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# A Contestable Professional Development Fund: Interpretations of the Applicant Experience.

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## Abstract

This research was undertaken to understand health workers lived experience of applying for contestable professional development funding in the health sector. It responds to the World Health Organizations' (WHO) call for further inquiry into professional development funding (WHO, 2013). In this thesis, the literature on the landscape of professional development in Aotearoa New Zealand is considered in relation to the investment in national health workforce development. A comparison with global averages is explored as the background to barriers and enablers to health workers participation in professional development. Financial matters emerge as a significant and consistent barrier to engagement.

The thesis research consists of a qualitative study using Interpretative Phenomenological Analysis with an existential phenomenological lens. It is idiographic, making meaning of the lived experience of staff at Waitemata District Health Board in Auckland, New Zealand, as they apply to the organisation's Professional Development Fund (PDF). The study also explores views of the PDF as a system in the specific context, and the outcomes of the PDF on staff engagement and career development.

Consistent with Interpretative Phenomenological Analysis, the research was carried out with an insider view of the organisation since the researcher is a staff member of the District Health Board, an eligible applicant to the fund and a past PDF committee member. This has assisted in a double interpretation, making meaning of the participants' meaning-making, and in seeing more clearly the practical and theoretical implications of the research findings.

The study findings provide insight into workplace attitudes and behaviours towards contestable funding, the particular impact on lives at work and at home, the professional aspirations of adult learners, and the

tension between professional expectations and financial limitations. An interesting outcome of this research is the importance of usability in electronic application processes, particularly the need for clarity, time efficiency and a focus on the user experience.

Crucially, the findings emphasise the importance of investment in health workers' professional development and support the re-orientation of funding prioritisation towards the needs of workers. Although participants acknowledged the constrained financial landscape in the public sector, they identified the investment in continued professional development as critical for their career progression and satisfaction. Ultimately it seems that prioritising the needs of staff improves worker morale and wellbeing, in turn contributing to organisational success.

Although the PDF is contextually specific, it is one example of typical contestable funding mechanisms accessed for activities such as professional development and performance-based research. This means the findings have implications across workforce development in both health and academia, and can offer insight to inform the development or review of similar funding mechanisms.

## Table of contents

## List of tables



## List of figures

# List of appendices

Appendix 1: Approvals

a) Ethics approval with 1 non-standard condition
b) Full ethics approval
c) Ethics amendment approval
d) Locality (research site) approval

Appendix 2: Tools

a) Participant recruitment advertisement
b) Participant Information Sheet
c) Participant Informed Consent – focus groups
d) Participant Informed Consent – written responses
e) Indicative focus group questions
f) Transcriber confidentiality agreement

Appendix 3: PDF documents

a) Waitemata DHB PDF policy (Sept 2017)
b) PDF Applicants cover letter template (June 2017)
c) PDF Line Manager cover letter template (June 2017)
d) PDF Application checklist (Feb 2017)
e) PDF deadlines for 2018
f) Steps for applying to the Professional Development Fund (Sept 2017)

# List of abbreviations

| | |
|---|---|
| ARDS…… | Auckland Regional Dental Service |
| ASMS…… | Association of Salaried Medical Specialists |
| AUT…….. | Auckland University of Technology |
| AUTEC……. | Auckland University of Technology Ethics Committee |
| CME……. | Continuing Medical Education funding |
| CPD …….. | Continuing Professional Development |
| DA……. | Discourse Analysis |
| DHB…….. | District Health Board |
| DHSc……. | Doctor of Health Science |
| FAQS…… | Frequently Asked Questions |
| FG1, FG2, FG3……. | Focus groups 1, 2 & 3 |
| FTE…… | Full Time Employment |
| GDP…… | Gross Domestic Product |
| HPCAA…….. | Health Practitioners Competence Assurance Act |
| HWNZ…… | Health Workforce New Zealand |
| IPA……. | Interpretative Phenomenological Analysis |
| IT…… | Information Technology |
| MECA…… | Multi Employee Collective Agreement |
| NZ…….. | New Zealand |
| Occ H&S…… | Occupational Health and Safety |
| OD……. | Organisational Development |
| OECD…… | Organisation for Economic Co-operation and Development |
| PD……. | Professional Development |
| PDF…… | Professional Development Fund |
| PDP…… | Professional Development Plan |
| PhD…… | Doctor of Philosophy |
| PIED…… | Perceived Investment in Employee Development |
| RDA…….. | Resident Doctors Association |
| RMO……. | Resident Medical Officer |
| ROI…… | Return on Investment |
| SMO……. | Senior Medical Officer |
| WDHB……. | Waitemata District Health Board (in this document) |
| Waitemata DHB……... | Waitemata District Health Board |
| WHO…… | World Health Organization |
| WR…… | Written Responses |

## Attestation of Authorship

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 acknowledgements), 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.

Signed ……

## Acknowledgements

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Finally I express my gratitude to the staff at Waitemata DHB who participated and shared their stories and to the PDF Committee for being supportive and open to this study. This research would not have been possible without the generosity and compassion of the organisation, and in this I know that I matter.

## Intellectual property rights

## Ethical approval and locality authorisation

This study was approved by Auckland University of Technology Ethics Committee (AUTEC) on August 2nd 2017, approval number 17/256.

Waitemata DHB locality authorisation through the Waitemata DHB Research and Knowledge centre was granted on August 3rd 2017, authorisation number RM13747.

# Chapter 1: Introduction

This thesis presents a qualitative Interpretative Phenomenological Analysis (IPA) undertaken in order to shed light on health workers' experiences of applying for professional development funding in one District Health Board in the public health system in Aotearoa New Zealand. The study draws on the principles of insider research where the researcher's positionality supports connection with participants and contributes to the interpretation of their stories through personal experience and insights. The context for the study is Waitemata District Health Board (Waitemata DHB) in Auckland New Zealand, where there is a professional development fund (PDF) available by application.

This introductory chapter provides a brief summary of the New Zealand health system and situates Waitemata DHB as a publicly funded health provider. This is followed by an overview of health workforce professional development funding, along with an outline of Waitemata DHB's Professional Development Fund. The approach to the study and the researcher's positionality are introduced, followed by a synopsis of the chapters in this thesis.

## Study context

**New Zealand health system overview.** In Aotearoa New Zealand, health and disability services are delivered by privately and publically funded providers. The public system is divided into twenty districts across New Zealand. Each District Health Board (DHB) is responsible for planning, delivering, managing and purchasing health services for their region. The public services are delivered in hospitals, community and primary health, as well as through public health organisations. The DHBs administer around three quarters of Ministry of Health funding (Ministry of Health New Zealand, 2017a).

**Waitemata District Health Board.** Waitemata DHB is one of three DHBs in the Auckland region; it is the largest and one of the fastest growing DHBs in New Zealand. The population of the Waitemata district, over 600,000 people, are served by more than 7000 DHB staff across 31 locations in North and West Auckland (Waitemata DHB, 2016c).

**Strategic health-workforce professional development.** On their website, the State Services Commission articulates a high level of intent for building capacity and capability in the public sector in New Zealand:

> The Public Service needs to attract and retain highly skilled workers from an increasingly diverse and mobile labour market. Therefore the State Services Commission needs to ensure that the Public Service is well positioned to attract and retain a diverse and capable workforce. (State Services Commission, 2010, para 1)

The Health Practitioners Competence Assurance Act 2003 (HPCAA, 2003) is the legislation through which fitness to practice is regulated in the New Zealand health sector. The administration of the act is the responsibility of health registration boards (Ministry of Health New Zealand, 2003). In order to ensure patient safety, the Act requires that currency of practice be maintained throughout professional careers.

The New Zealand Health Strategy Future Directions (2016) recognises the importance of a highly skilled workforce as it proposes that the health system must *"*draw on the skills, professionalism and commitment of the health workforce so that we continue to make improvements" (Ministry of Health New Zealand, 2016b, p. 25).

The Northern Regional Health Plan (2016/2017) that relates to the Auckland and Northland regions specifies that "Ongoing investment in health service capacity and capability is required, both in the hospital and the community setting" (Northern Regional Alliance, 2016, p. 15).

Locally, Waitemata DHB generally takes a strategic view and aligns mandatory training with targeted areas of safety, patient need and health goals (Waitemata DHB, 2016c). The allocation of the Professional Development Fund however is not constrained in this regard and remains available for applications for aspirational training agreed between employees and their managers, and approved by the PDF committee.

**National health workforce funding.** Public funding for post-entry health workforce development in New Zealand is largely administered through Health Workforce New Zealand (HWNZ) a funding and administration function of Vote Health, which is the funding arm of the Ministry of Health. Vote Health equates to 6% of gross domestic product (GDP), of which the allocated funding for health workforce development amounts to around $185 million or 1.1% of the total Vote Health budget (Health Workforce New Zealand, 2016; The Treasury New Zealand Government, 2017).

Workforce development funding is distributed to the DHBs through a contract for services model, with funding amounts varying across different DHBs. The total value of each DHB's contract is indicative of the numbers of trainees in each organisation; the amounts allocated to each DHB are not publicly available. However, the national percentage of funding allocated to each professional group is provided by the Ministry of Health. Sixty-three percent is allocated to training junior medical workforce (house officers and registrars), 21% to nursing, 3% to midwifery, 2% to allied health, scientific and technical professions, 12% to mental health and addiction services staff, 2% to providers of disability support, 2% to Māori and Pacific staff and 4% is allocated to a voluntary bonding scheme (Ministry of Health, 2017b). The funding supports training positions, including salaries and associated costs of professional development for the training roles. The money is allocated by HWNZ to the DHBs who invest in an agreed number of trainees

proportional to the percentages given above (Health Workforce New Zealand, 2017).

In 2016, the Ministry of Health, under a National (centre right) Government, proposed a change from the current contract model to a fully contestable model assessed against performance indicators. They expressed their intent to introduce this return on investment approach in stages, initially with ten percent contestability of the fund, gradually increasing to the entire $185 million (Health Workforce New Zealand, 2016). A consultation on this change was undertaken, and whilst most respondents agreed to a review of the funding model, the proposed options, the rationale to support the review and even the consultation process were criticised (Health Workforce New Zealand, 2017).

Despite this, and a newly elected Labour-led (centre left) government taking office and instigating a health system review that may further change this landscape, HWNZ has initiated the first step in their plan. A top-slice of ten percent of the post-entry training funding has been dedicated as a contestable innovation fund accessible to training providers from both the health and health education sectors. Not surprisingly by broadening sector access an overwhelming number of applications have been made, and as a result the application decision-making process has been delayed (Ministry of Health, 2017b). Arguably, this does not bode well for the planned revision of the entire funding model towards contestability. It also indicates that the demand for training amongst health workers has been greater than expected, suggesting that the overall funding commitment requires further consideration.

It is also worth noting that HWNZ provides a separate contestable fund dedicated to the furtherance of careers in nursing and Māori health. Applications can be made annually by individuals, and eligible employees working at Waitemata DHB are able to apply to both the

HWNZ fund and the PDF, although in-house committees review and rationalise the applications to both funds.

Whilst a significant proportion of investment in staff training comes through HWNZ, it is also the case that the DHBs' financial commitments extend beyond these contracts. For example, mandatory training such as health and safety and infection prevention and control are often provided through online learning, developed by in-house learning design teams. Other in-service or in-house face to face training, for example Grand Rounds and team training sessions delivered by staff, might occur in education or conferencing facilities provided by the DHB.

A national inquiry into all DHB spending on staff development is beyond the scope of this study; however, a brief review of DHB website content was undertaken. This revealed that all 20 DHBs offered information regarding the HWNZ contestable fund for nursing and Māori health workers, whilst three also featured application forms for funding through service budgets and two had philanthropic grants and scholarships listed. All DHBs offered in-house training and online learning. Many had training units and/or education centres and facilities but only Waitemata DHB provided information about an in-house contestable fund. Waitemata DHB also has education facilities, online learning, and a number of teams dedicated to learning and development. In addition, there is ongoing in-service training organised by clinicians working in the clinical services. In conclusion, DHB spending on staff training appears to extend beyond allocated HWNZ funding; an interesting next step might be to inquire about the extent of investment in each DHB, providing a more holistic view of CPD investment in New Zealand's health sector.

Although the full extent of this investment is not easily visible, HWNZ dedicated funding (1.1% of vote health) is low compared to the global average of two percent (WHO, 2013). Despite this comparatively low

level of investment, State Services Commission data shows that the health workforce is the 3rd most highly qualified professional workforce in New Zealand, with 56% of employees holding undergraduate or post graduate degrees (State Services Commission, 2016, p. 24). This suggests that personal investment from employees, commitment from DHBs as employers and HWNZ funding all contribute to a high-quality workforce. In addition, it is important to make the connection with funding through Vote Education, which subsidises the tertiary qualifications of workers, adding yet another facet to the considerable public investment.

**The Professional Development Fund at Waitemata DHB.** The Professional Development Fund (PDF) at Waitemata DHB was established in 2014 with the following express purpose:

> Waitemata DHB's purpose and values shape the development of our organisation and workforce. Consistent with the value of 'everyone matters' (in this case, staff) Waitemata DHB's chief executive has established a centralised budget to enhance staff access to professional development opportunities. (Waitemata DHB, 2017b, p.1)

The PDF enables access to funding for those staff not entitled to professional development funding through their collective employment agreements. It supports aspirational learning such as tertiary study, external courses and conferences. It does not replace funding for mandatory training or education required to enable service delivery which remains in the DHB service budgets. Eligibility to apply to the fund relies on 12 months service in a permanent role, support of direct managers and up-to-date organisational mandatory training and professional development plans. The fund is administered by a committee comprised of representatives of the eligible professional groups. The committee reports to the Waitemata DHB Education Governance Committee which in turn reports to the Senior Management Team.

Since the PDF was established, the committee has considered a wide range of funding applications with varying outcomes, including those that have been approved, those that have required resubmission, those re-directed to other funding sources and those that have been declined for a variety of reasons. The differing outcomes of applications would suggest varying applicant experiences. Whilst there has been demographic and financial analysis of the PDF, a study of staff experience has not been undertaken until now.

My study enquires about:

- Perceptions of the PDF as a system within the context of Waitemata DHB.
- The experience of staff members in applying to the PDF.
- The outcomes of the applications in terms of career progression and the impact on staff engagement.

The PDF Committee was invited to contribute to the design of the study through a consultation in the planning stages which is the full extent of their involvement in the study. The committee have received progress reports and will receive a final report on the study outcomes.

## Research overview

**Study question.** What is the experience of applying for contestable professional development funding for health workforce employees?

**Study rationale.** This study came about as a result of time served on the PDF committee when I gained a new perspective on the decision making processes of the panel. I became interested in the outcomes of decisions, particularly on applicant experiences, and engagement with both learning and the organisation. Around the same time I was asked to contribute to a national consultation on post-entry

workforce funding. These two experiences were instrumental in bringing my attention to this topic.

In my interest in conducting this research I perceived a number of potential contributions; to add to the academic conversation by shedding light on health workers' personal experiences of seeking financial assistance for continued professional development; to inform the national conversation around moves towards contestability; and to provide Waitemata DHB with an evaluation of the PDF from the applicants' perspectives.

**Participants.** The participants in this study are members of staff working at Waitemata DHB who have applied to the Professional Development Fund. Excluded are direct colleagues as well as those who were applicants during my time on the committee.

**Researcher Positionality.** Throughout my twenty seven year career in health and health education, I have worked across disciplines and I am passionate about enabling quality education for health sector workers. This passion created the impetus for the study.

As a member of staff at Waitemata DHB I am an insider in the organisation. I have an emic view, having been an applicant and recipient of the fund, a committee member in the past, and a peripheral observer at the time that the PDF was established. Whilst I acknowledge that my positionality has no doubt flavoured the work, I have attempted to remain mindful and reflexive of my assumptions in my interpretations. This is an important consideration in insider research that is counterbalanced by rapport with participants through contextual insights which can enhance and enrich the study (Merriam & Tisdell, 2016). This reflexivity is also customary in my chosen methodology, Interpretative Phenomenological Analysis (Smith Flowers & Larkin, 2009).

**Philosophy.** The research is based in a holistic phenomenological approach to the experience of being an applicant of the PDF at Waitemata DHB. This reflects the belief that the lived experience is multidimensional and encompasses the physical, mental and situated experiences of being human (Smith et al., 2009). While this allows researcher flexibility in the philosophical underpinnings, the research is primarily understood through an existential lens, which is influenced by the work of Martin Heidegger (Moran, 2000).

**Methodology.** Interpretative Phenomenological Analysis (IPA), the methodology for this study, is a qualitative methodology that is useful for illuminating the specific in its broader context. This methodology is based on an idiographic hermeneutic phenomenological epistemology that supports a detailed focus on individuals with a common experience in their particular context (Smith et al., 2009). Thus IPA methodology acknowledges that the previous life experiences of individuals will colour their perceptions and stories, that the researcher's ontology is intersubjective since he/she exists with the participants and makes meaning through self-reflection, and that this inter-subjectivity grounds the interpretation of the participants' accounts in shared experience (Larkin & Thompson, 2012; Smith, 2011).

This study is guided by the work of Smith et al. (2009) who offer a 'road map' to the novice researcher for the systematic undertaking of the work (Smith et al., 2009, p. 41). IPA offers a pragmatic approach not commonly found with other phenomenological methodologies (Pringle, Drummond, McLafferty, & Hendry, 2011). The choice of IPA for this study was influenced by its congruence with the intentions of the study and my philosophical approach as the researcher, and by confidence in the methodology which resonates with my personal work preferences such as pragmatism and process.

**Method**. When collecting data for an IPA study, the participants must be able to voice their experiences and tell their stories. As a result, individual interviews are often used to collect the data. However, focus groups are an increasingly popular method used in IPA because of the richness created through shared stories within the group (Palmer, Larkin, de Visser, & Fadden, 2010). Participants are able to tell their stories, relate to the stories of others, and increase sense making through their shared experiences and ideas. Thus the group's mutual collaboration increases thematic resonance and arguably the potentiality of the findings (Palmer et al., 2010).

My primary method of data collection in this study is focus groups. Those with funded applications were in separate groups to those with declined applications. Written responses were also received from those who wished to contribute but were unable to attend focus group sessions. The written responses were analysed alongside the transcripts and recordings of the focus groups. They provide further depth of understanding and a means of triangulation, therefore supporting the trustworthiness of the study.

**Data analysis.** A comparative thematic analysis using an iterative approach identified the themes in the transcripts and written responses, which were initially treated as individual cases, after which I considered the overall themes from the data as a whole. Reading and re-reading supports a detailed thoughtful examination of the phenomenon from the point of view of the participants. Consistent with IPA, this process then extends to include personal insights and interpretations, expanding the data for an in-depth appreciation of the area of interest (Pringle et al., 2011).

**Study findings.** Three main themes emerged from the findings, each with three subthemes. Within the first theme, 'Blind spots', the unknowns about the PDF, the committee and their assessment criteria

emerged. This theme looked at communal narratives, team strategizing and collective approaches taken to navigate these unknowns. Theme two, 'The applicant in context' focussed on individuals; it shed light on the impact of funding on life at home and at work. Personal sacrifices made to maintain high levels of competence and the importance of professional validation, peer esteem and investment in a high-quality work force emerged within this theme. The third theme, 'Systems matter' considered the PDF application process in context; human factors in systems design, compassionate systems design and connectedness were all factors here.

**Discussion and conclusions.** In the discussion, identified themes are expanded, layered with personal experiences and views, and discussed in relation to relevant literature. The implications of this study relate to workplace attitudes and behaviours towards funding for professional development. They emphasise the need for a shift in thinking towards the importance of investment in health workers, supporting the idea that prioritising the needs of staff improves worker morale and wellbeing which in turn contributes to organisational success.

This contextualised study provides an example of the applicants' experiences of applying for contestable funding which has implications for the design of other such funding systems. This means the findings have cross-sector and multi-discipline implications for the development or review of funding mechanisms.

## Summary

This chapter has outlined some background information, the study rationale, approach and implementation, and a brief synopsis of the main findings. The following chapter reviews current literature related to professional development funding in the context of New Zealand's health sector. The third chapter explains the philosophical and methodological

underpinnings of the research approach and study design as well as the data gathering and interpretation. The fourth chapter details the study findings, and the fifth chapter is the discussion which expands on the findings, synthesises them with the extant literature and identifies the contribution that this study makes to the existing body of knowledge. Chapter six states the implications of the findings and the importance of the research locally, nationally and internationally. The limitations of the study and a summary can also be found in chapter six.

# Chapter 2: Literature review

## Literature search

An Auckland University of Technology online library database search using variations of key words and phrases was undertaken. The search terms included: Professional development, professional learning, continuing education, workforce education, fund*, grant*, subsidy, organisation*, company, institution*. This yielded 1774 articles.

The search was narrowed by adding 'health sector' which reduced this number to 68 articles; titles and abstracts of the results were reviewed and 38 articles were found to be relevant, six of these being New Zealand based studies. Following a review of the academic literature, New Zealand health sector strategic plans and documents were also reviewed; these are detailed later in this chapter.

## Professional development literature review

Health professionals with legislatively mandated 'responsible authorities' require annual practicing certification, attainment of which relies in part on the ability to evidence achievement of prescribed levels of continued professional development. For workforces where professional registration is not a requirement, appropriate qualifications, experience and currency of practice remain fundamental in the provision of safe quality services. This is a primary motivator for investment in health professional development.

Despite the acknowledged relationship between currency of practice and patient outcomes (Hastings, Armitage, Mallinson, Jackson, & Suter, 2014) driving the need for health services to devote funding to building workforce capability, the literature relating to professional development in the health sector is limited (WHO, 2013). Indeed, commentary in grey literature from the United Kingdom where Continuing Professional

Development (CPD) funding cuts have recently been debated laments the lack of research on the value of investment in CPD (Kleebauer 2016; McQueen, 2017).

Some studies focus on investment in professional development from the perspective of the organisation. For example, Kuvaas and Dysvik (2009) developed a five-point Likert scale survey to measure Perceived Investment in Employee Development (PIED) which they tested with 400 nurses in two countries. They then undertook three cross-sectional surveys of employees ($n = 826$) in Norway to assess the relationship between organisational performance, staff engagement and perceived commitment derived from training investment, and individual perceptions of expertise and professional esteem (Kuuvas & Dysvik, 2009). Participants were employees of a government agency, banking, utilities companies, media, a temporary staff agency and a labour union. Outcomes such as the relationship between commitment to organisational strategy, staff retention and staff morale were considered. The study asserted that PIED was connected to job satisfaction and commitment, but not to retention of staff.

The return on investment (ROI) of CPD is therefore worthy of consideration, but whilst there is interest in quantifying this (Walsh, 2013; Walsh, Levin, Jaye, & Gazzard, 2013) the considerable difficulty of and limited focus on formulating a metric is recognised (Brown, Belfield, & Field, 2002; Bjork, Torstad, Hansen, & Samdal, 2009). This is most likely because of the multi-factorial cost/benefits of staff training. Costs include attendance fees, travel, accommodation and workplace-generated expenses of releasing and covering staff to attend. Where training is delivered in-house, equipment, consumables and training rooms, man-hours or contractor costs for trainers also require financial outlay.

Defining and measuring the benefit is also not straightforward. For example, although Kuuvas and Dysvik (2009) found staff perceptions of confidence, job satisfaction and engagement could be linked to investment in professional development, accepted theories associated with staff satisfaction show numerous motivational factors are also influential (Herzberg, 1966). Distinguishing specific effects of CPD investment on staff satisfaction therefore requires an understanding of staff perceptions of their remuneration, work environment and supervision, as well as their sense of achievement and recognition in their work. Although Kuuvas and Dysvik (2009) capture the importance of CPD investment to workers, there are arguably other variables that might also have influenced their participants' perceptions.

With regard to ROI, commonly used organisational performance measures include improvements in patient outcomes and experiences, shortened hospital stays and reduced re-admittances; however, these are also measures of staff capability. Equally, although staff competence contributes to patient health outcomes, factors such as the patient's social situation and compliance also contribute. The quality of food and cleanliness of the healthcare environment and the efficiency of systems and availability technology are also influential. These varied factors make it difficult to pin-point the exact ROI of professional development on patient outcomes.

Yet another point of view for developing ROI metrics might be organisational and strategic. Hastings et al. (2014) carried out a systematic literature review of over 4300 abstracts of international literature published between 2002 and 2012, finding 113 relevant publications that discussed governance structures and skilled workforces linked to improved patient health outcomes. Implicit in this study was the strategic emphasis that organisations place on workforce development and the confidence that this generates in employees (Hastings et al., 2014). The authors advocate for supportive equitable

CPD funding systems that are based on generating desired skills sets and that are aligned to workforce development plans. They highlight that emphasis is often placed on patient outcomes and cost saving initiatives, but that human resource outcomes are less often a factor of concern (Hastings et al., 2014). The authors call for improved trust through transparent strategy, articulated within the organisational planning and clearly communicated as part of a learning organisation culture. They contend that, along with allocation of appropriate resources and strong leadership, decision makers might holistically evaluate the relationship between governance structures, staff development and patient outcomes (Hastings et al., 2014). Whilst professional development undoubtedly contributes to each of these factors the problem of measuring the exact benefit of associated staff training is noted in the authors' commentary on the ROI of training in the health sector.

Systematic reviews provide insight on the limited literature that takes account of ROI. For example, Brown and Belfield (2002) conducted an extensive literature search and found only nine academic articles detailing return on investment for CPD. Only two of the identified articles provided a cost/benefit analysis, and these were limited in scope to patient outcomes and salary benefits for specialist trainees. In 2018, Opperman, Leibig, Bowling and Johnson provided an update on CPD-related articles measuring the value of training initiatives, yielding only four new articles between 2016 and 2018 (Opperman et al., 2018). The ROI metrics in these articles largely related to increased staff confidence and competence as a result of training which reduced critical incidents and produced fiscal savings.

Aside from these literature reviews, there is evidence of sustained interest in developing ROI metrics for CPD in the health sector. In 2017, Rivers et al. described a method developed at the inaugural Symposium of the Society for Cost and Value of Health Professions Education. Whilst the society referred to existing metrics for evaluating the benefits

of research, they acknowledge that “there remains a lack of any resources tailored to applying cost analyses to continuing health professions education” (Rivers et al., 2017, p. 230). They support this assertion with their review of studies on the value of simulation training where only 1.6% of 967 reviewed articles reported on costs, and propose an evaluative tool including consideration of the design, estimation of effects and costs, calculation of cost-effectiveness ratio, adjustments for variables and reporting of results. The society concludes that evaluating the ROI of training is important for both workforce and society, that health educators require improved economic skills in order to undertake such evaluation, and that the methodologies of evaluation require further development (Rivers et al., 2017). The ROI literature also supports reports from the World Health Organization, (2013) suggesting that professional development economics require greater and more sustained consideration.

Whilst measuring value for money has been elusive, some limited understanding of the impact of spending has been gained through qualitative inquiry into staff experience. Perkins and Kron (2007) undertook an analysis of 248 applications to a contestable professional development fund for Australian radiation oncologist medical physicists, showing high demand for professional development with applicants considering access to funding a “highly valued opportunity” (p 231). Informative themes from other studies identify the motivators and barriers to engagement with professional development. The pleasure and interest in one’s role and its body of knowledge is described as a motivational factor for employee participation in CPD (Kuvaas & Dysvik, 2009). A New Zealand based study on CPD among dental technicians emphasised interaction with peers and keeping pace with technological advances in health as important to workers (Anderson, Pang, & Aarts, 2012). New Zealand authors Bryson and O’Neil, (2009), discuss the development of human capability in terms of the benefits to

employers, but also identify improved clinical or workplace confidence and a sense of personal achievement and wellbeing derived from learning as important for workers. Enhancing career progression, improving and maintaining status among peers and the prospect of increased remuneration also feature (Hastings et al., 2014). Other benefits found include the ability to contribute to a body of knowledge and improve or challenge currently accepted understandings (Stephens, Taylor, & Leggat, 2009).

Although the rationale for employees to engage in their CPD is evident, the barriers to doing so are also described. Factors such as accessibility, relevance and frequency of available training (Anderson et al., 2012; Martin, 2014), and unallocated CPD time during the working week are described (Barnes, Bullock, Bailey, Cowpe, & Karaharju-Suvanto, 2013). One interesting outcome from a New Zealand study of 427 survey responses outlining nurses' understanding of the Professional Development Recognition Programme was that, despite general support for a robust approach to CPD governance, the required volume of CPD is seen as unrealistic within the constraints of work load demands (Carryer, Russell, & Budge, 2007). Underinvestment in workplace resources is described as a barrier, undermining the growth and development of the individual as well as the organisation (Barnes et al., 2013). Lifestyle demands are pivotal; undertaking CPD during personal time, or at personal expense, requires a balance of family, social and learning time commitments (Anderson et al., 2012).

In their 2004 book, Smedley, Butler and Bristow discuss entry to undergraduate training in the United States of America. They highlight cultural background as influential, particularly in relation to lower socio-economic groups who are often from indigenous populations (Smedley, Butler, & Bristow, 2004). Culture was not a feature of other literature reviewed on post-entry professional development, although salary levels were a factor in the ability of employees to self-invest

(McPake, Squires, Mahat, & Araujo, 2015). Colonialization was also a significant factor in cultural disparity (Manchester, 2018) which is also an important consideration in Aotearoa New Zealand. Critically, while affordability and investment feature frequently as a consideration (Brown et al., 2002; Kuvaas & Dysvik, 2009), little attention is paid to funding mechanisms for CPD or the experience of applying to them.

To further investigate the applicant experience, parallels were drawn with contestable research funding, which has many similarities in terms of its application process; however, there is also limited work in this area. Published work concurs with the theme of ongoing organisational investment as an important factor in building professionalism (Marshall et al., 2016). Strategically it is seen as important to increase research capability through education so as to develop evidence-based practice as fundamental to quality practice, and in health to patient care (Stephens et al., 2009). Whilst it is acknowledged that incentivised systems create enthusiasm and stimulate innovative thinking (Orrell, Yankanah, Heon, & Wright, 2015), concern is also expressed that contestable approaches lead to elitism and diminish equity of funding access which potentially reduces the diversity of research outcomes (Hicks, 2012). These concerns are also relevant to professional development funding mechanisms, particularly where time intensive processes or stringent judging criteria limit access for some employees. When considered from this perspective, the applicant experience becomes increasingly relevant and highlights the need for increased attention to this topic.

Critically, The World Health Organization (2013) describes the quality and volume of available research on funding for professional development as “moderate” (p.48) and calls for further research in this area, specifically on the “…comparative advantages of different modalities of financing and scaling up of the education and training of health professionals” (WHO, 2013, p. 52). The WHO Report supports the idea that transformative success relies on “significant long-term

financial investment, and effective leadership and management, good information systems and political commitment" (p. 17).

Thus, the current research available relating to CPD in the health sector and calls for increased attention suggest a gap in knowledge in relation to the experience of accessing funding. The predominant perspectives of much of what is written are 'what's in it' for individuals and organisations. The study reported in this thesis differs in that it seeks to understand the idiographic experience of applying for professional development funding as a mechanism to engage with professional development. Whilst undertaken within a specific health institution, the gap in this sort of research suggests that the study has potential to inform other organisations as they design, deliver and evaluate staff development funding strategies.

## Health Workforce funding literature review

In 2013, the level of global investment in continued professional development (CPD) was identified by the World Health Organization (WHO) as a risk to healthcare worker capability and therefore to patient care (WHO, 2013). The report accounted for population growth and longevity, the resulting demand for increasing numbers of health workers and the associated increase in resource required to keep pace with CPD demand. Calls have been made for investment in health professional development to be doubled within this decade; however, the sensitive political landscape of population health and the complexity of how best to invest limited resources for better health systems were also expressed as considerable concerns (Frenk et al., 2010; WHO, 2013).

The most recent figures (2016/17) from New Zealand Treasury show that the primary source of public health funding in New Zealand, administrated through Vote Health, constitutes around one fifth (6%) of the government's expenditure at $16,142 million. The proportion of government health funding in New Zealand, as opposed to private health funding systems seen in other OECD countries, accounts for New Zealand being in the median percentage of GDP spending when compared internationally (The Treasury, New Zealand Government, 2017). As previously noted, funding dedicated to health workforce training in Aotearoa New Zealand equates to around $185 million or 1.1% of the total Vote Health fund, which sits below the international average. Medical, nursing and midwifery, allied and technical, mental health and disability services, Māori and Pacific support and a voluntary bonding scheme are beneficiaries of this funding (Health Workforce New Zealand, 2016).

It is worth noting that funding for health workforce education is a multi-agency endeavour. The relationship between Vote Health training investment and health workforce capability is therefore not a linear

calculation. For example, Vote Education also makes a considerable contribution through subsidised tertiary studies at undergraduate and postgraduate levels (Tertiary Education Commission, 2016).

The changing labour market in health results in the need for new and extended scopes of practice and shifting expectations on how and where health services are delivered (Carryer et al., 2007; McKinlay & Pullon, 2004; Taylor & Copeland, 2006; Toop, 2017). Those working in this changing terrain must face the challenges of keeping pace with professional demands whilst maintaining the delivery of high standards of patient care. The professional development required to meet this challenge predominantly occurs within the limitations of the strategic application of taxation revenue, philanthropic grants or private investment of individuals funding their own training (WHO, 2013).

The reality of an ageing workforce and changing population health needs is a global health challenge; the New Zealand health workforce is not exempt from its impact. In a Lancet commissioned report from 2010, Frenk et al. convey the global impact:

> The extraordinary pace of global change is stretching the knowledge, skills, and values of all health professions. That is why we call for a new round of more agile and rapid adaptation of core competencies based on transnational, multi-professional, and long-term perspectives to serve the needs of individuals and populations. (Frenk et al., 2010, p. 32)

Investment in health professional development also has a direct correlation with migration (Saravia & Miranda, 2004). New Zealand relies heavily on immigration of overseas trained workers to augment its health workforce; for example in 2015 twenty six percent of nurses were migrants to New Zealand (Ministry of Health New Zealand, 2016a, p. 12) and 31.6% of midwives were trained overseas (p. 16). The significant cultural differences and variance in clinical practice between countries

would indicate that further investment is needed when in some disciplines over one quarter of health workers did not gain their qualifications in New Zealand.

Therefore, in order to meet legal and strategic requirements for a highly competent contemporary health workforce there is high demand for professional development resources (Balabanova et al., 2013; Brown et al., 2002; State Services Commission, 2015); however, the cost of learning activities has been identified as a barrier to engaging with continuing professional development, particularly for some health workers who receive relatively low salaries (Burrow, Mairs, Pusey, Bradshaw, & Keady, 2016; Hyden, Escoffery, & Kenzig, 2015; Keating & Jaine, 2016).

## Professional Development Fund documentation review

The Waitemata DHB professional development fund was established in August 2014 to respond to a staff call for greater equity and access to professional development funding.

The Professional Development Fund (PDF) is guided by the following intentions:

- Enhance equity and access to professional development funding
- Create greater funding transparency across professional groups and services
- Work in a connected and complementary way with existing decision-making processes for professional development funding; streamline the application and approvals processes
- Rationalise DHB spend on external courses, conferences and tertiary study
- Support capability development for the realisation of Waitemata DHBs priorities
- Maximise the contribution of all staff in achieving health equity for Māori
- Support innovation at Waitemata DHB to be 'better, best, brilliant'.

(Waitemata District Health Board, 2017, p. 4)

**Scope and eligibility.** The PDF defines professional development as tertiary study, external courses and conferences that employees elect to do in agreement with their managers. The fund is not for mandatory training, and does not replace funding entitlements under collective employment agreements which remain with the respective services. Employees are eligible to apply to the PDF if they have been employed by Waitemata DHB in a permanent role for 12 months or more at the time of application. The fund is not accessible to doctors and senior

management. Part-time staff members receive pro-rata funding. Staff members are expected to have shown a commitment to their own learning before applying to the fund by completing all Waitemata DHB mandatory staff training for their role and having up-to-date professional development plans.

The stated criteria for considering applications include the realisation of Waitemata values and purpose, relevance to role and service, likely utility of learning, commitment to own development and contribution to the area of interest, such as presenting at a conference. In addition, the committee also considers the likelihood that the investment will remain in the DHB, the potential to reduce inequalities in health status for Māori and the benefits or risks to the DHB if the professional development is not undertaken (Waitemata District Health Board, 2017, p. 4).

The following is an overview of the official information provided to applicants. The documents and guidance available on the staff intranet and located alongside the application form are:

- Waitemata DHB Professional Development Fund Policy 2017
- An application checklist 2017
- The annual committee schedule
- A template for the application
- A template for a manager's supporting letter

(See Appendix 3)

In order to apply to the PDF the following supporting documents are required:

- Completed Professional Development fund application form
- Completed applicant's cover sheet (information about how the training will contribute to the applicant's learning and role)

- Completed line manager's cover letter (support for the applicant to undertake the training)
- Copy of current performance appraisal goals (a customary annual staff requirement)
- Conference, course, seminar brochure/registration form
- Copy of current staff record for mandatory training (a customary annual staff requirement)
- Quote for travel and accommodation from approved WDHB business and travel provider
- Completed and signed 'Business related travel and conference expenses' claim form.

(See Appendix 3.d)

In addition, those applying for support for postgraduate Masters or Doctoral study must provide additional information about the research and its value to the organisation. Once all supporting documentation is collected, the applicant completes the electronic application form and uploads the associated documents before submitting.

Nursing and Midwifery, and Allied Health (for example, Physiotherapy, Occupational Therapy, Laboratory Technicians) submissions are considered by their divisional PD committees before progression to the PDF committee. Applications of all other eligible staff groups are solely considered by the PDF committee. The divisional and PDF committees meet monthly to consider applications, and following assessment applicants are advised of outcomes. In some cases, if the content of the application is not sufficient for their decision making process, the PDF committee may request further information from the applicant. The following table shows the numbers of applications received each year between 2014 and 2018, including those approved and those declined or redirected to the Health Workforce New Zealand fund for nursing. The

table also shows the distribution of claims between tertiary study, conferences and courses funded.

Table 1

*An overview of PDF Application Outcomes 2014-2018.*

| Financial year | Applications received | Applications approved | Declined or Redirected to HWNZ | Request for resubmission | Tertiary study applications approved | Conference applications approved | Course applications approved |
|---|---|---|---|---|---|---|---|
| 14/15 | 321 | 261 | 37 | 23 | 57 | 110 | 94 |
| 15/16 | 374 | 335 | 39 | 0 | 65 | 163 | 107 |
| 16/17 | 327 | 263 | 64 | 0 | 54 | 122 | 87 |
| 17/18 | 291 | 237 | 38 | 16 | 23 | 142 | 72 |

(Waitemata DHB, 2015, p. 2; Waitemata DHB, 2016b, p. 2; Waitemata DHB 2017, p. 2; Waitemata DHB 2018, p. 2).

## Literature summary

The current academic literature provides insight into the motivators and barriers to engagement with professional development for health sector employees, as well as the perspectives of organisations on investment in professional development. Strategic documents suggest high level intentions for maintaining a competent workforce in the health sector, but also contextualise those intentions against the limited global investment in health workforce. Locally, espoused commitment of the DHB to support employee participation in development activities is elucidated, including the stewardship of resources through the Professional Development Fund. Critically, the experience of applying for funding through contestable modalities has received little attention in the literature. The PDF at Waitemata DHB offers an ideal opportunity to study the idiographic view of the applicant experience.

# Chapter 3: Research design

## Primary research question

*What is the experience of applying for contestable professional development funding for health workforce employees?*

This question was designed to allow exploration of three aspects of the applicants' lived experiences: applying to the PDF, the PDF as a system within the context of Waitemata DHB, and the meaning attributed to the outcomes of applications in relation to staff engagement and career development. This chapter describes the design of the study undertaken to research these questions.

## Study overview

**Introduction.** The paucity of literature concerning professional development funding, especially in relation to the applicant's experience, suggests the need for an in-depth qualitative phenomenological study of these experiences. The researcher's position as an employee and recipient of the fund provide an opportunity for insider research, where the researcher's positionality contributes to a layered interpretation of participant stories through an emic, or insider, view (Smith et al., 2009). The philosophy, methodology and methods explained in this chapter demonstrate the alignment between the study approach and design.

**Philosophical underpinnings of phenomenology.** Phenomenology is fundamentally a transcendental philosophical view of the distinct experiences of the lives of human beings. Through phenomenology we regard, bring consciousness to and depict the distinct evident and obscure aspects of our lives, how our experiences shape our interactions, and who and how we are (Janicaud, 2010). Although the study of being human had been a philosophical endeavour for centuries, Edmund

Husserl (1859 -1938) is credited as the originator of the term and philosophy of phenomenology as we know it today. In the introduction to the second volume of the first edition of his work "Logical Investigations" (1900 – 1901), Husserl identified phenomenology as a new beginning in philosophy (Kaufer & Chemero, 2015; Moran, 2000). He framed phenomenology as a way of knowing through rigorously scientific but definitively non-empirical enquiry into the essential nature of things, or the 'essence' of the concerns of everyday life as they have meaning to those involved (Cerbone, 2006; Moran, 2000).

Husserl's work was in contrast to earlier Cartesian philosophers who proposed that interaction with our outer reality could be understood through deduction, disconnected from the senses and emotional inner experiences of human beings (Moran, 2000). Husserl regarded this as the "natural attitude" (Sokolowski, 2000, p. 47), the world taken-for-granted, objective and separable from our subjective experience (Sokolowski, 2000). In contrast, his transcendental phenomenology was concerned with uncovering meaning from the consciousness of the mind, developed during the interactions of everyday lives (Finlay, 2009). In this he referred to the theory of 'intentionality', as used in the work of Brentano (1838–1917), and emanating from the work of ancient Greek philosopher Aristotle (Moran, 2000), where the intentional nature of interactions between the mind and the objects of the world is acknowledged.

Husserl brought consciousness to these intentional essences in their own right, seeking to go "back to the things themselves" (Smith et al., 2009, p. 12). This he identified as the "phenomenological attitude" (Sokolowski, 2000, p. 47), a way of suspending or 'bracketing' our preconceptions, and looking separately and singularly at the conscious and subconscious content of specific everyday acts in order to articulate their nature (Smith et al., 2009; Smythe, Ironside, Sims, Swenson, & Spence, 2008). Thus, by transcending situational influences, intimate

understandings of distinct shared experiences may be gained. This became known as phenomenological “reduction” (Sokolowski, 2000, p. 51).

Husserl had many students, most notably Martin Heidegger (1889 – 1976) who is hailed as one of the most influential philosophers of the twentieth century (Moran, 2000). Heidegger’s thesis was focused on the ‘fundamental ontology’ of the ‘question of being’ which he referred to as “Dasein” or “there being” (Cerbone, 2006, p. 42). His seminal work “Being and Time” (1927) is celebrated for its focus on what it means to be in the world for the person who is being, a question to which he had found earlier philosophers lacking in their approach (Cerbone, 2006).

Heidegger’s fundamental disagreement with Husserl’s transcendental stance is well documented (Cerbone, 2006; Moran, 2000; Sokolowski, 2000). In contrast to Husserl, Heidegger’s existential view of the world encouraged the uncovering and interpretation of latent but significant meaning in everyday situated existence. He looked to create unity between the objective world and subjective experiences of the world (Moran, 2000). Heidegger’s thesis was that one could not suspend experience and the world apart from each other, but rather that ‘there being’ is in the world and thus intersubjective with the world. He affirmed ‘relatedness’ between somatic material factors and semantic mindful acts as influences on how we understand and interpret our being conscious in the world (Smith et al., 2009).

Later philosophers built upon Heidegger and Husserl’s foundations in order to explore different facets of the lived experience. For example, drawing on Gestalt psychology, Merleau-Ponty (1908 – 1961) developed perceptual phenomenology in order to understand the ‘embodied’ experience as related to behaviour, culture and knowledge (Moran, 2000). Gadamer (1900-2002) was interested in text and tradition, Derrida (1930 -2004) explored the deconstruction of culture and history, Arendt

(1906 - 1975) made meaning in the political sphere, Levinas (1906 - 1995) concentrated on ethics and ego, and Sartre's (1905 -1980) interests were in belief systems and freedom (Moran, 2000).

As there are many possible phenomenological ways of understanding the world, selecting an appropriate philosophy for this study involved consideration of this erudite diversity, from which existentialism emerged as most resonant with my positionality, with the intersubjective situated nature of the participants and my engagement with them.

**Methodological rationale.** I chose Interpretative Phenomenological Analysis (IPA) as my methodology as it is holistically phenomenological and inclusive, but does not constrain the researcher to any particular theoretical approach. IPA originates from the study of qualitative psychology (Larkin, Watts, & Clifton, 2006) and has a phenomenological, idiographic (interested in the individual), hermeneutic (interpretive) epistemology (Smith et al., 2009). It is useful for illuminating and interpreting a detailed understanding of specific lived experiences in their broader context (Pringle et al., 2011; Smith, 2011). IPA also makes provision for insider research, which is important in this case as I am an employee of Waitemata DHB and past applicant to the PDF, and therefore share the experiences of the participants.

Known as a 'double hermeneutic', analysis in IPA allows the researcher to make meaning of the participants' meaning making. As such, the researcher's ontology is intersubjective and layered with that of the participants (Smith et al., 2009), a position that is further supported in this study by the researcher's positionality as an insider in the organisation. An 'insider' researcher comes from within the context being studied and for the purpose of enquiry also assumes a researcher role within their situation or cultural context (Holian & Coghlan, 2013). The advantages of insider research include access to participants, established connections which can help to normalise the researcher-

participant relationship, as well as local knowledge and experiences which support the researcher's depth of understanding. Although preconceptions have been seen as a disadvantage of insider research (Blythe, Wikles, Jackson, & Halcomb, 2013), IPA relies on the researcher's ability to apply a double hermeneutic which is enhanced by their coincidental lived experience (Smith et al., 2009).

IPA takes a pragmatic and systematic approach to phenomenology whilst remaining firmly within the social rather than the empirical paradigm (Pringle et al., 2011). IPA studies are contextualised, which often makes them transferable to other similar settings; however, the utility of IPA is not to create generalisations, but rather to be generative of the interpretation of people's stories of their lived experiences (Pringle et al., 2011). Although concerned with discursive data, IPA is distinct from Discourse Analysis (DA). Where IPA is generative of meaning making, DA analyses text and spoken interaction to understand what people do within and as a result of semantic liaison (Wood & Kroger, 2000). IPA offers the opportunity to interpret what meaning is being made as a result of contextual interactions (Pringle et al., 2011), while DA supports the view that discourse leads to doing, which generates rather than reflects our social world (Wood & Kroger, 2000).

Although methodologically distinct, there is certainly a connection between meaning making and talk to generate doing. Phenomenologically this was acknowledged by Hannah Arendt in "The Human Condition" (1958). This is sequentially captured as experiencing the world, making meaning of experiences, articulating and conveying stories and generating action which transforms our experience of the world. Arendt (1958) asserts that lives are meaningful only because of understanding gained through interaction, and that story telling makes things live in people's minds. The sharing of experiences allows for interpretation and meaning making and supports shared intelligence and actions (Moran, 2000, p. 313). The findings of this study of an experience that has

professional, personal and social meaning relates to the concept of talk to generate doing. As such, there is commonality between Arendt's thesis and the narrative interests in IPA; as stated by Smith et al. (2009) "IPA has a strong intellectual connection with various forms of narrative analysis" (p. 196).

Collecting stories is fundamental to qualitative research, and making meaning of the participants' meaning making is the fulcrum of IPA. Drawing on the work of Smith et al. (2009) to provide a framework for this study, the individual and shared experiences of applying to the Professional Development Fund in the context of Waitemata DHB are explored. This methodology allows an empathic interest in the lives and stories of participants, while the researcher's in-depth insider knowledge informs additional layers of insight and interpretation through the hermeneutic cycle.

**Rationale for data collection methods.** Methods of data collection need to enable direct interaction with participants and enliven their voices in the research, so semi-structured one-on-one interviews are often used for data collection in IPA (Pringle et al., 2011). However, for this study I chose to undertake focus groups as the method of data collection. Focus groups are an emergent method in IPA, but are increasingly used because they provide enhanced articulation between individual experience, shared stories and how people make sense of their situated encounters (Palmer et al., 2010). Focus group interaction enables participants to share experiences, relate to the stories of others and increase sense-making through their ideas and shared accounts (Morgan, 2017). Whilst this may seem incongruent with the idiographic commitment of IPA, each group session and even the specific context, can still be considered as an individual case, as Larkin et al. (2006, p. 103) describe:

> IPA research is generally pitched at the idiographic level. This term has traditionally been associated with the study of 'individual' persons in psychology, although it originally served a wider function, namely to distinguish the study of specifics from the study of 'things-in-general'. Hence, the study of any specific situation or event might also be called idiographic.

Although not part of the original design of the study, a number of participants who could not attend the focus groups wished to provide written responses. This was pleasing as it confirmed the importance of the study to those eligible to apply to the PDF. A change to my ethics application was approved and facilitated inclusion of their views. The written responses stand in their own right, but also offer a means of method triangulation which supports the trustworthiness and rigour of the study (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). Within focus groups participants collectively make meaning, but are also influenced by each other. In written responses perspectives are individual, but are also likely to be more sanitised than the spoken word. Thus having both sources of data potentiates a well-rounded and balanced set of findings.

**Researcher positionality, trustworthiness and reflexivity.** It is common that within insider studies, the researcher's values and positionality are a recognised influence throughout the study. Transparency and reflexivity allow for their inclusion and influence on the work (Creswell, 2007). In IPA methodology, it is expected that researchers will bring their own experiences and contextual intelligence to bear on the interpretation of the data as they endeavour to amalgamate the accounts of others (Smith et al., 2009). Through this thoughtful process, IPA researchers seek to gain and convey an intimate understanding of the phenomena, which is fundamental to the trustworthiness of the study (Finlay, 2008).

Being true to the approach of IPA and detailing methodological process also demonstrate trustworthiness. This supports the interpretation and integrity of the findings by ensuring that the approach is consistent with the intentions for the study. In addition, participant checking and consideration of interpretations during supervision meetings are also features of IPA which support the trustworthiness of the work.

In this research I acknowledge my position as an insider with a number of standpoints; I am an employee of Waitemata DHB, I was a peripheral observer at the time that the PDF was established, I have been a committee member and a recipient of the fund. I bring perspectives from each of these positions that serve to enrich the interpretation of the findings of this study; however, such an immersive situation requires reflexivity and careful self-management.

Potential to influence and be influenced by others is a significant risk in studies that involve collegial relationships. To mitigate this, exclusion criteria for the study were set out to minimise the influence of direct work relationships (Moore, 2012). Potential conflicts of interest from my role as an education manager were eliminated since my cohort of learners are medical practitioners (doctors in training) who are not eligible to apply to the fund; they are therefore not influenced by or influential to this study. *Ad hoc* departmental conversations about the PDF are a reality of my work, and are therefore a noteworthy feature of positionality. Colleagues who were aware of this study offered regular commentary on their own experiences, requiring sympathetic and reflexive engagement. The potential impact of these conversations was reduced by the exclusion of direct colleagues from the study, but they are acknowledged to have had an influence on my interpretations.

**Transparency.** The study design decisions are explained in detail in this thesis for clarity on the appropriateness of the approach. Each step of the data processes and interpretative analysis is detailed in order

to ensure that there is transparency throughout the study. In addition, direct de-identified participant quotes are included to give voice to those who took part and to ensure that their thoughts are conveyed with probity (Marshall & Rossman, 2014).

**Consultations.** During the planning stages of this study a number of consultations informed the direction of the work. These included conversations with the PDF Committee Chair, the Committee as a whole, and cultural representatives. It was important to have the PDF Committee Chair's support and permission to proceed with the study. She was interested in opinions on the application process and the types of activities funded. Her comments guided the development of some of the focus group questions, the findings from which may be used to guide the future administration of the fund.

I also met with the PDF Committee; they were fully supportive of the proposal and interested to eventually hear about the study findings. The potential influence of the committee has been managed by maintaining distance during the research, whilst providing progress reports that focus solely on the research activities rather than the research outcomes. The final report conveying the outcomes of the research will be submitted once the research is complete.

Representatives of Māori, Pacific and Asian populations were also consulted. The relationships between the Crown as the primary funder of the DHB, Māori populations in the communities the DHB serves and staff who identify as Māori are recognised in this research (Health Research Council, 2010). My Māori colleague offered her wisdom in relation to culturally appropriate facilitation of the focus groups to create cultural inclusivity, including respect for Tikanga Māori (Māori traditions) by opening each session with a waiata (a song to open or announce a formal occasion). As a result, each focus group commenced with the group singing 'Te Aroha', acknowledging our context in

Aotearoa New Zealand and the joint partnership of Te Tiriti o Waitangi (The Treaty of Waitangi).

My Pacifica colleague was extremely supportive of the study and offered a sage piece of advice for the focus groups; *"not to let people sink back into the 'brown ground'"* (Personal communication, June 27, 2017). When faced with group situations or those perceived as having greater knowledge, Pacifica peoples may retreat to the back ground, or 'brown ground' as she described it. Mindful of this tendency, I took great care to create space for everyone to have a voice during the focus group sessions. I had commenced the focus group by asking everyone present to be respectful of each other's opinions, and when opportunity arose for a culturally appropriate opinion I encouraged those present who could best speak to this world view to contribute. For example, during one of the focus groups there was a lengthy discussion about the PDF question on Māori health equity and I asked specifically for opinion from a Māori participant.

I also consulted with an Asian colleague who also expressed support for the study. She referred to the diversity of cultures amongst those who identify as Asian and advised me to support their inclusion on an individual basis. The outcomes of these consultations, embedded in appropriate research practice, provided the framework for managing the safety of participants in this study.

**Ethical conduct and safety of participants.** Moral obligations of research governance were upheld to ensure research adequacy as well as to protect the reputation of the organisations involved, Auckland University of Technology (AUT) and Waitemata DHB. All documentation including consent forms, email correspondence, written responses, transcripts, recordings and backup copies are stored securely in password protected files and in locked cabinets. All study data and

documentation will be held securely in the School of Interprofessional Health Studies for six years post study and then deleted or destroyed.

The rights and wellbeing of the participants have been carefully managed throughout to protect their personal and cultural rights and customs, and to protect them from deceit, harm and coercion. This included the following actions:

- I consulted with cultural representatives to ensure that my actions were culturally appropriate.
- I advertised the study on notice boards, allowing people to respond of their own free will.
- I kept all email responses in a password protected file.
- I provided a Participant Information sheet with details about what is expected of participants during the research.
- I asked participants to give their informed consent, not coercing them in any way.
- I ensured that participants were aware that they had the right to withdraw from the study, up to the recording of the group sessions, without consequence.
- I allocated participants to groups with similar PDF outcomes.
- The focus groups were carried out in private rooms to minimise identification of participants.
- I held the focus groups on different days to reduce potential cross over of participants with different outcomes.
- Those who attended groups were reminded at the beginning of the session and by email following each session of the need to maintain confidentiality; however, I also advised them that anonymity could not be guaranteed.
- I commenced focus groups with a waiata (Māori song) as is culturally appropriate for Hui (meetings).

- I encouraged cultural points of view to be expressed during the focus group sessions.
- I encouraged shared respect in the group sessions, respecting diverse opinions.
- In reporting, I de-identified all direct quotes using a system of pseudonyms.
- I monitored the protection of participants throughout the study in order to avoid harm.
- I ensured that participants had access to staff support through the WDHB Employee Assistance Programme if required.
- Some respondents unable to attend the groups asked to submit written responses; a variation to the ethical approval and the consent form allowed for this.

The Participant Information sheet (Appendix 2.a) assured participants of their rights and safety in taking part in this study. The participants in this research are partners who have shared their individual and collective experiences. In the spirit of participation, protection and partnership representatives of the focus groups have reviewed a summary of the findings. The generosity of the people of Waitemata DHB in sharing their stories is acknowledged in this thesis. Those participants who requested a summary of the findings will be sent a report after completion of the study.

**Participant Recruitment.** Recruitment started on the 8th of August 2017 with A4 posters placed on eighty physical notice boards around Waitemata DHB's North Shore Hospital campus and on the electronic notice board emailed out weekly to all staff. This resulted in thirty seven expressions of interest received by the end of September 2017. Participant information sheets and informed consent forms were emailed to respondents for their consideration. The returned signed forms indicated the participant's intention to proceed with the focus

groups. Some respondents who could not attend a focus group asked to contribute in writing. Following ethical approval for this variation, written responses and adapted signed consent forms were collected during October and November 2017. A separate secure folder was created for the email correspondence. Written responses and a Microsoft Excel® 'spread sheet' created to keep track of participants, were also stored securely.

Recruitment for the focus groups was completed by the end of October 2017. Microsoft Outlook® calendar invites and email reminders were sent to participants in the three focus groups which took place on the 10th and 17th of November and the 10th of December 2017.

## Data gathering

**Focus groups.** Initially two one-hour focus groups of six, with a desired minimum four and maximum eight participants (Smith et al., 2009) were planned. One focus group was for those with applications approved outright or following resubmission and the other for those whose applications were declined either straight away or after resubmission. However, as the number of respondents was larger than anticipated three groups were run, two for those with positive outcomes and one for those with declined applications. This ratio was reflective of the PDF application outcomes shown in Table 1 (p.32) where funded applications were greater than those not funded. Nonetheless, the study focuses on the idiographic meaning that people ascribe to their experiences rather than a collated comparison of positive and negative outcomes, and as such the greater number of funded versus unfunded applicants was not a concern for the study.

I applied my experience of chairing meetings and working with groups of learners to facilitating the focus groups. I further prepared by reading related material, including articles and text books by Barbour (2017), Kitzinger (1994) and Merton (1987). I also consulted with an experienced colleague and watched related YouTube® videos. From this I prepared the room set up and a plan for each session.

Room set up:

The focus groups were held in a comfortable, private, sound-proof room with the group seated around a table. As the sessions were in the middle of the day, lunch was provided which helped to create a convivial atmosphere. Name cards were provided for all participants. The conversations were recorded on two iPads®, one at each end of the table. Some participants brought prepared notes and printed copies of the PDF documents to discuss.

Session plan:

1) Welcome and thanks for attending
2) Check on voluntary informed consent
3) Explanation of purpose and use of the focus group
4) Ground rules:
    a. Mobile phones on silent
    b. All views welcome and accepted
    c. Allow others to speak and finish their point
    d. Identify - say name for the transcriber
5) Explanation of recording process and security
6) Reminder of need for confidentiality within the group
7) No social media or discussion outside of the group
8) Waiata
9) Round table introductions and ice breaker question
10) Discussion using indicative questions as required

During the conversation I attempted to ensure that each person had the opportunity to speak. I encouraged group interactions and asked for points of clarification. Towards the end of the session I signalled to the group when there was ten minutes left for final thoughts. At the conclusion of the focus group, all participants were thanked for taking part and given unanticipated koha (gifts) for their time.

Focus Group questions:

Although indicative-questions were developed for the focus groups, my intention was to facilitate by letting the conversation flow, whilst retaining sight of the topic at hand (Smythe et al., 2008). The following semi-structured questions were used to initiate and direct the conversation as needed:

1. The PDF as a system in our DHB.

a. What does the group know about how the PDF came about and what its purpose is?
b. How well do you think it is meeting its purpose? Is it fair and well represented?
c. How do people see the PDF In the context of our DHB culture and the set of values that we ascribe to?

2. The experience of applying to the PDF.
    a. Why did you apply to the PDF?
    b. What do people think about the process of applying? How was it for you?
    c. There are criteria to meet in the application. How do people feel about what we are asked to think about and justify in our applications?
    d. How could the system be improved? How else might the applications be prioritized?

3. The impact of the PDF on staff engagement and career progression.
    a. The PDF provides for external courses, conferences and tertiary study. What other types of professional development activities have you known to be funded or would you like the PDF to consider?
    b. How do you feel about being funded / not funded in terms of your relationship with the DHB?
    c. What is the impact of your outcome?
    d. Is there anything else that you would like to talk about in relation to your own experience?

The use of these questions was not prescriptive and in fact I used them sparingly. At the time of the first focus group, I noted that the participants focused on me and tended to interact less with each other than I had hoped. During the introduction to the next two focus groups, I

articulated the intention for group interaction as a way of enhancing thinking and meaning making. As a result the second and third groups' conversations felt more engaged and free flowing.

All three focus groups were recorded and the files transcribed with assistance from a professional transcription service. The transcriber signed a confidentiality agreement, the recordings were provided to her using a Drop-box® to which only she and I had access. Following transcription she gave assurances that all copies of the recordings and transcripts were deleted from her records. The transcripts and recordings have since been stored securely by me throughout the study, and afterwards will be stored securely for six years in the School of Interprofessional Health Studies, according to AUTEC expectations.

**Written responses.** A number of participants who could not attend the focus groups wished to provide written responses. A change to my ethics application facilitated inclusion of their views. I had prepared some semi-structured questions to guide the focus group sessions which I sent to those wishing to give their accounts in writing so that the written responses were comparable with the focus group data (Mann, 2018). However, I encouraged the writers to use the questions as a guide and gave them licence to convey what was most important to them about their experiences, although most responded to the questions directly.

Written responses were collected by email and stored in a password protected file before deletion from the Microsoft Outlook® email programme. Collection of this data was in parallel with the focus groups but it was not reviewed until after all data collection was completed. This was to ensure that the facilitation of the group sessions was not influenced by the content of the written responses.

## Data analysis

**Coding.** The raw data comprised three transcripts from the recorded focus groups and a collation of the written responses into one document. Pseudonyms were applied to all data prior to analysis. All data was gathered prior to commencing a four-month period of holistic comparative thematic and interpretive analysis. Qualitative analysis software (NVivo11®) was used during the data coding.

IPA analysis focuses on individual cases and then on seeing the data as a whole so that the researcher gains insight into individual voices which can then be imagined and enlivened with others in their context (Smith et al., 2009). Given that my data was primarily collected in group formats, and not in individual cases normally favoured by the idiographic commitment of IPA, I analysed each transcript in turn as a distinct case. To become immersed in the data, I initially read each case whilst listening to its related recording without taking notes or coding. I found this helpful to allow memories of the conversations to come back to me (Smith et al., 2009). Although I initially felt the first focus group was less fluent, listening to the recordings I found all three conversations flowed well, despite my recollections. Each group shared their stories generously and meaningfully, suggesting that my internal dialogue about my limited experience as a researcher had been colouring my experience of the conversation.

I then read and listened to each case several times while coding each line of data. As each subsequent document was coded new themes emerged. This led to revisiting and recoding of each case. The codes continued to expand iteratively as I engaged repeatedly with the cases, keeping in mind the main research questions:

1. What are people's perceptions of the PDF as a system at Waitemata DHB?

2. What is the experience of applying to the PDF?
3. What is the impact of the PDF on career progression and staff engagement?

In order to develop the codes further, I used mind maps to see how early themes worked with or nuanced from each other. I discussed the findings and some initial thinking with my supervisor who supported my direction, helped me to retain reflexivity and further developed my thinking.

**Expanding the data.** Data coding took place over a period of six weeks, initially using the Qualitative analysis software NVivo11®. The iterative process of repeatedly reviewing the data, expanding through note taking, grouping themes and considering congruence and dissimilarity in the data continued for a further four months during which the themes emerged (Smith et al., 2009).

During this time I followed the guidance of Smith et al. (2009) I then expanded the data through interpretive note making (Smith et al., 2009). Using a table format with the transcript in the left column, I made notes about my interpretations in the right column. I drew on my recollections of the focus group dynamics, the participants and my contextual knowledge as I engaged with the data at a greater level of interpretation. I began to interpret the participants' meaning making, layering my own interpretation in my notes. Whilst some of the codes were more frequent than others, often the less prolific ideas were more meaningful which is not uncommon when analysing data in IPA studies (Wagstaff et al., 2014). When I later referred back to my emergent notes I found many useful and leading insights that supported the development of main themes and subthemes.

To firm up my thinking about the emergent themes, and following the suggestions of Smith et al. (2009), I cut up printed codes onto separate

slips of paper and collected them together under headings. I spent time with the codes, moving them around, in and out of similar or dissimilar collections, until I felt that I had meaningful clusters. In some cases the themes remained consistent; in others they were changed, further developed or subsumed into other themes. I followed this with a white-board exercise to consider the theme titles and decided on some initial ideas; however, the theme titles continued to evolve throughout the writing phase.

**Participant checking.** In order to check for resonance with the themes I invited one person from each focus group to come to a theme-checking session. I explained the key concepts of the themes and provided direct quotes to check that my interpretations were consistent with their experiences (Smythe et al., 2008; Wagstaff & Williams, 2014). The invited participants affirmed the findings of the study and offered some further supporting thoughts that were noted down.

## Summary

This chapter has mapped the research design, data collection and data analysis. The next chapter will provide a comprehensive report on the findings supported with de-identified verbatim quotes in order to meaningfully reveal the participants' stories.

# Chapter 4: Study findings

## Introduction

This chapter presents the findings of the study, showing the development from codes to preliminary themes, and from there to three final themes each with three subthemes. Verbatim quotes are used to give voice to the participants and to illustrate how the final themes and subthemes arose from the data. The quotes are attributed to the participants and the provenance of each quote is also provided. At times the participants' mannerisms are described in order to convey the energy and emotion behind the words, but otherwise every effort is made to protect identities, whilst being true to their contributions.

## Participants

There were 37 responses to the advert to participate. Four respondents did not meet the inclusion criteria, two respondents did not return consent forms after the initial contact, and two returned consent forms but were unable to attend and did not return written responses. There were 15 written responses, ten had received PDF funding, two had been declined and three did not define their PDF application outcomes. Fourteen participants attended the focus groups; there were six funded participants at focus group one, and three funded participants at focus group two. Five participants attended focus group three which was for those with declined applications. Overall, there were 29 participants, 19 funded, seven declined and three with undefined outcomes.

Table 2

*Groups and Roles of Participants Identified with Pseudonyms*

| Pseudonym | | Area of work |
|---|---|---|
| Focus Group 1 (FG1) - 10th Nov – Funded PDF applications | | |
| 1 | Abbie | Practice Improvement Nurse |

| | | |
|---|---|---|
| 2 | Briar | Physiotherapist |
| 3 | Casey | Nurse |
| 4 | Daisy | Nurse Team Leader |
| 5 | Ellen | Pharmacist |
| 6 | Frank | Occupational Therapist |
| Focus Group 2 (FG2) - 17th Nov – Funded PDF applications | | |
| 1 | Alice | Occupational Health & Safety (Occ. H&S) |
| 2 | Beryl | Nurse |
| 3 | Cora | Auckland Regional Dental Service (ARDS) |
| Focus Group 3 (FG3) - 1st Dec – Declined PDF applications | | |
| 1 | Agnes | Nurse Educator |
| 2 | Betty | Pharmacist |
| 3 | Celia | Clinical Case Coordinator |
| 4 | Deena | Community Engagement |
| 5 | Eric | Patient Literacy Educator |

| Written respondents (WR) – Roles were not identified | | | |
|---|---|---|---|
| 1 | Annie | 9 | Irene |
| 2 | Blanche | 10 | Janice |
| 3 | Chloe | 11 | Kathy |
| 4 | Daryl | 12 | Larry |
| 5 | Eloise | 13 | Moira |
| 6 | Faith | 14 | Neil |
| 7 | Glenda | 15 | Olive |
| 8 | Hollie | | |

The participants have been identified with pseudonyms and, where known, their job title. Although the focus group participants introduced themselves and their area of work at the beginning of each session, those sending written responses did not identify their roles. Where a job title might easily identify an individual, the general area of work is referred to instead. Abbreviations are used to denote the data sources as follows, Focus Group one (FG1), Focus Group two (FG2), Focus Group three (FG3) and written responses (WR).

## Codes

After several examinations of the focus group transcripts and collated written responses, nineteen main codes had emerged. The codes clustered together in three groups that were directly related to the three main study questions, indicating that the data had been collected in line with the intentions for the study. Table 3 provides an overview of the emergent codes.

Table 3

*Emergent Nodes and Codes with Numbers of Sources and References*

| | **Name** | **Sources** | **Refs** |
|---|---|---|---|
| Node 1 | Perceptions of the PDF as a system in our DHB | 4 | 252 |
| 1 | Comparisons with other DHBs, funding systems or other disciplines | 4 | 9 |
| 2 | Complexity and time taken | 4 | 74 |
| | - Manager's role | 3 | 10 |
| 3 | Does the PDF meet our WDHB values | 3 | 7 |
| 4 | How did the PDF come about | 3 | 15 |
| 5 | System and process | 4 | 112 |
| | - Suggestions | 4 | 21 |
| | - When things change | 2 | 5 |
| 6 | Weighting on cultural question | 4 | 35 |
| | - Examples of why this is important | 1 | 1 |
| | - Lip service to cultural question | 4 | 16 |
| Node 2 | The experience of applying to the PDF | 4 | 190 |
| 7 | Gratitude and value | 4 | 40 |
| | - Negative | 2 | 9 |
| | - Positive | 4 | 23 |
| 8 | How does it feel when applications are accepted or rejected | 4 | 20 |
| 9 | Lip service on applications | 4 | 19 |
| 10 | PDF committee criteria | 4 | 22 |
| 11 | Personal factors | 4 | 15 |
| 12 | Professional standing (peer esteem) | 4 | 47 |
| 13 | Telling stories about the PDF | 3 | 15 |
| 14 | Team work to get applications across the line | 3 | 12 |
| | - Work arounds | 1 | 3 |

| Node 3 | The impact of the PDF on careers and engagement | 4 | 72 |
|---|---|---|---|
| 15 | Cost of training (time and monetary) | 4 | 23 |
| 16 | Personal factors | 4 | 15 |
| 17 | Engagement and career progression | 4 | 23 |
| 18 | Impact of the PDF on training expectations | 4 | 15 |
| 19 | The value of attending conferences | 3 | 11 |
| | - The changes to patient care resulting from learning | 1 | 1 |

The coding table shows that the greater volume of narrative focussed on the participant perspectives of the PDF as a system. Secondary to this in terms of volume was the experience of applying for funding and third the impact of the PDF on career progression and staff development. If a sentence pertained to more than one idea it was coded against all relevant codes rather than one single code. As explained in the previous chapter, further interrogation included making notes of emergent thinking, as shown in Table 4.

Table 4: *Example of Emergent Thinking Notes Taken During Interpretive Analysis*

| **Excerpt FG1 Transcript (de-identified)** | **Emergent thoughts** |
|---|---|
| Ellen - Yeah, I have similar thoughts that I understand why it was set up because they wanted it to be fair across the organisation but, on the other hand it is quite difficult having to prove to somebody that doesn't know you, or your work, why you should or should not attend a particular conference.<br><br>*Interviewer - And, when you think about the culture of our DHB and the values which is where it came from in the first place, how do you see PDF in relationship to…*<br><br>Daisy - Convoluted!<br><br>*Interviewer - …those expectations and those values that we hold as an organisation.*<br><br>Casey - I think they do cover those | The proving to unknown others seems like a trial, there are assumptions here about the committee but also a strong sense of being an expert in her own field and wondering why it is necessary for other people that she doesn't know to make decisions about her learning needs. I wonder why people don't realise that the committee membership is tailored for the eligible groups.<br><br>The difficulty of not knowing –This is such a dilemma, they don't know that their own directors and managers are on the committee – such a surprise! |

| | |
|---|---|
| values but actually writing it in is very convoluted, and no one knows who you're sending it to, a body of people I have no idea who they are. And they have no idea what I do or what I need this for. And unless I get that right and unless I put it across properly, they can go well what's the use of this and say no. | |
| Daisy - or ask a whole lot more questions and then you have to do a whole lot more justification, which creates a whole lot more work, when you're already time stretched. | Exposed in this, needing help there is a sense of vulnerability here…. This can relate to both the judgement of the committee and also to the sense of self, as a professional going cap in hand, being subject to judgement of those unknown is also a vulnerable place, people need to have clearer connection with the panel – it will really help |
| Casey - So to be able to put yourself forward for the process anyway, you need to be very clear that that's what you want to do, it's very long and involved so you really do want to be going ahead with the conference or the paper. So to actually be able to put yourself forward that way you're already putting yourself out there saying well I need some help to be able to do this, whatever it is. | |
| Abbie - I do think having to justify it is a good reason, you do need to justify why you want to go and how it will relate to your work otherwise you may well get people who just apply! | |
| Daisy - I get that too but as a team leader nobody applies to that fund without going through me first because I have to approve it, I have to support it and I would of thought that as a team leader my, support of that person would be valued and I don't feel like it has been valued at times because they've been pushed back on things that to me seems so obvious. I just feel that part there is a little bit of a frustration for me as well. | This is so strong, retaining a sense of control in the situation. Ultimately though her opinion can be overruled by the committee, what does her staff think about it when her judgement is not supported by the committee, she might be worried about how that reflects on her in their eyes? |
| *Interviewer - Has anybody else had that or that or similar experiences?*<br>Frank - It's like you don't know - who is | The unknown is difficult for health |

| | |
|---|---|
| that group, do you? You know it's out there, well up there but... | professional people who have strong rationalisation abilities. Healthcare is based on formulaic conventions and is outcome driven, so navigating this system presents challenges. This is despite there being a lot of information available – maybe it's something to do with the format? |

Following the note taking exercise the provisional themes developed were:

**What is the experience of applying to the PDF?**

Theme 1 - How it feels when you get approved or declined.

Theme 2 - Being a professional in professional development.

**What are the perceptions of the PDF as a system at WDHB?**

Theme 3 - The PDF Committee, their criteria and decision making – "It's like you don't know who that group is"

Theme 4 - Collective Intelligence – "Learning through their eyes"

**What is the impact of the PDF on career progression and staff engagement?**

Theme 5 - Personal outcomes of applications

Theme 6 - Why the investment of the PDF is important – "The amazing sunshine effect"

## Themes

Following the IPA iterative process of pattern searching aided by white-boarding and mind mapping, three final themes and nine subthemes emerged. They were:

1. **Theme one: Blind spots**

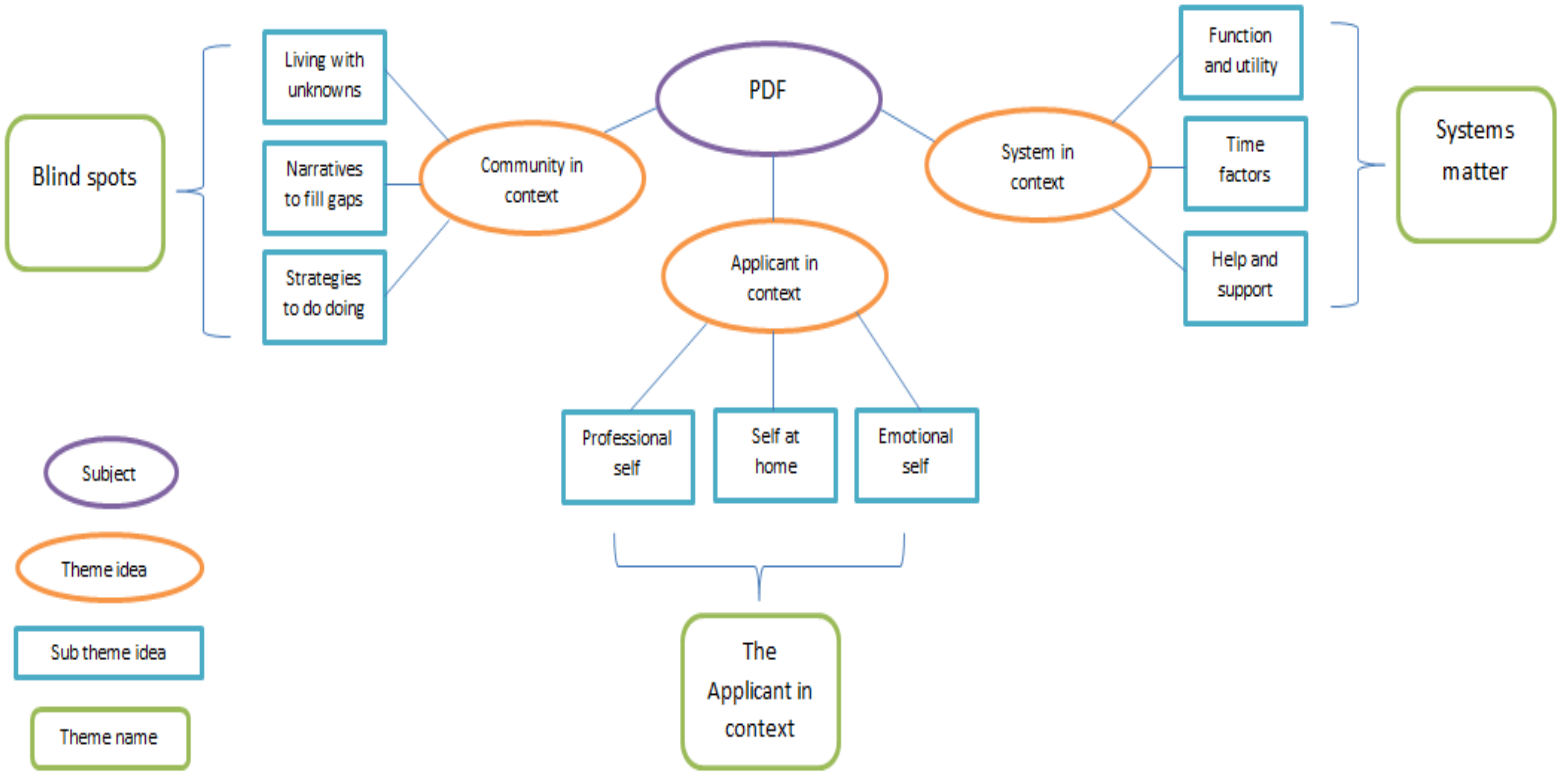
   a. **Who is that group?** - This subtheme relates to common knowledge gaps about the PDF committee and their decision-making criteria.
   b. **Hive learning** - This subtheme explores the collective meaning making, storytelling and responses that have emerged from peoples' experiences.
   c. **Work arounds** - This subtheme considers the collective navigation strategies in order to have successful outcomes.

2. **Theme two: The applicant in context**
   a. **Sizing things up** - In this subtheme the participants talk about their self-perceptions in the application process, they compare themselves with other professional groups and with other organisational groups.
   b. **Beyond the workplace** - This subtheme relates to the impact of application outcomes on home, familial and financial matters.
   c. **Values and feelings of value** - This subtheme gives voice to the participants' views of the PDF in relation to the organisational values and creates space for their work-related emotional responses.

3. **Theme three: Systems matter**
   a. **"I don't know what 2 megabytes is equal to"** - Design and functionality are important and this subtheme considers the participants' experiences of the electronic process.
   b. **Time is precious** - The participants describe the application experience in the context of busy workplaces.
   c. **The 'help desk' idea** - Suggestions made for how things could be improved are captured in this subtheme.

The following diagram is a map of the theme ideas and main theme titles.

Figure 2: *Map of Theme Ideas and Main Theme Titles*



Collectively these themes recount the lived experience of professional people applying for funding through the PDF, shedding light on workplace relationships and vocational commitment, personal and familial stories and the experiences of navigating a financially constrained system so common in the public health environment.

**Theme 1: Blind Spots.** The Blind Spots theme reflects Heidegger's phenomenological concept of "unverborgenheit" or 'unconcealment' (Wrathall, 2010, p.13) which asserts that things show themselves in the world or are uncovered where and when we have access to them, and that seeing things in context is necessary to understand their constitution and essence. What emerges when encountered in the world has degrees of truth and concealment, and as a result 'untruths' can develop to fill the vacuum and explain unknown factors (Koskela, 2012).

The three subthemes in 'Blind spots' are: 'Who is that group?', which focuses on the participants' knowledge gaps about the PDF committee and their assessment criteria; 'Hive learning' which represents the collective learning emerging from narratives to fill the knowledge gaps and inform doing; 'Work arounds' which enlivens the 'doing' by shedding light on collective navigation strategies developed as a result of communal learning and employed to get applications over the line.

***Who is that group?*** Despite some participants having previous experience of applying to the PDF, many were unfamiliar with the committee membership.

In FG1, Frank, an Occupational Therapist, shrugged his shoulders and said, "*It's like you don't know - who is that group do you? You know it's out there, well up there but…"* He left the statement hanging as he

smiled and raised his hands, palms upwards. Later in the conversation Ellen, one of the pharmacists, developed this thinking further:

> *I understand why it was set up because they wanted it to be fair across the organisation but it is quite difficult having to prove to somebody that doesn't know you, or your work, why you should or should not attend a particular conference* (Ellen, Pharmacist FG1).

Casey and Daisy's exchange echoed Frank and Ellen's concerns about the panel's perceived lack of familiarity with the applicants:

> *I have no idea who they are and they have no idea what I do or what I need this for. And unless I get that right and unless I put it across properly, they can go 'well what's the use of this?' and say no* (Casey, Nurse FG1).

Daisy responded:

> *[They] ask a whole lot more questions and then you have to do a whole lot more justification which creates a whole lot more work, when you're already time stretched* (Daisy, Nurse Team Leader FG1).

In this exchange Casey and Daisy appear to be risk-assessing the situation. From their perspective, the risks of the committee saying 'no' or asking more questions involves potential disappointment, but also critical factors such as time expenditure which receives more detailed attention in theme three. Focusing on the committee membership, Betty had this to say:

> *So it's just about understanding where money is wisely spent and understanding who is actually on the committee making these decisions and how do they know whether it's something of value?* (Betty, Pharmacist FG3).

Briar (Physiotherapist FG1) picks up on the issue of unfamiliarity, "*I just think there has to be some consideration of what your actual role involves, and you hope [that there is] when it goes to the panel, but none of us have any idea"*. It seems to make sense to her that panel

membership would be reliant on insight into the roles of those eligible to apply, although she is unsure if this is the case.

In addition to vagueness about the panel membership, this subtheme also included blind spots around the criteria used to consider the applications. Eloise's written response offers an example:

> *I was declined funding. While I understand that not all applicants can be funded I felt disappointed with the rationale which was that my application did not reach the required score for approval. There was no indication as to how the scoring is done* (Eloise, WR).

Ellen expressed similar thoughts:

> *You don't know what their marking criteria are and so it's very difficult to sort of tailor your answers to something that they want to hear. I found that quite difficult. You don't know what you're being marked against* (Ellen, Pharmacist FG1).

Briar's application was successful only after resubmission; she felt that the criteria were not transparent from the outset of the application process:

> *It became clear they had criteria that they were looking for, if that had been spelled out sooner we could of spoken to that upfront, so it felt like they were actually holding back what they were looking for until you applied and then they came back to it* (Briar, Physiotherapist FG1).

Similarly, Deena felt confused:

> *You know I had no awareness of what they were looking for; it was all very much 'I don't know what they need here'. You know I could have been stronger if I'd known [or] if I'd had more clarity around what they'd expected* (Deena, Community Engagement FG3).

In FG3, Agnes was thinking along the same lines, emphasising her meaning by repeating herself:

> *I think for me it's more about the lack of clarity in regards to how much information do they want or need? That is, how much information do they actually want? Or what do they actually need? Because really from my point of view the training itself says what it is!* (Agnes, Nurse Educator FG3).

During FG3 I pointed out the guideline documents and where they could be found to the group. Eric's response was telling:

> *Oh yeah I've read through the policy [but] I guess that anecdotal evidence that I'm hearing around this particular type of education [is that it] isn't prioritised in this particular field. If there was somebody to ask or there was something to read that was more helpful, maybe that's out there and I don't know* (Eric, Patient Literacy Educator FG3).

Eric appears to be more drawn to anecdotal information despite having read the official information provided by the committee.

Having established a deficit of certainty about the PDF committee the next subtheme deals with the resulting collective responses and knowledge creation used to fill this vacuum.

***Hive learning.*** Made manifest in this subtheme is participants' experiences of a collective and proliferating intelligence around the PDF, which is the result of shared experience and stories. In addition, although PDF applications are individual endeavours they often appear to be group-initiated. As a result, outcomes affect both the individual and the group involved, thus reinforcing collective perspectives.

Eric, an educator and relatively new member of staff at the DHB, spoke of learning about the PDF:

> *I haven't been working for the DHB for too long but my co-workers, a lot of them have been around for a very long time. So I'm kind of, I suppose, learning about the PDF fund through their eyes. [The first time I applied] I didn't invest a huge amount of time because I heard from my teammates that there have been no*

> *issues before and so it was a bit confusing [when it was declined]* (Eric, Patient Literacy Educator FG3).

Listening to others in this case did not serve Eric well. Conversely, others had positive experiences of sharing, for example Briar (Physiotherapist FG1) reported seeking advice from colleagues; "*I did go to team members, who said 'Oh yeah you've got to really be careful because that's what lots of people get bounced back on' and I said 'Well, what do you need to say?'"* At this point in the conversation she was smiling and rubbing her hands together conveying a sense of good-hearted collusion, and this amused and resonated with the others in the focus group. Betty also described experiences of team support:

> *Within our department there's a lot of support for how to fill in the forms, who's done well before, how do we support each other, what guidance can we provide, what information you need to be a bit stronger. Getting people to look over each other's stuff and help each other, which is great you know because a lot of people who are not pharmacists and technicians are even scared of filling in forms, and so having that support within the department is great* (Betty, Pharmacist FG3).

The team approach was also prominent in Olive's response:

> *I didn't initially understand what the questions were looking for and so I spoke to a number of colleagues who had gone through the process. A colleague sent me an exemplar of a successful application. Once I had this and understood what they were looking for it made it easier. If I didn't have the exemplar I don't know if I would have been successful* (Olive, WR).

Through this collective approach came a sense of team work and compassion, as seen in Celia's comments on the empathic response of her team:

> *My whole team were really cross as well, everyone was really gutted and they all said 'Come on you can apply for another' and I was like 'I don't think I can', you know they really did have to kind of push me to do it* (Celia, Clinical Case Coordinator FG3).

Celia's work mates were influential in her engagement and were energised to support her. Clearly Celia's experience affected them, and most likely others outside of the group, suggesting an epistemic culture growing within the organisation. In FG3, Betty also spoke about the influence of hearsay, but framed it as having the potential to create a more positive view:

> *I think it would be helpful to hear a bit more about what kind of things people have had opportunities to get funded for, and the range of things in different areas and how they've achieved that, and what difference it's made. Because I've heard snippets around the place but it would be really helpful to have that. I think it's in the monthly reports that are produced by the PDF people but it's not widely distributed - to say 'look you can access these things, it can be possible'. Because we often hear the inter-people conversations where there are barriers and it's hard to take away from that, it kind of leaves a lasting impression. To counteract that would be a lot of work - PR, advertising, support* (Betty, Pharmacist FG3).

It seems that there are high levels of trust amongst team members and that this is coupled with low levels of engagement with official information about the PDF. Briar (Physiotherapist FG1) explained how stories circulating amongst team mates influenced her view; *"You hear stories through colleagues about getting rejected and you think oh, is it really worth all of that for the possibility of getting told no?"*. Deena from Community Engagement (FG3) offered another related experience; "*Most of my colleagues discouraged me from bothering to apply. So you start off with that expectation that you're not going to get very far, it doesn't really encourage you to try"*. Eloise had also heard that making an application was not as easy as perhaps it could be "*The anecdotal feedback I have had is that although this fund is touted as a support for PD opportunities, there are only a few, well-educated and select staff likely to be able to access funds through this avenue"* (Eloise, WR).

Worryingly, according to Celia, the story-telling is not limited to employees:

> *I remember even when I was a student nurse and the nurse educator was coming in and saying [to the staff] 'Come on we've got this fund, why aren't you applying?' and the answers from everyone was, 'We have not got time to fill in the forms while we're working'. So right back then when I was a student it was quite negative* (Celia, Clinical Case Coordinator FG3).

The 'Hive learning' subtheme demonstrates story-telling and communal meaning making about the PDF. Applications are made communally and outcomes are felt communally; as a result perceptions are generated which inevitably influence future engagement and endeavours. From this shared storytelling, participants went on to talk about the resulting strategies deployed by applicants in their endeavours to access this funding, which is the focus of the next subtheme.

***Work arounds.*** Work arounds, the final subtheme in 'Blind spots' reflects how applicants, rather than relying on the available guidance, found new and novel ways to understand how to be successful in their applications. People reported acting in synergy rather than as individual entities, employing a variety of ways to understand and meet the perceived requirements of the committee in order to get applications across the line. The strategies included seeking supervisory advice and seeking advice from knowledgeable others:

> *I was fortunate because I also had a bit of a problem and I went to the woman who supervised me for a bit of guidance, because you do have to get the terminology right - I mean I'm not that bad, but having to fill that in with the relevance to what you're doing [was important]* (Alice, Occupational Health & Safety FG2).

> *[In the] second round I got through but that was after quite a long conversation with a lot of people, talking specifically to the Māori Health Team and how they could help me get over the line because*

> *that was the area that the application was rejected (*Ellen, Pharmacist FG1).

Another approach was to use related documents:

> *There's a yearly Māori Health Services Plan, so when I was writing I had the plan and kind of screened it, I was saying to my team we will try and get as good an outcome as we can, you know we are going to go there, but I think it could be kind of [easier]. We need it [the PDF] but also answering it can be a bit OTT* (Frank, Occupational Therapist FG1).

Other participants felt it was necessary to be formulaic in their responses, which conveys a shift towards tailoring applications for successful outcomes. At times the participants spoke about this in terms of '*paying lip-service' or* '*Jumping through hoops'*. '*Saying the right words',* and using '*management-speak waffle'*. The participants were concerned about this experience and described feeling '*disingenuous'* in the following direct quotes.

Examples included Irene (WR) who reported "*a feeling that if I quoted the right phrases I would score higher. But I don't have time to be writing pages of what someone wants to hear"* and Eloise's written response "*I would be writing what the committee wanted rather than what was important to me"*. Kathy's written response said "*It was frustrating to have to prepare all the documentation and then have to re-write it to suit the 'right answer' to get approval"*.

Casey (Nurse, FG1) said that it was important to her to *"write something truthful and genuine because that's what you want to be - genuine, but sometimes it's just ticking that box if you get the right words"*. Glenda (WR) highlighted this as a potential barrier for younger colleagues in her written response, *"I'm pretty good at writing the right kind of management-speak waffle. Many of my more junior colleagues struggle to know what to put in"*. Daisy (Nurse Team Leader FG1) spoke about this in relation to her team's applications – *"It felt false because it*

*wasn't coming from their hearts, it was what they thought was wanted to be heard. And even though there was nothing wrong in what was said, it just didn't feel right".* This was consistent with Celia's experience:

> *And basically you know our manager provided us with an exemplar and said 'Here, change it'. It was a real farce you know. It wasn't heart-felt stuff – 'this is what I'm thinking and this is how it's going to help me'. I just felt like it was an, 'Oh this is what they want to hear' - which didn't feel quite right* (Celia, Clinical Case Coordinator FG3).

This sense of unease was often related to the question in the application that asks how the training might address health inequity for Māori (Applicants cover letter - Appendix 3.b). There were some interesting conversations about this question in each of the focus groups. Briar in FG1 was a migrant to New Zealand and remarked that as her patient demographic is largely European and Asian with very few Māori patients she struggled to develop a genuine answer to this question; "*I'm understanding more and more the importance of the Treaty but you do feel a bit disingenuous trying to say how it's going to really impact that aspect of your care [when you have very few Māori patients]"* (Briar, Physiotherapist FG1). Like Briar, other participants spoke about their difficulty in answering this question:

> *One of the things that I think myself and my staff are quite passionate about and aware of is that the Māori population often don't have the same outcomes; it's always an access thing because they have trouble getting to their appointments to come and see us. So part of the work that we do is providing a remote service. We're acutely aware that it's really important and so you know we talked about that in the applications, and still getting pushed back and wanting all these other words and all these other phrases which eventually got them over the line. They just weren't things that were coming out of our mouths; I suppose we just maybe hadn't explained it in the way that was wanted to be heard or something. But that's where I found quite frustrating. We thought we'd written something appropriate but it wasn't enough. I don't*

> *know how to fix that and make it feel like it's genuine. And it's fair enough to make us think [about Māori health] I think it's very valid. But, when you've actually done some thinking and you've thought about how it can help, but it's not enough?* (Daisy, Nurse Team Leader FG1).

In FG2 Alice had similar feelings:

> *See this is probably one of the questions that I know a lot of people struggle with, the question around how is what you're doing going to reduce disparities for Māori. When you're going to something that is very specific to what you do it's hard to work out what you're trying to say there without sounding a little bit waffly* (Alice, Occ. H&S FG2)

And in FG3 the same matter came up when Celia made this poignant comment:

> *In the experience I had where I was declined they actually just wanted more on the Treaty of Waitangi, and this was like after I'd spent hours doing the paperwork. I recently had some really unwell Māori clients that I was spending my time with and I just thought I don't want to sit behind my desk telling you how I'm going to do this, I'm actually out there doing it* (Celia, Clinical Case Coordinator FG3).

This was seemingly an important matter as it was consistent across all of the groups with most participants also describing their efforts to achieve an acceptable answer. Ellen sought help from colleagues in He Kamaka Waiora (Māori Health Services) when she had to re-submit her application:

> *I have to say that Māori health were very helpful. None of them could help me with the question, but they did tell me who to call so that was very useful. […] They were all a bit dumbfounded as well as to how to answer it. [In the] second round I got through, but I felt very strongly that I didn't want to say anything false in my application, so I found it really hard to change the wording to make it sound like I was promoting Māori health or the Treaty*

> *when my work specifically wasn't targeted at any particular group* (Ellen, Pharmacist FG1).

Focus group 1 spent some time discussing this issue. Abbie, a Māori participant, listened graciously, nodding to show her understanding but allowing the conversation to take its course. It was important to make space for her perspective and so in an appropriate pause I asked Abbie for her opinion.

> *I'm interested to know what you think Abbie* (Researcher).

> *Funny that! So, I'm Abbie and I am Māori,* (smiling, looking around the group; others beckoning for her to contribute*) Well when it comes to the Māori question from my perspective in regards to the Treaty there's a protection, and as long as you're providing care that allows Māori to have equal access then that's fine. And I think that's what they're looking for. So I know you might think it's disingenuous, but when the Treaty was signed, it was 'you must protect the health of the indigenous population'. … It's not an 'I'm going to treat these ones differently because that's what they're looking for'. It's an – 'as long as they have the same access as everybody else'. And I think that's all they're looking for […] because when the culture has been so changed, even though its generations ago, it still holds them back. Well it doesn't hold me back personally, but I understand - I get it* (Abbie, Practice Improvement Nurse FG1).

The positive affirmation of this by others in the group is demonstrated in Casey's response:

> *I totally respect what we're trying to do, for me I want to make it genuine and I know it's there, I know it's important and the way you've just explained it is probably the best I've ever heard* (Casey, Nurse FG1).

Knowledge gaps, shared learning and collegial ways of figuring things out were all demonstrable in real time during this conversation. Observing this communal interaction in action and in context revealed

the constituent parts of a thought process, understood and summarised as follows:

- Who are the panel, what do they want to know?
- What information can I find out from others? What do others think they want?
- How can I use what I have learned to get what I need?

Degrees of understanding and uncertainty in the participants' views of the committee and their assessment criteria have been manifest throughout this first theme. In the next theme, attention turns to the emergence of the applicants' views of themselves as health professionals in relation to the PDF, reflecting expressions of their professional status, themselves in the context of the organisation and relatedness with their personal lives.

**Theme 2: The applicant in context.** This theme gathers together the self-perceptions of the participants as individual health professionals in the context of their discipline group, in their home life context and in their organisational context in relation to applying to the PDF. It has three subthemes; the first, 'Sizing things up', sheds light on the participants' professional comparisons with others. The second, 'Beyond the workplace', deals with personal factors, since home life was significantly connected to the experience of engaging with professional development for the participants in this study. The third, 'Values and feelings of value', considers the participants' work place emotions and feelings of worth, particularly when contextualised against the background of the organisational values and the organisation's investment in their professional development.

***Sizing things up.*** In this subtheme the participants illuminate the importance of professional validation through comparisons with peers. Linked with this are views on the contrasts between the funding entitlements of different disciplines. Comparative funding systems vary

across professional groups, career stages and organisations, and the participants shed light on how they regard these differences.

An early example of sizing up occurred when Briar spoke about her experience of attending a professional forum:

> *So I applied to attend our national Hui [meeting] which runs every other year and in conjunction with that there was a course that was running at the same time, and an international speaker had come over to present. They covered 50 plus percent of my caseload and so that was really important to my role and wanting to see - am I up to national standard, am I up to international standard? I sort of knew that we actually do pretty well here in terms of what we can provide with the resources. I thought we were doing okay and we're providing a good level of care for our patients. And so going in and hearing this international speaker from the States present I thought, yeah we're doing all that. And then going to the Hui and listening to the speakers and the consultants that presented from around the country and a couple of international speakers from Europe. So again it was nice and reassuring that we're actually providing really good care for our patients* (Briar, Physiotherapist FG1).

Briar felt that this was a good opportunity for her to measure up against others because of the quality of the event which she emphasises in several ways. She uses the word 'Hui', a Māori word meaning a gathering or assembly with great 'mana' or esteem. The dual nature of the Hui and course together, the international speaker and the relevance of the conference to her patient cohort also adds weight to this event as an appropriate forum for her professional validation.

Sizing things up through conference attendance is not often articulated so candidly; however the idea of placing oneself in the professional 'pecking order' was mentioned by other participants too:

> *The networking is important and there are unanticipated consequences you know like, checking that we're actually doing okay, and that kind of validation. But also when an opportunity*

> *came up I had to write something, and I was able to draw on some of their data and the literature and put it into a business case, it was great* (Frank, Occupational Therapist FG1).

Frank sees the ability to compare with others as giving a measure of confidence derived from positive peer interaction so he feels more assured of the status of his own team. This in turn enables him to confidently represent the team's needs. Beryl and Daisy also highlight the value of peer interaction in professional forums:

> *Conferences are a huge value and personally I think I should be able to attend something like that nearly every year because it's not just the meeting and presenting, its participating and the extra meetings that go on where you are connecting with your peers from around the country and Australasia as well, and it's just such a valid time* (Daisy, Nurse Team Leader FG1).

> *They have a New Zealand conference every second year and so that gives us an opportunity to network and to get some more information about our speciality. The ones I've been to have been really worthwhile. I've been really privileged to go to them, on both occasions I had heard about something which I had never heard of and then come back and had a patient literally with that same diagnosis. …There's quite a close collegial thing between the Australian and New Zealand therapists and for me that's been helpful* (Beryl, Nurse FG2).

It is apparent that increasing confidence and validation through self-comparisons with respected others is important to health professionals. Engagement in such activities is however reliant on available finances and for many health workers without contractual entitlements this presents a challenge. As a result, comparisons of funding entitlements arose; the participants were keenly aware of the diversity in employment conditions for different professional groups and in different organisations.

The Senior Medical Officers (SMOs) Continued Medical Education (CME) allowance was generally held up as the gold standard. Larry

(WR) wrote "*Also seems that medicine and their CME funding are still far superior to any other professional discipline in the DHB".* Hollie also pointed this out in her written response:

> *I felt very honoured to have been funded and I think that the DHB have been very supportive, it felt like a great reward – however the doctors seem to be able to gallivant around the world several times a year without having to justify it* (Hollie, WR).

Betty had similar thoughts:

> *The SMOs have it [CME] as part of their contract and they get certain thousands per year, and nursing I think has an allocated amount per year. And you know everybody [in that discipline] gets that and so they can spend it as they wish within criteria. When that's understood that's part of how they become an expert in what they do. The people in the room here and who you work with, you're all experts in what you do and so the organisation runs with everybody. Everybody should have that, I think that's probably quite a good model of working* (Betty, Pharmacist FG3).

Betty's cross-discipline comparison also expresses her perception of the value of expertise to the function and success of the organisation. Later in 'Values and feelings of value' particular attention is paid to perceptions of worth associated with professional development funding. Returning to the focus on professional comparisons, Betty also points to nurses as a group with a PD entitlement; however what Janice wrote contradicted this view "*All of us felt that for nurses in particular it should be something we are given, capped per year, as an appreciation or reflection from 'the company' that they appreciate what we do as nurses"* (Janice, WR).

Although the PDF is for aspirational learning rather than required learning, Agnes' perspective was that:

> *Some portfolios have absolutely no funding at all in regards to training, everything goes via the PDF. But as nurses we have different pathways that we can potentially access, so for nurses*

> *it's a bit easier. But when it comes to the social workers and the Occupational Therapists I couldn't tell them you can go to Health Workforce [New Zealand] to get the funding, there is no other option it was PDF - all or nothing. And quite often that hit barriers of too much work, too much time, coming back with decline so people just didn't [apply]* (Agnes, Nurse Educator FG3).

Interestingly, there were also differing perceptions amongst participants about the diversity in entitlements for nurses working in different organisations. An exchange during FG2 between Beryl and Alice, both of whom are nurses, captured this comparison:

> *I've got a colleague at [another] DHB and my understanding, and I haven't been able to confirm this because it's only her that's told me, is that every nurse gets a funding allowance for training per year* (Beryl, Nurse FG2).
>
> *Yes they do its $500* (Alice, Occ. H&S).
>
> *Well I heard it's a $1000* (Beryl).
>
> *And they can choose how they spend that; they can save it up and go to one big conference. Anyway I do know they have dedicated funding (*Alice*).*
>
> *Wow, so they call it PDP?* (Cora, ARDS).
>
> *Well no they call it the same as the doctors 'CME'. She called it CME, and I said 'but you're not a doctor'* (Beryl).

Whilst this dialogue reveals participant understandings of different organisational approaches, it also holds meaning as it highlights the perceived ownership of words; for Beryl the word 'medical' is the reserve of doctors, which was an interesting facet of the conversation.

There were other instances where varying organisational approaches were highlighted although opinions ranged about their effectiveness:

> *I also think the PDF is a good system because I know in other DHBs all the nurses get so much per person, but it wouldn't be*

> *enough to cover any of the conferences that I've attended that's for sure* (Abbie, Practice Improvement Nurse FG1).
>
> *The nurses at [another] district health board, I can't speak for any of the other disciplines I'm afraid, but for nursing - they get it with their individual pay. But I still think there's always a process [for accessing the funding]* (Beryl, Nurse FG1).
>
> *Previous work places that have had a PD committee just asked for course information, price and manager approval. They then decide on how many people can go and what monetary amount will be allocated - depending on how much was in the pot. If lots of people wanted to attend the same course and their manager had approved them all, then they may all get partial funding only* (Daryl, WR).
>
> *I know of people working in other DHBs that don't have to complete time-consuming applications as theirs are approved by their service manager* (Olive, WR).
>
> *Nurses here often compare what we have to other DHBs where nurses have their own money like the doctors, thus they are somehow better off. There is still a process which requires application and approval but they don't seem to see this aspect. Our system allows better access to funding. I would not have been able to fund my Doctor of Health Science based on the other DHB model - I worked there for 10 years and used that model* (Blanche, WR).
>
> *I mean I'm grateful because, I do know there are people from other DHBs and they've gone through hoops to get any funding to come to things. So I think in that way the PDF is quite generous* (Alice, Occ. H&S FG2).

These comments suggest that health professionals are keenly aware of the hierarchy of financial investment and its intrinsic links with professional validation, equity and competence. They define the reasons for the variance as being situational, but more critically as being driven by the perceived value of professional groups.

It is clear through this theme that organisational investment in professional development contributes to participants' views of professional statuses. It is also the case that personal lives are affected, and this is explored in the next subtheme.

***Beyond the workplace.*** When considering professional development, personal lives are easily forgotten; however, for the participants in this study the overlap between home and work was intrinsic. The 'Beyond the workplace' subtheme focuses on familial and home factors, shedding light on how application outcomes affect people's personal lives. Here Alice talks about changes on the home front as a result of receiving funding:

> *You put a lot of personal time, energy and effort into study and that had a huge impact on my family and my kids. Some of it really good - they're better cooks, they know how to clean!* (she laughs). *Because we sat down at the beginning and I went 'this is what I'm going to do, this is what I need from you, what you all can do?' And they both cook once a week and they took turns at doing various household chores. I have to say by the end of it they'd kind of lost a bit of that enthusiasm* (group laughs), *but it's had a huge impact on me on a personal level and on a professional level. So I mean I'm nothing but grateful* (Alice, Occ. H&S FG2).

Although Alice was generally quite buoyant about the impact on her family, others described more challenging situations, including logistical issues.

> *[Because the application process took a long time] there was a change of flights and because the times had changed, we then had to change the times of our car hire. But this was all at the last minute and we had already arranged the kids based on the flights and then we were out by quite a few hours. So it was like 'Oh my gosh we need to change plans for the kids! And don't forget to do the car booking changes!'* (Cora, ARDS FG2).

This conveys the tension between parental matters, financial constraints and professional commitment. Betty also experienced logistical issues with home life implications:

> *It had a very difficult impact because I chose to self-fund, I've now had to work five Saturdays away from my child in order to pay back and I work part time to spend more time with my child so I earn less money in general. […] I come to work because I love what I do, not for the actual money, but it's difficult because you make other sacrifices and it has an impact on your home life* (Betty, Pharmacist FG3).

Betty also spoke about the push-pull of home and work in an earlier experience of applying:

> *So I then applied for a much, much cheaper thing, and I could only apply because of a change in personal circumstances, my husband was meant to be working and then he wasn't - so I could apply, but then I was declined because I was too late* (Betty, Pharmacist FG3).

The tensions between familial financial commitments and professional demands were noted particularly by participants for whom financial considerations were an intransigent challenge:

> *If you are fortunate in the situation that you actually can pay for it yourself, then at least you can make the choice of 'Oh well I'm going to take that risk to pay for it myself whether it's approved or not'. There are many clinicians in our portfolio that haven't got that opportunity. They cannot afford to pay for it themselves. So the choice is already eliminated* (Agnes, Nurse Educator FG3).

Others supported this position; in the written responses Janice wrote "*Most nurses can't afford the fees and therefore wouldn't go on to further education unless they were assured of being funded"*. Annie (WR) commented that "*The funding was very helpful and gave me an opportunity I would not have been able to afford"* and Alice spoke about the outcomes of being funded for postgraduate training:

> *From a personal point of view, doing my post grad diploma meant that my career progressed quite substantially; I wouldn't have been able to do that [without funding] so it's had a huge impact on me. It's meant more responsibility, it's meant more pay and that just wouldn't of happened without the PDF* (Alice, Occ. H&S FG2).

Irene (WR) crystalized the importance of funding further, "*I found the cost of the conference ($250 for one day early bird rate) to be too excessive to pay for out of my own pocket. If I couldn't get funding, I would not be going".*

Although the PDF is not supposed to cover the cost of mandatory training, it was evident that health workers need financial support to maintain their currency of practice, registration and continued employment to provide for their families. Both Glenda and Betty commented on registration requirements:

> *I feel that staff such as physiotherapists who have to complete some formal learning each year in order to maintain their competency with the Physio Board, should just have funding allocated each year automatically so that they can complete this requirement. It is in the best interest of WDHB to help their staff to maintain their registration (*Glenda, WR).

> *I think the health sector is often around good quality because we're all pretty much caring people who give our hearts and souls to improve and help other people with themselves, that's what we do. That's the essence of what we're doing in whatever we do. Within our profession we're expected, like others to have a certain amount of professional development which is expected in order to gain registration, if you don't meet it you can't practice and all of those things come up* (Betty, Pharmacist FG3).

Having previously expressed the passion for and privilege of helping others as syntonic with vocational commitment, Betty's comments about professional expectations appear to reflect a dichotomy; the commitment

to abide by regulation and a personal commitment to service, versus limited financial resources to grow and develop in practice.

These personal stories capture the interplay between funding outcomes and the participants' lives beyond the workplace. These are personal matters impacting on relationships and families, but also intrinsic in many of the statements were feelings of value and worth at work. These are explored more explicitly in the next subtheme which links professional emotional factors with the organisational values as understood by the participants.

***Values and feelings of value.*** Enlivened in organisational philosophies, mission statements, promises and values is the association between emotional connections and functional operations of an organisation. Organisational value statements are designed to convey the soul, direction and intention of the organisation. Successful workplace transactions rely on the integration of clear organisational messages with workers' perceptions of alignment to their feelings of being valued. In this case, the Waitemata DHB value of 'everyone matters' is particularly relevant. Investment in professional development is one way in which organisations demonstrate commitment to valuing workers; in turn workers bring their skills to bear in delivering the goals of the organisation. This interdependency between the philosophical belief that 'everyone matters' and whether people feel that they do in the PDF process is synthesised in this theme.

*The Values.* The first part of this subtheme conveys the participants' views on the PDF in relation to the organisational values. Later, emotional workplace experiences come through, including how it feels to have applications endorsed or declined. Another factor within this subtheme is what happened for budget managers when the fund was centralised, and how this impacted on their sense of value.

The organisational values, The Waitemata DHB values developed by the staff and patients of the organisation, are:

- Everyone Matters
- With compassion
- Connected
- Better, best, brilliant

The intention is that these values are manifest across strategies, activities and behaviours and the written purpose of the PDF espouses this intention – in particular 'everyone matters':

> Waitemata DHB's purpose and values shape the development of our organisation and workforce. Consistent with the value of 'everyone matters' (in this case, staff) Waitemata DHB's chief executive has established a centralised budget to enhance staff access to professional development opportunities. (Waitemata District Health Board, 2017b, p. 1)

For the context of this study it was important to seek the participants' views on alignment. Expressions emerged in the focus groups and the written responses which offered the opportunity for triangulation of opinions. The values were often correlated with perceptions of self-worth or feelings of value, which is why these two concepts are intertwined.

In the written responses there were differing opinions. Hollie (WR) wrote "*[The PDF] is a great asset to staff becoming 'better, best, brilliant' & 'everyone matters' - to be able to access this fund occasionally"*. Moira (WR) wrote, "*I think it is a good way of aligning your career objectives with WDHB values and makes you think about them in relation to your work"*. Conversely in Neil's written response, the PDF is "*An overly bureaucratic barrier to treating staff as part of the everyone in 'everyone matters' and to staff becoming 'better, best,*

*brilliant' and 'connected' with outside expertise"*. Olive (WR) agreed with this: "*I don't think it reflects our values. I don't feel valued by having such limited access to professional development".*

Others conveyed ideas about how professional development might align to the core business of the organisation if guided by the values. Chloe (WR) said *"The applicant is constantly reminded of the WDHB values and has to carefully consider what benefit the money/ study will have to the service and our patients"*. Betty (Pharmacist, FG3) pointed out "o*bviously the PDF has to meet the values of the organisation and be beneficial to the people we serve".* Deena (Community Engagement FG3) pointed to the need for alignment "*It should meet the values of 'everyone matters' and 'better, best, brilliant', that's what I would hope it would do"*. These points were important as they conveyed the participants' understanding of the values as the compass to guide organisational development, strategy and investment.

For Agnes (FG3) it was also important that the PDF Committee demonstrate the Values:

> *When people make an application it comes with an expectation that it will be accepted. I think that's where the PDF team particularly can look at how they can still uphold those values. Being aware that when people apply they've got the hope that it will be accepted, so if it gets declined they will have that sense of rejection and [they might think] 'Okay obviously I didn't matter' you know? So how can you then still keep that value of 'You do matter' alive?* (Agnes, Nurse Educator FG3).

Briar had this to say on the subject:

> *I think the concept of the PDF in terms of what we've all talked about sounds great, of course it speaks to our values of 'better, best, brilliant' and all the rest of it. But then when we start talking about the process of doing it, it's enough to put you off* (Briar, Physiotherapist FG1).

The application process is explored in the next theme, so here the emphasis remains on alignment between the PDF experience and the organisational values, with mixed responses:

> *Outcome of PDF = awesome. I'm VERY proud of my work, and VERY grateful for the support I've received. Outcome from attendance at the other conferences funded by the PDF = dissemination of the knowledge to the wider Physiotherapy and multi-disciplinary team. Evidence-based practice shared, meeting the value 'better, best, brilliant' in our teams, and Knowledge translation in action!* (Chloe, WR).

And conversely:

> *If 'everyone matters' as per our values, then it shouldn't have to take that much effort and work for us to be able to access the funding for training that our managers already indicate 'yes this is relevant'* (Agnes, Nurse Educator FG3).

It is clear from the accounts that perceptions of alignment with organisational values vary. One written response captures this well:

> *If I speak for myself, I feel the PD fund meets the WDHB Value of 'better, best, brilliant' and 'connected' and 'everyone matters'. It feels like there's an even playing field to value professional development/ personal learning/ striving for best-practice across the service. However, if I speak for how 'other people' see the PD Fund, then there might not be a general agreement with my view. For other colleagues this feels like 'gate-keeping'* (Chloe, WR).

The values of an organisation underpin its culture and community; they convey identity, norms and belonging, the emotional factors that help people to feel commonality and acceptance. So in addition to views on alignment of the PDF function to the organisational values, there are underlying and deep seated emotions associated with the value statements. Entrenched in this are loyalty and motivation, as well as feelings of worth and value. These personal responses are in this theme because they relate to emotional reactions to workplace experiences.

*Feeling valued.* Both positive and negative emotional responses to application outcomes emerged. People expressed a variety of feelings from confusion, rejection and feeling cross to opposite emotions such as being happy, grateful and engaged. Others conveyed mixed emotions, such as Olive (WR) who wrote "*I feel lucky to have got mine approved but annoyed that it took so much time".* Alice (Occ. H&S, FG2) had a similar response *"I am very grateful for what I got, but I also would really like it to be easier for other people".*

Deena (Community Engagement, FG3) was more definitive "*I'm very unhappy, and a lot of people around were very surprised that I didn't get the funding, so you just feel unsupported and unvalued".* Celia (Clinical Case Coordinator FG3) also spoke about a negative reaction *"After my rejection I felt so deflated I didn't know if I wanted to go through the process again, but I did".*

Ellen conveyed a heartfelt response to being declined in the first instance; she was later approved after resubmission:

> *So then I went down the track of applying for the fund. My first round was rejected and I felt really quite deflated. For the first time in my career I was in tears at work, I found it very difficult* (Ellen, Pharmacist FG1).

Eric was confused by his outcome:

> *You know I come from the community so I'm used to not being offered training. I wrote an application, I heard from my teammates there's been no issues before, so when everyone else had that training and that support, and I had my manager and my team support to get it, and it was rejected. And it just, it was a bit kind of confusing [when I was the only one not funded]* (Eric, Patient Literacy Educator FG3).

Celia spoke about feeling rejected and cross; both she and Betty were concerned about developing and maintaining capability to serve patients

well. Their comments link capability and emotional capacity with patient outcomes:

> *I just felt really, really rejected and really cross. Because the training I wanted to go to was not terribly expensive, it was under $1000 and it was completely relevant and appropriate for my place of work, and it just felt like where's the support to kind of develop and grow so that I can do this job better?* (Celia, Clinical Case Coordinator FG3).

> *So it's just made me feel really emotional about it all because you give your all to the people that you're serving, and we're privileged to serve this population, improving people who are very vulnerable. And you don't want to feel that way yourself when you're trying to give to others because you need to be wired to be okay to help other people, and I felt that was quite demoralising* (Betty, Pharmacist FG3).

Blanche also made this connection but in a more positive light where the commitment to her development created loyalty in improving patient care. There is a sense of value and reciprocity in her experience:

> *I feel very engaged with the DHB as they are providing commitment to my career goals and progression. This means I have a commitment to the DHB in regards to staying with the organisation but also focusing my research on improving patient experience* (Blanche, WR).

Similarly, Moira's written response captured her professional progress and her gratefulness for the support received from the PDF:

> *I have had a great experience applying to the PD fund, and it has really enabled my professional development. I can honestly say that I would not have embarked on a DHSc had I not had the support from the PD Fund to explore the difficulties with the clients that I work with. My DHSc is very relevant to my work, my role, the WDHB service objectives and the NZ health strategy, so I am really happy. I am extremely grateful* (Moira, WR).

Betty, who often captured the mood in what she had to say, also connected emotion and performance:

> *And this is to people who genuinely appreciate if they get anything, I'm that kind of person if somebody did one little thing I'd feel so valued for so long that you know I'd have an 'amazing sunshine effect'[…].but it's not necessarily the opposite, I'm not totally despondent, but it's just everybody's a bit different. Some people brush it off. Some people don't. But you don't want it to impact their performance at work in having a decline* (Betty, Pharmacist FG3)

Another facet of valuing came through in relation to the role of the line manager. When the fund was established, money that originally sat in individual budgets was centralised to the PDF. When people apply to the PDF, their manager must submit a supporting letter with the application and sign off on individual professional development plans. However, manager approval no longer equates to certainty of funding allocation. Daisy conveyed her feelings about this:

> *As a team leader nobody applies to that fund without going through me first. Because I have to approve it, I have to support it and I would have thought that as a team leader my support of that person would be valued and I don't feel like it has been valued at times. Because they've been pushed back on things that to me seem so obvious and I just feel that is a little bit of a frustration for me* (Daisy, Nurse Team Leader FG1).

Later in the conversation Daisy explained a little more about her situation, balancing her previous comments about feeling devalued with the value of fairness she perceived to underpin the development of the PDF:

> *I was one of the fortunate managers with a budget that did have a small amount of money set aside for my staff to attend professional development meetings and conferences. So I found it quite hard to have that taken away and then suddenly having my staff apply to somebody else to get something that I know they needed to attend.*

> *I found that quite difficult but I do appreciate the fact that it was maybe done to be fair to everybody and that everybody should have the opportunity to get funding to go to things* (Daisy, Nurse Team Leader FG1).

Agnes and Celia felt that their manager's approval should be sufficient:

> *I mean we've got our manager's approval and they indicate actually yes this is relevant to the field that we're working in and it's relevant to our job, we shouldn't have to write a whole essay* (Agnes, Nurse Educator FG3).

> *Your manager is clearly identifying yes, it's relevant to the job. It shouldn't have to take more than 10 lines for me to say this is why it's relevant or this is why I think I will develop my professional practice because of this* (Celia, Clinical Case Coordinator FG3).

Faith (WR) conveyed similar sentiments *"In the past managers have been more able to make decisions around appropriate training for staff and guide ways in which the service is developing"*. Neil (WR) wrote "*How about trusting the manager's sign off that service gains will follow?"* Daryl's (WR) thoughts were *"I feel the process doesn't give enough credit to Team Leaders to make a call on whether courses are relevant"*.

Betty also spoke about the impact of centralising the fund on the valuing of departmental management:

> *I don't think the PDF should be done away with, but I think there needs to be some level of control given back to the individual services in regards to having a certain budget that they can manage themselves. So actually they have got that level of control, but if that budget is exceeded or there is enough time to be able to apply to the PDF, then people can still make use of the PDF* (Betty, Pharmacist FG3).

Perceptions about centralisation of funding included devaluing the managers' role through removal of autonomous rights to funding allocation, and some participants' who are managers felt disempowered

as a result. Those participants who were team members were also cognisant of the effects of this apparent proprietary shift. Centralising some funding moved access from the relational situation of the team manager and team member, to a less relational function of applicant and committee. Whilst there is some recognition that this was done to provide greater equity of access, there is disquiet for those who previously enjoyed discretionary access and distribution.

Factors of ownership and autonomy, value and worth and espoused organisational values come together because they capture the sensibilities of the workplace in relation to accessing this contestable fund. The premise of the fund is greater equity of access based on the values of the organisation. Employees make meaning of the values at personal and emotional levels, and their experiences of workplace functions are often correlated with how they feel about being part of the organisation. When the committee support or do not support their application, they perceive this as being or not being valued by the organisation, connecting the feelings of value with the organisational values, especially ‘everyone matters’.

This theme has explored the applicant in context, including the personal, professional and value-related aspects of applying for contestable funding. The next theme encompasses perceptions about the process of application.

**Theme 3: Systems matter.** Often in this study participants focused on the application process, both in terms of the supporting documentation required and the experience of completing the electronic forms including time commitment and the format of official information. Conversations about these aspects were often animated, especially around factors such as usability, time and access to assistance. The ‘Systems Matter’ theme focuses on these thoughts and has three subthemes; the first, ‘I don’t know what 2 megabytes is equal to’, relates

to the participants' understanding and experience of the electronic application form. In the second subtheme, 'Time is precious', participants discuss the time commitment required to apply, and in the third, 'The 'help desk' idea', their desire for a stronger direct connection and personalised support between applicants and the committee is expressed.

The Information about the PDF process and priorities is available to staff through the DHB intranet and includes documents such as the policy, relevant forms and checklists alongside the electronic application form (Appendix 3). The applications of some eligible groups, such as nursing and allied health and technical staff, are assessed by a divisional sub-group before being sent to the PDF committee.

***'I don't know what 2 megabytes is equal to'.*** When uploading the application there are some limitations such as the upload file size; this subtheme reflects participants' frequent comments about being frustrated with the electronic process:

> *When the actual [conference] programme is quite large and you have to put it into these megabytes or whatever they are and I don't understand what amount of data is equivalent to the megabyte. So anyway it took me about three days because it didn't save it, so every time you went through it you had to start again. Then in desperation I went and had to get something scanned and shrunk down so I could actually get it in. It was still a bit of a fiddle* (Beryl, Nurse FG2).

> *I'm not particularly savvy, I don't know what 2 megabytes is equal to, is it 2A4 pages? Is it such and such? Because I have no idea you know, and you go there in good faith and click the thing, it doesn't take it if it won't fit* (Alice, Occ. H&S FG2).

Briar, more fluent with computer use also had trouble uploading documents:

> *The other thing was the file size was quite small as well. So if I had to scan a thing from a multiday conference, by the time I scanned it, even shrinking it, it was still too big for what they wanted. So then I was going back, I was cutting and pasting to make it a word document to try and get it smaller, it just was not user friendly at all* (Briar, Physiotherapist FG1).

As well as the file size, other concerns emerged when people were distracted by day-to-day tasks and the form 'timed out':

> *There were a couple of times I lost all the information I had because I took too long with it sitting there (*Celia, Clinical Case Coordinator FG3*).*

> *I've also found that when you're doing the application, you can look up, oh it's gone! So we just start all over again. If you forget something again, you're in trouble!* (Abbie, Practice Improvement Nurse FG1).

> *You can't save it when you're half way through, so you had to have a block of time - which does not exist in any of our roles. So it would be staying late or doing it through lunch because otherwise you've got patients all day and if you got half way through and then had to leave you couldn't come back to it because it was all gone. Or if you had one thing uploaded incorrectly the whole thing 'blew up' and you had to start all over again. Like it was just such a nightmare and I consider myself a reasonably computer savvy person, and I know other people on my team really have expressed the same frustration* (Briar, Physiotherapist FG1).

Some participants found ways to manage these issues:

> *I think knowing that you've got to get everything you need first and then sit down, put it all in. I think if people know that it will help. Because I think if you're part way through and you're missing something you've got to go away and find it, you can't save the form and go back to it later. I think that's a bit of an issue because people spend a lot of time on that form* (Betty, Pharmacist FG3).

> *I think I downloaded everything and saved the documents, I wrote it out and then got the manager part and then actually just had to find some time to sit down and go through the tick boxes. But if you forget one thing it's 'Oh how do I get it back in there? Do I have to start the whole thing again?' Or if I forgot to put one of the attachments I couldn't go back, it's gone. And I thought 'I hope they've got everything' because if I send it in again, then I probably might miss something.* (Casey, Nurse Specialist FG1).

Others commented on the function of the form and a desire for simplification:

> *Having to find an overview of my mandatory training, scan it and attach it in today's technical age seemed almost a bit archaic. It should be a simple search or attachment* (Irene, WR).

> *A bit confusing as to what was needed & difficult to add to application forms and save properly – get quotes from travel agents and so on, it's not in a great format* (Hollie, WR).

> *Less forms and requirements: Simplify it* (Neil, WR).

Daisy (Nurse Team Leader FG1).and Alice (Occ. H&S FG2) conveyed a sense of appreciation for the funding that they received, but were also concerned about the process itself which they respectively described as '*frustrating*' and '*another issue'.*

Agnes spoke about the impact of the application process on staff engagement:

> *We certainly saw a huge shift from people applying for training regularly to hardly ever applying because of the process that was involved and the time delay that was involved. For the people that are actually active in accessing training, for them to suddenly stop doing that, for me it was actually quite a concern as an educator. There I was advocating training, and you just get back the resistance 'Oh but you know it takes time' and that kind of answer, and I was constantly answering the questions, and me having to say all the time 'No sorry I can't do that, we need to follow*

> *processes'. And so they just stopped or they don't apply, you know it's disheartening* (Agnes, Nurse Educator FG3).

Thus, success or failure to use the electronic system related not only to the system itself, but also to user capability and perceptions of competence and effort required, particularly when needing to seek assistance. Applicants expressed technical concerns but also issues with completing the form during working hours with other distractions and priorities. Overwhelmingly, regardless of application outcomes, the participants' were of the view that the electronic function requires upgrading with user needs in mind.

This subtheme highlighted the need for continual improvement through stakeholder feedback to ensure that processes meet user needs. The complexity of the electronic process described in this subtheme goes hand-in-hand with the time commitment factors in the next.

***Time is precious.*** Participants expressed concern about the knock-on effects of the process of gathering the supporting documents, navigating the process and completing the form. Most prevalent were concerns raised about the time required to make an application. For example in FG2, Cora (ARDS) stated *"It just took so much time"* which was a typical sentiment:

> *I'm spending a lot of hours on getting paperwork together, getting my yearly appraisal up to date, and then having to fill everything in, whilst all the time I'm here actually for my clients* (Agnes, Nurse Educator FG3).

Frank, Eloise and Daryl concurred:

> *You've got to do the business claims expense form; you've got to do the applicant letter. Got to do another thing - you know! To be coherent you've actually got to put in a bit of energy and thought, especially into the applicant's letter and you know it just all takes time* (Frank, Occupational Therapist FG1).

> *It took a reasonable amount of time (2 weeks, mostly in my own time) to compile all the required documentation which I know for some others has dissuaded them from even commencing the application process* (Eloise, WR).

> *There are multiple pieces of paper that you have to gather and put together, and several forms that look similar but are used for different types of applications. If you fill out the wrong form or miss a form, then you are wasting not just your own time, but also your manager's time, they have to get back to you with the correct paperwork* (Daryl, WR).

With repeat applications, as Frank explains, preparatory work done for a first application smoothed the way for the next, saving valuable time:

> *When I first applied I needed my PDP [Professional Development Plan] for the PDF, so it was a bit pressured and bit rushed. Then I went to a conference later in the year and I had 'all the ducks lined up'. The PDP was done already, the letters were done already and I was just tweaking, I'd already done all the mandatory training, so that was a lot easier to write because I almost pre-loaded all the ducks in a row and I got about a three or four month run in. It was a lot easier, almost pleasant! May wasn't. May was not, November was* (Frank, Occupational Therapist FG1).

Frank mentions having a reasonable 'run in' on his second application, which helped him to apply more easily. Others also spoke about the time frames both in terms of the run up and the time involved in processing applications:

> *If you've got a conference sometimes you missed the early bird or you miss even registering if you have to wait for them to make their decision and get back to you. You miss the cheap flights. So all of this kind of escalates a bit having to wait so long for feedback, and it does take quite a long time in the first place to send it all in, to have a meeting with your manager where you do your professional development with them and get them to fill a form* (Ellen, Pharmacist FG1).

> *I had not applied before so did not realise that I should start organising immediately. I also did not realise that the committee only met once a month and would take time to consider the application. To get early bird rates I needed to have my application in early. I sent my application; it took me over a week to put together. I found it so time consuming. I was sent an email to give more information which I replied to and I got my acceptance* (Irene, WR).

It seemed clear from responses that in many cases people were not up to date on the various documents and requirements to complete the application. Up-to-date professional development plans and mandatory eLearning are customary annual activities for all employees of the DHB. These items are required for the PDF application, but evidence of currency of annual requirements came as a surprise to some who then had to find the time to complete and collect the relevant documents. This raises questions about the clarity and visibility, and common knowledge, about the requirements of making an application. It seems that although there is guidance available, the users, for whatever reasons, are not able to find or engage with it. Some participants thought it would be useful to have a 'help' contact to try to alleviate their difficulties in following the process, and these perceptions are explored in the final subtheme.

***The 'help desk' idea.*** A number of participants were of a mind that it would be useful to have a 'help desk' contact in case questions should arise during the process. In addition, participants felt that increased information about the committee priorities and spending capacity would help them understand the likelihood of their applications being supported. Betty, Cora, Deena and Agnes all made comments along these lines:

> *Being able to get some guidance from the committee that isn't just a policy document would be quite helpful. So, maybe that would be getting access to the PDF people around their priorities, or around what they're looking for to get some guidance from the horse's mouth. You could say 'Now I'm thinking of this, is this*

> *something that falls within the remit?' Because I think all those little steps put into the big puzzle piece would make people feel a bit more like well actually we would give this a go and even if you've been declined before, you feel you'd be willing to try it again* (Betty, Pharmacist FG3).
>
> *I also had a little bit of issue with working out who to talk to. There wasn't a – 'if you've got questions contact this person'. You get all the forms, but I wanted someone to ring and say 'Look I think I'm complete'. I printed out the steps all the information is there, it's just the way it's set out it wasn't so clear* (Cora, ARDS FG2).
>
> *Maybe it's a preliminary application – 'Is this the sort of thing? Can I get early bird?' all that sort of thing* (Deena, FG3).
>
> *It would be helpful to know 'you were just that application too many in regards to our budget'. Okay that's unfortunate but you get an understanding* (Agnes, Nurse Educator FG3)

This subtheme brings the findings full circle to the first theme of 'Blind spots', where applicants spoke about their unfamiliarity with the committee. It suggests that if provided with a 'key contact', the participants may have had a greater sense of connectedness, and in turn perhaps more assurance about embarking on an application. While not a prominent subtheme, the 'Help Desk' subtheme speaks to a potentially simple remediation of the participants' concerns; the human factor missing from the applicants' experiences.

## Summary

What has emerged from these findings is that access to professional development funding is of high importance to health professionals, and that it impacts at both professional and personal levels. There is a sense of community and collective learning within the organisation in relation to the PDF as a mechanism to access such funding. It is also true that the participants in this study valued the opportunity to apply to the PDF and were in favour of keeping the fund;

however, there was a desire for greater connection with the committee, improved clarity and more user friendly processes to enable better engagement and access. User focus included the technology which people were keen to see streamlined and less time-consuming. In addition, organisation wide communication was considered essential to improve the reputation of the PDF.

The next chapter orients these thoughts with the official information of the PDF to balance what has been said with the available information and guidance. The findings of this study are also synthesised with the extant literature, and new knowledge that has come about as a result of this work is identified.

# Chapter 5: Discussion

## Introduction

This discussion chapter begins with a reminder of the study question which guided this research. Consistent with IPA, consideration is then given to the personal insider experiences of the researcher on which interpretations are based. Following this the themes are expanded through interpretation and considered in relation to the professional context of the participants. In order to develop thinking about the participants' views on their experience of the PDF in relation to the official PDF information, the relevant documents are discussed.

Throughout this discussion, the importance of this work and the synergy and dissonance with the extant literature in this area of interest are highlighted. This emphasises the new knowledge emanating from this study and how this adds to the relevant literature. The implications of this new knowledge include recommendations for the future administration of the fund, some of which will be transferable concepts for similar funds in other areas.

**Study question.** The research sought to understand the experience of applying for professional development funding; perceptions of the Professional Development Fund as a system in the context of Waitemata DHB, and the impact of the PDF on engagement and careers. The findings provide insight into one example of a contestable professional development fund and a cohort of its applicants. The study question was: What is the experience of applying for contestable professional development funding for health workforce employees?

Since my personal experiences as an insider situate my perspectives, these are summarised before discussing the themes. This is important as the following synthesis will be layered with personal interpretations.

**Personal experience of the PDF.** This year I submitted my fourth PDF application; each year for the three previous years I have requested support for conference attendance and this year I requested partial assistance with my post graduate study fees. All of my applications have been successful, two following requests from the committee for further information. The funding has enabled me to build knowledge and skills and thereby progress in my area of work; it has also given me the opportunity to build relationships with others in my field. Without the PDF I would not have engaged with these developmental activities.

My applications have all been for partial funding alongside a self-funded component, since the policy is clear that partial self-funding is desirable. I have aimed for a PDF funded amount below the limit that requires the Chief Executive's approval, and acknowledge that this is my 'work around' to reduce the approval process and time line. The prerequisites for making an application, such as completion of mandatory eLearning and a signed-off professional development plan, are customary annual processes that I generally keep up to date. Completing travel quotes and the expense forms is a perfunctory process made easier by following the instructions. Writing the cover letter and requesting a cover letter from my manager is time-consuming and challenges thinking, but apart from the question on Māori health equity I have not struggled to complete the form.

I recall feeling some frustration at the complexity of the application process when I first applied; however, subsequent applications have been less challenging to collate as I have become accustomed to navigating the system. I find the format of the electronic system unintuitive and somewhat antiquated.

For three months at the end of 2016 I had the opportunity to sit on the committee, my experience as a panel member provided me with insight on the extensive work required to administer the fund. The panels' sense

of accountability for this limited financial resource, as well as their desire to make every dollar count, was apparent. I heard them speak about the PDF as 'the icing on the cake'; additional to funding for mandatory training. I also witnessed the panels' dedication to staff development when they sought clarification on applications that did not provide all information needed for a decision to be made and justified. The experience of being a past committee member provides me with a differing perspective from most other applicants, enhancing and balancing my point of view in this study.

Prior to conducting this study, I was familiar with the circulating anecdotes about the PDF and although they were not consistent with my own experiences, they were sufficiently prolific to raise questions in my mind about the experiences of others and to motivate me to undertake this study. I acknowledge that this study is specific to Waitemata DHB and therefore has limited generalisability in and of itself. This is consistent with IPA methodology in terms of focusing on individual experience in a specific context. Despite this, other New Zealand organisations with contestable funding models may find the outcomes of this work informative. In addition, the protocol used in this study is transferable and could be implemented to inquire about staff experiences of similar funding models in other organisations, such as the HWNZ contestable funds or research-related contestable funding models.

I will now move on to elaborate on the underlying meanings of the findings, which I will synergise with relevant literature.

## The underlying meaning of the findings

The three main themes and their subthemes reflect not only answers to the initial questions, but also a wealth of insight pertaining to the lived experience of health workers engaging with a professional development funding mechanism. The first theme reflects the community

in context in relation to the PDF, the next theme sheds light on the applicant in context, and the third illuminates the meaning placed on the PDF as a system in the context of the organisation.

**Theme One: Blind spots.** 'Blind spots' provides insight into the collective uncertainties, knowledge creation and activities described by the participants as they apply to, or consider applying to, the PDF to support their learning. It conveys a sense of place, the social networks that exist in the organisation and the way that people interact around uncertainties when the stakes are high.

***Who is that group?*** This subtheme indicates participants' common knowledge gaps about the PDF committee and the criteria used to assess applications. The participants often commented on their unfamiliarity with the committee; however, the PDF policy (Appendix 3.a) makes clear that the membership of the committee includes representatives of the eligible groups. Members from Nursing, Allied Health, Scientific and Technical, Corporate and Organisation Development, Employment Relations, Operational Management, Workforce Development, Māori Health and Asian Health are involved. Thus, it seems that there is a mismatch between the available official information and the knowledge and perceptions of the applicants. This is apparent from several 'Who are they?' conversations which included assumptions that it was likely that the committee might be mutually unfamiliar with the applicants and that this might impact on their decision making.

One simplistic reason that the participants were unclear about the committee representation is that they may not have read the policy. Perhaps this is a symptom of our information-rich era and the contemporary tendency to present information in sound bites or succinct swift-read formats. A study from the United Kingdom of the generational communication preferences of health workers (Jones, Warren, & Davies, 2015) provides a salient insight. The study describes the Baby Boomer

generation as likely to seek out information and group problem solve, and Generation X as a work-smarter time efficient cohort. Generation Y prefer swift systems, instantaneous information and practicality, whilst Generation Z are understood as digital natives who are highly informed and connected through mobile technologies (Jones et al., 2015).

Thus, devising resonant information strategies for diverse cohorts can be a complex matter, suggesting that the way information is presented, in this case as a policy document, may not be meeting the needs of different groups. This has broader implications in terms of the presentation of information for health workers, particularly when considered in the context of health care practice that relies on evidence and documented process. However, it also reflects the healthcare learning environment where professional socialisation and clinical learning routinely occur experientially through collegial interaction (Hafferty, Castellani, Hafferty, & Pawlina, 2013; Hafferty, Gaufberg, & O'Donnell, 2015).

Not having read the policy may account for some of the confusion, but some participants stated that they had read the policy and were still left with uncertainty about the committee membership. Perhaps another possibility is that some of the committee members' role titles are unfamiliar, or are not perceived as representative of applicant cohorts. Without specific statements about which role title represents which professional group, applicants may not perceive that they have a designated representative. Disconnected from the application process, the users are left to wonder about the knowledge base and world views of the committee members who influence their application outcomes.

Furthermore, there were also expressions of unfamiliarity with the assessment criteria used by the committee to consider applications. Concerns were voiced about not knowing how applications are assessed, leading to difficulty in identifying and addressing key points; one participant even suggested that it felt like the criteria were being held

back. However, the ten points for consideration of applications are described in the policy under the heading ‘Guidelines for Approvals and Prioritisation’ (Appendix 3.a, p. 4). The question of why was this unclear to the participants arises. Notably, the guideline is written to support the activities of the committee rather than those of the applicant. As a result it seems that the applicants struggle to align thinking in order to produce answers that correlate with the committee’s requirements. Interestingly, whilst stringent judging criteria were considered as a mechanism that creates elitism in other contestable systems (Hicks, 2012) the impact of vague or incongruous guidance was not a consideration in the literature.

Although infrequent, thoughts about elitism emerged in the findings. One of the participants pointed to the level of ability required to complete the application process, which was in contrast to the formal purpose of equitable access to funding. Whilst many of the applicants are registered health professionals, this fund extends to non-registered professionals who may be less academically experienced. The ability to synthesise the content of the policy with the requirements of the application, along with the characteristics of the desired training, may be limiting novice engagement. For some with large cohorts of Māori patients, the ability to express how the training might support the day-to-day delivery of care was also paradoxical when their applications were not accepted. Whilst in my experience the committee takes the quality of writing into account, their consideration can only be applied to those applications received. If making an application is too challenging, some employees may not apply at all.

While there are a number of possibilities for the apparent lack of knowledge about the committee and their assessment criteria the primary reason interpreted from the findings is that the official information is designed to guide the activities of the committee and is not rationalised

to meet user needs. Thus the applicants, not being well informed, have difficulty in making meaningful and appropriate applications.

This connects with an idea explicated in Wrathall (2010) who explains Heidegger's concept of propositional and perceived truths. Propositional truths are seen as those which constitute the actual 'state of affairs' and perceived truth as the meaning that people attribute as they endeavour to understand their encounters with the world (Wrathall, 2010, p. 12). Arguably however the actual state of affairs differs depending on perspective; to the committee it seems that all is clearly articulated in the policy, to the applicant the policy is confusing. This indicates the need for reconsideration of the official information such that it addresses the needs of the applicants to know who 'that group' is and how they consider applications.

***Hive learning.*** This subtheme relates to the information networks within the organisation through which people learn by storytelling and sharing experiences. Whereas the previous subtheme focussed on unfamiliarity and things unknown about the committee, this one sheds light on narratives employed in pursuit of clarity and understanding. The narratives emerged from personal experience, directly observed situations and hearsay; the participants did not discriminate between these sources as being valuable to assist their understanding. In some cases the participants described information gathering that was positive and helpful while others found advice they received from peers was less so. In most cases sharing stories and experiences created a stronger sense of community and camaraderie which was particularly strengthened when outcomes of PDF applications were not favourable; in these cases people reported uniting in the face of adversity. The stories evoke a sense of collective activities or 'Hive learning'.

The reviewed literature on professional development funding does not directly allude to knowledge creation in organisations but research that

is closely linked concentrates on what is referred to as ‘learning organisations’ (Chumg, Seaton, Cooke, & Ding, 2016). The sharing of knowledge in learning organisations has been described as a form of altruism and has been shown to increase satisfaction through social and collegial support (Chumg et al., 2016). Healthcare workers often exhibit a caring nature and have been shown to be motivated by self-efficacy, achievement and autonomy, as well as collegiality and collaboration (Judge & Bono, 2001; Kontodimopoulos, Paleologou, & Niakas, 2009; Zangaro & Soeken, 2007). Interpreted as an innate desire to be well thought of and to support and help others, this seems in part consistent with the findings. It supports the participants’ collegial motivations, but also their enthusiasm to take part in this study which they considered an opportunity to make a positive contribution. The reputation of the PDF amongst the workforce concerned participants, whose suggestions about how to counter the negative impressions through widespread dissemination of success stories indicate that, far from wanting to disestablish the PDF, they were keen to see it refined to address their needs and continue with more favourable repute.

Evident in the participants’ communal information sharing was the perception of knowledge as an indicator of efficacy. The sharing of knowledge was seen as an act of generosity and high levels of trust developed amongst team members as a result. The participants described sharing and collecting stories that might later inform or support their own efforts or those of their colleagues. When coupled with the low levels of engagement with official information seen in the previous theme, the reliance on anecdotal information becomes increasingly comprehensible – after all, a good yarn is certainly more enjoyable to hear, and more natural to tell, than a policy is to read.

The enjoyment of sensationalism (the art of drama) also seems intrinsic in this phenomenon. Arendt’s thesis on narrative supports the idea that people like to be entertained, to perform, make known, and create reality

through stories (Thiele, 2009). Indeed, there is also literature from the world of media that supports the idea that a sensational story brings colour to an otherwise drab report (Bird & Dardenne, 1990). This idea is also expressed in the literary world; in her 1968 novel "*Towards a Poetic of Fiction"*, British scholar Barbara Hardy wrote:

> I take for granted the ways in which storytelling engages our interest, curiosity, fear, tensions, expectation, and sense of order. What concern (sic) me here are the qualities which fictional narratives share with that inner and outer storytelling that plays a major role in our sleeping and waking lives. For we dream in narrative, day dream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticize, construct, gossip, learn, hate, and love by narrative. In order really to live, we make up stories about ourselves and others, about the personal as well as the social past and future. (Hardy, 1968, p. 5)

Hardy (1968) makes a useful connection between the stories we tell each other and the stories we tell ourselves in constructing our realities and perceptions. This relates to Heidegger's ideas about how our previous experiences colour our future interactions with and in the world (Moran, 2000) and are built upon perceptions of self and those values held dear. These thoughts are explored further in the later theme 'The applicant in context', but here it is simply important to state that there is a connection between the narratives with self and with others, our perceptions of self and others, and the sense of belonging and acceptance as related to our narrative worlds.

Storytelling is also an acknowledged means of introducing novices to established groups and helping to develop their sense of belonging (Lamdin, 2006). Professional socialisation is a long standing and erudite area of interest which focuses on acculturation during liminal transition and how observed behaviours, heritage and history-telling shape new arrivals to the community (Hafferty, 1988; Hunter & Cook, 2018; Lamdin, 2006). One example of this emerged during the focus groups

when Celia reminisced about her experiences of hearing about the fund as a student nurse, and how this influenced her future interactions. Students on placement at the DHB are the prospective workforce and socialisation into a negative perception of the PDF may influence their later engagement with professional development, or even direct employment decisions. On hearing these narratives, impressionable novices can develop engrained ideas that mature into potent beliefs through which they influence their peers. The long term reputational impact of such early interactions should therefore be a consideration for the future of the fund.

The sense of community in the DHB that supports narration of experiences also relates to the cultural dynamics in Aotearoa New Zealand. The value of relational networks is highlighted in Māori cultural studies. *"Māori culture is a 'lived' set of deep networks and connections between individuals"* (Reid, Varona, Fisher, & Smith, 2016, p. 32). Māori culture is woven with a holistic world view that relies heavily on orientation towards a collective and connected whakapapa (genealogy) and whanau (family) (Mlcek, 2017); people need to feel connected and they bring their collectiveness to their interactions with day-to-day experiences. A connection may be seen between the phenomenological view that one's past experiences are influential in making sense of one's day-to-day encounters, and the Māori world view that the lived experience is not just influenced by one's own experiences, but also those of one's community and forbears. The narratives of a people inform how those people are and understand the world, and this connectedness is imperative to wellbeing, both psychological and social (Swann, Swann, & Crocket, 2013). Thus, the sense of detachment in the PDF process takes on greater relevance for those applicants from Pacific Nations where the integrity of the community is so vital to life. The lack of collectiveness in the PDF, where one applies singly for one's own development activity, is

evidently at odds with the cultural norms of acting as a collective. Alternative solutions that promote collective thinking, learning and development would be of benefit to applicants, Māori and non-Māori alike.

The concept of hive learning is important because whatever influences engagement with the fund also ultimately influences engagement with professional development, staff morale and potentially the quality of patient care. Negative stories may be preventing people from forming their own opinions, which may be dissuading engagement. The PDF is suffering from a case of 'bad-press' built up over time. Although not insurmountable, this will take time to change.

***Work arounds.*** In light of the knowledge-creating narratives expressed in the last subtheme, the narratives to create doing, the 'Work arounds' are now considered. This subtheme also conveys a sense of community and networks, but differs in that it focuses on doing rather than talking. Strategic approaches and team efforts in making applications were evident in the findings. People described turning to others for support and advice, and collectively synthesising past experiences, hearsay and advice from knowledgeable and experienced others to inform their endeavours. Thus, despite the resulting funding being only applicable to the individual, application outcomes were often felt communally. This in turn reinforced the storytelling and strategizing cycle, making it increasingly influential.

The literature reviewed on professional development did not provide a link with concepts of collective agency; the interdependence of applicants resonates with James Coleman's concepts of Social Capital Theory. Häuberer and Jeřábek (2011) offer the following description:

> Coleman embeds his concept of social capital in the context of the rational choice theory. Social interdependencies arise among actors, because

> they are interested in events and resources controlled by other actors to maximize their utility by rationally choosing the best solution for them. (Häuberer & Jeřábek, 2011, p. 39)

Social Capital Theory is frequently associated with political or critical research focussed on power imbalance (Nahapiet & Ghoshal, 1998). In this case the applicants' perceptions appear to reflect the PDF committee as a benevolent power, holding the resources and determining the applicants' access to aspirational learning opportunities. Consistent with Coleman's view, there is also a collective interdependency in the reliance of the committee on the applicants, since the PDF would be purposeless if not to meet their training needs. As such, there is agency between past and future applicants, and agency between the applicants and the committee. In addition the needs of the organisation, and therefore the patients, are a factor. Good relationships rely on transparency and explicit expectations, otherwise perceptions of power imbalances can easily become established and create narratives that inform negative actions.

Another 'work around' that emerged was formulating applications that would be palatable to the committee. There were several cases where people were concerned with tailoring their responses to what they imagined would be important, and what would help to get their application over the line. In this they felt they were not articulating their own motivators which felt disingenuous. This dilemma suggests a mismatch of user and provider priorities, and further alludes to the official information being more suitable as a guide for the provider than the user, because although not intentionally prohibitive it does little to guide the applicants in their endeavours.

This dilemma is especially apparent in the question asking how the learning activity will reduce health disparities for Māori. Inequity of self-determination, policy, design, access and outcomes in Māori health

is well documented in the literature (Beckfield & Krieger, 2009; Ratima et al., 2007; Reid & Robson, 2007). Working in the context of healthcare in Aotearoa New Zealand requires awareness of the importance of these matters and the demonstrable practice of the principles of the Treaty of Waitangi; partnership, protection and participation (Ministry of Health New Zealand, 2014). It was not surprising then that those taking part in this study were generally supportive of the inclusion of this question on reducing Māori health disparities, but their concerns focused on how to be genuine in answering it.

The participants had particular difficulty when the activity they sought funding for did not have cultural content, address health equity for Māori, or integrate Māori health models into the teaching. For those applicants new to Aotearoa New Zealand, levels of culturally fluency added further complexity. This led to them seeking advice from knowledgeable others, borrowing and copying previously successful content, or contriving politically correct responses. In some cases the participants were concerned about the tenuous links that they were suggesting and described this as paying lip service or jumping through hoops. Copying other people's answers or being obviously 'politically correct' further degraded relatedness with this question. Others had a good sense of how their proposed activity related to their cultural context, but were frustrated and confused when their application did not pass muster. Participants either expressed difficulty in equating all learning with cultural concerns, or otherwise had trouble matching their answers with expectations. In some cases the participants felt that their time was better spent serving the needs of Māori patients than writing about their work in a funding application.

Interestingly, when considering the wording of the question and the associated expectations of answers in the applicants' cover letter (Appendix 3.b), an anomaly that may be contributing to the confusion becomes evident. While the question is practical in nature, "*explain how*

*this learning can support and influence your effectiveness…"* the desired response includes expression of ideology "*Awareness of your own cultural perspective"*. There is disparity between the composition of the question and the preferred focus of the answers. Adding to this is the undefined ideological stance of the committee, not articulated beyond the link to the Ministry of Health website. Interestingly, in section 4 point 3 of the PDF policy, alignment with the Māori Health Workforce Strategy is identified as important (Waitemata DHB, 2014); however the internet link provided in the question (shown below) takes the reader to the New Zealand Māori Health Strategy instead. Whilst the two strategies are aligned, they are inherently different in focus, a potential source of bewilderment for applicants.

Figure 1

*Excerpt from applicant cover letter; question on addressing Māori Health disparities*

Please reflect upon the Treaty principles of partnership, participation, protection and explain how this learning can support and influence your effectiveness in reducing disparities and create better health outcomes and equity for Māori (Please refer to Ministry of Health website: http://www.health.govt.nz/our-work/populations/maori-health for further guidance)

*The committee expects to see evidence of thoughtful consideration around:*

- *Maori cultural elements of the programme / course*
- *Awareness of your own cultural perspective (personal and work environment),*
- *Awareness of the Maori Health inequalities issues facing the communities we serve,*
- *Implications from attendance to demonstrating improvements for Maori in your work/ service.*

It is interesting to note that no other question on the applicant cover letter has integrated guidance as is found here. This is indicative that the committee may recognise the difficulty experienced in answering this question, perhaps as a result of the number of applications returned for further consideration. It seems that efforts have been made to guide responses but the various sources of information require reading time and the ability to synthesise ideas. Crucially, the volume of information and the varying foci of the question and guidance may confuse some applicants who then rely on other forms of assistance to navigate this question. One participant spoke about consulting subject matter experts

in Māori Health Services (He Kamaka Waiora), but found them unable to help with answering the question. Others felt their own knowledge or scanning of strategic documents was sufficient to make a reasonable response, and did not understand why their answers were not fitting.

The apparent confusion driving these navigation strategies is informed by narratives; the narratives are driven by uncertainties. The ‘work arounds’ described by the participants included good-hearted collusion, accessing knowledgeable others, team work, supporting each other and reliance on anecdotal knowledge gleaned from previous successes. The various strategic manifestations described provide an insight into the tenacity of health workers and the importance they place on professional development. It is also an unpromising commentary on the sustainability of the fund when applicants require such levels of persistence and resilience to prevail, suggesting the need for expedient realignment in approach to ease this tension.

The three subthemes in ‘Blind spots’ bring awareness to the collective and communal responses to living with unknowns, creating narratives to fill in the gaps, and narratives to create strategies for doing. The next theme reveals a more individual view of the applicant experience in relation to home, work and work place emotions.

**Theme Two: The applicant in context.** While the previous theme considers the PDF from a community perspective, this theme brings focus to individuals in context. It acknowledges that an individual’s professional self-perception is intrinsically linked with their perceived status amongst peers and draws attention to the emotional self in the context of the workplace, specifically in relation to espoused organisational values. In addition, home lives are influenced and are influential in career development decisions.

***Sizing things up.*** This subtheme captures comparing the professional-self with professional-others in the learning environment. It relates self-insight with understandings of training needs. It also interprets the participants' views on working conditions and employment contract entitlements both in different disciplines and in different organisations, and how that impacts on career progression.

Health professionals hold responsible roles and deal with complexity and critical decision making on a day-to-day basis. Professional development is fundamental for their continued confidence, competence and status amongst peers (Holland, Middleton, & Uys, 2012). As such health workers must maintain professional relevance and build their expertise so that they are competent to meet the responsibilities and accountabilities of their roles. The participants in this study spoke about their status as competent experts, particularly in relation to their ability to make decisions about their own professional development needs. This was in contrast to the limited autonomy offered by the process of applying for contestable funding. Furthermore, uncertainty about the committee's situational understanding, as seen earlier in 'Who is that group?' led to comparisons between the applicants' perceptions of the value of training and committee members' understandings when considering applications. Some of the participants saw themselves as competent responsible experts, intent on progressing careers and enhancing quality of care, but felt they were limited by bureaucracy.

Participants also spoke at length about the importance of peer validation as a motivator in professional development activities. The opportunity to compare levels of own expertise with professional others was seen as important when connecting with one's larger professional community. This speaks to professional self-evaluation through comparison which has received attention in the literature. Links have been made with the need for professional improvement, integration of learning to practice and recognition from professional peers (Kokun, 2014). Connections

between competence and confidence have also been articulated as being closely associated with building professional self-esteem and peer-esteem (Holland et al., 2012). The interface with peers is seen as essential for self-awareness and identity formation (Cheetham & Chivers, 2001) and role satisfaction, career development and organisational acceptance are also closely linked concepts (Mohammad, Habib, & Alias, 2011). Whilst professional connection and the value of networking are recognised, the idea of judicious selection of training opportunities as forums for self-evaluation was not apparent in the literature.

This ‘sizing up’ exercise when individuals interrogated the benefits of various training included consideration of quality and relevance, as well as the potential collateral learning to be gained. Whilst the opportunities for professional relationship building were a consideration, the level of expertise of other delegates and speakers, and the value of presenting to a particular audience also seemed to influence choice. The amount of contact time gained from multi-conference opportunities when considered in relation to the associated financial investment was also a factor. Ideas about discernment of quality, relevance to self and value in professional development are an interesting facet of the findings in this study that would benefit from further investigation.

In the literature, significant influencers of participation in training were cost and access to funding (Bjork et al., 2009; Brown et al., 2002; Kuvaas & Dysvik, 2009). This correlates with my findings, particularly in terms of comparisons of funding entitlements between different professional groups. Contrasts were encountered in relation to different disciplines in the same organisation, as well as those of the same discipline working in different organisations. Many health professions are unionised and rely on their terms of employment negotiated through collective bargaining. In some cases the resulting employment contracts, or ‘multi employee collective agreements’ (MECA) include individual

professional development leave and funding. In others it is a requirement of the MECA for the organisation to provide a percentage of funding to support professional cohorts. The PDF is not a MECA requirement and does not replace contractual entitlements or training mandated by services. This is different from the understandings of some of the participants who believed the PDF to be their only source of training funding. MECA entitlements vary across workforces, and as the participants alluded to, they also differ between organisations. Although this study was not undertaken with a critical or industrial lens, comparisons of diverse working conditions arose.

One of the comparisons made was with medical colleagues whose entitlements were considered to be the gold standard, conveying a sense of elitism in the ranks. This linked with another conversation about the use of the term ‘CME’ which is the Continued Medical Education funding received by Senior Medical Officers (SMO). Confusion during focus group 2 about use of the word ‘medical’ in relation to nurses education was curious in terms of the acceptance of established norms in the nomenclature of healthcare and raises questions about the intentional use of this terminology as a potential equity statement. Whilst there is a significant body of literature that relates to professional identity in health care, with considerable focus on the medical profession (Hafferty & Castellani, 2010; Lamdin, 2006; Porter, 2002) and the role of professional artefacts in changing the social constructs in health professions (Greenwood, Hinings, & Suddaby, 2002), ideas about professional identity in relation to funding entitlements have received little previous attention.

Considering the participants’ references to various entitlements, an overview of the collective employment agreements of the various professional groups is of use. The Association of Salaried Medical Officers Multi-Employer Collective Agreements (ASMS MECA), through which SMOs are remunerated, entitles them to ten days professional

development leave and a basic allowance of $16,000.00 per year pro rata (Association of Salaried Medical Specialists, 2015). This differs from their junior colleagues, the Resident Medical Officers (RMO), whose MECA places greater emphasis on in-house training. The RMO contract provides a more conservative time allowance than their senior colleagues' contract, and reimbursement for external courses only under specific circumstances, such as prerequisite training for registration with vocational training colleges (New Zealand Resident Doctors Association, 2017). Although there are differences between the career level allowances for medical staff, the difference in entitlements remains noteworthy when compared with other professional groups. The SMO and RMO MECAs are the reason why surgeons and physicians at all career levels are excluded from applying to the PDF.

Other comparisons were raised between Allied Health staff and Nurses, although in some cases these comparisons were perceived differently. For example, one of the pharmacists pointed to nurses as having PD entitlements; however a nursing participant contradicted this view when she pointed out that not all nurses have a commitment of funding in their employment contracts. This conflicting understanding of nursing entitlements can be better understood by reviewing the section on professional development entitlements in the nursing and midwifery MECA for staff working in DHBs (New Zealand Nursing Organisation, 2015, p. 51). The MECA deals with PD leave entitlements, which are applicable to the entire workforce, although funding entitlements are stratified according to levels of seniority. In addition, in some cases funding for nursing cohorts is also available through a contestable fund managed by Health Workforce New Zealand (HWNZ). At Waitemata DHB those outside of these entitlements or those declined through HWNZ, may apply for funding through the PDF (Waitemata District Health Board, 2016a). Different nursing levels have different allowances, which accounts for the varied perceptions encountered.

For Allied Health, Scientific and Technical workforces the approach is different again; their MECA requires that the DHBs provide in-house training and it makes provision for study leave to be negotiated by the individual on a case-by-case basis. It also allows for discretion in DHB specific arrangements regarding access to professional development funding for mandatory training required to maintain registration (New Zealand Public Service Association, 2016). If the desired training is beyond budget or outside of mandatory requirements Waitemata DHB provides the opportunity for employees to apply to the PDF. It was interesting that this was not the common understanding of the participants, some of whom expressed concerns that all training budgets had been centralised. Despite the collective approach of unionisation, the complexity and variation of working conditions seems to be a factor that impacts individuals and creates a 'grass is greener' mentality.

This was also true when participants spoke about professional development strategies in other organisations. Organisational approaches to training commitments were a point of discussion, particularly for the nurses in this study who pointed to other settings where provision is made through allocations to salary packages. However, those with personal experience of such systems described their limitations which included required negotiation processes and the likelihood that set amounts might not cover the whole cost of training. This was in contrast to the PDF where the full cost could be applied for. Underlying these conversations seemed to be a general cognisance that differing organisational approaches are determined by available, but often limited, resources. There appeared to be a strong awareness amongst participants of the need for ethical spending decisions and careful stewardship of financial resources, a finding that is consistent with the literature on health economics (Gibson, Martin, & Singer, 2005). Intentions to create equitable access to limited reserves through the PDF are stated in the PDF Policy (Waitemata DHB, 2017b) and were acknowledged by

participants, but concerns were raised by the participants about the impact on staff capability, organisational function and quality of patient care created by holding the resources in a contestable system.

The relationship between self-esteem and professional entitlements was understood in terms of greater recognition for different disciplines and levels of seniority. However, it is also true that the industrial priorities of professional groups are highly influential on an individual's career progression. Organisation-specific funding strategies also influenced views on the difference in access for individuals via contestability or personal allocations to salary packages, but 'grass is greener' views were tempered by those with personal experiences of both systems. A more comprehensive study on the comparisons between professional, organisational and industrial approaches nationally and internationally is indicated as an area for future investigation.

***Beyond the workplace.*** This subtheme revealed the impact of application outcomes on home, family and financial matters. It is unsurprising that participants regularly connected the impact of professional development funding to their personal finances when training costs are often high and, if self-funded, constitute a considerable investment. Through their comments, participants articulated the relationship between limited personal resources, uncertainty about access to organisational funding and inaccessibility of training. Concerns extended beyond knowledge acquisition, and encompassed competing personal priorities and the impact on family. Whilst the cost of training was a consideration in the literature (Brown et al., 2002; Kuvaas & Dysvik, 2009), and the World Health Organization has called for further enquiry on investment for healthcare workers development (WHO, 2013), there is a paucity of research related to the impact of professional development funding on personal situations. My study has provided some valuable insights into this important issue, suggesting that the provision of contestable funding is

an incomplete solution for improving access to professional development.

The reviewed literature provides some insight into lifestyle demands as a barrier to professional development (Anderson et al., 2012). Another study investigating equilibrium between home and work in terms of work-life-balance (Haar, 2013) highlights engagement with learning as an integral but defined dynamic of adult life. My study contributes to this conversation as it draws attention to professional development as a means of maximising income, but notes direct competition between personal financial commitments and the cost of self-funded learning activities. The sense of being demoralised by having limited means to dedicate to training was apparent in my study. The compromises between day-to-day family needs and vocational enjoyment, as well as missed parenting time in lieu of study or conference attendance also emerged. Thus, whilst some studies focus on access to staff training as important at a systems level for staff retention and meeting changing market needs (Aretz, 2011; Finlayson, Dixon, Meadows, & Blair, 2002; Ricketts & Fraher, 2013), the associated personal implications that emerged in my study are more meaningful for workers than may have previously been identified.

Participants who had received funding acknowledged the benefits in their personal and home lives, such as increased salary as a result of promotion due to their developed capability. They also described greater cohesiveness in the family unit around household chores when they became busy with study commitments. Others spoke about the detrimental effects of not receiving funding such as missing out on family time whilst working extra hours to recoup conference costs. In other cases where funding was received, the logistics of managing home lives around training opportunities created tensions over childcare. Often the participants who voiced these concerns were working mothers who, notwithstanding home responsibilities, retained their desire to pursue

learning activities. A recent study on the influence of motherhood on engagement with academia sheds a contrasting light on the gender dynamic reporting lowered self-expectations of study and career progression amongst mothers working in the academic environment (Hamilton, 2017). Although parental gender was not explicitly named as a barrier by participants in this study, the experiences of working mothers in both studies provides insight into the level of persistence required to pursue learning whilst balancing motherly responsibilities.

What the participants conveyed about matters 'Beyond the workplace' provides the opportunity to synthesise important factors relating to professional development and personal lives, and extends current thinking beyond ideas about the barriers to engagement. The balancing act of adulthood includes a wide range of responsibilities; for health workers this includes professional development which is essential for their career progression, job satisfaction and self-esteem. Whilst financial matters can present intransigence and contestable processes require perseverance, it was noteworthy that many of the workers in this study were passionate about their learning and overcame these barriers.

Having money, or not, is fundamental to achieving professional goals and maintaining a desired family lifestyle, which is intimately connected with the motivators for seeking professional development. In light of this the perseverance of workers is testament to their dedication, but sadly this often seems to rely on sacrificed family time which also emphasises the importance of allocated PD leave for workers. I would argue that for many workers vocational commitment and the benefits of professional development are important motivators in overcoming the barriers to engagement, but this carries significant implications for personal lives.

Home lives are full of emotions, but so too are work lives. How people feel about their work place is emotionally charged. The next subtheme considers the vibrant and meaningful ways participants spoke about their

emotional feelings in relation to professional hopes and dreams, and their connection to their place of work.

***Values and feelings of value.*** This subtheme considers the applicants' feelings of value and worth in the organisational context in relation to the espoused organisational values. This was an important factor when considering the express purpose of the PDF, to recap:

> Waitemata DHB's purpose and values shape the development of our organisation and workforce. Consistent with the value of 'everyone matters' (in this case, staff) Waitemata DHB's chief executive has established a centralised budget to enhance staff access to professional development opportunities. (Waitemata District Health Board, 2017b, p. 1)

Waitemata DHB's organisational values are the compass that guides strategy, activities and expectations about the way in which the business is conducted in the DHB. The values are:

- Everyone matters
- Connected
- With compassion
- Better, best, brilliant

The values are embedded in the organisation; they appear on posters, lanyards, behavioural guidelines, employment contracts, position descriptions, and in many other forms and functions. As seen in the excerpt above, they are also integral to the intentions of the PDF. More than this though, they are the cultural foundation for the behaviours and beliefs of the people; they were developed by the staff and they are woven into the fabric of the way people expect to be treated and the way things get done. The particular value statement associated with the PDF is 'everyone matters'; this establishes expectations of respect and valuing of others. It upholds the intention that each and every person is worth caring for whether they are patients, staff or family members. In

the analysis of these research findings, the subtheme ‘Values and feelings of value’ brings together the participants’ perceptions of alignment with the organisational values and their associated feelings of value and worth, because visceral reactions to PDF, both positive and negative, were often directly related to how people perceived the values being upheld.

The applicant’s cover letter (Appendix 3.b), a component of the application process, requires a statement about how the choice of training will enable the applicant to work consistently with the organisational values. In this the committee encourages the applicants to align their work with the agreed values of the DHB. What became clear in the analysis was that not only are the committee holding the applicants to account, but the applicants also have opinions on how well the PDF aligns to the organisational values. The participants had mixed sentiments and their thinking was granular in that they differentiated between the intentions of the PDF, the application process, the committee, the outcomes and the communications received in this regard. Interestingly, the outcomes of applications were not the primary indicator for how participants viewed the commitment of the fund to the values, for example a declined application did not necessarily translate to negative views on alignment. Instead there was general consensus that (a) the intentions for the PDF were consistent with the values, but that (b) the process was not, and (c) that it would be desirable for the committee to make their commitment more visible and be more connected and compassionate in their communications.

The most often expressed frustrations about the process related to impatience and irritation about the bureaucracy. Participants conveyed that if they ‘matter’, then the process should be more considerate of their time and acknowledge their professional status more appropriately. This carries a sense of lost agency in the process. The desire for self-agency is linked with theories of adult learning that elucidate accepted

cornerstone principles of autonomy and self-direction for adults in the learning environment (Knowles, Holton, & Swanson, 2012). In addition, literature on the hopes and dreams of professionals considers knowledge-seeking to be partly driven by emotional aspirations (Day & Sachs, 2005; Newman, 2000). Applicants of the PDF seem to demonstrate motivation for growth, readiness and desire to learn, sense of self and sense of existing professional status, thus directly correlating with Knowles et al.'s 1998 taxonomy of how adults engage with learning (Knowles et al., 2012, p. 4). Therefore, respect for the self-agency and aspiration of learners seems to be a particularly important factor in the design of contestable funding mechanisms. It is unlikely that this was considered in the development of the PDF or other similar funding systems and I would argue that a user-centric design might sensibly take these factors into account as a means of valuing the applicant's professional status.

The experience of applying to the PDF included a range of outcomes-related emotions; there were both positive and negative responses from participants. Sentiments about funded applications included happiness, gratitude and relief; participants reported feeling engaged, delighted, committed and motivated by being funded. One participant even referred to this as an '*amazing sunshine effect'* which is a particularly compelling analogy. At the other end of the emotional range, unsuccessful applications provoked feelings of bewilderment and rejection; participants reported feeling unsupported, deflated and cross. One participant spoke about being brought to tears at work for the first time, and another related the potential negative impact on role-dedication undermining the ability to be caring towards patients while dealing with such difficult feelings. Positive outcomes engendered a sense self-worth; people felt as if they mattered, although the process was still seen as contrary to the organisational values. Conversely negative outcomes created feelings of worthlessness; these participants felt like they did not matter, further compounding concerns about the process.

Job satisfaction and staff morale are identified as motivators towards professional development in the earlier literature reviewed (Brown et al., 2002); however, alignment of professional development with organisational values was not recorded. In organisational psychology literature, the relationship between organisational citizenship behaviour and job satisfaction alludes to this connection (Williams & Anderson, 1991). Concepts of the personal values of staff and their skills utilisation (Finegan, 2000) as well as autonomy and collegial collaboration associated with loyalty and professional wellbeing (Zangaro & Soeken, 2007) also correspond. However, a direct link between professional development investment and the embodiment of organisational values is not apparent in this particular body of work. By specifically making this connection between training and values, my research adds to the existing body of knowledge about the motivating factors of staff engagement with professional development.

Another strongly emotive area discussed by participants was the relationship between applicant and manager, and the manager's perceived credibility in the application process. Manager-participants were concerned about their loss of status in the eyes of their teams and their perceived lack of influence in the decision-making process. They also conveyed a sense of disempowerment as a result of funding being centralised. Staff-participants were concerned about their managers' loss of autonomy, and worried that contextual intelligence (the manager's direct knowledge of the person and service) was being devalued. They felt that the opinions of managers should be a primary consideration and should not be overruled by an authority external to their team. The PDF process requires that applications include a letter of support from the manager (Appendix 3.c); however, this does not automatically guarantee the funding. Literature on organisational citizenship highlights the importance of legitimacy in the staff-manager relationship (Aryee, Budhwar, & Chen, 2002; Kuvaas & Dysvik, 2010). This is supported by

the findings from my study in which staff-participants placed value on the professional opinion and expertise of those in their direct hierarchy. These sentiments conveyed the desire for ‘everyone matters’ to be demonstrated towards managers.

Often emotional reactions dictated levels of commitment to profession, patients and the organisation, but were underpinned by the desire to contribute to the success of the team or the DHB. This sense of reciprocity links closely with ideas of organisational interdependencies, positive work behaviours and organisational citizenship (Cole, Schaninger, & Harris, 2002; Kuvaas & Dysvik, 2010; Wayne, Shore, & Liden, 1997). My research makes a contribution to the large and longstanding literature around these concepts, and to work on Organisational Development (OD) with its sustained interest in alignment of professional development with organisational goals (Jones & Robinson, 1997). Contemporary literature on OD shows that progress has been made towards alignment and has evolved to also encompass organisational values (Smith, 2004a); however, recommendations for improvement persist even in the most up-to-date articles (Cheung-Judge, 2018; Harmon, Kowalski, & Kowalski, 2018; Smith, 2004b). Critically, much of the OD focus is directed towards organisational strategy when arguably greater inclusion of staff perspectives may be instrumental in achieving a more synchronous state. Similarly, whilst it is encouraging that the PDF was developed with a strategic fit in mind, the limited focus on users appears to be central to the sense of being devalued and to negative emotions experienced.

Taking into account the experiences shared by the participants in this study, it is clear that acknowledgement of the professional status and contextualised expertise of managers and staff should be a key consideration in the development of funding mechanisms. It shows that organisational philosophies must be demonstrated consistently by all

parties, because employees are emotionally invested in their workplaces and congruity is necessary for their satisfaction.

The particular value of this study is that it sheds light on the views and experiences of the primary users' experiences of accessing funding in systems designed with organisational, rather than user, needs in mind. Discussion of the next theme pays closer attention to the importance of human factors in systems design as it explores the participants' experiences of the process of the PDF.

**Theme Three: Systems matter.** In this electronic age the quality of technological interfaces is of high importance for users, particularly in the work place where employees are increasingly expected to use electronic platforms. People have become accustomed to intuitive systems designed for ease of use for all technological capabilities. Frustrations can arise when things do not work at the press or tap of a button and, whether due to user capability or systems design or both, the experience of technology can vary amongst users. Discussion of the theme 'Systems matter' includes consideration of the three subthemes that explore ideas of user capability and systems design in the digital interface, the impact on time and work, and the need for increased technical support as a result of the widespread use of digital platforms.

***'I don't know what 2 megabytes is equal to'.*** Intuitive design in electronic platforms has become an expectation of users (Palfrey & Gasser, 2011), and enabling accessibility for broad audiences with varying levels of capability is critical for the survival of businesses (Paul & Stegbauer, 2005). User interfaces have evolved towards simple attractive design and elegant functionality; consumers are become increasingly discerning, accustomed to ease of use and less tolerant of antiquated formats (Ash, Anderson, Gordon, & Langley, 2018). The participants' experiences of the electronic forms used in the PDF application reflect this phenomenon.

Each PDF application requires a series of accompanying documents (Steps for applying to the PDF - Appendix 3.f) which are uploaded to a browser box in the electronic application form; the browser box has a maximum upload limit. The participants spoke at length about the frustration associated with this aspect of the form. Those less familiar with technology said that they did not understand the value of megabytes when compared to the documents they had to send, while those who considered themselves 'computer savvy' felt the upload limit was too small. Either way, participants identified that documents such as conference leaflets with high resolution images were too large and required re-formatting or 'shrinking' to enable the upload to be completed.

The other main functionality concern was not being able to save the form part way through. Participants found this particularly frustrating when dealing with competing workload demands which reduced the likelihood of being able to complete the process all at once. As the form 'times-out' after a given period, participants described having to re-do their applications at a later stage. Others reported instability in the form and some participants described having to get everything ready to upload to reduce the likelihood of having to search for missing items part way through or forgetting something important the second time round. Similarly through my own experiences I have learnt that preparation is vital and as such I keep my own professional development files ready in preparation for PDF applications. While these may sound like trifling concerns they are good examples of how people become familiar and adept, and less taxed in following processes. Moreover, when considered in relation to the time commitment involved in repeated attempts, a larger implication for core roles and patient care emerges. This is revisited in the next subtheme on time factors.

When considering user capability and systems design, the body of work on generational technology acceptance is of interest. Assumptions about

older generations are particularly important given the acknowledged aging demographic of the global health workforce (Frenk et al., 2010). In 2001, Prensky wrote about this in relation to learning environments where he identified an apparent difference between younger students and older lecturers. The students born into the digital era and defined in his work as ‘digital natives’ were fully conversant with technology, while older academic staff, the so-called ‘digital immigrants’, were described as adapting to new technologies (Prensky, 2001a, p. 3). Prensky points to the growing inter-dependency of people and technology, and the generational differences in digital uptake. However, in another article he points out that neuroscientific research has shown plasticity of the brain is enduring throughout healthy lives, with more mature generations able to learn and adapt to digital environments (Prensky, 2001b). This resonates with subsequent work by other authors showing increasing internet use amongst older generations, particularly due to convenience and the ubiquitous nature of services such as e-Banking and internet shopping (Paul & Stegbauer, 2005).

Another later study described ‘silver surfers’ as the fastest growing users of social media as a means of reducing isolation (Russell, Campbell, & Hughes, 2008). Other studies argue that education, frequency of use and gender are contributing factors to technological uptake (Helsper & Eynon, 2010; Salajan, Schönwetter, & Cleghorn, 2010). More contemporary research suggests that rather than age determining technological engagement, socialisation to user-centric technological dimensions is the key to supporting connectivity amongst digital immigrants (Jacobs & Cooper, 2018). The design of the PDF e-System is therefore crucial to support access and engagement with professional development for all applicants.

Usability is also a defining factor for digital natives. Having grown up in a world of connectivity, this demographic expects informal engagement, immediacy, ease of use and instant gratification in their digital world

(Palfrey & Gasser, 2011). Indeed, the younger participants in my study shared the frustrations of their older counterparts, not because they did not understand the workings and terminology, but rather because they expected greater technological sophistication. It is unsurprising therefore that the esoteric megabytes upload limits and lack of a 'save button' is confounding users in the PDF application process - a friendly and simple-to-use interface is desirable across all user capability levels.

The importance of online functionality has been recognised in the banking sector where user behaviours are intentionally influenced by 'frictions' in the interface (Ash et al., 2018, p. 14). For example, a friction such as requiring proof of ability to service a loan might encourage users to think about borrowing consequences. In other cases, frictions are removed to maintain the aspirational state of mind of the applicant and encourage completion of the application. Here, applied cognitive psychology is used to persuade or dissuade consumer decisions; friendly website formats for example, encourage the feel-good factor thus minimising negative feelings associated with borrowing. Similar strategies are also recognisable in online retail environments, where heuristics and interaction behaviours have been understood as human factors in systems design for some time (Bannon, 1995; Keshavarz, Fahimnia, & Talemi, 2018). The implication for my study is that advanced design principles are tried, tested and available and could be used quite elegantly to make the PDF more engaging for all users. This may create a greater sense of resonance amongst applicants and more well-informed user activity. Such improvements may in turn reduce the time spent applying, allowing more time to focus on core roles.

***Time is precious.*** This subtheme reflects the participants' views on the time factors involved in completing applications, the impact of this on core roles and patient care, the dynamic between manager and staff, and perceptions of time in the workplace. The discussion begins

with consideration of Heidegger's existential themes in relation to the temporality of being an applicant to the PDF.

Concepts of time differ; Heidegger explicated this in "Being and Time" (1953), when he described views of temporality in relation to existence:

> If being is to be conceived in terms of time and if the various modes and derivatives of being […] become intelligible through consideration of time, then being itself – and not only beings that are 'in time' – is made visible in its 'temporal' character. (Stambaugh, 1996, p. 16)

In this statement, the interdependence of temporality and spatiality are conveyed; existence is in the world and in time. Furthermore, Heidegger's work promotes the idea that being is time and being human is in essence temporality (Mulhall, 2005). Thus, time is life, and the moments are irreplaceable; once past they remain only in our memories - 'time is precious'.

In our work lives, time is often referred to as a resource, objectified in economic terms within the employment transaction. Full Time Employment (FTE), if equivalent to forty hours per week, comprises ten four hour work sessions and is represented as 1.0FTE. My own employment contract is 36 hours or 0.9FTE; 0.6FTE dedicated to managing junior doctor education and 0.3FTE to managing the education campus, leaving half a day per week for study. Study time also includes weekends and some weekday evenings; this is time that might otherwise be spent with my husband, friends and family. The participants in this study conveyed similar experiences of the impact of study time on their home lives. When dedicating time to an activity, an endeavour or another person, there is a commitment of time and of life. For example, by taking part in this study and sharing their stories, the participants gave of their lives and time to summon memories about work relationships, families

and home lives, themselves as professionals, and the day-to-day of encountering the PDF.

A concern of the participants was how long the application process had taken, with the timelines varying from several hours to several weeks. Longer times were invariably required when employees were not up-to-date on professional development plan meetings and mandatory eLearning. Participants spoke about the time required to gather documents in preparation and commented that the second time they applied was easier because they were more familiar and better prepared. Time is precious also reflects participants' anxieties when waiting on decisions from the committee, particularly in relation to their views on wise stewardship of the DHBs dollars when delayed decisions decrease the opportunity to capitalise on early bird conference fees and less expensive flights. There is a sense of waiting and wondering in extended anticipation, and as the days go by there is anxiety, hope that the time spent has not been wasted, and hope that the funding will become a reality. These feelings linger in the time between submission and decision, and when the inevitable decision arrives, it is a moment of great expectation. For some, delight and relief ensue, while for others perhaps, frustration and disappointment.

Whichever way the chips fall, both the commitment of time and the time spent waiting appeared to amplify the outcome for the applicants, who seemed to be stranded in time, their 'there being' caught up in waiting. As a consequence of these tensions, participants conveyed a sense of wanting to reach out and connect to insiders in the process, to know more and to receive help. Some participants thought it would be useful to have a 'help' contact to try to alleviate their difficulties and save time; this is explored in the next and final subtheme.

The participants also expressed varied concerns about time taken away from core roles and patient care to complete applications. For some

participants, such interruptions to care provision were unacceptable. Others were concerned about the impact of time taken on the workloads of managers, which captured tension associated with meeting the manager's daily service expectations whilst trying to complete a PDF application. The staff/manager relationship aspect of 'Time is precious' was also voiced in concerns about bothering busy managers or wasting mangers' time. Other participants stated that they would prefer to self-fund rather than spending hours away from core roles to complete forms. Some indicated that they had completed the forms at home because they did not have time to do so at work. Meaningful in these concerns is participants' dedication towards being present for patients and respect towards managers; however, the limitations of demanding daily schedules and the pace of work also indicate that the needs of employees are seen as secondary during working hours.

This raises questions over what is considered essential in the work of health workers, and why in this case applying to the PDF is seen as extra to core roles rather than an integral part of daily work. Is time for professional development activities taken into account when planning the worker to patient ratio, or is it assumed that every remunerated moment of a clinician's day will be engaged in patient care, and how does this impact on staff wellbeing?

In the literature review, these concerns about patient care and work demands not leaving time for professional development were also apparent (Barnes et al., 2013; Carryer et al., 2007). However, I am increasingly aware of a growing imperative towards staff wellbeing. Recently there have been calls for the Institute for Healthcare Improvement's Triple Aim of 'improving the health of populations, enhancing the experience of care for individuals, and reducing the per capita cost of health care' (Institute for Healthcare Improvement, 2017, para. 2) to become a quadruple aim with the fourth aim focusing on staff wellbeing (Berwick, Nolan, & Whittington, 2008; Bodenheimer &

Sinsky, 2014; Jacobs, McGovern, Heinmiller, & Drenkard, 2018). A 2013 Gallup poll showed that on average 68% of clinical health workers in the United States were either 'not engaged' or were 'actively disengaged' (Gallup, 2013, p. 33) and this seems to have been a watershed moment in driving a focus on improving staff experience. In addition, other studies show that the pace of work in hospitals and staff burn-out can negatively influence patient outcomes (Braithwaite, Ellis, Churruca, & Long, 2018; Hall, Johnson, Watt, Tsipa, & O'Connor, 2016), a motivating factor for organisations to reconsider their approach to staff welfare.

Efforts to mitigate occupational risk has gained further momentum in New Zealand due to recent changes to Occupational Health and Safety Law (WorkSafe New Zealand, 2016) in which healthy workplaces are a key focus. Other signs of the step-change towards improved staff wellbeing include the 2017 review of the Hippocratic Oath, which now includes a pledge for doctors to attend to their own wellbeing as well as that of their patients (Goldman, 2017). Later this year I will be involved in a study on the 'take a break' culture of workers at Waitemata DHB, another initiative towards worker wellbeing which, similar to other studies, enquires into the physiological needs of employees, such as nutrition and sleep (Regional Public Health, 2012). My study on the PDF differs in that it is more concerned with higher level needs of personal fulfilment gained through professional development as part of worker wellness. Links with professional development as meaningful to self-fulfilment are not well acknowledged in the literature and therefore this study also offers a somewhat novel contribution to the conversation about being well at work.

In summarising, the theme of 'Time is precious' has shown that life is folded into time, and time at work, although perceived as a resource, is life being lived. Fulfilment of work place expectations, where there is limited capacity for growth and development activities, can take a toll on

worker wellbeing. Although there is increased focus on healthy workplaces, generally interest lies in physiological needs rather than fulfilment needs. Questions remain over what is considered 'legitimate' use of working hours in relation to the care of one's self. My study shines some light on the idea the that time to care for patients must be balanced with protected time for staff to pursue self-actuating activities that support their self-esteem as a means of improving wellbeing. Further work in this area is indicated.

***The 'help desk' idea.*** This final subtheme was relatively short but conveyed important ideas about the participants' desire for help to navigate the system. It emphasises the participants' expressed need for connectedness with the committee which was also prominent in the 'Blind spots' theme. However, I believe that the need for connectedness is not simply limited to information seeking, but also conveys the strong sense of community within the DHB. It has cultural resonance with collectives in Aotearoa New Zealand described in 'Hive learning'. Although this theme is not as prominent as some of the earlier themes, it continues systems thinking ideas about the need for connection, assistance and acknowledgement in systems design; in fact, kindness in systems design.

The literature on Values Sensitive Design is of interest in this matter; human existence is increasingly integrated with technology and the conversation about goodness in the functionality of eSystems is evolving. Issues such as ownership and property, privacy, usability, autonomy and courtesy, ethical practice, social interaction, collaboration and participation are all important (Friedman, Kahn, Borning, & Huldtgren, 2013). It is apparent that the electronic/human interface is the coming together of emotions and values with objective functionality, and as such it seems that creators of the electronic sphere are increasingly aware of the importance of maintaining humanity in eSystems.

The desire for access to a ‘help desk’, more personalised guidance beyond the policy, guidance from the horse’s mouth, and transparency about the committee’s funding priorities were all conveyed. These were seen as ways that applicants might be encouraged to apply despite previously being declined. One participant felt that even though she had printed out all the information and tried to follow it, she was still confused and felt it would have been useful to be able to call someone for help. Some people described reading the instructions and complying with each step, and others read them when all else failed. Others navigated comfortably, but saw the process as unnecessarily convoluted. These comments together convey the participants’ thoughts that a help contact might manage people’s expectations around the likelihood of application success, support navigation of the system, or provide guidance on the available resource in the fund.

In studies of customer service portals and help desks, moves towards automated responses such as Frequently Asked Questions (FAQs) pages or ‘Help’ documents available through web sites have been documented; however it is also acknowledged that human interaction is still a necessary component of the service (Brandt, 2002). In this field of knowledge, the user experience is considered the priority, and levels of assistance are stratified so that people can self-help in the first instance. Those seeking help are transitioned through layers of interaction; for example one might graduate from the FAQS and help guides to a chat box on the web site, and if resolution is not found to a one-to-one conversation. This way the service centre can offer quick and ready responses and deal with multiple enquiries in simultaneous chat boxes before committing resources on an individual basis (Brandt, 2002). User orientation is described as a helpful strategy to create satisfaction and encourage people to connect with official information, so wayfinding in the system is also important (Serbest, Goksen, Dogan, & Tokdemir, 2015).

Self-service models are increasing, and although this reduces the need for personal service for every user, it is also driving the need for help desks and support services. To counter the need for personal interactions in automated systems, design thinking must focus on the usability of e-Platforms, with particular consideration of the user and their context (Darzentas & Darzentas, 2014). Acceptance of the complexity of the user experience is seen as important, and design of systems that enable rather than inhibit the user are considered crucial; this in turn delivers savings of man hours required to run help desks (Darzentas & Darzentas, 2014). A consistent driver for development of support functions is undoubtedly user experience, but the capacity to deal with growing demand and associated financial implications are prominent concerns. Whilst the limitations of automated systems are acknowledged, undoubtedly the benefit of self-help is that it reduces high staffing demands. A tension appears here where provision of service versus cost of service might be at odds.

Whilst automation may be applied to the PDF with good effect some applicants may continue to feel the need for a connection with the committee through personal customer service. The implementation of a help desk represents a considerable investment for the PDF and measuring effectiveness would be necessary to assess the ongoing value. A helpful area of thought in this regard relates to the evolution of library services; where once libraries were seen as book repositories, they are now ‘library information centres’ with both physical and electronic holdings. In the educational environment particularly, IT help desks are being integrated into library settings. In this business model, IT services which were previously independent become a customer-facing function of the library information centre. Accuracy, volume and economy of help desk services are measured along with reliability, courtesy and responsiveness as metrics in the customer experience (Hernon & Altman,

2010). An ongoing assessment of the user experience with automated or manned interventions would be worth consideration.

Taking these ideas into account, re-design of the PDF interface, inclusion of automated responses such as FAQS, short vignettes of the committee members talking about their work, easy to complete forms, save buttons, and a simple graph to show the funding and spending levels, would I believe alleviate much of the concern. Implementing the principles and practices of self-help, maintaining a human element and considering the tenets of cognitive psychology in interface design, may reduce the PDF applicants' desire for one-on-one support. Measuring any interventions would be of value to the committee.

In summary, this subtheme has functional systems elements as well as a human interaction element, although arguably these are integral and captured by human factors in eSystems design. When it comes to the idea of providing a PDF 'help desk', the desire for human interaction might be mediated by well-designed automated self-help interfaces. This has been shown in the literature where innovative low-cost responses, and stratified levels of assistance can reduce reliance on one-to-one support. Alongside the emphasis on practical features, emotional factors are increasingly prominent in values based design and creating an engaging online environment would be a useful consideration for the future administration of the PDF.

# Chapter 6: Conclusions

## Implications of the findings

The findings of this study enliven the applicants' lived experience to reveal a rich view of being a professional engaging in professional development. Locally, there are implications for the future administration of the PDF and for the experience of its applicants. Nationally, other organisations considering the development or review of contestable funding mechanisms might also be guided by this study. Internationally, this study adds to a limited body of literature which until now has not included the experience of health workers in applying for contestable professional development funding.

The findings resonate with a number of established theories, adding weight to the local experience. Narratives to generate doing and talk that creates realities emerged in the shared experience of navigating this organisational system; this has a direct correlation with phenomenological concepts about epistemic cultures (Thiele, 2009) and with social capital theories of communal knowledge building (Häuberer & Jeřábek, 2011). The desire for acknowledgment of professional status and expertise as competent decision-makers relates strongly to theories of adult learning (Knowles et al., 2012); the self-concept and motivation of the adult to learn was juxtaposed with the bureaucracy of the contestable model. The importance of peer status amongst professionals when discerning between different professional development opportunities, especially when related to the cost of the event and available financial support, emerged as an addition to the existing literature. More detailed inquiry into his aspect of professional development choice would add to the current body of knowledge.

The participants acknowledged the apparently limited resources available for PD in the public sector but keenly felt the tension between the

limited investment and the impact on professional progression as well as their home lives. This dilemma has not previously been articulated so poignantly, particularly when linked with the rewards of vocational commitment. The participants conveyed their desire for self-actualisation and fulfilment through learning; this they connected directly with investment from the organisation. Feeling valued was an indicator of being able to do their best work. Beyond the workplace, on the home front there were clear benefits to receiving funding, such as the potential for increased income and improved status. However, study time and conference attendance went hand in hand with sacrificed time to spend with family. Where funding was not forthcoming, the decision to self-fund came at a personal cost of both time and money. For some however, self-funding was not an option and in these cases the impact on motivation, status and career progression was apparent. Investment strategies for workforce development should therefore include consideration of both professional and personal factors related to professional development and questions should be asked about appropriate levels of dedicated and protected PD time allocated as 'legitimate' work during employment hours.

Views on contractual funding entitlements and formally allocated PD time emerged. Participants expressed their views on the differences between collective agreements as well as how they are applied in various organisations. Although the participants' knowledge about the detail was not always precise, there was an obvious awareness of disparity and inequity which did not sit comfortably with them. Although beyond the scope of this study, these findings indicate the need for further national and international multi-disciplinary research on the value of PD entitlements in collective agreements, which links strongly to indicators of quality and levels of qualification in the workforce and ultimately to patient outcomes.

This research connected professional development investment with feelings of value and worth, particularly in this specific context where organisational values ascribe the importance of each and every person. The study findings indicate that respect for others is not limited to personal interaction but can also be manifest in eSystems design. Integrating compassion or kindness towards the users of eSystems should be a primary principle in systems design thinking. As Hastings et al. (2014) point out, financially driven models for professional development funding with key performance indicators linked to cost efficiencies and patient outcomes rather than staff satisfaction are less likely to be successful.

The findings highlight the importance of user focus; engagement with the learning environment should be motivational and aspirational and this extends to the preparatory phases of finding meaningful learning opportunities and applying for funding. Despite limited resources, the application process should not be used as a barrier to engagement. This is particularly true in a time-poor environment where extensive and convoluted processes can consume precious time recourses. This was seen strongly in the subtheme ‘Time is precious’ which brought meaning to the time at work as life being lived. Finding value and fulfilment, and therefore wellness, in life relies on self-actualisation. Workplace wellness activities often focus on the physiological aspects of health and wellbeing, but this study brings to the fore the importance and value of intellectual growth and self-esteem in healthy professional lives for health care workers. Ensuring that ‘legitimate’ work includes professional development actively supported by time and financial investment is crucial for highly motivated workers and ultimately for quality outcomes for patients and the organisation.

## Importance of this research

In highlighting the relationships between funding availability and staff experience, my study sheds light on the struggle for betterment in a constrained system. It raises the importance of self-agency, professional status and career progression for health workers. It also highlights the vocational commitment and values held dear by people who have committed their lives to the care of others, and for whom the personal costs of seeking funding may be significant. The participants' fundamental understanding of the need for careful stewardship of public finance is clear, but more critical is their recognition of the value of investing in staff training as a means of improving staff competence, confidence and wellbeing. This provides significant motive for greater organisational focus on staff development as a priority since ultimately improvements in patient care will follow.

This research also provides an insight into the current landscape of professional development funding in Aotearoa New Zealand and relates national contributions to levels of global investment. It offers a synthesis of the literature on continued professional development and explicates the known barriers and enablers, in particular availability of funding, for health worker participation in professional development. Linking the extant literature with the findings of this study shows that although the future success of funding systems relies on systems-level thinking, the primary priority and focus for administrating PD funding must be the development and status of health workers themselves.

## Limitations of this research

**Limitations of the study design.** Whilst this study sheds light on the applicant experience, it is limited to the views of the participants and does not capture the views of all previous PDF applicants. However, the participant group was sizable for a qualitative study of a specific

experience and included a cross section of the eligible applicant groups. The focus group participants' views were triangulated with the written responses which further supported the trustworthiness of the study.

Because this research took a qualitative approach, it did not involve all potentially eligible individuals. A quantitative approach using a survey tool might have captured broader empirical data from this much larger cohort but would not have offered the depth of meaning that emerged from the findings of this study.

Whilst the official information provided by the committee was included and discussed, the study does not include the experiences and perspectives of the committee members and the executives, such as the Chief Executive, on whose behalf the fund is administered. A further study to capture their experiences and perspectives would provide insight from 'both sides of the table' of the PDF and therefore a fuller picture of the situation; this would be a useful next step.

**Limitations of the methodology.** IPA is a flexible and accessible methodology but its credibility has been critiqued because findings are based on one person's subjective interpretation of the data (Pringle et al., 2011). In my study, the participant checking of the initial findings has helped to counter this concern. IPA has also been criticised as having limited demand on the researcher as well as being more descriptive than interpretive (Larkin et al., 2006). However, I would argue that although there is more structure than some other phenomenological approaches, implementing IPA requires sustained attention on several conceptual, practical and philosophical fronts. In addition, analysing the meaning making of others and overlaying this with personal interpretation requires greater concentration of work and construction of knowledge than critics of IPA have conveyed.

Concerns have also been raised about supervision intensity when using IPA (Larkin et al., 2006). I believe these concerns are confounded by factors other than the chosen methodology that affect the level of supervisory support required. For this study, supervision conversations were thought provoking and intellectually challenging, as well as supportive and mutually respectful. The self-efficacy, contextual immersion and understanding of the PDF I brought to this work has made the need for intense supervision less relevant in my case. As a mature student, I valued supervision that allowed for appropriate levels of autonomy and the ability to work at my own pace.

Another criticism of IPA is the insider nature of the approach; however, the intention to make meaning of the participants' meaning-making relies on insider knowledge and experience. The potential preconceptions associated with contextual intelligence are counterbalanced by the benefits of deeper understanding and richer meaning-making, which are of value in phenomenological studies (Morgan, 2006). The multi-faceted nature of being an insider raises potential issues around personal agendas that might misdirect the study and I have been careful to maintain reflexivity and mindfulness skills in this regard. Doing research in and about my normal context entailed considerate management of collegial expectations to limit the potential impact on my workplace relationships. Fortunately, I have experienced sustained but considerate interest at various levels of the organisations in the outcomes of this study.

**Limitations of the data collection.** While methods allowing generalisations or data saturation would be expected in quantitative studies, IPA is a qualitative methodology grounded in a phenomenological world view that seeks in-depth views of individual participant experiences (Pringle et al., 2011). The choice of data collection reflected this position, creating the opportunity for participants to hear and share experiences of applying to the PDF. Whilst

focus groups are an emergent form of data collection in IPA, they are an accepted approach that has the benefit of enriching the data through story-sharing (Palmer et al., 2010). It is acknowledged that this study was limited to the individual setting of Waitemata DHB, and the in-depth experiences of a group of 29 self-identified members of staff who have previously been applicants to the PDF. This was an intentional limitation of data gathering because of the specific interest in this setting. The research protocol could however be used in any setting where similar competitive funding is available. Data gathering was informed by the methodology and was consistent with the study paradigm.

Considering these factors, I feel confident that IPA using focus groups and written responses to collect the data has been an appropriate approach and research protocol. I believe that the findings interpreted through personal experience provide answers to the research question. The process of being open to the stories of others also means that paths are explored in ways that allow for the unexpected to come through as part of the research. The themes reflect the participants' experiences of applying for professional development funding and enliven the phenomena at a personal level.

## Recommendations

There are a number of recommendations that arise from this study and these fall into two categories. First, there are recommendations to the PDF committee at Waitemata DHB regarding the future administration of the fund. These include suggested principles that emerged during presentation and discussion of the study outcomes at the PDF committee meeting. The second set of recommendations includes ideas for future research associated with the funding for professional development in the health sector nationally and internationally.

**Recommendations for the Professional Development Fund.** The outcomes of the study were presented to the committee in November 2018. Discussion of the findings resulted in three principles for the review of this funding mechanism. The first, clarity, underpins the intention that all future information provided to applicants be clear about the purpose, process and intentions of the fund. The second, re-design of the application process with user-focus in mind, intends to make the experience of applying both straightforward and aspirational. The third and final principle that emerged from the discussion was the importance of acknowledging applicants as professionals, especially their limited time resources and patient-oriented vocational and professional development needs. These three principles support the following recommendations.

The policy document or official information presented as guidance has limited resonance for the applicants. Rather, the document reveals fiscal responsibility and constraint as primary drivers for the committee's decision-making. Whilst the financial responsibilities of the committee and the DHB executive are highly relevant, this study shows that the priorities of the applicants differ. I therefore recommend that user-centric guidance, distinct and separate from financial information, should be provided to guide applications. This requires a shift in thinking towards user needs over organisational motivators, within the limitations of available funding. This is not to say that motivators should be hidden, but rather that the criteria for applying should be presented in a more relevant format from the point of view of applicant rather than the committee.

The second recommendation arose because applicants raised concerns about the adjudication of applications being carried out by competent figures. Therefore, the committee should clarify their membership confirming the appropriate representation of the eligible groups.

In order that applicants can in future understand the purpose and process of the fund, I suggested that clearer lines of communication be created to effect greater connection between the committee and the applicants. This might be through an upgrade of the application portal, with a more modern and appealing layout. Transparency would be further enhanced if graphics could be made available to show the levels of available funding alongside the value of applications currently being considered in any given month. This would mean that prospective applicants could decide whether to apply or not based on the available resource.

Raising the profile of the PDF by sharing success stories and positive outcomes through internal communications was identified as a way of improving the reputation of the fund. This was in response to the somewhat negative epistemic culture that has developed which undermines the value of the fund. This extremely important recommendation might influence staff perceptions for the better, which is surely worthwhile considering that the PDF seems to be a unique and laudable initiative in the New Zealand Health DHB sector. By showcasing the good news stories, the committee would also make more visible their demonstrable commitment to the organisational values.

Users of a process will often have insight that can be used to improve or refine the experience; therefore, a further recommendation would be to develop a responsive feedback mechanism within the application process. This would allow users to communicate their experiences, ideas and suggestions directly to the committee, thereby reducing the need for negative hearsay and storytelling, particularly if the feedback results in positive improvement.

Because so many applicants were confused about how best to respond to the question on Māori health equity, and not always because of a lack of cultural fluency, it is highly recommended that careful consideration is given to rewording this question. In addition, if specific criteria are

required in responses to this question, they should be clarified in the guidance.

A key concern of applicants was the quality of the technological interface; this was in terms of both form and function. However, the underlying concern was the time expended in completing the electronic process. In order to alleviate this tension, I strongly recommended an update of the interface to reduce the time required, to allow users to save applications part way through, and to remove uploads/ upload limits.

Finally, in addition to functionality, the electronic interface should be updated to encourage sense of aspiration throughout the application process. It is my strong belief that learning should be an aspirational endeavour, including the preparatory stages such as acquiring financial resources. The PDF is a valuable asset to Waitemata DHB and as such people should feel a sense of pride and enjoyment in tendering their applications. Both positive and negative outcomes should be well-rationalised and staff should feel that they have had a fair opportunity to receive the support possible within the constraints of a transparent system.

**Recommendations for future research.** This study has been undertaken to inquire about the applicants' experience of one specific funding mechanism in one particular context. The knowledge gained has been contextualised in the national landscape of professional development funding. A next step for this area of interest might be to explore professional development investment as a whole in Aotearoa New Zealand, including DHB or employer investment and personal investment of workers. This information could be correlated with other funding sources such as Vote Education subsidies in the tertiary education sector. This would provide a more holistic view of actual spending on professional development in the health sector in New Zealand. It may also be the case that a research design such as this might

be scaled up to provide an international view of health professional development spending in OECD countries. This could be particularly valuable if ideas about novel and innovative funding mechanisms could be shared.

Another stand-out concern from the literature is the limited consideration and capability for measuring return on investment. Developing validated metrics to assess specific and general training outcomes and creating and reviewing them may mean more usable and consistent data on the ROI, patient and staff benefits of training investment. This in turn would support decision-making and strategies for more appropriate levels of professional development investment for health workers.

## Summary

This research has presented the experiences of twenty-nine members of staff at Waitemata DHB who have engaged with the Professional Development Fund in order to financially support their learning. It is clear from their consonant and dissonant views that participants have had varying experiences and outcomes. Their stories provide insights into their lived experience at work and their lives at home, supporting the idea that professional development is both a professional and personal matter. The participants were united in their vocational commitment, expressed their desire for growth and development while acknowledging the financial landscape in the public sector, but also understood the critical importance of workforce investment.

The participants made meaning of their experiences which I overlaid with my own meaning-making. Answers to the research questions appeared through understandings of the lived experiences of applying to the PDF, of the PDF as a system in the context of Waitemata DHB, and

of the outcomes of application on staff engagement and career development. Without the generosity of the participants in this study and the support of the PDF committee, this study would not have been possible. My hope is that the contributions of the participants and the openness of the committee to insights gained will be instrumental in supporting improvements to the future administration of the fund.

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# Appendices

Appendix 1: Approvals

e) Ethics approval with 1 non-standard condition

f) Full ethics approval

g) Ethics amendment approval

h) Locality (research site) approval

Appendix 2: Tools

a) Participant recruitment advertisement

b) Participant information sheet

c) Participant Informed Consent form – focus groups

d) Participant Informed consent – written responses

e) Indicative focus group questions

f) Transcriber confidentiality agreement

Appendix 3: PDF documents

a) Waitemata DHB PDF policy (Sept 2017)

b) PDF Applicants cover letter template (June 2017)

c) PDF Line Manager cover letter template (June 2017)

d) PDF Application checklist (Feb 2017)

e) PDF deadlines for 2018

f) Steps for applying to the Professional Development Fund (Sept 2017)

# Appendix 1: Approvals

## 1. a) Ethics approval with 1 non-standard condition

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/research ethics

2 August 2017

Susan McNaughton
Faculty of Health and Environmental Sciences

Dear Susan

Ethics Application: 17/256 **A contestable professional development fund: Interpretations of the applicant experience**

I wish to advise you that a subcommittee of the Auckland University of Technology Ethics Committee (AUTEC) has **approved** your ethics application.

This approval is for three years, expiring 1 August 2020.

**Standard Conditions of Approval**

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/research ethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. 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.

**Non-Standard Conditions of Approval**

1. In the 'How was I identified' section of the Information Sheet inclusion of advice that they have responded to an advertisement.

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

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that 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.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
**Auckland University of Technology Ethics Committee**

Cc: naomi.hoap@waitematadhb.govt.nz; n.hoap@xtra.co.nz; Helen Gasta

## Appendix 1.b) Full ethics approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/research/ethics

25 September 2017

Susan McNaughton
Faculty of Health and Environmental Sciences
Dear Susan

Re: Ethics Application: **17/256 A contestable professional development fund: Interpretations of the applicant experience**

Thank you for your request for approval of an amendment to your ethics application.

The amendment to the data collection protocols (additional focus group and written feedback) is approved.

I remind you of the Standard Conditions of Approval.

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/research/ethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. 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.

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

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. If the research is undertaken outside New Zealand, you need to meet all locality legal and ethical obligations and requirements.

For any enquiries please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
**Auckland University of Technology Ethics Committee**

Cc: naomi.hoap@waitematadhb.govt.nz; n.hoap@xtra.co.nz; Helen Gasta

## Appendix 1.c) Ethics amendment approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: (64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/research/ethics

25 September 2017

Susan McNaughton
Faculty of Health and Environmental Sciences
Dear Susan

Re: Ethics Application: **17/256 A contestable professional development fund: Interpretations of the applicant experience**

Thank you for your request for approval of an amendment to your ethics application.

The amendment to the data collection protocols (additional focus group and written feedback) is approved.

I remind you of the Standard Conditions of Approval.

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. 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.

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

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. If the research is undertaken outside New Zealand, you need to meet all locality legal and ethical obligations and requirements.

For any enquiries please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
**Auckland University of Technology Ethics Committee**

Cc: naomi.hoap@waitematadhb.govt.nz; n.hoap@xtra.co.nz; Helen Gasta

## Appendix 1.d) Locality (research site) approval

----Original Message-----
From: Research & Knowledge Centre [mailto:research@waitematadhb.govt.nz]
Sent: Thursday, 03 August 2017 11:15 a.m.
To: Naomi Heap (WDHB)
Subject: RM13747 Locality Authorisation

Dear Naomi

The Research & Knowledge Centre has now received the relevant approvals for the following study:

Title: A professional development fund: Interpretations of the applicant experience
Registration #: RM13747

This study now has Waitemata DHB Locality Authorisation. Please continue to forward to us copies of all correspondence regarding ongoing ethics approval for this study (if any). All amendments to your study must be submitted to the Research & Knowledge Centre for review. Any substantial amendment must also be submitted to the Ethics Committee for approval.

Note that all research, audit and related activity must meet ethical standards in relation to the safe storage, retention and destruction of research data.

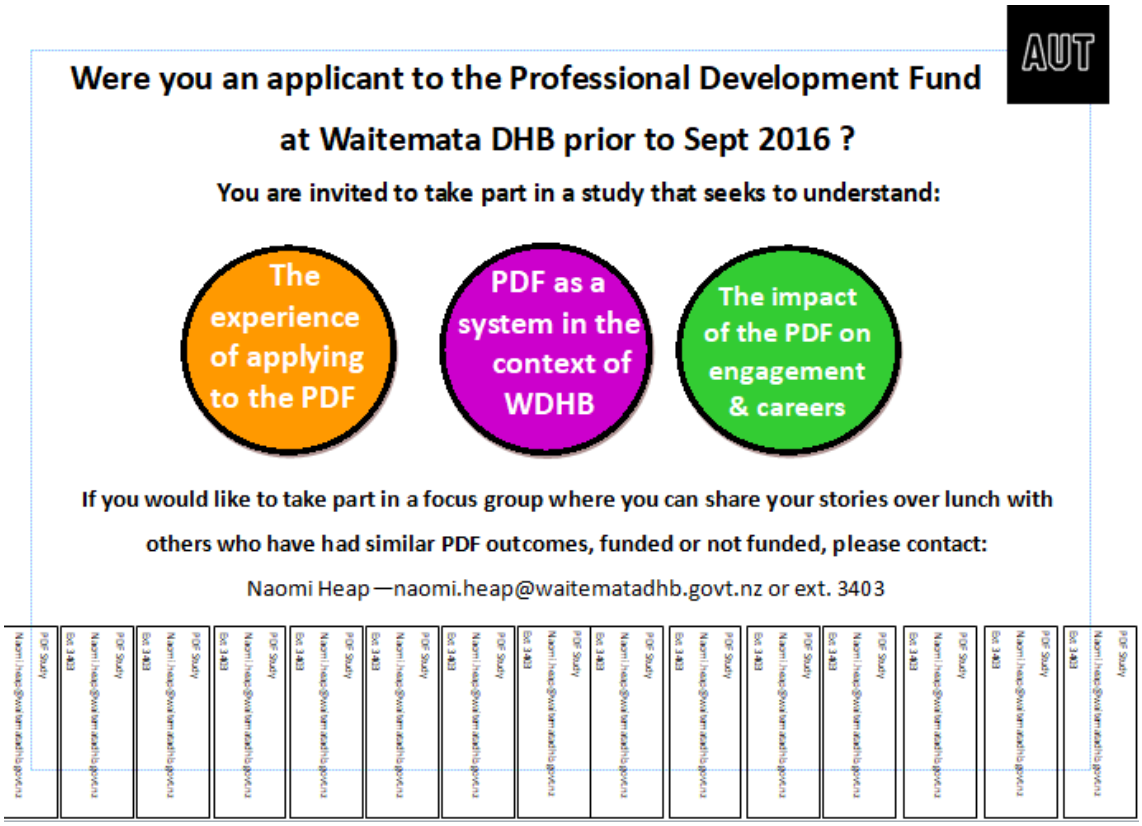
At the conclusion of this study a copy of any outputs, reports or publications should be forwarded to research@waitematadhb.govt.nz

Good luck with your study.

Regards

Research & Knowledge Centre
(09) 4868920 ext 3740
http://scanmail.trustwave.com/?c=7264&d=ia2C2Ym2Yu8qrASVJWfZwDeuOdPCu7eKED33Xykhlg&u=http%3a%2f%2fwww%2eawhinahealthcampus%2eco%2enz
Legal Disclaimer : www.waitematadhb.govt.nz/Disclaimer.aspx

## Appendix 2.a) Participant recruitment advertisement



# Appendix 2.b) Participant Information Sheet

## Participant Information Sheet

**Date Information Sheet Produced: 20th May 2017**

**Project Title - A contestable professional development fund: Interpretations of the applicant experience**

**An Invitation**

Kia Ora, my Name is Naomi Heap and I am a post graduate student at AUT. I am doing a research project on the staff experience of applying to the Professional Development Fund (PDF) at Waitemata District Health Board (WDHB) and I would like to invite you to take part and share your story about applying to the fund.

Like you I am a member of staff at WDHB, and between October 2016 and February 2017 I served on the PDF Committee. During that time I began to wonder about the experience of applicants; what does it mean to apply to the fund? What does it mean for people when an application is granted or when it is not approved? The staff experience of applying to the fund hasn't been evaluated as yet, and so I thought that it would be a useful area of interest for my Master's Degree research project. I would like to hear your story about your application, whether it was successful or unsuccessful, what it meant to you and what you think about the Professional Development Fund at Waitemata DHB.

**What is the purpose of this research?**

The purpose of this research is to find out about:

- The staff experience of applying to the PDF.
- The outcomes of the applications in terms of career progression and the impact on staff engagement.
- The PDF as a system within the context of the DHB.

The findings will be used to create a thesis for my Master of Health Science Degree and a summary report of general findings for the PDF Committee which will be used to support the future administration of the fund. I may also use the findings to produce relevant publications or conference presentations. I would like to assure you that any information that could identify you as a participant will be removed to protect your identity.

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

You have identified yourself as a potential participant through your response to an advertising poster placed on general noticeboards at North Shore Hospital, Waitemata DHB. I am interested in your perspectives, thoughts and outcomes of applying to the Waitemata Professional Development Fund, and what you think about the fund in the context of WDHB. It is the personal experiences of applicants to the fund that I am trying to capture.

You have been invited to participate because you have identified as someone who applied for professional development funding before September 2016. This was prior to my involvement on the committee and therefore I will not have seen your application. I have also excluded anyone with whom I work directly and anyone who is employed in my team - the Organisational Development Team.

**How do I agree to participate in this research?**

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. If you would like to participate after you have read this information and have understood what your involvement in the study will be, you can sign the attached informed consent form, provide a preferred contact phone number and email your consent form back to naomi.heap@waitematadhb.govt.nz

If you decide to participate in this research I will telephone you to ask you what the outcome of your PDF application was and then I will invite you to participate in one of two focus groups. The focus group meeting times will be negotiated with participants but may be in working hours, and we can talk about this when I call you.

**What will happen in this research?**

There will be two focus groups, one for those with applications approved outright or following resubmission; the other focus group will be for those whose applications were not approved either straight away or after resubmission. I am interested to find out about the experience from both perspectives, and so if you wish to participate I will ask you to indicate whether you were successful or not, and if you are happy to be part of a group of others with similar outcomes. The two groups will be kept separate and will be run on different days in different locations.

At the focus groups I will ask some general questions and will encourage open discussion of the subject. The focus group sessions will be around one and a half hours and will be audio recorded on a digital recorder. The recordings will be down loaded and stored digitally. The recordings will be sent to an independent transcriber, who has signed a confidentiality agreement, so that a word-for-word transcript can be produced. When the transcript comes back I will change the participant names to pseudonyms (false names) to protect identities and I will listen to the audio recordings and read the transcripts. I will take notes whilst doing this and this will help me to find themes and interpret meaning in what has been said.

After I have a summary of the findings, which will probably be about two months after the focus groups, I will ask to meet with one or two participants from each focus group to check for accuracy of the main points.

A summary will be made available to all other participants who wish to see the findings. The summary will include direct de-identified quotes from the focus groups.

You may withdraw at any time from the research until the point of analysis. Choosing to participate or not at any stage in the project will be without consequence. If you choose to withdraw from the study, then you will be offered the choice of having any data that is identifiable as belonging to you removed, or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

**What are the discomforts and risks, and how will my privacy be protected?**

You will be asked to talk with others about your experiences in a recorded conversation. This may feel uncomfortable but the recordings and transcripts will only be used for research purposes. Recordings and transcripts will be stored in a locked cabinet whenever they are not being analysed. The recordings and transcripts will not be shared or uploaded to any public internet or media platform, or used for any other purpose other than this research. Whilst participants will be asked to agree to maintain confidentiality within the focus group, anonymity cannot be guaranteed.

The Waitemata DHB Employee Assistance Programme (EAP) is available for confidential support should participants have any issues that arise as a direct result of participating in this project. EAP contact details can be found on the staff intranet directory.

I will not ask you to discuss the monetary value of your fund application and would ask that you do not ask other participants about the value of their applications.

**What are the benefits?**

This research offers participants the opportunity to talk openly with others in a safe environment about the experiences of applying to the PDF, what this means for your career and what you think about the PDF as a system within the context of Waitemata DHB. Whilst there is no direct benefit to the participants, the general findings from this study will be reported to the PDF Committee to support the future administration of the fund and may therefore be of benefit for future applicants.

**What are the costs of participating in this research?**

The focus group will take about one and a half hours. After the focus groups, I may contact you to discuss the findings and check my early understandings. I expect that this follow up meeting will take about one hour.

**What opportunity do I have to consider this invitation?**

You will have three weeks to consider this invitation.

**Will I receive feedback on the results of this research?**

All participants who wish to can receive a summary of the findings; you can indicate your preference on the informed consent form.

**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 (see below for contact details).

Concerns regarding the nature or conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, ethics@aut.ac.nz, 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 also able to contact the research team as follows:

Researcher Contact Details:
Naomi Heap
North Shore Hospital
Whenua Pupuke - Waitemata Clinical Skills Centre
09 4868900 ext 3404
naomi.heap@waitematadhb.govt.nz
Project Supervisor Contact Details:
Dr Sue McNaughton, Lecturer
Auckland University of Technology
Private Bag 92006, Auckland 1142, New Zealand
09 921 9999 x7107
smcnaugh@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on date final ethics approval was granted 7th August 2017, AUTEC Reference number 17/256.

## Appendix 2.c) Participant Informed Consent - focus groups

# Consent Form

*Project title:* **A contestable professional development fund: Interpretations of the applicant experience**

*Project Supervisor:* *Dr Sue McNaughton*

*Researcher:* *Naomi Heap*

- O I have read and understood the information provided about this research project in the Information Sheet dated 20th May 2017.
- O I have had an opportunity to ask questions and to have them answered.
- O I understand that the data in this study is being collected at focus groups, but I have requested to send written feedback to the researcher in order to participate in this study. I agree to my written feedback being used as part of the data and for it to be analysed alongside the data from the focus groups.
- O In my written feedback I agree to provide information about the outcome of my application to the Professional Development Fund, whether it was successful or not.
- O I agree to the use of direct anonymised quotes from my written feedback when the study is written up and/or published.
- O 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.
- O I understand that if I withdraw from the study and I understand that I will be offered the choice of having any data that is identifiable as belonging to me removed or allowing it to continue to be used. I understand that once the findings have been produced, removal of my data may not be possible.
- O I consent to the researcher contacting me to check her understanding once key ideas have been identified.
- O I agree to take part in this research.
- O I wish to receive a summary of the research findings (please tick one): Yes O No O

Participant's signature_____

Participant's name_____

Participant's preferred contact phone number_____

Date_____

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

**Approved by the Auckland University of Technology Ethics Committee on** *date final ethics approval was granted 7th August 2017*, **AUTEC Reference number** *17/256*.

## Appendix 2.d) Participant Informed Consent - written responses

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

### Consent Form

*Project title:* **A contestable professional development fund: Interpretations of the applicant experience**

*Project Supervisor:* *Dr Sue McNaughton*

*Researcher:* *Naomi Heap*

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 20th May 2017.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that the data in this study is being collected in focus groups, but I have asked to send written feedback to the researcher in order to participate in this study. I agree to my written feedback being used and analysed alongside the data from the focus groups.
- ○ In my written feedback I agree to provide information about the outcome of my application to the Professional Development Fund, whether successful or not.
- ○ I agree to the use of direct anonymised quotes from my written feedback when the study is written up and/or published.
- ○ 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 I will be offered the choice of having any data that is identifiable as belonging to me removed or allowing it to continue to be used. I understand that once the findings have been produced, removal of my data may not be possible.
- ○ I consent to the researcher contacting me to check her understanding once key ideas have been identified.
- ○ 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 preferred contact phone number_____

Date_____

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

**Approved by the Auckland University of Technology Ethics Committee on** *date final ethics approval was granted 7th August 2017*, **AUTEC Reference number** *17/256*.

## Appendix 2.e) Indicative focus group questions

**Naomi Heap 0829844**

**Semi structured questions for focus groups.**

**The PDF as a system in our DHB**

What does the group know about how the PDF came about and what its purpose is?

How well do you think it is meeting its purpose, is it fair and well represented?

In the context of our DHB, where we have a culture and set of values that we ascribe to, how do people see the PDF?

**The experience of applying to the PDF**

Why did you apply to the PDF?

What do people think about the process of applying? How was it for you?

There are criteria to meet in the application, how do people feel about what we are asked to think about and justify in our applications?

How could the system be improved? Also can you talk about how else the applications might be prioritized?

**The impact of the PDF on staff engagement and career progression**

The PDF provides for external courses, conferences and tertiary study what other types of professional development activities have you known to be funded or would you like the PDF to consider?

How do you feel about being funded / not funded in terms of your relationship with the DHB?

What is the impact of your outcome?

Is there anything else that you would like to talk about in relation to your own experience?

## Appendix 2.f) Transcriber confidentiality agreement

### Confidentiality Agreement

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

*Project title:* **A contestable professional development fund: Interpretations of the applicant experience.**

*Project Supervisor:* ***Dr Sue McNaughton***

*Researcher:* ***Naomi Heap***

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- ✓ 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: .....

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**Approved by the Auckland University of Technology Ethics Committee on** *date final ethics approval was granted 7th August 2017*, **AUTEC Reference number** *17/256*.

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

2 July 2015 page 1 of 1 This version was last edited in July 2015

# Appendix 3: PDF documents

## Appendix 3.a) Waitemata DHB PDF policy (Sept 2017)

Waitemata District Health Board
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# Waitemata DHB Professional Development Fund

## Contents

Contents



## 1. Overview

### 1.1 Purpose

Waitemata DHB's purpose and values shape the development of our organisation and workforce. Consistent with the value of 'everyone matters' (in this case, staff) Waitemata DHB's chief executive has established a centralised budget to enhance staff access to professional development opportunities.

This policy outlines the principles and process guiding the allocation of that fund.

### 1.2 Scope & eligibility

All staff employed by Waitemata DHB in a permanent position for a minimum of 12 months at the time of application (including those in joint ADHB/Waitemata DHB roles) except doctors and the senior management team.

Part-time staff members are eligible to apply to the fund. However, the level of funding approved may take into account part-time status (i.e. pro-rata according to fte).

Waitemata District Health Board
Best Care for Everyone

Human Resources

# Waitemata DHB Professional Development Fund

The fund is for tertiary study, external courses, conferences and seminars that a staff member (with the support of her/his manager) elects to do. It is not for mandatory/required training and does not replace staff members contractual entitlements specified in their individual employment agreement or collective agreement. This responsibility remains with the respective service.

Nurse applications for Health Workforce New Zealand (HWNZ) funding for tertiary study will continue to be managed by the Director of Nursing & Midwifery, using the already established process. Nurses wishing to apply for Health Workforce New Zealand funding for tertiary study should refer to the Nursing website for details on how to apply.

Nurse applications for funding tertiary study from the Professional Development Fund will only be considered from nurses who have applied for Health Workforce New Zealand funding and are waitlisted.

Applications to attend Health Round Table events should be addressed to the Director of the Institute of Innovation and Improvement.

## Associated documents

| | | |
|---|---|---|
| 1 | Policy | Post Graduate Education [HWNZ] - Nursing |
| 2 | Policy | Post Graduate Education [HWNZ] – Processes and Template |
| 3 | Policy | Travel |
| 4 | Form | Expenses Reimbursement Claim Form |

## 2. Policy statement

### 2.1 Context

Health care in Aotearoa New Zealand is characterised by Treaty of Waitangi obligations, an accelerating pace of change, increasing complexity, an unprecedented growth in information and ever-increasing societal expectations. In this context, continuing professional development is essential so that health care professionals may contribute to reducing health inequalities, and improve the quality and safety of care provided to all patients and their whanau.

### 2.2 Alignment to the purpose and values of the organisation

The Waitemata DHB Board and executive have approved the three-fold purpose of the organisation and the organisation's four values. Demonstrating how an applicant's request will help realise the purpose and values of the organisation is part of the approval criteria for funding.

The organisation's purpose is to

- prevent, ameliorate and cure ill-health;
- promote wellness
- relieve suffering of those entrusted to our care.

The organisation's priorities are

- Better patient experience

Waitemata District Health Board
Best Care for Everyone

Human Resources

# Waitemata DHB Professional Development Fund

- Better clinical outcomes

The organisation's shared values are

- "everyone matters" (in this policy the focus is on staff)
- "better, best, brilliant"
- "with compassion"
- "connected"

Continuing professional development

- Contributes to a compassionate workforce and safe workplace
- Reduces barriers to workforce recruitment and retention
- Facilitates the transfer of knowledge and skills from one staff member to others, consistent with being connected
- Provides opportunity for communities of practice to emerge and enable knowledge management
- Enables continuous improvement consistent with better, best, brilliant
- Supports service development directions oriented to Waitemata DHB's organisational purpose (prevention, amelioration and cure of ill health; promotion of wellness; and relief of suffering).

All professional staff need to be engaged in their own on-going professional development to meet Treaty of Waitangi obligations, maintain professional competency requirements and provide best care for everyone.

## 3. Professional Development Fund Committee

### 3.1 Role

The Professional Development Fund Committee is a sub-committee of the Waitemata DHB Education and Learning Governance Committee. It administers the professional development fund on behalf of the chief executive and the organisation.

### 3.2 Membership

Members of the committee are

- General Manager Specialist Medicine and Health of Older People (Chair – on 3 yearly rotation)
- Associate Director of Nursing ( delegated by Director of Nursing & Midwifery)
- Group Manager, Organisation Development
- Employment Relations Manager
- Finance Manager Corporate
- Maori Workforce Development Consultant
- Director Allied Health, Scientific and Technical Professions
- Operations Manager Asian Health Services
- Clinical Nurse Director Pacific Health ( delegated by GM Pacific Health)

### 3.3 Frequency of meetings

The committee will meet each month to consider applications to the fund.

Waitemata District Health Board
Best Care for Everyone

Human Resources

# Waitemata DHB Professional Development Fund

**Deadlines for submissions and notification dates will be published on StaffNet > HR > Forms > Professional Development Fund**

## 3.4 Quorum

The quorum is 50% of the committee and must include 1x Allied Health Scientific and Technical, 1x Nursing & Midwifery representative and 1 x Maori Health representative or delegate

## 3.5 Allocations and reporting principles

The committee undertakes to

- Work to ensure equity of allocation of professional development funding for all staff eligible to apply to this fund
- Centralise DHB spend on external courses, conferences and seminars
- Work in a complementary way with existing decision-making processes for professional development funding eg HWNZ funding for tertiary study for nurses
- Report quarterly on the administration and allocation of professional development funds approved by the committee to the chief executive
- Publish report activity on intranet and provide to relevant unions and staff on request. Provide an annual report to Manawa Ora
- Maximise the contribution of all staff in achieving health equity for Maori.

## 4. Guidelines for approvals and prioritisation

**NB Please go to *StaffNet > HR > Forms > Professional Development Fund* for details and updates of the application process and deadlines for application submissions.**

Priority for funding external courses, conferences, seminars and tertiary study is based on the following:

1. Supports the realisation of Waitemata DHBs values and purpose
2. Applicability to individual/service/patient priorities and goals
3. Potential to reduce inequalities in health status for Maori and applicability to the Waitemata-Auckland DHB Maori Health Workforce Development Strategy
4. Evidence of benefits to Waitemata DHB and/or risk to the DHB if the professional development is not undertaken
5. Supports innovation in Waitemata DHB to be better, best, brilliant
6. Employee considerations
    - Level of professional development support previously
    - Relevance to role/scope of practice
    - Likelihood the investment will stay in the DHB
    - Likelihood the learning will be shared, well-utilised in practice and contribute to service improvement
    - Has demonstrated commitment to own development. For example, mandatory training requirements are met, for nurses PDRP (Professional Development and Recognition Programme), for midwives has participated in the Midwives Quality and Leadership programme (QLP) and for Allied Health, Scientific and Technical PRPP (Performance Review

Waitemata District Health Board
Best Care for Everyone

Human Resources

## Waitemata DHB Professional Development Fund

and Performance Plan) compliant, portfolio is within date (for relevant professional groups), has a current annual practicing certificate, has a performance appraisal plan & career plan that this professional development links to

- A plan is in place to support the staff member to embed the learning/apply the learning in practice

7. Number of other staff seeking to attend the professional development
8. Cost/benefit analysis – are there other ways to meet this learning need? Is it available in-house through Awhina Education and Learning? Is the employee contributing to the costs?
9. Applications from staff representing the DHB and presenting at courses and conferences will be viewed more favourably than applications from staff who are attending with no formal commitment to present
10. For tertiary study, the course is approved by an accredited provider and registered with the New Zealand Qualifications Authority. Associated tertiary study travel, accommodation or book costs are not covered.

### 5. Funding allocations

The fund is for external courses, seminars and conferences and for tertiary study. The fund covers reasonable travel and accommodation costs for course and conferences both national and international as per the Travel Policy.

Applicants should apply for professional development funding before enrolling on a course, conference or tertiary study.

Where appropriate, applicants may request funding for Kaumatua support. This request must be included in their application to the Committee.

The Professional Development Fund Committee will review each application against the criteria stated in section 4 of this policy, *Guidelines for approvals and prioritisation*.

The Professional Development Fund Committee allocates funds along the following lines

- For tertiary study, only one 30 point paper, or equivalent, per application, per semester will be accepted. A maximum of two papers per year may be supported, either partially or fully, depending on the cost of the papers. There is no guarantee of continued support to cover full funding of an entire qualification.
- Tertiary study funding covers fees only and does not cover associated travel, accommodation or book costs
- Those applicants who receive over $3,000 in a single application for conference attendance will be subject to a two year stand down period before they may apply for further conference support.
- For funding guidelines for Masters and Doctoral Study Programmes please refer to Appendix 1

The allocation of this fund is solely at the discretion of the Waitemata DHB Professional Development Fund Committee. Their decision is final and there is no appeal process. The Committee aims to allocate all funds available on an annual basis.

Waitemata District Health Board
Best Care for Everyone

Human Resources

# Waitemata DHB Professional Development Fund

## 6. Application & approvals process

### 6.1 Key steps

**NB Please go to *StaffNet > HR > Forms > Professional Development Fund* for details and updates of the application process and deadlines for application submissions.**

#### Step one – Prepare application

1. Refer to the policy to check your eligibility to apply to Waitemata DHBs professional development fund
2. Discuss your application with your line manager and seek her/his approval
3. Seek leave approval from your line manager
4. Gather supporting documentation (leave approval, manager support letter, information about course/conference, travel quotes via WDHB approved travel provider) for your application.
5. Ensure all five Mandatory Training e-learning modules have been completed.

#### Step two – Submit application

**NB The period of time from submission of your application to notification from the committee on the outcome of your application will be up to 4 weeks. Please take this into account when you submit your application. You need to submit your application by the submission deadline and no later than 6 weeks prior to enrolling in the activity/6 weeks prior to early-bird registration for conferences.**

**FAST TRACK REQUESTS WILL NOT BE CONSIDERED**

1. Use the online form found at *StaffNet > HR > Forms > Professional Development Fund* to apply to the professional development fund
2. When you submit your application you will receive a confirmation email message. If you do not receive this please email Awhina@waitematadhb.govt.nz
3. Applications must be submitted and all online manager approvals completed by the deadline as advertised at *StaffNet > HR > Forms > Professional Development Fund*

#### Step three – Approval process

Once applications have been received

- The Director of Nursing & Midwifery and the Executive Leadership Group Nursing & Midwifery will review all applications from nursing/midwifery staff and forward their recommendations for approval to the Professional Development Fund Committee
- The Director of Allied Health, Scientific & Technical Professions and an allied health, scientific and technical panel will review all applications from allied health, scientific and technical staff and forward their recommendations for approval to the Professional Development Fund Committee
- Applications from all other staff will be considered by the Professional Development Fund Committee at its monthly review meeting. The committee will review the allied health and nursing/midwifery approval recommendations at the same monthly meeting.

Waitemata District Health Board
Best Care for Everyone

Human Resources

# Waitemata DHB Professional Development Fund

- Applications for over $3,000 will be sent on to the CEO for review and final endorsement. Only those of the highest quality will be considered.

### Step four – Notifying you of the outcome

Applicants will be notified via email of the outcome of their application no later than four weeks following the submission deadline. Those applicants requesting funding of more than $3000 will need to allow an extra week for notification to come through due to additional CEO endorsement process

## 7. Staff member commitments

All those who receive funding from Waitemata DHBs Professional Development Fund are

1. Expected to share their learning with relevant others within six (6) weeks following the learning event. This may be a presentation, a written report, a reflective learning entry in a portfolio, Career and Salary Progression (CASP) process, Merit process, or any other mode that is deemed appropriate by the staff member and her/his manager. The report is to cover key learnings, implications for practice and how the new knowledge has been applied in practice.
2. Expected to reimburse the DHB for all monies paid if the staff member fails to attend/complete the course requirements
3. Submit claims for reimbursement within 3 months of attending the course/seminar/conference. All claims must have invoice and tax receipts attached.

All those who receive over $3000 will be required to complete a survey and submit a report to the Professional Development Fund Committee which may be used for the quarterly report.

## 8. Leave

This professional development fund does not provide funding for leave or backfill to attend external courses, conferences or seminars or for tertiary study. Applicants must get leave approval from their manager prior to applying to Waitemata DHBs Professional Development Fund.

Waitemata District Health Board
Best Care for Everyone

Human Resources

# Waitemata DHB Professional Development Fund

## Appendix 1

## Funding guidelines for Masters and Doctoral Study Programmes

Masters study programme will be considered for funding and all the criteria required for any PDF funding applies however additional criteria is as follows:

- **Master's Study Programme (Paper and Dissertation Pathway)**

Consideration for funding will be based on the relevance of the papers and the dissertation/project to the applicant's area of work and profession.
Career planning and progression is an important aspect of higher levels of academic study and this will be considered alongside all the other stated criteria for funding.
Funding will be capped at a maximum of 30 points per semester of any academic year and a maximum of two papers per year may be supported. Only one paper per application will be accepted

- **Master's Study Programme (Thesis Pathway)**

Consideration for funding will be based on the relevance of the thesis to the applicant's area of work and profession.
Applicants will need to provide the committee with an outline of the significance of the research or research project to the applicant's area of work and profession and verify how the outcomes of the research will improve practice or service outcomes. This can be provided as an appendix with the application form.
Should the committee have questions or need further clarity about the research or research project. The applicant may be invited to attend a committee meeting and do a presentation of the research proposal including its significance to the applicants practice, service area, profession and how the applicant intends to implement the study recommendations at Waitemata DHB.
Thesis programmes should be completed as part time study however exceptional cases for full time study will be considered with the endorsement of the applicants Manager
Funding of Paper A and Paper B of the Thesis Programme must be applied for separately and application for funding of Paper B must include a thesis progress report signed by the applicant and Thesis supervisor.
Application for Paper B funding will follow the rigours of Paper A application and can include an updated version of the initial application.
Funding will be capped at a maximum of the equivalent of 30 points per semester of any academic year and a maximum of two papers per year may be supported. Only one paper per application will be accepted

- **Doctoral Study Programme**

Funding will only be considered for the paper component of a Doctoral Programme. Note the thesis study component of the programme may funded by the University offering the programme and Doctoral candidates are requested to take advantage of this funding if available.
Funding will be capped at a maximum of 45 points (one paper) per semester and a maximum of two papers per year may be supported. Only one paper per application will be accepted.
Applications for each paper must be submitted separately and continuing Doctoral study candidates will need to furnish the committee with previous paper results to be eligible for further study grants.

## Appendix 3.b) PDF Applicants cover letter template (June 2017)

Applicant's Cover Letter

Name: ……

To the chair of the Waitemata DHB Professional Development Fund Committee

**How learning from this course/seminar/conference will assist me/our DHB to realise our purpose, values and priorities**
(State the relevance of this learning activity to your service/team goals and DHB purpose, values and priorities)

**Relevance of this learning activity to my learning, career and job**
(State your learning outcomes and career goals and how you will apply this learning in your work)

**Please reflect upon the Treaty principles of partnership, participation, protection and explain how this learning can support and influence your effectiveness in reducing disparities and create better health outcomes and equity for Māori** (Please refer to Ministry of Health website: http://www.health.govt.nz/our-work/populations/maori-health for further guidance)

*The committee expects to see evidence of thoughtful consideration around:*

- *Maori cultural elements of the programme / course*
- *Awareness of your own cultural perspective (personal and work environment),*
- *Awareness of the Maori Health inequalities issues facing the communities we serve,*
- *Implications from attendance to demonstrating improvements for Maori in your work/ service*

**How I will share the learning from this course, seminar or conference with others**
(State who you will share your learning with, how you will do that and when you will do that. Discuss this with your manager first)

**How my learning experience will support innovation in Waitemata DHB to be "better, best, brilliant".**
(How will this learning help you to do things in new/better ways to improve health outcomes?)

**My funding application**
In my application form the **total amount I am applying for** is $_____
This is made up from the following:

1. Course, conference, seminar costs $_____
2. Tertiary study costs $_____
3. Accommodation $_____
4. Travel $_____

**My commitment to my own learning**
(Please tick all the boxes that apply to you)

**N.B. Your application will be declined if your mandatory training is not up to date**

| All staff – I have done these mandatory e-Learning modules **in the last 12 months** | Yes | No |
|---|---|---|
| • Infection, Prevention and Control e-Learning module | | |
| • Fire e-Learning module | | |
| • Occupational Health and Safety e-Learning module | | |
| • Privacy & Confidentiality | | |
| • CPR Skills | | |
| Nurses – I have done these mandatory e-Learning modules **at least one** | | |
| • Code of Conduct e-Learning module | | |
| Staff in clinical roles | | |
| • CPR | | |

| Nurses – I am up to date on the following | | |
|---|---|---|
| • PDRP compliant | | |
| • My portfolio is within date (**12 months if new to role, or 3 years for all other nurses**) | | |
| Midwives – I am up to date on the following | | |
| • Midwifery standards review | | |
| • APC requirements | | |

## Appendix 3.c) PDF Line Manager cover letter template (June 2017)

Line Manager's Cover letter

To the chair of the Waitemata DHB Professional Development Fund Committee

Here are the reasons I support this application for funding for _____
(employee's name)

**Benefits of this learning activity in relation to our service/team goals and the realisation of the DHBs purpose, values and priorities**

**Relevance of this learning activity to this employee's learning, career and job**

**Ways in which we will support this employee to apply their learning in the work of our team/service**

**Your commitment to this learning**
(Please tick all the boxes that apply to you)

| Leave to attend this course, seminar or conference | Yes | No |
|---|---|---|
| I approve this employee attending this course, seminar or conference | | |
| I will provide leave cover for this employee from my service budget | | |

Line Manager's Name: .....

Signed: .....

Date: .....

## Appendix 3.d) PDF Application checklist

Professional Development Fund – Application Checklist

**TO FACILITATE PROMPT ASSESSMENT OF YOUR APPLICATION TO THE WDHB PROFESSIONAL DEVELOPMENT FUND PLEASE ENSURE THAT:**

- ☐ You are eligible to apply by referring to the Professional Development Fund Policy
- ☐ You have completed any similar offerings available internally through Learning and Development – applications will not be supported if these are not done in the first instance.
- ☐ Any leave requirements have been approved by your manager
- ☐ You have attached all required documentation to your application:
  - completed Applicant's cover sheet
  - completed Line Manager's cover letter
  - copy of your current performance appraisal goals
  - conference, course, seminar brochure/registration form
  - Copy of your current training record - available through Employee Kiosk
  - quote from approved WDHB Business & Conference Travel provider for any flights and accommodation
  - completed and signed Business related travel and conference expenses application form
- ☐ All sections of the Professional development fund application form have been fully completed and you have used the online templates listed above– if any information is missing your application may be rejected.

## Appendix 3.e) PDF deadlines for 2018

**Professional Development Fund - Deadlines and notification dates for 2018**

**Please note that fast-track requests will not be considered**

| **Deadline for committee to receive application*** N.B This is **not** the date that you should submit your application but rather the date that all online approvals need to be completed | **Latest date you can expect to hear the outcome of your application** -N.B If your application is for over $3000 it will need final approval from the CEO so please allow an extra week for the outcome |
|---|---|
| 12pm Friday January 26th | 5pm Friday 16th February |
| 12pm Friday February 23rd | 5pm Friday 16th March |
| 12pm Friday March 23rd | 5pm Monday 16th April |
| 12pm Friday April 27th | 5pm Friday 17th May |
| 12pm Friday May 25th | 5pm Friday 15th June |
| 12pm Friday June 22nd | 5pm Friday 13th July |
| 12pm Friday July 27th | 5pm Friday 17th August |
| 12pm Friday August 24th | 5pm Friday 14th September |
| 12pm Friday September 21st | 5pm Friday 12th October |
| 12pm Friday October 26th | 5pm Monday 16th November |
| 12pm Friday November 23rd | 5pm Friday 14th December |

* **N.B Ensure you factor in plenty of time for both your line manager and the GM of your service to complete their on-line approvals in order to meet this deadline.**

Please refer to the document "Steps for applying to the Professional Development Fund" at Staffnet>HR>Forms for further information.

# Appendix 3.f) Steps for applying to the Professional Development Fund (Sept 2017)

Waitemata District Health Board
Best Care for Everyone

**Steps for applying to the Waitemata DHB Professional Development Fund**

**Step one - Prepare application**

- To get earlybird rates it is important you get this process underway in good time
- Go to *StaffNet>Quality/Policies>Controlled Documents>select Human Resources* to find Waitemata DHBs Professional Development Fund policy
- Refer to the policy to check your eligibility to apply to Waitemata DHBs professional development fund
- Go to *StaffNet>HR>Forms > Professional Development Fund forms* for documents for applying to the fund.
- Discuss your application with your line manager. Seek leave approval from your line manager. The professional development fund does not cover leave and backfill; this will be covered by your service.
- Gather supporting documentation for your application. This consists of:
  - A completed cover letter from you; and one from your line manager;
  - Your current performance appraisal goals;
  - Information about the course, conference or seminar you are applying to go to.
  - A quote from approved WDHB travel provider for any flights and accommodation.
  - Completed Business related travel and conference expenses application form

  Go to StaffNet>Travel>Business & Conference Travel for travel form and further information

- All these documents must be submitted with your application – have them ready **before** you begin filling in the application form.

**Step two – Submit application**

- Use the online form to apply to Waitemata DHBs Professional Development Fund. The form is found at *StaffNet>HR>Forms*
- Complete and submit your on-line application form. Once you have submitted your form you will receive an automatic response acknowledging your application. If you do not receive this please email Awhina@waitematadhb.govt.nz
  - **N.B Applications will not be received by the Professional Development Fund until both your line manager and the GM of your service have completed their on-line approvals. Please allow plenty of time for this to happen. We recommend at least a week.**
- On-line applications, with line manager and GM approvals, must be received by the professional development fund committee by the deadline in order for your application to be considered.

**Step three – Approvals process**

Once applications have been received by us

- The Director of Nursing & Midwifery and the nursing Executive Leadership Group will review all applications from nursing staff in the first instance and forward their recommendations for approval to the Waitemata DHBs Professional Development Fund Committee
- The Director of Allied Health and an Allied Health core group will review all applications from allied health staff in the first instance and forward their recommendations for approval to the Waitemata DHBs Professional Development Fund Committee
- Applications from all other staff will be considered by Waitemata DHBs Professional Development Fund Committee at its monthly review meeting. The committee will review the allied health and nursing approval recommendations at the same monthly meeting

**Step four – Notifying you of the outcome** You will be notified via email of the outcome of your application no later than four weeks following the submission deadlines.