportunity, the report missed the opportunity to strategically promote health systems leadership by allied health clinicians into and beyond the allied health professions. It did not validate the prevalent voice calling for support to mature and grow the allied health professions in Aotearoa New Zealand (New Zealand Institute of Economic Research, 2021).

Across the literature, there continued to be direct and indirect mention of a dearth of allied health clinicians in leadership positions and a lack of overall diversity in health systems leadership (Martin et al., 2021; Mizzi & Marshall, 2024). Aligning with the earlier literature review, research identified the absence of allied health clinicians in strategic leadership roles persists (Colesby, 2024; Eddison et al., 2023). Even though these later studies were constrained by geographical location (Colesby, 2024) and limited data recorded (Eddison et al., 2023) both sets of findings provided a compelling snapshot of the lack of allied health presence within strategic leadership forums. The challenge of identifying allied health clinicians within leadership is influenced by board membership policies which typically state they only require a registered doctor/dentist and nurse/midwife and a lack of membership data recorded. This undermines the ability to monitor the progression of diversity of even very senior leaders (Mizzi & Marshall, 2024).

The absence of allied health clinicians within systems leadership roles limits their visibility to the broader workforce and projects a lack of capability for leadership by allied health professions. The allied health clinicians who contributed to the *Hauora Haumi – Allied Health Report* called for improved professional recognition of leadership roles and identified that despite highly translatable skill sets, there was poor representation of professions within senior leadership roles throughout the health sector (Manatū Hauora – Ministry of Health, 2024b). Eddison et al. (2023) contended that the presence of allied health clinicians within senior leadership roles not only raises the profile of allied health professions but also establishes their leadership credibility within governance groups and strategic decision-making forums. There was a strong emphasis across the literature on a desire to see more allied health clinicians in health systems leadership roles at all levels and a greater diversity of leadership in place. Literature identifies a self-perpetuating cycle of invisibility and underrepresentation of allied health clinicians in health systems leadership roles. It is suggested that the drive for diversity and equity could break this cycle and positively transform the health system (NHS England, 2022).

Concern about the current state of organisational culture surrounding health systems leadership is the final emphasis observed within the literature. In the NHS, a raft of system pressures had impacted behaviours, leading to a culture of discrimination, bullying, blame and avoidance of responsibility (Department of Health and Social Care, 2022). Inadequate leadership development was identified as a critical contributor to these outcomes, leading to significant disparities in leadership competency. The Department of Health and Social Care (2022) called for the medical profession to examine candidly their own role and influence on culture, emphasising individual accountability and responsibility for creating a positive behavioural culture. This view of existing disparity was endorsed by the New Zealand Institute of Economic Research (2021) who called for an approach to governance that saw a breakdown in professional hierarchy and funding that supported diversity in collaboration. Despite discussing governance and hierarchy, the report did not mention or advocate for allied health systems leadership. The Department of Health and Social Care (2022) strongly argued for equity, diversity and inclusion as foundational tenets of behaviour and culture. The report recommended that the implementation of equity, diversity and inclusion become the universal indicators for how systems respect and value their workforce. It suggested the provision of an inclusive and fair culture could become a key metric by which leadership at all levels is judged. The health and social care workforce was held responsible for the leadership culture created and for implementing the changes suggested to enable effective leadership for strong and successful teams. This was an influential sector-wide report, and the findings and recommendations held the entire health and social care workforce accountable for their behaviour.

Investigating the current state of allied health leadership has found a strong belief in the value and efficacy of having allied health clinicians in leadership roles. The dearth of allied health clinicians within leadership roles remains in conjunction with the lack of existing leadership development and a health system culture that does not actively promote equity, diversity or inclusion across leadership roles.

2.3.5 Barriers and Enablers

The literature reviewed identified a diverse range of enablers and barriers for allied health systems leadership. The literature examined them as either active mechanisms intentionally implemented as enablers or discussed them as elements embedded within systemic infrastructure; highlighting how they influenced allied health clinicians, their peers, or the health organisation's context.

Mizzi and Marshall (2024) examined the barriers and opportunities for allied health clinicians in early to mid-career leadership and professional development. Their findings have been informative for the allied health workforce in the UK, identifying that leadership development was as important as clinical skills development. A summary of their recommendations for enabling allied health clinician leadership and career development are listed in Table 3 below.

Table 3*Mizzi and Marshall (2024) Study Recommendations*

| |
|--|
| General |
| Regular communication or promotion of opportunities with encouragement |
| Changes to preregistration training |
| Talent management and resources |
| Equitable time, funding, staffing |
| Departmental training needs analysis/framework |
| Job plans for protected development time |
| On-the-job training e.g. quality improvement projects/audits |
| Formal development: In-house training |
| Formal development: external training |
| Non-medical prescribing courses |
| Widening types of training accessed e.g. MSc modules/research/role play |
| Improving the quality of training offered e.g. having a varied offer and make it responsive to the learner |
| Formal Shadowing, mentoring and coaching |
| Development posts between bandings |
| Increased equity to and frequency of secondments/opportunities |
| Effective appraisals |
| Regular and effective supervision, reviewing appraisal and career objectives |
| Facilitated networks/links |
| Structural change to organisations |
| Parity with other professionals' leadership and career progression e.g. generic professional titles, increased senior AHP leadership posts, research/leadership/practice development departments, learning environment leads, placement expansion facilitators |

The study found there were mixed views regarding the embedding of leadership development within career progression versus voluntary engagement. There was agreement though that accessing leadership development was often reliant on the manager's understanding of the employee, their view on leadership, and their priorities for staff (Mizzi & Marshall, 2024). Creating standardised mechanisms for access, integrating leadership development, and formalising accreditation were strategies that could counterbalance dependence on individuals (Mizzi & Marshall, 2024). These strategies, where leadership development is built into the design of health systems, were also identified and endorsed by Dalton et al. (2021), Wiedman (2023), Koh et al. (2022) and NHS England (2023). These strategies were argued to enable allied health clinicians because of their standardisation, consistency and objectivity, reducing the limitations imposed by subjectivity.

Kutz (2004) endorsed the integration of leadership development within the undergraduate curriculum as an enabler. Kutz (2004) argued that society highly values strong leadership and urged organisations to address leadership development as a necessity for effective survival. The argument emphasised the need for sustainable leadership development, enabling access to development throughout the career timeline. Positioned within the American health system Kutz (2004) argued for leadership development to be intentional. Such a call for intentional action may reflect the challenges in enabling consistent allied health leadership development across a more privatised and segregated health system. However, the view that allied health education was behind the leadership curve and fails to educate students about leadership beyond the clinical management of services resonated within this literature review (Dalton et al., 2021). Contemporary research continued to emphasise the need for leadership development integration, thereby identifying an ongoing need that has not been resolved over the last twenty years.

The challenge of identifying as a leader was emphasised by several studies focused on allied health clinicians transitioning into leadership (Mizzi & Marshall, 2024; Wiedman, 2023). The development of certain leadership skills and attributes were found to be key to enable allied health clinicians to identify as leaders (Mizzi & Marshall, 2024). Koh et al. (2022) found that particular skills were statistically significant predictors of allied health professionals' perceptions of career advancement. These included the ability to manage interpersonal dynamics, to motivate and provide mentoring, and to demonstrate the values of compassion and collegiality. Specific skills and values were found to be significant for establishing competency in leadership. The study emphasised that, increasingly, personal values are highly regarded for careers within healthcare (Koh et al., 2022). They found that relationships were important and accumulated social capital through networks of alliances and relationships with colleagues. Koh et al. (2022) argued that many skills are required for competent leadership, and that relational skills play an equal, if not more important role than hard skills in influencing career advancement. In conjunction, Wiedman (2023) refuted the perception that leadership was simply a set of skills separate from clinical work. While he took a single-disciplinary perspective, limiting generalisability to other professions, he reported that key attributes of leadership were an integral part of being a clinician. Predominantly these studies found the development of key skills and attributes central to leadership identity were also integral to being a clinician, and that both hard and soft skills were of equal importance in career advancement.

Conversely, several pieces of literature identified a hesitancy in allied health clinicians to use their skills and capability to lead. A tension was identified between literature advocating for infrastructure to support allied health systems leadership roles and evidence of allied health clinicians feeling disempowered to progress. Mizzi and Marshall (2024) found participants were reticent to step up if they thought they would lose credibility with their peers or ties to their professional identity. A perception of distance between health systems leadership and clinical practice is conveyed by allied health clinicians. *The AHP Strategy for England: AHPs Deliver* (NHS England, 2022) indicated an ongoing challenge with enabling the workforce to

step into leadership roles despite the clear need to build diversity and influence system design. The hesitancy exists with both the individual's identity and the drive to develop services. These findings are situated within the context of the NHS UK. Despite this limitation, both documents identified barriers for allied health clinicians that are likely relevant across international boundaries. These barriers implicate both the system and the individual allied health clinician as contributors to the resolution. It is evident within this literature review, as it was in the earlier review, that there continues to be a tension in the juxtaposition between hesitancy to step into leadership and the need to have visible health systems leaders.

Lastly, a prominent barrier identified across the literature was the legacy of traditional thinking surrounding health systems leadership. NHS England (2022) strongly identifies this legacy culture as a disabler of allied health leadership, stating:

it is essential that providers recognise the sustained cultural shift needed to remove outdated practices that prevent AHPs from harnessing their leadership ability. By thinking differently about how leadership is developed and managed, systems and providers will maximise the contribution of the NHS's third largest clinical workforce. (p. 17)

The report addresses key stakeholders, urging them to shift their perspective on health systems leadership development. It identifies the existing leadership culture as a clear limitation preventing the allied health workforce from harnessing their leadership capability (NHS England, 2022). Mizzi and Marshall (2024) recommended that organisations need to consider creating a visibility and representation strategy to improve opportunities and influence perspectives. The need for intentional action was reflected by recommendations to address the lack of the allied health voice at senior levels of leadership system-wide (Lindsay, 2022; Mizzi & Marshall, 2024). A specific piece of work undertaken by the King's Fund to enable allied health clinicians to step into health systems leadership roles was commissioned for one NHS Trust. Using action research methodology, the intention was to empower participant's voices, identity and influence as leaders. The work was commissioned on the premise that allied health clinicians were not represented well in the more senior leadership roles (Lindsay, 2022). This study was targeted to allied health clinicians and commissioned to be delivered by an internationally prestigious agency. By their intentional actions the NHS Trust publicly highlighted the issue of marginalisation. A far broader systemic level of marginalisation was indicated by the Department of Health and Social Care (2022) who strongly recommended the use of equity, diversity and inclusion as the indicator for how a workforce is valued and respected. Literature clearly identified organisational culture as a prominent factor influencing allied health clinicians' progress into health systems leadership roles.

2.4 Chapter Summary

In this chapter I have reviewed a range of literature addressing allied health leadership across national and international health systems. Using the subheadings, health leadership frameworks, current state and enablers and barriers, I have synthesised existing literature to develop an understanding of the contextual landscape of allied health systems leadership within global health systems. The two literature reviews have been aligned to deliver a cohesive picture of the literary landscape. The synthesis of evidence identified several key issues facing allied health clinicians and health systems leadership. Literature illustrated the lack of recognition for the value of allied health clinicians in leading health systems, despite contributing to system design and delivering improved health outcomes. The evidence available demonstrated that the allied health professional scope ideally positioned them for leadership in alignment with future models of care and system design to meet contemporary population needs.

A common thread through literature was the lack of existing, consistent and standardised leadership development available and accessible for allied health clinicians. The riposte was a strong recommendation for integrating leadership competencies within professional regulatory standards and early integrated training with ongoing professional development to enable allied health clinicians to identify as leaders more easily. There remains an ongoing dearth of allied health clinicians in senior health systems leadership roles nationally and internationally (Eddison et al., 2023; Koh et al., 2022; Lindsay, 2022; Mizzi & Marshall, 2024). An evident reticence from allied health clinicians to lead may contribute to this underrepresentation, as might a lack of equity, diversity and inclusion identified within organisational cultures.

Considering the available literature and the lack of research directly addressing the topic of allied health clinicians and health systems leadership, there is a gap in the existing knowledge regarding how allied health clinicians in Aotearoa New Zealand are enabled into health systems leadership roles. Pursuing new knowledge on this topic will provide direction and guidance for enabling allied health clinicians into health systems leadership roles for the benefit of consumers, services and the workforce. The epistemological and theoretical framework chosen to explore this topic and develop new knowledge is presented in Chapter 3.

Chapter 3 Methodology

3.1 Introduction

Having located the focus of this research within existing literature in Chapter 2, Chapter 3 presents the epistemological and theoretical framework chosen to inform the design and approach of this research study and the rationale for those choices. This chapter will describe how the study was designed to fulfil the first and second objectives outlined in Chapter 1: 1) to explore and identify a breadth of enabling experiences; and 2) develop an understanding of what and why those experiences were meaningful. Using first person is methodologically consistent with Interpretive Description, which recognises the researcher as having an integral role in the research process and outcome (Thorne, 2008). Therefore, first person is used throughout this chapter to align with the theoretical framework and reflective position.

I will begin the chapter by discussing my position within this research, reflecting on my professional background, clinical practice, and leadership experiences. I will explain how they have shaped my view of the world and my approach to this research. A second manuscript published in a peer-reviewed international journal is embedded within this chapter. The manuscript has been amended for APA style alignment and to provide links to the Appendices. It was written in a reflective style to discuss the philosophical choice for Social Constructionism and the methodological choices of Interpretive Description with a lens of appreciative inquiry. I illustrate the impact of those choices on the study design and why they aligned with this research study's aims and objectives. To conclude, the chapter summary will synthesise this content and present the main points. These insights will connect to Chapter 4, which provides further detail on the methods chosen and how they were implemented to establish credibility and rigour.

3.2 Positioning Self within the Research

In this section, I will outline my position within this research, and explain how my professional training, clinical practice, and leadership experience have influenced my approach to this research. Manuscript 2 overlaps with these key reflections on the alignment between theory and position; therefore, there may be some repetition of information.

As an occupational therapist, the scope for human occupation and its purpose and meaning in everyday life are core to the philosophical foundations of practice (American Occupational Therapy Association, 2011; Jungersen, 1992). Enabling and empowering others to expand their potential, problem-solve, and overcome obstacles is part of our approach to practice. All elements impacting the individual's life, whether biological, psychological, or social, are critical for consideration. The ability to think broadly, 'laterally' and outside of the box is essential for solving challenging issues facing our consumers. This means a relational approach is essential, and influential for how we walk alongside our consumers and their whānau, to engage with them, encourage them and enable them to determine their meaning of purpose. This

professional approach is applied throughout the entire age range spectrum and across the physical and mental health sectors (Occupational Therapy Board of New Zealand – Te Poari Whakaora Ngangahau o Aotearoa, 2024).

As part of my undergraduate experience, I trained in conjunction with physiotherapists and lived with medical students. They all expanded my understanding of, and broader consideration for, the health workforce and their perspectives of each other. While these are strongly positive memories, there were moments when fellow students and their peers would joke dismissively about occupational therapists and comment derogatively on the value of non-medical professions. This experience informed my understanding that there was a definite tiered hierarchy for health professions within the broader health system. I experienced a continuance of this hierarchical culture during my postgraduate clinical practice within the public health system both overseas and in Aotearoa New Zealand. I observed my nursing and medical colleagues' behaviours influence daily events such as meeting agendas, who spoke first in a forum, the staff's seating positions in a room, and the time allowed for communications between different professions. Colleagues across the professions have anecdotally acknowledged a tiered dominance of professions. The daily existence of a hierarchical professional culture embeds bias within the system. It privileges the positioning of medical and nursing professions in relation to allied health professions, creating a culture of inequity.

As I progressed through various leadership roles, I began to recognise several recurring challenges faced by allied health clinicians in health systems leadership positions, as well as by emerging leaders seeking leadership opportunities. One significant challenge was the behavioural changes observed in my medical and nursing colleagues once they realised I was an allied health professional. It was apparent that some colleagues would defer to a nurse or doctor instead of an allied health clinician, which disempowered the allied health professional and undermined their capabilities.

Additionally, there were instances where allied health clinicians were excluded from email invitations to strategic meetings involving multiple stakeholders. This exclusion minimised the presence and voice of allied health clinicians in important decision-making processes. Each instance contributed to a growing sense of frustration at the inequitable inclusion of allied health professions to influence services and help improve outcomes. Furthermore, an obstacle to career progression was the experience of exclusive recruitment, where the stipulation of a nursing or medical background superseded the relevance and value of skills possessed. This led to feelings of injustice in the recruitment for health systems leadership roles, as the criteria appeared to favour profession over leadership skills and capabilities. As my leadership experience grew, so did my desire to affect change and address these challenges for future generations.

My philosophical views and professional training have shaped my approach to clinical practice and strongly influenced how I live my life. I interact at work and home with a relational approach that seeks to

empower, encourage, and collaborate with others to achieve their full potential and success. My ability to think laterally about the various interactive components of life and systems enables me to see the broader picture while also understanding the details through task analysis. As I journeyed through my clinical practice and into my first health systems leadership roles, I noticed how these skills provided a strong foundation for systems leadership. They helped me to engage effectively with staff, consider the broader system impacts of geopolitical boundaries, expand my view of systems interaction and recognise the criticality of interprofessional practice. I believe each person has a unique perspective on their social reality, and together we can identify common perspectives and learn from them.

In my own practice and in observing others, I noted that professional training, culture and identity strongly influence the perspectives individuals hold. This in turn affected their behaviour towards each other. This awareness led me to appreciate that the conditioning arising from professional training, with the legacy of health systems culture and public identity perpetuated influential views of healthcare professionals. These influences can be so powerful that, from experience, they ultimately impact policy, process, and behaviour and therefore appear to restrict opportunities for career advancement.

My views expressed above, aligned with the philosophical epistemology of Social Constructionism. This philosophical foundation purports that each individual constructs their own social reality, and together, people can generate a collective meaning out of their interactive human community (Crotty, 1998). It endorses the belief that each individual's story and experience are their own and equally important. As a group of individuals, By identifying common threads among these individual narratives, we can generate collective meaning that offers insights and new knowledge. To share and apply this new knowledge could influence perspectives and behaviours , potentially leading to changes in practice.

I tend to be pragmatic, influenced by my professional emphasis on problem-solving. However, my choice of methodology was critical in creating the space for evidentiary interpretation while using my disciplinary experiences to inform the research grounding. Interpretive Description methodology uses applied disciplinary grounding and looks beyond the evidence to uncover additional insights that can address complex issues, such as how to facilitate greater participation of allied health clinicians in health systems leadership roles (Thorne, 2016). This methodology, premised on social constructionism, provides a framework for enabling applied health research that aims to explore complex issues and develop actionable outcomes for implementation.

I chose to apply an appreciative inquiry lens to the study design to sensitively handle the complexities of the allied health clinician's experiences (Bazeley, 2021; Whitney & Cooperrider, 2012). This choice to emphasise sensitivity using a strengths-based approach was required to ensure any outcomes were positively constructed rather than developed from within a deficit approach. I believed a positive approach was needed because experience indicated there were many shared challenges in occupying health systems

leadership roles that elicited negative feelings. Taking a deficit approach with participants may have reinforced those negative emotions towards their contextual situation and hampered a constructive focus on outcomes. Therefore, I wanted to avoid designing a research study which exposed participants to negative experiences or produced outcomes with a deficit focus. Using the phases of appreciative inquiry as a lens across the study design situated the methods within a strengths-based approach and supported the participants to contribute within a positive framework (Whitney & Cooperrider, 2012). This strengths-based approach was a critical part of the study design and strongly influenced the use of language, tone and development of this research study.

As a result of my experiences, I recognised the advantages that systems thinking, critical analysis and effective interpersonal dynamics gave to a leadership role. These skills and capabilities were embedded in the practice of, and frequently demonstrated by, allied health clinicians. In conjunction I realised many existing health systems leaders had a narrow capability for collaborative partnership, limited interprofessional understanding and an inequitable approach to health systems design. The theoretical baggage and assumptions I bring to this research study are based on my experiences of clinical practice and health systems leadership. The experience of bias, exclusion and limitations imposed upon my leadership career progression has led to a sense of frustration and injustice. Being transparent about how these experiences have influenced this research study is an essential part of applying Interpretive Description (Thorne, 2008). I have discussed my motivation, potential subjectivities and subsequent angle for this interpretive inquiry. I have identified my historical drivers and the persistent desire to embolden and enable allied health clinicians into health systems leadership roles as critical momentum for this research (Thorne, 2016).

I have chosen to focus this research on understanding how allied health clinicians are enabled to take on leadership roles within health systems. This study takes a positive and constructive approach to explore the meaningful and influential factors that help and support allied health clinicians into health systems leadership roles, and explore how these factors could influence the future development of allied health systems leadership.

3.3 Manuscript 2

A reflective article explicating the methodological approach to this research study was completed and submitted for publication in early 2024. This article was successfully submitted to the Australasian Journal of Health Services Management. It is included below as it was published with minor amendments to the table layout, headings and citations to align with the APA referencing style.

George, R. K., Webster, K., & Kayes, N. M. (2024). Investigating leadership: Reflections on the methodological choices used to research how allied health clinicians are enabled to step into health system leadership roles. *Asia Pacific Journal of Health Management*, 19(2).
<https://doi.org/10.24083/apjhm.v19i2.3399>

3.3.1 Abstract

This article examines the methodological choices made for a research study into Health Systems Leadership. Reflections on key learnings are provided as a way of offering insight for researchers navigating these decisions for the first time. Embarking on qualitative research to effect change is purposeful but challenging; choosing the most appropriate methodology and methods can often be confounding and stressful for new researchers. This article explores the decision to use Interpretive Descriptive methodology with an appreciative inquiry lens and makes visible decision junctures in the development of this research. Literature provides a wealth of expert guidance and excellent insights into research methodology and methods. However, very little expounds on the learnings of those who have gone before and what their insights and learnings may be. Research into allied health clinicians and their journey into health systems leadership roles provides an opportunity to reflect on an applied research journey.

KEYWORDS: qualitative research, health, methodology, appreciative inquiry, interpretive description, leadership

3.3.2 Introduction

Good quality health research is needed to address a range of challenges within the health sector and perpetuate improvements in clinical practice, alongside effective policy change. Qualitative research has a long and rich history of researchers seeking to understand perspectives, experiences, and behaviour relevant to a particular phenomenon of interest. It allows in-depth analysis and interpretation, using theoretical foundations and methodologies to explain why the researcher claims what they claim (Braun & Clarke, 2019). However, the full value and significance of qualitative research as an evidence-based source for informing effective health system development waits to be fully realised.

Understanding the complexity, decision-making, and balance of organisational system tensions depends on the knowledge generated through small, in-depth qualitative studies and large-scale clinical trials (Braun & Clarke, 2019). Health and disability systems around the globe are inherently complex. Greenhalgh and Papoutsi (2018) assert where complexity is often discussed, it is also 'sub-optimally' studied. Greenhalgh and Papoutsi (2018) recommend 'new standards of research quality, namely (for example) rich theorising, generative learning and pragmatic adaptation to changing contexts.' Using qualitative research is critical to illuminating and investigating contemporary health issues amidst the complexity (Connelly & Peltzer, 2016).

Findings revealed by qualitative research can impact and influence how health and disability services are led and delivered, changing the course of investment and system design. Using qualitative research creates a space for subjective focus, embracing different methods of inquiry and epistemological frameworks. The diversity of choice compels the researcher to justify and clarify their philosophy and aligned practical approach. This leads to robust study design and findings founded on integrity (Peditto, 2018). The breadth of methodological choice, however, can elicit discomfort in the researcher when faced with an expansive range of options. Therefore, it is essential to support health researchers in their methodological decisions as they seek to understand systems and influence change.

This paper explicates key methodological decisions, and the outworking of those decisions, in a research study exploring how allied health clinicians are enabled to step into health system leadership roles. The research was prompted by the lack of diversity of clinicians within health systems leadership roles and, in particular, a paucity of allied health clinicians in those roles (Bradd et al., 2018a; NHS England and NHS Improvement, 2019a). Research was needed to understand why there is a lack of diversity of clinicians in leadership roles to guide future allied health and health systems leadership development. The overarching objective of this research was to enable a greater diversity of clinicians to inform future health system design, development and delivery.

Giving visibility to the reasoning behind methodological selections and how they are applied supports emergent and developing researchers and optimises the contribution of qualitative health research to service and system design (Hunt, 2009). There is an absence of digestible work that provides detailed accounts of methodological decisions for the novice health researcher. This article seeks to narrow this gap. It will outline and explore the methodological decisions and challenges encountered during the use of specific methodology applied to a health research question. Given the focus of this paper is to reflect on the methodological choices made and learnings garnered from that, the 'methods' and 'results' sections do not follow usual conventions. Rather, the 'Methods' section focuses on introducing the methodological decisions and rationale. Whereas the 'Results' section includes a reflection on the outcomes of that methodological decision making and the outworking of those in the research process. These insights and experiences are candidly provided to help others feel less daunted by the qualitative research approach.

3.3.3 Method

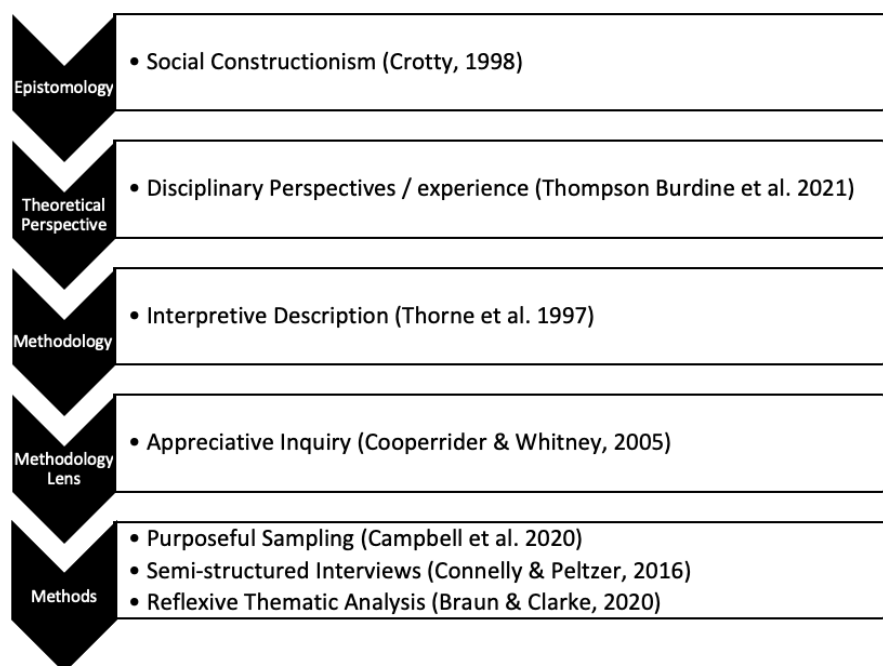
Ethical approval #21/353 for the associated doctoral research undertaken was granted by the Auckland University of Technology Ethics Committee in October 2021, and all participants gave informed written consent. See Appendix C. Tools, for approved ethics documentation. This includes the ethics application, recruitment information, participant information and consent forms, interview questions and demographic categories, and transcription agreement.

Positioning the Research

How a research study is approached amidst the interplay of external influences will impact the researcher's thoughts and actions and influence their findings. Determining the positioning of a research study within its field and the researcher's own position within the research topic is essential. Crotty (1998) suggests that researchers use four key elements when determining and describing their research approach: epistemology, theoretical perspective, methodology, and methods. He argues for congruence across these four elements to ensure coherence. While many novice researchers find determining these elements challenging, achieving coherence supports the theoretical logic, rigour and credibility of their research findings. The use of these four elements to inform the development of the methodological framework underpins this research study. Figure 2 provides an overview of the four key elements relevant to the research study, and a further detailed discussion of each element follows.

Figure 2

Study Design Overview –Based on the Work of Crotty (1998)



Why Social Constructionism?

Social Constructionism contends that reality is constructed, and meaning is attributed to that reality. 'All reality, as meaningful reality, is socially constructed' and includes the likelihood that people can generate a collective meaning from 'interactive human community' (Crotty, 1998). Given the multiple and varied experiences of the allied health workforce progressing into leadership roles, social constructionism frames and facilitates the exploration of participants' social, interpersonal, and contextual constructs. Social Constructionism stems from the work of Karl Mannheim and the sociology of knowledge, which Crotty evolved to recognise that the individual's social reality is absolute and relative to them (Crotty, 1998; Mannheim, 1993).

A health systems leader experiences constant change, competing demands and dynamic social interactions that require flexible collaboration, consultation, and the management of diverse teams (Guba & Lincoln, 1994). Their social reality is rapid decision-making, strategic planning, and interpersonal dynamics, which rely on their values, experience, and leadership skills. People step into leadership roles for different reasons, motivated by a variety of factors, both internal and external. Since there is no specific pathway in Aotearoa New Zealand for allied health clinicians to progress into leadership roles, they typically experience different realities. Given this, each participant's perspective provides rich insight and contributes to a broader view of the phenomenon of interest.

Why Interpretive Descriptive Methodology?

Interpretive Description is an approach to qualitative research that can address complex questions. Consistent with social constructionism, it assumes that realities are local in nature, socially and experientially based, and contingent in form and content on the persons who hold them (Guba & Lincoln, 1994). Rooted in the social sciences, Interpretive Description provides a way to conduct applied qualitative research that produces valuable insights into 'complex experiential phenomena', applicable and useful for health professionals (Thorne, 2016). Interpretive Description was designed to 'explore and understand how individuals and groups make meaning and act in real-world situations' to build knowledge that will inform clinical practice (Thompson Burdine et al., 2021; Thorne, 1997). While it originated in nursing, Interpretive Description has since been used to inform practice-based research in various other disciplines (Hunt, 2009; Snowden et al., 2019).

Thorne (2016) upheld the value of motivated health professionals asking pertinent clinical questions in methodological development. Interpretive Description methodology was developed to provide rigour and credibility for clinical research so that research findings could be applied to address real-world practice challenges. According to Thorne (2016), using the researcher's perspectives and experience can enrich the discovery and understanding of the data. However, using a single theoretical perspective can influence the interpretation of data and obscure insights likely to be gained. The interaction between participant and researcher will also provide an encounter with multiple realities (Thorne et al., 2004). Therefore, it is essential to employ reflexive practice to prevent these pre-existing perspectives from limiting analysis or influencing interpretation.

Bias typically exists in objectivism, where external influences are identified and their scope of influence over the research is controlled for. In contrast, in qualitative research, the subjectivity of the approach allows for influences to have an effect, and therefore this effect needs to be analysed as part of the methodology. When using Interpretive Description, bias does not exist as an external entity but as multiple factors that interplay as part of the subjective perspective, explained and interwoven into analysis and

discussion. A researcher must retain humility to appreciate their impact and balance it appropriately with their curiosity about the topic (Thorne, 2016).

Strategies to retain humility throughout a qualitative study are essential to developing the findings. Where there is value in discovering multiple realities, it is essential to explore those realities with a robust 'theoretical scaffold' (Thorne, 2008). According to Thorne (2008), there are two key elements to theoretical scaffolding: the literature review and understanding the researcher's position within the study, which Thorne refers to as 'theoretical baggage' (Thorne, 2016). The exploration of the researcher's theoretical baggage, in balance with the curiosity for the topic, will guide and shape the theoretical forestructure of the research. Although it can be a challenging process, the practice of reflexive thinking to understand this theoretical baggage is very productive. It reveals insights that add depth and colour to the contextual nature of the research. It allows the researcher to expand their thought connections and better understand their practice. Most notably, reflexive practice provides the scope and space to explore a deeper understanding of the data and its interpretation. The theoretical baggage brought into this particular research study includes professional practice and relational and developmental experiences. This includes suppositions of bias towards and inequities for allied health clinicians' leadership development, recruitment into health system leadership roles and inclusion within strategic health system design. As Thorne argues, detailing these reflections enables the researcher to 'convey an integrity of purpose that will not be confused with misuse of methods or erroneous claims' (Thorne, 2016). Working within the same landscape as the participants, the theoretical forestructure supports and provides rigour to explore a complex phenomenon while acknowledging the experience and learnings brought into the study.

Interpretive Description is consistent with the intent and purpose of this research, which seeks to provide applicable findings based on new knowledge about the experiences of allied health clinicians stepping into leadership roles. Interpretive Description aligns with a constructivist and naturalistic orientation to inquiry, affirming the qualitative approach, the engagement with a specific population, and investigating meaning as applied to a particular phenomenon (Hunt, 2009; Thompson Burdine et al., 2021). As such, the research findings need to be tangible, applicable, and able to be used to help change the current approach to health leadership development. To uncover applicable findings and inform the leadership development of allied health clinicians, the study sought to explore experiences, events and memories allied health leaders attribute meaning to as being formative to their progress into leadership roles.

Why an Appreciative Inquiry Lens?

Appreciative inquiry provides the opportunity to apply a positive lens and assumes that the system in focus has 'rich and untapped' descriptions of its strengths, possibilities and successes (Cooperrider & Whitney, 2005; Stavros et al., 2015). Tapping into these descriptions can facilitate positive growth for both individuals and organisations. Cooperrider and Whitney (2005) assert that when the means and ends of a

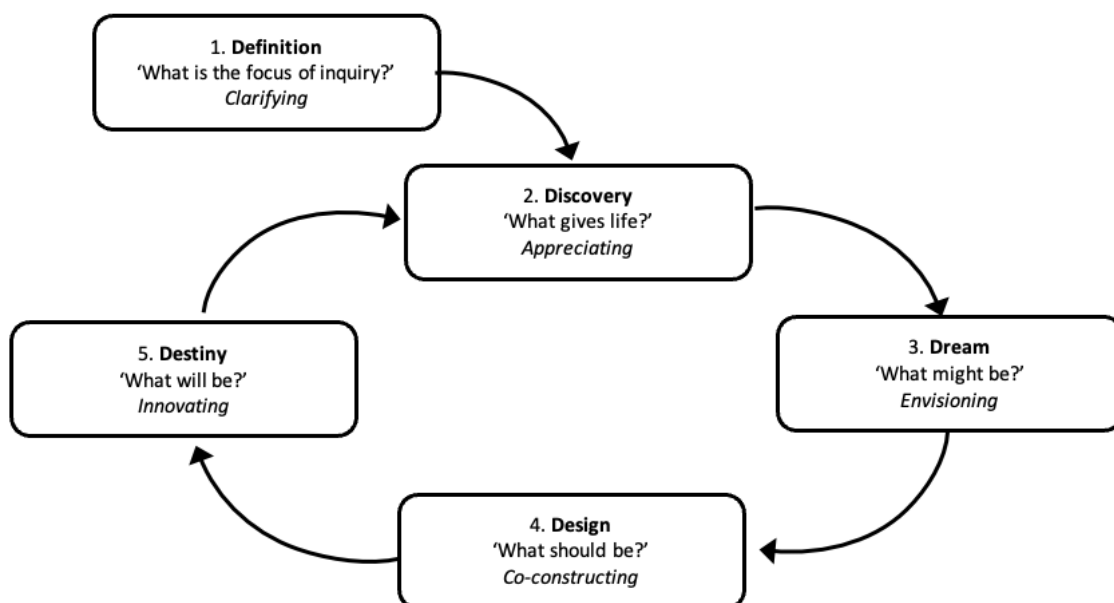
change inquiry are positively correlated, the outcome is more robust and sustainable. Drawing on an appreciative inquiry lens in the study design of this research underpins the intent to elicit positively constructive findings.

Appreciative inquiry is identified as a social constructionist approach to change, supporting inclusion, magnifying the voices of recognised experts, and engaging with a whole system perspective (Nel & Govender, 2019). This approach aligned closely with the experience intended for participants, empowering them through their valued perceptions and shared experiences. Therefore, the Interpretive Description methodology was chosen to support and underpin the study rigour for clinically applicable research and an appreciative inquiry lens to shape the methods.

Appreciative inquiry methodology draws on the 5-D cycle (Figure 3). Using an appreciative inquiry lens facilitated the application of the general tenets of these 5-D stages within the interviews. Beginning with 'define,' participants were invited to articulate an understanding of the topic and identify their positioning. The remaining stages helped to frame subsequent questions.

Figure 3

The 5-D Cycle of Appreciative Inquiry



Reproduced from David L. Cooperrider Center for Appreciative Inquiry (Accessed 2022).

Using a problem-solving approach to answer questions focusing on the potential for change is more common. However, this approach can focus heavily and unhelpfully on the problem, a deficit approach to finding solutions (Fogarty et al., 2018). Unfortunately, the societal culture in which health and disability exist nurtures this focus, and the health and disability system regularly endures critique and unfavourable

commentary from various stakeholders (Forbes, 2022; Thompson Burdine et al., 2021). This commentary impacts the health workforce but is not the only negative cultural influence.

Considering the contextual positioning of many allied health professions, a deficit-focused approach to interviewing can undermine the aim to effect positive change. To question the participants on barriers may result in a negative focus on the problems, and deficit-focused discussion is known to have demoralising effects (Patton Davis & Museus, 2019). The aim was to empower participants during the interview and focus on enablers. Therefore, it was important to lean on the principles of appreciative inquiry as a strength-based approach to guide and give positive focus to the conversational framework.

The five Principles of appreciative inquiry also informed the theoretical rigour and evidence base for pursuing the positive experiences identified within the participants' narratives. Table 4 provides an overview of the five principles.

Table 4

The Five Principles of Appreciative Inquiry (Cooperrider & Whitney, 2005)

| | Principle | Description | Application |
|---|-----------------|---|---|
| 1 | Constructionist | We are constantly involved in understanding and making sense of people and the world around us. | The experience and perspectives of allied health clinicians are all valid and hold value in making sense of the leadership journey. |
| 2 | Simultaneity | Inquiry and change are simultaneous. | The sharing of insights promotes awareness and understanding of positive outcomes. |
| 3 | Poetic | Pasts, presents, and futures are endless sources of learning, inspiration and interpretation. | The diversity and rich breadth of experiences shared will be empowering and informative. |
| 4 | Anticipatory | Our positive images of the future lead to positive actions. | Future casting questions will encourage positive ideas and promote change. |
| 5 | Positive | Building and sustaining momentum for change requires large amounts of positive affect. | Validating the allied health practitioners provides positive affirmation, and disseminating the research findings creates momentum. |

Each of these principles contributed to establishing the authenticity of the study findings and their subsequent interpretation. Williams and Haizlip (2013) endorsed using appreciative inquiry for positive culture change, an aim consistent with this research's goals: to elicit findings for application across the health and disability system and create positive change. Appreciative inquiry allows for an organic and iterative process using a strengths-based approach to build positive knowledge for future applications (Williams & Haizlip, 2013). In a societal context where the health and disability system faces a persistent deficit focus, creating change using an alternate lens provided a new and refreshed perspective from which participants could contribute.

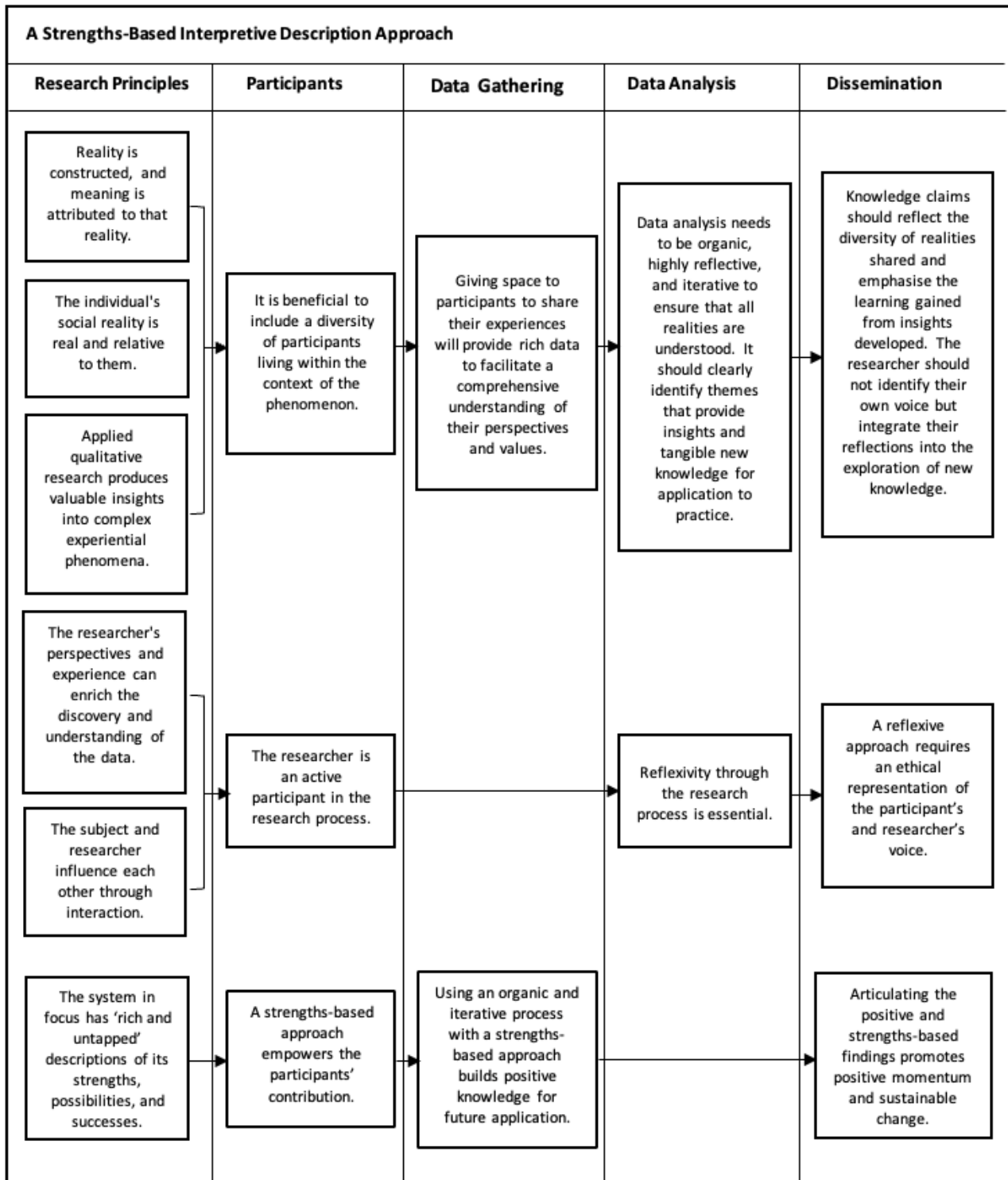
3.3.4 Results

A Synthesis of the Methodology

It is essential to understand how the theoretical aspects of the study align to support the sequence of practical logistics. Figure 4 demonstrates this study's coherent alignment and illustrates how the methodology supports and underpins each practical step of the study.

Figure 4

The Synthesis of Methodology and Study Process



Demonstrating theoretical and methodological coherence adds credibility and articulates the reasoning and evidence employed. Sharing this overview supports and guides emergent researchers to appreciate the 'big picture' perspective and avoid getting overwhelmed.

Choosing the Methods

The Importance of Context

This research process commenced during the early stages of the COVID-19 global pandemic. Therefore, as well as being informed by the epistemological and methodological influences described above, the decision-making for methods was guided by the social context in which this research was undertaken. Key characteristics of this context included: a) potential participants were busy responding to the demand of health care needs within a pandemic situation; and b) the New Zealand Government had introduced restrictions on the movement of, contact with and interaction between people due to the rise in COVID-19 case numbers. In alignment with these conditions, in-person interviews were unable to be conducted. Therefore in response, the methods required needed to be flexible to work around participants' schedules, minimise their burden, enable allied health leaders to take part in the context of other competing demands, and be managed remotely to mitigate the impact of government restrictions. For these reasons, participant interviews were conducted remotely using the institute's Microsoft Teams programme, which provided recording functionality and delivered the additional benefit of the institute's information security and protection protocols.

Participant Recruitment

Purposive sampling was used to recruit a suitable pool of Allied Health clinicians, chosen to provide rich detail relevant to the research objectives (Campbell et al., 2020). This sampling method provided the opportunity to engage with specific participants living the experience under focus. It ensured that the data was relevant and contemporary to the applicable contexts for new knowledge. As such, purposive sampling is congruent with Social Constructionism and Interpretive Description; it focuses on potential participants within the environment and context that the research applies to and creates the opportunity to explore meanings provided by the sample specifically identified.

Eligibility criteria ensured that the appropriate participants could share current and contemporary experiences. Allied health clinicians were eligible to take part if they:

1. Identified with one of the Allied Health professions listed by the Ministry of Health (Manatū Hauora – Ministry of Health, 2020b).
2. Worked in a position of authority that aligned with the Edmonstone definition of 'health systems leadership': 'Leadership within and across organisational and geopolitical boundaries, beyond individual professional disciplines, involving a range of organisational and stakeholder cultures, often without direct managerial control of resources and working on issues of mutual concern that cannot be addressed by any one person or agency.' (Edmonstone, 2020)

People were excluded if they were concurrently accredited with a medical or nursing professional qualification. This exclusion criterion was critical to understanding the perception of participants who only

had the experience of the 'allied health' collective and did not have insights blurred by the experience of other professional training and practice.

Initially, expert sources were identified from their public profile using available information to characterise them as health systems leaders with an allied health background. These expert sources were approached to participate and also asked to nominate and facilitate introductions to eligible Allied Health clinicians, drawing on their knowledge of eligible potential participants from across Aotearoa New Zealand's health and disability system. A number of strategies were used to mitigate the risk of coercion as part of the recruitment process due to the likelihood that they would be known to the researcher. Additional recruitment methods included advertising through established forums such as the National Allied Health, Scientific and Technical Directors Forum and Ngā Pou Mana, the Aotearoa New Zealand Māori Allied Health forum (Tangata Whenua Allied Health – Ngā Pou Mana, 2022). Access to publicly available information was also valuable and enabled through online search engines such as Google and LinkedIn. Finally, snowballing was used to identify additional eligible allied health clinicians to optimise sample diversity and address sampling gaps where alternate methods did not work sufficiently to identify eligible participants. Snowballing involved asking known allied health connections to forward the research information to a colleague they considered would be an eligible candidate. This multi-pronged approach to recruitment was necessary because allied health systems leaders can be hard to find (Naderifar et al., 2017). An Allied Health clinician in a health systems leadership role can typically take on a role and title that does not readily identify their professional or clinical background. Therefore, recruitment strategies aimed to capitalise on the collective allied health community network knowledge and broad connections to identify potential participants.

Decisions about sample size and when to stop data collection in qualitative research are subjective. While it was anticipated that a sample size of $n=15-20$ would be sufficient, the final sample size was $n=19$. All participants provided informed written consent, completing an electronic consent form. Interpretive judgment was applied to decide when to stop data collection based on the need to consider time, resources available, volume, and richness of data accrued. Thompson Burdine et al. (2021) affirm that where a relatively small sample size is available, it can provide sufficient in-depth data to achieve information power and answer the research question (Malterud et al., 2016). Another key factor contributing to decisions regarding sample sufficiency was the extent to which there was diversity in key characteristics, such as ethnicity, gender, and profession. In particular, given this research was undertaken in Aotearoa New Zealand, it was important to ensure that the research was purposefully inclusive and actively sought Māori (the indigenous population) participation. This inclusive approach reflected the commitment to Te Tiriti o Waitangi obligations (Occupational Therapy Board of New Zealand). These bi-cultural obligations are upheld through the researcher's professional code of conduct, by their employer and by the academic institution. Recognising the Western perspective brought into the research study as a

non-Māori, it was essential to explore any culturally specific 'enablers' experienced by allied health clinicians.

Data gathering

Qualitative interviews are an effective tool and can elicit rich data from those who have experienced the phenomenon of interest (Connelly & Peltzer, 2016). Individual interviews, rather than group interviews, were completed with each allied health clinician for two reasons. First, to give space to their unique experiences and depth of insight, consistent with social constructionism and Interpretive Description. Second, to enable flexible scheduling due to their increased workloads, responding to health service demand, and shifting priorities in response to case numbers and movement restrictions. Evidence demonstrates that applying an appreciative inquiry lens during one-to-one interviews has successfully elicited 'detailed and often intimate information from busy heads' (Michael, 2005).

Using interviews for the accrual of a richly layered data pool, they facilitated an immersive opportunity to explore and develop an intimate understanding of the phenomena and emergent themes. Advice and guidance were sought from the Mātauranga Māori Committee, an advisory forum at the researcher's academic institution, to review design and research plans and ensure cultural alignment and safety. It was agreed that a Māori advisory group to guide, support and ensure bi-cultural interpretation of the findings would also support transferability across the health and disability workforce. The importance given to this bi-cultural application is aligned in the interim to the Whakamaua: Māori Health Action Plan (Manatū Hauora – Ministry of Health, 2020a) while Te Aka Whai Ora (Māori Health Authority) develops the Hauora Māori Strategy (Te Aka Whai Ora – Māori Health Authority, 2023). The plan includes 'Māori leadership' as one of its priorities in achieving Pae ora (healthy families). It seeks 'to increase and support Māori participation in governance, leadership and management decision making at all levels of the health and disability system' (Manatū Hauora – Ministry of Health, 2020a).

The Individual interviews were used to obtain rich, layered and detailed experiences and support the transferability of findings by allowing others to identify with those experiences and relate the findings to other settings (Smith & Johnson, 2023). Online interaction was a necessary method and could have affected the engagement and connection between the interviewer and interviewee. However, many participants had become accustomed to communicating online due to the social conditions, and despite some initial hesitation, participants willingly shared their experiences.

The appreciative inquiry lens facilitated a strengths-based perspective and a positive style of questioning. Table 5 lists the questions used during the interviews to collect data. These questions evolved during the data collection phase to capture the information required and extract positive and empowering thoughts and perspectives.

Table 5*Interview Questions*

| | Question | Phase of appreciative inquiry |
|---|---|-------------------------------|
| 1 | What does Health Systems Leadership in NZ mean to you? What makes a good health systems leader? | Definition |
| 2 | Tell me about the experiences or events that inspired you to consider leadership. | Discovery |
| 3 | Can you describe an event or experience that encouraged you in your leadership journey? | Discovery |
| 4 | What factors supported you in achieving your leadership role/s? | Discovery |
| 5 | Tell me about when you overcame a challenge or limitation stepping into leadership. | Discovery |
| 6 | What possibilities do you see for future allied health clinicians leading health systems? Are there any roles or conceptual roles you would suggest? | Dream |
| 7 | What would it look like if you could design a system that was inherently enabling AH clinicians? Where/when would this enabling process start? | Design |
| 8 | What advice would you give to a colleague on a leadership journey? | Destiny / Delivery |

Approaching Analysis with Attitude

Choosing to use thematic analysis as the preferred approach, in conjunction with a strengths-based perspective, helped define the whole study design. Deciding which thematic analysis method required consideration of the study aim, context, and personal strengths. There was expectation that the participant's stories and experiences would overlap and intermingle, building upon each other to construct themes. Therefore, it was intended that the methods would weave together an analytic framework from which the findings would be produced.

To reflect the perspective of data interweaving with each other, the iterative method of reflexive thematic analysis (Reflexive TA) was deemed the most appropriate (Braun & Clarke, 2020). This choice linked the interview method, interview questions and method of analysis in congruence to support and underpin the development of themes (Connelly & Peltzer, 2016). Clarke and Braun (2018) assert that 'reflexive' TA is just one of several TA approaches. It embraces qualitative research values, providing an open and organic process for iterative thematic development (Braun & Clarke, 2020). It enables the researcher to have an immersive experience with the data, identifying repeated patterns of meaning (Braun & Clarke, 2006). Exploring those patterns, interpreting their meaning and identifying emergent themes provide space and scope to produce robust outcomes for developing guidance and recommendations for policy development. Making it appropriate for use with Interpretive Description (Thompson Burdine et al., 2021).

Reflexive TA draws on six analysis phases to uphold the rigour required for credibility;

1. Familiarising yourself with the data,
2. Generating initial codes,
3. Searching for themes,
4. Reviewing themes,
5. Defining and naming themes
6. Producing the report (Braun & Clarke, 2006).

However, reflexive TA is not a linear process where the researcher moves sequentially from one phase to the next; instead, it requires shifting back and forth throughout the analysis phases to elicit the required refinement (Braun & Clarke, 2006).

Following the interviews, all the audio recordings were transcribed professionally, reviewed for accuracy and read as part of familiarisation. Tools such as visual mapping and reflexive journaling were used to support data immersion, clarify emerging insights, and continually identify theoretical baggage. The immersion process was valuable; it allowed for the exploration of coding across the whole data set, consider emergent themes, and use an iterative approach to categorising and grouping the codes differently (Sandelowski & Leeman, 2012).

While developing codes and analysing the data, the lens of appreciative inquiry was applied to sustain a strength-based perspective for balanced interpretation. The software programme NVivo was used to support the analytical process and provide organisational clarity for the codes. Positive language was applied when coding, such as 'being equipped' and 'self-investment', and the aligned references were contextual and meaningful. This does not mean information shared about barriers or disabling factors was ignored or marginalised. The strengths-based approach emphasised negative examples or experiences because they were contextually different from the interviews' positive focus. As such, the analysis provided rich and detailed information on the full spectrum of participants' social, emotional and interactive experiences.

Acknowledging Assumptions

Researcher reflexivity was a key strategy used to identify any assumptions about the participants, their context and the research approach. For example, it was assumed that health systems leaders would have experienced an active transitional process when stepping into leadership roles. It was assumed recruitment would be hard because potential participants may not include their professional background as part of their publicly available information. It was also assumed that pre-existing connections might exist between the researcher and participants. The potential for positional power to influence the participants was recognised and strategically mitigated. Employing reflexive practice with techniques such as journaling helped clarify

assumptions, evaluate the research process and design the study accordingly. Employing a reflexive journey is as important as the outcome.

Establishing Rigour

To attain rigour in qualitative research, there is a need to achieve and maintain consistency in the approach, analysis, and reporting of outcomes (Daniel, 2019; Johnson et al., 2020; Ospina et al., 2018). Establishing rigour in qualitative research is often challenging and Thorne (2008) recommends using evaluation criteria to underpin the research and demonstrate transparency in the process.

Thorne (2008) identifies four criteria. The first, 'Epistemological Integrity', refers to evidence of congruity between epistemology, theoretical perspective, methodology and methods. Figure 4 above makes explicit the methodological alignment. Second, 'Representative Credibility' was established through the sampling process and how individual interviews enabled rich and in-depth data collection. The third is the use of 'Analytic Logic' to detail and demonstrate a coherent progression of analysis from data collection to outcomes. Evidence of audit trails, graphics, and records of progressive thematic development to illustrate this researcher's refinement logic. The final criterion is 'Interpretive Authority', which ensures that the researcher takes responsibility for the significance of data immersion. Techniques to facilitate this included, reading, familiarisation doodling (representative pictures and text of the researcher's thinking), NVivo analysis software, audio playback, visual mapping and reflexive journaling. These techniques integrated the critical questions of, 'What is happening here? [and] Why am I seeing this?' as part of the analytic process (Thorne, 2008).

In addition, Thorne (1997) urges the researcher to consider a further set of criteria for critiquing qualitative research as part of their accountability and quality assurance. These five criteria include moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness and probable truth. These criteria underpin the pragmatic approach of Interpretive Description, and each strategy identified achieved the rigour required and endorsed the transferability of findings into practice.

3.3.5 Discussion

As health systems continue to evolve, appropriate research tools are required to provide research rigour to study the adaptive health landscape (Lavoie-Tremblay et al., 2018). This article has detailed insights into the approach taken at key decision junctures of the research journey. In addition to the above, several key learnings emerged; they include the use and application of appreciative inquiry, the approach to engaging with Māori values and principles, creating the right interview environment, the study's impact on organisational change and how to approach the power differential between researcher and participants.

Appreciative inquiry allows for discussing numerous factors, dependencies and influences without constraint. Healthcare researchers have used it as a powerful tool to study and facilitate change

(Learmonth et al., 2018). The lens of appreciative inquiry was chosen as a proven perspective through which to engage credibly with participants amidst their complex and ever-changing context. Using the 5-D Cycle (Figure 3) provided a framework to lead the participants through sharing their experiences. Asking for contextual insights at the start (Define) critically helped with providing immediate feedback to inform the interview's progress.

Engaging in a culturally appropriate and inclusive research design is critical. In Aotearoa New Zealand, whether a study is explicitly engaging with Kaupapa Māori research (Smith et al.) or undertaking research involving Māori, the design and methodology should be culturally responsive to support Māori engagement in the research and to optimise the likelihood that the research findings can contribute to Māori aspirations. This researcher's associated academic institution offered access to the Mātauranga Māori Committee. With their support, additional evidence was identified supporting the use of appreciative inquiry by Te Tangata Whenua Community and Voluntary Sector Research Centre (Tangata Whenua – Community and Voluntary Sector Research Centre, 2022). The Research Centre endorses appreciative inquiry as 'compatible to Kaupapa Māori approaches' and aligned with the research principles within their Code of Practice (Tangata Whenua – Community and Voluntary Sector Research Centre, 2007). Using Māori advisory forums was essential for supporting and underpinning the methodology with rigour and epistemological integrity (Thorne, 2016).

Maintaining momentum and energy during data collection helps to facilitate participants' contribution and engagement. Finding a methodology that enabled momentum and energy during the interviews was essential to create an unrestrictive context for data collection. Using an alternate pathway to discussing phenomena challenged the well-known default problem-solving approach for creating change. When a group or individual uses deficit-based discussion, it can bring a negative emotional response that limits vision and creativity of thought. When an individual or group wants to create change, an appreciative inquiry approach can elevate their morale, commitment and ongoing discovery of innovative ideas (Whitney & Cooperrider, 2012). Appreciative inquiry was chosen because it helped to frame the interview questions and support the development of a positive tone of engagement for obtaining the data required.

It was evident that despite a strength-based approach to questioning, the participants' experiences were not all positive. Avoiding a discussion of barriers might create a misperception that barriers do not exist, and assumptions could have been made that the allied health collective workforce is successfully enabled and empowered into health systems leadership roles. Ignoring or restricting the exploration of barriers could have impacted the data extracted, the themes generated and the study's final findings. During the interviews, participants did share experiences that had been challenging and hard for them, often identifying them as limiting factors. These experiences were used to inform the findings and identify limitations that further the understanding of what positively enables allied health clinicians.

This study did not anticipate being able to effect organisational change across each participant's employing agencies (Whitney & Cooperrider, 2012). Health and disability systems are complex, multifaceted and constantly changing. Notwithstanding the diversity of research participants, who came from public and private health agencies, ministry, and national and regional leadership situations, the study sought to understand the experiences of a group of individuals whose insights would give rise to common themes or patterns in meaning. These themes, once interpreted and discussed, could be applied across the broad health and disability system to impact those types of individuals who align themselves with the participants.

This research is ongoing at a time when the most extensive national health system reforms Aotearoa New Zealand has experienced in twenty years are underway (Department of Prime Minister and Cabinet, 2021). As operational clarity emerges, it is an excellent time to explore and share new evidence for the development of future health system leaders. The potential for positive change within the leadership context remains; it will continue beyond the life of this research and is part of a much broader health system agenda (Health New Zealand – Te Whatu Ora & Māori Health Authority – Te Aka Whai Ora, 2022).

Participation in this research was limited to a small group of eligible people, excluding a large proportion of the broader system's employees. The limitations on the scope of this study potentially reduced the impact for change. Broad socialisation could increase visibility and influence positive change. This socialisation could support uptake and engagement with the findings, enabling individuals to find alignment and influence emergent and developing allied health clinicians.

The influence of a possible power differential between researcher and participant required practical consideration. The Tangata Whenua – Community and Voluntary Sector Research Centre (2020) also identified this as a potential issue for individuals participating in appreciative inquiry. Differences in perception of power may occur between the concurrent involvement of leaders and staff in group situations or because of who the employing organisations are for the researcher and participant. While this study did not use groups of participants, the power balance issue between researcher and participant required sensitivity. It was essential to be transparent about employment details, university support and positioning alignment within the information provided to participants. All interviews were conducted outside of the time of paid employment, all communications went through a non-work-related email address, and the demeanour and dress code did not reflect a typical work context. It was apparent that the practical and administrative aspects mattered, along with how this sensitivity influenced the approach and mindset going into the interviews. Overt recognition was given to the value and importance of asking participants to share their treasured experiences. They were handled as precious taonga (sacred), as a gift of memories, received with care and honour.

3.3.6 Conclusion

This article has examined the choice to use combined methodologies to deliver new and credible knowledge to guide future allied health and health systems leadership development. Completing an applied health research study with the intention to effect change requires robust methodology and rigour. Sharing these learnings and insights with the research community and identifying how and why those choices were made has the potential to inform how research can be approached, now and into the future. Reflecting on the congruency of a methodological approach and how an additional methodological lens positively influenced the study design identifies opportunities for consideration. Using Interpretive Description with an appreciative inquiry lens has demonstrated an effective pathway to engage with research and deliver findings intended to affect positive change across the health system. These shared learnings provide further understanding of an applied qualitative health research process.

3.4 Chapter Summary

Chapter 3 has outlined and justified my personal positioning within this research and the methodological choices made for this study. The use of Social Constructionism which aligns with my worldviews, provides a philosophical foundation for understanding, valuing and exploring participants' experiences. Interpretive Description provides a theoretical framework for this applied health research study design, enabling the interpretation, extraction of meaning and identification of new knowledge. Using an appreciative inquiry lens shaped the study's design, through the phased interview questions (Appendix C), data analysis, data interpretation, thematic development and positive naming, through to constructive and positively focused recommendations. . Where Manuscript 2 briefly described the methods involved, further detail about the tools and strategies used are fully discussed in Chapter 4. Both chapters identify and explore the value of rigor in the study's design and methods. The application of criteria to establish and maintain rigour is complimented by Figure 4, which illustrated theoretical coherence across the study design. Together, these elements demonstrate a strong desire to ensure the integrity and credibility of this research study. The chosen methodological approach lays the foundation for the analytic logic that delivers interpretive authority and provides new evidence-based knowledge for application to practice (Thorne, 2008). Chapter 4 will continue with a detailed description of the methods not able to be addressed in detail in the manuscript, demonstrating their alignment with the methodology and illustrating the depth of rigour developed.

Chapter 4 Methods

4.1 Introduction

The purpose of Chapter 4 is to complement and expand on the methodology discussed in Chapter 3. It clarifies how the methodology was implemented to ensure rigour and credibility. A comprehensive description of the methods, tools, and strategies used to apply the methodological approaches of Interpretive Description methodology (Thorne, 2008) and reflexive thematic analysis (RTA) (Braun & Clarke, 2022) is provided. As indicated within the Attestation of Authorship several of the Figures included within this chapter focus the reader on the research process, rather than give detail of substantive content. They provide clear illustration of the process undertaken to ensure rigour and credibility of thematic development. See Appendix D for a summary of the outputs generated from the analytical methods discussed in this chapter. This chapter's explanation is contextually situated and, therefore, may repeat information where it overlaps with Manuscript 2. Where repetition occurs, reference is made to the relevant Chapters and Sections.

Chapter 4 is structured using the four evaluative criteria proposed by Thorne (2016) and mentioned in Chapter 3, Establishing Rigour (Section 3.3.4). This structure was chosen to provide coherence for the information omitted from Manuscript 2. This complements the reflective approach taken to Manuscript 2 by providing practical detail and illustrative evidence of the study's rigour. The four criteria used as subheadings are *Epistemological Integrity*, *Representative Credibility*, *Analytical Logic*, and *Interpretive Authority* (Thorne, 2016). A qualitative methodological approach typically includes guidance on principles of evaluation and Thorne (2016) identifies these four general evaluative criteria as assurance measures. They offer guidance to help readers understand the epistemological, theoretical, and technical rigour of qualitative research. Using these evaluative criteria is methodologically coherent and provides the opportunity to demonstrate how the chosen methods establish and sustain consistency in the approach, analysis and reporting of outcomes (Daniel, 2019; Johnson et al., 2020; Thorne, 2008). Each criterion identifies specific aspects of the research for review while maintaining an overview of the entire study for quality assurance.

Alongside the generic evaluative criteria provided, Thorne (2016) developed an additional set distinctly aligned to Interpretive Description. Their application supports the more subtle critique of qualitative research outputs within the disciplinary, social and historical contexts in which they've been produced (Thorne, 2016). These additional criteria include *Moral Defensibility*, *Disciplinary Relevance*, *Pragmatic Obligation*, *Contextual Awareness*, and *Probable Truth*. The discussion of these additional criteria within this chapter will focus on their unique alignment with Interpretive Description. Doing so offers an alternate

evaluative perspective that addresses the rigour of meaningful interpretation within the broader contextual situation.

The position of this research within the health sciences means that useful insights derived from the findings may find their way into practice within the health system (Thorne, 2016). Therefore, it is important to consider that the researcher's disciplinary responsibility influences the application of rigour to ensure quality research and credible outcomes. Applying these criteria evidences the value placed on the importance of quality within this study.

4.2 Methodological Overview

As outlined in Chapter 3, this research study was founded on the philosophy of Social Constructionism, a view described by Crotty (1998) and Mannheim (1993). This philosophical approach suggests meaningful reality is socially constructed, where individuals create their social reality through the meanings they attribute to their social, interpersonal and contextual constructs. When common meanings applied to these constructs are identified, they can generate a collective meaning (Crotty, 1998). Exploring collective meanings applied within healthcare systems requires a theoretical framework that is robust enough to address complex questions. Interpretive Description provides a scaffold for conducting applied qualitative research into complex experiential phenomena relevant to health professionals (Thorne, 2016). To avoid a deficit approach, typically taken to solving complex issues, this study applied a strength-based lens to the design through the principles of appreciative inquiry (Cooperrider & Whitney, 2005). Collectively this methodological approach endorses the value of participant experience, empowers the contributions of participant data and frames the study to deliver constructive outcomes.

4.3 Epistemological Integrity

Establishing epistemological integrity means evidencing the congruity between epistemology, theoretical perspective, methodology and methods. Thorne (2016) emphasises the importance of establishing congruity to illustrate reasoning, critique and understanding of the framework in which the research is completed. The researcher needs to demonstrate: how the epistemology aligns with the topic in focus; how the methodology supports and enables appropriate data gathering and investigation; and how the methods empower the researcher to undertake analysis and synthesis to produce credible findings.

The inclusion of graphics, figures, and tables throughout this thesis illustrates a coherent epistemological approach, providing a multi-modal synthesis of information for the reader (Whittemore et al., 2001). In Chapter 3, Figure 4 (Section 3.3.4) illustrates how principles drawn from Social Constructionism (Crotty, 1998), Interpretive Description (Thorne, 2016) and Appreciative Inquiry (Whitney & Cooperrider, 2012) were formative to key decisions regarding methods, including sampling, data gathering, analysis and dissemination. In conjunction with the explanation in Section 3.3.3 and *The Study Design Overview* in Figure

2, this demonstrates congruence between these philosophical views and methodological choices. Whittemore et al. (2001) endorsed the use of creative illustration, arguing that the essence of qualitative research can be threatened by overemphasising the scientific method instead of giving space to the art and creativity of interpretation. They recommend the researcher become immersed in the research process thoughtfully and creatively but not at the expense of the quality of science.

Practicing reflexivity throughout the thesis upheld the integrity of reflexive thematic analysis (Braun & Clarke, 2022) and was congruent with the need for interpretive significance (Thorne, 1997). Chapters Three and Four illustrate the depth of critical reflection and analytic process alongside the subjectivity of interpretation grounded within the data. The personal positioning in Chapter 3 (Section 3.2) acknowledges the influence of my professional training, clinical practice, world view and leadership experience and reflects on the influence of disciplinary philosophy, social connections and the health system.

Assumptions about the participants and anticipated findings are identified and explained in Chapter 3 (Section 3.3.4). The analytic approach was informed by these assumptions, and as more assumptions were identified, the analytic process became more visually creative. This creativity facilitated transparent thought evolution and close association with source data. Using various types of graphics helped to explore multiple meanings within the data and made assumptions visible for testing and challenging. The analysis process was completed transparently and thoughtfully, working to identify and reflect robust and grounded interpretations.

4.4 Representative Credibility

Establishing credibility means ensuring that the interpretations of data are trustworthy and reveal truths external to the researcher's experience (Thorne, 1997). Representative credibility is the assurance that this research study's theoretical claims are consistent with the process by which allied health clinicians occupying health systems leadership roles were sampled (Thorne, 2016). Claims made across populations, cultures and contexts that extend research findings beyond their credibility are typically dismissed. This undermines the effort and work that went into developing those findings. It is, therefore, essential that the claims made about enabling allied health clinicians to step into health systems leadership roles are congruent with the sampling process.

Participants were initially identified using publicly available information and then purposively recruited according to the inclusion criteria (see Chapter 3, Section 3.3.4). Eligibility was self-determined and then reviewed with the researcher by phone or email. One participant was declined following a discussion regarding the scope of their existing role and leadership experience. It was found that their role did not have the breadth and inclusion of multiple geopolitical boundaries, services or professions in alignment with the definition of health systems leadership used by the researcher (Edmonstone, 2020). It was

essential to ensure that the scope of participants' experience aligned with the parameters of a broad health systems leadership identity. If the scope of their roles were too narrow, the findings might not have effectively captured the diversity of health systems leadership positions that allied health clinicians can fulfil. In addition, the nature of health systems leadership roles means that any allied health clinician could be capable of fulfilling a role. Therefore, the representation of allied health professions was a secondary consideration to their identification as an allied health clinician occupying a health systems leadership role.

Conversely, the exclusion criteria (see Chapter 3, Section 3.3.4) kept the focus on allied health clinicians and the collective of allied health professions, reducing the impact of overlap from additional professional identities, cultures or training philosophies. It was assumed that an allied health clinician who had also experienced medical or nursing educational training might have experiences that negate the distinctive differences under investigation and potentially cloud the data collected. It was important that the participant's experiences were solely and directly related to their allied health practice and experiences. This sensitivity helped scaffold the relevancy of the findings, interpretation and outcomes for the allied health workforce.

Pursuing representation of all 43 allied health professions would not be feasible and would be unlikely to produce rich and meaningful data. Instead, diversity was sought across a range of sampling criteria. Consideration and effort were given to ensure there was a proportion of Māori and Pacifica participants and a diversity of allied health professions represented. During the sampling process, allied health clinicians initially self-selected to express their interest in participating. This approach inherently pre-determined a cohort of participants who applied value and meaning to the research focus. From those that expressed interest, participants were purposefully selected from various ages, locations, and roles across the private and public health sectors to capture a breadth and depth of experience. While direct representation of all 43 professions was not achieved, the diversity of demographics and use of consistent health systems leadership definition (Edmonstone, 2020) framed the sampling process to ensure contextual relevance for the allied health workforce and health system of Aotearoa New Zealand.

4.5 Analytic Logic

This thesis needs to provide sufficient evidence of the logic employed with the inductive reasoning process used to confirm (or reject) the interpretations. The decision-making process must be sufficiently visible to identify where the interpretive claims are founded within verbatim data. Using this approach, the explicit reasoning of analytic logic is conveyed from the fore structure, through to the interpretations and the knowledge claims (Thorne, 2016). In Chapter 3 (Section 3.3.4), a brief overview of the methods and strategies used is provided, but further information is required to explain the evolution of analysis. This section will use the six phases of reflexive thematic analysis as subheadings, interspersed with graphics showing how the tools and analytic strategies enabled a logical analysis progression.

Reflexive thematic analysis was chosen because of the value given to the subjectivity and experience brought to the study by the researcher (Campbell et al., 2021). Reflexive thematic analysis supports the researcher to engage with data using creative tools and methods, encouraging the use of diverse creative methods to process information. Reflexive thematic analysis fosters an iterative, non-linear analysis approach, encouraging the researcher to choose reflexive tools suited to their personality and analytic behaviour. This individualistic approach supports the researcher to engage with the data through the lens of their theoretical perspectives and multiple analytic strategies. Theoretical perspectives, subjective experience and diverse strategies underpin both rigour and quality in the analysis (Terry & Hayfield, 2020). Manuscript 2 provided an overview of how the six phases of reflexive thematic analysis were enacted within the study (see Chapter 3, Section 3.3.4). Below, Table 6 further describes each phase along with details on the tools and strategies employed.

Table 6

A List of the Strategies Employed with Reflexive Thematic Analysis

| Analytic phase | Description | Strategies |
|---------------------------|--|---|
| Data familiarisation | Immersing oneself within and engaging with the breadth and depth of content Searching for meanings and patterns | Reading and listening to the interview transcripts Note taking Visual doodling |
| Initial code generation | Identifying features of data that are meaningful to the phenomenon Working to give full and equal attention to each data item | Labelling raw data items Organising data items into meaningful groups |
| Generating initial themes | Sorting of codes into potential themes Thinking about the relationship between codes and themes | Mapping and diagramming Writing the themes down and describing their properties |
| Theme review | Refining the themes to become distinctive and clear Review at the coded data level and across the whole data set | Identifying overlaps and collapsing themes Making sure there is enough meaningful data to support the theme Refining and aligning the themes across the data |
| Theme defining and naming | Identifying the 'story' of each theme Considering each theme in relation to each other and their coherence with the broader overall 'story' Considering concise names that provide an immediate sense of the theme | Clearly defining what your theme is and is not. Mapping the development visually. Identifying the 'essence' of what each theme is about Organising the data into a coherent and internally consistent account |
| Report production | Delivering a concise and coherent account of the 'story' within and across the themes | Writing a compelling argument, embedded with extracts, that goes beyond theme description Distilling the themes to provide coherent and logical outcomes. |

Adapted from Braun and Clarke (2022).

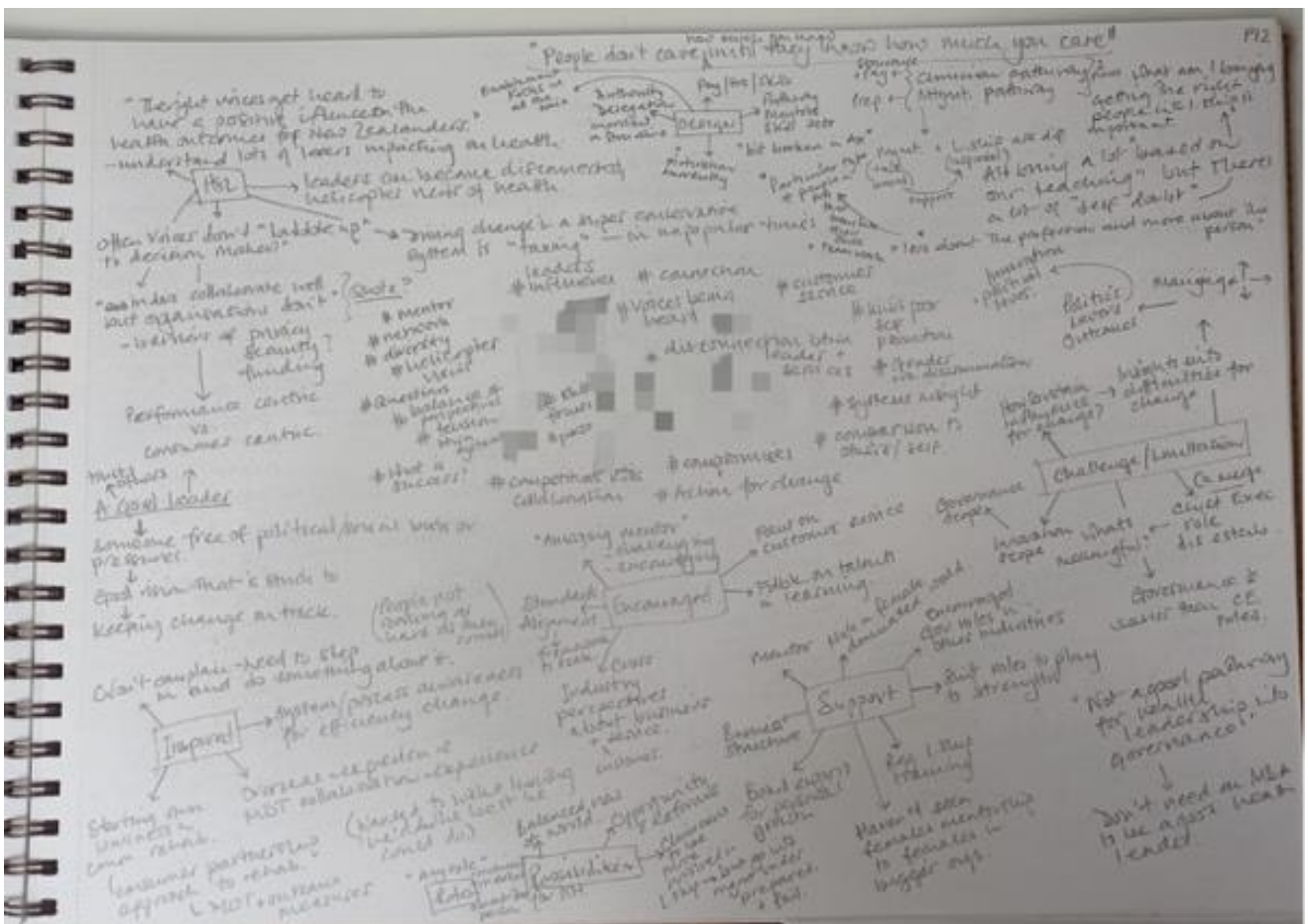
4.5.1 Data Familiarisation

To become familiar with the data, it is important to be immersed in the language, fluency, and content of the experiences shared (Braun & Clarke, 2022). This research study used several stages of immersion. Initially and as close as possible to the completion of each interview, time was spent journaling in reflection of the interview conducted. Notes were made regarding the thoughts, emotions, and ideas conjured by the participant for the researcher. This reflexive practice explored what meaning was conveyed by the use of particular words or phrases and how those meanings connected across the interview content.

Following the narrative reflections, each recorded interview was watched and listened to again. This provided an opportunity to attend with focus and note key descriptions, phrases, or ideas. Engaging with the data in this way enabled the production of visual doodles for each interview, a creative example of familiarisation practice (Braun & Clarke, 2022). Examples of three visual doodles are provided below in Figure 5 (participant names have been blurred out to protect confidentiality). These doodles helped illustrate how data sequenced with or connected to one another using lines and arrows. Creating them provided a fluency of reflection and enabled the identification of emphasis on particular issues or topics.

Figure 5

Three Familiarisation Doodles of Interview Data



4.5.2 Initial Code Generation

Once the visual doodles were completed initial code generation shifted onto digital platforms. The graphics software programme XMind was used to display and organise keywords and phrases identified during the visual doodling and reflective journaling. These keywords and phrases were chosen because they were deemed relevant to the research question, how are allied health clinicians enabled into health systems leadership roles? Keywords and phrases included: 'support'; 'coaching'; 'curiosity'; 'not about power'; 'talent management' and 'lack of business training.' Figure 6 is a snapshot of the early stage of identification.

After adding all the keywords and phrases, and with the reflexive journal notes, an active process was initiated to identify connections and groupings. Duplicate terms were removed, but closely associated terms such as 'coaching' and 'mentoring' were retained. This was to facilitate a richer context for interpretation and give space to existing inconsistencies across the data (Braun & Clarke, 2006). Patterns and meaningful groupings became evident as each interview's doodle and journal reflections were reviewed and items added. As each group was considered, patterns and meanings were more clearly identifiable. Reflections about what the groupings meant and how each might interact and contribute to overall thematic development were reflexively journaled for ongoing consideration. Braun and Clarke (2022) refer to this form of grouping as domains, a categorisation of the dataset typically captured in one word. Figure 7 and Figure 8 are illustrative of the process of mapping the domains. Over 380 items were identified and grouped into six domains at the end of this mapping process. Each domain was named, and the meanings of those names were explored within reflexive journaling.

The manual process of identifying keywords, meaningful phrases and repeated terminology provided insight into which issues the participants emphasised and associated. However, this initial approach disconnected keywords and meaningful phrases from the source data and the decision was made to use the NVivo coding programme (Lumivero, 2023). This would combine the completed manual work with a more systematic digital coding process. This decision enabled further data immersion, review and consideration of different interpretations to align source data with the developing codes. Initial data domains and associated subcategories were uploaded into NVivo along with the 19 transcripts.

These initial categories provided a starting point only for the more systematic coding approach and built on the familiarisation already achieved. This process enabled a review of the source data, the identification of codes, and the consideration of different interpretations of the participant's narrative. There was substantial organic movement between identifying codes, interpreting meanings, and establishing connections within the data content. Initially, the coding was more descriptive and semantic. However, as the coding and analysis progressed, the codes became increasingly interpretive, delving into the latent meanings within the data. Table 7 displays the initial Codebook exported from NVivo, which identifies the

six domains of codes. These domains are data categories that recognise associations of meaning within the data (Braun & Clarke, 2022). This iterative phase using manual and digital strategies spanned data familiarisation and the generation of initial codes.

Figure 6

XMind Map of Initial Keywords and Phrases



Figure 7

Organising the Items into Meaningful Groups as Above

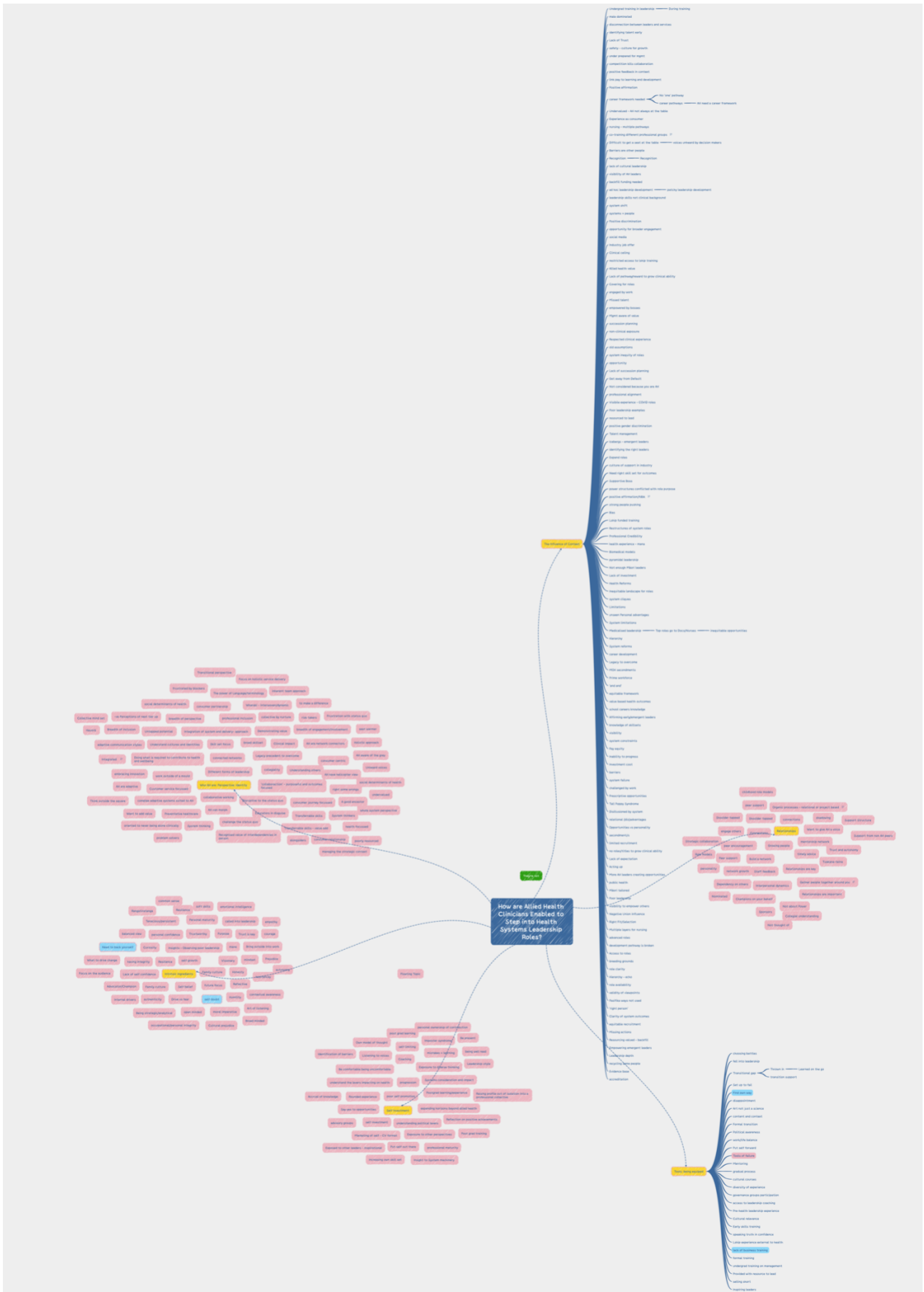


Figure 8

Groupings of Data Elements and Initial Coding

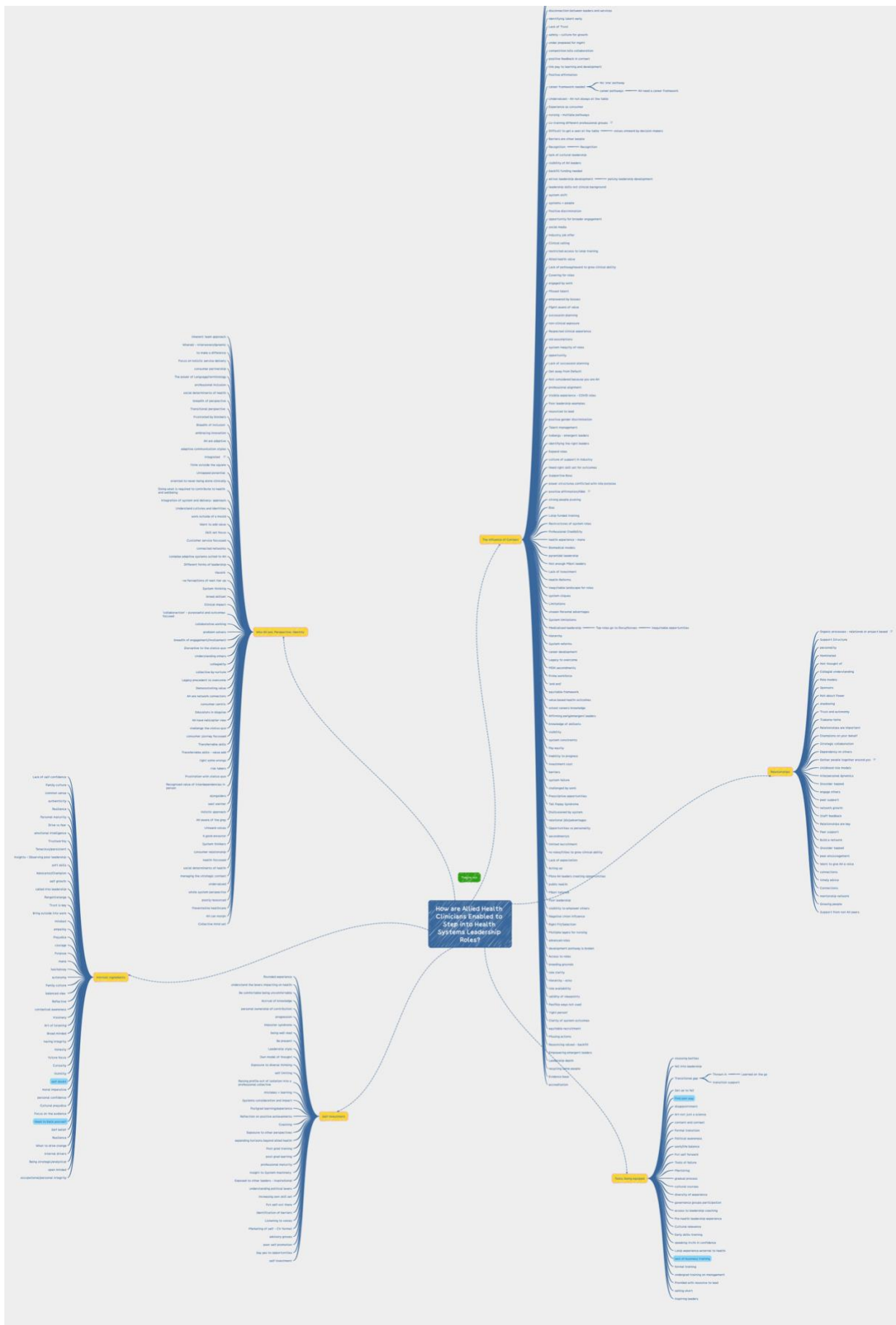


Table 7*Initial Groups, Codes and Descriptions*

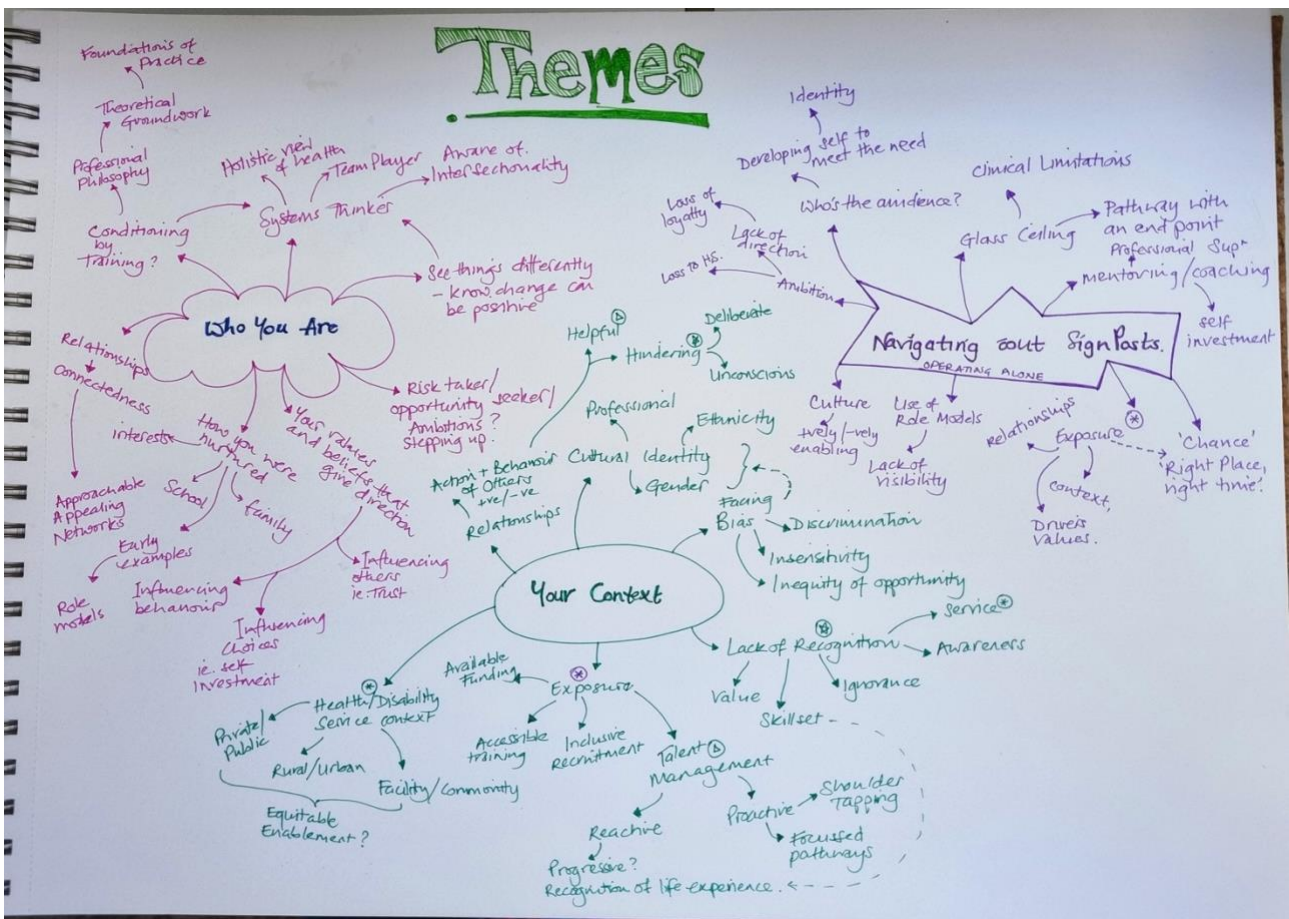
| Code | Sub code | Description |
|----------------------|--------------------------------|---|
| Being equipped | | The tools and skills (or lack of) that enabled or disabled the clinicians to progress their leadership |
| Identity | | How the clinician perceived themselves or their profession or role which influenced their progress by enabling or limiting their progress. |
| Influence of context | | Contextual factors that enabled or disabled the clinicians in their journeys. These factors were external, out of their direct control but influential upon them. |
| | Culture | Contextual culture influencing leadership – the culture of agency, organisation, indigenous, whānau. |
| | Equity | Factors that influenced the equity of and/or an equitable context for the allied health clinicians |
| | Exposure | The factors of contextual exposure to events/opportunities/people for allied health clinicians |
| | Recognition | The factors that support or disable AH clinicians as being identified as having value/potential. |
| Intrinsic factors | | The intrinsic and personal behaviours, experiences and values that the clinicians identified as enablers or disablers of their leadership journey. |
| | Behaviour | An internal driver acted on |
| | Values | Beliefs held as important enablers or disablers |
| Relationships | | Influential interactions that have meaning for the participants. These experiences translated into choices and behaviours that contributed to their leadership journey. |
| | Action and behaviour of others | The actions and behaviours of others that positively or negatively influenced the participants leadership journey |
| | Connections with others | The different types of interaction and relational dynamic with others that enabled or disabled the participants from progressing their leadership role i.e. proximity, familial, friendship, professional |
| Self-investment | | The experiences/events/learning and behaviours that clinicians chose to participate in to enable themselves into leadership roles |

4.5.3 Generating Initial Themes

After the manual handling of key terms and using NVivo to code source data, there was a period of focused reflection. Stepping back from the source data and considering the whole dataset provided perspective on the emphasis of meaning developed from the categorisation and coding process. Figure 9 illustrates early thematic development through visual mapping of initial thematic buckets. These metaphorical buckets were: Who you are, Your context and Navigating without signposts. Each bucket focused on an obvious meaning and retained a semantic view rather than identifying the latent shared meanings sought by applying reflexive thematic analysis (Braun & Clarke, 2022). However, creating the buckets gave space to explore why they were there and what meanings were hidden within the data associated with each bucket.

Figure 9

Early Mapping of Thematic Development



This was an uncomfortable time of reflection, requiring deep thought, consistent self-belief and a critical awareness of how themes were developed. Recognising that the buckets conveyed superficial insight propelled the data investigation out of NVivo and back into manual processing. This tangible movement of words, terms and phrases supported greater freedom for agile thinking. Using the software programme XMind (XMind Ltd., 2024), the evolution from thematic buckets to themes occurred. Alternately stepping back to view the dataset and focusing back on data points helped ensure the participants' voices were

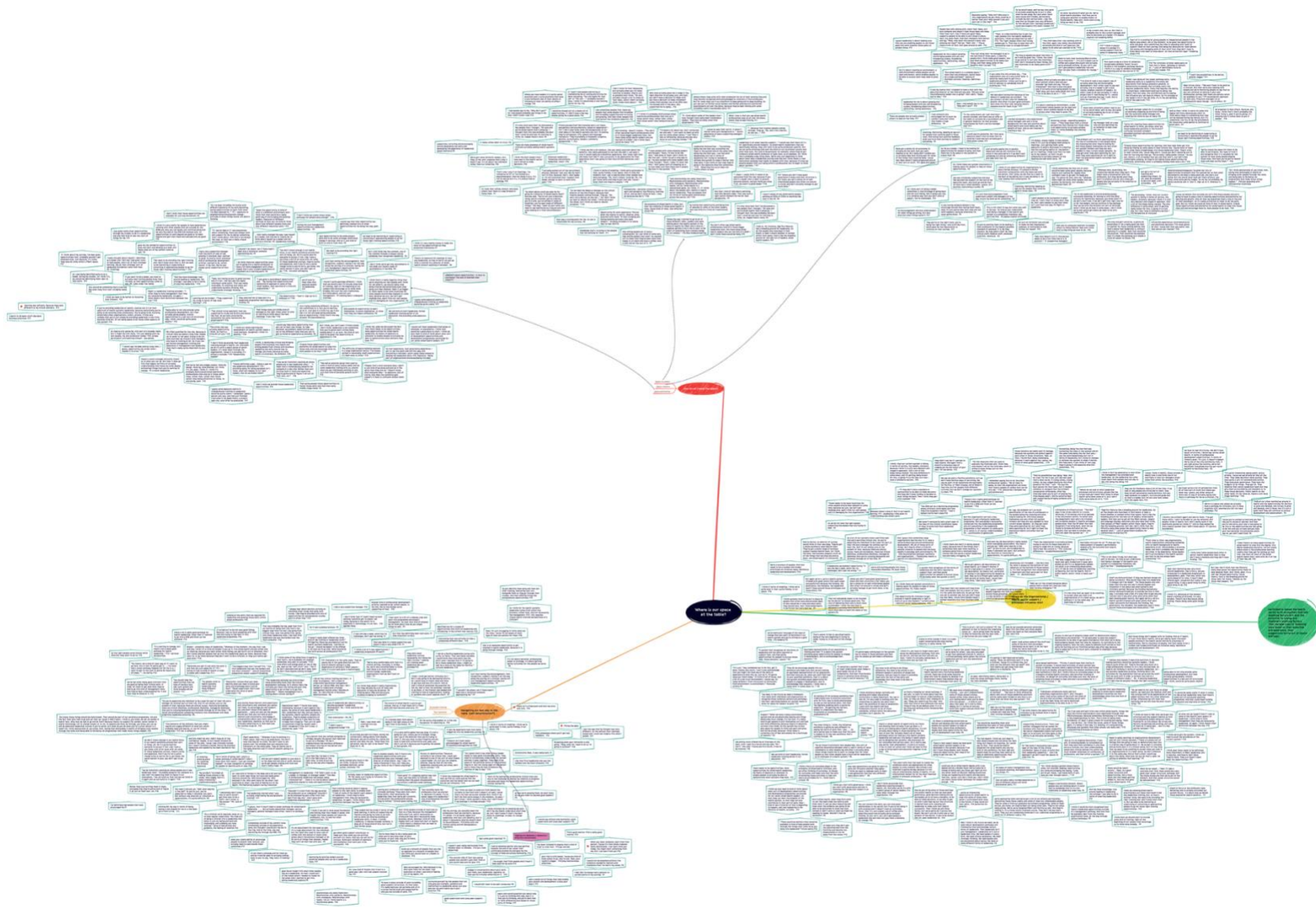
closely aligned with the analytic process. This close alignment gave increased confidence in the evolutionary thematic development process. This confidence was upheld through the caution given to understand the parameters of the themes, to determine their uniqueness and to ensure there was enough substance to explore and discuss (Braun & Clarke, 2022).

4.5.4 Reviewing Themes

Each theme was brainstormed using digital mind maps to organise key terms, phrases, and concepts to refine them further (Bazeley, 2021). Progressive visual representations of the themes were created using the XMind programme (XMind Ltd., 2024), mapping key concepts, ideas and experiences. A progressive series of maps provided a creative source that was visited repeatedly to review how the meanings and associated thinking were evolving and to ensure that key initial impressions continued to resonate. Figure 10 below illustrates the mind mapping review of one theme using XMind (XMind Ltd., 2024). It is illustrative of the exploration and simplified layout of initial meanings, concepts and their source data (for A3 view see Appendix E). The use of this digital platform facilitated the creative movement of recorded concepts and ideas as both the source data and themes were considered and developed.

Figure 10

Mind Map of Thematic Review



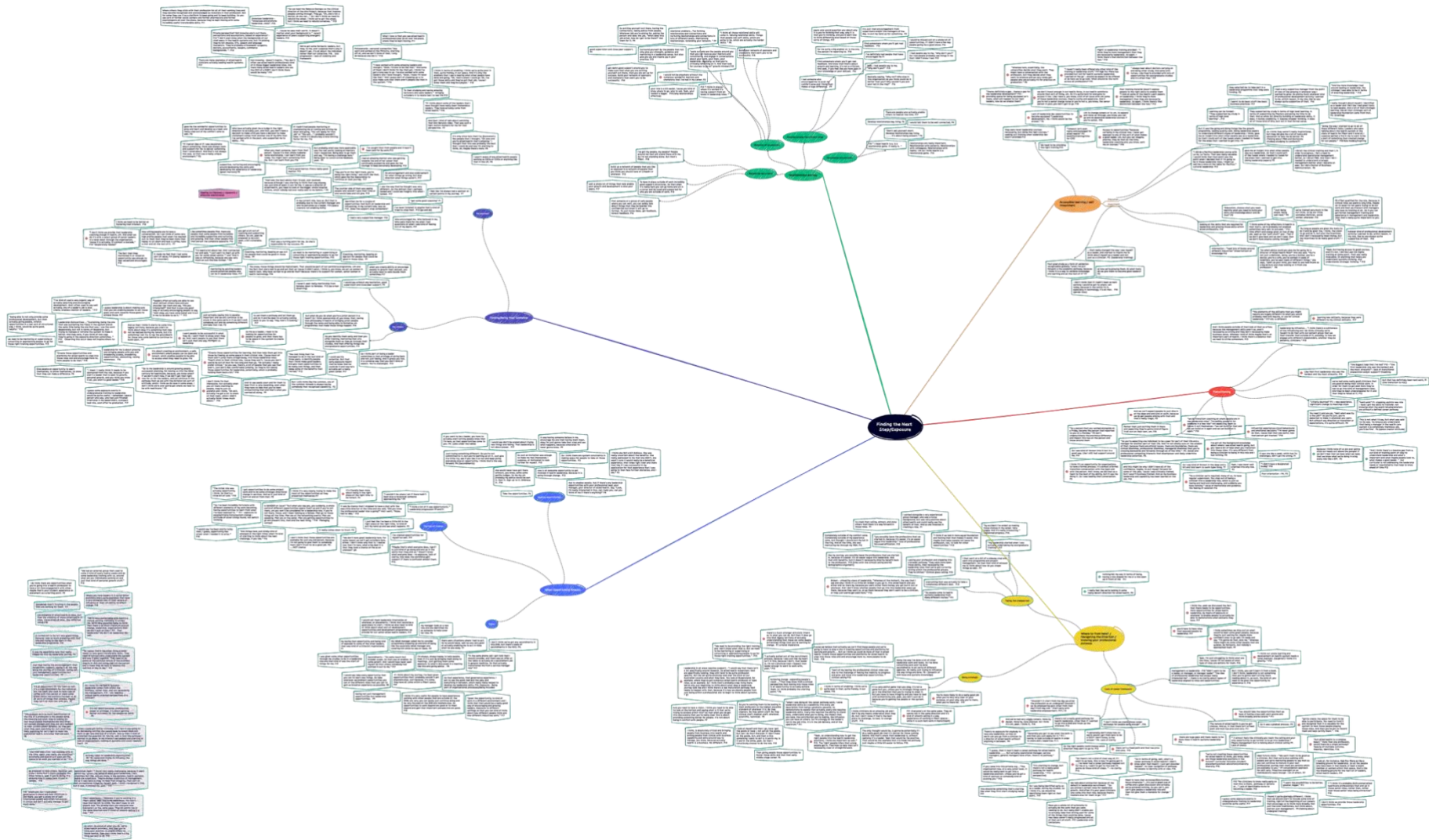
4.5.5 Thematic Definition and Naming

The mind maps were carefully formed around the central organising concept of the theme, creating images of interconnected stories and quotes reflecting emotions, views, and insights. Key concepts and ideas were critically considered, and some were discarded through refinement. Reading and reflecting on these maps enriched the interpretation of participants' shared perspectives and what gave them meaning. The initial three concepts were descriptive of the journey that the data represented and effectively remained domains of data rather than themes. They focused on the individual, then the allied health collective and finally, the health system. This contextual sequence was instinctive, but the domains did not fully embrace the breadth of latent meaning offered by the data.

The dataset required further exploration to sufficiently emphasise the latent meanings prominently raised by the participants. Refining the mind maps and reforming the data associations facilitated further investigation and interpretation of meaning. This reflexive and iterative approach guided the development of six initial themes: *The Leader Within*, *Finding The Next Step*, *Achieving Visibility*, *When Opportunity Knocks*, *Overcoming Bias*, and *Being At The Mercy Of Infrastructure*. These names conveyed a better understanding of the latency of meaning within the data. However, a step back to review the dataset and themes with a broader perspective helped to recognise where there was overlap in defining them and evidence of unequal substantiation. Figure 11 provides an illustrative view of the full mapping of one theme with elements discarded and key concepts colour-coded (for A3 view see Appendix F). This process led to the evolution of the final four themes, merging thematic content where required and refining source data for others, thereby building confidence in the integrity of their definitions.

Figure 11

Mind Map of Thematic Development



Braun and Clarke (2022) recommend the use of enticing and attractive thematic names. They suggest that using a thoughtful tagline is critical to reflecting the essence of a theme and indicates its shape and form. Therefore, the evolution of the final four taglines was an integral part of the analytic journey of this study. Various taglines were considered, and during this process, a greater sense of ownership was felt and a conviction of how the themes were grounded within the participants' voices. This demonstrates the investigator's role as an interpreter while maintaining a close connection to the source data (Thorne et al., 2004). With such a rich data set, it was hard to avoid feeling overwhelmed by the nuance and diversity of what the participants had to say. With a conscious and strong connection to the research question, the reflexive and iterative approach helped to define and deliver the names required. The image below (Figure 12) illustrates the evolution of one theme's name; the full image of the four themes is found in Chapter 5, Section 5.1.

Figure 12

A View of Thematic Naming Development Using XMind



A Thematic Summary Table (see Chapter 5, Section 5.3) was developed to define the themes, their scope, and boundaries. Creating the table provided clarity of the salient elements that existed within each theme (Braun & Clarke, 2022). These elements helped shape the themes' content, structure, and coherency. They originated from within the source data, identified through reflexive analysis, and served to substantiate the theme's identity. The final four themes were developed with a strengths-based perspective in line with appreciative inquiry. Māori and Pacifica participants were invited to review the Thematic Summary Table individually so that their views could inform interpretation and thought development in alignment with my commitment to Te Tiriti o Waitangi. In response, two participants shared their views and thoughts on the content, discussing how it aligned or didn't, with their expectations and experiences. Their views

contributed to my reflections on the emphasis and interpretation of the findings in relation to culture and career progression. This process of consultation helped to iteratively focus in on the data and step back for a broader perspective. This helped keep the data intact and effectively engage in the intellectual process of qualitative data analysis (Thorne et al., 2004).

The four themes emphasise the positive personal attributes, contextual factors, mechanisms, processes and behaviours participants identified as influential in their leadership progression. The graphic examples in Appendix F and Figure 11 illustrate the development of the themes in connection with the participant's experiences. The depth of mapping the connections within the development of the four themes reflects a strong commitment to producing findings that have practical application (Thorne et al., 2004). The thematic definitions presented in Chapter 5 were developed using data familiarity, reflexive notes, the Thematic Summary Table, participant review and digital mind maps. They represent the culmination of a logical and congruent analysis process using multiple creative strategies and tools.

4.5.6 Report Production

The emphasis placed on report production by Braun and Clarke (2022) covers multiple aspects of assembling the research thesis. They recommend writing a clear and concise account of reflexive thematic analysis, focusing on the research's theoretical positioning and assumptions, explaining the specific approach and how reflexive thematic analysis was implemented. Chapter 3 and Section 4.5 illustrate this by reflecting on the researcher's position and theoretical framework in conjunction with the choice for reflexive thematic analysis. Braun and Clarke (2022) contend it is the transparency of the written work that identifies fit between what was claimed and what was done. The illustrations and analytic process detailed within this chapter demonstrate alignment with the six phases of reflexive thematic analysis and support the Interpretive Description methodological approach described in Chapter 3 (Thorne, 2016). Alignment is conveyed through the value given to the subjective experiences shared by participants, the depth of considered interpretation of the data and the creative approach to exploring shared meanings.

To sustain congruity, the language used throughout this thesis reflects an understanding of Social Constructionism (Crotty, 1998), Interpretive Description (Thorne, 2016), appreciative inquiry (Cooperrider & Whitney, 2005) and reflexive thematic analysis (Braun & Clarke, 2022). Contextual recognition of subjective reality, unique experience, and the crucial value of reflexive practice to develop authoritative interpretations of the data are woven through the narrative and synthesis of information. Throughout the thesis, there is evidence of the active researcher. This is conveyed in the reflective approach to Manuscript 2, the rationale and motivation for this research, the insights of personal positioning (see Chapters One and Three) and the development of recommendations (Chapter 7).

Engagement with these six phases of reflexive thematic analysis has been iterative, organic, and creative. A sequential approach to their discussion illustrated a progression of analysis within the broader context of theoretical framing and methodological alignment. There is no expectation of linear progress through the phases of reflexive thematic analysis, rather the anticipation of creative evolution in thought and practice. The six phases of reflexive thematic analysis provided direction and enabled the study to reflect the researcher's unique approach to interpretive data analysis (Byrne, 2022).

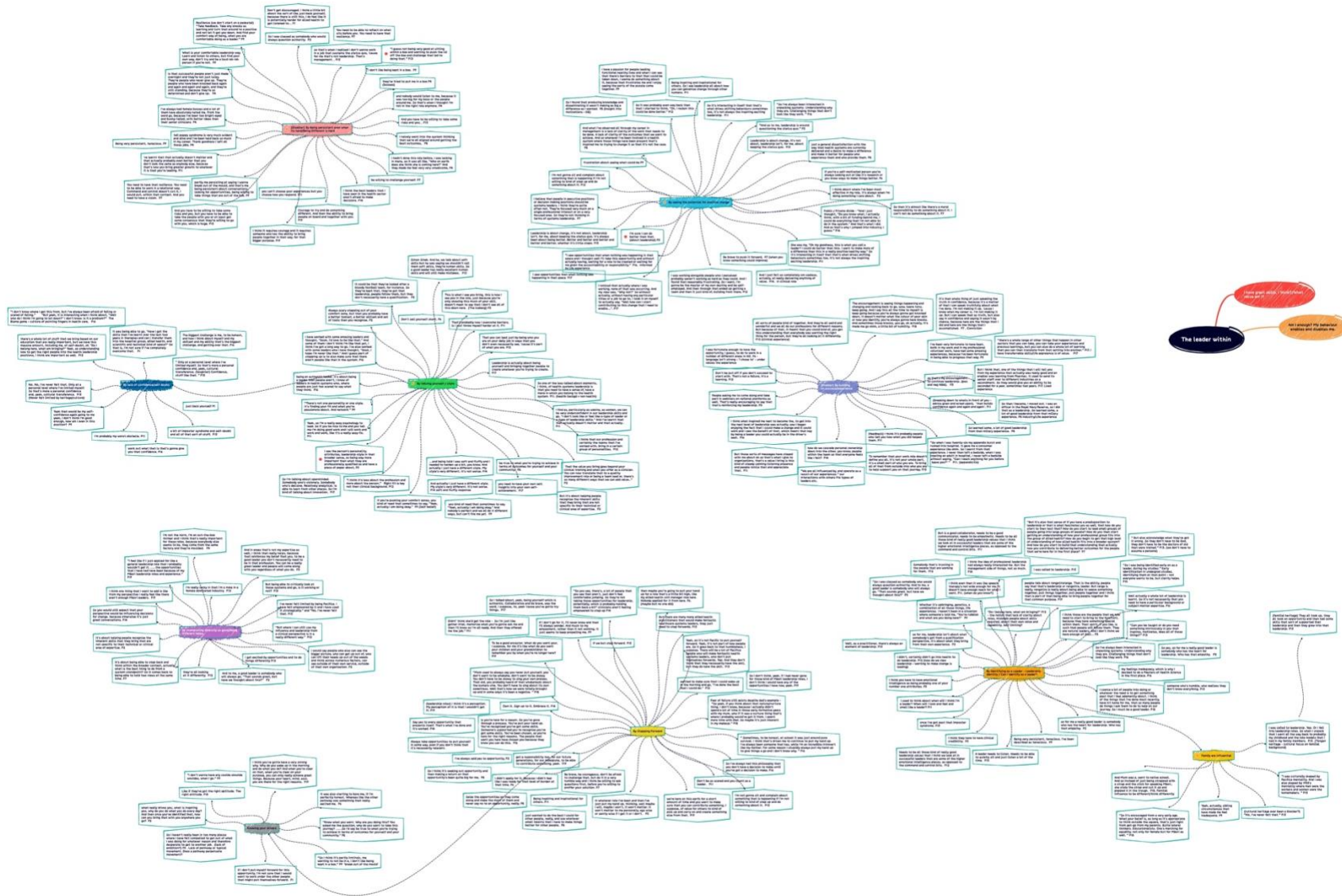
4.6 Interpretive Authority

The transparent approach taken in this chapter is intended to provide sufficient information to establish trust in the findings. With knowledge of the process and information presented, the reader can determine credibility of the findings. This credibility is founded on interpretive authority, the need to ensure that the interpretations reveal a truth beyond the researcher's subjectivity or experience (Thorne, 2016). The strategies and tools described and illustrated within this chapter have indicated frequent data immersion, multiple familiarisation processes, a close connection between source data and thematic development, and an ongoing critically reflexive mindset. Using digital and manual platforms to interact with the data and explore the participant's meanings and value for their experiences has been critical to developing trustworthy outcomes.

The strategies and tools used with reflexive thematic analysis have created junctures during the process where the interpretations have been questioned, picked apart and rebuilt to ensure they are grounded in the data and not the researcher's subjectivity (Thorne, 2016). The need to stop, pause and consider using a change in tool or strategy was essential for recognising assumptions, ensuring enough substance supported the interpretation and building researcher confidence. Figure 13 illustrates a thematic mind map for reviewing interpretations and inductive imagining (Thorne et al., 2004). It shows a theme's main elements and their associated source data (for A3 view see Appendix G). This mapping approach was used to help explore interpretations and structure thematic coherency; it helped with giving visibility to the language expressed, iteratively move items around, and use colours for identification and emphasis. Interpretive authority is underpinned by a sense of ownership cultivated through analysis and interpretation. Thorne et al. (2004) suggests ownership of interpretation is one of the most challenging aspects of qualitative research. This view is embodied by the measures and methods undertaken within this research study to establish interpretive authority.

Figure 13

Mind Map Supporting Interpretation and Thematic Coherence



4.7 Beyond Evaluation to Meaningful Interpretation

Applying evaluative standards to a research study doesn't guarantee a product of high quality. Following a set of guiding principles may narrow the scope of view instead and create a false sense of quality assurance. The standards may have been fulfilled, but a focus on general qualitative criteria has missed the opportunity to consider the broader contextual, disciplinary, social and historical contexts within which the findings were produced (Thorne, 2016). This research study applied Interpretive Description because it promoted a theoretical framework that supported translating knowledge into practice. It inspired the aspiration to produce research outcomes with real-world applications. Thorne (2016) developed a distinct set of criteria to evaluate research that aspires to deliver knowledge for practice implementation. These criteria include *moral defensibility*, *disciplinary relevance*, *pragmatic obligation*, *contextual awareness* and *probable truth*. Discussing these criteria clarifies the understanding and appreciation for research that delivers real-world applications.

This research study identifies the absence of allied health clinicians within health systems leadership roles, the prevalence of the medical and nursing professions, and the capability of allied health clinicians to lead and design health systems for the future. The research is necessary and morally defensible because it provided data to help understand how allied health clinicians are currently enabled to step into health systems leadership roles. Without this information, there is a vacuum of practice knowledge to help plan and design leadership development for allied health clinicians within Aotearoa New Zealand. With this knowledge, it is possible to identify specific mechanisms, processes or structures that enable allied health clinicians to advance their leadership careers.

Translating this knowledge to inform policy, process, learning, and development content across various stakeholders could impact allied health clinicians' ambitions, progress, and achievements. The additional use of a strengths-based lens with Interpretive Description provided a positively framed research focus and set the parameters for an inclusive perspective on allied health clinicians. The study created a space to discuss the findings from within the broader context of health systems. Given this, the findings were perceived to be unlikely to have marginalising effects or lead to negative consequences. This research is morally defensible because of the benefit this new knowledge will provide allied health clinicians who want to advance their leadership careers and those who are positioned to invest in developing allied health systems leaders.

The disciplinary relevance of this research is underpinned by the focus on a defined disciplinary cohort of clinicians, the research question posed, and the eligible participant sample. The relevance

is emphasised through the study's contextual siting within Aotearoa New Zealand and the consideration of similar global health systems and their allied health workforce. An argument could be made that the allied health professions collective does not have a universally agreed cohesion and that each profession would prefer to identify its leadership pathways. However, research suggests that the allied health collective within Aotearoa New Zealand came together under one umbrella to become more influential as a collective workforce than is possible as individual professional groups due to smaller workforce numbers (Nancarrow & Borthwick, 2021). This research study investigates allied health clinicians across Aotearoa New Zealand to generate new knowledge and inform leadership pathways for the collective of allied health clinicians within Aotearoa New Zealand.

This research study was anticipated to develop findings that could translate into practice. The transparent approach to rigour was intended to establish the credibility of the knowledge produced. Thorne (2016) asserts that teasing out the difference between truth and opinion is a third perspective from which to establish a study's credibility. Clinicians in practice seek to identify the difference between truth and opinion to determine whether knowledge is credible for implementation. A clinician's pragmatic obligation means they must be convinced new knowledge is authentic and valid before it can be enacted. The credibility of this research is demonstrated through analytic logic, progression of thematic development, richly evidenced findings, and critical discussion. Woven through these elements is a strong contextual awareness of the elements that impact and influence the research focus.

The personal positioning, rationale, and background all contribute to clarifying the landscape in which the study is situated. However, not all influential elements, including assumptions, can be identified. For those elements that are yet to be seen or known, their impact on the research cannot be clarified. Tacit understandings and invisible assumptions are part of shared social constructions and change over time. Therefore, it was important to situate this research within the context of the existing global health paradigms, the health reforms underway in Aotearoa New Zealand, and the existing legacy of health systems leadership identified through literature. This contextual landscape positions this research as it exists at this juncture in time. The new knowledge produced by this study needs to be considered within this contextual landscape.

Lastly, Thorne (2016) suggests reverence is given to the 'ambiguous zone of validity and shared reality', known as probable truth (p. 238). This research study did not seek absolute truth but strived for a measure of value to be given to meaningful interpretations so that they could be recognised as probable truth. Since this research study is the first of its type in Aotearoa New Zealand, these

probable truths will be the best we have at this time. This research study sought to create meaning from multiple realities and to identify the impact those meanings might have on allied health clinicians in Aotearoa New Zealand.

Therefore, this research study's findings will continue to stand as probable truth until they are proven wrong or superseded by research conducted within a contextual landscape that has shifted to create new shared realities (Thorne, 2016). Discussion of these additional evaluative criteria has sought to align the distinct nature of Interpretive Description (Thorne, 2016) with evidence of rigour within this research study. Evaluation has been taken beyond establishing generic quality assurance and demonstrated the unique approach that applied health research brings to the qualitative research process.

4.8 Chapter Summary

This Methods Chapter set out to complement and expand on the Methodology discussed in Chapter 3. I explained how Interpretive Description (Thorne, 2016), appreciative inquiry (Cooperrider & Whitney, 2005) and reflexive thematic analysis (Braun & Clarke, 2022) were implemented and woven through the research study. The traceable development of themes was illustrated and evidenced the study's alignment of theory with practice. This Chapter has demonstrated the integrity of Social Constructionism within the study methods and emphasised the congruence between epistemology and methodology. The graphic representation of the analytic progression underscores the iterative use of both manual and digital platforms, emphasising the organised approach used to iteratively engage with a range of creative tools for data analysis. Reflexive practices and verifiable methods establish credibility for interpretive authority, providing foundational rigour for Chapter 5, where the Findings will present evidence of the participants' shared meanings and their interpretation.

Chapter 5 Findings

5.1 Introduction

In this Chapter, four themes are presented which were constructed using the analytical methods outlined in Chapter 4. The themes are presented with embedded participant quotes to support contextual understanding and illustrate the interpretations. First, the participants' context and the development of the themes are described to enhance understanding of their perspectives. Following this the four themes are discussed, with an exploration of the meanings and insights they generated. Participants were invited to choose their own pseudonyms for this research study to facilitate meaningful involvement through the naming process, and convey a degree of personalisation with the illustrative quotes (Allen & Wiles, 2016). At the end of the chapter the interpreted insights will be summarised, highlighting key points for discussion in Chapter 6.

5.2 Participant Characteristics

Participant characteristics are summarised in Table 8, illustrating diversity across gender and age. Details were aggregated to maintain participant confidentiality due to the closely connected participant community involved. For similar reasons specificity of some demographics, for instance ethnicity, are not included in the table. Seven different professions were represented across 19 participants of nine different ethnic identities. There was a higher proportion of female participants which reflects the workforce gender predominance in global health systems but contests the evidence for leadership gender (Manzoor & Thompson, 2019). International evidence indicates that men are more commonly found in health leadership positions than women (Manzoor & Thompson, 2019; Smith & Sinkford, 2022). The disparity observed among the participants in this research study may be influenced by various factors. These factors warrant further investigation beyond the scope of this study.

Table 8*Participant Characteristics*

| Baseline characteristics | n |
|-------------------------------|-------|
| Gender | |
| Male | 5 |
| Female | 14 |
| Age | |
| Range in years | 34–60 |
| Median in years | 48 |
| Profession | |
| Speech and language therapist | 3 |
| Physiotherapist | 4 |
| Dietitian | 4 |
| Clinical scientist | 1 |
| Pharmacist | 1 |
| Occupational therapist | 5 |
| Social Work | 1 |

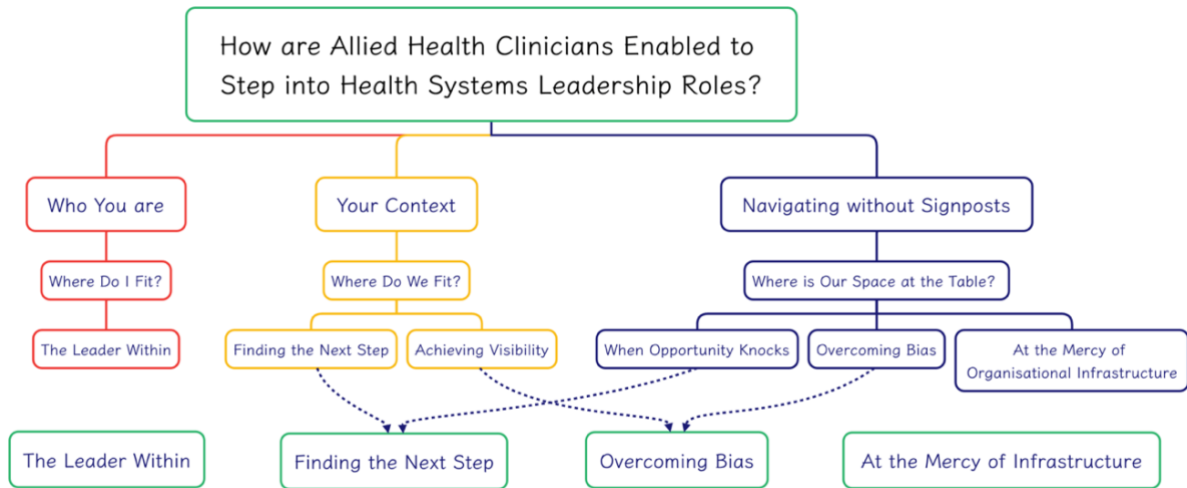
5.3 Themes

The thematic development process began with the generation of three initial categories and evolved into three domains from which six themes were ultimately developed. These six themes were reviewed and Figure 14 illustrates the process of refinement into four final themes:

1. ***The Leader Within,***
2. ***Finding the Next Step,***
3. ***Overcoming Bias*** and
4. ***At the Mercy of Infrastructure.***

Figure 14

An Illustration of the Thematic Development Process



During the process of thematic development, key elements for each theme were articulated. Table 9 summarises these elements. They evolved through the analysis process and provide the structure for the findings presented in this chapter.

Table 9

Thematic Summary Table: A List of the Key Elements of Each Theme

| Theme 1 - The Leader Within | Theme 2 - Finding The Next Step |
|--|--|
| Seeing The Potential for Positive Change | Where To From Here? |
| Valuing Your Own Style | When Opportunity Knocks |
| Being Different is Hard | Finding That Someone |
| Championing Diversity | Being Equipped |
| Building on Experience | Transitioning is Hard |
| Identifying as a Leader | |
| Stepping Forward | |
| Theme 3 - Overcoming Bias | Theme 4 - At The Mercy Of Infrastructure |
| Unrealised Potential | The Silence of Silos |
| The 'Allied Health' Stigma | Exposure Helps |
| Fighting for a Voice at the Table | Talent Spotting is Personal |
| The Impact of Systemic Bias | Meeting the Need |
| Creating a Culture to Thrive In | The Influence of Governance |

5.4 Theme 1 – The Leader Within

This theme describes insights generated from the data regarding enabling and dis-enabling leadership behaviours, valued qualities and attributes for health systems leadership, and how their perceived leadership differences impacted practice. Across the data, participants strongly believed that to achieve being able to identify as a leader took time and involved introspection. They shared the experience of observing the potential for system change but hesitated to initiate and lead it. Participants indicated ongoing debate between doubting their value in leading change and needing someone to step up and into leadership. Participants reported facing persistent challenges in gaining validation as health systems leaders and attributed them to differing perspectives held by their nursing and medical colleagues. Participants felt these differences were hard to navigate and reconcile within practice. This context created further introspection, uncertainty and self-doubt about their health systems leadership identity. Participants emphasised a range of leadership attributes and skills they believed enabled good health systems leaders. Many participants identified how they perceived a leader should or could behave and talked about how they had experienced a wide variety of leadership styles from colleagues. Participants felt they did not align with what they perceived to be as the traditional approach to health systems leadership and, therefore, struggled to find validation as health systems leaders.

5.4.1 Seeing the Potential for Positive Change

Participants spoke reflectively of a drive for, and an ability to see, how influencing change within the systems around them would create positive outcomes. They frequently conveyed a sense of purpose and a strong intent to improve the system's situation: 'a desire to make a difference' (Tony). Many shared a sense of discontent with the systems they worked within: a 'dissatisfaction with the way that health systems are currently delivered' (Tony). Participants spoke of experiences where they saw opportunities for improvement but were limited by their clinical role: 'frustration...[at]...seeing what could be' (Clara). Data indicated participants felt constrained and hindered from changing their situation or influencing decisions. Yet, many participants felt a responsibility for effecting change and George described it as a 'moral responsibility to do something.' Data inferred participants felt a strong sense of duty towards those impacted by the service inadequacies they observed, arguing the need to: 'make it better for people who experience them and who provide them' (Tony). Participants conveyed a common belief that health systems leaders could be more effective and 'do better' (Rachel). There was a clear sense participants could see a need for improvement but felt limited in their ability as allied health clinicians to effect change.

In contrast, participants shared positive and motivating experiences about realising the potential for positive change. They optimistically discussed being motivated to lead change and be valuable to the health system. They wanted to avoid feeling 'useless...at really delivering anything of value' (Mel). There was a sense that change was possible, and there was an attitude of 'why not?' (Simon). Participants talked about leading change in situations where no one else had seen positive possibilities. Simon spoke of acting in situations where 'nothing was happening' and using his health systems leadership role to create a positive difference. Participants implied that health systems leadership was all about positive change. Atu contended that health system leaders weren't meant to lead and keep everything the same: 'Leadership isn't, for me, about keeping the status quo.' It was evident that participants had positive experiences of effecting change as health systems leaders, but there was the sense that it wasn't always expected of them. Participants implied that their positive experiences resulted from their own determined actions rather than planned system changes.

Participants conveyed a strong sense of knowing who and what made for good leadership. Participants spoke about leading intentionally, arguing that 'leadership is about questioning the status quo' (Caitlyn) and behaving assertively to achieve positive outcomes, 'challenging things that don't look like they work' (Lorraine). Participants spoke of observing inspirational leadership behaviour in others and acknowledging a desire to emulate that. Others spoke about observing poor leadership behaviour and the widespread impact that leadership behaviour could have, and expressed incredulity at these individuals: 'Oh my goodness, this is what you call a leader?' (Swan). Many indicated that their insights about leadership enabled them to understand which behaviours contributed to good leadership. They implied that they knew how to behave to be effective leaders, and that leadership impacts the initiation, management and outcome of change. In summary, participants associated leadership identity and capability with the ability to see and act on the potential for positive change. They identified a strong motivation to improve their situation as clinicians and a desire to be intentional change makers as health systems leaders. Participants felt that effecting change appropriately enabled them to identify as good health systems leaders.

5.4.2 Valuing Your Own Style

Participants widely agreed on the importance of valuing who they were and what they brought to health systems leadership. Participants discussed valuing their style and leadership approach as enablers for stepping into leadership. Many participants identified it was essential to consider personal attributes for health systems leadership before their clinical experience was assessed. Mike asserted it was 'less about the profession and more about the person.' There was a strong emphasis

on valuing the person's attributes above their clinical background, identifying who they were was 'way more important than what they professionally qualified as and have a piece of paper about' (Rachel). This was emphasised by Leanne's experience of medical staff questioning her ability to lead them: 'Who on earth does she think she is coming here?' This example highlighted the experience of an assumption that allied health clinicians were incapable of leading medical personnel.

Participants indicated the need for allied health clinicians to value themselves, their leadership perspective and their approach to health systems. Strong emotions were expressed when participants discussed their experiences of medical and nursing colleagues' responses to themselves as health systems leaders. Data implied that there was a lack of value and respect shown to allied health clinicians in health systems leadership roles. It was clear that participants strongly believed in the value of bringing their own approach to health systems leadership. There was a sense that this enabled them to fulfil health systems leadership roles irrespective of negative experiences.

Emphasis on the value of personhood over professional and clinical experience inferred that participant's experienced the opposite. Renee argued that the value of allied health clinicians within the healthcare system was not constrained to the scope of their clinical practice: 'the value you bring goes beyond your clinical training and what you offer as a clinician.' Other participants talked about appreciating the whole person and the authenticity of their leadership: 'There's not one personality or one style, it's finding your fit and what you're passionate about' (Clara). Life experience and activities outside of the work context were discussed as important elements that informed and influenced leadership style. However, participants implied it was difficult for allied health clinicians to appreciate this. Their narratives emphasised the need to help allied health clinicians value their skillset: 'recognise the inherent skills that they bring that are not specific to their technical or clinical area of expertise.' (Renee). Participants implied that their more common experience in leadership was to be judged based on their clinical training rather than their personal capability.

Despite facing prejudiced behaviour and being underestimated participants ardently believed leadership was about being true to your personhood, they asserted it was about: 'being yourself' (Simon) and practicing as 'an authentic leader' (Lorraine). Participants frequently considered what being authentic meant and indicated a preference towards 'being a leader that people aren't' (Lorraine). They implied that allied health clinicians brought a different approach to health systems leadership. Data suggested participants felt being different to others was a strength and yet, these sentiments co-existed with self-doubt.

Participants held in tension the need to value themselves and their authenticity while dealing with insecurities. Mike described this context by identifying questions he would ask of himself: 'Do I belong here? What am I bringing?' Participants' self-doubt created uncertainty and they frequently described themselves as the obstacle that required effort to overcome: 'the biggest challenge is me...and how I think about myself' (Lorraine). Many participants talked about how doubting their own health systems leadership capability got in their way: 'I'm probably my worst obstacle' (Swan). They shared how it impacted their decisions and behaviour and some participants identified situations where self-doubt had 'limited' (Atu) their perceived options, and consequently their health systems leadership progression.

There was a strong sense that by valuing their own style participants were enabled to overcome prejudicial behaviour, promote personhood before professional qualifications, and mitigate self-doubt. All of which, they indicated, could limit health systems leadership progression. Data indicated participants found it hard to value their own style and approach to health systems leadership. They felt strongly that if they could it would enable themselves and help 'get the right people into health leadership positions' (Mike). Participants were often assailed by self-doubt and uncertainty but held to the belief that their approach to health systems leadership was of value, even in the face of persistent challenges.

5.4.3 Being Different is Hard

Participants discussed how they felt their leadership approach positively differed from their colleagues but implied being different was a hard state to occupy, and took effort to sustain. Several participants spoke about negative experiences when their differences were pointed out. Mel shared a situation where colleagues believed her leadership style did not align with their leadership team. Mel was told she was 'soft and fluffy, and I needed to harden up a bit.' While she conveyed a sense of frustration and disappointment in this situation, she also identified that after reflection she felt a greater sense of ownership over her style: 'My style's very different. It's not worse' (Mel). Participants consistently expressed the difficulty of striving to be authentic while differing in their approach to other leaders around them.

The participants' resilience within their health systems leadership roles was evident in their stories and frequently appeared as an enabler. Clara said, 'Take any knocks as learning and turn that around to a positive and not let it get you down. And find your comfort way of being, what you are comfortable doing as a leader.' There was widespread agreement for continual self-learning and this statement of encouragement illustrates the positivity expressed for navigating leadership

differences. Participants indicated they were willing to appreciate the differences they observed in others and engage in navigating those differences. There was a strong emphasis across the participants on accepting differences in leadership to find a way forward: 'nobody's perfect, and we all do it in different ways' (Clara). However, it was evident that remaining authentic to their own leadership approach without compromising their style presented challenging situations that were emotionally hard.

The frequent use of analogies and imagery associated with being limited and required to conform communicated a strength of emotion carried by participants. The analogy of a box was frequently discussed: 'I don't like being kept in a box' (Clara), was a sentiment shared by several participants. The sense of being constrained by expectations was shared often, Eve described it as 'not very good at sitting within a box.' Many participants spoke of resisting the need to conform, working to break out of 'the mould' (Clara). This shared sentiment implied participants felt expectations on them to bring a particular approach to health systems leadership. The box analogy communicated a sense of constraint and a requirement for compliance on the participants' approach to health systems leadership. However, their responses clearly illustrated a determination to avoid changing their leadership styles, to embrace their differences and persist in expressing them in practice.

Navigating the leadership journey required active intent and an inner strength to overcome difficult circumstances. Within the discussion of being different participants noted that the attributes of 'courage' (Emma), 'persisting' (Clara) and 'resilience' (George), were important for helping them manage their leadership journey. Participants indicated that not only did challenging situations occur but it was necessary to have inner strength to negotiate them. Participants implied that being a leader who did not conform was a state of being that required effort to navigate. In response to the expectations that constrained their leadership participants either actively sought an alternative path by 'being persistent about conversations, looking for opportunities' (Clara), or could not see another way and felt 'held back' from progressing in their leadership journey. This response by participants communicates a strong sense of intent to persevere in the face of managing their differences to other health systems leaders.

Participants communicated this intent to persevere and remain authentic as a belief in the value and advantages of being different. They talked about being 'willing to take some risks' (Atu) as a way of enacting their differences. Several participants urged others to find their own identity as a leader: 'find your own way, don't try and be a loud rah-rah person if you're not' (Clara). The importance of individuality was communicated strongly by participants in association with being different. Participants suggested that standing apart from other leaders and not conforming to expectations

was a leadership advantage. They felt that this advantage could support leadership development: 'even better that you don't look the same as anybody else because that's how you bring greater growth to whatever it is you're leading' (Swan). In summary, participants viewed their differences positively because of the value they could bring to health systems leadership. However, they believed colleagues outside the allied health professions had more negative perceptions of their differences. Participants felt this had a reciprocal impact on their interactions with others and influenced their career choices.

5.4.4 Championing Diversity

The data associated with the value of leadership style and individuality emphasised the participant's voice in championing leadership diversity. Participants talked about diversity in terms of the inclusion of different cultures, professional identities, personalities and diversity of perspective. Cultural differences were viewed as a positive enabler for leadership; participants felt 'empowered' (Atu) by their cultures, and where appropriate, they 'used it strategically' (Atu). Participants who identified as non-European shared that they hadn't found their culture to be a disadvantage for leadership; Atu felt that she had 'never felt limited by being Pacifica', and Emma suggested, 'the opportunities that I have had have been because of my Māori leadership roles and experience.'

Diversity across the professions was important to the participants because it emphasised the capability of the leader rather than their professional background. Caitlyn asserted, 'to be a good leader you don't necessarily need to be in that profession. You can be a really great leader and people will come along with you regardless of what you do.' The participants expressed positive views for extending and diversifying the range of personalities and professions in health systems leadership. They suggested that it helped to diversify the perspectives provided: 'I'm not the norm, I'm an out of the box thinker, and I think that's really important for these roles because everybody else seems to be, they come from the same factory, and they're moulded' (Leanne). It was evident that participants felt strongly about empowering allied health clinicians in their cultural and professional identities to enable them in their leadership.

Participants gave the impression that contributing diverse perspectives involved broad systems thinking and promoting alternative viewpoints. They spoke about the criticality of systems thinking in health systems leadership, of the ability to think broadly and inclusively across boundaries and stakeholder groups. They endorsed the ability to think differently and bring an alternate perspective to contribute to the diversity of health systems leadership. Renee suggested that the ability to 'see

the bigger picture' and 'think across numerous factors...outside their own service, outside their own organisation' was essential for health systems leadership.

Participants indicated in their strength of conviction for different perspectives that this type of diversity was not always evident in existing leadership. They strongly agreed on the need to consider all perspectives, the ability to 'hold two views at the same time' (George), and 'always go, "that sounds great, but have we thought about this?"' (Renee). The language participants used conveyed an engagement with their leadership, 'excited by opportunities to do things differently' and a drive for contributing non-traditional perspectives, 'to critically look at systems and go, is it working or not?' It was clear that participants thought well of allied health clinicians who championed diversity, particularly when they were 'looking at it [the health system] differently' (Mike) and perceived them to be valuable health systems leaders.

5.4.5 Building on Experience

Participants conveyed contrasting views on the emphasis of their life experience and clinical practice to inform their leadership progression. Some participants indicated uncertainty about whether their experiences were credible enough to inform their leadership journey. Their tentative language implied hesitancy in their suggestions, 'I guess' (Cate) and 'I think' (Lorraine) were used frequently to introduce examples of successful health systems leadership. Other participants identified that reflecting on previous successes and building on those experiences were enablers for their progression. They suggested that these reflections and knowledge helped to consolidate confidence and self-belief. They emphasised a belief that life's experiences inside and outside of the work context contributed to the leadership journey, 'remember your work role doesn't define you all. It's not your whole part; it's a small part of who you are' (Eve).

Some participants used language that demonstrated conviction and certainty about the use of their life experience to give credence to their leadership behaviours. Participants talked of how their previous experiences were 'encouraging' (Caitlyn), taught them to value all of their skills and 'inspired' them (Lorraine) to 'haere tonu, keep going' (Mary). Feedback on their leadership was highly valued and Swan described it as an enabler that 'builds confidence again and again and again' while several participants talked about taking the 'knocks' (Mary) and not being 'put off if you don't succeed to start with. That's not failure, it's a learning' (Eve). In that sense, the full range of experiences was perceived as valuable and worthy of leadership credibility, 'we are all influenced by, and operate as a result of our experiences' (Lorraine). The data evidenced that even though many

participants considered their lives to be full of credible health system leadership examples, some were hesitant to present that evidence to others.

A tension existed between acknowledging and taking ownership of credible health systems leadership experience, and the uncertainty of knowing if those experiences were credible enough. The dataset inferred a lack of understanding in translating experience into credible leadership knowledge. Although participants had different views on prior experiences, it was clear that learning from past experiences was essential for their leadership development. For those participants, they voiced how they would use their experiences with intention: 'speak truthfully about what I've done' and 'say [it] in confidence, and saying it wasn't by chance, because here are the things that I did and here are the things that I accomplished' (George). A number of participants held strongly to the view that their range of life experiences was worthy and of value to fulfilling health systems leadership roles. They believed that both failures and successes provided growth opportunities that empowered their leadership behaviour and self-belief.

5.4.6 Identifying as a Leader

Data emphasised the challenges participants faced with the concept of identifying as a health systems leader. Swan captured the struggle saying: 'I used to think about when will I think I'm a leader? When will I look and feel and smell like a leader?' Participants shared experiences of questioning and self-doubt about when, and if, they identified as health systems leaders. Participants believed particular characteristics were essential to identifying as a good leader, and nearly all the participants shared various personal characteristics they saw as enabling health systems leadership (see Table 10).

Table 10

List of Enabling Characteristics

| Personal Enabling Characteristics for Leadership | | |
|--|--------------------------------------|----------------------------------|
| 'their own experience' (Caitlyn) | 'to listen' (Eve) | 'do the best I could' (Tony) |
| 'emotional intelligence' (Rachel) | 'be brave, be courageous' (George) | 'clear on your purpose' (Emma) |
| 'clinical credibility' (Rachel) | 'inspiring and inspirational' (Swan) | 'see the bigger picture' (Renee) |
| 'always question' (Caitlyn) | 'be willing' (Emma) | 'a good communicator' (Swan) |
| 'trusting in people' (Mike) | 'persistent...tenacious' (Clara) | 'empathetic' (Swan) |
| 'a good collaborator' (Swan) | 'authentic' (Lorraine) | 'someone who's humble' (Atu) |

They argued that the importance of these personal characteristics co-existed with the concept that training and experience helped too: 'a whole lot of leadership is learned' (Lorraine). They considered

their validity as health systems leaders and questioned the inherency of, or ability to learn, leadership and the role of personal characteristics: 'Can you be taught or do you need something intrinsically?' (Eve). Within this deliberation, participants agreed a range of important skills and attributes underpinned health systems leadership capability. Lorraine asserted, 'It's not necessarily that you need to have a particular background or subject matter expertise.' They emphasised that they saw leadership identity as a personal rather than professional issue. Despite the insights and understanding shared about good leadership, data highlighted the struggle participants experienced with knowing when and if they could identify as leaders. Participants agreed that personal characteristics helped identify good leadership, yet they emphasised the personal challenge of validating their own leadership identity.

Familial culture and context came across as an influential aspect of leadership identity, and participants shared particular stories that spoke of long-lasting impact and influence. Mary shared a story about her mum dealing with challenges at school to illustrate this point: 'instead of just being strapped with a strap and the stick for speaking Māori, she stole the strap and cut it up and put it in the trough.' Mary suggested that as a result, she viewed thinking differently as a positive strength, saying: 'it was encouraged from a very early age. What your belief is, as long as it's appropriate to think outside the square.' This familial influence was also shared by Atu, who felt 'called to leadership' and said that this feeling 'went all the way back to probably my childhood and the role models I had in my family members.' In contrast, Clara felt the opposite, identifying 'sibling circumstances that have made me feel inadequate' had negatively influenced her career choices and leadership progression. The familial influence was both a positive and negative enabler for leadership progression, able to inspire but also instil long-lasting self-doubt.

It was apparent among the participants that knowing when and if you were a leader was not always a recognisable state. Participants questioned how they were supposed to know without validation: 'if you have a predisposition to leadership or that is what fascinates you as well, then how do you start to test that?' (George). Yet others strongly believed clinicians had an inherent leadership identity: 'as a practitioner, there's always an element of leadership' (Atu). These contrasting views illustrated the juxtaposition of knowing how and identifying when they emerged as leaders. There was a clear indication across the dataset that participants were hesitant to identify themselves as leaders, did not know where to go for validation and were unsure of what contributed to leadership capability.

5.4.7 Stepping Forward

Many participants spoke emotively about stepping forward and being willing to lead, using positive and active language to describe their actions. They described it as a physical movement: 'I've just put my hand up' (Rachel); 'willing to kind of step up and do something about it' (Mike); to 'go for it' (Clara); and to 'seize' opportunities (Tony). They described progressing into their health system leadership roles as positive and intentional. Participants spoke of being intentional to leave a legacy and a positive impact on others. They shared insights into what gave them momentum, they described the importance to: 'be a good ancestor...what do you want your children and grandchildren to remember you by when you're no longer here?' (Emma), 'make sure I could wake up in the morning and go "I've done the best I could do"' (Mike), be 'inspiring and inspirational for others' (Swan) and do so 'for our future generations, for our mokopuna' (Emma). Participants identified being intentional about stepping into, and progressing through their leadership journey as an enabler. In association, they felt a sense of duty to be purposely proactive on behalf of others.

The importance of understanding themselves and knowing what motivated them to step into leadership was strongly emphasised by many participants. Participants agreed that being self aware was necessary: 'I think you've gotta have a very strong why' (Emma) and 'Know what you want' (Tony). Participants suggested it was important to question your motives too, asking yourself: 'why you do what you do every day' (Renee). This process of introspection was perceived as essential to enabling yourself into leadership opportunities. Some of the participants identified that they didn't want any regrets on their leadership journey, Lorraine clarified her drive, saying: 'I don't wanna have any coulda shoulda wouldas, when I go.'

However, Atu argued with herself about the conflict between her cultural values and her progress in leadership. She shared, 'It's not Pacific to put yourself forward', yet contended that allied health clinicians 'would make fantastic healthcare system leaders; they just need to step forward.' This conflict was also shared by Mary, who identified that cultural influences had limited her behaviour: 'Mum used to say you never put yourself, you don't want to be whakahe, don't want to be showy...that's how we were totally brought up, and in some ways, it's been a negative.' It was clear that stepping forward was seen as a positive and enabling behaviour but it wasn't always a comfortable experience.

This theme, *The Leader Within*, has identified a range of enablers for allied health clinicians stepping into health systems leadership roles. There was tension for participants who saw the potential for change and had the drive but doubted their capability for leadership. Participants identified a range

of empowering leadership attributes and behaviours including the ability to perceive and appreciate the potential for change, the value of being different, the ability to pursue those differences with resilience and determination, and the recognition that stepping forward takes courage and purpose.

5.5 Theme 2 – Finding the Next Step

This theme focuses on being prepared for and navigating through health systems leadership roles. This theme was constructed from participants' experiences of confusion about roles, reliance on chance, the importance of relationships and connections, being equipped, and transitioning beyond their comfort zone. The confusion that participants described also conveyed resignation and frustration. They discussed the absence of a clear career path and the lack of progressive steps for navigating leadership development. Participants described their career journeys as non-linear, with a 'wiggly' (Mel) career trajectory. There was widespread emphasis on the role of chance for many participants and how they responded to it. They frequently described their exposure to leadership as chance encounters and opportunistic possibilities. Participants talked about how relationships were crucial for generating those opportunities and enabling them to engage with them. They discussed the challenges and advantages of becoming equipped with knowledge and skills for health systems leadership. However, they expressed frustration about limited funding for skills development and limited access to training opportunities. They also expressed gratitude for support when training and education were provided, inferring that external factors had a positive influence on their ability to access these resources. This theme, *Finding the Next Step*, discusses how all these elements have enabled participants (or not) to navigate and prepare for progression through their health systems leadership careers.

5.5.1 Where To From Here?

Most participants shared experiences about their struggle in navigating an undefined career pathway and determining the next step in their leadership journey. There was a strong sense that many participants had experienced a marked degree of uncertainty about the direction of and what their next career step should be. Nearly all the participants discussed the lack of a defined leadership career pathway emotively, using strong language to describe the lack of a leadership career path and its impact. Participants indicated they would have preferred certainty and a clearly defined career direction. They spoke of wanting a 'fixed path' (Warwick) but could see 'no pathway' (Mary) for leadership progression. Mel described her non-linear career as a series of steps, none of which had been predictable, 'none by design' (Mel). She contended that her allied health peers had not been able to clearly determine each career step.

This view resonated with participants whose positive navigation experiences were often centred around taking unexpected steps or unusual roles in their leadership careers. They spoke with surprise and bemusement, describing these actions as ‘a completely different door’ (Eve); a ‘sideway step’ (George). These reflections suggested that in the absence of a clear career path, unexpected roles contributed to their progress. The elements of risk and unpredictability in those career choices were discussed positively, and suggested participants held a favourable view of uncommon roles for allied health clinicians.

Regardless of whether they worked in private or public health organisations, participants agreed on the difficulty of autonomously navigating their careers. They talked about a lack of progressive steps identifying leadership competencies needed or direction of learning development: ‘there’s not a kind of clear way of if I want to go here, this is how I’m gonna get it’ (Mel). Participants held predominantly negative views regarding the learning and development culture for health systems leadership and the opportunities provided to allied health clinicians. Participants lamented a lack of clarity about what steps constituted their career path, they wondered what ‘kind of steps’ (Mike) were required for progression. Mel suggested it needed a ‘total overhaul’ and was ‘ghastly,’ and many agreed that more could be done to provide greater access to skill development. Clara wondered whether the culture had perpetuated a situation where potential leaders were not being developed: ‘we sometimes miss out on what would’ve been some great people.’

Participants also reflected that education about health systems leadership was not provided ‘early enough’ (Mel). There was a sense that planting the seed early may help allied health clinicians value themselves as leaders and begin to shape their identity as health systems leaders. There was agreement across the data for the allied health workforce to be encouraging from the early on: ‘empowering each other...from day one’ (Eve). This approach was seen as a way to address some of the implicit messages that individuals felt were present within the system. Planting the seed early was argued to have the potential to identify allied health clinicians who had the interest, drive ‘them [potential leaders] right at that point’ (Emma) so ‘the right people could choose which direction they want to go’ (Mike). Participants indicated that the challenges with autonomous navigation signalled leadership within health systems was not meant for them.

Participants discussed the unclear development pathway and their confusion regarding what, and where, health systems leadership roles could be found. There was a strong belief that a career pathway for health system leadership roles for allied health clinicians needed to be evident and identifiable: ‘Not the mishy moshy one that we’ve got at the moment’ (Atu). Participants believed that without a career pathway, they couldn’t identify a path for competency development that could

enable progression to specific roles, wouldn't 'know how on earth [they] would get from here to be a CEO' (Mary). Several participants agreed and contended that roles were not made available to allied health clinicians to progress into; there were 'huge gaps' where there 'needed to be more roles' (Lorraine). This impacted the advice they could give to others and created uncertainty about career suggestions since they could not know with certainty about the 'types of roles as options for them' (Mary).

Despite this lack of clarity and uncertainty about choices, there was a positive perspective on how this lack of pathway gave allied health clinicians greater flexibility. It was suggested flexibly in translating their leadership skills into non-traditional roles was an advantage: '[taking] opportunities that we have of a less worn groove and think broadly and lateral' (Swan). It was evident participants felt the lack of clear progressive direction for leadership advancement. However, the absence of an established groove presented alternate choices. These perspectives sat alongside each other rather than in opposition.

Associated with the optimism for early development and accessing atypical roles, was a sense of weary frustration. Participants shared experiences of what could be, using language like 'should' and 'want' to communicate their ideas for how allied health clinicians could be enabled into health systems leadership roles. The data implied that their own experiences had been challenging, requiring more effort than expected to find an appropriate direction for their leadership progression. These same participants urged for change, 'What are those leadership positions in the future?' (Mel) they asked, as they discussed how to enable future allied health systems leaders that followed them. They felt strongly for their colleague's futures, arguing that the situation needed to change and to provide a more easily navigable pathway: 'I want the possibilities to be better, greater, bigger' (Swan) and 'create the space for them to be able to participate.'(Mel).

Participants framed their experiences of navigating leadership roles by talking about how oblique and confusing the leadership pathway was to them. They spoke of a lack of roles for allied health clinicians to step into. There was a suggestion that this gave freedom to consider the unexpected, but participants emphasised how learning about allied health systems leadership could all begin much earlier and help shape their identity.

5.5.2 When Opportunity Knocks

The role of chance was evident in many of the participant's experiences. Participants called themselves 'incredibly fortunate' (Swan) and 'lucky' (Warwick). They suggested that it was a matter of timing and positioning for accessing leadership roles: 'being in the right place, at the right time'

(Cate). Leadership progression was 'opportunistic' (Jo) and it was suggested allied health clinicians 'just kind of go along and end up in the spots that they end up in' (Mike). The belief in chance or luck framed the participant's argument for seizing those transitory moments of opportunity. They expressed empowering statements such as: 'make the most of the opportunities' (George), 'don't be scared about trying new things' (Simon), 'ask if there's any leadership opportunities' (Leanne) and 'own it, sign up to it. Embrace it' (Mel). These positive statements emphasised a marked degree of urgency and importance towards making the most of opportunities. There was a sense that if those opportunities were not acted upon there was no guarantee more would come along.

Participants spoke of being proactive, 'You have to actually start letting people know' (Leanne) to present their availability for opportunities. This assertive behaviour was frequently associated with responding to leadership opportunities; there was a sense of urgency, of a limited timeframe, to engage when an opportunity presented itself. Clara believed her position would not have occurred if she hadn't been proactive: 'I wouldn't be where I am.' Many participants implied that chance played a transient role in their leadership progression. This state implied a risk of missed opportunities without guaranteeing further chances, a marked contrast to an assured and structured path for health systems leadership.

Participants noted experience with different types of opportunities where the leadership role was temporary but still held value for experience and exposure to health systems leadership. They talked positively of: 'secondments' (Tony); 'exposure' to other leaders (Leanne) and different settings; 'internships' (Simon); 'placements' (Cate); and 'stepping up' (Jo), or acting up into a role. These short-term, transitional opportunities and experiences were favourably described as: 'inspirational' (Jo), 'the start of things' (Emma), 'useful' in gaining that 'important perspective' (Warwick), and helpful to 'think about how different people think and how different industries work' (Simon). Participants indicated that with the risk of missing out on health systems leadership roles, these types of opportunities gave them further knowledge and skills, visibility to others in leadership and affirmation of their identity as a health systems leader. There was a sense that these opportunities filled gaps in their knowledge about health systems leadership and validated their leadership aspirations. However, the participants also argued that there needed to be more of these opportunities and more thought given to: 'development opportunities and development programmes we provide our senior allied health leaders' (Simon). There was a strong sense that allied health clinicians were not provided enough opportunities to develop as leaders. Participants compared Aotearoa New Zealand less favourably with international health systems: 'I don't think we've got any secondments in this [region], but there are loads of secondments in the NHS'

(Leanne). It was clear from the data that these types of opportunities were highly valued by the participants in their health systems leadership progression and were viewed as strongly enabling of allied health clinicians who felt they would benefit from a greater degree of intentional planning and coordinated development.

5.5.3 Finding that Someone

There was widespread agreement among participants of the value in finding someone who could provide mentorship and support for leadership development and progression. Mike was adamant 'Find a good mentor. Find a really good mentor', while others encouraged mentorship 'without hesitation' (Rachel). Participants spoke positively of receiving mentorship and engaging with mentors to further their professional development. Connecting with a mentor was described as 'amazing' (Simon) and participants discussed the benefits of talking about their careers, suggesting positive mentor interactions could provide 'the best advice' (Leanne).

Many participants identified the value of mentorship as pivotal to their career progression, a 'turning point' (Leanne) in their professional development. They felt that being mentored validated their leadership ambitions and imbued them with a sense of 'value' (Emma). They experienced a greater sense of direction and frequently identified experiences where their mentor had pointed them actively towards leadership opportunities. Renee spoke positively of her mentors: 'I would not be anywhere without the numerous wonderful mentors and champions that I've had in my career.' However, several participants agreed that mentoring was not often routinely encouraged in health organisations; it wasn't part of the leadership development expectations of allied health clinicians. They asserted that the value of mentoring needed to be communicated more clearly. Participants urged for health organisations 'to be better at fostering that interest' (Warwick), and to embed it within workforce expectations. They suggested it become part of 'mainstream. That [mentoring] should be part of our workforce programme' (Mel). Participants placed substantive value on engaging with a mentor but identified that it was not actively encouraged as part of allied health clinicians' leadership development path.

Participants identified positive outcomes associated with mentorship. Participants discussed how having a mentor enabled them to learn about themselves and others, about taking risks 'to grow, learn and develop...really step out of my comfort zone' (Renee). They discussed the mentoring relationship could be constructive in the hard times, where they received 'encouragement and endorsement' and in the good times; 'direction....reassurance' (Simon). They grew in 'courage' (Mike) during their mentoring connections and there was a sense that participants found that

mentoring relationships provided a safe space for reflection, growth and direction. One participant fondly described the connection as akin to the 'tuakana-teina³ relationship', emphasising the mutual experience provided, 'where I can learn from you today. You might learn something from me, but I can learn from you' (Mary). Mentoring was conceptualised as a relationship based not on age, gender or profession but where respect, authenticity and appreciation enabled growth, development and direction. There was a clear indication that interacting with and responding to that connection encouraged growth, self-belief and ambition. Finding that someone to guide, support and inspire was identified as a key enabler by participants.

Participants often spoke of particular people as role models who had inspired their leadership aspirations and ambitions. Their reflections frequently brought a specific person to mind who featured as part of their leadership journey. Two types of memories were shared about these inspirational people. The first was a role model who illustrated by their profession and health systems leadership role options for a particular leadership direction: 'Oh, that's where I could go. Oh, I've got those skills, and they've got that job, 'cause I know them, and they are a physio' (Mary). Participants indicated that this encouraged them because those individuals were professionally associated, and by being so, inspired them to consider that it was possible to achieve similar roles. This emphasised the value of meaningful association for allied health role models and the ability, when meaning exists, for those role models to inspire other allied health clinicians.

The second type of role model was someone whose behaviour and leadership inspired a broad horizon of possibilities for leadership. For example, an allied health clinician who had chosen a health systems leadership role that had not been considered before: 'I thought, "Oh wow, and you're allied health. That's amazing." I thought this was the best I could do, and now I'm starting to think, oh, maybe there's more' (Leanne). Participants spoke of being inspired as they became aware of allied health clinicians occupying health systems leadership roles. They emphasised the value of noticing the variety of occupied roles, seeing 'allied health professionals pop up all over the place where they've kept moving' (Swan). They were inspired by their observations of allied health clinicians who had translated their skills into different roles: 'So you see former social workers and

³ Tuakana-teina relationship - A relationship that is an integral part of traditional Māori society; 'an older or more expert tuakana (brother, sister or cousin) helps and guides a younger or less expert teina (originally a younger sibling or cousin of the same gender).' The tuakana-teina roles may be reversed at any time in a mutual exchange of teaching and learning. Te Kete Ipurangi. (2025). *The concept of a tuakana-teina relationship*. Retrieved February 3, 2025, from <https://tereomaori.tki.org.nz/Curriculum-guidelines/Teaching-and-learning-te-reo-Maori/Aspects-of-planning/The-concept-of-a-tuakana-teina-relationship>

former pharmacists and former psychologists all over the place because they've kept moving with some incredibly useful transferable skills.' (Swan).

The importance of being encouraged to consider a variety of roles was frequently discussed in emboldening terms, 'that inspires people coming through. They go, "Oh, she's not a doctor, oh she can"' (Eve). Across the dataset, it was evident that role models empowered the participants in their aspirations for health systems leadership roles. Role models provided meaningful association through professional, organisational and skill-based connections. There was a sense that participants were better able to appreciate their possible leadership career options through those connections.

Despite the outcomes of positive engagement with allied health system leaders as role models, data conveyed a sense of frustration about the lack of visibility of these role models. Participants believed that unless you sought them out intentionally, they remained difficult to find, 'you don't often see allied health professionals kind of in those bigger leadership roles' (Emma) and hard to identify, 'I wasn't aware of any allied health people working as CEOs or COOs or anything like that' (Leanne). There was evidence this low visibility of allied health systems leaders exerted a negative impact. Participants discussed how a lack of visibility limited their understanding of where allied health systems leadership roles could be found and of what could be achieved: 'she went and worked at the Ministry...and we don't think of that. I only do because she did it' (Mary). Illustrating how a lack of awareness may limit career choices. Data indicated that proximity often helped participants identify allied health role models: 'It's only since [being] here that I've discovered [them]' (Leanne). Participants associated the poor visibility and profiling of allied health systems leaders with a limited choice of leadership roles for allied health clinicians.

There was conviction that finding a way to give visibility to allied health clinicians who held health system leadership roles was important. Participants suggested a need to 'showcase and promote leadership' (Warwick), to find a way so that others could 'see allied health professionals pop up all over the place' (Swan) within health systems leadership roles. Role models were highly valued by the participants, particularly for their impact on considering options, career direction and ambition. Participants felt strongly about finding ways to give greater visibility to allied health clinicians within health systems leadership roles to inspire and support others.

Being that someone for others was also a critical enabler for participants. There was a sense that mentoring others enabled them to grow in their leadership capability and feel validated as a leader with valuable contributions. They spoke positively of the relational aspect of mentoring, of feeling honoured to be that someone, 'to walk beside them' (Simon). They spoke of the criticality of timing

to inspire and empower those allied health clinicians who expressed interest in health systems leadership, 'identify them early' (Emma) was a shared sentiment. There was an overwhelming sense of reward and satisfaction from providing mentorship and coaching to emergent leaders. Participants talked of 'creating opportunities' (Mel) for growth and development and working to help others access postgraduate training and leadership programmes.

There was a drive to enable others to reach their potential, to be 'successful in what they do. I want them to enjoy what they do. And I want people to see that there isn't just that one way' (Caitlyn). Participants expressed a common desire to create a better situation for allied health clinicians who will lead in the future, to leave a 'legacy' for 'those who come behind to continue' (George). There was an incredible feeling of positivity and a drive for investment in allied health emergent leaders through mentorship. The need to look at 'creating an environment, a safe environment where people can be open and honest, which enables people to access what they need to grow' (Lorraine) was powerfully conveyed.

Participants believed that relationships were essential for leadership progression and that their leadership progression may be stymied without an intentional network of connections. They saw relationships as 'key' (Cate) to their leadership journeys. There was a strong emphasis on the notion that the health system was a 'relationship game' (Cate) and participants believed the health system was fundamentally organised around meaningful relationships, 'relationships with patients. Relationships with colleagues. Relationships with teams' (Mel). With a focus on key relationships, participants promoted relational diversity and suggested leaders should surround themselves with 'the people that not only give you strength, guidance and mentoring in a leadership sense, but also give you joy and inspire joy in your practice' (Eve).

Participants felt encouraged by their peer networks and found it valuable when their peers created a safe space to engage in constructive and supportive conversation, 'would question you about why it is you're thinking that way' (Simon) and provide 'real feedback' that supported growth and learning to fill the 'gaps in your knowledge or your skillset' (Lorraine). Participants valued these key relationships because they helped to challenge them in ways they wouldn't for themselves, often beyond their 'comfort zone' (Clara). The deliberate effort of creating such a relational network and to 'extend' (Clara) connected relationships was important to participants. They spoke positively of the type of person that would help to be in the network: 'build your network of sponsors and champions' (Mel). They expressed how important such a network could be, that it created a platform from which to progress, enabling them to be 'set up for success' (Mel).

Participants shared that these networks often helped by providing access to a collective pool of leadership wisdom and expertise; it made their health systems leadership role 'easier...'cause you kind of know where to go, who to ask' (Warwick). Participants believed that had these relationships not existed, they would have been isolated and made slower progress in their leadership journey; they 'would've missed out on a whole lot of opportunities' (Lorraine). They strongly emphasised the support they credited their networks with, the 'encouragement' (Clara) they felt, and the inspiration to persist in their health systems leadership journey. In summary, mentorship was a particularly valuable and constructive relationship and receiving and providing mentorship contributed to participants' enabling experiences amidst a network of supportive relationships. Role models were highly valued as enabling inspiration, but there was evident frustration at how difficult it was to identify allied health clinicians in health systems leadership roles.

5.5.4 Being Equipped

A key discussion point for many of the participants focused on the skills and knowledge required to be equipped to lead. Participants indicated that being equipped meant they felt prepared, knowledgeable of what was required and able to anticipate what was expected of them in a health systems leadership role. Health systems leadership training was seen as an essential enabler in elevating their thinking and expanding their understanding of leadership, '...[it] really changed the way I saw myself as a leader and started to inspire me to think about myself as a leader and not just as a clinician' (Renee). However, how they became equipped appeared to be a point of disagreement. Some participants suggested that formal training with tertiary accreditation, an 'academic pathway' (Eve) was the best way to establish leadership validity, 'build credibility. It teaches broader thinking' (Eve), and 'validate[s] knowledge and learning and all the rest of it' (George). While others were uncertain about when and how to engage the development opportunities.

Participants spoke at length about a lack of inclusion for allied health clinicians to health systems leadership training and development courses. Many participants believed that insufficient opportunities were provided, 'there's a gap for like leadership development' (Warwick). Some participants were critical in their comments and held emotive views on the absence of development opportunities: 'Leadership development. No. I think would be the answer' (Cate). Some participants appreciated that many leadership courses were 'costly and expensive' (Mel) but most emphasised lacking financial support, 'we don't invest enough in our health workforce' (Mel). Participants frequently compared themselves to their non-allied health peers, expressing resignation and occasional resentment. These comparisons centred on their medical and nursing colleagues who

they suggested were able to gain access to funding more readily and pursue additional training more easily.

Participants spoke with a sense of defeat when sharing their experiences, suggesting no recourse to reconcile their ambitions similarly, 'always hear about [Doctors] carrying on and doing other study. And same with nurses. Like they're provided with lots of opportunities for postgraduate studies and it's often free' (Emma). However, participants who had worked in private health care shared their experience of the differences between private and public workforce development. These participants indicated they highly valued private health workforce investment as a strong enabler of health systems leadership development: 'in my clinical role [public health system], I never got exposed to any of the sort of what makes a good leader...pharma, they do that all the time, leadership coaching and you know, sent me on courses' (Mel).

In contrast, several participants spoke of building on their 'hard work' and experience to achieve leadership progression rather than seeking academic accreditation. Data indicated that some participants perceived seeking tertiary accreditation was over-compensating and perpetuated the belief that allied health clinicians had less to offer from the start. Amidst this uncertainty, participants questioned the overall approach to leadership development for allied health clinicians. They argued not having clear career development guidance or expectations of development led to confusion and a scattered development focus across the health sector: 'a) how [are] we growing them, b) what tools do we give them to become good leaders?' (Caitlyn). These diverse views identified a discordant understanding of what validation meant and confusion about how that was identified for allied health clinicians stepping into health systems leadership.

Data indicated that a lack of inclusion was not only influenced by a lack of opportunities but also by factors within the infrastructure of the health organisation. These organisational factors included a lack of investment, a lack of prioritisation and a lack of operational support to pursue health systems leadership development. Participants expressed frustration about the lack of support in the early stages of leadership development, identifying the absence of operational investment to release them for study time: 'timeout isn't even acknowledged for allied health' (Renee). Participants shared how they had responded to these experiences by intentionally focussing on learning within the context they had access to. They were insightful and determined where opportunities for formal development did not occur: 'so my business leadership and capability has been learned on the job' (Mel). Participants implied their lack of inclusion in leadership development limited their ongoing professional education, created discord among the workforce and channelled their capabilities away

from leadership. Data inferred inequitable inclusion across the workforce contributed to dissatisfaction and disengagement by allied health clinicians with the broader organisational system.

In contradiction to the idea of early development as an enabler, participants identified that access to and consideration for accredited leadership education often depended on the accrual of leadership experience, 'you can go and do expensive leadership courses if you're senior' (Mel). Participants indicated that this created a tension between gaining leadership experience and being equipped to get the roles to get the leadership experience. There was a strong sense that when development opportunities were provided, participants felt channelled into operational management training rather than strategic leadership development. Even when they expressed their preference for health systems leadership education, the courses that were funded were operationally focussed, 'more management' (Eve). One participant identified that having completed 'all the clinical training' (Tony), he chose to pursue several tertiary levels of education outside of his organisation to evidence his strategic leadership capability. Participants were unclear about when and how best to engage with leadership development. Data indicated the lack of guidance for a defined leadership development approach created uncertainty for allied health clinicians.

Some participants spoke gratefully of accruing knowledge about health systems leadership. They discussed the completion of 'leadership programme[s]' (Renee) and training for 'leading quality care' (Caitlyn) with a sense of accomplishment. Many participants held positive views of the value training gave them: 'the more knowledge I had around leading or leadership, the stronger I was able to be in terms of enacting leadership' (Atu). There was a sense that their gratitude to get the training opportunity stemmed from the view that leadership training was a reward, a gift, and not a development expectation for their careers. Participants strongly emphasised the inconsistency of employment relationships, service priorities, and operational management, which they believed contributed to variations in the leadership knowledge they could learn. They suggested support for learning came more consistently from external forums, private health organisations 'pharma' (Mel) or specific individuals, like their 'manager' (Warwick). There was a clear tension between feeling gratitude for any training provided and the frustration caused by the lack of support for learning about health systems leadership.

Participants discussed how allied health clinicians could be empowered through a consistent approach to implementing health systems leadership development: 'there's a massive gap from a, our kind of training point of view to understand leadership and what's important and what maybe people look to, what makes a good leader' (Mike). They suggested that existing expectations were not suitable and called for the need to review the training provided, 'to be providing the right

training' (Atu); 'looking at the skills that are required for leadership and growing those skills within allied professionals' (Warwick). Participants agreed on the delivery and focus for strategic leadership development; to broaden allied health clinicians' perspectives 'to understand systems thinking...and strategic thinking (Atu), 'to see healthcare as a big picture' (Leanne). Participants shared the view that allied health clinicians would benefit from greater engagement with self-reflection. To understand which leadership skills they required would help direct their development focus, 'identify what you need to build your skills and knowledge about and do that' (Rachel). Participants identified the lack of appropriate learning content, limited access, and constrained work situations as limiting health systems leadership progress. Participants argued that access to and support for the most appropriate training at the right time was a key enabler.

5.5.5 Transitioning is Hard

Transitioning into and between health systems leadership roles was expressed as a challenging experience by many participants. Participants shared that the first transition was typically the hardest and 'most stressful' (Jo). Stepping into their first health systems leadership role was perceived as the 'biggest leap' (Warwick) between roles they had to negotiate in their career. As a new experience, many participants shared feelings about stepping into the first roles and described being under-prepared and 'utterly daunted' (Swan). A lack of transitional support was identified as a barrier to feeling competent and confident stepping up. Leanne shared, 'without any direction or transition or expectations, it's quite difficult.' Many participants shared experiences of feeling left alone and isolated once they stepped into a health systems leadership role. Rachel described the transition as a survival experience: 'we can't expect people to just dive in at the deep end and sink or swim, because we do get people sinking with that, and that's really tragic.' It was evident that participants found the transition into or between health systems leadership roles an uncomfortable, lonely experience.

Coping with the unknown featured strongly when discussing transitioning into or between health systems leadership roles. Participants expressed concern that, typically, they had to manage the unknown of a new role without guidance. The participant's experiences of entering a new leadership role were frequently framed as a physical movement; they felt 'thrown into it' (Emma) and had to 'stick our heads out above the parapet' (Renee). The data indicated that participants perceived an element of risk in these transitions, an experience that required courage and agile thinking to respond effectively. Several participants described having 'nothing' to lean on (Lorraine) in those early transition days. They viewed the absence of guidance or support as a key disabler that contributed to making the transition an unknown process.

Participants shared their observations of others in transition and agreed that transitions could be more structured and empowering. In one example Mike described a colleague's situation where they were 'underprepared for it, and then they've failed at it.' The data suggested inadequate preparation undermined success and contributed to the negative experiences of transitioning between roles. Data indicated how the transitional process is handled not only impacts the participant but also those around them and future leaders in their journey. Several participants implied the experience of others had been a constraining influence on their career choices: "'I'm never gonna do that, 'cause that was awful, how that person got treated'" (Mary). There was a strong sense that the transitional process needed active management to support and enable allied health clinicians.

These powerful negative transition experiences coexisted with positive participant experiences. For example, when an employer focused on supporting people through the transition into leadership roles and provided 'transition coaching' (Mel), the support proved invaluable, 'incredibly powerful for someone in a new role' (Mel). As such, the clear guidance provided through such a process as coaching was empowering and an enabler for transitioning into a health systems leadership role. Approaching the transition actively was endorsed by other participants who emphasised the need to bridge differences between roles. They suggested that the first transition, acknowledged as typically the hardest, needs intentional guidance: 'the elements of the skillsets that you might require are hugely different to what you would probably need and require, or use for clinical leadership' (Simon).

Participants contended that transitioning into health system leadership roles required support to implement new skill sets. They agreed that a lack of support could impact someone's intention to step into health systems leadership roles, 'I think none of us are ever gonna stick our heads out above the parapet if we don't feel that we have what we need, that we know what we're doing' (Renee). Participants emphasised that transitioning between clinical and health systems leadership was challenging but could be overcome with preparation and support. In their experience, the transition process felt hard and uncomfortable because they were unprepared for the knowledge, support, orientation and expectations required to enable success. Participants strongly emphasised that an intentional approach to supporting the transition process for allied health clinicians would enable them to be equipped for success.

In summary, the theme of *Finding the Next Step* has emphasised how participants found navigating their health systems leadership journey full of hurdles to conquer. There was a sense that the lack of a structured career pathway had generated a reliance on key relationships and transient

opportunities to navigate direction. Participants took a survival approach to transitioning between roles and indicated that the provision of appropriate knowledge, training, and mentorship would strongly influence their progress. This theme identified several key issues that had negatively influenced and limited the leadership journey for participants. There was, however, a strong emphasis on how those issues could be addressed and enable future leaders to navigate their leadership journey more easily. Participants suggested the key enablers for navigation were: a defined career pathway, intentional leadership exposure, having a mentor, accessing leadership development, and being coached through role transitions.

5.6 Theme 3 – Overcoming Bias

This theme presents the wealth of experiences participants' have had with systemic bias. Participants reported recurring experiences of exclusion and marginalisation in response to their professional identity as allied health clinicians. Theme 3 outlines how the participants observed the manifestation of this bias, responded to and worked to overcome it. Many participants expressed a strong desire to be recognised, valued and rewarded for their skills and attributes that contribute to effective health systems leadership. A common sense of bewildered frustration emerged regarding the lack of respect and the impact of systemic bias, which many viewed as a significant barrier to leadership. This theme illustrates the shared struggle among participants to engage in decision-making and to be acknowledged as key contributors within health system leadership. It also emphasises the value participants place on diverse perspectives and inclusive approaches that they bring to health systems leadership.

5.6.1 Unrealised Potential

The data associated with this theme revealed a strong sense of frustration, defensiveness, and, at times, perplexity among participants. They felt allied health clinicians were not recognised as potential health systems leaders. Participants firmly believed in the capability and effectiveness of allied health clinicians as leaders, discussing this topic with confidence. Their well-rehearsed statements and ideas indicated that this issue was something they frequently contemplated.

Participants framed their frustration and discussion by identifying their potential as latent and 'untapped' (Jo). This latent potential was perceived by participants to encompass specific skills not typically observed in the existing leadership, 'skills that we don't see so overtly in other health professions' (Swan). They suggested that those skills, while frequently employed, often went undetected, 'there's a subtleness of the influencing, and I do think clinically we're taught to do that with our patient group that we then transfer that outside of it' (Eve). Data emphasised the belief

that allied health clinicians were frequently underestimated, 'nobody sees' (Caitlyn). One participant used the analogy of an 'iceberg' (Caitlyn) to describe their capability, indicating that participants felt judged by what was obvious and assumed rather than taking a closer look.

Participants suggested that the subtlety of relational dynamics used within their clinical practice translated effectively into leadership. They believed these skills, which helped them to adapt and respond appropriately to others, provided an advantage in health systems leadership roles. One participant mentioned, 'they do that every day. That's actually just part and parcel of the work that they do and the work they deliver across the system.'(Mel). They felt that many of their colleagues lacked this advantage of interpersonal skills, stating 'a lot of other professionals just don't do that.' (Mel). Nearly all participants expressed how their skill set was in alignment with the requirements of effective health systems leadership, enabling them to 'sit perfectly at the leadership table' (Lorraine).

Participants felt they were underestimated and therefore overlooked for health systems leadership roles. They perceived existing health organisations were undervaluing the capabilities of allied health clinicians' for health systems leadership. One participant shared their experience of the recruitment process for a health systems leadership role. His application for a health systems leadership role was unsuccessful, and when he requested feedback, he was given what he felt was a contradictory response, 'I didn't have enough broad experience because I was an allied health clinician.' (Simon). This participant felt he had been judged based on his professional background leading to incorrect assumptions about his capabilities. The data indicated that health organisations were not always fully aware of their workforce's capabilities, which hindered robust recruitment processes.

Many participants felt that the leadership roles they were typically encouraged to pursue, which were focused on operational tasks, influenced how others perceived their abilities. This emphasis on operational leadership contributed to the belief that their capabilities were limited. One participant, Simon, noted that allied health clinicians have 'full potential, but it's often coloured by the opportunities they receive.' Participants identified that the challenge of obtaining health systems leadership roles was perpetuated when organisational leadership maintained a narrow view of the potential talent pool. They felt health organisations were 'constantly looking for doctors to do stuff' (Jo). Participants expressed their frustration by sharing how ready they felt to step into health systems leadership roles, 'already prepared' (Warwick). However, they felt constrained by the available recruitment opportunities and often overlooked for the health systems leadership roles they believed they were capable of fulfilling.

The frustration of feeling misjudged co-existed with an overwhelming belief and conviction of the allied health clinician's ability to perform well as health systems leaders. They celebrated their ability to connect, influence and 'work across boundaries' (Tony), strongly contending these characteristics qualified them to be considered for health systems leadership roles. Participants believed they operated as health systems leaders, providing alternate ideas and suggestions to those typically offered, 'being able to do things differently and be systems leaders and systems thinkers' (Tony). Participants contended that experience delivering multidisciplinary professional leadership within the allied health collective and practicing with a biopsychosocial health focus enabled them to be effective in health systems leadership roles, 'that is the beauty of having one of us in these leadership roles. We're very holistic' (Leanne). This holistic approach and systems thinking capability were frequently identified as important for successful innovation in health service design, 'giving them [consumers] the recipe to help fix tomorrow and the next time' (Rachel).

Participants argued that they sought to improve consumer outcomes, both now and in the future, through collaboration and leadership. They felt the insights they brought to health system design, strategy and leadership aligned closely with the fiscal efficiencies sought by the governance forums of their organisations. As Tony noted, 'the cost of delivering that care is much more sustainable.' Nearly all the participants emphasised their holistic and inclusive breadth of perspective as a compelling predisposition for health systems leadership. They viewed this approach as such an inherent part of their disciplinary grounding that 'we don't see it because we're just doing it. It's inherent; it's just what we live and breathe' (Renee). Participants argued that such a breadth of perspective was an important point of difference to their medical and nursing colleagues and positioned allied health clinicians for influential health systems leadership. They noted that their holistic and inclusive practices positively influenced their leadership. As Simon said, 'They're agile enough to step out of their professional boundary and act as leaders as opposed to actually bringing the baggage with them around their clinical background' (Simon). Data implied the clinical background of a clinician influenced the perspectives they brought into leadership, that clinical practice conditioned a leader's inherent views towards the workforce and health system.

The ability to be flexible and adaptive was viewed as an enabler to 'bringing greater perspectives' (Simon) to leadership and service design. This adaptability also facilitated 'a really natural maturation' into leadership, fostering collaborative practices, especially when, as Swan described, 'you're so oriented to never being alone and working alongside others to achieve what you're aiming for.' However, participants remained perplexed as to why these attributes were not capitalised on for health systems leadership roles. Their perplexion was conveyed through their conversation and

insights regarding a career ceiling and feeling limited in their ambitions. Eve described it as ‘that sense of hitting your head against a brick wall’ (Eve). Participants identified their contributions in alignment with the contemporary health paradigm. They felt capable of addressing ‘the patient’s large journey’, and focused on prevention, ‘not only just fixing today’ (Rachel).

In contrast, participants spoke positively about the change they saw when allied health clinicians took on health systems leadership roles. They firmly believed the holistic approach brought into action by allied health systems leaders was impactful. As Renee stated, ‘we will truly start to see sustainable systems because you have people that understand the value of the full health workforce’, working to ‘create less barriers between sectors,...is exactly what’s required’ (Emma). Participants identified these system insights and workforce understandings as essential knowledge for taking on health systems leadership roles. They suggested the untapped potential of allied health clinicians needed to be developed and applied. Tony contended, ‘there’s huge power in allied health clinicians being able to do things differently and be system leaders and system thinkers. And take on roles that they’re trained to do, but which they haven’t done in the past.’ Participants believed that the capability for and evidence of, allied health systems leadership demonstrates how effective supporting allied health clinicians into leadership roles can be.

5.6.2 The ‘Allied Health’ Stigma

There was a strong sense that participants felt judged by their workforce colleagues as clinical members of the allied health professional collective. Participants felt these judgments were cast upon allied health clinicians because they were not nursing or medical professionals. Participants felt excluded and professionally quashed. However, they reported persisting with their leadership journeys despite feeling the stigma for being an allied health clinician.

Several participants shared how they felt self-conscious about being an allied health clinician. Participants explained when introducing themselves at work, ‘it’s almost like an apology’ (Mary), while others argued that they ‘shouldn’t have to apologise for what we are and what skills we have’ (Eve). The practice of apologising for their professional identity was associated with data that emphasised lack of collegial respect and understanding. Participants felt their credibility as senior health system leaders was challenged because of their profession, ‘How come you got that role?’ was a question Lorraine frequently answered when delegated a prominent portfolio of work.

In response to the discussion about the allied health collective and the feeling of stigma, several allied health clinicians spoke about a need for their fellow allied health peers to be brave, ‘to come out from behind the curtains to the front’ (Eve). They contended that ‘groups of [allied health]

professions actually influence people's view on what the full potential of allied health leaders is' (Simon). They cautioned that if allied health clinicians didn't showcase their potential and promote their leadership capability, they would continue to operate 'in the shadows' (Eve). Participants identified that changing behaviour and stepping forward could help influence and enable a more positive view of their health systems leadership capability.

Despite this stigma surrounding allied health professions, many participants celebrated their unique identity within this collective. They appreciated the diversity and various career choices available and valued the collaborative culture that emphasises interprofessional practice. As Swan said, 'What appeals to people about allied health professions is they're not the same as any other profession.' Participants highlighted their flexibility and ability to navigate the complexities of healthcare, contrasting this with their medical and nursing colleagues. One participant described it as being able to 'play in the grey' because healthcare is 'not black and white' (Eve). This point of difference was highly valued, 'So what, be proud of what you do. We're allied health providers.' (Mary) and their pride in being of the allied health collective was evident. They described their peers as, 'passionate people' (Renee) who bring a 'richness' (Rachel) to the health workforce. Despite feeling judged, they celebrated their differences and recognised how these could inspire allied health clinicians to step into leadership.

5.6.3 Fighting for a Voice at the Table

Participants discussed the concept of a metaphorical 'table' to represent the inclusion of allied health clinicians in health system leadership. They perceived gaining a seat at this table as a positive milestone, emphasising the desire to be part of organisational leadership and contribute their skills, 'I want to be part of that' (Jo). The sentiment expressed was that achieving this seat would not only benefit the individuals but also highlight the value of allied health professionals within the organisation and 'bring [their skillset] to the table' (Lorraine). Participants felt having a voice would foster recognition of their contributions to leadership, they wanted others to appreciate 'that having us represented at the table added value' (Jo). This achievement was seen as the creation of a dedicated space for allied health clinicians as leaders in health systems.

Participants described having a seat at the table positively but highlighted the effort and struggle required to navigate the challenges to get there. They often felt excluded, 'we very rarely get asked to the table' and had to question their presence for a meeting, 'where is the seat for us?' (Mary). While they held low expectations of a consistent seat at the table they hoped for the occasional invite to present their capability. The language used to describe their actions to achieve recognition

were emotive, 'we have to fight really hard to get a seat at the table' (Leanne). Many participants felt they exerted more effort than their nursing and medical colleagues, acknowledging 'allied health has struggled' (Eve). Participants described their pursuit of inclusion with assertive language such as, 'we're used to punching up' (Eve). The language used also reflected the expectation to rise from lower positions into health systems leadership roles. Participants felt this change required strategic intent, 'propelling allied health into leadership roles where they can genuinely influence' (Renee). Language used to describe attaining a seat at the table was emotive and visually description of the effort required.

Participants viewed the allied health voice as an effective analogy for showcasing their health systems leadership capability and identity, 'I think we need to find our voice...how do we get our voice around the table' (Eve). There was a firm desire among participants to have their voices heard and valued. The data suggested the perception of allied health clinicians affected how their voices were recognised, 'allied health isn't quite as well respected around that leadership table as they should be' (Mel). They noted that the allied health voice was not always evident or acknowledged by others, 'I think the challenge for allied health is that we find our voice and we find the conviction and the belief that we can lead and we can influence' (Eve). Participants contended their ability to contribute to the system was hindered by not being heard, 'they fail to listen to the voice that comes up. And when somebody does raise that voice, they try to dampen it down.' (Caitlyn). They drew comparisons with their medical and nursing colleagues, 'it is potentially harder for allied health to get listened to' (Jo). Arguing that their voice was valuable and worth the persistence for being heard, 'equally valid viewpoints...don't think that what you have to say is of lesser value' (Cate). Participants advocated for change in the behaviour of those they worked alongside; Cate called for them 'to be more broadminded and not make assumptions and immediate judgments....we all have different skills to bring to the table.' The participants felt their voice was frequently excluded despite efforts to be heard.

Participants celebrated the appointment of visible allied health systems leaders e.g. national roles within the public health system, because they provided a platform for having a voice; '[those roles are] really good because that's highlighting allied health...we've got a voice there' (Caitlyn).

Participants felt having a voice at the table was an essential enabler for allied health leadership recognition. Taking their place at the table affirmed the participant's leadership credibility, 'You've got worth' (Mary). Participants felt strongly about having a consistent seat at the leadership table 'you should be asked from the get-go rather than an afterthought, as a seat warmer' (Mary). Working to gain a seat and a voice the table frequently took effort, time and energy. Once

accomplished it represented an enabling platform to contribute as an acknowledged health systems leader.

5.6.4 The Impact of Systemic Bias

There was compelling evidence from participants about how systemic bias impacted their ability to advance in health systems leadership. Participants recounted various experiences highlighting systemic bias in behaviours, situations, and cultural contexts, which influenced their progression into health systems leadership roles. Hierarchy and bias was consistently evident in the data, and participants expressed a range of emotions when discussing them. Participants made both tentative and assertive statements regarding the presence of systemic bias, such as 'There is a bit of a bias, or a hierarchy if you like, within health around whose knowledge is best' (Emma) and 'Of course, power imbalances and hierarchies [exist]' (Simon). Systemic bias affected how the participants assimilated into health systems leadership roles, shaping their expectations and creating anticipatory behaviours, 'how I would be perceived as a non-nurse' (Simon). In essence, the outcomes of systemic bias were discussed at both a personal level and as a result of system structure.

Participants described an inherent hierarchical workforce tier structure that translated across all health organisations. Participants described the allied health collective as being located at the 'bottom of the heap' (Rachel) in the health system. Participants believed this perception negatively influenced others' behaviour towards allied health clinicians and impacted their collective reputation undeservedly, 'allied health, in particular, has had a bad rap' (Clara). Participants believed this negatively impacted decisions regarding their inclusion in health systems leadership roles, 'the last cab off the rank to be considered' (Cate) and 'you're not actually considered because you are an allied health practitioner' (Mary). Participants implied that leading within this context took extra energy and strategic thinking to position themselves effectively; they described it as an obstacle to overcome, a 'hurdle' (Mary) to conquer. Participants felt disappointed by the perception of allied health clinicians at the bottom of the workforce layers, creating the need for extra effort to gain recognition.

Participants translated these layered tiers as a hierarchy embedded within systemic perceptions. They contended it impacted practice, interactions and leadership progress, 'a very autocratic hierarchical system' (Lorraine). Participants felt this systemic hierarchy contributed to assumptive judgments made by their peers, who then acted accordingly. This view was informed by challenging conversations with medical and nursing colleagues when they were appointed into health systems leadership roles. Lorraine recalled, '[they] challenged me and said, "How can you be my boss, you're

not even a nurse?".' Not only were allied health clinicians frequently regarded ineligible for health systems leadership roles, but in this example, the nursing profession was not given credibility either. This systemic bias was seen as a positional hierarchy that negatively affected how allied health clinicians were viewed as health systems leaders.

Participants believed a legacy of perceptions of superiority, based on profession, created a hierarchy that translated into health systems leadership development and recruitment. They contended there was, 'still so much harkening back to traditional models of healthcare where the doctors know everything, the nurse knows next to everything, and what's allied health?' (Renee). They felt that this profession-based systemic hierarchy contributed to poor performance in health organisations, 'there's a hierarchy that's enormously complex, enormously disjointed and probably quite dysfunctional' (Rachel). Participants argued leadership appointments continued to be based on particular professions, a 'medical homogeny' (George) and 'doctor driven' (Emma). They believed health organisations employed an inequitable approach to appoint health systems leaders and 'automatically go to nursing and doctors' (Lorraine). Even when an allied health systems leader was appointed, legacy behaviours frequently continued to manifest. One example illustrated the challenge for allied health clinicians as health systems leaders operating within the existing hierarchical power dynamics, 'having been specified as bringing new thinking and bringing the strengths of the allied health workforce into system design, system thinking, but then finding the power structures within it were very much wanting that not to happen' (Simon). Participants frequently experienced bias and an organisational culture which constrained their capability and disabled them from thriving in health systems leadership roles.

Participants frequently felt diminished in their professions as part of the allied health collective. They felt their years of experience and breadth of knowledge were discounted when they applied for health systems leadership roles. Their wealth of experience 'equated to being a good therapist' (Eve) rather than viewed as a rich variety of transferable skills and knowledge. They suggested recruitment to health systems leadership roles was influenced by systemic bias and hierarchy rather than based on the required attributes and skills. They believed roles were judged according to an inherent hierarchy, 'on the basis of seniority rather than necessarily on being the best skill fit for that opportunity' (Eve). Several participants described the health systems leadership recruitment process, an example of systemic bias, as having a default approach. They suggested there was a predictable outcome expected from the recruitment process. Participants noted systemic bias shaped job descriptions and restricted access to health systems leadership positions, stating 'old assumptions carry through' (Mary) and, 'when people are pulling together leadership roles, their

default is nursing and medicine.' (Eve). Participants contended that systemic bias and predictable behaviour were evident through organisational layers. This suggested organisational leadership held particular views of health systems leadership, framed by established power dynamics instead of the strategic objectives of the health organisation:

The problem isn't so much specification of the role a profession; it's the people doing the choosing and what they're looking for. And those people themselves are very often not system thinkers, and they are wedded to their current power dynamic. So they get what they were searching for, but what they were searching for isn't right to meet the population health outcomes that we want. (Tony)

Participants expressed concerns that inequities within organisational leadership and governance forums contributed to recruitment outcomes. Clara noted, 'equitable landscape? No, there's still a lot of pale, male stale in those roles, right?' When it comes to recruiting for health systems leadership roles, participants felt the professional experiences of allied health clinicians were often overlooked and misunderstood. They believed understanding the value of these experiences would help enable allied health clinicians to access health systems leadership roles.

In counterbalance to how systemic bias was perceived to disable leadership progress, participants discussed ways to reframe health systems leadership. Participants acknowledged the influence that came with the sheer number of nurses and the symbolic capital that doctors held, '[the] power base that sits with our medical colleagues' (George). Participants expressed the drive to counter this influence by advising health organisations to focus on consumer outcomes rather than system efficiencies, 'delivering better outcomes' (George). Participants suggested that a focus on consumer outcomes would enable a more equitable approach to health systems leadership recruitment.

George said:

saying actually this is about delivering better outcomes, then it becomes a much different discussion that you can have. And keeping your focus on that allows it to become much more of an even playing field because you're not debating whose space it is per se, but you're trying to say how can we provide the better outcomes for people from that perspective.

Participants emphasised this view within the context of Aotearoa New Zealand's health reforms. They contended the health system's reform would provide an opportunity to shift focus to improving consumer outcomes and promote allied health clinicians for health systems leadership roles, 'I think the power of allied health in transformation is going to be seen. So I think it's likely that, following the reforms far more of those roles will be recruited, allied health people will be

recruited too.' (Tony). Participants expressed hope in the reform process and recognised the value of enabling allied health clinicians into health systems leadership roles.

The focus on reframing health systems leadership was associated with aligning health system design to the current health paradigm. Participants ardently expressed the belief that allied health clinicians were ideally positioned to fulfil health systems leadership roles and support reframing the health system's alignment to focus on consumer outcomes. The need for alignment was expressed by noting the difference in the leadership allied health clinicians could bring, 'having allied health in there would bring a different view, a different style, a different way of bringing people along.' (Lorraine). Participants argued that defaulting to a traditional leadership approach perpetuated the biased narrow view of recruitment requirements. They contended the traditional approach put an additional burden on the health workforce, 'the most skilled, highly trained part of our workforce to do work that they don't need to be doing' (George). Participants emphatically agreed the focus for health systems leadership needed to be on outcomes and not the traditional approach to leadership, 'It's not about personal, professional, power of privilege, it's about getting better outcomes for the people we serve.' (Tony).

Participants believed their health systems leadership could be influential in aligning system design with the current health paradigm. They believed this meant focusing on consumer-centric services and outcomes, 'what the patient requires' (Caitlyn), rather than system flow and crisis response. The participants agreed that focusing on a health system design for consumer outcomes could counter the existing bias in health systems leadership. All participants agreed that allied health clinicians were ideally positioned to lead this alignment, 'to look at a broader health system that looks at the social determinants of health as well as the health presentation, then allied's your guys' (Rachel). Participants contended that it was about adding value to health systems leadership not about disputing whose turn it was to lead to the exclusion of others, 'multiplying what we do...[not]debating whose space it is per se' (George). They believed strongly that reframing health systems leadership and focusing it on achieving consumer outcomes would identify the need for and promote recognition of the allied health clinician's perspective for health systems leadership. Consequently, their value for system design would promote the need for more allied health clinicians in health systems leadership roles.

The data provided clear evidence of experiences of systemic bias and its impact on behaviour, culture, and context. The experience of systemic bias was frequently identified as a limitation on the participant's progress into health systems leadership roles and how they were received into those roles. Participants supported reframing health systems leadership to shift the focus to consumer

outcomes and the bias away from power and privilege. They believed this would prompt a more equitable approach to recruitment, value the allied health clinician's perspective and enable health system leadership opportunities.

5.6.5 Creating a Culture to Thrive In

The argument for greater inclusion in health systems leadership developed out of the data as a countermeasure to the emotive issue of bias and stigma. Data conveyed the participant's belief that leaders came in all 'shapes and sizes' (Swan). Participants strongly advocated for including diverse perspectives in health systems leadership roles to offset a homogenous leadership tradition and experiences of systemic bias. They argued that including different types of leadership was essential for diffusing systemic bias and a power imbalance, thereby creating a culture for all types of leaders to thrive in. Associated data implied this level of inclusivity did not exist and that participants typically worked alongside traditionally recruited health systems leaders, 'folks who were exceptionally individualistic and dominant or assertive in how they expect the world to work' (Swan). Participants spoke of the need for leading differently, 'we need leaders in every form' (Renee) and enabling relational leadership because the style of 'command and control doesn't cut it' (George). Nurturing a culture to thrive in was viewed as beneficial for the system, the entire health workforce and for enabling allied health clinicians into health systems leadership roles.

Participants reasoned that a diverse leadership culture where 'leaders come in all shapes and sizes' (Swan) was an advantage for the design evolution of health organisations. Swan shared:

that's all part of the joy of the diversity and the experience of improvement. And the way that we can learn from each other and build from each other's skills. And stand on the shoulders of others and great past folks as well as current folks to learn from.

Participants believed that each profession had value to contribute to a thriving leadership culture, 'their own way of being in the world that is complementary to each other' (Lorraine). They felt this value enhanced the rich diversity available within the workforce for health systems leadership. They held the view that different styles of leadership were an asset. Participants expressed frustration that health organisations did not share this perspective. They suggested health organisations and those leading recruitment need to, 'look for the strength in people and what they can bring to the table and that can help the greater good, rather than prejudice or have their own agendas or own egos' (Clara). However, data indicated that the health system and the organisational governance forums were not aware of the poor leadership culture and appreciate why enabling allied health clinicians into health systems leadership roles would benefit them. Participants felt that where there

was recognition organisations were hesitant to change tradition. They argued for effective organisational change, they need to 'be willing to do things differently. You have to be willing to put different people in the positions of power and influence' (Renee). Participants urged an open-minded approach to health systems leadership that intentionally utilised diverse leadership styles and perspectives. Without organisational change to create a culture for diverse leadership to thrive data suggested traditional practices and their outcomes would continue.

Data on diversity highlighted participants' views on effective leadership in complex health systems. Participants emphasised the need for a nuanced and agile approach, adapting leadership styles based on the audience. As Emma noted, '[it] is about determining on what style of leadership is required for whoever your audience is.' Participants acknowledged that leading across multiple professions, sectors and systems was more challenging than focusing on only one of those aspects, 'providing leadership across the professions, across the system, is harder' (Warwick). The ability to collaborate adaptively was seen as essential as Simon explained, 'rangatira⁴...being able to weave something together, pull things together, pull people together.' Furthermore, participants believed that a leaders interactions were more telling of their capabilities than their titles or accomplishments. Eve asserted, 'leadership isn't about sitting behind a big desk in a big office while having a flash title.' There was also a firm belief in the capability of allied health clinicians to lead effectively across boundaries, as Renee remarked 'you have a workforce out there with the inherent skills to bring about this kind of systems change.'

In summary, participants pinpointed critical factors related to systemic bias that hindered or obstructed their leadership progress. These factors included the persistent hierarchical culture and power dynamics, reliance on traditional recruitment models, the stigma and systemic biases observed in their colleague's behaviours, and a lack of understanding about their leadership potential. Nevertheless, participants believed that positive action for change was achievable and suggested enabling actions to support their health systems leadership. These included an emphasis on health organisations to acknowledge the value of their diverse perspectives, appreciate their inherent systems thinking, and align their recruitment approach for health systems leadership toward the benefits of multiplying skillsets and the advantages of diversity. The participants

⁴ Rangatira – 'To be a leader, a rangatira, is to excel at weaving people together, to encourage or inspire others to go on a journey together, to exercise agency, and to light the way toward a world in which all flourish' Spiller, C., Maunganui Wolfgramm, R., Henry, E., & Pouwhare, R. (2020). Paradigm warriors: Advancing a radical ecosystems view of collective leadership from an Indigenous Māori perspective. *Human Relations*, 73(4), 516–543. <https://doi.org/10.1177/0018726719893753> .

contended that aligning health systems leadership with the current health paradigm was fundamental to creating a thriving health systems leadership culture.

5.7 Theme 4 – At the Mercy of Infrastructure

This final theme addresses how organisational infrastructure (systems and process) impacted allied health clinicians' progression into health systems leadership roles. Participants emphasised the negative impact of siloed service structures on organisational awareness of the challenges faced by allied health clinicians. They highlighted the strategic importance of talent spotting to support their development while stressing the need to have strategic connections to enable the process. Participants noted that limited exposure to leadership experiences hindered their growth and restricted their ability to direct their career development.

The issue of sustainable health systems leadership was also raised, with participants sharing their views on organisational strategies for workforce development. They recounted both positive and negative experiences related to governance forums and how governance decision-making affects priorities. A strong focus was placed on consumer outcomes which participants believed would highlight the value of allied health clinicians as health systems leaders. They suggested an organisational approach was required to address, generational differences across the workforce, ensure effective leadership training, and create suitable leadership roles. Participants asserted these issues could be addressed by focusing on system design and delivery to enhance consumer outcomes rather than just system outcomes.

5.7.1 The Silence of Silos

Participants believed that existing organisational structures within the broader systems hindered the ability for the workforce to understand each other's professional value. They suggested structures that created practice silos limited knowledge development and the ability to observe each other's professional impact. Participants expressed a strong desire to change these circumstances and support integrated practice and collaboration to increase professional awareness. They believed that understanding allied health professions would enhance their perceived value and increase opportunities for leadership roles for clinicians. Their views addressed the importance of bridging division and raising awareness of their value to others, 'for the medical staff and nursing staff to appreciate the added richness that this other dimension [the allied health workforce] brings. Otherwise, we still have that hierarchy, and we still have the poor cousin thing' (Rachel). Participants felt frustrated by the impact of organisational practice silos that limited interprofessional practice and collaborative services. They believed this hindered their leadership careers.

Participants expressed clear ideas and suggestions for how to overcome and work across boundaries. Participants identified simple administrative mechanisms that influenced how included they felt within the health systems leadership. They emphasised how these simple mechanisms could enable or hinder their contribution. One participant felt disempowered by their consistent exclusion from leadership communications out to the workforce. In response, she worked to successfully resolve it and subsequently felt valued, 'the fact that my name is always at the bottom of that signature...it's that recognition that allied health is important and that we're part of the team' (Jo). Participants expressed frustration and disappointment with their experience of divisive administrative obstacles and the need for thoughtful organisational integration of allied health systems leaders.

Several participants felt showcasing allied health clinicians in leadership roles across system barriers was a positive idea. They felt it was important to intentionally engage across the silos of services, geopolitical barriers and health organisations. Raising the profile of allied health systems leaders was conveyed as a critical enabler for promoting their value and capability across boundaries, within organisations, and across the national health system, 'I remember saying to all the other professional leaders, "we all need to apply, so that the organisation can know that there's people of calibre that can do this job".' (Atu). Participants believed that despite fewer profiles available, it was critical to publicly emphasise the skills and abilities of allied health clinicians for health systems leadership roles.

Participants frequently highlighted the importance of understanding the broader health system and organisation in relation to their capabilities. They urged allied health clinicians to recognise how their skills translated across the complex landscape, to engage with 'understanding where that clinical skillset fits within the much broader landscape of professions, and then within a system' (George). Participants felt it was essential for colleagues to see that allied health clinicians bring valuable systems thinking for process, design and collaborative practice to the table from across the allied health collective. However, participants recognised that siloed working could hinder allied health clinicians from understanding the system beyond their immediate organisation. Simon suggested that clinicians should, 'learn the breadth of the health system so that they can also contribute.' Overall, participants emphasised the value of acquiring system-wide knowledge which would allow them to engage beyond the limitations of their individual silos.

Data emphasised how operational silos within health agencies and organisations negatively influenced the coherence and standardisation of health systems leadership development. Participants identified the variations in focus, content, and quality of health systems leadership

development training, stating that 'it's very variable. There'll be a few places doing nothing. [Other] Places doing some good things.' (Warwick). Frustration was expressed regarding the failure of organisations and agencies to collaborate and ensure consistency, 'individuals collaborate really well, but sometimes organisations don't.' (Swan). Participants recognised that the inconsistency in leadership development led to a variable understanding of the capabilities of allied health clinicians for health systems leadership. This inconsistency hindered a unified appreciation of how allied health clinicians could contribute. As one participant remarked, 'my job description's really woolly...without any direction or transition or expectations, it's quite difficult.' (Leanne). There was a shared desire among participants for a coordinated approach to health systems leadership development, one that would provide health organisations with a consistent understanding of their skills and abilities.

5.7.2 Exposure Helps

Participants indicated that a lack of exposure hindered their opportunities to learn about, collaborate with or engage in health systems leadership roles. They indicated this lack of exposure was limited by a lack of process within organisational system design. Most participants implied poor exposure limited their understanding of the skills and knowledge necessary for health systems leadership roles. As Renee stated, 'I'm gonna keep coming back to, the system has to invest in those skillsets and then also let people go and make a difference.' Participants perceived the lack of exposure for allied health clinicians to health systems leadership roles was due to two main factors. Firstly, as a lack of equitable prioritisation of the allied health workforce's leadership development:

those things don't happen with no funding...we've got 87,000 people working in the health sector, and we're a business of relationships. We're a business of people. And that needs to be a number one funded, prioritised initiative, really. Workforce leadership and development. (Mel)

Second, participants contended that limited organisational design perpetuated several key processes that influenced how allied health clinicians were enabled, or not, into health systems leadership roles. These elements included a lack of funding for ongoing professional development, limited access to health systems leadership training, and the accessibility of health systems leadership roles for allied health clinicians to step into. Participants believed that how health organisations delivered these structures and processes influenced whether they were enabling or disabling for allied health clinicians, 'If we really want to have a flourishing health system and a flourishing leadership culture, there has to be some resource given and time for people to develop in an environment where they believe they can step up to the challenges that exist' (Renee).

The participants expressed frustration with the system, citing inconsistent access to training opportunities, 'there are system constraints in making space for people to take on those opportunities' (Renee). They provided numerous suggestions for improving access and engagement, emphasising the importance of equal opportunity in leadership development. Renee noted that success would entail, 'the system providing equal opportunity for people to engage in development, and to acknowledge their passions'. Participants spoke openly and emotionally about the need for system change to provide equal opportunity for leadership training. Participants passionately expressed their dismay at a lack of investment in the allied health workforce, 'We're one of the only workforces that, if you look across the country, we're not backfilled. Everybody else has got roster backfill to facilitate that' (Renee). Participants identified that an inconsistent approach to workforce investment influenced and impacted allied health clinicians' exposure to career development activities. Participants felt concerned that the inequities within health systems leadership would continue without intentional changes to prioritise allied health workforce investment.

Participants highlighted the importance of introducing health systems leadership training early in allied health career development. Many suggested that integrating this training into undergraduate curricula would better prepare allied health clinicians for health systems leadership roles. Clara spoke with, 'We should start to include some kind of training, right at the beginning of our careers, that encourages us to think more broadly.' Participants felt optimistic that student leadership education would broaden career horizons, allowing students to consider various options for health systems leadership. Lorraine shared:

it's not about being in those disciplines for the rest of your life. Actually, there are all of these pathways which can lead you into health systems leadership and lead you into teams where you're designing new systems, and new processes for our consumers and service users.

Participants compared postgraduate access of leadership development across private and public health organisations. They noted how private organisations excelled in supporting their professional development, with one participant describing it as 'an amazing, amazing place for coaching' (Mel). . In stark contrast experiences within public health organisations revealed a lack of similar infrastructure. One participant stated, 'there need to be opportunities, more opportunities for allied health leadership, by means of exposure or whatever to enable people to demonstrate what skillsets they have' (Simon). Some participants pointed out that even when health systems leadership training was implemented, systemic bias has continued to affect access. As Rachel stated, 'The organisation can tick a box because it's got a fantastic leadership programme. [But] Not everybody's necessarily connected into the leadership programme'. Similarly Mel expressed concern saying, 'I

don't think we provide that leadership coaching enough in health, and when we do, it's with a select group of senior leaders. It's never down through the organisation.' . Overall, participants emphasised the inequities of access and support available to allied health clinicians. They identified allied health clinicians in private health organisations enjoyed greater opportunities and access to health systems leadership development activities.

Participants discussed how the limited availability of roles impacted their career choices and direction, 'I remember talking to a colleague about this, saying the thing is I need to create the roles for me to then be able to apply for, which is unusual in anybody's career. Generally, you get to see what the path is, and then you just apply for it.' (Swan). Several ideas emerged from participants, on how to increase exposure to health systems leadership roles to support career progression. The most prominent suggestion was to implement a structured career framework to inform and guide the clinician's development. They felt it would help allied health clinicians identify their current stage in progression, understand the expectations and utilise this information to help negotiate exposure activities. The tiered approach was seen as beneficial for planned development and progression. As Rachel highlighted, there is 'merit in having several steps', while Warwick stated that it involves 'giving people stretch opportunities in a real structured way.' Participants emphasised that providing a career framework outlining progressive expectations would enable allied health clinicians to collaborate with their organisation to coordinate development activities. Swan noted that, 'really rounded experiences in lots of different places will build phenomenal skills.' Despite the positive discussion of potential system change, participants expressed views that challenges related to access, funding, and training were burdensome, wearying and negatively impacted their health systems leadership journey.

5.7.3 Talent Spotting is Personal

Participants expressed disappointment regarding their limited exposure to leadership opportunities but they spoke positively about their experiences with talent spotting. They emphasised that talent spotting was a personal experience, whether as individuals being recognised and supported or as facilitators helping emergent leaders. This individualised experience of enablement stood in contrast to the prevailing system-wide changes participants suggested to increase exposure to health systems leadership. Participants felt that successful enablement was achieved through intentional personalisation and engagement, especially in light of the limitations posed by the system. They referred to talent spotting as a process for identifying emerging leaders, suggesting that they and others acted as key enablers, essentially 'talent scouts' (Lorraine) for 'talent management' (Swan). The main outcome of these experiences, as identified by the participants, was the advancement of

their careers in health systems leadership. Leanne shared her experience of positive enablement, 'she pretty much offered me an interview on the spot.'

Participants viewed talent spotting as a crucial mechanism for their entry into health systems leadership roles. They discussed the need to implement talent spotting within the current landscape more broadly for allied health clinicians, stating 'you have to target every spot along the development pathway, from who we recruit, and how we train and who we train.' (Renee). Participants held the firm view that an individualised approach to talent management, alongside a consistent system-wide strategy for enabling talent, was complementary rather than mutually exclusive. They emphasised that the success of personalised connections with intentional engagement were key factors in enabling their advancement.

5.7.4 Meeting the Need

Participants identified several factors related to health systems that collectively formed a set of needs for enablement. Addressing these needs reflected the participants' desire to align a sustainable culture of enablement for allied health systems leaders with the population health landscape. Participants emphasised the need for a fit-for-purpose workforce capable of leading, engaging with new generations, and supporting clinicians into focused leadership roles. They highlighted the importance of anticipating future workforce needs, population health demand, and service delivery, noting that "not everybody needs to be touched by the doctor to receive good care" (Tony).

A key argument, which underscored the need for a fit-for-purpose workforce, was to shift towards earlier health interventions to sustain healthy consumers, support fiscal efficiencies, and reduce the emphasis on system measures. This approach was based on the allied health clinician's biopsychosocial model of care, focusing on outcomes for both the population served and how the workforce resource was allocated. As Tony noted the importance of 'thinking about the outcomes for the population that we serve and the staff that we work with in order to achieve that.'

Participants implied the potential for regulatory and supporting bodies to align with contemporary health evolution and anticipate changes in service design. They suggested these bodies could create mechanisms to develop emerging leaders, enabling them to acquire the necessary skills and capabilities. Participants suggested building on existing processes in place, 'things like that the clinical psychologists have negotiated through their MECA (Multi-Employer Collective Agreements) processes because sometimes formalising it in those ways is the stepping stone to that. That's kind of laying some foundation...it's using existing processes and systems that other groups use really

well' (Eve). They agreed existing frameworks were available foundations for the development of enabling mechanisms.

Professional standards and competency requirements were seen as crucial for career progression, allowing clinicians to transition between health systems, 'being able to step out of a health system that I knew and take my knowledge and skills into another health system' (Swan). Participants stressed the need for appropriate processes within professional regulation to support their identity as health systems leaders. They argued formalised support would benefit their leadership careers, 'I think we have to feel that we've got the structure and support behind us from our professional bodies being out there. Pushing us into places.' (Eve). They believed that collaboration between professional bodies, tertiary institutes, and employers could significantly influence and enable clinicians to take on leadership roles.

Lastly, participants expressed frustration with hybrid leadership roles that split time between leadership and clinical practice. They felt these roles did not allow clinicians to fully demonstrate their capabilities. The complexity of navigating dual roles was seen as problematic, with ethical, professional, and managerial dilemmas. Rachel said:

So, you're expecting one individual to be a peer for part of their life and a manager for another part of their life. And I'm not wholly sure on the wisdom of that because there are ethical issues, there are boundaries, there are clinical dilemmas, professional dilemmas, managerial dilemmas that you're crossing backwards and forwards through, all of the time.

Participants felt this context compromised organisational and workforce needs, leading to negative outcomes such as poor leadership and "thankless roles" (Cate). Participants reasoned that this duality hindered clinicians from developing and progressing as health systems leaders.

5.7.5 The Influence of Governance

Participants identified governance as a key factor in enabling allied health clinicians into health systems leadership roles. In their view, governance, defined as the leadership forums setting the culture, tone and expectations, varied across different environments, 'from microcosm to microcosm. From environment to environment' (Renee). The leadership structure was noted to be conventional, 'traditionally we've grouped people together and then put a leader around those groupings. So I guess there is a big variation in how that's constructed across the system' (Rachel). Data inferred this legacy of variability led to inconsistencies in the creation, management and expectations of health systems leadership roles.

Effective governance was seen as crucial for successful health systems leadership. Participants noted their experience of poor governance resulted in well-intentioned efforts without successful outcomes. One participant commented, 'where you don't have great governance in place, and that structure is not there, you got a whole lot of well-intentioned people who often run around in circles and don't actually manage to get much done' (Mel). They believed existing governance forums often lacked the insight needed to translate organisational values into suitable structures for allied health clinicians, leading to a disconnect between workforce needs and governance actions. Tony described it as 'this sort of cognitive dissonance between what is said in terms of value statements or what people say and what is actually done.' Participants recounted experiences of organisational discord that hindered their potential for delivering successful leadership. One participant shared their frustration of a lack of leadership recognition, 'we're a health system littered with great pilots that were super successful, but because of the funding, the governance, the mandate, the leadership wasn't there around those prototypes and those pilots' (Mel). They felt a lack of effective governance was reflected in the lack of support for allied health systems leadership to deliver successful outcomes.

Participants highlighted the need for robust governance policies and processes to support allied health clinicians in leadership roles. They pointed out funding inequities and policy exclusions that disadvantaged allied health clinicians. Participants recognised the embedded challenges of fiscal legacies for public health service governance but asserted the need for change, 'nursing leadership structure is immense and well resourced. Allied health, we are still trying to do things on the smell of an oily rag...we know that there's an issue here. We know we've got to do something.' (Cate). Participants argued inequities were often perpetuated by existing governance forums. They suggested governance forums did not anticipate and therefore stipulate for equitable professional treatment across the workforce. Participants identified the public exclusion of allied health and a preference of doctors or nurses for contemporary health system leadership roles. As an allied health systems leader, Lorraine conveyed a sense of frustration when she described implementing such a requirement: 'The SOP [Standard Operating Procedure] says it has to be a doctor or a nurse.'

In contrast, participants described private health governance as robust models to learn from and recommended that the public health governance forums change their expectations. Mel agreed and urged for durable models:

so that we have good governance, good decision making and we set people up to have a mandate, to be able to make decisions, to be able to get on with it and then we put the structure in behind them with coaching and leadership to make sure

that they're successful...we can't just do it with one or two pockets of the sector. It has to be almost like, yeah, leadership 101. (Mel)

Participants identified that good governance was a key enabler for developing and enabling allied health clinicians into health systems leadership roles. They asserted governance forums needed to cultivate more inclusive and equitable perspectives when considering health systems leadership. . They believed improved governance could prevent the loss of valuable allied health workforce members. One participant noted colleagues had left because of difficulties with advancing their careers, 'lacking the opportunity for people to lead. Way up to a fifteen-year career, and then we end up losing them, 'cause then they think, "Well, what next?"' (Leanne). Participants suggested governance forums in health organisations could create positive change by deliberately using policies and processes to shape expectations for health systems leadership.

Many participants believed that health organisation governance forums significantly influenced leadership within allied health systems. They highlighted the responsibility for equity by individual members within these governance forums. Participants emphasised members play an important role in determining how health systems leaders are selected. As Tony noted, 'I think you start with governance. I think you start with governance and who is choosing the top decision-makers in an organization.'

Participants suggested members of governance forums should reflect the type of leaders they needed to guide health systems. Tony mentioned, 'people in executive positions or decision-making positions should be systems leaders. I think they are quite often not. They're focused very much on a single professional interest or on a very focused area. So they're not thinking in terms of systems leadership'. They believed the mix of membership influenced the recruitment culture for health systems leadership. Participants agreed that the current mix did not enable allied health clinicians, 'We have to think differently about who sits at those leadership positions and be really open-minded to who else is out there that can drive this new system' (Lorraine).

Participants suggested that a lack of systems thinking within governance negatively influenced system design and who was chosen to lead. One participant asserted that embedded beliefs influenced governance decisions, 'I think systems tend to be put in place by people that often have preconceived ideas of who should be in roles and what skills they should have' (Clara). Participants advocated for behavioural change in health organisational governance forums. Renee emphasised, 'you have to be willing to do things differently. You have to be willing to put different people in positions of power and influence. And you have to invest in providing them with the rest of the skills

and knowledge that they need to be able to flourish.’ Participants agreed that a robust and effective health organisational governance membership used systems thinking to enact inclusive policies for the benefit of health system design and outcomes.

5.8 Chapter Summary

This chapter presents a comprehensive analysis of the extensive data, encapsulating participants' experiences and emotions. Four key themes emerged, reflecting various factors perceived to influence the ability of allied health clinicians to assume health systems leadership roles. The four themes; The Leader Within, Finding the Next Step, Overcoming Bias, and At the Mercy of Infrastructure, highlight individual, contextual, and systemic factors that either hindered or facilitated participants' progression. Key enablers include:

1. **Validating allied health systems leaders:** Recognizing allied health clinicians as valued health systems leaders, with professional expectations, training curricula, and employers endorsing and affirming their identity within these roles.
2. **Embedding equitable access to leadership development:** Integrating allied health clinicians into health systems leadership through the provision of consistent and inclusive leadership development.
3. **Creating a culture to thrive in:** Endorsing the value of allied health clinicians and recognising their capability with the Implementation of robust governance structures, policies, and operational processes.

Chapter 6 will synthesise these findings and discuss them within the context of existing research and the current health systems landscape. This discussion will provide insights into how allied health clinicians can be effectively enabled to step into health systems leadership roles. Additionally, it will highlight the strengths and limitations of this research study, reflecting on the knowledge produced.

Chapter 6 Discussion

6.1 Introduction

This research study aimed to understand how allied health clinicians are enabled to step into health systems leadership roles. Chapter 2 provided a literature-based investigation of health systems leadership, focused on allied health clinicians leading health systems and how health leadership described allied health involvement. Following this, in Chapters Three and Four, empirical study using Interpretive Description methodology (Thorne, 2008) with an appreciative inquiry lens (Cooperrider & Whitney, 2005) is described. Participant interviews were undertaken to understand the leadership journey experience of existing health system leaders with an allied health clinical background. The results of these interviews were analysed using reflexive thematic analysis (Braun & Clarke, 2022) and are presented in Chapter 5.

This chapter will synthesise the key findings, critically discuss these findings in the context of existing research, and identify the new contributions this study makes to the field of allied health and health systems leadership. It will demonstrate how these findings challenge and/or add to the current knowledge of how allied health clinicians can be enabled into health system leadership roles. The discussion in this chapter is organised into three parts reflecting the key contributions of this research; Part 1, **Validation and Identity**; Part 2, **Inclusion and Equity**; and Part 3, **Creating a Culture to Thrive In**. These three parts were developed through a review of; the breadth of raw data; the thematic elements, and with use of an insider's perspective. Together, they served to create further synthesis of the findings and focus the discussion for coherence. The three parts address the individual, the interpersonal dynamics and the environmental context in an ever-widening perspective of discussion.

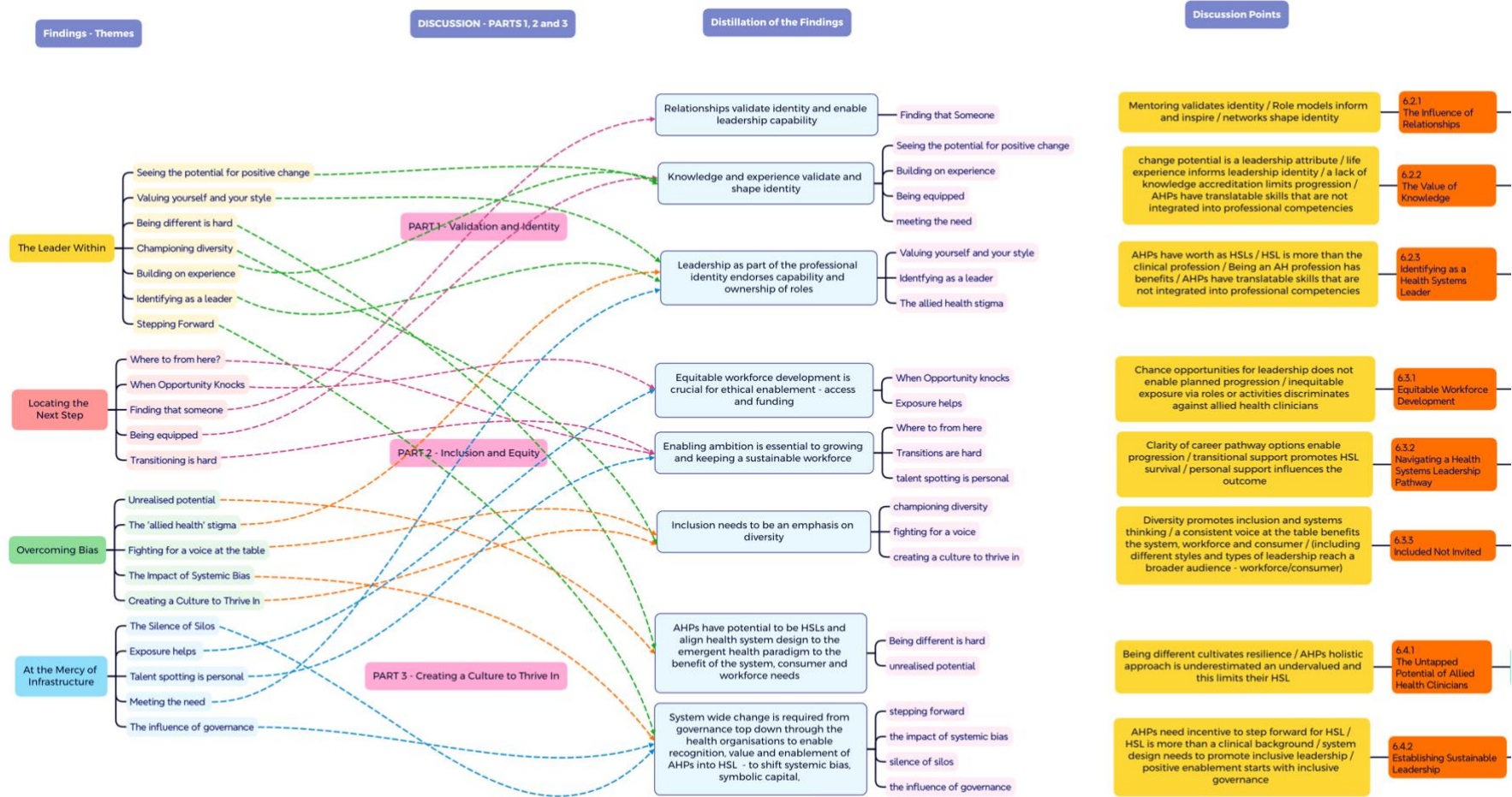
Each of the three parts will discuss the findings and position them within the existing body of knowledge. Together, these parts will provide an understanding of how allied health clinicians are enabled to step into health systems leadership roles in Aotearoa New Zealand. Figure 15 (an excerpt from Appendix H) illustrates the connections between the Findings and Discussion. It shows the progression of data interpretation and synthesis highlighting how each part of this chapter remains strongly connected to the four Themes.

Before concluding Chapter 6, the **Strengths and Limitations** of this study will be critically discussed. Key points will identify aspects where changes could have enhanced the study, and explore the choices that benefited its completion. The synthesis of information presented in Chapter 6 is

undertaken in conjunction with the literature available at the time of writing. New documents that have a national impact continue to be published, and new versions of documents referred to within Chapter 6 may exist at the time this thesis is read. At the end of Chapter 6 the Chapter Summary will emphasise the key outcomes that form the basis of the implications for practice presented in Chapter 7.

Figure 15

Illustration of Connections Between the Findings and Discussion



6.2 Part 1 – Validation and Identity

Part 1 will discuss the meaning and value participants attributed to three key issues: *The Influence of Relationships*; *The Value of Knowledge*; and *Identifying as a Health Systems Leader*. The findings suggest these factors are key enablers for allied health clinicians, and may benefit the broader health system through the recognition of allied health clinicians as health systems leaders. Data evidenced the positive influence of relationships and connections in validating participants' capabilities for health systems leadership. Existing research on health systems leadership emphasises the importance of validation and identity in enabling or disabling individuals stepping into leadership (Daire & Gilson, 2014; Koskiniemi et al., 2019; Nancarrow & Borthwick, 2021; Rasa, 2019). Within this context of existing research, Part 1 will discuss the enabling influence of relationships, the impact of leadership credibility, and leadership capability as part of the professional identity.

Participants highly valued and emphasised the influence relationships had on enabling their health systems leadership journey. Navigating through the health system was frequently referred to as a 'relationship game' (Cate). Participants argued that connecting through relationships provided support and guidance, and facilitated opportunities for health systems leadership progression. The participants indicated that establishing enabling relationships was often by chance rather than by design. They suggested it was dependent on context and individuals. They believed they had little control over the arbitrary opportunity of these relationships, which enabled their health systems leadership journey.

The literature typically refers to initiating connections within health as 'relational practice', an approach to establishing and maintaining ways of connecting with others in complex systems (Lamph et al., 2023, p. 1; Pollard & Wild, 2014). Research depicts the implementation of relational practice as somewhat transactional, primarily focused on establishing relationships as a method for enhancing clinical interactions and managing cross-boundary working. The contrast between the view of creating connections to facilitate practice, and establishing relationships to enable personalised career progression, emphasises the limited view literature has on the impact relationships can have within health systems.

The findings have highlighted the lack of recognition by health organisations of the enabling influence relationships can have on workforce professional development. Participants viewed relationships as personally meaningful and as having valuable impact on their leadership career progression. They talked about creating connections based on personal attributes and values rather

than a model of care. Participants felt it was an important social process rather than a transactional one. This view held by participants speaks to the value and importance literature places on relationships for enhancing interprofessional, collaborative and successful systems leadership performance (Bigland et al., 2020; Jackson et al., 2021). The current research highlights the importance of moving away from a focus on relationships for organisational or system benefit (Lamph et al., 2023) to both a more intentional approach to relationship development, and recognising the role of relationships in fostering personal development and opening up career pathways.

6.2.1 The Influence of Relationships

Participants identified that engaging with a mentor for personal and professional growth was a significant enabler of leadership progression. They felt that engaging with a mentor created a positive and safe environment to access feedback and insights on their professional journey. Participants contended that it challenged them to expand their thinking about what was possible. Research identifies mentorship as ‘a continuous journey of discovery and shared learning, and personal and professional development to achieve leadership excellence’ (Batara & Woolgar, 2017, p. 155). Literature asserts that connecting with another person to discuss professional, personal, and contextual issues validates and helps inform an individual’s identity (Batara & Woolgar, 2017; Davey et al., 2020; Germeroth et al., 2024). For leadership development and progression, mentoring is known to be valuable beyond the influence and production of good leaders; it also contributes to recruitment, retention and future health system development (Hawkins & Fontenot, 2010). Research addressing career advancement in allied health clinicians identified that mentoring also benefits mentors. The provision of mentorship was shown to demonstrate a high level of leadership competency and positively contribute to the mentor’s career advancement (Koh et al., 2022). Consistent with this study’s findings, existing research endorses mentorship across the allied health workforce, from students to senior leaders, identifying it as a health systems leadership enabler (Abrishami, 2024; Germeroth et al., 2024; Rodríguez et al., 2021).

Participants also emphasised the importance of having role models who positively inspired them. The close association and connection they felt with this role model was key to validating a health systems leadership identity. The value of role models, endorsed by international research, found that in the absence of mentoring and role models, allied health clinicians’ sense of identity was diminished (Eddison et al., 2023). Paramedic research in the UK recommends intentionally finding someone who is inspiring and should not be left to chance (NHS England, 2023).

Participants highlighted the importance of a network of connections providing access to collective support, advice, and expertise to help allied health clinicians develop capabilities for health systems leadership. They spoke of the value of having a broad range of connections across the health system: 'build your network of sponsors and champions' (Mel). This network of relationships was perceived to be influential in enabling health systems leadership progression. Bourdieu (1986) ascribes the term 'social capital' to 'the aggregate of the actual or potential resources which are linked to the possession of a durable network' (p.21). Bourdieu suggests that the volume of social capital, and thereby available resources, is influenced by the 'size of the network' (p.21). The data in this study suggests that the relationship quality in conjunction with the network's diversity provided value. This contrasts with Bourdieu (1986) whose view of value focuses solely on the volume of connections made. This difference between the participants' view, and that of Bourdieu, highlights the participants' belief that individual connections within diverse networks provided greater success for the validation of identity and for enabling their progress. Participants did not ascribe meaningful value to how many connections they could accumulate. Koskiniemi et al., 2019 argue that the personalisation of relationships help shape leadership identity. Similarly, Koh et al. (2022) argue that allied health clinicians' relational attributes and skills are equally crucial as quantifiable assets in influencing effective leadership. Consistent with this, the current study found the personalisation of diverse networks to be of greater value in enabling participants to step into health systems leadership roles than accumulating connections.

Participants believed the quality and integrity of their relationships helped with, and were influential for their career progression. Research on relationships in healthcare typically focuses on how they impact the delivery of healthcare services (Tran et al., 2018). As the participants pointed out, personalised connections can provide successful outcomes for enabling career development. International literature supports workplace relationships as a vital resource worthy of consideration for creating a sustainable work culture as well as improving the quality of care (Schön Persson et al., 2018). Consistent with this study, international research found that proximity has a positive effect on workplace relationships, and health systems do not have the enabling processes in place to support the development of key attributes, like trust. The lack of mechanisms and process, such as mentoring, to promote positive interpersonal dynamics obliges individuals to rely on their own initiative to make and cultivate effective relationships (Sutherland et al., 2022).

6.2.2 The Value of Knowledge

To enhance their academic standing, participants emphasised that achieving certificates, completing training programmes or gaining additional qualifications provided them with assurance and

confidence in their ability to fulfil health systems leadership roles. This view aligns with Bourdieu's (1984) concept of 'cultural capital' where the accumulation of assets, for example qualifications, is argued to give individuals 'cultural authority.' This authority translates into leadership influence derived from the demonstrated skills and credentials. The data suggested that the validation obtained through accredited training and education was a crucial enabler for a participant's leadership journey. When participants could attend focused health system leadership training, they gained a deeper and more comprehensive understanding of what health systems leadership entailed.

Existing research supports the notion that accredited learning provides clear outcomes and can positively impact 'confidence and ambition' for leadership practice (Koh et al., 2022; Lindsay, 2022, p. 298). It is also argued that the value of skills and knowledge can be demonstrated through development activities and alignment with professional standards (Bradd et al., 2018a; Dalton et al., 2021; Manatū Hauora – Ministry of Health, 2024b). The current study's findings align with existing research and theory regarding the societal value placed on accreditation. Participants sought educational training for health systems leadership in different forms and levels, to obtain tangible proof of strategically valuable skills and knowledge for their leadership development. However, the strong desire to accumulate assets to validate their skillsets for health systems leadership roles co-existed with the desire to be recognised for their personal value-based behaviours.

The current study highlighted a tension for participants between having formal training to gain socially recognised forms of credibility, and the belief that life experience along with their practice philosophy, values and training, equips and enables them to lead with competence and skill. Allied health research points towards the value of intangible personal or behavioural skills for effective leadership and collaboration, as well as a relational skill set that underpins successful influence in leadership roles (Koh et al., 2022; Wiedman, 2023). Value is given to the accrual of knowledge assets, but emphasis is also given to the experience and personal skills of the individual that form the whole person as a leader (Koh et al., 2022). The literature highlights a tension for professional development between evidencing competency-based and experience-based development (Hays et al., 2020). The current study's findings argue that both need to be valued and inform consideration of the validity and identity of a health systems leader. The limited research available that discusses allied health systems leadership competency requirements suggests the implementation of a standardised development framework that meets contemporary systems thinking. With publicly endorsed accreditation, such a framework would enable recognition of both accrued knowledge and experience (Dalton et al., 2021; Jackson et al., 2021; Te Whatu Ora – Health New Zealand, 2023).

6.2.3 Identifying as a Health Systems Leader

Participants found it challenging to identify as potential leaders early in their career, despite their conviction regarding the value of the unique contributions allied health professions make to health systems leadership. The literature highlights several key contributions allied health can make to health systems, including systems thinking, interprofessional collaboration, working across boundaries, and a biopsychosocial approach to improving outcomes (Australian Healthcare and Hospitals Association (AHHA), 2022; Markham, 2015; Mickan et al., 2019; NHS England, 2022). These characteristics are also core components of systems leadership for health and social care as defined by Edmonstone (2019).

Even with this affirming evidence, participants reported doubts about their capability for leadership when comparing themselves to medical and nursing colleagues. These doubts stemmed from various sources, with data indicating that implicit signals, including the behaviours of their colleagues, contributed to these uncertainties. The prevalence of research about leadership identity in nursing and medicine (Daire & Gilson, 2014; Johnson et al., 2023; Koskiniemi et al., 2019) contrasts markedly with the comparatively limited evidence specific to allied health professions (Wiedman, 2023). This disparity reinforces the limited health systems leadership identity that allied health clinicians have within health systems.

Participants in this study indicated that being able to identify as leaders more easily would have facilitated a much smoother progression into health systems leadership roles. The negative impact of systemic bias on participants' self-view (see section 5.4.4) was noted, with self-doubt clouding their judgement regarding the credibility of their leadership skills and attributes for health systems leadership roles. There is little research addressing professional or leadership identity within healthcare. One study suggested that clinical practice heavily influenced leadership identity (Koskiniemi et al., 2019), while another focused on a specific profession and found professional identity was informed, but not bound, by one's clinical identity (Wiedman, 2023). Much of the literature on identity in healthcare focuses on identity within the profession rather than the translation of identity between roles (McGowan et al., 2018a). Koskiniemi et al. (2019) highlighted the individuality of the clinician and those around them as influential in shaping leadership identity, referring to the influence of self and others as reflective mechanisms of feedback for the clinician (Koskiniemi et al., 2019). Such mechanisms, including training and development activities, align with factors identified by the current study. These findings are supported by literature advocating for focused training and development to help shape professional leadership identity (Chandran et al., 2019; New Zealand Institute of Economic Research, 2021; Wiedman, 2023). Indeed, this current

study found that allied health clinicians struggled to translate their professional identity and capability to broader health systems leadership roles. Reflective factors, such as leadership training and feedback, have the potential to help allied health clinicians shape and validate their health systems leadership identity.

To embolden allied health clinicians within the existing systemic bias, participants believed that signalling the validity of their contributions for health systems leadership could begin much earlier. Participants asserted that learning about health systems leadership competencies within undergraduate education curricula would enable allied health clinicians to understand and validate their identity as potential health systems leaders. Existing research promotes early exposure to leadership education, highlighting its advantages in strengthening allied health leadership graduate outcomes (Dalton et al., 2021; Kutz, 2004; Mizzi & Marshall, 2024). Introducing leadership education early in allied health careers would contribute to a systematic approach for the continuous development of allied health systems leaders (Tilson, 2023). The Hauora Haumi Allied Health Report (Manatū Hauora – Ministry of Health, 2024b) identified an overwhelming call from across 14 allied health professions for early leadership development and undergraduate education, and pathways for health system leadership career options. Consistent with this, data from the current study emphasised that when participants were supported through education, relationships and peer recognition, they felt enabled to progress into health systems leadership roles. This alignment suggests a motivation to embed a validated health systems leadership identity from the outset of their careers.

Participants were passionate about early education but hesitant to suggest that professional competencies be established to validate health systems leadership identity through competency frameworks. Research endorses integrating leadership competencies within professional standards and regulations (Dalton et al., 2021; Kutz, 2004) to support the expectation of undergraduate education in health systems leadership. Given the interrelated and complex dynamics between professional standards and competencies, and the expectations for undergraduate curricula in health professions (Churchman & Woodhouse, 1999; Shaw & Tudor, 2021), excluding leadership competencies from professional standards may be detrimental to allied health system leadership development. Including leadership competencies could validate an allied health clinician's knowledge, experience and understanding of health systems leadership. The evidence of competencies would form a tangible reflection of skills, knowledge and experience. Dalton et al. (2021) argue that incorporating leadership within professional competency standards could be critical in supporting allied health clinicians as influencers of future health system reform. Dalton et

al. (2021) suggest that graduates not educated in alignment with a contemporary leadership framework or informed of leadership theory may not align personal leadership attributes with their competency standards and leadership capability. Given that these solutions are not universally implemented, this study's findings align with existing research outcomes and highlight the struggle allied health clinicians face in professionally evidencing their identity as health systems leaders.

6.3 Part 2 – Inclusion and Equity

Part 2 discusses issues related to *Equitable Workforce Development*, *Navigating a Health Systems Leadership Career Pathway* and *Included Not Invited*. Participants valued the support for health systems leadership education and training, but noted disparities in access and funding, leading to inequitable development compared to their colleagues. Participants suggested clearer career pathways and skill expectations would help emerging allied health system leaders navigate their development and aspirations. They perceived a strong connection between the inclusion and equitable treatment of allied health clinicians and their ability to assume health systems leadership roles. When applying for health systems leadership roles, participants believed recruitment should focus on relevant skills, attributes and perspectives rather than professional clinical background. Participants believed in equitable inclusion as health systems leaders rather than contributing via invitation.

Aotearoa New Zealand has an estimated 250,000 health workforce personnel, with approximately 90,000 in Health NZ and more than 30,000 allied health clinicians nationwide (Allied Health Aotearoa New Zealand, 2017; Te Whatu Ora – Health New Zealand, 2023) encompassing at least 45 professional groups. Utilising this diverse talent pool for health systems leadership can provide rich and varied perspectives beneficial for system design, workforce and delivery. Participants experienced inequitable recruitment, training and funding processes, feeling excluded from leadership roles both individually and collectively. In contrast, inclusive recruitment criteria, educational training and support for allied health integration into strategic decision-making were viewed positively. They argued a lack of diversity in health systems leadership limited the benefits to the system, workforce and consumers.

6.3.1 Equitable Workforce Development

Data emphasised a reliance on inconsistent access to development activities, and a disparity across the allied health collective regarding funding for education and professional development. Mizzi and Marshall (2024) highlighted inequities of access to resources, development support and training in comparison to nursing and medical colleagues. Literature recommends consistently developing

leaders across the health and disability sector (Harding et al., 2024; Mizzi & Marshall, 2024; Mucheru et al., 2024). It is suggested health systems leadership development requires an approach that helps leaders understand complexity theory, systems design and leadership styles best suited for leading health services (Stolarek et al., 2022). Stolarek et al. (2022) suggest this approach transcends the workforce and is inclusive of all professions. They infer there should be no disadvantage for an allied health professional seeking access to develop their health systems leadership skills amidst the health workforce. Consistent with Mizzi and Marshall (2024), this current study found that inequitable access to health systems leadership development was believed to disadvantage career progression.

In contrast to the medical and nursing workforce, there is no publicly available data to explain provision regarding health systems leadership education of the allied health workforce (Harding et al., 2024; Te Whatu Ora – Health New Zealand, 2023). Health NZ acknowledges historical limitations for allied health leadership development within the Health Workforce Plan 2023-2024 (Te Whatu Ora – Health New Zealand, 2023). This suggests that a significant portion of the allied health workforce lacks access to equitable frameworks for health systems leadership development. Given their strategic independence, this situation could differ for private health organisations and NGOs. However, the inferred lack of profession-based expectations as part of allied health professional competencies (see section 6.2.3) suggests there are few levers placed on health workforce employers to ensure equity in access to funding for workforce development. Existing research suggests there is emphasis on the provision of management training ahead of leadership development (Australian Healthcare and Hospitals Association (AHHA), 2022; Kutz, 2004).

As evidenced in the literature review (see Chapter 2), there is an emphasis on management training within allied health research, for the operational delivery of allied health services rather than strategic leadership (Boyce & Jackway, 2017; Fry, 2009; Marinelli-Poole et al., 2011; McGowan et al., 2018a, 2018b). Dalton et al. (2021) advocates for equipping future allied health graduates with an understanding of leadership competency. Otherwise, they suggest, the opportunity to ensure they can step into leadership and address the complex reality of the health system for design innovation will be missed. Mizzi and Marshall (2024) supported the findings of this research, arguing that access to equitable provision of and funding for health systems leadership development is a critical factor in enabling career advancement into health systems leadership roles.

Data indicated that equitable access to workforce development would reduce the reliance on chance opportunities, expand career choices, and enable more allied health clinicians to apply for health systems leadership roles. International research about the prevalence of allied health clinicians in leadership roles and the barriers to career progression has highlighted gaps in providing education

for, and appointing allied health professionals into, health systems leadership roles (Boyce & Jackway, 2017; Mizzi & Marshall, 2024; NHS England, 2023). Additional literature has advocated prioritising the inclusion of allied health professions in health systems leadership development (Mizzi & Marshall, 2024; NHS England and Health Education England, 2018; NHS England and NHS Improvement, 2019a). The call for inclusion emphasises the concerns raised that allied health clinicians would be ill-equipped to take on health systems leadership roles without adequate development and preparation (Dalton et al., 2021). Dalton et al. (2021) also found that allied health clinicians frequently felt underprepared for health systems leadership roles. Yet, when leadership development training was provided, the clinicians were able to expand their knowledge and continuously build on their development to lead more effectively. The provision of leadership development training across the workforce, regardless of profession, is evidenced to equitably enable clinicians to equip themselves for stepping into health systems leadership roles.

6.3.2 Navigating a Health Systems Leadership Career Pathway

The lack of clear and progressive career guidance is a significant barrier for participants navigating their health systems leadership journey. There is a compelling need for clear career pathways to enable intentional progression. Recent guidance from the UK and Australia for allied health clinicians endorses the implementation of structured career frameworks to provide clarity and guidance for aspiring leaders (Australian Healthcare and Hospitals Association [AHHA], 2022; NHS England and NHS Improvement, 2019a). However, these guidelines have limitations. Geographical and contextual differences prevent these outcomes from being universally applicable. Additionally, the narrow focus on allied health leadership limits the potential for these frameworks to benefit the entire health systems workforce.

Without clear career direction, research indicates that careers are hindered, and individuals struggle to navigate their own progression creatively (Harding et al., 2024; Watson et al., 2024). Despite the publication of NHS guidance, Mizzi and Marshall (2024) identified an ongoing need for a career pipeline in their study of early to mid-career allied health leaders. These findings highlight the absence of formal, progressive career direction for allied health clinicians aspiring to health systems leadership roles. Consistent with this, the current study found that the lack of a phased career framework consistently limits allied health clinicians from stepping into health systems leadership roles.

This study identified that transitioning into and between health systems leadership roles requires resilience and adaptability. Leadership transitions are often challenging (Faculty of Medical

Leadership and Management, 2018; Lindsay, 2022; Mizzi & Marshall, 2024), and evidence suggests allied health clinicians frequently assume these roles without adequate preparation (Vito & Hanbidge, 2021). Successful transitions are enabled by a strong identity based on personal attributes, a focus on relationships, and alignment between leadership roles and professional capabilities (Wiedman, 2023). These factors resonate with the findings of the current study, as discussed in Part 1 of this chapter.

Participants reported that their experiences of career transitions were frequently impacted by the level of support and preparation they received. Participants typically shared more negative experiences, citing a lack of support and preparation as major challenges. Conversely, consistent support from colleagues and clear organisational guidance created positive feelings of encouragement and affirmation. Asimwe et al. (2019) found that predictive factors for successful role transitions among nurses included adequate preparation and positive transition experience. Successful transitions affirm the health systems leader in their new role, benefiting both the workforce and the organisation. In contrast, a lack of collegial support can predict unsuccessful transitions (Asimwe et al., 2019). Consistent with this current study, evidence suggests that supporting clinicians through positive and successful transitions into health systems leadership roles is advantageous for the organisation, the clinician and the systems they lead.

Participants emphasised the positive impact of personalised support in facilitating their career navigation. They highlighted how this attention positively influenced their decisions and aided their development in their leadership journey. The literature on talent management in healthcare is sparse, but it broadly defines talent management as the identification of emergent leaders and active participation in their development (Nowak & Scanlan, 2021). Existing research supports talent management as a positive and supportive method for developing health systems leaders (Daire & Gilson, 2014; Nowak & Scanlan, 2021).

A lack of interpersonal support has been identified as a major deterrent to pursuing health system leadership roles (Kalaitzi et al., 2019). Conversely, encouragement and guidance are argued to promote confidence and reduce self-doubt (Haines & McKeown, 2023). Positive outcomes of talent management include enhancing and sustaining the stability of health systems leadership positions within healthcare (Daire & Gilson, 2014; Nowak & Scanlan, 2021). In the current study, outcomes for allied health clinicians were perceived as positive and enabling when support and talent management were provided.

6.3.3 Included Not Invited

A focus on diversity within health systems leadership promotes the inclusion of a broad range of professions, thereby enhancing workforce representation and better aligning with the population they serve (Martin et al., 2021). Much of the literature addressing diversity focuses on gender, noting that while 70% of the global healthcare workforce are women, only 25% occupy health systems leadership roles (Gangwani et al., 2024; Haines & McKeown, 2023; Mousa et al., 2023; Mucheru et al., 2024). International gender-based literature highlights the importance of diversity in organisational leadership as a critical factor in enabling women's involvement and inclusion in leadership roles (Mucheru et al., 2024; Riche et al., 2023).

This study's findings support these international research outcomes. Alignment occurs when diversity and inclusive leadership are addressed as a practical approach to involving marginalised groups. They recognise the need for embedded inclusion rather than invitational involvement. Embracing diversity to embed involvement presents both a challenge and an essential opportunity for effective health systems leadership (Edmonstone, 2019). Intentionally recruiting a broader range of professions would challenge the traditional approach of appointing specific professions into health systems leadership roles. Engaging in an intentional approach to inclusion represents a significant shift for many health organisations, necessitating changes in their leadership structure (Aspinall et al., 2023; Gangwani et al., 2024). Despite the challenges posed by historical practice, participants in the current study expressed a desire for a considered approach to increasing diversity in health systems leadership. Developing an inclusive leadership culture that values different professions, styles and types of leadership is strongly endorsed as a means to address the complexity of healthcare (Ashikali et al., 2021).

Having a consistent voice and position at the health systems leadership table was perceived as providing allied health clinicians with recognition and value. A consistent presence enhances the credibility and visibility of allied health clinicians as health systems leaders (Colesby, 2024).

International literature underscores the need for an equitable approach to membership at the health systems leadership table (Haines & McKeown, 2023; Mizzi & Marshall, 2024), enabling all professions to have a voice (Lindsay, 2022; Roberson & Perry, 2022).

Mizzi and Marshall (2024) identify equity of opportunity and voice as critical for enabling early to mid-career allied health clinicians to assume leadership roles. Their findings align with this study's research on allied health systems leaders. However, in Aotearoa New Zealand, equitable inclusion of allied health clinicians in recruitment, involvement and contribution to health systems leadership

still needs to be established. The Health Workforce Plan 2023-2024 (Te Whatu Ora – Health New Zealand, 2023) presents allied health clinicians as non-traditional participants in the leadership development pipeline for Aotearoa New Zealand.

Many allied health professions have been in practice for over 100 years (Institute of Medicine (US) Committee to Study the Role of Allied Health Personnel, 1989). They possess a wealth of historical development, regulatory governance, and research to support contemporary evidence-based practice. Employed in both private and publicly funded services, they deliver numerous interventions across various stages of life and health (Nancarrow & Borthwick, 2021). As part of a diverse global health workforce, they have an equitable claim to health systems leadership roles. Boyce and Jackway (2017) identified that allied health clinicians face difficulties accessing roles rather than lacking motivation to assume them. Evidence advocates for allied health clinicians' perspectives in health systems leadership, and for their voices to be heard for the design, development and provision of services to meet the needs of diverse health populations (NHS England and NHS Improvement, 2022; Stanford, 2020).

Participants had mixed views regarding their perspectives on leadership as compared with those of their nursing and medical colleagues. Within the existing frame of health systems leadership, many participants saw themselves as disruptive to traditional health leadership approaches. They believed that their perspectives could support improved system design and consumer outcomes. Chapter 1 discusses health systems leadership as a social influence process that can encompass different leadership styles, such as transformational leadership, within the complex organisational landscape of health and disability services (Bolden, 2004). Health systems leadership seeks to effect change through multiple interacting and intersecting services, and requires working across professional and geopolitical boundaries (Edmonstone, 2019).

International research identifies key benefits of tapping into a broader base of knowledge and experience for effective leadership. These benefits include increased capacity for innovation, enhanced engagement and improved workforce satisfaction with the health system (Martin et al., 2021; NHS England, 2023). Roberson and Perry (2022) endorse these benefits, highlighting the value of diverse contributions and supporting the divergence from traditional membership to achieve these aims. Providing health systems leadership for interprofessional health services requires a unique blend of knowledge and skills (Smith et al., 2018). Without diversity, dominant perspectives that find universal favour can perpetuate themselves, limiting organisational development (Bourdieu, 1984). Edmonstone (2019) suggests that successful organisational development requires diverse thinking to ensure sustainable evolution. Notwithstanding the advantages described above,

this study's findings align with existing international research that acknowledges the paucity of allied health clinicians in health system leadership positions (Colesby, 2024; McKeever & Brown, 2019; Mizzi & Marshall, 2024). This lack of diversity hinders allied health clinicians from stepping into health systems leadership roles. An intentional approach to fostering diversity and inclusion in health systems leadership would provide more opportunities for allied health clinicians to step into health systems leadership roles and deliver key benefits.

6.4 Part 3 – Creating a Culture to Thrive In

Part 3 explores the participants' experiences of how they are viewed by others and of their perceptions of health system culture. Under the headings of *The Untapped Potential of Allied Health Clinicians* and *Establishing Sustainable Leadership*, Part 3 focuses on the experiences of systemic bias, and how existing policies and processes either enable or hinder allied health clinicians from stepping into health systems leadership. The current study found that participants believed the health system governance mechanisms strongly influence the development, recruitment, and visibility of allied health systems leaders. Participants highlighted the untapped potential of allied health clinicians to strategically align health services with the emergent health paradigm. The findings underscore the need to raise expectations for governance forums to reflect the diversity of membership required for effective health systems leadership.

Part 3 discusses how systemic culture, health paradigm alignment and governance impact allied health clinicians' career journeys. The study indicates a pervasive culture of systemic bias against allied health systems leaders, manifesting in daily practices, policies, and processes. Participants identified organisational infrastructure as a contributor to systemic bias, citing the complexity of service design, legal requirements, and workforce resource management. Positive outcomes were observed when colleagues and governance forums understood and proactively involved allied health clinicians in delivering consumer-centric and timely community oriented services.

National and international literature calls for the global health system to embed allied health clinicians in health system leadership roles, and to shift perspectives to recognise their value (Boyce & Jackway, 2017; New Zealand Institute of Economic Research, 2021; NHS England and NHS Improvement, 2019a, 2019b). This integration is essential for evolving our health systems within the context of fiscal constraints, technology innovation and increasing population health needs (Dalton et al., 2023). Effective leadership facilitates culture change and transforms health and disability services to better meet population needs and expectations (Jackson et al., 2021; Watson et al.,

2024). While there is overlap in the discussion of systemic bias with elements of Parts One and Two, Part 3 uniquely focuses on holding the broader system accountable.

6.4.1 The Untapped Potential of Allied Health Clinicians

The current study produced compelling evidence of a misalignment between existing health systems leadership and the leadership perspectives required to align service design with the emergent health paradigm. Participants argued that their interprofessional education, practice and diverse connections enabled them to comprehend and practice a biopsychosocial model of health care, an inherent approach of allied health clinical practice that aligns with the emergent health paradigm of consumer-focused, outcome-oriented services (Ickovics & Park, 1998; New Zealand Institute of Economic Research, 2021; van den Broek-Altenburg & Atherly, 2025) (see section 1.5). There is a paucity of research focused on the alignment of allied health systems leadership with the emergent health paradigm. Nevertheless, existing literature illustrates that allied health clinicians' perspectives on consumer-focused outcomes equips them with the skills and capability to identify where service design may benefit the consumer, the clinician and the system (Barker et al., 2022; Manatū Hauora – Ministry of Health, 2023a; Musuza et al., 2020). Global healthcare systems are shifting towards an increased integration of services and systems, and international literature calls for a rethink of how leaders are recruited and equipped to lead consumer-centric, complex adaptive health systems (Wojtak & Goldhar, 2019).

National and international literature illustrates a close alignment between how allied health clinicians practice and the emergent health paradigm pursued by global health systems (New Zealand Institute of Economic Research, 2021; NHS England and NHS Improvement, 2022). The Triple Aim (Berwick et al., 2008) advocates for health systems to provide preventative interventions at reduced costs with customised experiences and, more recently, to achieve equitable health outcomes and enable workforce well-being (Nundy et al., 2022). Regardless of the evidence for allied health clinicians' potential to enable health system transformation, appreciating the value of professional diversity, this potential has not yet translated into health systems leadership practice and recruitment, which remains focused on nursing and medicine (Garman et al., 2020). To support health system transformation and align service design with emergent health paradigms, there need to be more allied health systems leaders contributing their knowledge and perspectives. The dominant view of specific professions leading and managing health systems needs to be challenged to enable allied health clinicians to assume health system leadership roles (Briggs & Isouard, 2016).

Participants in the current study were in agreement about the shortfalls of the health system culture in not recognising the value of allied health clinicians in health systems leadership roles. The predominance of medical and nursing professions in leadership roles, a lack of visible allied health role models and the limited publication of relevant research, negatively influenced participants' perspectives of their health system leadership capabilities. Public awareness and recognition of nursing and medical professions is typically greater than of the allied health professions (Nancarrow & Borthwick, 2021).

Participants shared examples of feeling compelled to apologise when introducing their professional identity in meetings, reflecting feelings of a lack of credibility and symbolic capital (Bourdieu, 1984). Bourdieu (1984) argues that an imbalance in symbolic capital translates into symbolic violence (systemic bias). This study's findings are consistent with this theory, as participants provided examples of exclusion and oversight of allied health clinicians. Furthermore, literature suggests that the dominance of medical and nursing professions in health systems leadership has become accepted as the norm (NHS Improvement, 2019). Participants believed this normalisation contributes to higher confidence levels among nursing and medical clinicians, who can continually draw on the knowledge and observations of their colleagues in health systems leadership roles. Eddison et al. (2023) found the absence of allied health professions within health systems leadership roles is associated with a lack of role models and mentors to inspire allied health clinicians to step into leadership roles.

Contemporary research advocates for the presence of role models, emphasising that awareness of how colleagues practice, interact, and navigate their interprofessional work environments enables clinicians to practice more effectively (Edmonstone, 2019; Jackson et al., 2021; McGrath et al., 2019; Mizzi & Marshall, 2024). Participants identified the paucity of research as a key factor in limiting knowledge and awareness of allied health role models. A wealth of international research supports the need for further studies on the contributions of allied health clinicians to health systems leadership, which would benefit and advance the professions (Eddison et al., 2023; Harding et al., 2024; Hillier et al., 2024; Watson et al., 2024). This study found that a lack of knowledge and awareness about allied health clinicians in health systems leadership roles is a limiting factor.

Participants were confident of the positive impact allied health clinicians have on health system outcomes for the consumer, workforce, and broader system. They argued that recognising their value would promote the development and appointment of allied health clinicians to health systems leadership roles. As discussed in Chapter 2 (see 2.2.4 and 2.3.3), international research clearly demonstrates the positive impact of allied health clinicians on consumer health outcomes, service

design, and interprofessional performance. The weight of literature emphasises the capabilities of allied health clinicians to enhance interprofessional practice and enable consumers to live well and integrate into communities (Mizzi & Marshall, 2024; New Zealand Institute of Economic Research, 2021; NHS England, 2022; NHS England and NHS Improvement, 2022).

The limited literature addressing the impact of allied health clinical value frequently misses the opportunity to advocate for the full potential allied health systems leadership has to offer. One example is an NHS report (NHS England and NHS Improvement, 2019b) based on interviews with Trust Boards regarding their existing allied health system leadership roles. This report took the opportunity to advocate for allied health systems leadership, but focused on leadership for the allied health workforce only (NHS England and NHS Improvement, 2019b). This focus did not tap into emphasising the allied health potential for leadership across the entire health workforce. The NHS report found overwhelming recognition by Trust Boards of the immediate impact of allied health systems leadership on services and systems, and presented five key recommendations for NHS Trusts to implement. All five recommendations underscored the need to increase allied health systems leadership presence.

The first recommendation suggested NHS Trusts appoint a substantive and strategically focused chief allied health professional for each NHS Trust, to help engage and enable the allied health workforce. A further recommendation was to give recognition to the allied health workforce's contribution and impact on services (NHS England and NHS Improvement, 2019b). This recommendation emphasised the allied health workforce as an untapped potential, fragmented and disengaged. The remaining recommendations urged health organisations to challenge historical practices on traditional roles, review governance arrangements, and address allied health leadership development and career pathways. The historical practices were identified as traditions perpetuating particular professions into leadership roles. The report contended that allied health clinicians were hindered from applying for health systems leadership roles and prevented the 'right skills being the right place at the right time for patients' (NHS England and NHS Improvement, 2019b, p. 6). The report sought to highlight the value of recruiting allied health clinicians into leadership roles to benefit the allied health workforce and ensure their contribution is not overlooked.

The report directly associated the recruitment of a chief allied health professional with achieving leadership recognition. This view of allied health systems leadership being promoted for the allied health workforce only was discussed in Chapter 2 (2.3.3). This self-limiting perspective misses the opportunity to encompass the full breadth of potential allied health systems leadership offers. In

spite of this limiting perspective, the report retained value in sharing influential insights and recommendations between NHS Trust Board governance members, and in raising the profile of the allied health workforce for leadership. Consistent with the current study, the report identified the need for greater recognition and increased recruitment of allied health clinicians into health systems leadership roles.

6.4.2 Establishing Sustainable Health Systems Leadership

The current study identified that allied health clinicians were reluctant to step forward for health systems leadership roles due to experiences of systemic bias and stigma associated with being an allied health clinician. Data revealed few positive incentives to attract allied health clinicians into health systems leadership roles compared to their nursing and medical colleagues. These findings corroborate the conclusions of Mizzi and Marshall (2024) and the combined work of NHS England and NHS Improvement (2019b), which highlighted the negative impact of hierarchical structures that favour medical and nursing professions for leadership career progression. This literature recommends challenging the historic practice where specific professions are recruited for health systems leadership roles.

In contrast, the literature addressing health systems leadership for nursing and medicine frequently emphasises incentives, including specialised training programmes, professional leadership credibility and organisational support (Faculty of Medical Leadership and Management, 2018; Howard et al., 2022; Lee et al., 2024). International literature argues that globally, existing health system design does not promote inclusive leadership or appeal to interprofessional leadership perspectives. Instead it permits male predominance, the legal emphasis on single decision-makers, and prioritises the system rather than consumer outcomes (Riche et al., 2023).

The reluctance of participants to assume health systems leadership roles may be attributed to an unappealing environment. Recent NHS reports illustrate the systemic bias against the allied health workforce, and call for challenging system-wide, taken-for-granted practices that may have historically marginalised or obscured allied health strategic contributions (NHS England and NHS Improvement, 2019b). Literature argues that incentives are a key driver for professional development (Wang et al., 2023), but this view suggests merely having a seat at the table (see 5.6.3) is insufficient if the surrounding cultural environment remains unchanged. Occupying a seat at the table may still feel isolating, require continuous challenges to the status quo and favour dominant voices. The findings of this study corroborate existing research, indicating that the cultural

environment must evolve to encourage allied health clinicians to pursue health systems leadership roles.

Research indicates that advertisements and recruitment for health systems leadership roles often emphasise nursing and medical professions in their role descriptions, job titles, and personal specifications (Mizzi & Marshall, 2024; NHS England and NHS Improvement, 2019b). Although these roles encompass the allied health workforce, literature suggests that the eligibility criteria for allied health clinicians are not always transparent (Mizzi & Marshall, 2024). This lack of clarity can deter allied health clinicians from applying, perpetuating the misconception that allied health clinicians are not interested in health systems leadership roles. By focusing on specific professions, the recruitment process narrows the pool of available talent, hinders the development of allied health systems leaders and limits an inclusive approach to sustainable leadership (Yarnall, 2011).

In alignment with existing literature, the current study found that systemic bias within health organisations, agencies and systems is rooted in established processes and structures (Mizzi & Marshall, 2024; Te Whatu Ora – Health New Zealand, 2023). The call for change in these mechanisms and the overall system culture is gaining traction in the published literature. Recent work emphasises the need for health systems to focus on the skills required for recruitment rather than specific professions, and to implement strategies that promote broader inclusion of the professions (Mizzi & Marshall, 2024; NHS England and NHS Improvement, 2019b). Consistent with the findings of this current study, Turato et al. (2024) identified that the inclusion of accessible organisational strategic roles enabled allied health clinicians to contribute positively to an organisation's objectives and performance.

Participants believed that those in health organisation governance influence organisational culture. They considered the development of a diverse and courageous leadership culture to be influenced by the governance forums that oversaw the workforce, systems, strategy, and design. Participants indicated that they held these forums accountable for setting the tone of organisational leadership culture and development. The negative impact of poor governance in health systems is globally recognised (Jiyenze et al., 2023), and the positive influence celebrated in successful outcomes is well established (McVeigh et al., 2016; Turato et al., 2024). As discussed in Chapter 1, this study used the concept of governance as determined by broader industry leadership focused on strategic issues (Institute of Directors, 2019). This means that when discussing governance for the purposes of this research, these positions are considered to hold accountability for strategy, direction and health outcomes. Appropriate governance arrangements need to ensure every part of the system is

ultimately engaged (Edmonstone, 2019), and successful strategies require diverse organisational leadership driving them (Smith & Johnson, 2023).

Where there is strategic organisational involvement, there are enhanced leadership development outcomes (Mucheru et al., 2024). Research has shown executive inclusion of allied health clinicians can support strategic workforce planning, add value to the business and achieve improved outcomes for the population (Mickan et al., 2019). The important role of governance for allied health systems leadership has been emphasised to NHS executive board members; collectively NHS England and NHS Improvement (2019b) make a critical point in their recommendations despite a representative focus rather than a broad systems leadership focus. They also identified the need to review existing governance arrangements to increase the visibility and engagement of allied health. The lack of allied health visibility at the executive level persists (Colesby, 2024; Eddison et al., 2023), and this lack of inclusion influences strategic decision-making and the ongoing provision of allied health services (Shahabi et al., 2023).

A lack of available data regarding allied health clinicians in health systems leadership roles is being addressed by emergent research on the inequitable representation of allied health clinicians in board membership. Boyce and Jackway (2017), Colesby (2024) and Eddison et al. (2023) have completed reviews of allied health clinicians occupying senior and executive roles in Australia and England. They have highlighted notable disparities across the membership of health organisations' governance forums. Their research identifies how well-embedded medical and nursing professions are, and highlights the inclusion requirements written into the constitutional requirements. Eddison et al. (2023) and Mizzi and Marshall (2024) point out that there is no obligation to include clinicians from other professions. In Australia, Boyce and Jackway (2017) identified an access gap but not an engagement gap; with an average of three times the number of leadership roles for medical personnel compared to allied health clinicians, they emphasised the allied health workforce remained in pursuit of sustainable visibility.

The lack of allied health clinicians within governance has been indicated to negatively impact inclusive strategic planning (Shahabi et al., 2023) and reduce engagement with the second-largest health workforce (NHS England and NHS Improvement, 2019b). As mentioned in Chapter 1, before the 2021 health reforms in Aotearoa New Zealand, consistent senior allied health roles existed at the executive level in public health services. These roles have changed due to the centralisation of services and a change in Government (Health New Zealand – Te Whatu Ora, 2025). The health structure continues to evolve, but the expectation for allied health inclusion within senior health systems leadership roles, across private and public services, remains (Manatū Hauora – Ministry of

Health, 2023b). Consistent with existing research, this current study found that health organisation governance influences the visibility of allied health systems leadership, allied health workforce engagement and the outcomes of health systems leadership development. In particular, the findings of this study highlight the crucial role governance plays in fostering a positive culture for allied health systems leaders to thrive in.

This current study makes a valuable and meaningful contribution to the knowledge and resources of the allied health workforce in Aotearoa New Zealand. Completing the study provided worthwhile opportunities to engage with allied health clinicians across Aotearoa New Zealand, and explore what was meaningful in enabling them to step into health systems leadership roles.

6.5 Strengths and Limitations

This study presents several strengths and limitations that have shaped the new knowledge discussed in this chapter. Initially, very little research had been completed in Aotearoa New Zealand on allied health clinicians in health systems leadership roles. Similar research has since been published in England (Mizzi & Marshall, 2024), and related topics have been explored in Australia and the United States (Dalton et al., 2021; Wiedman, 2023). This emergent field of research has gained momentum in both academia and government. Although much of the relevant literature is international, there is now a growing body of national evidence, which can inform the allied health workforce, health organisations and the government of Aotearoa New Zealand, regarding allied health systems leadership.

Within the context of the Doctor of Health Science (DHSc) Programme, the application of Interpretive Description methodology (Thorne, 2016) was a strength. This methodology has facilitated the design of an applied research study that is aimed at delivering tangible insights for practice. Chapter 7 presents recommendations derived from a synthesis of data analysis and existing research, critically examined within this chapter. These practical implications for practice are key outcomes of knowledge translation (Ocean et al., 2022). By setting out recommendations for change to practice, this research study marks the beginning of ‘something bigger, better, stronger, deeper and more critically informed than the status quo’ (Thorne, 2016, p. 282). Grounded in clinical experience and driven by an inherent pragmatism, there was a strong commitment to producing practical research outcomes. This commitment was motivated by the insider research position, the benefits of which were recognised as mutually advantageous. This motivation sustained the focus on ethical rigour and ensured the production of robust and relevant outcomes.

Applying the lens of appreciative inquiry supported a strengths-based approach to the interview questions, data analysis and interpretation, thematic development, and consideration of key findings. This approach was intentionally chosen to mitigate the influence of a deficit-based problem-solving perspective, which would have otherwise emphasised limiting factors and hindered the discovery of meaningful enablers. In spite of the strengths-focused design, participants were still able to highlight factors that impeded their transition into health systems leadership. They typically framed these insights as factors that could or should be in place to enable them. The use of appreciative inquiry was a strength for this research study and supported the accrual and interpretation of rich and relevant data.

In Chapter 6, the discussion of key findings included what could be implemented to address these hindrances, highlighting the existence of significant disadvantages for the participants. While this emphasis of the disadvantages contrasts with the strengths-based approach of the study design, it retains relevance for allied health clinicians, allied health systems leadership and health organisations. An alternate approach could have focused solely on enablers, disregarding limiting factors or the absence of enablers. Although this would present a more positive perspective, it might limit the depth of learning derived from the participants' insights.

The restrictions imposed during the COVID-19 pandemic were a limitation and precluded the possibility of conducting in-person interviews. However, most participants were comfortable connecting online and willingly engaged amidst the demands and pressures of the health response. The necessity of mask-wearing made it challenging to interpret non-verbal cues from a few participants during conversations. Nevertheless, high-quality data was gathered. Videoconferencing did not detrimentally impact data collection; the recorded visual interviews complemented the audio recordings and transcriptions used for data familiarisation. While in-person interviews offer advantages and are preferable when travel is feasible (Johnson et al., 2021), videoconferencing provides a viable alternative. Johnson et al. (2021) recommend weighing these options based on participant preference, data collection needs and the study's fiscal constraints.

The participants chosen were already engaged with a leadership journey, navigating obstacles and stepping into leadership roles. This meant the data obtained was shaped by their particular perspectives and insights, limiting the data accrued. There may be a lot to learn from those allied health clinicians who haven't yet stepped into such roles and other key informants who would have relevant insights to help understand how allied health clinicians are enabled. Accordingly a different researcher may have produced different findings with the same data and offer insights that have not been covered.

Throughout this research, a consistent emphasis on demonstrating rigour has been prioritised and remains a strength of this research study. This design emphasis stems from an appreciation of the insider research perspective and the use of reflexive thematic analysis. The insider research perspective informed the study design and facilitated access to participants, it created opportunities for rich data gathering and fostered an insightful connection with the findings. This approach aligned with and translated into the application of reflexive thematic analysis, an analytic method that encourages creativity in the reflection process (Braun & Clarke, 2022).

Another strength of this current study was the range of manual and software-based tools employed to map the evolution of the research process. The creation of tables, figures, and graphics included in the Appendices exemplifies this approach. Each element was intentionally developed to clarify the subjectivity involved and provide transparency of the active reflexive process. These methods demonstrate the integrity and rigour of this study, instilling confidence in the reflexive exploration of data and in the production of meaningful outcomes.

The diverse sample of participants was not intentionally designed to represent all 43 professions within the allied health collective. Given the qualitative nature of this study, the data was not expected to be generalisable or representative. However, the strength of this study's integrity ensures that the outcomes are transferable and applicable to the reader's context (Braun & Clarke, 2022). This transferability is premised on the meaningful connections identified between the audience or reader and the sampled participants. The findings and recommendations of this research are intended to be relevant to members of the allied health workforce who, within their own contexts, identify with the participants.

6.6 Chapter Summary

This chapter has contextualised key findings within existing research and identified the new knowledge contributed by this study. It explored how enabling the **Validation and Identity** of allied health clinicians as health systems leaders is foundational for engaging the allied health workforce in leadership roles. The study identified the importance of intentional relationships and networks, the value of knowledge and accredited development, and the critical need to acknowledge their leadership capabilities practically.

The impact of **Equity and Inclusion** revealed key disparities experienced by allied health clinicians in Aotearoa New Zealand. The absence of equitable workforce development for health systems leadership emerged as a key barrier to career progression. Intentional support was deemed essential for navigating indistinct career pathways. Recognising the value of diversity in health systems

leadership is consistent with existing research and is critical for enabling allied health clinicians to have a consistent voice at the table.

Creating a Culture to Thrive In addressed the impact of health system culture on allied health systems leadership in Aotearoa New Zealand. Greater visibility of allied health systems leaders' capabilities could inspire future leaders and enable them to support health systems to align with the emergent health paradigm. Finally, the study emphasised the need for governance forums to reflect the diversity called for in health systems leadership, address systemic bias, and strategically engage allied health clinicians in health systems leadership roles.

In fulfilment of this study's methodological coherence Chapter 7 examines the implications this new knowledge presents to practice. These implications take the form of recommendations and are the output of this current study's strengths and limitations and its position within existing research.

Chapter 7 Implications for Practice

7.1 Introduction

The intended outcome of this applied health research was to facilitate the discovery of new knowledge and provide insights that can advance practice. It addresses the research question: *How are Allied Health Clinicians Enabled to Step Into Health Systems Leadership Roles?* Chapter 5 and Six present novel findings in the context of existing research, distilling key insights that actively support the development of actionable recommendations for positive change in practice. This chapter builds on these insights to outline practice implications for enabling allied health clinicians to step into health systems leadership roles.

The choice to draw on Interpretive Description methodology was deliberately aligned with the pragmatic intention of translating this study's new knowledge into practice (Thorne, 2016), and the strengths-based approach of appreciative inquiry provided a positive lens (Cooperrider & Whitney, 2005). Framed as recommendations, the implications for practice presented in this chapter are grounded in the study's strength based approach and suggest practical actions for positive change across policy, practice and culture in Aotearoa New Zealand's health system.

Each recommendation will identify topics for further research. Relevant areas of knowledge that remain unexplored and would benefit from further exploration will be highlighted. Following the recommendations, this chapter presents the **Knowledge Contributions** generated by this research study. It will outline the novel findings produced, highlight additional insights provided to existing research and discuss new implications for practice developed from this study. The **Thesis Conclusion** will close this thesis and research study, summarising key findings and their significance.

7.2 Overview of Recommendations

The recommendations in this chapter are derived from both practical suggestions by participants and thematic findings. They are categorised under three main headings:

1. **Validate Allied Health Systems Leaders**
2. **Develop Allied Health Systems Leaders**
3. **Endorse Allied Health Systems Leaders.**

Each section presents key recommendations for enabling allied health clinicians to assume health systems leadership roles. These recommendations discuss the relevance, justification, and

challenges associated with their implementation. Table 11 provides an overview of the recommendations.

Table 11

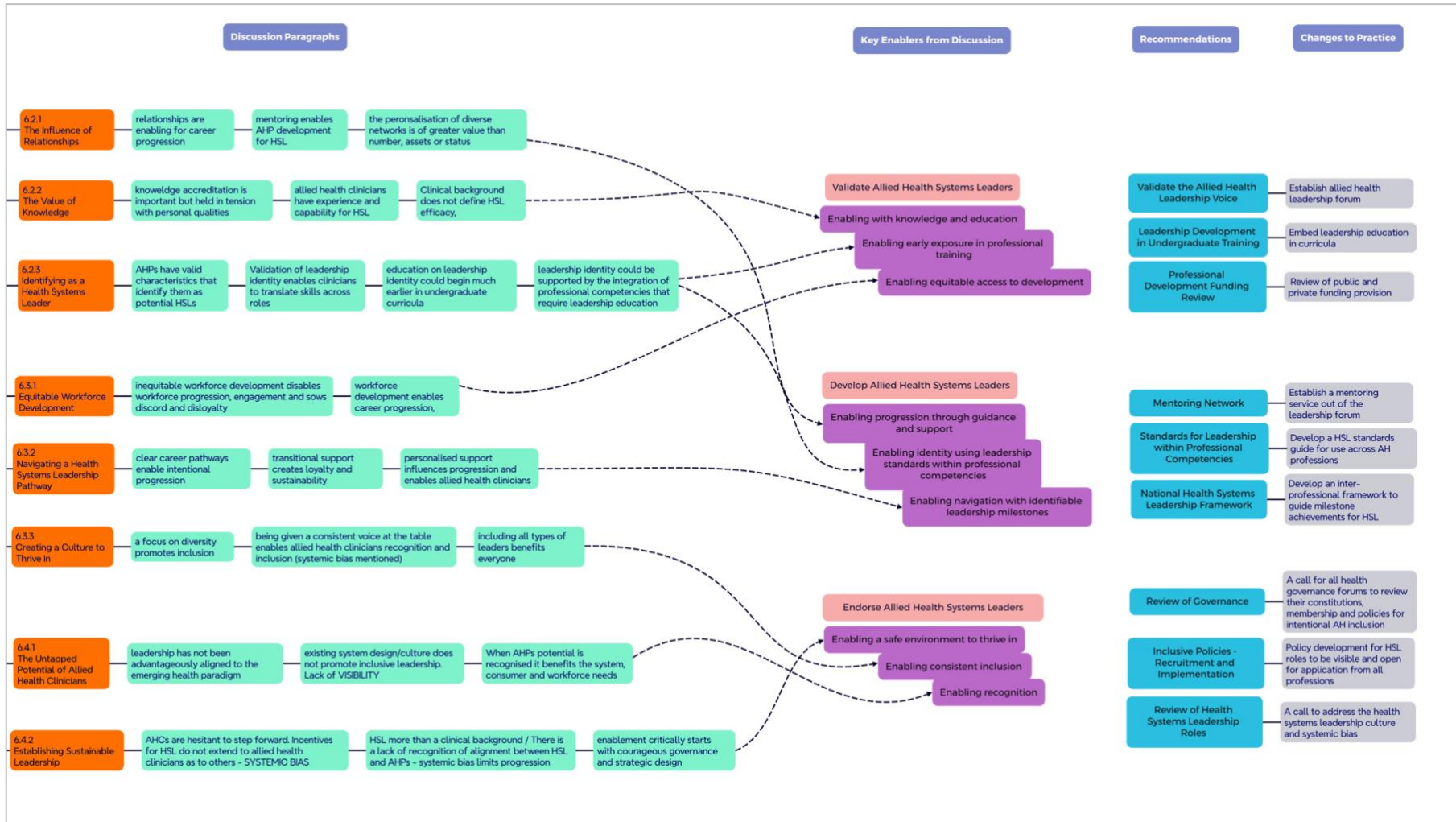
List of Recommendations

| |
|--|
| To Validate Allied Health Systems Leaders |
| <ul style="list-style-type: none"> Establish a National Allied Health Systems Leadership Forum Embed health systems leadership education within undergraduate training Review funding provision for allied health clinicians' professional development |
| To Develop Allied Health Systems Leaders |
| <ul style="list-style-type: none"> Establish a national mentoring service for aspiring health systems leaders Develop a health systems leadership standards guide for use across the workforce Develop an inter-professional framework to guide milestone achievement in health systems leadership development |
| To Endorse Allied Health Systems Leaders |
| <ul style="list-style-type: none"> Review health organisational and system governance to ensure a diversity of professions Review recruitment policy to ensure health systems leadership roles are open for application from all professions Develop and publish a position statement that outlines and emphasises the value of allied health clinicians in health systems leadership aligned with the emergent health paradigm |

Figure 16 (excerpt from Appendix H) illustrates how these implications are mapped back through the Discussion and connected directly with the Findings, ensuring they remain grounded in the study's results.

Figure 16

Illustration of Connections Between Discussion and Implications for Practice



7.3 Validate Allied Health Systems Leaders

The following recommendations outline three actions intended to validate and affirm allied health clinicians as health systems leaders. They are drawn from the data, participants' experiences and synthesis of discussion. The recommendations provide direction for health organisations, tertiary institutes, executive leaders and the workforce to help allied health clinicians identify as health systems leaders. Under the headings of *Allied Health Systems Leadership Forum*, *Undergraduate Education*, and *Equitable Access to Development*, recommendations are made for change to practice to enable allied health clinicians into health systems leadership roles.

7.3.1 An Allied Health Systems Leadership Forum

Participants believed the validity of relevant life experience, accredited knowledge, and personal attributes are key enablers for stepping into health systems leadership roles. They argued the clinical profession of an aspiring leader did not define their health systems leadership capability. It is recommended that ***a National Allied Health Leadership Forum be established*** to substantiate the existing network of allied health systems leaders in Aotearoa New Zealand and provide for the validity sought. This recommendation is aimed at allied health systems leaders employed across private, public and non-governmental organisations within the national health and disability system. Effective implementation strategies could include gathering connections through existing networks between allied health systems leaders, identifying an online platform for communication, and developing governance policies to underpin a sustainable forum.

The research revealed that participants needed help identifying as health systems leaders, justifying the need for a community of practice that distinguishes and validates allied health clinicians within those roles. A national allied health leadership forum would exist alongside similar forums for the nursing and medical workforce. Further research could explore how membership of a national allied health leadership forum impacts the identity of allied health systems leaders working across different sectors. This recommendation is based on data from seven of 43 professions within the allied health collective and may need to consider the impact of broader professional variation.

7.3.2 Undergraduate Education

Knowledge and education of health systems leadership raised awareness for participants about career options and supported the validity of leadership capability. It is recommended that ***education about health systems leadership is consistently embedded in the undergraduate training curricula across allied health professions***. This recommendation is for tertiary institutes, academics who contribute to allied health undergraduate training, and allied health professional councils that advise on curricula. Implementation strategies could include investigating what the medical and nursing workforce provides, along with

facilitating academic institutions, allied health systems leaders and professional councils to work collaboratively, to develop a consistent approach to appropriate educational content.

The findings indicated that early exposure to information about health systems leadership informed allied health clinicians about how their skills and attributes supported leadership careers. Without early exposure, there was hesitancy and a lack of confidence in stepping forward for health systems leadership roles. This highlights the need for the integration of consistent and tailored education about health systems leadership within allied health undergraduate training. Embedding this education is expected to improve the awareness of leadership careers for allied health clinicians and increase the number of allied health clinicians applying for health systems leadership roles. Further research could explore the long-term impacts of embedded leadership education on allied health graduates to determine if early exposure to their potential as health systems leaders does indeed impact their career choices. This recommendation is based on those allied health professionals who receive tertiary training in Aotearoa New Zealand.

7.3.3 Equitable Access to Development

The research identified the experience of inequitable access to professional development activities for allied health clinicians compared to their nursing and medical colleagues. It is recommended that ***a review of professional development funding sources for allied health clinicians across Aotearoa New Zealand*** is undertaken. This recommendation is aimed at Manatū Hauora – The Ministry of Health, chief executives of healthcare organisations and their governance boards, and allied health professional regulators.

Implementing this recommendation would include committing to the investment of a formal review, identifying disparities in funding sources, and designing a strategic response to address the inequities.

This study indicated that operational inconsistencies created inequities in professional development across the health workforce and discriminated against allied health clinicians regarding access to health systems leadership development. This situation justifies the need for a national review. Improved funding equity will increase allied health clinicians' ability to access professional development activities and enable health systems leadership development. Further research could explore how the inequities have impacted different subgroups of allied health professions, i.e. gender, ethnicity and less well-established professions, by investigating the demographics of current allied health systems leaders. The recommendation for a funding review is based predominantly on data from well-established allied health professions such as occupational therapy, physiotherapy, and social work. This recommendation may need to be adapted to ensure attention is given to all allied health professions regardless of size.

7.4 Develop Allied Health Systems Leaders

The following recommendations outline three actions that aim to develop and grow allied health clinicians as health systems leaders. Detail is provided under the headings of *A Mentoring Network*, *Professional*

Standards and A National Health Systems Leadership Framework. Each recommendation provides direction for health organisations, regulatory bodies, executive leaders and Hauora Manatū – Ministry of Health to guide, invest and equip allied health clinicians to step into health systems leadership roles.

7.4.1 A Mentoring Network

Progression into health systems leadership roles was enabled by the support and guidance provided through relational and interpersonal connections between allied health clinicians and their colleagues. It is recommended that ***an allied health mentoring scheme be established and made accessible nationwide***. This recommendation is aimed at existing allied health systems leaders across the health and disability system and emergent allied health clinicians interested in pursuing a leadership role. Implementation strategies could strategically align this network with the National Allied Health Systems Leadership Forum, acknowledge existing schemes, and develop policies to emphasise their focus on allied health professional development.

The research identified the positive impact of talent management and mentoring on improving confidence, affirming leadership identity, validating the skills of allied health clinicians. These positive impacts justify the need for a recognised mentoring network. Accessible and personalised support is expected to improve confidence and self-awareness and increase engagement in health systems leadership development. Further research should investigate the impact and outcomes of allied health workforce engagement with mentoring with a specific focus on health systems leadership in Aotearoa New Zealand. Furthermore, research could explore in more depth *how* mentoring might serve to enable allied health clinicians to step into health systems leadership, including *what works* for *whom* and *in what circumstances*. Such research would underpin an evidence-based approach to mentorship in this specific context. The recommendation for a mentoring network is supported by international research based on data from overseas, it may require adapting to a bicultural health sector.

7.4.2 Professional Standards

Participants found it challenging to balance their roles as health systems leaders with their allied health professional identities. They found it difficult to orient their health systems leadership identity within their allied health professional competency standards and were therefore challenged to retain both identities simultaneously. The recommendation is ***to develop a consistent set of Health Systems Leadership Standards*** for all allied health professions to sit alongside their individual professional competencies. Including a set of health systems leadership standards within allied health professional competencies makes health systems leadership explicit as a legitimate pathway for allied health clinicians and legitimises the identity of allied health systems leaders. This recommendation is aimed at professional regulatory bodies, existing allied health systems leaders, and regulatory policymakers. The approach to

implementation would benefit from partnering with allied health regulatory bodies and policymakers, working with an expert allied health system leadership advisory group, and developing resources to facilitate the adoption of new standards.

In this study participants felt it was hard to see themselves as health systems leaders, at least in part because it is absent from professional competencies and not embedded in the narrative of allied health professions. Furthermore, allied health clinicians in health systems leadership roles struggled to retain their visible identity as allied health professionals. Professional competencies and standards have an important role to play in determining what is privileged, given priority and foregrounded in curriculum, professions, organisations and practice. Further research could investigate how the integration of the allied health systems leadership standards within professional competencies impacts on allied health systems leaders and their colleagues. This recommendation for standards is based on data provided by the more well-established allied health professions and the medical workforce. The standards' development process will need to consider all 43 professions within the allied health collective and how integration is implemented.

7.4.3 A National Health Systems Leadership Framework

The research identified that allied health clinicians experienced a lack of clear career guidance for stepping into health systems leadership roles. This deficit was felt to dis-enable career progression. Therefore, it is recommended that a ***National Health Systems Leadership Framework be developed*** to guide allied health clinician's development into health systems leadership roles. The framework could provide a clear phased competency approach for allied health clinicians' development, helping them to orient themselves in their journey and identify the next step of career progression. This recommendation is aimed at Manatū Hauora—Ministry of Health, allied health systems leaders, and Health NZ. Implementation strategies may include aligning this work with the development of the professional standards for allied health and in relation to other frameworks for the broader health workforce. Utilising existing allied health and broader health systems leadership frameworks to inform the competency requirements (Australian Healthcare and Hospitals Association (AHHA), 2022; Dickson & Tholl, 2014; NHS England and NHS Improvement, 2019a) as well as investing in an expert allied health advisory group to unify the various stakeholders.

This current study found that the provision of clear guidance for allied health clinicians helped to identify the next steps in developing their allied health systems leadership career, justifying the need for a nationwide inter-professional framework. Improved clarity for career progression and competency expectations are anticipated to increase the number of allied health clinicians engaging with health systems leadership development. Further research could explore how the framework influences allied health clinicians to engage in leadership development activities. This recommendation is premised on data collected during the health reforms (Health New Zealand – Te Whatu Ora, 2022) and may need to be adapted to consider the reform's outcomes and plans for the Leadership Development Institute.

7.5 Endorse Allied Health Systems Leaders

Drawing on the experiences of organisational and cultural systemic bias and using the synthesis of the discussion, the following recommendations outline three actions that aim to embed and endorse allied health clinicians as health systems leaders. These recommendations are *Informed and Inclusive Governance*, *Diversify Leadership Using Skills-Based Recruitment* and *Future Focused Leadership*. Each recommendation provides information for health governance forums, executive leaders, and Hauora Manatū—Ministry of Health to navigate how to enable, facilitate and provide governance to endorse allied health systems leadership.

7.5.1 Informed and Inclusive Governance

This study revealed a culture of systemic bias against allied health systems leadership. The implicit bias frequently experienced impacted their inclusion and ability to contribute as health systems leaders. It is recommended that ***all health governance forums conduct reviews*** of their membership, constitutions, and processes to ensure allied health inclusion. This recommendation is for health organisations' executive board chairs and their directors, chief executives and Manatū Hauora-Ministry of Health. Strategies for implementation could include a national call for a review of governance led by Manatū Hauora-Ministry of Health as the peak health governance body. It could involve the development of inclusive membership policies and procedures and the development of governance strategies that set expectations of inclusion and parity in health systems leadership roles for all professions.

This research identified a burden of effort and time required by allied health clinicians to ensure they were included in decision-making and strategic planning and considered for health systems leadership roles. The experience of systemic bias within the health system culture justifies the call for a review of governance as the top tier of leadership culture. Inclusive policies and processes embedded within governance will help to change the culture and increase the consistency of inclusion of allied health systems leaders. Further research could investigate the broader impact of systemic bias on allied health clinicians across the health sector, investigating *what it means, for whom and in what context* the impact is felt. This recommendation outlines actions to instigate cultural change in healthcare. Embedding such change will require additional system and organisational structural and behavioural change with the support of policy and process.

7.5.2 Diverse Leadership Using Skills-Based Recruitment

Allied health clinicians experienced exclusion from opportunities that would enable their contribution to health systems leadership and where they felt their unique perspectives could have added value and strategic improvement. They particularly emphasised inaccessible roles and exclusionary recruitment processes. It is recommended that ***health workforce recruitment policies be updated*** to embed and promote equity in professional inclusion across all health systems leadership roles. This recommendation is

aimed at people and capability leaders, policymakers, and health organisation administration. Strategies for implementation should include partnering with people and capability leaders, offering informative workshops for the people and capability workforce and hiring managers, and developing policies that focus on equitable skills-based recruitment.

The research identified an access gap that emphasised a need for all health systems leadership roles to be visible and accessible for all professions to apply for, justifying an intentional review of recruitment policies and procedures. Broader inclusion for recruitment of health systems leadership roles will engage a wider pool of leadership talent and increase the diversity of professions in health systems leadership. Further research could investigate the prevalence of inequitable policies developed for health systems leadership roles to understand *how* health systems leadership roles are described, *what could work*, and *in what context* they would be most appropriately advertised. This recommendation requires collaboration with the workforce involved in recruiting health systems leadership roles. The transient nature of workforce personnel means that additional policy change is required for accessible guidelines and consistent training to be embedded within the organisation's workforce development programmes.

7.5.3 Future Focused Leadership

This study found a lack of recognition regarding the potential of allied health clinicians for assuming health systems leadership roles. This study recommends ***the development and publication of a position statement that outlines and emphasises the value of allied health clinicians in health systems leadership aligned with the emergent health paradigm***. This recommendation is aimed at the Chief Allied Health Professions Office (Manatū Hauora), allied health systems leaders and allied health research academics. Implementation strategies include establishing a partnership between the Chief Allied Health Professions Office and the future National Allied Health Systems Leadership Forum, as well as the formation of an expert advisory research group. Existing research could effectively inform the development of this position statement, and strategies for dissemination could include broad distribution and presentation of this information to health organisational governance forums and leadership teams.

This study found that when allied health clinicians' value was acknowledged, they experienced inclusion in health systems leadership and were recognised as future-focused leaders. This focus enabled them to contribute to health system designs which promoted innovative practice across boundaries to improve consumer outcomes, rather than perpetuating existing system limitations. This finding justifies a report specifically focused on raising allied health systems leaders' value profile and positive impact. Improved visibility and awareness of the allied health clinician's potential is expected to lead to purposeful action for the inclusion, recruitment and development of allied health systems leaders. Further research could explore the impact of systemic bias on allied health systems leaders through the investigation of perceptions and insights of health organisation leaders in Aotearoa New Zealand. This recommendation is

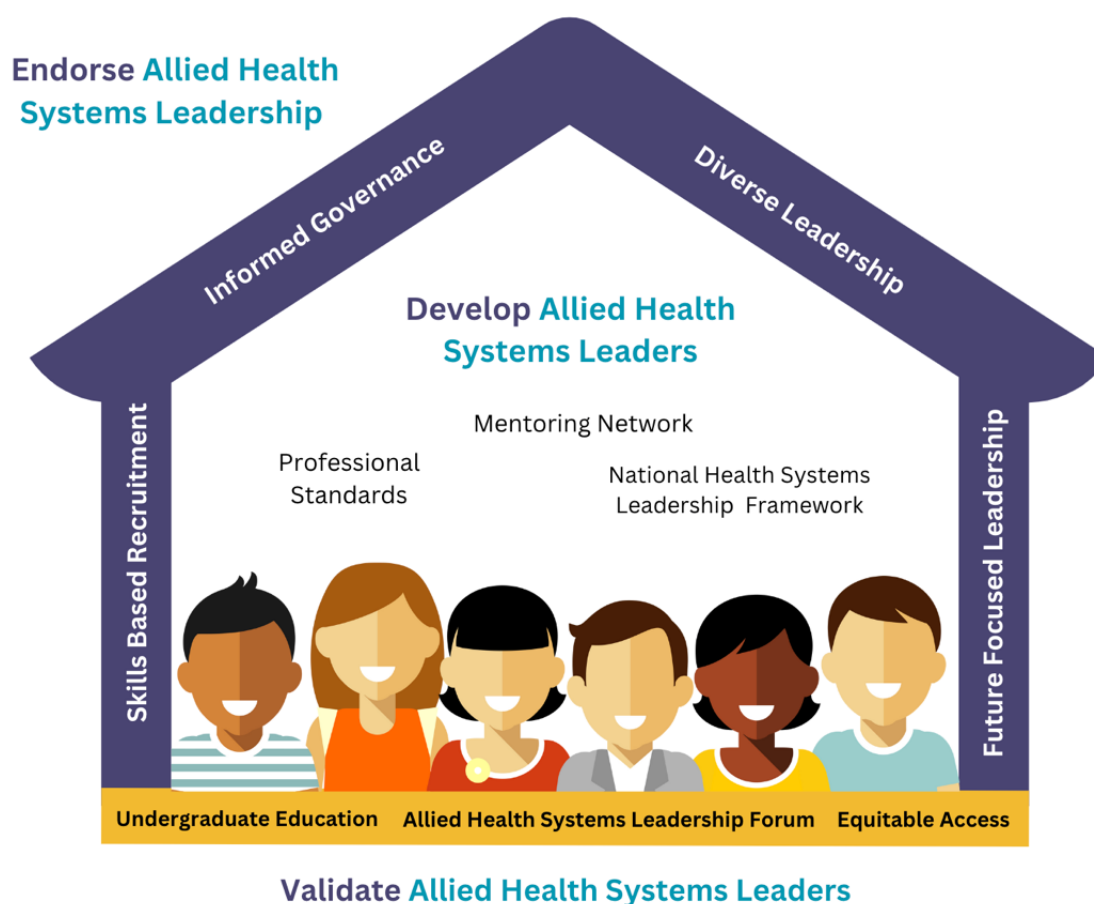
based on the perceptions of existing allied health systems leaders, and may need to adapt in response to future research capturing the broader perspectives of health organisation leaders.

7.6 Positioning the Recommendations

At the time of writing, Aotearoa New Zealand's health system is navigating the complexities of continuous change, compounded by the reforms initiated in 2021. This dynamic context presents numerous challenges for health system leadership as it strives to chart a coherent way forward. Simultaneously, it offers key opportunities to reshape the system. Implementing the above recommendations would strategically position allied health systems leaders to actively contribute to the transformation of the health system and so enhance health outcomes. The recommendations have the potential to influence the development and integration of new policies and processes, fostering a culture that enables allied health clinicians to step into health systems leadership roles. Figure 17 (below) illustrates that while each recommendation can stand alone, their collective adoption as a multipronged approach creates a robust enabling framework. This visual representation underscores the concept that embracing all the recommendations would establish an environment where allied health clinicians are well-equipped, informed and deeply embedded in health systems leadership roles.

Figure 17

Enabling Allied Health Clinicians into Health Systems Leadership Roles



7.7 First Steps for Implementation

The first steps for implementation to sustain momentum and translate these research outputs into actions are outlined below. These first steps are contingent on establishing connections with persons and communities beyond academia. The Health Research Council of New Zealand (2020) urges researchers across Aotearoa New Zealand to apply their research, using effective communication tools and practical action to achieve successful implementation.

7.7.1 A Community-led Inclusive National Allied Health Systems Leadership Forum

The first step to creating a critical core membership will be connecting with the existing professional leadership networks. These leadership connections will be found through Health NZ, the Aotearoa Allied Health New Zealand Association, and individual professional associations. The proposal information will emphasise the point of difference this network has to offer in uniting allied health clinicians who occupy health systems leadership roles nationwide. Communicating with these networks could initially invite expressions of interest in creating a small working group to set up this national forum. Connecting a smaller interprofessional working group could promote communications, prepare draft governance documentation and bring multiprofessional cohesion to the initial steps.

Once a proposal has been distributed, allied health systems leaders would be invited to attend an open meeting to discuss how to establish the forum. This would be an opportunity for suggestions and discussion of what the network could offer regarding connections, guidance, support and a platform for providing expertise to the broader health sector. Ideas for the forum's development could be shared, including the mentoring programme, a call to review professional development funding, and contributing to a health systems leadership development framework. The National Allied Health Systems Leadership Forum would seek endorsement from Manatū Hauora-Ministry of Health to substantiate a partnership for health governance. It would demonstrate and model interprofessional governance and sustainable future-focused membership. To position itself strategically within the global landscape and maintain an active national movement, connections could be made with similar forums in Australia, the UK and Canada. This process could lead to developing a global health partnership that promotes Allied Health Systems Leadership within global health systems.

7.7.2 A Network of Enabling Connections – a National Allied Health Systems Leadership Mentoring Programme

There are several mentoring programmes for the health workforce in place across Aotearoa New Zealand. They cater to specific genders, professions, or work environments, but a gap remains for allied health

systems leaders. A mentoring programme with a particular focus on allied health systems leadership would support engaging with existing allied health systems leaders to provide guidance, support, and advice, regardless of gender, context, or profession. It is recommended that such a mentoring programme align itself with the National Allied Health Systems Leadership Forum. However, a programme can also be established to exist independently using a similar method. This working group would be established through existing connections and may target members from key leadership groups. This would encourage collaboration and connection of expertise from across the health sector for the programme's development. Such collaboration would create a focused working group to generate the policies and procedures required to deliver a safe, quality programme that supports short- and long-term mentoring relationships. Once designed, the programme would be advertised through existing networks and across the allied health workforce community, and would work to recruit both mentors and mentees to engage in the programme, providing connections, structure, and evaluation. The working group would need sponsorship and endorsement for sustainable administration for ongoing development and operational delivery. Data focused on understanding the impact of the mentoring programme on both mentees and mentors would be collected. This process would provide ongoing information for continual improvement and ensure sustainable value and focused outcomes for allied health systems leaders.

7.8 Contributions to New Knowledge, Practice and Methodology

This research advances the understanding of allied health clinicians' involvement in health systems leadership. It represents the first known study to explore the mechanisms enabling allied health clinicians to step into health systems leadership roles in Aotearoa New Zealand. This section presents the novel contributions produced within the specific context of this research focus. Furthermore, where applicable, this study contributes new insights to the global discourse on the allied health workforce within health systems. The implications of these contributions extend beyond the local context, offering valuable perspectives for the international allied health community engaged in health systems leadership.

7.8.1 Knowledge Contributions

This research set out to explore what enables an allied health clinician to step into a health systems leadership role, from the perspective of existing allied health systems leaders within the broad Aotearoa New Zealand health system. The findings offer insights into the unique context in which allied health clinicians operate in Aotearoa New Zealand, and the extent to which health systems leadership is seen as a visible, viable and legitimate career pathway.

Allied health systems leaders experience daily practice within a culture of systemic bias. The operational infrastructure, normative behaviour and social expectations create an environment that overlooks allied health clinicians for health systems leadership. This environment limits their inclusion as health systems

leaders and restricts their recruitment for career advancement opportunities. These findings are new for Aotearoa New Zealand and add to the international literature (Mizzi & Marshall, 2024; NHS England and NHS Improvement, 2019b).

Compared to their nursing and medical colleagues, allied health clinicians experience inequitable access to leadership development. This finding provides an additional contribution of knowledge within the context of allied health systems leadership in Aotearoa New Zealand. It adds to the work of Mizzi and Marshall (2024) within the allied health workforce of the NHS, and of George et al. (2019) for the rural allied health workforce of Aotearoa New Zealand, who identified inequities of professional development. The emphasis of the current study indicates these inequities may lead to career limitations and perpetuate systemic bias for health systems leadership in Aotearoa New Zealand.

Allied health systems leaders experience difficulties developing a leadership identity that complements their professional identity as clinicians. Without clear guidance, they use a variety of strategies to explore, affirm, and validate what an allied health systems leadership identity means to them. This knowledge contributes to the emerging pool of literature regarding allied health systems leadership development (Dalton et al., 2021; NHS England and NHS Improvement, 2019a). However, the novel aspect of this knowledge clarifies the gap in supporting allied health systems leaders to shape their health systems leadership identity beyond their professional identity, highlighting the need to establish professional standards that support a health systems leadership identity in concurrence with professional identity.

Allied health clinicians use relationships to strategically guide and identify the direction of their career progression. Intentionally using connections, networks, and relationships to enable career progression is not a new phenomenon in business (Chollet et al., 2021). However, this is new knowledge regarding allied health systems leaders within the healthcare sector, influencing our understanding of their current career progression and highlighting the value they place on their interpersonal skills. This emphasises the importance placed on valuable contextual connections and highlights the absence of complementary mechanisms to enable guidance and direction.

7.8.2 Practice Contributions

This research has led to nine tangible recommendations for practice, underpinned by the perspectives of allied health systems leaders. The recommendations outlined in this chapter are purposefully constructed to ensure they are both actionable and usable. In each case, the intended target audience has been made clear, and consideration has been given to the context and data that has informed the recommendation. This purposeful approach will optimise the likelihood of uptake, with the intention of creating the context for allied health systems leadership to flourish in Aotearoa New Zealand.

Embedded leadership education in undergraduate training would enable allied health clinicians into health systems leadership roles in Aotearoa New Zealand. This knowledge is new for the country and would help to identify a broader range of future career options. Raising graduate awareness of the validity of pursuing health systems leadership roles adds to the existing international literature produced by Dalton et al. (2021), Kutz (2004), and NHS England (2023).

Implementing Health Systems Leadership Standards for adoption and use across the allied health professions in Aotearoa New Zealand would be a new contribution to practice. Health systems leadership frameworks have been adopted internationally to guide professional leadership development. However, there is no evidence of the application of consistent standards for allied health professions to address the practice of health systems leadership (Dalton et al., 2021).

Creating and establishing a National Allied Health Leadership Forum is a change in practice for allied health systems leaders in Aotearoa New Zealand. There is no national forum uniting allied health systems leadership across private, public, and non-governmental organisations, sectors and services. This contribution is based on the essential networks that participants emphasised, and their belief in important connections for development and progression, supporting the collaboration, visibility, and potential influence that allied health systems leadership can achieve nationally.

The creation of a focused mentoring network for allied health systems leaders in support of their development and progression would be a change in practice for the allied health collective across Aotearoa New Zealand. Similar networks exist in particular contexts, according to profession or gender, both nationally and internationally, but this particular change to practice is novel at a national level in Aotearoa New Zealand. The intention to provide a diverse platform of interprofessional expertise nationwide supports this research's findings of the need for greater visibility, validation, and profiling of the skills that allied health systems leaders practise.

A call to review existing recruitment policies and processes for health systems leadership roles is a novel contribution to practice. It is essential to adapt recruitment policies and processes to reflect an inclusive, equitable approach independent of an applicant's clinical profession. Changing practice to recruit equitably from the entire workforce will challenge implicit beliefs about health professions. This change in practice may be required only for some organisations, but it is a novel change and will contrast with existing exclusionary practices. A review is needed to identify the required changes and reveal the existing systemic bias.

An important contribution to change in practice is the call for a greater diversity of professions across health governance forums. This aligns with the practice changes recommended by NHS England and NHS Improvement (2019b), and Boyce and Jackway (2017). This change intends to broaden the access

opportunities for allied health system leaders' contribution at the governance and executive strategic levels for health organisations. This contribution to knowledge provides supplementary information to support allied health workforce development.

7.8.3 Methodological Contributions

Employing an appreciative inquiry lens with Interpretive Description is an innovative fusion of qualitative research methodology. This methodological synergy promotes a strengths-based approach to knowledge development for practice application. By leveraging a positive perspective, this combination facilitates research designs that acknowledge and constructively address the more negative experiences uncovered during the study. The lens of Appreciative Inquiry influenced all aspects of the research process including a) drawing out positive experiences were drawn out in interviews (e.g. how participants overcame obstacles), b) giving careful consideration to language during coding and in the interpretation of data (e.g. Finding that someone/Valuing your style), c) focusing on constructive and positive terms in thematic naming (e.g. Overcoming Bias); and d) focusing on creating and building enablers rather than breaking down or removing obstacles when forming recommendations. Consequently, the orientation towards generating positive outcomes is maintained, ensuring the research contributes to both theoretical advancement and practice change.

The graphic mapping of this research study's progression, from findings through discussion to recommendations, introduces a novel method for demonstrating rigour and clarifying subjectivity (see Appendices G and H). This approach to mapping knowledge development enhances transparency by clearly delineating the connections and illustrating the study's progression. Such illustrative mapping aligns with similar examples promoted as analytical methods. These examples underpin the implementation of Interpretive Description methodology with rigour, coherence, and quality (Thorne et al., 2004).

7.9 Thesis Conclusion

This thesis encapsulates a comprehensive research study focused on contributing new knowledge and practice for the allied health workforce in Aotearoa New Zealand. Personal experience provided the motivation and focus to explore allied health clinicians' views and perceptions of their health system leadership careers. The aim was to understand how allied health clinicians are enabled to step into health systems leadership roles (Chapter 1). Through the initial investigation of the literature in 2019, a gap was identified addressing the topic of allied health systems leadership for Aotearoa New Zealand. This gap presented a broad scope for investigation (Chapter 2).

International literature provided insights into the deficit of allied health clinicians across health systems leadership roles and health executive forums; an absence of equitable development was emphasised, and limited access to health systems leadership roles was highlighted. Allied health leadership frameworks,

guides and reports were pitched for leadership within the allied health professions workforce and with optimism for, rather than ownership of, the allied health systems leadership capability.

To fulfil the research aim and contribute new knowledge, the following research question was posed: **How Are Allied Health Clinicians Enabled to Step Into Health Systems Leadership Roles?** Three objectives were developed to focus this research study:

1. Explore and identify a breadth of enabling experiences
2. Develop an understanding of what and why those experiences were meaningful
3. Develop recommendations for change that will support and encourage allied health clinicians into health systems leadership roles

Each of these objectives has been achieved and evidenced through the content of this thesis and the rich data across a breadth of enabling experiences was developed into four themes (Chapter 5). These themes included **The Leader Within, Navigating the Next Step, Overcoming Bias** and **At the Mercy of Infrastructure**. Each theme was developed to explore the various ways participants felt enabled or not to step into health systems leadership roles. The interpretation of meaning investigated why those experiences were meaningful amidst the context of existing research (Chapter 6). These interpretations evolved into three topics of emphasis for discussion. They included **Validation and Identity, Inclusion and Equity**, and **Creating a Culture to Thrive In**. Appendix H provides an illustration clearly demonstrating the progression of thematic development, emphasising the connections between findings, interpretation and discussion, through to the recommendations (Chapter 7).

In total, nine recommendations were developed from the discussion and interpretation of this study's findings. The final objective was achieved by completing this process and using the rich insights developed from the research data. The recommendations were formed into three groups that reflect the evolution and sustainability of allied health systems leaders. These three groups emphasise the need to *Validate*, *Develop* and *Endorse* Allied Health Systems Leaders. Figure 17 illustrates the recommendations and emphasises that together, they create a robust framework for sustainable allied health systems leadership. Yet, individually, they can be developed to impact the allied health workforce in Aotearoa New Zealand and progressively build a sustainable future for allied health clinicians.

This study has focused on capturing allied health systems leaders' insights and experiences of the various ways in which they were enabled to step into health systems leadership roles. Social Constructionism was the foundation for Interpretive Description with a lens of appreciative inquiry. Together, they provided the framework for delivering an applied health research study exploring allied health system leaders' meaningful experiences. These methodological choices were evident in the structural scaffold that enabled

the transparent application of Reflective Thematic Analysis and a strengths-based approach to the interviews, analysis and reporting (Chapter 3).

The insights produced translate where allied health systems leaders exist and where allied health clinicians find alignment between themselves and the findings. The opportunities identified for further research reveal a broad array of issues that warrant exploration. These opportunities include: investigating the demographics of existing allied health systems leaders; exploring the impact of systemic bias on the allied health workforce; and examining how a national mentoring programme impacts allied health systems leaders and their leadership careers.

This research study delivered new findings for knowledge, practice and methodology (see section 7.8).

Table 12 summarises the contributions made to the field of allied health systems leadership:

Table 12

List of Contributions to Knowledge, Practice and Methodology

| Knowledge Contributions |
|---|
| Allied health systems leaders experience daily practice within a culture of systemic bias. |
| Compared to their nursing and medical colleagues, allied health clinicians experience inequitable access to leadership development. |
| Allied health systems leaders experience difficulties validating a leadership identity as an adjunct to their professional identity as clinicians. |
| Allied health clinicians use relationships to strategically guide and identify the direction of their career progression. |
| Practice Contributions |
| Embedded leadership education in undergraduate training would enable allied health clinicians into health systems leadership roles in Aotearoa New Zealand. |
| The implementation of Health Systems Leadership Standards for adoption and use across the allied health professions in Aotearoa New Zealand. |
| The establishment of a National Allied Health Leadership Forum |
| The establishment of a focused mentoring programme for allied health systems leaders |
| Review existing recruitment policies and processes to improve inclusive and equitable access to health systems leadership roles for all professions |
| Health governance forums to increase diversity of professions in health systems leadership |
| Methodological Contributions |
| The application of an appreciative inquiry lens with Interpretive Description Methodology |
| The graphic mapping of this research study's progression to illustrate transparency of rigour |

Notwithstanding the current health reforms and their impact on the health workforce in Aotearoa New Zealand, the novel findings and additions to existing research will inform the allied health workforce, allied health systems leaders, health executives, and health system organisations. The opportunity these reforms

provide regarding health system design, workforce alignment and service delivery contribute to creating a space for integrating this study's recommendations.

Conversations about allied health systems leaders need to continue. Health governance forums, executive leadership, policymakers, regulatory bodies, and tertiary bodies all have a role to play in changing the context and culture of allied health systems leadership. The challenges and opportunities have been identified; the onus is now on the system to partner with allied health clinicians and create an equitable and enabling environment where allied health clinicians can thrive as health systems leaders.

'If I continue to believe as I have always believed, I will continue to act as I have always acted; and if I continue to act as I have always acted, I will continue to get what I have always got.' (Anonymous, n.d.)

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Appendices

Appendix A. Ethics Approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics



TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

20 October 2021

Karen Webster
Faculty of Health and Environmental Sciences

Dear Karen

Ethics Application: **21/353 Building Health Leadership Capacity – enabling allied health clinicians to step into health systems leadership roles.**

We advise you that the Auckland University of Technology Ethics Committee (AUTEC) has **approved** your ethics application at its meeting of 11 October 2021.

This approval is for three years, expiring 11 October 2024.

Non-Standard Conditions of Approval

1. Use of the project title given on the Participant Information Sheet for all documents, including the advertisement, as this title is the one that most-accurately describes what is happening in this research.
2. Use of the current AUT logo and the AUTEC approval details in the advertisement.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: Nqq7212@autuni.ac.nz; Nicola Kayes

Appendix B. List of Allied Health Professions

Publications and Government documents routinely refer to 43 plus allied health professions (Manatū Hauora – Ministry of Health, 2019) but there is no published list. This list of allied health professions is not a formal record and may not be exhaustive.

| | |
|-----------------------------------|---|
| Anaesthetic technician | Orthoptist |
| Art Therapist | Orthotist / Prosthetist |
| Audiologist | Osteopath |
| Cardiovascular technologist | Paramedic |
| Chinese Medicine/Acupuncturist | Perfusionist |
| Chiropractor | Play Therapist |
| Clinical laboratory scientist | Pharmacist |
| Counsellor | Phlebotomist |
| Dental hygienist | Physiotherapist |
| Diagnostic sonographer | Podiatrist |
| Dietitian | Public health epidemiologist |
| Nutritionist | Psychologist |
| Electrocardiogram technician | Radiotherapist |
| Emergency medical technician | Diagnostic radiographer |
| Exercise physiologist | Recreational therapist |
| Genetic Counsellor | Renal dialysis technologist |
| Medical laboratory scientist | Respiratory Therapist |
| Medical Physicists | Social Worker |
| Music therapist | Diagnostic Sonographer |
| Neurophysiologist | Speech and Language Therapist/Pathologist |
| Occupational therapist | Surgical technologist |
| Operating Department Practitioner | Orthoptist |

How are Allied Health Clinicians Enabled to Step into Health Systems Leadership Roles?

Are you someone who leads within and across organisational and geopolitical boundaries, beyond individual professional disciplines, involving a range of organisational and stakeholder cultures, often without direct managerial control of resources and working on issues of mutual concern that cannot be addressed by any one person or agency? (Edmonstone, 2020)

This research is focused on enabling allied health clinicians to step into health system leadership roles. I invite you to share your experiences of stepping into a health systems leadership role.

You will be asked to complete an individual interview, approx. 60mins
The resulting data will be thematically analysed
You will also have an opportunity to contribute to the translation of findings into recommendations

Are you eligible?

To be eligible you must:

- Identify as an allied health clinician
- Align your role with the definition above

Register your interest at:

nqq7212@autuni.ac.nz

Or text 0211062185 by November 30th

The logo for Auckland University of Technology (AUT), consisting of the letters 'AUT' in a bold, white, sans-serif font on a black rectangular background.

Approved by the Auckland University of Technology Ethics Committee on 11 October 2021
AUTEK Reference number 21/353.

Appendix E

Participant Information Sheet

Date Information Sheet Produced:

September 2021

Project Title

How are Allied Health Clinicians Enabled to Step into Health Systems Leadership Roles?



Invitation

Kia ora,

Ko Schiehallion toku maunga
Ko Basingstoke Canal toku awa
No Ingarangi toku iwi
No Camberley ahau
Ko Christchurch toku kāinga ināinei
Ko Peter, Ben, Evie, and Alex toku whānau
Ko Becky George toku ingoa
Kia ora.

Schiehallion, in the Highlands of Scotland is my mountain,
The Basingstoke Canal is my river,
The English are my tribe
I come from Camberley
My home and roots are now in Christchurch
My husband is Peter, my children are Ben, Evie, and Alex
My name is Becky George
Kia ora,

Allied health clinicians have a diverse range of skills and a breadth of perspective across systems and professions. I am undertaking this research to find out how allied health clinicians are enabled to step into health systems leadership roles.

I work for the Ministry of Health as Clinical Director, in the Data and Digital Directorate. I am a professional mentor and am involved with or sit as Board Chair for several national forums i.e., Health Informatics New Zealand.

This research is being undertaken independently of my employment in my capacity as a student enrolled in the Doctor of Health Science (DHSc) programme, the DHSc is being privately funded. I am supervised by [Karen Webster](#), Senior Lecturer, Paramedicine, at Auckland University of Technology (AUT) and Associate Head Postgraduate; and [Nicola Kayes](#), Professor of Rehabilitation and Associate Dean Research and Director, Centre for Person Centred Research at AUT. In recognition of my employer and potential conflict of interest, please note that whether you participate or not will neither advantage nor disadvantage you or the organisation you work for or with.

You are invited to participate in this research project in alignment with the eligibility criteria.

What is the purpose of this research?

The purpose of this research is to find out about the enabling factors that have supported allied health clinicians to step into health systems leadership roles. By researching these enablers, it is intended that the findings will influence the development of, and support provided to future allied health leaders.

This research is part of the requirement for a Doctor of Health Science qualification. A literature review has already been published and the researcher intends to submit a series of articles over the course of this research, including the methodology and findings. The findings of this research may be shared in presentations.

How was I identified and why am I being invited to participate in this research?

You have received this information as part of the deliberate sampling strategy for this research. You may have identified yourself, been identified by a colleague, or your information is available in a public domain.

You are eligible for this research if you:

- Identify as an allied health professional, recognised by the [Ministry of Health](#), New Zealand.
- Align yourself to the role definition of 'health systems leadership' detailed by Edmonstone (2020)

"Leadership within and across organisational and geopolitical boundaries, beyond individual professional disciplines, involving a range of organisational and stakeholder cultures, often without direct managerial control of resources and working on issues of mutual concern that cannot be addressed by any one person or agency."

Participant Information Sheet 2/3

How do I agree to participate in this research?

If you are eligible to participate then please contact me using the contact details listed and I will respond. Once confirmed you will be sent a consent form to sign and return. Your participation in this research is voluntary (it is your choice) and whether you choose to participate will neither advantage nor disadvantage you. You can withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once analysis has commenced removal of your data is not possible.

What will happen in this research?

Once your consent form is returned you will be contacted to arrange an interview. This interview can be conducted in person or online, at a location of your choice. The interview will be expected to last no longer than 60 minutes. Initial demographic data will be confirmed and then the discussion will be guided by a series of open-ended questions. The demographic data collected will include gender, role title, ethnicity, and age and will be used to provide overall context for the participant sample.

The interviews will be recorded and transcribed. You will be offered the opportunity to review your transcription and share any additional thoughts or reflections. Reflexive thematic analysis will be completed, and the findings will be derived from these themes. The data collected will not be used for any purposes other than those outlined above.

What are the discomforts and risks?

It is not anticipated that participants will experience discomfort or embarrassment as a result of the researcher's questioning. The researcher will use positively framed questions in the interviews to support identifying positive experiences. However, participants may share information about their own leadership journey that they find upsetting.

Some participants may be worried about the level of confidentiality that can be maintained and express concerns about sharing some aspects of their experience.

How will these discomforts and risks be alleviated?

AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into the centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on <https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health>.

Each participant will be allocated an ID number and all information will be deidentified for analysis and thematic development. Your confidentiality will be maintained through secure storage of all data in accordance with AUT requirements.

What are the benefits?

The benefit of this research is the opportunity to contribute to and influence the future of allied health leadership development within the broader health system. It is recognised that the health and disability system of the future needs a sustainable leadership pathway. Your participation in this research is timely and applicable to the health and disability system reforms. Your participation in this research will enable the researcher to gain a rich and deep understanding of the influence and impact of enablers that support allied health clinicians stepping into health systems leadership roles.

This research also supports the researcher to achieve a Doctor of Health Science qualification from AUT.

How will my privacy be protected?

All data will be securely stored in accordance with AUT requirements and transcription services will be conducted under Confidentiality Agreements.

What are the costs of participating in this research?

If any financial costs are incurred for your participation i.e., travel to attend an interview, then they will be fully reimbursed. The interview process will take approximately 60 minutes. You may choose the time you contribute to reviewing your interview transcripts.

Participant Information Sheet 3/3

What opportunity do I have to consider this invitation?

Once you have been in contact with me you will be given as much time as you need to consider the invitation (at least two weeks) or until recruitment closes.

Will I receive feedback on the results of this research?

You will be contacted by email and offered a Summary Report of the research findings.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Karen Webster, karen.webster@aut.ac.nz, +64 9 921 9999 ext.6745 or 027 4458 267.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, ethics@aut.ac.nz, (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the consent form for your future reference. You are able to contact the research team as follows:

Researcher Contact Details:

Becky George, nqq7212@autuni.ac.nz, 0211062185

Project Supervisor Contact Details:

Karen Webster, karen.webster@aut.ac.nz, +64 9 921 9999 / 027 4458 267

Approved by the Auckland University of Technology Ethics Committee on 20th October 2021, AUTEK Reference number 21/353.

References

Edmonstone, J. D. (2020). Beyond healthcare leadership? The imperative for health and social care systems. *Leadership in Health Services (1751-1879)*, 33(4), 351-363. <https://doi.org/10.1108/LHS-02-2020-0005>

Appendix F

Consent Form

Project title: How are Allied Health Clinicians Enabled to Step into Health Systems Leadership Roles?

Project Supervisors: **Karen Webster**, Senior Lecturer Dept. of Paramedicine, AUT
karen.webster@aut.ac.nz

Nicola Kayes, Professor of Rehabilitation, Director of Centre for Person Centred Research, AUT Nicola.kayes@aut.ac.nz

Researcher: **Becky George**, Occupational Therapist, Clinical Director, Ministry of Health nqq7212@aut.ac.nz 0211062185

- I have read and understood the information provided about this research project in the Information Sheet dated September 2021
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped, video recorded (when online) and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes No

Participant's signature :

Participant's name :

Participant's Contact Details :

Date : _____

Approved by the Auckland University of Technology Ethics Committee on 20th October AUTEK Reference number 21/353.

Note: The Participant should retain a copy of this form.

Interview Questions and Demographic Information Collected

| | Question | Phase of Appreciative Inquiry |
|---|---|-------------------------------|
| 1 | What does Health Systems Leadership in NZ mean to you? What makes a good health systems leader? | Definition |
| 2 | Tell me about the experiences or events that inspired you to consider leadership. | Discovery |
| 3 | Can you describe an event or experience that encouraged you in your leadership journey? | Discovery |
| 4 | What factors supported you in achieving your leadership role/s? | Discovery |
| 5 | Tell me about when you overcame a challenge or limitation stepping into leadership. | Discovery |
| 6 | What possibilities do you see for future allied health clinicians leading health systems? Are there any roles or conceptual roles you would suggest? | Dream |
| 7 | What would it look like if you could design a system that was inherently enabling AH clinicians? Where/when would this enabling process start? | Design |
| 8 | What advice would you give to a colleague on a leadership journey? | Destiny / Delivery |

Demographic Categories

Gender

Ethnicity

Role title

Age

Profession



Appendix C

Confidentiality Agreement

For someone transcribing data, e.g. audio-tapes of interviews.


Project title: Building Health Leadership Capacity – enabling allied health clinicians to step into health systems leadership roles.

Research Question: How are allied health clinicians enabled to step into health systems leadership roles?

Project Supervisor: Karen Webster karen.webster@aut.ac.nz

Researcher: Becky George becky.george@hotmail.co.nz

- I understand that all the material I will be asked to transcribe is confidential.
- I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: 

Transcriber's name: Korina Tuahine

Transcriber's Contact Details (if appropriate):
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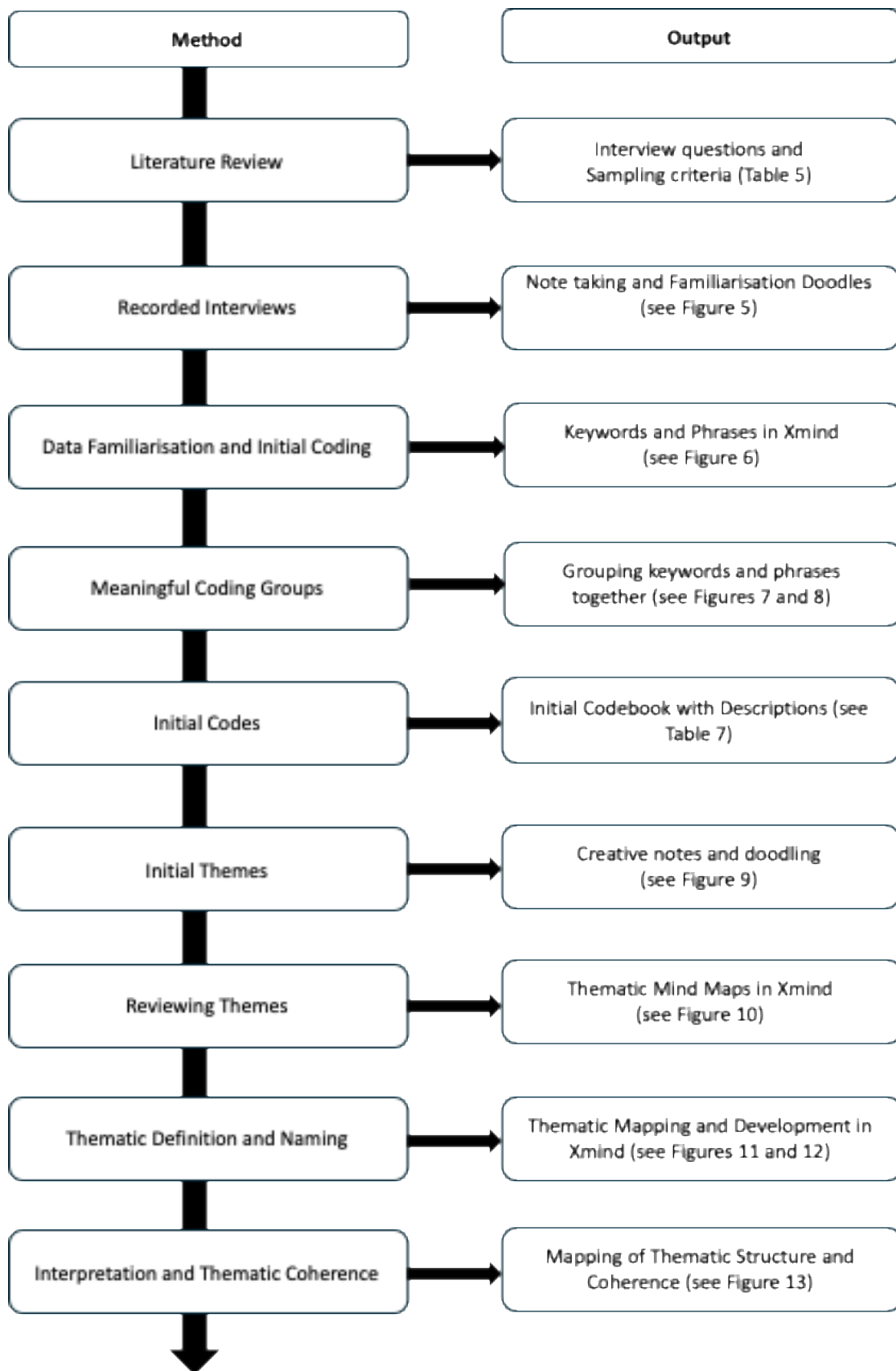
Date: 16/01/2022

Project Supervisor's Contact Details (if appropriate):
Karen Webster, [Karen.webster@aut.ac.nz](mailto:karen.webster@aut.ac.nz)
AUT +64 9 921 9999 ext.6745 or 027 4458 267

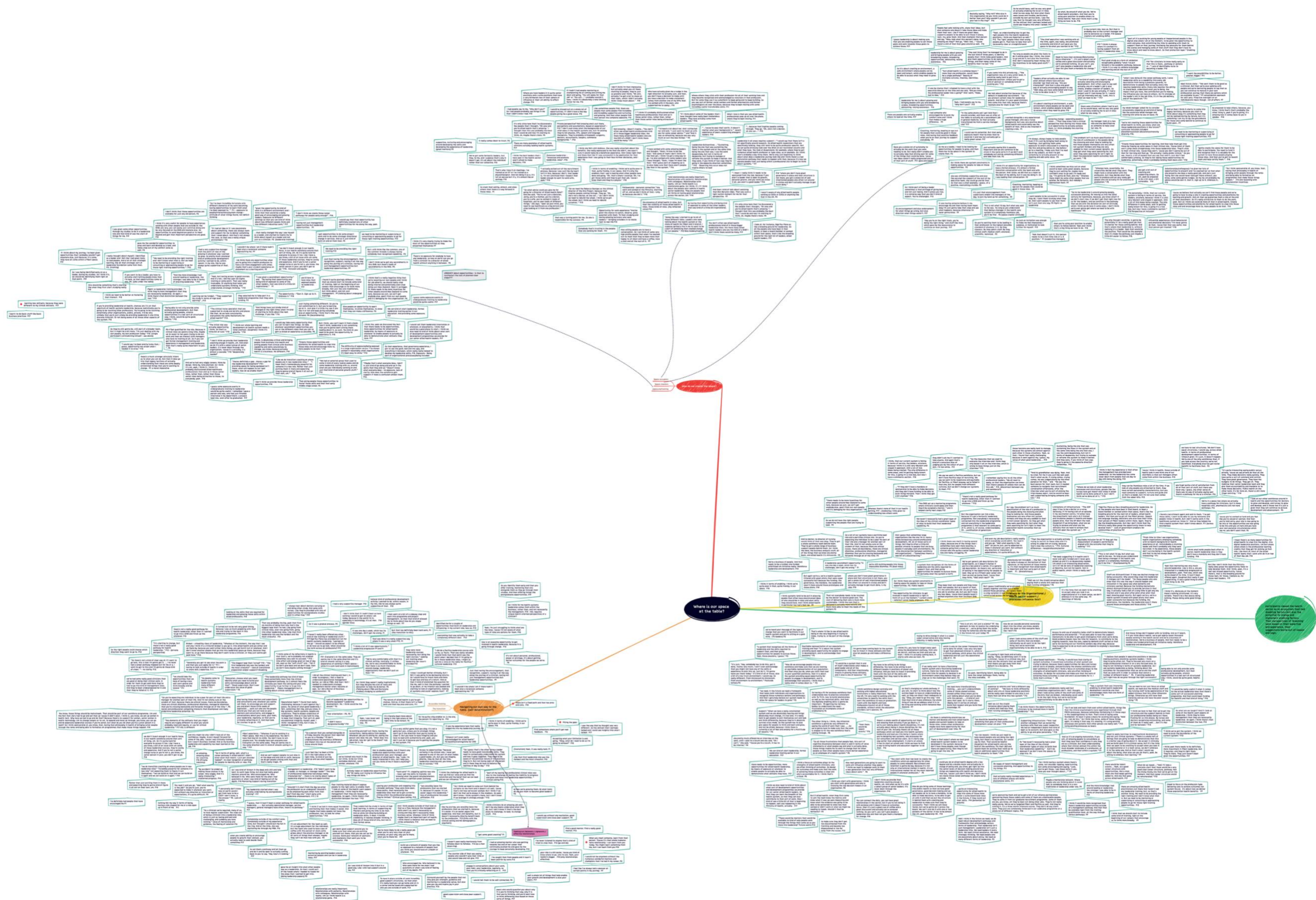
Approved by the Auckland University of Technology Ethics Committee on 20th October 2021 AUTEK Reference number 21/353.

Note: The Transcriber should retain a copy of this form.

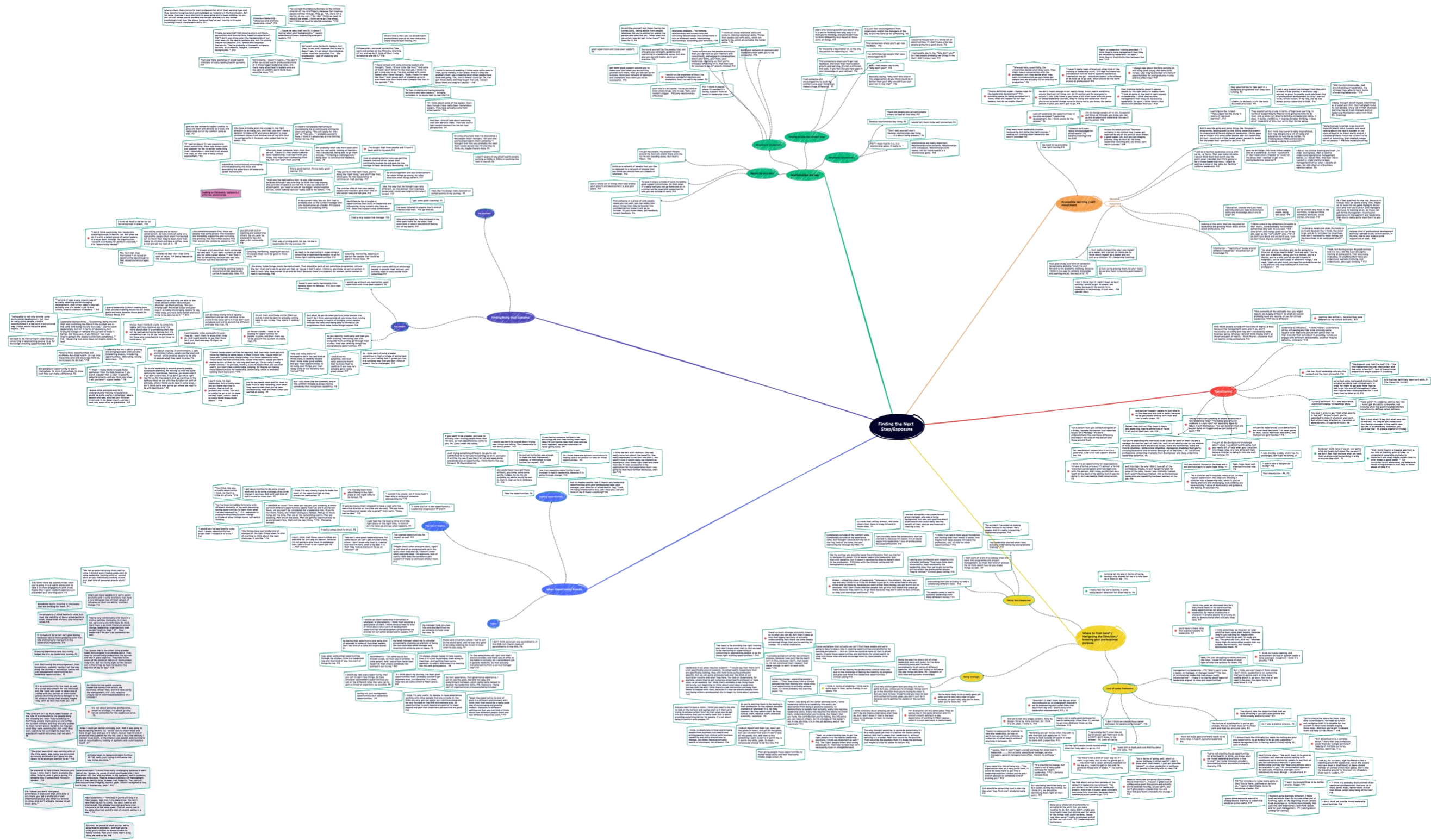
Appendix D. Vertical Chart Showing Relationship Between the Analytic Methods and Outputs Generated



Appendix E. Illustrative Mind Map of Thematic Review



Appendix F. Illustrative Mind Map of Thematic Development



Appendix H. Mind Map of the Evolution and Development of Thought from the Findings Through the Discussion to the Implications for Practice

