How Well Do Occupational Therapy Competencies Support the Transition Into Health Service Management and Leadership?

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Abstract

Purpose: While many health professionals are employed as health service managers in District Health Boards (DHBs), little is known about the competencies (skills, knowledge, and attitudes) occupational therapists carry forward from their professional education and the management competencies they are least prepared for when transitioning into these roles. The questions at the centre of this thesis are: "*What do occupational therapists employed in health service management roles in the DHBs identify as the core management competencies they developed through their professional training and experience?*" and "*What were the competencies required in their management role that they perceived they were least prepared for?"* The research objectives were to conduct an exploratory study to generate new knowledge that is useful to health professionals, their professional associations, the health services that employ them, registration bodies, and undergraduate and postgraduate educational providers by informing competency identification and development initiatives.

Method: The research methodology, interpretive description, informed by the writing of Dewey (1859-1952) and Thorne (1951-), was selected because of the emphasis on individual experiences and learning in the health workplace, and the inclusion of the researcher's experiences and knowledge. Twelve participants with experience as occupational therapists and in health service management roles were interviewed. Data were collected through one interview with each participant and the collateral material they provided. Data analysis utilised inductive thematic and abductive methods.

Findings: Four themes were developed from the data analysis: occupational therapy competencies employed, management competencies least prepared for, career journey, and ongoing competency development. Key findings are that occupational therapy competencies of perspective, approach, and attitude; clinical, technical, and operations skills; and culture and sector knowledge, are employed in health service management, but their professional education does not fully prepare occupational

therapists for all competencies required for management. Core competency domains of leadership, business, and administration; managing within the healthcare environment; and building self-confidence and resilience were identified as least prepared for. The research revealed that line managers and mentors play a vital role in creating a supportive learning environment for aspiring and emerging managers, and the provision of challenging service opportunities is crucial to developing new skills, knowledge, and attitudes. The study also found that further competency development was primarily self-directed via informal workplace learning. Finally, the findings suggest that annual performance review and competency assurance processes are limited in their applicability and usefulness to health service managers' ongoing competency development.

Conclusions: There would be value in individual occupational therapists in managerial positions being able to identify and communicate the competencies they possess from their professional education and experience, and which they bring to health service management. The benefit of this knowledge is the confidence that they are not restricted to clinical practice and can show alignment between occupational therapy competencies and the requirements for effective health service management.

There would also be value in targeted competency development informed by the areas of competence that occupational therapy managers identify they lack and where competency gaps may emerge. This knowledge will support the transition into management by targeting known competency gaps and minimising training in areas of existing competence.

While the findings are specific to occupational therapy, they suggest that there would be value to individual managers, organisations, and the health sector as a whole from establishing competency development programmes, including programmes at university level, to support and prepare individuals for career opportunities and role responsibilities in the transition from clinician to manager. Such a programme can be informed by the knowledge of competencies developed from previous professional education and competency frameworks, and the competency gaps.

Overall, health professionals have skills, knowledge, and attitudes developed from their professional education and sector experience that are applicable in health service management; however, further competency development is required. This knowledge supports the position that health professionals should consider health service management as a career option for which they are already partially prepared.

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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 used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

Signed

Jennifer Coles

Date: 10 June 2024

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This thesis is my 'Everest'. The journey started in the 1970s when I qualified as an occupational therapist and my parents asked, "Where does this lead to?" I am forever grateful to Jean and John Coles for setting the challenge to pursue what can be accomplished and contributed.

This study was approved by the Auckland University of Technology Ethics Committee (AUTEC) on March 22, 2021; AUTEC reference number 21/58.

Chapter 1. Introduction to the Study

The structure of the New Zealand publicly funded health system provides career options for health professionals to transition into health service management roles. This study takes the position that health professionals transitioning to health service manager roles have transferable, discipline-specific knowledge, skills, and attitudes (competencies) that can be employed in their health service managerial positions; while acknowledging that their professional education and experience may not fully prepare them for such roles. This area of interest aligns with my own background as an occupational therapist who moved into managerial positions, with occupational therapists who take this career option being the focus of this study.

Gap in Knowledge

Little is known about the experience of occupational therapists who transition to health service management; specifically, the competencies they employ from their prior professional education and experience, and those competencies for which they believe they are least prepared. In this context, competencies are broadly defined as the skills, knowledge, and attitudes required to perform a task or job (Liang & Howard, 2010). As the language of professional competencies is not part of the everyday terminology I and the participants are familiar with, identification of the competencies participants have or lacked was assisted through the incorporation of current, context-specific occupational therapy and health service managerial competencies frameworks into the design of the study; viz the Occupational Therapy Board of New Zealand (OTBNZ): Competencies for Registration and Continuing Practice (2015) and the Australasian College of Health Service Management (ACHSM): Master Health Service Management Competency Framework (2016).

That health service managers are competent to fulfil their roles is critical to the performance of health organisations and health outcomes, and the implementation of strategies and policies, and sector reforms. Healthcare is a complex and constantly evolving sector, and there is pressure on managers to have the skills, knowledge, and

attitudes to lead and manage health organisations to achieve care outcomes, and to meet operational targets and financial boundaries.

The purpose of this research is to identify occupational therapy competencies that the participants recognise they brought to health service management, to discern the influences a health professional education and experience has on the development of management competencies, and to identify the competencies they acknowledge they were least prepared for and needed to develop to fulfil the requirements of the role and as part of career progression.

Doctor of Health Science

The Auckland University of Technology Doctor of Health Science (DHSc) programme was identified as the best fit for the area of interest I wanted to research. The DHSc programme strongly emphasises providing leadership in informing, changing, and potentially developing new practices in healthcare in New Zealand.

The DHSc programme is offered in the bicultural context of Aotearoa New Zealand. Consistent with that context it is recognised that all research has relevance to Māori, the Indigenous people of the land. Therefore, prior to submission of the ethics application, I consulted with a member of Occupational Therapy New Zealand Whakaora Ngangahau Aotearoa and the Occupational Therapy Roopu, for cultural advice on the scope and appropriateness of questions and analysis in respect to the interpretive approach taken for this study. The advice and guidance from this meeting were incorporated into the AUTEC application. Furthermore, I accepted and incorporated the support and contribution of a respected elder, who has extensive experience as a leader of Māori health services, as kaumatua for the study.

The complexity and variation across the research environment suggested the need for input from a peer advisory group with a variety of perspectives and knowledge that complement my own. The members of the peer advisory group were purposively selected for their expertise and experience as practising occupational therapists and health service managers; experiences as professional leaders and supervisors; and

knowledge of the health sector, including management structures, roles, and responsibilities.

For this study, the two academic supervisors were chosen for their capacity to support the dual focus of occupational therapy and health service management. Both have experience as occupational therapists and, thus, knowledge of clinical practice. Individually, they brought knowledge of leadership and managerial competencies and theories, as well as the understanding of occupational therapy competencies, theorists, and education.

The Research

This study takes a profession-specific approach and asks, "*What do occupational therapists employed in health service management roles in New Zealand District Health Boards (DHBs) identify as the core management competencies they developed through their professional training and experience?*"

A second question asks, "*What were the competencies required in their management role that they perceived that they were least prepared for?"*

For this study, 12 participants were purposively selected to participate. The participants had experience as occupational therapists and as health service managers in a New Zealand DHB and were invited to participate in the research.

Dewey's (1859-1952) writings of pragmatism underpin the approach taken to this study and the research methodology selected. Dewey (1929) held a naturalistic view that all experiences result from engagement with the environment. Dewey held a philosophical belief in humans' ability to adapt to the environment and to have the insight and capacity to share their understanding of this adaption. Understanding that there is a constant change for humans and the environment, as well as ongoing change in understanding, is meaningful for this study. This thinking by Dewey supports the positioning of the study with a focus on the individual, as each participant's experience and understanding is unique and real to them at the time it is known.

In addition to Dewey's philosophy, interpretive description methodology (Thorne, 2016) was used to provide the philosophical context within which to apply qualitative methodology and allow for the contribution of my experience and knowledge of the sector to the research. A semi-structured interview format was utilised for data gathering. The data analysis used iterative investigation and inductive reasoning. The inductive analysis was supplemented by abductive analysis of collateral data and sector competency frameworks. This study focuses on each participant's experience, understanding, and insights that were real at the time. To ensure their anonymity, all participants, locations, and events are anonymised.

The overall objective of this course of study is to generate new knowledge with which to inform initiatives for competency identification and development. My aim is that this knowledge will be helpful to health professionals, their professional associations, the health services that employ them—all which influence the professional development opportunities available to them—and undergraduate and postgraduate educational providers.

Overview of Thesis Document

This thesis is presented in eight chapters, plus a references section and appendices. It is consistent with the format for the DHSc at Auckland University of Technology, New Zealand.

Chapter 1: Introduction

This chapter introduced the study, the academic programme undertaken, and the research questions. It also identified key features of the study, including using existing competency frameworks as a point of reference, establishment of a peer advisory group, the bicultural context of the study and the actions responsive to that context. The academic supervisors were introduced, along with a summary of the participants, the underpinning philosophy, research methods, and an overview of the thesis document.

Chapter 2: Context

Chapter Two outlines the conceptual and material context of the study. Key concepts are defined, and the scene is set regarding the period over which the study was conducted and the aspects that I anticipated or identified through the literature search to impact health service managers in DHBs. This qualitative study is contextual and the participants' contributions reflect their professional education, the work environments they experienced, and the societal and political environments of the time.

Chapter 3: Literature Review

This chapter presents a review of the related literature that was undertaken at the time the study was initiated to inform its design. Its purpose was to provide a summary of what was known in the relevant area of interest and to delineate the knowledge gap that the study intended to address. This knowledge base informed participant selection and data gathering, and provided a starting point for data analysis.

Chapter 4: Methodology and Method

The Deweyan pragmatist concepts guiding this study are presented and aligned with the interpretive description philosophy and methodology. This is a qualitative study using the interpretive description methodology as described by Thorne (2016), which is identified as suitable for qualitative studies in complex health service environments. The research method and procedures are presented. The rationale and processes for participant recruitment, data collection, and data analysis based on Braun and Clarke (2013) are described. In line with the qualitative interpretive descriptive method, the interpretation of the data was informed by my experience and knowledge of employment within the New Zealand health sector.

Chapter 5: Findings: Competencies Employed and Least Prepared For

This chapter introduces the research participants. It outlines the competencies identified that they had employed in their management roles and those they needed to develop.

Chapter 6: Findings: Abductive Analysis

In this chapter, the findings are presented from abductive analysis (Patton, 2015) matching the competencies employed and least prepared for within existing industry competency frameworks to ascertain if the competencies recognised by the participants were recognised industry competencies. In addition, and to provide for triangulation of primary data, the findings from analysis of the collateral data (position/job descriptions, individual performance review, and performance planning documents) provided by participants are presented.

Chapter 7: Findings: Career Journey and Competency Development

In this chapter the contribution and influence of the career journey, and organisational performance review and planning systems on competency development, following appointment to a health service management position are presented.

Chapter 8: Discussion and Recommendations

The findings of this study are presented and discussed in relation to the current published literature. The identified strengths and limitations of the research are presented; and, in line with the applied nature of this course of study, implications for practice are presented. Finally, recommendations for further research are made.

Chapter 2. Context

This study was based on three fundamental premises. Firstly, organisational management, including leadership, is required for planning, organising, and controlling work processes and systems to ensure the quality of work output. Secondly, occupational therapists are well-positioned to transition into health service management due to their discipline-specific knowledge, skills, and attitudes (competencies). Thirdly, occupational therapists who move into management roles acknowledge that their professional education and experience may not fully prepare them for health service management roles and responsibilities.

The study sought to 'flesh out' these premises, testing them against the real-world experiences of occupational therapists working in leadership and managerial roles within the publicly funded health services in New Zealand. As stated previously, the aim was to generate insights useful to occupational therapists who move into such roles to inform their competence development journey, as well as usefully informing the various bodies that provide professional development opportunities including professional associations, health services, and undergraduate and postgraduate educational providers.

Informed by these initial premises, the first section of the chapter outlines the definitions utilised for this study, followed by the New Zealand publicly funded health system, bicultural New Zealand, and Te Tiriti o Waitangi – The Treaty of Waitangi. To give context to the professional and managerial competencies at the heart of the study, the New Zealand health reforms of the past 40 years are summarised and include the evolution of opportunities for health professionals to transition into management roles and the development of new roles and responsibilities. The current health reforms are considered, including the concerns and aspirations outlined in the Health and Disability Interim and Final Reports (New Zealand Parliament, 2019, 2020) regarding leadership and management and their impact on the New Zealand publicly funded health sector.

Following this scene setting, the constructed concept of 'competence' and its application in competency-based education is introduced. Then, the implication of this concept for individuals, professions, regulatory bodies, and organisations is considered. The legislation governing health professionals, the New Zealand Health Practitioners Competence Assurance Act (HPCAA) (2003), and its application and utilisation by occupational therapy as a registered health profession under this Act are described. Following is a perspective of health service management in New Zealand regarding recognition of the role, creation of competency frameworks, and workforce development. The chapter concludes with a summary of the 2020 health reforms, the further changes announced in 2024, and the opportunities and challenges these reforms present in relation to the competencies health service managers require.

Definitions

Defining key terms utilised in a study is recognised to be a critical step in establishing the context. While acknowledging that many of these terms are complex, with definitions varying across authors and situations, I have elected to provide a broad introduction drawn from recognised sources. These key terms are listed alphabetically.

Competencies: The skills, knowledge, and attitudes required to perform a task or job (Liang & Howard, 2010). "Explicit measures, indicators, or statements that define specific areas of knowledge, skills and abilities related to essential functions and assigned to duties within a role or job" (Henry & Braveman, 2022, p. 383).

Competency: "An observable characteristic involving knowledge, skills, and attitudes, shown empirically to be related to the performance of tasks related to role and job, and can be improved with training and development" (North & Park, 2014, p. 13).

Competency frameworks: These endeavour to delineate the scope of competencies required to perform an identified task adequately or to fulfil a role. They are developed when knowledge, skills, and abilities are grouped into categories of competencies and then into frameworks of categories (Calhoun et al., 2008). Competency frameworks can be utilised as a basis for assessing an individual's current

competence and identifying areas for development. As a constructed and applied concept, decisions are made by educators or professional bodies that involve consultation with subject matter experts on identifying and selecting areas to include and what competencies must be demonstrated, also described as performance indicators and competency statements (ACHSM, 2022a; OTBNZ, 2022c).

Core competencies: These are defined as a bundle of technical know-how linked to identifying the key competencies required for successful performance in a role (Calhoun et al., 2002). In the process of identifying and categorising competencies, some are identified as core to the health service management body of knowledge and its application (Ayeleke et al., 2018; Howard et al., 2018). Specific competencies were common across a range of roles in the healthcare context and most likely will include communication, interpersonal skills, business skills, knowledge of the health environment, and leadership (Ayeleke et al., 2018).

Description (Research): This term is used for studies whose purpose is to record something that requires documenting (Thorne, 2016).

Enabling and enablement: A core competency of occupational therapy, drawing on “an interwoven spectrum of key and related enablement skills which are value-based, collaborative, attentive to power inequities and diversity, and charged with visions of possibility for individual and social change” (Townsend & Polatajko, 2013, p. 375).

Health service manager: Considered to be someone holding the responsibility for leading and managing individual healthcare services, large healthcare organisations, or health systems (ACHSM, 2016). Health service managers have, as the core of their activity, the coordination and allocation of health resources to deliver health services to the population. The outcome required is to operate within budget, according to strategic plans and to achieve agreed targets. This purpose and outcome sit as the reason for the existence of health service management and influence operational and resource allocation decisions through the lens of practicality, cost-effectiveness, and time utilisation.

Interpretive: The term used in research to describe engagement with the data that extends beyond the self-evident, including prior knowledge and research, to see what else might be there (Thorne, 2016).

Leadership: The art of mobilising others to want to struggle (work) for shared aspirations (Kouzes & Posner, 1995). Leadership is a process and it can be assigned in relation to a role or position, or emergent—as a result of what a person does that engenders support from others, "a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2016, p. 6). Leadership depends on the relationship and context in which it occurs, with the same person being a leader in one situation but not another (Maccoby, 2021).

Management: The process of coordinating and integrating work activities to ensure that they are completed efficiently, effectively, and through the efforts of others (Robbins et al., 2000). "The process of guiding a work unit by planning for future work obligations, organising employees into functional units, directing employees in the process of completing daily work tasks, and controlling work processes and systems to ensure adequate quality of work output" (Braveman, 2019, p. 1119).

Management and leadership are two concepts and, at times, the words are used interchangeably. However, there are apparent differences between the two, with management seeking to create order and consistency in organisations and leadership seeking to achieve change through movement. In the ACHSM (2022a) Health Service Management Competency Framework, leadership is positioned as a competency domain within health service management as is the position of this study. Distinguishing between the constructs of leadership and management provides for the identification of the competencies associated with each role (Braveman, 2022a).

Manager: An individual formally appointed to a position or positions of authority within organisations. Managers direct and support others to work effectively, are responsible for resource utilisation, and are accountable for work results (Guo & Calderon, 2007).

Occupations:

> are the activities and tasks of everyday life. These include things people do to look after themselves, enjoy themselves, and contribute to the social and economic fabric of their communities. It is also about fostering health and well-being and creating a just and inclusive society so everyone can participate to their fullest potential. The things occupational therapists do to help people participate in everyday living are sometimes referred to as 'enabling occupation' (OTBNZ, 2022e).

"Occupations include things people need to, want to and are expected to do" (World Federation of Occupational Therapists, 2021).

Occupational Therapy - Whakaora Ngangahau: "Occupational therapy is the art and science of helping people take part in everyday living through their occupations" (OTBNZ, 2022e).

New Zealand

New Zealand is in the southwestern Pacific Ocean. It comprises three main islands: North, South, and Stewart Islands. The population of New Zealand is estimated to be 5,305,600 people on December 31, 2023 (Stats NZ, 2023). New Zealand is a constitutional monarchy with a democratically elected House of Representatives.

At the commencement of this study, the provision of publicly funded health services was outlined in the New Zealand Public Health and Disability Act 2000 (New Zealand Legislation, 2024b). The purpose of the Act was to provide a mechanism through the Ministry of Health – Manatū Hauora for the funding and provision of personal health services, public health services, and disability support services; and to establish publicly-owned health and disability organisations. The Ministry of Health, as a public service, contributes to the Crown meeting its obligations under the Te Tiriti o Waitangi – The Treaty of Waitangi , which is a constitutional document that establishes and guides the relationship between the New Zealand Government and Māori (Ministry of Justice, 2022).

The Pae Ora (Healthy Futures) Act was introduced in 2022 (New Zealand Legislation, 2024c), replacing the Public Health and Disability Act 2000. The purpose of the new Act is to provide for public funding and provision of health services, the establishment of Health New Zealand and Māori Health Authority, and the development of a New Zealand Health Strategy. Overall, the purpose of the Act is to build pae ora (healthy futures) for all New Zealanders. The Act set a new direction and partnership approach with Māori for the provision of publicly funded health services and the disestablishment of DHBs. In my experience of previous sector reviews, sector reforms result in changes to the vision and priorities for health services which impact organisational and management structures, leading to new career opportunities and to the skills, knowledge, and attitudes required of health service managers.

New Zealand Publicly Funded Health Sector

This section provides an overview of some factors which have influenced the New Zealand publicly funded health sector over the past 40 years; and, thus, the emergence of health service management and of competencies required of health service managers. The key factors identified include the structure and funding of the health sector, the impact of health reforms on the responsibilities of the public service, and the outcome and future direction from the 2019-2021 Health and Disability Review and 2021 health reforms.

Historical Context 1980–2024

With neoliberal economic and political philosophy underpinning, changes commenced in the publicly funded health sector in the 1980s (Cumming & Mays, 2002). These changes focused on meeting the needs of a growing population and the desire to improve health outcomes, as well as increasing accountability and efficiency while managing the growing health expenditure (Ashton et al., 2005; New Zealand Parliament, 2009).

In the early 1980s, the restructuring of publicly funded health services commenced with the transfer of responsibility for delivering hospital services, health promotion and protection, and environmental health to Area Health Boards (AHBs). The AHB

performance expectations were based on *The New Zealand Health Charter* and included specific health goals and targets to be achieved (Ministry of Health, 1989). The AHBs were responsible for the delivery of care and performance, and improvement to meet the changing needs of the population in their region; this duality of responsibility and accountability was a challenge and seen as a deficiency of management across the healthcare system (Laugesen & Salmond, 1994).

To address concerns about rising costs and accountability, further restructuring occurred in 1993-1997, with Regional Health Authorities (RHAs) and Crown Health Enterprises (CHEs) established, separating providers and funders (Laugesen & Salmond, 1994). The intent of these changes was to facilitate regional coordination and introduce market principles, as well as quasi-market structures, to healthcare delivery (Ashton et al., 2005).

In 2001, DHBs were established (New Zealand Public Health and Disability Act, 2000; New Zealand Parliament, 2009) with the aim of achieving public health improvement by achieving national health goals. The DHBs, with their elected boards, chief executives, and support structures, were designed to decentralise and democratise healthcare planning and decision-making (Gauld, 2012). Twenty-one DHBs were established for a population of four million people, and the DHBs varied widely in the number of residents in the geographical area from the smallest (at approximately 35,000 residents) to the largest (with over 550,000 residents). Employee numbers, including health service managers, ranged from several hundred up to exceeding 10,000 (Auckland District Health Board, 2018).

DHBs were the employing bodies for the participants in this study. They provided emergency, acute, and subacute care to a geographically based population. Larger DHBs also offered specialist regional or national tertiary services such as burns, paediatric oncology, and tertiary cardiac care to smaller DHBs. From their creation until the 2020 health reforms, DHBs were responsible for funding allocation and delivery functions and needed to operate within the New Zealand legislative

environment which shapes DHB policies and procedures and, thus, the competencies required of health service managers.

In 2018, concerns were expressed by the government and the public regarding the health system's complexity and fragmentation. It was apparent that the system was struggling to maintain services amidst rising costs and workforce issues, leading to poor health outcomes for Māori and disparities in access and outcomes for all New Zealanders. This concern resulted in the Labour-led coalition government commissioning the New Zealand Health and Disability System Review.

2020 Health and Disability Reports

By 2020, the Health and Disability Interim and Final Reports (New Zealand Parliament, 2019, 2020) had been completed. From a management and leadership perspective, The Interim Report-Pūrongo Mō Tēnei Wā (New Zealand Parliament, 2019) identified the lack of leadership and management at both a systems and service level and inferred the same at an individual level, although the authors did note the positive impact of a few highly motivated individual leaders. The final report, The Health and Disability System Review – Hauora Manaaki Ki Aotearoa Whānui Review (*The Review*) (New Zealand Parliament, 2020), proposed that institutional change was needed to achieve a sustainable sector, one which would lead to equitable outcomes, and place emphasis on health and well-being as well as treatment of illness.

Vision for Health New Zealand

As a result of the recommendations from the Health and Disability System Review – Hauora Manaaki Ki Aotearoa Whānui, changes are slated to be made to the publicly funded health system with the aim to provide a simpler and more coordinated system, and the provision of better and more consistent care (Department of the Prime Minister and Cabinet, 2021). In 2021, two entities were established—Māori Health Authority-Te Aka Whai Ora and Health New Zealand-Te Whatu Ora—to work in partnership and hold the responsibility for the delivery of publicly funded health services. Health New Zealand-Te Whatu Ora Health would be responsible for the day-to-day running of the whole New Zealand publicly funded health system. The Māori

Health Authority-Te Aka Whai Ora was established to work alongside Health New Zealand-Te Whatu Ora, with shared responsibility for decision-making, planning, and delivery of health services across New Zealand (Department of the Prime Minister and Cabinet, 2021). The partnership approach to leadership and management in both philosophy and structure was a powerful signal, modelling the collaborative and cooperative approach, behaviours, and competencies required across the health sector to achieve a reduction in disparities, improvement of Māori health, and ensure Māori are involved in decision making and service delivery.

In late 2023 the general election resulted in a change of government, and in early 2024 the coalition government announced a 100-day plan which included proposed changes to disestablish The Māori Health Authority-Te Aka Whai Ora, introduce new health targets, and review the previous government's strategy to centralise core functions of the health system (New Zealand Government, 2024). These changes continue a centralist pathway of sector reforms, and the proposed changes may again impact the roles held and competencies required of managers.

Public Service Healthcare

At the same time as New Zealand's publicly funded health sector was being restructured, there was a change to the legislation covering all the state sector and public servants. This legislation included and clarified the responsibility resting with the governors and managers of all the publicly funded services, including health. The Public Service Act 2020 (which replaced the State Sector Act 1988) saw the governing boards and the managers of DHBs expected to have their actions and performance monitored, and matters advised to the appropriate government ministers and ministries.

Knowledge of the requirements of the State Sector Act and then the Public Service Act is important in the day-to-day operational management of New Zealand health services. The legislation addresses matters such as responsibilities regarding employment practices, contracting for outsourced services, procurement, adherence to strategic plans, and key health performance and outcome targets. The DHBs are

directed to ensure managers have the required competencies to develop relevant organisational policies and procedures and provide employees with orientation to the operational implications of these policies and procedures. This directive emphasises the responsibility held by DHBs to provide education and training for health service managers, as managers are required to have some competencies contained in this legislation.

Managerialism in Health Care

Health care reforms are a global phenomenon, and many of the changes in New Zealand's health systems and delivery were informed by the United Kingdom (UK) reforms (Ashton, 1993; Easton, 2002; Laugesen & Salmond, 1994). In 1983, the UK government commissioned an enquiry into the effective use and management of the workforce and related resources in the UK National Health Service (NHS). The Griffiths report (Department of Health and Social Security, 1983) recommended that regional and district health authorities should adopt business-like methods and appoint general managers, with the responsibilities for performance and budgets moving closer to the delivery of care (Nuffield Trust, 2024). The introduction of managerialism in the UK in the 1980s was to employ private sector methods in the public sector to make it more efficient and business-like (Beck & Melo, 2014). The time frame of these recommendations in the UK aligns with the introduction, in New Zealand, of the general management model in publicly funded health services (Ashton, 1993).

Critical aspects of managerialism in the healthcare sector were the focus on efficiency, value for money, management by targets, monitoring of performance, and handing over the power for decision-making to senior managers, who were considered experts in organisational management. Criticisms included transposing this business-like approach without critical review; concerns about competencies required of generalist managers, including lack of sector knowledge regarding directing and monitoring performance (Beck & Melo, 2014); and the skills in persuasion, negotiation, and influence to achieve effective and timely management action (The King's Fund, 2010). The introduction of managerialism into publicly funded health was a radical change

and remains the current management model in New Zealand. This change in management structures and the resulting increase in management positions opened the opportunities for health professionals to consider management as a career option. In addition, business skills were added to the competencies required of health service managers.

Management Competency Development

The emphasis placed on further improving healthcare quality of care in the UK resulted in a report, *A High Quality Workforce*, NHS Next Stage Review (Department of Health, 2008). Also known as the Darzi Report, it described the challenges of healthcare delivery and placed a focus on the need for quality improvement, and of structured training and career pathways for the clinicians. This solution was premised on the basis that health professionals who have experience working within complex health systems are the providers and users of the systems and are positioned to lead and develop services and systems.

In response, the NHS established the Leadership Academy (National Health Service Leadership Academy, 2013), to promote the development of leadership and management competence. This NHS initiative can be interpreted to reflect an understanding of the key role that health service managers play in the provision of health care and that they, therefore, require specific and tailored education and training. In contrast, however, even though the New Zealand health system reforms were repeatedly informed and influenced by the UK reforms, New Zealand does not have a similar leadership academy structure for health service managers at this time, although the development of a leadership academy has recently been announced (Te Whatu Ora-Health New Zealand, 2023c).

This concise overview has explored the driving forces behind the evolution of management and leadership in the health sector. It sheds light on the shifting roles and responsibilities of health entities and, consequently, health service managers. It emphasises the essential role that managers play as they hold the triple responsibilities of care delivery, financial management, and quality control. The

evolving roles of managers provide numerous benefits and opportunities for health professionals to take on management and leadership positions at all levels of the DHBs. Finally, it underscores the need for education in health service management in this complex environment and emphasises the importance of a national approach to competency development for health service managers and leaders.

New Zealand Health Service Management

Prior to the 1980s, New Zealand hospitals were led and managed by the hospital manager, who was responsible for facilities and infrastructure, alongside the matron leading the nurse workforce and the medical superintendent (senior doctor) overseeing clinical care. This triumvirate of leadership model of hospital services was replaced after 1988 by a general management model (Ashton, 1993).

The DHBs created management structures and configurations, as well as titles and responsibilities, to the perceived needs of the organisation. Within the DHB leadership and management team, there are clinical leadership positions and a hierarchy of junior, middle, and senior management roles, depending on the size of the DHB. These positions can align to a service or support speciality, or deliver corporate rather than clinical oversight, such as the Chief Operations Officer or Director of Hospital Services (Auckland DHB, 2018; Canterbury DHB, 2019).

There is little available data on the number of health service managers in New Zealand DHBs. A recent 2023 New Zealand Health workforce quarterly report dataset reported 17,201 employees occupying corporate or other roles out of a total 85,643 employees (Te Whatu Ora-Health New Zealand, 2023a). However, it is important to note that operational management is not a separate category in this report. Therefore, the number reported may not account for managers in non-corporate or senior roles and may include those in corporate functions who do not hold operational management roles.

Throughout the changes in the New Zealand health entities there has been a steady increase in the focus on achieving strategic and output objectives and managing

services within allocated budgets (Ministry of Health, 2019). The increasing demands for more effective performance and the complexity of roles have placed a focus on the scope of competencies required of managers to develop and progress in management roles. The next section discusses the concept of competencies and acquiring competence, and the application of this concept in education and the health sectors.

Competencies and Competency Frameworks and Assessment

This section examines the development of individual competence as the foundation for education and skills development, and as a concept that has been adopted internationally. The word competent, as described by Jessup (1991), refers to a standard of performance that is required to perform an activity or task successfully. Jessup (1991), writing from the perspective of vocational education and training, also linked the standard of performance to the concept of quality and performance to professional or occupational standards.

The rationale behind the adoption of competency models is that formalised and tested competencies are the best way to predict performance (Caldwell, 2010; Calhoun et al., 2002). The linking of performance to a body of knowledge allowed competencies to be "objectified, analytically disaggregated, and grouped into skills, knowledge, self-concepts, traits and motives" (Caldwell, 2010, p. 41). Competence, as it relates to knowledge and education, is a constructed concept and the foundation of the development of competency-based education and learning models.

The development of the competency approach to contemporary education can be traced back to the United States of America (USA) when concerns were raised in the late 1950s regarding the perceived failure of the education system (Hodge, 2007). The theoretical underpinning of competency-based education can be linked to John Dewey and William James' 'naturalism' (Dewey, 1929). Other theoretical influences can be seen in the work in the early 1900s by F.W. Taylor in scientific management and a systems-based investigation of workflow and task analysis (Calhoun et al., 2002; Hodge, 2007). A systems approach looks to break down each skill into small actions and uses these elements of knowledge as the basis for the education process; thus,

allowing for the analysis and clarification of the purpose of the tasks required (Hodge, 2007). Also identified is behavioural psychology, with its emphasis on learning theory as proposed by Skinner and Piaget (Hodge, 2007). Behavioural psychology contributed to the assessment of observable human behaviour as the expression of competence (Hodge, 2007). Lastly, Hodge (2007), citing Ralph Tyler, linked the emphasis placed on the use of the term 'competency' to the belief that the purpose of the programme of study needs to be clear. The influence of this belief is seen in the concept (theory) that competencies can be learned and mastered and then demonstrated (Hodge et al., 2020).

The advantages of a competency-based approach to education and learning were seen in the focus given to the achievement of skills as an outcome of the education system; and its applicability in the real world, with a focus on the workplace including professional practice, management and business administration (Bowden, 1997; Calhoun et al., 2002; Hodge, 2007). McClelland (1973) proposed that competency-based assessment in education should occur at points throughout the education process to assess progress, and as a basis to adjust the teaching-learning process. A competency-based approach can be applied across a wide range of educational needs and sectors (Flood et al., 2019; Hodge, 2007; Silcock et al., 2016), as well as across a variety of levels of expertise including post-compulsory, vocational, and continuing education (Ayeleke et al., 2018; Hodge, 2007). It can be used to identify gaps in proficiency and to inform ongoing education (Caldwell, 2010). In summary, the strength of a competency-based approach to education and training can be demonstrated in its ability to be tailored to specific occupational groups and roles, and in identifying the education and training needs of both the group and the individual in real-world work environments.

Challenges to a competency-based approach for a sector or role are perceived in the construction, currency, and utilisation of the competencies and competency frameworks. Decisions are made on identifying and selecting areas to include, and the competencies that need to be demonstrated, which reflect the environment and social structure of the time and the past, and not necessarily what is needed for the future

(Ruderman et al., 2014). In addition, identified competencies may not include aspects of performance that are difficult to objectify, measure, or assess, such as interpersonal and leadership skills, contextual awareness, and political savvy, but which may be desirable for success (Flood et al., 2019; Ruderman et al., 2014). Challenges also arise in the implementation of competency-based education, as it is often associated more closely with assessment and regulation than the activities of teaching and learning (Morcke et al., 2013).

Because competency-based education focuses on the mastery of tasks, rather than more generically applicable training, a criticism of the approach is that students would not be prepared to deal with situations that cannot be defined or prepared for in advance (Bowden, 1997; Ruderman et al., 2014). Finally, the understanding that individuals will already hold their own unique combination of skills, knowledge, and mindsets which influence behaviours, highlights a limitation of the application of competency frameworks (Ruderman et al., 2014). Therefore, a one-size-fits-all approach to competency assessment and development will not necessarily suit when it comes to the identification of competencies held by an individual, those they require to be developed, and contextual considerations of the competencies to be developed in the fluid and less clear-cut real world.

The employment of competency-based education models can be informed by the Dreyfus model of skill acquisition (Dreyfus & Dreyfus, 1980), and is seen in the nursing context (Benner, 2004). This model describes the staircase of competency development from novice to expert—that the individual can be an expert in one competency domain and a novice in another, and that advanced competence would be beyond formal testing (Stefl, 2008).

Competency Frameworks in the Health Sector

The use of competency frameworks is pervasive in the education and health sectors (Flood et al., 2019; Morcke et al., 2013). A competency framework can provide clarity regarding professional characteristics (Briggs et al., 2012), scopes of practice, and performance expectations by a professional body, regulatory authority, employer,

supervisors, and the managers themselves. Competency frameworks have been developed for health professional groups (e.g., OTBNZ, 2022c), and for health service management as a guide for these groups' competency domains, performance indicators, assessment, and development (e.g., ACHSM, 2022a). Consequently, such frameworks are relevant in this study to inform, conceptualise, and group the skills, knowledge, and attitudes required for a health service manager role.

Health Practitioners Competence Assurance Act 2003

In the early 2000s, the New Zealand Government commenced work to develop legislation to ensure all registered health professionals were competent to practice. The HPCAA (2003) provides a framework for the regulation of health practitioners to protect the public, where there is a risk of harm from professional practice. The Act resulted in work to implement systems for mandating education standards, and ongoing demonstration of competency across all registered health professionals, including the requirement to provide proof of undertaking continuing professional development. All health professionals must be registered with the regulatory authority governing their profession, and those who are practising must maintain requirements for an Annual Practicing Certificate (APC).

The functions of the responsible regulatory authority include reviewing and promoting competence; recognising, accrediting, and setting programmes to ensure ongoing competence; and setting standards of clinical competence, cultural competence, and ethical conduct. A second function is the maintenance of the register of practitioners and their scope of practice. This legislation was directive, but not prescriptive, allowing for a variation of approaches across the professions to meet the requirements of the HPCAA. It is noteworthy that health service managers are not covered in this legislation, and the assumption, therefore, can be made that a manager may not generate 'harm' from their role.

Occupational Therapy

The primary goal of occupational therapy, as described by the World Federation of Occupational Therapists (WFOT, 2021),

> is to enable people to participate in the activities of everyday life … Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement.

Occupational therapists have at the philosophical core of their professional activity, the focus on the human and human occupation in the real world. The approach is holistic, looking through a biopsychosocial lens at the whole person and their wellness in the context of promoting and improving well-being, health, and social outcomes (OTBNZ, 2022b).

Occupational Therapy Education

Occupational therapy education and training in New Zealand commenced in the 1940s and was administered by the Department of Health until in the 1970s when the Department of Education took over this responsibility. At this time, the training changed to a 3-year programme at diploma level, provided by technical institutes (Department of Health, 1988). In the 1990s, the qualification became a bachelor's degree. The completion of the undergraduate qualification, both at diploma and bachelor's level, provides evidence of achievement of the OTBNZ competencies for initial registration as an occupational therapist.

Registration and Employment Data

In the most recent OTBNZ Pūrongo ā-Tau - Annual Report, as of March 31, 2023, 3,393 occupational therapists held a current APC, and 563 were registered as non-practising. Of those holding APCs, 91.5% identified as female and 8.2% as male. Over 8% of the occupational therapists on the register indicated they were employed in management

or leadership roles. The DHBs were the employer for 44% of occupational therapists on the register (OTBNZ, 2023).

Occupational Therapy Competency Framework

The OTBNZ Competencies for Registration and Continuing Practice for Occupational Therapists (CRCPOT) identify 'broad' competency domains which are periodically revised. The 2015 version of the OTBNZ's CRCPOT was used as the reference document for the data collection and analysis for this study, rather than the January 2022 updated version (OTBNZ, 2022c). The rationale for this decision was that this is the document which covered the competency requirements for the participants over the period of data collection in the study.

The 2015 competencies document identified (1) *Applying occupational therapy knowledge, skills and values*, (2) *Practicing appropriately for bicultural Aotearoa New Zealand*, (3) *Building partnerships and collaborating*, (4) *Practicing in a safe, legal, ethical and culturally competent way,* and (5) *Engaging with and being responsible for your profession* (OTBNZ, 2015a). The competency domains had associated desired outcomes which describe and identify performance indicators.

The individual's actions relating to all five competency domains are developed with an authorised supervisor and must be demonstrated for competence and sign-off. Supervision and self-reflection are a key component in continuing competence and are incorporated into the practice of all occupational therapists. The OTBNZ competency domains were constructed for registration as an occupational therapist, for ongoing practice, as well as non-traditional roles including health service management. While the occupational therapy competency framework is clinically based, there are performance indicators that apply to occupational therapists employed in health service management. Occupational therapists who work in health service management, and identify as occupational therapists, are required to be registered and to hold an APC (OTBNZ, 2015a).

Health Workforce Development

No data were located on the education and qualifications held by New Zealand health service managers, although many roles require experience in the sector, and some require health professional qualifications. Research in the Australian health sector found that many healthcare managers have progressed through the organisations and have formal management qualifications, and little management training is included in healthcare-related degrees (Liang, Howard, et al., 2018). While no equivalent studies have been found in the New Zealand context, my personal experience of the New Zealand system aligns with the Australian findings.

The requirements for a workforce that is fit for purpose has been the topic of many reports, and many training and development initiatives have been put in place to address the identified needs. The New Zealand Ministry of Health developed health workforce strategies, reports, and planning documents (Ministry of Health, 2011). An example of this work is the 2006 report on the medical workforce which describes a changing landscape and was seen as requiring an increased range of broad-based competencies that are relevant to this study; reflective practice, teamwork, responsibility, accountability, engagement, and leadership skills (Medical Reference Group Health Workforce Advisory Committee, 2006). Most recently, the Health Workforce Plan 2023/24 included a national approach to competency development for health service managers. The development of healthcare leadership is being prioritised with a Pae Ora (Healthy Futures) Leadership Institute to be established (Te Whatu Ora-Health New Zealand, 2023b).

Chapter Summary

This chapter's purpose was to set the scene for the study. The health sector is often described as complex and constantly changing. To provide background to the competencies required of health sector managers, this chapter outlined some of the challenges and complexity of health aims, and the initiatives developed to address these challenges in the New Zealand context.

The next chapter turns to existing literature of what is currently known of the relevant areas of interest; occupational therapy, health service management, competency and competency frameworks, the transition to management, and the competencies health professionals employ in management roles and those they were least prepared for. The objective was to discern if there is a gap in knowledge to be addressed regarding occupational therapists making a career step into health service management.

Chapter 3. Literature Review

The research questions guiding this study assume that health professionals, including occupational therapists as the focus of this study, developed competencies during their education and experience that would be applicable in health service management roles, while also identifying gaps in required management competencies for which their clinical education had not prepared them. In mounting that argument, this literature search and review begins with a broad view, both internationally and within New Zealand.

Literature Review Methodology

The literature review was undertaken to identify the published work relevant to the research question and the broader area of interest. Efron and Ravid (2018) divided the purpose of the literature reviews into three areas: to set the context for the study, inform the design and methodology for the study, and identify the areas for advancing knowledge. This literature review reports the state of the knowledge that informed the design and conduct of the study. More recent literature that informed the analysis and findings is integrated into the discussion chapter.

There are two standard types of literature reviews; systematic and non-systematic, also known as narrative reviews (Ferrari, 2015) . The objective of systematic reviews is to provide and analyse qualitative and quantitative evidence and present it in chronological order. A narrative review aims to summarise what is previously published, synthesises this knowledge into key themes, and seeks to identify knowledge gaps not yet addressed (Ferrari, 2015). Therefore, to achieve the purposes of the current study, a narrative review of the literature was selected.

A literature review utilising a narrative methodology is appropriate for studies using a qualitative interpretive approach. Thorne (2016) described the literature review that supports interpretive descriptive study as one that centres the study on existing knowledge, includes reflections on existing literature and what does not exist, and

includes interpretive commentary on the strengths and weaknesses of the body of knowledge. Thorne opined that the narrative approach is appropriate for studies within an interpretive paradigm. The strengths of narrative methodology for qualitative studies are that it can address more than one research question, and the selection criteria for the literature to be included do not have to be specified. The weaknesses identified and to be considered in the review process are the subjectivity of the literature chosen for review and potential bias; therefore, the review findings may not be reproducible (Ferrari, 2015).

Search Strategy

The goal of the literature search was to identify if the proposed questions had already been researched, and what was known in the area of interest. This initial search was broad and looked for relevant publications and research from New Zealand and internationally. Between 2019 and 2022, I searched the Auckland University of Technology library databases CINAHL, EBSCO, and ERIC using the following search terms: health management, health leadership, occupational therap*, NZ legislation/strategies/reviews, competenc*, and NHS. Using Safari as the search engine, I also searched Google scholar. I further searched through occupational therapy and health management publications. Of the publications identified as relevant, the reference lists were scanned for pertinent articles and to identify the thought leaders and active researchers in this area of interest. In addition, I discussed the programme of study with colleagues who drew my attention to articles and publications that might be of interest.

Literature Selection and Analysis

I selected publications situated in New Zealand, and those from countries with health systems similar to New Zealand, including Australia, Canada, and the UK. The USA was also included as although this health system has differences from the more publicly funded models of the other countries, there has been considerable research regarding the importance of education and training of health managers, including the identification of competency requirements of health service managers that is relevant to this study. I looked for the historical perspective for context, although I prioritised

the most recent publications. In line with the interpretive description methodology, ongoing literature searches and reviews continued over the duration of the programme of study.

A staged, systematic, and recursive approach to the literature search and review (Efron & Ravid, 2018) was undertaken. The stages consisted of locating the research sources; selecting, scanning, and cataloguing the articles; analysing and grouping to themes; analysing the articles; and selecting those relevant to the research topic and potential to include in the review summary. The articles were catalogued in an Excel document and in EndNote, hard copies were made and filed numerically (EndNote identifier). The articles were read and reread over the duration of the study. Document summaries were developed of the key themes, and notes on the strength of the articles including author, publication date, country, research or opinion, key points, and comments.

Summary of Literature Review

The summary of the literature review commences with the foundations, philosophy and application of occupational therapy, and the theories and models of management and leadership. This is followed by the growth of health service management, resulting in the skills development required to support the performance of the individual and health sector. The review continues with insight into the work completed to quantify and critique how the skills, knowledge, and attitudes (competencies) required for a task or role have been identified, and how this knowledge has been recorded and utilised. The application and utilisation of competency frameworks was explored, and their application in the health sector for health professionals and health service managers considered. The literature review then moved to studies of health professionals transitioning into health service management roles with a dual focus: the competencies they identified they employed from their professional education and experience and those they were least prepared for and needed to develop. The final section focuses on what is known about occupational therapists and role transitions. The chapter concludes with a discussion of the current knowledge in relation to the research questions, and whether a gap in knowledge was identified.

Occupational Therapy

The foundation, philosophy, and application of occupational therapy within the health sector are central to this study. The literature search explored the essence of occupational therapy that flows through and underpins the skills, knowledge, and attitudes occupational therapists employ in their clinical, management, and leadership roles. Fundamentally, occupational therapy is aligned with action and doing in the realm of occupational endeavours, which includes all actions in the activities of daily living. As described by the OTBNZ (2022c), occupation includes things people do to look after themselves, enjoy themselves, and contribute to the social and economic fabric of their communities. Occupational therapy aims to foster health and well-being and create a just and inclusive society so everyone can participate to their fullest potential.

Historically, occupational therapy arose from those involved in caring for people who are disabled and chronically unwell. In the 1700s, led by Phillippe Pinel and William Tuke, therapies based on occupation began to emerge in response to the way patients were treated, particularly those with mental illnesses (Wilcock & Hocking, 2015). Pinel believed that activity or occupation was beneficial to wellness, and treatment became based on purposeful daily activities, using activities to improve the ability to perform daily living. Early occupational therapy was influenced by the Arts and Crafts movement, and extended to include physical conditions, particularly following World Wars One and Two, and the necessity to rehabilitate returned service members. Societal pressure to rehabilitate resulted in the challenge of demonstrating how and why occupational therapy contributed to improving health outcomes, and shifted the focus of occupational therapy interventions from diversional activities to functional rehabilitation in the workplace and home (Reed et al., 2013).

This evolution of occupational therapy has led to what Polatajko et al. (2013) described as the domain of concern. Occupational therapy has travelled from the provision of diversional therapy, to the therapeutic use of activity, and onto the current position of enablement through meaningful occupation for the individual and society at large (Polatajko et al., 2013), and the view that occupation “is something that is all

encompassing, without bounds" (Reed et al., 2013, p. 41). The basis for this perspective is that the knowledge occupational therapists hold of occupation applies across these roles, as "everyone engages in occupation in every place and time imaginable" (Townsend & Polatajko, 2013, p. 280). The evolution of occupational therapy has resulted in the refinement of the profession's purpose, the focus of the professional activity, thereby developing an understanding of the skills, knowledge, and attitudes therapists hold.

Occupational therapists have knowledge of physical and mental health, and how health services are provided. They have an understanding of occupation and the link between occupation, the individual, and community health; emphasising the perspective of the individual's lived experience (Reed et al., 2013). Knowledge and understanding encompasses how individuals and families live and engage with their communities, what resources are in communities that support health and wellbeing, and the service gaps and injustices that disable individuals and communities.

Occupation therapy education includes interpersonal and technical competencies that are employed within professional practice to address occupational challenges (Schell & Gillen, 2019). Interpersonal skills include working effectively with healthcare teams and establishing and maintaining therapeutic relationships. Technical competencies include assessment, planning, documentation, intervention, and review as part of the occupational therapist toolkit. Additionally, interventions are guided by models, theories, and evidence.

Occupational therapists have a holistic perspective and work to a biopsychosocial model of care. Through education and experience, they know how the medical world functions, and can translate language, practice, and methods between the everyday world and the medical world while keeping the focus on enabling occupation (E. A Townsend et al., 2013; Townsend & Polatajko, 2013). The competencies to work collaboratively with health professionals who work to differing professional models of care are relevant for management and leadership roles with the multidisciplinary health sector.

Occupational therapists, as a professional group, are accountable for the application and effectiveness of their practice; they work within a scope of practice to ethical and professional standards and have a duty of fidelity to their clients by virtue of their client's vulnerability. Occupational therapy, as a registered health profession, is bound by professional ethics, practice guidelines, and legislation (New Zealand Legislation, 2024a; OTBNZ, 2015a, 2022b). This framework guides actions and personal accountability, including maintaining competence in the face of a rapidly changing knowledge base and health service structures and priorities. In summary, an occupational therapy approach to health and occupation, education, and the structures and processes of a registered health profession, provide for a comprehensive range of skills, knowledge, and attitudes that occupational therapists hold and apply in their professional practice.

Management and Leadership

Management and leadership are fundamental concepts in this field of study. Within the literature, these terms are, at times, used interchangeably (Kotter, 2012); while others argue that they are separate but overlap (Northouse, 2016). This section discusses both management and leadership, including the purpose and evolution of theories and models, linking these to their application in the workplace and the competencies required.

Management

Management is a crucial aspect of effectively and efficiently resourcing an organisation for its purpose. Management involves directing and overseeing the completion of daily tasks (Braveman, 2019; 2022b), and coordinating and integrating activities to ensure they are completed through the efforts of others (Robbins et al., 2000). The core functions of management include the processes of planning, organising, leading, and controlling (Wood et al., 2004). Management models and behaviours are shaped by a combination of experience, beliefs, values, education, current thinking, and the culture and structure of organisations (Robbins et al., 2000).

Academic studies of organisations and management have produced various theories that aim to explain different aspects of management, with the potential to explain and predict the behaviours of others (Harris, 2006). While there is no one universally agreed theoretical model of management (Ayeleke et al., 2018; Northouse, 2016), one model developed to understand management approaches is the *managerial grid* developed by Blake and Mouton (Northouse, 2016). This model describes the tension between two attitudinal dimensions of an organisation, the concern for production and concern for people, and that managerial approaches and behaviours can be defined in these terms (Northouse, 2016; Robbins et al., 2000). These two dimensions are seen in different proportions in different approaches to leadership and management. Hierarchical management structures and command and control, along with bureaucratic processes to ensure control, compliance, and accountability, emphasise concern for production. More contemporary notions of leadership take into consideration those being led (including transformational leadership) and, more recently still, the need for leadership to be shared among many. This behavioural approach to management supported the development of understanding of the impact of behaviours from task and relationship dimensions and the potential impact of management actions, including that different emphasis on task or people may be required in different situations (Northouse, 2016).

The developing concern on the impact of management perspective and behaviours influenced the changes in focus of management from a hierarchical command and control model to a collaborative decentralised model. This shift in focus signalled a change in the emphasis placed on the responsibilities and, therefore, the competencies held by managers (Wood et al., 2004). Wood et al. (2004) suggested that as a consequence of the newer models of management and leadership, less emphasis is placed on the management tasks such as “planning, controlling, allocating responsibility, contractual obligations, problem-solving”, and greater emphasis on the leadership competencies of “having a vision, motivating and inspiring, empowering others, creating commitment, stimulating extra effort” (p. 533).

While there may be a shift away from command-and-control bureaucratic management, managers still bear the responsibility for performance, outcomes, and outputs (Guo & Calderon, 2007). As such, they must possess competencies of planning and budgeting, organising, staffing, controlling and problem solving, resource utilisation, and accountability for work results. Additionally, as managers become concerned for employee well-being, they require competencies in leadership and human resources management. The following section delves into the development of leadership models, and an understanding of the leadership competencies managers require.

Leadership

Since the 1970s, there has been an increasing focus on organisational leadership with the aim of enhancing business performance. Research has shown that effective leadership and employee engagement have a positive impact on overall organisational success (Cakir & Adiguzel, 2020). A review of the literature has revealed numerous leadership theories as a response to the changing landscape of leadership (Northouse, 2016). These theories can be viewed as a continuum from autocratic to democratic or post-heroic (Robbins et al., 2000). They can also be described as a development from an individualistic perspective of leadership and leaders to a broader collective view where organisational leadership combines positional and emergent leadership. Current thinking emphasises understanding the "process of leadership, where an individual uses influence to achieve a common goal" (Northouse, 2016, p. 4).

Models of Leadership

Early studies on leadership focused on the individual as a leader and aimed to identify the characteristics that were associated with the expectations of a leader. Researchers tried to determine the traits or qualities that great leaders possess. This theory suggests individuals are born leaders but there was no evidence to support it (Northouse, 2016; Robbins et al., 2000). This work on traits may not have been wasted and may be helpful in identifying traits an individual may want to possess if they wish to be perceived as a leader, including self-confidence, determination, integrity and sociability (Northouse, 2016). The increasing complexity of organisations led to a

rethink of the “individualistic idea of leadership” (Northouse, 2016, p. 6). The size and fast-changing nature of organisations exposed the weakness of a leadership model that relied on the wisdom and competencies of a single person. A single person (or small group) controlling an organisation may not have all the relevant information to make timely, effective decisions or address critical issues and decisions.

In the 1980s, Bass and others promoted a new leadership model called transformational leadership which gained popularity (Bass, 1990; Bass & Steidlmeier, 1999; Northouse, 2016). This model linked leadership with followership, aiming to harness the followers’ motives to achieve better results for both the leaders and followers. The power of leadership shifted from an individual to a concept of joint leadership (Northouse, 2016). Transformational leadership inspires others to perform beyond their perceived capabilities and achieve results for the organisation (Ayeleke et al., 2018; Copeland, 2014; Northouse, 2016; Phipps, 2015). This model focuses on the development and empowerment of followers, sharing the leadership, and considers the concerns and needs of both leaders and followers, including the development of followers. However, some criticise it for the view that leaders have traits or unique qualities that transform others, inferring that leadership is difficult to learn and that it is elitist and undemocratic and potentially suffers from heroic leadership (Northouse, 2016). Limitations to a transformational leadership approach can be seen when the leader has moral and ethical deficiencies that are exposed (Bass & Steidlmeier, 1999; Copeland, 2014).

In the 21st century, organisations became increasingly complex, prompting a re-evaluation of the traditional individualistic concept of leadership (Northouse, 2016). This led to the exploration and description of leadership models that place greater emphasis on the impact of leadership on followers, such as authentic, adaptive, shared, and distributed leadership (Copeland, 2014; Northouse, 2016; Turnbull James, 2011). These models emphasise collaborative actions, teamwork supported by social networks, and have been described as post heroic leadership (Turnbull James, 2011).

Distributed leadership acknowledges that successful leadership relies on informal leadership practices in addition to formal positional leadership roles throughout the organisation (Ayeleke et al., 2018; Turnbull James, 2011). It promotes a more collaborative and shared approach to goal-directed activity where engagement with peers is key (Burns & Mooney, 2018). Adaptive leadership encourages followers to confront and solve challenges by adapting to them. However, a possible limitation of collaborative leadership models is that they rely on employees being available and sometimes putting aside self-interest. Individual performance objectives may or may not motivate participation in the collaborative effort (Burns & Mooney, 2018).

When considering leadership from the *managerial grid* perspective, these models retain a focus on production while recognising the importance of the knowledge and skills of others to tackle, challenge, and solve problems. Leadership competencies such as shared and distributed leadership foster collaboration and cooperation which requires education on leadership and followership across an organisation. From a management perspective, accountability for work results remain; thus, necessitating competencies in planning, organising, and controlling.

Impact of Structure and Culture on Leadership

Alongside the discussion of single and shared leadership models is the consideration of situational context, which includes organisational structure and culture. The literature suggests that organisational structure and culture are reflected in the leadership models and styles. If new leadership models are to be developed and benefit an organisation, the organisation structures should model the leadership culture desired, and create an environment where leaders can grow and flourish (Turnbull James, 2011). An organisational hierarchical service and management structure that supports individualistic leadership would require a shift to collective leadership to encourage a collective culture (Wood, 2021). An example of this shift in the health sector is the restructure of single profession groups into multidisciplinary teams supported by clinical leadership. Although in complex environments, such as health, leadership structures may be qualitatively different in the levels and sections in response to the purpose and the responsibilities held (Dinh et al., 2014), some sections may retain

strong hierarchical structures to meet legal and health and safety requirements. That may not, however, preclude collaborative and cooperative leadership practice.

Studies of the cultural aspects of leadership highlight the importance of understanding that there are many ways leadership is viewed and implemented by people and communities (Northouse, 2016). Within the New Zealand context is the interdependent leadership to achieve common goals encompassed in Te Tiriti o Waitangi – The Treaty of Waitangi, which inform leadership across state entities including health (Ministry of Justice, 2022; Panesar et al., 2021). From a broader perspective in this multicultural world, an understanding of how different cultures ascribe importance and desirability to leadership behaviours is essential (Northouse, 2016). Overall, considering leadership from a cultural perspective emphasises the complexity of leadership and opens an awareness of the range of competencies required.

To sum up, the relevance of leadership theory and practice to this study is that leadership is a core competency of management. This positioning of leadership is demonstrated by placing leadership in the centre of the ACHSM (2016) five competency domains, showing that "leadership is associated with all other [competency] domains" (p. 5). The literature identifies that if leadership is to meet organisational requirements, especially those with complex bureaucracies working across boundaries, leadership needs to be exercised throughout the organisation (Brown et al., 2009; Turnbull James, 2011). For managers, the reality of the workplace is that they are expected to demonstrate leadership understanding and competence to be successful (Ayeleke et al., 2018). Therefore, they require competency development at an appropriate level to know how to respond in different "situations and times" (Turnbull James, 2011, p. 10). Consequently, in this study leadership is positioned as a core competency for health service managers. Considering the ongoing changes to organisational structures and expected leadership models, regular evaluation and updating of an individual's leadership skills, knowledge, and attitudes would be required for the expected standard of leadership in the workplace.

Health Sector Leadership and Quality

The size and fast-changing nature of health organisations exposed the weakness of a leadership model that relied on the wisdom and competencies of a single person (or small group) who may not have all the relevant information to make effective decisions or respond to critical issues (Turnbull James, 2011). In 2011, as a result of concerns of the quality of care, The Kings Fund released the report *No More Heroes* (Rowling, 2011), which challenged the model of heroic leadership and advocated for shared leadership across systems of care.

In New Zealand, the introduction of managerialism has been identified as creating tension and mistrust between the managers and clinicians (Gauld, 2014). This tension led to concerns of detrimental impact on the quality and safety of care delivery because of the disengagement between clinicians and managers. In response to these concerns, DHBs and hospital specialists committed to "Time for Quality" (Brown et al., 2009, p. 1) a commitment partnership and principles of engagement. The resulting report, *In Good Hands* (Brown et al., 2009), proposed transformational change to achieve better patient outcomes, and included clinical governance and leadership structures based on clinical-manager partnerships, action to foster and train leaders, and enabled clinical review of administrative decisions.

The introduction of clinical governance in New Zealand DHBs gave additional impetus and opportunities for clinicians to hold leadership and management roles as an extension of their clinical practice. Respondents in Gauld's (2014) review of the introduction of clinical governance identified that, in addition to their clinical education, training in human resources, communication, accounting, and quality improvement was required for these roles. Some respondents went further and questioned the role of managers, suggesting the clinical and managerial domains should be dissolved, and clinicians should manage and lead both.

Occupational Therapy Leadership

In New Zealand there is limited literature on allied health leadership, and more needs to be understood of the enablers to support this group into leadership roles (George &

Webster, 2021). This acknowledged lack of knowledge further supports the need for the current study.

International research studies have found that for occupational therapists the experience of leadership was that it was a journey rather than a destination, and it took up to 2-years to feel like a leader (Truskowski, 2017). Knowledge and skills from professional training were employed in the practice of leadership, involved working to the core values and beliefs of the profession, and were seen to be aligned to authentic leadership (Shams et al., 2019; Truskowski, 2017). In addition to employing professional competencies, occupational therapists identified that they brought a drive to influence health outcomes for people (Heard, 2014; Shams et al., 2019) which influenced their decision to be leaders. They also identified the importance of taking responsibility for their leadership development (Heard, 2014), including investing to develop self-awareness and emotional intelligence, as these qualities of compassion and occupational balance and well-being are needed of current leaders (Rodger, 2012).

Health Service Management and Leadership

The capacity and quality of management and leadership in health organisations has been raised as a concern. The interim report from the 2019 Health and Disability Review (New Zealand Parliament, 2019) highlighted the positive impact of quality leadership and management, while raising concerns about whether “there was sufficient leadership and management capability and capacity for the number of existing roles and organisations”, plus the requirement for “people with project management and change management skills and experience to implement the changes needed” (p. 234). Concerns regarding managerial and leadership capability were also raised by Liang et al. (2013) who attributed non-achievement of best practice to the lack of expertise in designing and implementing large scale change initiatives and human resource management, and that health systems in Victoria, Australia were at risk due to “ill-informed and inadequate, or possibly …dangerous management practices” (p. 567).

The growth and complexity of the health sector have led to discussions of the training and skills development required to support the performance of the individual manager (Botwinick et al., 2006; Braveman, 2016; Harris, 2006; Stefl, 2008). Internationally, the need and obligation for education and training of health service managers to ensure they are appropriately qualified and skilled in managing the complex health environment has been identified (Briggs, 2008; Day & Casali, 2015; Howard et al., 2018; Liang et al., 2018). The importance of health service managers having a high level of management competence has recently been emphasised in the New Zealand and Australian health sectors which are large, complex, and face many challenges (Ayeleke et al., 2019; Briggs & Isouard, 2016; New Zealand Parliament, 2020; North & Park, 2014). However, the provision of education and training for health service managers has been seen by some as an area of neglect that has subsequently negatively impacted on sector performance (Briggs, 2008; Briggs & Isouard, 2016; Harris, 2006; Swanwick & McKimm, 2011).

In New Zealand's health sector, previous reforms have resulted in the decentralisation of the responsibilities for healthcare delivery within the financial allocations, while meeting the demand for service delivery and performance targets. The previous reforms and restructures have resulted in the establishment, and then often the disestablishment, of management roles and structures. The 2020 health reforms (New Zealand Parliament, 2020) call for a whole of system change which includes a collaborative cross sector approach to meet the needs of the community and address health disparities. The impact of these changes in roles and the level of responsibility and autonomy held impacts on the competencies required by the managers, and the capability of managers to adjust to the new challenges and opportunities.

Health Service Management Competencies

The concept, construct and utilisation of competency frameworks was covered in Chapter Two. This section considers the research findings on the identification of competencies, and the contribution to competency framework for health service managers in the New Zealand health sector.

A link between competency identification, education, and managerial performance on the job has been suggested (Liang et al., 2020; Stefl, 2008). This understanding supports continued work on the identification of management competency requirements in the health sector (Liang et al., 2020). Identifying healthcare management competencies is essential to create an evidence-based blueprint (Daouk-Öyry et al., 2020) and frameworks on which to base appropriate professional development to enhance individual competence and organisational performance (Ayeleke et al., 2018; Daouk-Öyry et al., 2020; Liang et al., 2020). This work is taking place on an international level, with some research conducted in the health sectors of Australia and New Zealand (Ayeleke et al., 2018; Ayeleke, North, Dunham, et al., 2019; Liang et al., 2020; Liang, Blackstock, et al., 2018; North & Park, 2014).

The literature search identified two health management competency frameworks that have been developed in Australia, with the contribution of New Zealand based academics and health service managers. The first is the Master Health Service Management Competency Framework developed by the ACHSM in conjunction with ACHSM-Aotearoa. ACHSM (2016) developed this framework, "to inform members on the competencies to master and to guide employers and policy makers on the competencies they should consider when employing, leading, managing, and mentoring health service managers" (p. 2). This ACHSM framework which builds on the work of the Global Consortium for Healthcare Management (ACHSM, 2016), and has been reviewed by the ACHSM (2022b) to ensure it reflects the current healthcare environment.

The second framework is the Leadership and Management Competency Framework (MCAP LMCF), an Australian initiative that has links to the New Zealand context through the contribution of New Zealand academics (Liang et al., 2020; Liang, Blackstock, et al., 2018; Liang, Howard, et al., 2018). An evaluation undertaken by Liang, Blackstock, et al. (2018) supported the MCAP LMCF as an important innovation to identify the skills required to manage. The research studies conducted by Zhanming Liang using the MCAP LMCF framework looked at the competency development needs of health managers transitioning from a clinically focussed role to managerial roles and

the competencies they had developed during their career as a clinician. One finding of these studies was that further research is required to understand the support required by health managers to transform their clinical work competencies to the context of management roles (Liang, Blackstock, et al., 2018).

Further, two studies have been conducted in New Zealand to gain an understanding of the competencies required of managers in New Zealand's health sector. Research by North and Park (2014) in primary care employed a survey to self-assess proficiency based on the ACHSM competency framework. The competencies identified as important were: "Analytical (decision making, results management, strategic thinking, problem solving, managing quality, flexibility, political skills, analytical skills), Interpersonal (teams, leadership, communication, and collaboration), Technical (budget related)" (North & Park, 2014, p. 13). The lowest professed proficiencies related to clinical professional practice knowledge, information technology, and employment relations; with proficiency gaps varying across management levels. Overall, participants reported that the identification of these competencies would assist to inform educational and professional development programmes.

Ayeleke's (2018) doctoral study identified seven core competencies for managers in Primary Health Organisations (PHOs). In addition to competence in communication, leadership, and analytical skills to inform decision making, which North and Park (2014) had identified, Ayeleke named "relationship management; change management; knowledge of the health environment; management skill and knowledge; evaluation and professionalism" (p. 249). This research linked improvement in competence to leadership development programmes of both formal and informal learning and mentoring and coaching. Further work by Ayeleke, North, Wallis, et al. (2019) at the policy level of PHOs found a lack of direction regarding the development of the skills and competencies of the health management workforce in primary health care services. The conclusion was that "management and leadership capabilities need to be strengthened and developed for the benefits of the reforms to be realised" (Ayeleke, North, Dunham, et al., 2019, p. 40). There is no reason to believe that this is not equally applicable to the secondary (hospital) health sector.

Overall, the two New Zealand studies had alignment in the competency areas required of health managers, and with the published competency frameworks described above. Likewise, there was agreement that the lack of a formal health management competency framework may limit future efforts to strengthen health management. The literature search confirmed the understanding that there has been limited published research conducted with New Zealand health service managers to ascertain the competencies they identify as required for their role, or to establish the level of competence required of them; and further and more comprehensive research is required (Ayeleke, 2018; North & Park, 2014). The review of the research literature indicated that over the past 30-years research conducted in New Zealand was initiated through academic study. No studies were located of published New Zealand government-initiated research on health service management, the competencies required of heath service managers, or of their workforce or professional development requirements. However, concerns are regularly raised about management effectiveness within the health sector (New Zealand Parliament, 2019).

Health Professions Address the Gap in Management Competency Development

The literature identified several initiatives undertaken by health professions to address the gap of workforce education and training in health service management. Gauld (2014) reported that the two New Zealand medical schools were working to enhance the teaching of leadership and address specific training areas identified when doctors had stepped up into leadership roles. The areas identified for training included human resources, communication, accounting, and quality improvement. The Royal College of Medical Administrators (RACMA, 2022) has implemented the training programmes *Management for Clinicians* and *Leadership for Clinicians,* which include understanding the healthcare system, workforce management, financial governance, and leading strategy and change. The New Zealand Nursing Organisation (NZNO), in their NZNO Strategy for Nursing 2018-2023 section 5, *Leadership, development, and sustainability* – *Rangatiratanga*, provides a vision and guidance for nurse leaders. However, it also identifies the impact of constant change and disruption on the development of the nursing leadership workforce. The OTBNZ (2022d) has identified management as

sitting within the general scope of practice, and informal peer support is provided to occupational therapists in leadership and management roles through membership of the Occupational Therapy New Zealand – Whakaora Ngangahau Aotearoa special interest groups. These profession-initiated responses have the advantage of utilising existing professional systems and support networks. A disadvantage may be the siloed approach of different professions, meaning they may not necessarily share a conceptual model of health management and leadership. A siloed approach may result in the inefficient use of resources and be counter to the collaborative and cooperative approach to leadership and management that is identified as required for health service management and organisations (Brown et al., 2009; New Zealand Parliament, 2019, 2020). A risk of using existing professional systems, such a competency frameworks, is that they will not contain all the competencies required by the health service manager in their management role (Thorne, 2016). Therefore, using a clinical framework for a non-clinical role may result in the provision of education to develop competencies people already have or miss competencies people do not recognise they require.

In summary, the literature indicates a mixed picture; competency frameworks for health service management, which have applicability in New Zealand, have been developed. New Zealand and Australian researchers have contributed to the ongoing development of competency frameworks, and advocated for education and support for health service managers and professional associations (Ayeleke, 2018; Ayeleke, North, Dunham, et al., 2019; Briggs, 2008; Briggs & Isouard, 2016; Liang et al., 2020; Liang, Blackstock, et al., 2018; North & Park, 2014). However, no evidence has been found that these have been implemented, or of assessment processes to support the identification of existing competencies and those needing to be developed.

In the absence of a national approach, health professions, including occupational therapy, have constructed their professional competency frameworks to span competency development needs from registration to ongoing practice and include non-traditional roles, which may include health service management. In addition, some health professional groups have implemented programmes to support members

in preparing for and transitioning to health services leadership and management through dedicated postgraduate study programmes. The actions of these professional groups support the existence of a gap in the education and support of health professionals who transition into health service management in the absence of an agreed and integrated competency framework for the New Zealand health system.

The following section delves into the research to find out what is known about health professionals who have made the transition into management. This search of the literature sought to find what competencies health professionals claim they employ in management that they developed through their professional education and for what they were least prepared.

Health Professionals Transitioning to Health Management

For some, the clinician's decision to move into a managerial role is a desired and logical career progression; others identified expectations of them to accept leadership and management responsibilities (Braveman, 2016; Lawson, 1994). In addition, studies of clinicians transitioning to managerial roles have identified that, for many, it was not an easy process (Cowan, 2010; Lawson, 1994; Prideaux, 1993).

The challenges experienced were attributed to lack of prior preparation and support when new to the role. In addition to a lack of prior management training, other gaps in support identified were limited or no orientation to the role, lack of role clarity, and limited information provided by line managers on performance expectations (Cowan, 2010; Lawson, 1994; McCallin & Frankson, 2010; Pilling & Slattery, 2004; Prideaux, 1993). Interpersonal challenges were identified that impacted the transition process, including a lack of acceptance by clinical colleagues and new management colleagues (Lawson, 1994). The gaps in preparation and orientation impacted their performance and confidence. In contrast, those who had engaged in prior management education and preparation or received mentorship found the support and competency development beneficial (Cowan, 2010; Heard, 2014; Pilling & Slattery, 2004; Prideaux, 1993; Thompson & Henwood, 2016). However, the overwhelming experience was of not being prepared for the role transition from clinical to managerial roles and

responsibilities. What is known from the research is that implementing a programme of training, mentoring, and the line manager providing clarity of role and performance feedback makes a positive difference in the transition experience. What is also known from the previous studies is that similar issues continue to be raised; therefore, identifying this is not a complete gap in knowledge. Rather, it is a gap in applying this knowledge to systems, processes, and attitudes that will best support health professionals' transitions into health management.

Competencies Employed

Research conducted with health professionals, including allied health, has identified clinical competencies that may be employed in managerial roles to efficiently and sustainably support the achievement of the organisation's goals and objectives (Hughes et al., 2018; McCallin & Frankson, 2010; Pilling & Slattery, 2004). Competencies identified are the use of a caring approach, communication skills, the ability to set a clear direction of action, establishing professional and personal credibility, and demonstrating professionalism. More specifically, speech pathologists identified their expertise in communication, teamwork, interpersonal skills, care planning, evidence-based practice, and problem-solving (Pilling & Slattery, 2004). Similarly, nursing professionals identified skills in interpersonal and relational skills, planning and evaluation, and problem-solving, along with competencies in decision-making and directing as key skills that are transferable to management roles (Hughes et al., 2018; McCallin & Frankson, 2010). Medical professionals identified caring, employing political awareness, and conflict management (Lawson, 1994). Thus, research has supported the position that health professionals may adapt and employ competencies from their professional education and experience to their managerial roles. As Thorne (2016) expressed, each professional group brings their competencies and care perspective to their management roles. These differences in professional perspective and the competencies they bring to management and leadership sit at the basis of the current study.

Competencies Least Prepared For

For those transitioning into health service management roles, research conducted over the last 30-years points to an awareness of competencies required over and above their clinical competencies, with these gaps typically identified in individuals first management roles (Cowan, 2010; Hughes et al., 2018; Lawson, 1994; McCallin & Frankson, 2010; Pilling & Slattery, 2004). Commonly identified non-clinical components include people and performance management, administration, financial management, and communication and change management (Cowan, 2010; Lawson, 1994). Competencies identified as arising and employed from professional education were also identified as areas for further development, including “advanced communication and leadership skills” (Cowan, 2010, p. 49). Also identified were competencies related to developing personal resilience to address the challenges of working in isolation, managing stress, and building support networks (Cowan, 2010). These competencies least prepared for showed similarities across the professional groups, suggesting they are generic management competencies required for operational rather than clinical management.

Although health professionals bring workplace experiences, as well as their prior professional education and training to their management roles, research reported in 2010 revealed that some expressed surprise that this knowledge had not fully prepared them for the non-clinical components of their new roles (Cowan, 2010; McCallin & Frankson, 2010). This surprise reinforces the importance of prior knowledge of the scope and responsibilities of management roles, and of the competencies required to meet those responsibilities.

Occupational Therapists’ Transition to Health Service Management

The review of the limited recent published literature of the transition by occupational therapists from clinician to health service manager identified four central themes: the call to management and leadership, the transition to management, the identification of competencies associated with occupational therapy education and experience that were employed, and the competencies they were least prepared for.

Call to Management and Leadership

There is a call from within occupational therapy for members of the profession to step up into management and leadership roles (Gilfoyle, 1989; Pattison, 2020; WFOT, 2021), and an intrinsic drive of the individual who sees management as a career option. Truskowski's (2017) research identified a common drive among individuals who are not content with their current positions and who want to advance their careers. This drive, which Truskowski described as "*Wanderlust*" (p. 103), encompasses sentiments such as seeking the next step in the career journey, increasing influence within the organisation, self-improvement, and advancing the organisation. The call to management and leadership is in line with other health professional groups (Brown et al., 2009; Medical Reference Group Health Workforce Advisory Committee, 2006; NZNO, 2021). Overall, the position of the profession in the literature is that occupational therapists and other health professions are not confined to aspects of clinical concern, and they do, and should, transition into formal and informal leadership and management roles within the health sector.

Transition Experience and Enablers

The motivations to transition into management and leadership roles were linked to the desire to influence care delivery, personal and career development, and seeking to be a leader (Heard, 2014; Shams et al., 2019; Truskowski, 2017). In spite of career ambitions, the literature described the participants' experience of falling into roles or being encouraged by colleagues or mentors, and, often, it was sooner than they may have expected in their career journey (Heard, 2014). The serendipitous aspect of career opportunities and timing may impact preparation for roles and disadvantage those with leadership interests or potential who were not exposed to these opportunities or encouragement (Heard, 2014).

Challenges to transitioning into management included the perception that there were limited leadership positions for occupational therapists due to the health system leadership and management structures (Shams et al., 2019). This perception is also held in the New Zealand context with allied health professionals, citing medically led

service structures and nursing leadership roles and structures in place that potentially exclude other professional groups (Gauld & Horsburgh, 2012).

The enablers critical to the success of the transition process were identified as the availability of mentors and support systems, including communities of practice (Heard, 2014; Shams et al., 2019). Also identified as important were orientation to the role, leadership and management education, family support, and the provision of resources specific to management (Cowan, 2010; Lapointe et al., 2013; Shams et al., 2019). Formal and informal education and training in preparation for management were identified as enablers (Braveman, 2019; Cowan, 2010; Guo & Calderon, 2007; Ross & Barker, 1988). Shams et al. (2019) highlighted the importance of leadership-specific education and suggested that this education be included in the occupational therapy under-graduate curriculum. It has been mooted that a lack of education and training could impact health professionals' confidence to take up leadership opportunities (Orton & Hocking, 2017).

Overall, the transition was experienced as a challenging career step and a steep learning curve (Shams et al., 2019) despite existing clinical knowledge (Cowan, 2010), which would indicate gaps in the prior preparation for the roles. At the same time, it is noted that the competencies occupational therapists developed through their professional education and experience supported success in the transition into leadership and management roles (Fleming-Castaldy & Patro, 2012; Heard, 2014; Shams et al., 2019; Truskowski, 2017). The research also provides guidance on what areas of learning and development may be required and the enablers to support the transition and competency development.

Occupational Therapy Competencies Employed

A wide range of occupational therapy competencies employed in leadership and management were consistently identified across the research studies located. These included establishing relationships and communication, understanding human behaviour, activity analysis, using the occupational therapy process of setting goals and reviewing progress, the use of self and occupation to create a safe work

environment, collaboration, self-confidence, and having both visionary and practical holistic outlook (Fleming-Castaldy & Patro, 2012; Heard, 2014; Shams et al., 2019; Truskowski, 2017). Also identified was the knowledge and application of theories and models; for example, the use of occupational therapy theory, such as Kielhofner's Model of Human Occupation, to guide the approach to people management (Truskowski, 2017). Others referenced leadership models and theories in response to the research questions, indicating the integration of these theories into their thinking and actions as leaders (Heard, 2014). Fleming-Castaldy and Patro (2012) emphasised the importance of self-reflection which can support leaders and managers to evaluate their current performance and identify areas for development. Although the research cited was not conducted in New Zealand, the competencies identified can be readily aligned with the OTBNZ (2022c) competency framework domains one and three: applying occupational therapy knowledge, skills and values; and developing and sustaining partnerships.

Management Competencies Least Prepared For

The research studies reviewed identified gaps in core leadership competencies, including understanding leadership and leadership approaches, and financial competencies including budgeting and forecasting (Truskowski, 2017). Broader aspects of communication competencies were identified including the technical skills of clear and coherent communication, and interpersonal communication including building professional relationships (Heard, 2014; Shams et al., 2019). System and organisational awareness, the importance of developing emotional intelligence, having an understanding of the big picture, and thinking from a strategic perspective were further identified (Heard, 2014; Truskowski, 2017). Developing competencies in self-care was also found; for example, learning to maintain boundaries between work and home (Truskowski, 2017). These studies identified the need for preparation and formal training (Shams et al., 2019; Truskowski, 2017). The challenge of this limited research in understanding the competencies least prepared for is that the initial purpose of the research was to examine leadership rather than management competencies.

Consequently, the business competencies associated with management may not have been included in the research scope.

The professional literature also identified the management competencies that occupational therapists require to effectively perform their management roles. These competencies were predominately in the areas of leadership and human resource management, business and administration, and organisational culture and rules. Leadership and human resources management competencies included supervising staff, overseeing the planning, and coordinating the functions of a department or service. Financial management competencies were identified including budgeting and financial planning (Guo & Calderon, 2007; Hooper & Wood, 2019), programme development and evaluation, and continuous quality improvement (Hooper & Wood, 2019). Knowledge of the organisation and its rules, regulations, traditions, and culture (Rodger, 2012), including the creation and maintenance of records of plans, actions, and understanding ethical and legal reasons for these, and ensuring the common good by being stewards of the organisation's resources (Guo & Calderon, 2007) were also identified. This professional literature does support the position that additional competencies are required and what they may be, over and above the occupational therapy education, and that management competencies are added to the individual's occupational therapy competencies in the practice setting to fulfil the management role (Hooper & Wood, 2019). The competencies identified above as least prepared for align with those identified by other health professions who transition into health management roles.

In summary, the research and professional literature identified numerous competencies that occupational therapists were least prepared for in their transition into management, some of which align with those identified by other health professional groups. Competencies least prepared for include leadership, communication, human resource management, financial management, organisation and sector knowledge, and selfcare. These are core to operational management and would be required early in management careers.

Existing competency frameworks suggest competencies have been overlooked in previous research but still may be relevant to this study. Using an interpretive lens when reviewing the literature and my sector experience, three examples of potential competency gaps are illustrated: managing internal changes by interpreting policy, legislation and how they apply (ACHSM 3.2), risk management and clinical governance (ACHSM 3.7), and project, supply chain, and facilities management (ACHSM 3.9).

Chapter Summary: Gap in Knowledge

The initial premise that health professionals transition into health service management and employ competencies from their professional education was supported by the literature review. Also supported in the literature is that additional competency development may be necessary, particularly early in management careers in the areas of business skills, leadership, and operational management. However, no research was located addressing occupational therapists who transition into health service management in New Zealand DHBs, the competencies they employ from their professional education and experience, and those for which they were least prepared. This gap in knowledge underpins the current exploratory study.

In addition to the gap in knowledge of the competencies employed and required, concerns continue to be raised on the need to develop leaders and managers, especially early in their careers (Hughes et al., 2018; Ross & Barker, 1988), and of the lack of coordination in leadership and management development (Briggs, 2008; North & Park, 2014). The challenge for the current research is mounting a compelling argument for that work so that the attention of all participants, from individuals to government ministries, is drawn to this topic.

Chapter 4. Methodology and Method

The four key concepts in the development and direction of any research, particularly in the social sciences, are methodology, ontology, epistemology, and method. The importance of this research structure is to ensure there is a clear understanding of the information to be generated from the research, how this information is gathered, that this information would be positioned to address the research question, and that the study meets the requirements for academic credibility (Guba & Lincoln, 1994; Sandelowski, 1986; Thorne, 2016).

This chapter is presented in two sections. In the first section, I describe and justify the qualitative research methodology of interpretive description. The philosophical underpinnings are described and linked to the study's desired outcomes. The ontology and epistemology fundamental to this study are identified and discussed. The second section outlines the methods employed in the research design, including details of the research process and techniques used. Key methodological components are described including my involvement, the reflective and reiterative processes, recruitment, data collection and analysis, and the process for academic rigour and trustworthiness.

Research Methodology

In the identification of a research methodology, understanding the purpose and the desired outcome of the research is central to identifying the research approach (Collins & Stockton, 2018; Denzin & Lincoln, 2000; Tuli, 2010). Research methodologies that require underlying components of uniformity, environmental control, and repeatability, as characteristic of quantitative methods (Laughlin, 1995; Thorne, 2016), are not appropriate in a dynamic health service management environment or with a participant group that will each have a unique experience of the demands of their managerial role. Therefore, a qualitative research methodology was selected, as it is the appropriate approach to examine a topic based on and representative of human experience. Furthermore, this qualitative approach allows the researcher to explore these experiences in detail, capture the individual's point of view and realities, identify

patterns and themes, and is suitable for small studies (Laughlin, 1995; Thorne, 2016), that are all appropriate for this doctoral level programme of study.

After reviewing the methodological options within qualitative research an interpretive approach was selected. This methodology allows for the inclusion of my knowledge of the area of study, derived from my own experiences as an occupational therapist, over 20-years in health service management roles, membership, and leadership in ACHSM New Zealand, and achievement of ACHSM Fellowship. Further, Thorne (2016) advised that utilising a descriptive approach to research was a useful way to bring a phenomenon and findings to colleagues' attention and this becomes the basis for new knowledge to contribute to the advancement of the profession and generate new questions to be asked.

Interpretive Description Methodology

Located within the field of interpretivism, interpretive description was identified and selected as the methodology for this study as it was specifically developed to understand issues of practical importance to the health sciences. Interpretive description was developed to address the research questions of applied health professions that are not readily answered by more traditional qualitative methodologies (Thorne et al., 1997) within the health sciences such as grounded theory (sociology), ethnography (anthropology), and phenomenology (philosophy) (Hunt, 2009; Thorne, 2016). These methodologies were found wanting as they required complex procedural rules to achieve methodological purity within the academic research context (Thorne, 2016). The development of interpretive descriptive methodology was also in response to nurse researchers' concerns that limitations associated with traditional quantitative research methods did not reflect the multifaceted and ever-changing health environment they were working in, and where measurement is inappropriate or misleading for the theoretical and practical questions they had (Thorne, 2016). This led nurse researchers to look for and investigate non-categorical qualitative research approaches (Hunt, 2009; Thorne, 2016; Thorne et al., 1997) that met the needs for academic acceptability and achieved a useful outcome.

Interpretive description sees that reality is complex, contextual, constructed, and subjective; and that the researcher and the participant interact to influence each other. Interpretive description methodology provides an interpretive lens to delve into and beyond the description or the reporting of an event or phenomenon (Thorne et al., 2004). Therefore, no prior theory could encompass these multiple realities and new knowledge develops from the analysis and interpretation of the data (Thorne et al., 2004).

Interpretive description allows for the utilisation of available qualitative techniques appropriate to the research question and to the professional discipline of the researcher and participants. As Thorne (2016) summarised, interpretive description provides for the development of a research design around disciplinary concepts and epistemological underpinnings to develop knowledge of interest to the professional discipline, and which are defendable as credible new knowledge.

In positioning interpretive description within research methodologies, Thorne (2016) clearly stated that it differed from the classical qualitative methodologies. Interpretive description is a non-prescriptive methodology that allows for customisation to include aspects relating to the area of study and the disciplinary orientation of the researcher and participants, with the overall objective being to gain valuable new knowledge rather than to develop theories. This positioning can be seen as the strength of this research methodology, as the design provides the flexibility to meet the needs of the problem to be investigated. There remains, nevertheless, the requirement for all studies to meet the standards for “sound methodological research” based on “solid theoretical foundations” (Thorne et al., 1997, p. 172).

In interpretive description, the researcher encourages the participants to share detailed descriptions of the phenomenon of interest, while leaving the interpretation or analysis to the researcher (DiCicco-Bloom & Crabtree, 2006; Thorne, 2016). One advantage of this perspective is that the design is informed by, and oriented to, the researcher’s experience rather than the structure of the organisations that are the location of the research (Hunt, 2009). This allows for the knowledge gap to be viewed

from an applied health perspective which opens the study up to generate new insights, inquiries, and potentially new practices (Thorne, 2016). However, the potential disadvantage is the risk of the researcher's closeness impacting the study's credibility (Sandelowski, 1986). Mitigating strategies such as reflective practice and consultation with supervisors and advisory groups can help to offset this risk. Overall, interpretive description is a good fit for the research with its grounding in the health sciences and the development of new knowledge relevant to the context of applied health disciplines (Hunt, 2009; Lopez & Willis, 2004; Sandelowski, 2002; Thorne, 2016; Thorne et al., 1997).

Philosophical Underpinning

Interpretive description methodology has a philosophical underpinning of pragmatism (Brinkmann, 2011; Thorne, 2016; Thorne et al., 1997). Pragmatism, as a philosophical movement, was developed in the 1870s led by Charles Peirce and John Dewey. Dewey believed that knowledge comes from the adaption of the human to its environment and that the mind and the body are connected and work together consciously and subconsciously to enable learning and knowledge to occur (John Dewey Project, 2002). Within pragmatism, as described by Dewey, three concepts of naturalism, transactionalism, and habit are relevant to the current research.

In contrast to the empirical view that experience is primarily a result of an outer world impinging on the senses, Dewey saw experience as transactions with a temporal structure (Brinkmann, 2011; Dewey, 1929). Thus, Dewey held a naturalistic view that all experiences result from engagement with the environment. As this engagement occurs, we, humans, react, suffer the consequences, and are changed (through the medium of cognition), as is the environment, in an ongoing cycle of transactions (Dewey, 1929). Understanding that humans and the environment constantly change, and that understanding is ongoing is meaningful for this study. Dewey's thinking supports the positioning of this study as a focus on the individual, as each participant's experience and understanding are unique and real at the time they are known.

Finally, the view that the interaction of the individual with the environment and the resulting experience results in temporal activity and cognitive change leads to the discussion of habit and its impact. Dewey described habit as forms of activity or responses to the environment that can be seen in the individual's subconscious patterns of thinking, and in the customs and shared habits of a group (Brinkmann, 2011; Dewey, 1929). Habits are seen as aspects of our learning process that may simplify our daily activities, and can be changed through considered inquiry into relevant conditions (Hildebrand, 2023). Awareness of the existence and impact of habits in personal and organisational behaviour informed the interview questions developed for this study, in that habits of thinking acquired from professional training and practice are anticipated to carry forward to managerial roles. Accordingly, I used probing questions to gain a deep understanding of the reasons behind actions and responses described by participants to discern alignment with the values; focus; practice imperatives; and practices of the occupational therapy profession, such as the occupational therapy process; and the conscious (or therapeutic) use of self in interpersonal interactions.

Research Approach

Interpretive description, as a clinically focussed research methodology, has identified clinical and professional knowledge as central and explicit in the design elements. This position in based on the understanding that each profession has its unique philosophical foundations, disciplinary objectives and assumptions which influence the inferences drawn from the data (Hunt, 2009; Thorne et al., 1997). This thinking supported the positioning of occupational therapy and occupational therapists as the participants, researcher, and academic supervisors for this study.

The interpretive descriptive methodology was used to bring out the voice of the individual engaged in health service management and in developing new knowledge in this area of inquiry (Thorne, 2016). For example, the questions asked, the way they are asked, the participant responses that are probed and those that are not, and the analysis of the data. This study considers participants' descriptions of events,

experiences, decisions and actions, and probes to draw out their understanding of the competencies that supported their managerial performance.

The research paradigm or model for qualitative research is based on a set of beliefs and assumptions. Researchers have their own worldview and knowledge that contribute to the development of their area of interest (Thorne, 2016). Identifying the beliefs about ontology (reality) and epistemology (knowledge) that inform the research guides the philosophical positioning and the choice of research design. Ontology and epistemology provide the guide to what the researcher believes and, together, describe how the researcher views the area of interest. This worldview influences the position taken in regard to the subject of the research (Aliyu et al., 2015).

Ontology

Ontology in a research study seeks to identify what is real or true in the domain of interest. In the context of this study, the ontological questions ask; what is reality, and what can be known about it? Followed by considerations of how things really are and how things really work (Guba & Lincoln, 1994).

For this study, the ontological positioning is interpretivism and subjectivism. From the interpretive perspective, the world is complex and dynamic and is interpreted and experienced by participants in their interactions with each other and within the broader social system. Reality is constantly in a state of revision because of the ongoing interaction between the individual and the environment (Davies & Fisher, 2018; Dewey, 1929). Consequently, reality is experienced in the different ways individuals think, feel, and see (Aliyu et al., 2015; Guba & Lincoln, 1994). As a result, it is anticipated that among the participants there will be multiple subjective realities, some of which may be contradictory (Thorne, 2016). Accordingly, as reality is experienced in different ways, generalisations may not be there to be discovered.

Interpretive researchers use qualitative research to investigate, interpret, and describe the realities that are the result of social processes (Tuli, 2010); although at times reality as experienced by others may be difficult to grasp (Aliyu et al., 2015). In an interpretive

approach, the enquirer and the participant interact with the other to delve into and beyond the description or the reporting of an event or phenomenon.

The social process of concern in this study centres on the management and leadership practices of occupational therapists in managerial roles in New Zealand's health services. Occupational therapists have at the philosophical core of their professional activity a focus on human occupation in the real world. Fundamentally, occupational therapists view people as having a desire and ability to change and a "biological need for occupation" (Hooper & Wood, 2019, p. 46), and these abilities and needs are utilised as part of the therapy medium. Occupation is central to the profession's activity, sets the professional values and identity, and directs the activity of occupational therapists in their assessment, planning, and intervention (Hooper & Wood, 2019). The focus on occupation and actions, the reasons behind these, and the resulting outcome were anticipated to be central to the experiences, reflections, and insights described and interpreted.

The research environment, the management experience, and the disciplinary underpinning of the study also influence the use of language (Thorne, 2016). The language used by the researcher and participants reflects each individual's knowledge, reality, and understanding (Aliyu et al., 2015). The participants may use profession-specific terminology as well as language, jargon, and acronyms specific to the health sector. The meaning behind the words used may need to be considered and clarified to ensure the language used describes reality and is understood by the participant and researcher.

The subjective nature of interpretive description enquiry and the insertion of myself as the researcher in the data collection, analysis, and interpretation is a core element of this study. The interpretation of data is a sense-making process led and informed by the knowledge and perspective of the researcher (Bhattacherjee, 2012; Thorne, 2016). I have a background both in occupational therapy and as a senior health service manager in the New Zealand publicly funded health system. This experience would influence the data collection, the interpretation of the data, and inform my

understanding; therefore, my contribution to the study and the findings of the study are subjective.

Epistemology

Epistemology is defined as "the nature of knowledge" (Thorne, 2016, p. 32); it is concerned with knowledge and how knowledge is acquired. In this study, how knowledge is acquired sits within the ontological positioning of what is the 'reality' being studied (Guba & Lincoln, 1994). The epistemological positioning is interpretivism and naturalistic and has the underlying assumption that in studies of social phenomena knowledge can be gained through exploring and understanding the ever-changing social world of the participants (Harris, 2006; Thorne, 2016; Tuli, 2010). Therefore, the data are gained in a non-manipulative, non-controlling manner (Tuli, 2010).

For this study, knowledge is understood to be constructed through the interaction between myself, as the researcher, and the participants (Thorne, 2016), and can be based on experiences, beliefs, values, and understandings of the individual (Aliyu et al., 2015). Therefore, the data are subjective, created in the real world in the moment each participant discusses their perspectives with me, as the researcher, and are real to the individual participant at the time of data collection.

The disciplinary orientation is central to the study and is specified in the research question and the intended participant group, and in the discipline and experience of the researcher. The reflections and insights of the participants' and researcher may be influenced by how the profession thinks about and describes a situation or problem. Hooper and Wood (2019) outlined as an epistemological premise for occupational therapists that an understanding of the purpose and function of a role is fundamental in identifying the knowledge required. If knowledge is situationally dependent, and the health sector is complex and ever-changing, knowledge held by the individual and what is relevant and known today may not be tomorrow.

Use of Theory in Developing Knowledge

The use of theories to assist in the understanding of phenomena is standard practice in research. Anfara and Mertz (2015) described using theory as a frame to guide the study as one method to apply theory in qualitative research. A "theoretical framework can allow the researcher to reveal existing predispositions about a study and assist with data coding and interpretation" (Collins & Stockton, 2018, p. 1). Theories make sense of social interactions and phenomena, and articulating a theoretical framework helps in the sense-making process and makes it more explicit.

Interpretive description research methods allow for researchers to be informed by relevant theoretical frameworks. Competency frameworks can be seen as discipline-based theories (Bradbury-Jones et al., 2014; Collins & Stockton, 2018). In this study, two competency frameworks, specific to the topic at hand, have been incorporated into the process of developing knowledge from the data. The OTBNZ CRCPOT and the ACHSM Health Service Management Competency Framework are positioned as existing theories in the identification of the skills, knowledge, and attitudes required for occupational therapists (the former) and health service managers (the latter).

There are advantages and disadvantages in using existing theory in this manner. An advantage is that an existing competency framework can be used to organise and connect the data. It can also be used as a spotlight to shed light on data which may have been overlooked or misinterpreted (Collins & Stockton, 2018). The disadvantages are the risk of over-reliance on the established frameworks and, therefore, missing themes and interpretations that are not included in them (Thorne, 2016). It is pertinent to remember that competency frameworks do not cover all aspects of a role and may not include aspects that are difficult to quantify but which may be important.

The purpose of using these theoretical frameworks was not to confirm the existing professional frameworks but to assist in identifying competencies and competency gaps interpreted through the events and insights described by the participants. The frameworks also provided standard competency descriptors and language known within the sectors, using terms and concepts familiar to the participant group and

readers. This will help ensure that the findings are accessible and relevant. However, using these well-developed and published OTBNZ and ACHSM theoretical frameworks presented a risk of dominating the data collection and analytic processes. To address this risk, they were utilised in a second phase of the data analysis process, following initial immersion in the data, applying Braun and Clarke's (2006) thematic analysis and developing the initial coding and themes.

Ongoing Literature Review

A feature of interpretive description is the encouragement to continue with the literature review throughout the study to add new knowledge and perspectives. Thorne (2016) asserted that new literature brought into the study, including that from outside the primary disciplinary focus, would add an advantage in interrogation and developing understanding. Thorne promoted the value of new literature to widen the lens and perspectives under which the data, themes, and insights are viewed, analysed, and critiqued. Examples of the new knowledge added to this study are the updated versions of the competency frameworks from OTBNZ and ACHSM, the commentary outlining why changes were made, and the article on the future of allied health leadership in New Zealand. I also engaged in a recursive process of re-reading existing literature and extended my understanding of these works because of my growing understanding of the research subject and findings.

Research Approval AUTEC

The AUTEC approved the commencement of this research on March 22, 2021, for a period of 3-years, application no. 21/58. The application and notification of approval are contained in Appendix A. Approval was received to recruit up to 15 participants.

Research Method

The question of what research methods are to be used asks, how does the researcher find out what can be known? The methods utilised are informed by the ontological and epistemological positions (Guba & Lincoln, 1994), and by the selection of the research methodology. Interpretive description has been selected as the research methodology

for this study. It is described as a non-categorical methodology and may utilise aspects of grounded theory, naturalistic enquiry, ethnography, and phenomenology in the study design as appropriate (Thorne et al., 2004).

Introduction to the Research Design

The method section outlines the research design and details of the research process and techniques used. Interpretive description is positioned as an operating logic within which studies can be designed (Thorne, 2016). This operating logic provides the theoretical basis for the selection of the processes and techniques; it does not provide a prescribed set of steps under which the research is conducted. Interpretive description is not a "cookbook" of prescriptive procedural guidelines (Thorne, 2016, p. 40). That stance is consistent with qualitative research approaches that allow for modification and elaboration of some methods during the study. Thorne (2016) supports modification to add depth to the data collection or expand into an area of questioning to further analysis and understanding. Therefore, each process and technique selected for this research is described and justified in relation to the research approach and philosophical underpinning. In the design phase of the study, consultation with my supervisors and discussion with members of the peer advisory group and kaumatua (outlined later) informed the consideration of the methods utilised.

Research Question

As described in Chapter One, after much consideration and revising I confirmed the research question as *"What do occupational therapists employed in health service management roles in the New Zealand District Health Boards identify as the core management competencies they developed through their professional training and experience?"* A supplementary question was added, "*What were the competencies required in their management role that they perceived that they were least prepared for?"*

In line with the methodological underpinning, I was not seeking consensus. Rather, I wanted to illuminate the phenomenon of occupational therapists carrying

competencies across from clinical to managerial roles, and that further competency development was required, irrespective of whether that carryover was cited by one or many of the participants.

Researcher Characteristics

My career journey involved qualifying as an occupational therapist and working in physical and mental health clinical services, and then moving into health service management roles. I have not worked in the New Zealand publicly funded health sector in the past 5-years; however, I maintain a keen interest in the sector, including the impact of the sector review and proposed changes (New Zealand Parliament, 2019, 2020). Overall, I wished to utilise my knowledge of and experience in the New Zealand publicly funded health sector to support occupational therapists, and other health professions, to consider health service management as a career option. From that broad ambition, I aimed to contribute to the body of knowledge of the competencies utilised and required by those making this career transition.

With my experience working in the health sector, I am aware that I may have existing conscious and potential unconscious understandings and presuppositions, which cannot be removed. The impact of the researcher on the research and the outcome has been identified as an advantage and risk in qualitative research design, data collection and analysis (Berger, 2015; Braun & Clarke, 2006; Hunt, 2009; Thorne, 2016).

The advantage of my experience in, and knowledge of, the New Zealand health sector is in the depth of understanding of the sector and how it functions; I can use this to explore and gain a depth of knowledge when gathering data and in the analysis. Thorne (2016) described the benefit gained from researcher knowledge and experience in qualitative studies that aim to generate practical knowledge to be applied in the real world.

The risk associated with this research design is the potential that the dominant aspects of my personality, experience, and prior knowledge would steer the research processes in a predictable direction (Thorne, 2016). The position taken in interpretive studies, such as this, is that the researcher is entwined in the data and the knowledge

being produced and must acknowledge their possible biases (Thorne, 2016). To mitigate the identified risks and to be open to new, unforeseen, and unexpected data (Stanley, 2015; Thorne, 2016), reflexive strategies were incorporated into the research method and implemented throughout this study.

Reflexivity

In research, reflexivity is seen as “self-appraisal” (Berger, 2015, p. 220) and is a technique utilised to identify and monitor the influences of biases, beliefs, and personal experiences on the research. Reflexivity is a crucial strategy in qualitative research in the generation of credible knowledge. Reflexive strategies to promote critical self-reflection and awareness (Berger, 2015; Thorne, 2016) were implemented throughout this research, and included a presupposition interview, the use of reflexive questions throughout the data collection and analysis processes, transcript (participant) checking, and triangulation of data. Also implemented were peer review and ongoing discussion with members of a research support group (peer advisory group), kaumatua and supervisors, journaling for self-supervision and as a record of decisions and personal reactions.

Peer Advisory Group

The complexity and variation across the research environment supported the need for input from an advisory group with expertise and a variety of perspectives and knowledge that complement my own. Their remit, in addition to my supervisors and myself, was to provide a check and balance in the application of the research design, contribute to the identification of prospective participants and act as intermediaries in their recruitment to the study, and contribute to discussion of the plausibility of the analysis and preliminary findings. The contribution from this group was important, especially in this methodology design framework in which I had a pivotal and influencing role and supported the trustworthiness of the study.

The members of the peer advisory group were purposively selected. The potential participants were identified through my discussions with the study’s primary supervisor, taking into consideration their experience relevant to this study,

availability, potential networks across the sector, and the proposed role to act as an intermediary in approaching the potential participants. All were known to me. The proposed membership of the peer advisory group consisted of four occupational therapists who were chosen for their expertise and experience as practising occupational therapists and health service managers, experiences as professional leaders and supervisors, and knowledge of the health sector including management structures, roles, and responsibilities.

I met with each separately, outlined the research proposal, and provided a copy of the participant information sheet and the rationale behind the establishment of the peer advisory group and the proposed role and actions of the advisors. Following the meetings, three accepted the invitation to participate. Following the initial face-to-face meetings, contact in 2020- 21 was predominantly via individual email and text due to the impact of New Zealand COVID-19 response restrictions on travel and gatherings. Face-to-face meetings restarted following the removal of COVID-19 restrictions and continued to the end of this course of study.

Kaumatua

Following a discussion with my primary supervisor, I met with a colleague who I have worked with previously in the health sector and has experience leading Māori health services, as a DHB manager, and supporting new researchers. We met kanohi ki te kanohi (face-to-face). I outlined the research proposal and my desire to consider a Māori New Zealand perspective in this work. Following this meeting, I accepted his offer of support as kaumatua, for this study. The COVID-19 response placed restrictions on our meetings; however, meetings did occur throughout the period this study was conducted. These meetings included a wide range of discussions on preliminary findings; the experiences of health service managers new to roles; and Māori perspectives of occupation and purpose, in life, family, and the workplace.

Recruitment

This section outlines the elements required for participant recruitment. It includes the pool of potential participants, deciding on sample size, selecting a sampling

methodology, developing the participant inclusion and selection criteria, and the recruitment process. In addition, the processes to ensure anonymity, confidentiality, and consent are described.

Prospective Participant Pool

Occupational therapy is a small professional group with unknown and potentially limited numbers working in management roles in DHBs. There was a potential risk of not achieving participant numbers that would ensure sufficient volume of data and variation to gain meaningful insights to answer the research question. To address this risk, the inclusion criteria included those occupational therapists who, over their career, had been registered as occupational therapists in New Zealand and been employed as a manager or leader in a DHB at some point(s). My experience and observation led me to assume that many occupational therapists, and other allied health professionals, who transition into management roles do not keep up their professional registration. This knowledge of occupational therapists deregistering, and the lack of a register of health service managers, reinforced the importance of the sector knowledge and connections of the advisory group members in the identification of potential participants.

Sample Size

Qualitative studies and those using interpretive methodology typically have small sample sizes because the intent is to collect depth and richness of data from the interviews and there is substantial amount of work required for these data to be transcribed, analysed, and interpreted (Bhattacherjee, 2012; Davies & Fisher, 2018; Patton, 2015; Thorne, 2016). Nonetheless, a rationale for determining the final sample size is required. For this study, the determination of the sample size was informed by the model of information power (Malterud et al., 2016). This model aims to ensure sufficient information is obtained to meet the aim of the study and identifies five key elements to be considered in the identification of sample size: the study's aim, the sample's specificity, the existence of established theory, the quality of the interview dialogue, and the strategy utilised to analyse the data. This model proposed that fewer participants are required in studies with a narrow (aim) focus, participants specific to

the study, using existing theory, where the interview dialogue is strong, and the analysis includes an in-depth longitudinal analysis of narratives. Conversely, more participants would be indicated where these five elements are less specific.

As an exploratory study to generate depth of knowledge from participants with specific skills (narrow aim or focus) and work experience from various New Zealand DHBs (participants specific to the study), the present study was deemed to fulfil these criteria. The primary data were to be generated using individual face-to-face interviews (strong dialogue), and the data would be analysed using inductive thematic methods (longitudinal in-depth analysis of narratives). As detailed earlier, theoretical frameworks from OTBNZ and ACHSM informed the study (use of existing theory), requiring data from sufficient participants in different roles and DHBs to provide insights to generate new understandings. Based on the five elements of the knowledge power model outlined above, a sample size of up to 15 participants was decided for this study.

In addition to the model of information power, advice from academics with expertise in qualitative interpretive methodology was considered in determining sample size or deciding that sufficient data had been collected. Thorne (2016) advised that participants represent infinite variation in their experiences; therefore, data saturation is not a consideration in determining sample size. Sandelowski (1986) advised that participants may initially be selected because of their knowledge of the subject and, subsequently, selection may be influenced by the early findings and desire to delve further into specific areas. Therefore, representation was not a consideration for sample size. Overall, the focus was on obtaining a depth of understanding while recognising that outliers would exist.

Purposive Sampling

In qualitative research, potential participants belonging to the specified group are considered to represent the group, and their real-world experiences are appropriate to include in the study (Sandelowski, 1986). The process of recruiting specific individuals to participate in the research based on their experience and insights into the area of

research is termed purposive selection (Bhattacherjee, 2012; Palinkas et al., 2015; Thorne, 2016), as compared with random sampling which could be used if more generalisable results were required (Palinkas et al., 2015). Purposive selection identifies potential participants to be included in the research whose contribution would add insights into the phenomenon and achieve the depth and breadth to the data gathered; thereby, supporting the credibility of the research (Patton, 2015; Thorne, 2016). The potential risk of purposive sampling is identifying participants with similar career backgrounds to the researcher (Thorne, 2016), and those who have successfully transitioned into management roles. In this study, to address this risk the advisory group was asked to identify potential participants, effectively widening the pool of candidates. My supervisors and I then considered whether the candidates were suitable for inclusion in the study.

Purposive sampling is helpful if a gap in understanding is uncovered when conducting the interviews and analysing the data, in which case another participant can be identified who could provide another view or describe a different perspective and experience (Thorne, 2016). It was anticipated that purposive sampling in this research design would support findings that apply to a broader range of occupational therapist health service managers and the DHB environments in which they work.

Participant Inclusion and Selection Criteria

Potential participants were selected for recruitment if they met the following inclusion criteria:

- Had been registered and worked as a New Zealand occupational therapist - kaiwhakaora ngangahau.
- In their career they had transitioned to DHB management roles that included responsibility for health service provision.
- Had held a health service management role for 6-months or more.

The selection criteria were designed to gather a broad range of data from diverse experiences across roles and workplaces. The identification of prospective participants took career experience, length of time in clinical and management roles, postgraduate

education in management (if known), gender, and ethnicity into consideration. The DHB they were employed by was also considered because the geographical spread of the DHBs, variation in size, and the cultural and ethnic makeup of the communities served indicated the role scope and experience prospective participants might bring to the study. There was scope to adjust the inclusion criteria during the period of data collection in response to knowledge gained, gaps in understanding identified in the data analysis processes (Thorne, 2016), or difficulty recruiting, although this option was not required.

In discussion with my supervisors, each prospective candidate identified was critiqued regarding the aims of the research, and to answer the questions of why recruit this individual and what qualifies them to address the issues under investigation (Palinkas et al., 2015)? In identifying the sample selection criteria it was assumed that every participant would have knowledge of the phenomenon being studied and would have an interest in bringing it to my attention, and that none would have the whole picture or all the information (Thorne, 2016).

Recruitment Process

To ensure appropriate participants would be recruited, a focussed recruitment strategy was used. The strategy included rolling recruitment and considered the pragmatic reality of the managers' availability.

The rolling recruitment method was utilised to support the purposive selection already described. These recruitment methods added depth and richness to the research data and supported the desire to develop meaningful information about complex issues (Thorne, 2016). As this was my first experience as a qualitative researcher, I initially recruited four participants. The balance of participants was recruited following the transcription and analysis of data gathered in the four initial interviews.

The prospective participants received an information sheet (Appendix B) when invited to participate by an intermediary and were offered the opportunity to consult with me about the research prior to participation. This offer was also repeated as part of the interview preamble. The information provided about the study included its aims, what

was asked of participants, and the process. The intermediary sent a reminder email after 2-weeks but was not informed of whether the invitation to participate was accepted.

The prospective participant was invited to contact me if interested. When the participant contacted me and their questions about the study were answered, the meeting date, time, and location were negotiated. The meeting date was set with a minimum of a 2-week gap to allow for a 'cooling off' period as required by AUTEC. A confirmation email, including the date and time, was sent to each participant prior to the interview.

The recruitment process and data collection and analysis were scheduled for March 2021 to June 2022. After interviewing 12 of the proposed 15 participants and generating over 400 pages of data, the decision made with my supervisors was that sufficient data had been collected to support the purpose and timeframes of this course of study.

Confidentiality and Consent

Confidentiality is required to protect participants' identities, employment locations, and the risk of unwanted exposure (Denzin & Lincoln, 2000). The limited number of potential participants in this study was identified as a risk to preserving anonymity, as it was possible that participants, their organisations, and other people and events mentioned might be identifiable. To address this risk of deductive disclosure (Zarate & Zayat, 2006), and protect the confidentiality of the participants, potentially identifying information about roles, workplaces, and colleagues, was removed from transcripts prior to data analysis, and is not included in the thesis or planned publications.

The audio recordings and transcripts were assigned individual codes and held in locked storage in my personal office. Computer files were password protected and all recordings have been deleted. The electronic copies of the transcripts will be destroyed after a period of 6-years.

Every participant completed a consent agreement prior to the interview. Members of the advisory group and the transcriber each completed confidentiality agreements.

These documents were securely stored as required by the AUTEC process and procedures. It was not envisaged that any psychological harm would come from participation in this research. Participants were advised they could withdraw from the research at any time; however, depending on the point at which they withdrew, it might not be possible to extract their contribution from the analysis. No participant withdrew from the research.

Data Collection

Qualitative interpretive research is dialectical. Dialectic is the art of delving into and probing the truth of opinions, and it is by way of the interaction between participant and researcher that the data are generated. Therefore, qualitative researchers cannot be separated from the research or the people involved (Davies & Fisher, 2018). In selecting a data collection method, the quality of the data required and the options of how to obtain this data were taken into consideration. Two options that fitted within qualitative interpretive descriptive were considered—small focus groups and individual interviews. These two options were evaluated against the requirements of the research to gain an in-depth understanding, have the time and environment to probe into the details, as well as take into consideration that the experiences under discussion were inherently personal and that confidentiality was required. Time available and costs for all participants were also considered as a pragmatic reality of conducting academic research. Individual interviews were identified as the most appropriate primary data-gathering tool. This method required more researcher time overall but provided for the development of an environment conducive to an in-depth interview.

Interview Questions

Participant responses can be influenced by the way the questions are phrased and asked (Turner, 1999); accordingly, questions were developed with care. I developed indicative questions, with guidance from my supervisors, and I conducted the interviews. The questions were initially developed from my experience, areas of interest, and understandings gained from the literature search and discussion with my supervisors and members of the peer advisory group. They underwent numerous

revisions to gain alignment with the research question, clarity in the question structure, and in the sequence in which they were asked. The questions were structured as open-ended and with flexibility built in to ask explanatory and or probing questions to gain a deep understanding of the reasons behind actions and responses as described by the participant.

I tested the questions with members of the advisory group to check their understanding and the timing of the questions and responses. Not all the planned questions were used in each interview due to time constraints and the digressions that often gave answers to those planned questions before they were asked. In some cases, responses were seen to be productive without the planned questions as they followed the participants' experiences, knowledge, and insights.

The iterative nature of the qualitative research process in which preliminary data coincides with data collection and analysis often results in modifying and adding questions (Thorne, 2016). Over the period the interviews were conducted, the question schedule had two reviews and the questions were revised because of emerging themes and new understandings. The initial questions were included as an appendix to the AUTEC application, were updated in consultation with my supervisors and advised in the quarterly progress report. A copy of the final schedule of questions is provided in Appendix C. To reiterate, not all the planned questions may have been asked in all interviews.

Interview Structure and Process

Although the preferred option was an in-person face-to-face meeting, the planning for this study included the alternative option of using video conferencing. This allowed for face-to-face meetings not being possible due to COVID-19 restrictions or the participant's availability. This option was utilised for half of the interviews and video conferencing via Zoom was undertaken.

A time-guide of 60 minutes was agreed with the participant prior to the interview. This time allocation provided sufficient time for me to delve into the work situations and explore the actions taken or not taken. It was a limited time allocation in order to

avoid the risk of the quality of the interview being compromised by the fatigue of the researcher and the participant (Adams, 2015). I developed and utilised an interview format guide as a prompt and check to ensure the time allocated was confirmed; comfort, confidentiality, and health and safety requirements were met; and the participant understood the topic and processes of the interview and transcript checking.

Primary Data

The primary data consisted of the transcripts of the interview; this is most common in interpretive description studies. The expectation was that the data-gathering strategies utilised would generate a large volume of rich data (Laughlin, 1995; Smythe, 2012; Thorne, 2016). The interviews were digitally audio recorded and transcribed. Participants were provided with a copy of their interview to check if there were any corrections, alterations, or additions they wished to make. This provided the opportunity for the participant to check the accuracy of their responses and further supported the trustworthiness of the study (Calson, 2010).

Collateral Data

In addition to the interview data, collateral data were requested from the participants in order to have a well-rounded collection of insights (Turner, 1999). Thorne (2016) advised that one tool is seldom sufficient when looking at complex phenomena, as it cannot represent the whole experience in context. The advantage of collateral data is that they provide a range of subjective and objective knowledge not generated by the researcher and provide for some triangulation of primary data (Hunt, 2009; Thorne, 2016).

Collateral data in this study comprised the participants' employment job descriptions (also known as position descriptions) and personal development plans. Not all the participants chose to provide this additional data, and some did not have these documents. Referring to these documents at the interview provided the opportunity for the participant to offer additional information; for example, views on the document's existence, construction, content, and usage.

The position descriptions provided background information on the organisation's purpose, key deliverables, and competencies required for the role (Robbins et al., 2000). They are core personnel documents that codify best practice (Munoz et al., 2022), providing further context of the participant's role. The participant's personal development plan (when available) provided insight into the participant's and organisation's priorities and investment into competency development, as well as providing data on the areas identified for competency development.

Findings from the Data Analysis

Interpretive description, as the name suggests, is interpretive and seeks understanding to describe and inform (Thorne et al., 2004). As Thorne (2016) described, interpretation seeks to consider the data from different angles, not to develop predictions of human behaviour but to understand the social and cultural contexts of human experience. The researcher interprets the subjective data to identify themes and patterns, while considering the variation between individuals (Hunt, 2009).

When using interpretive descriptive methodology, the researcher uses their knowledge of and experience in the research environment to interpret the data. Their personal and contextual knowledge and experience of the context of the research site is critical when developing the underlying insights into the research phenomenon (Thorne, 2016). While I have previously acknowledged the risk of my own subjective knowledge and experiences biasing interpretation, another identified risk with the interpretive approach can be failing to develop sufficient interpretation, thereby limiting the useable knowledge from the research (Hunt, 2009; Thorne, 2020).

For developing meaningful insights, the advice from Thorne (2016) was to immerse myself within the data, both the primary (interview) and the secondary (collateral) data, and before starting to code the data ask, what is happening here? What am I learning about this? I employed an inductive approach for initial data coding and theme development. Inductive analytic approaches to research (i.e., not using pre-determined concepts or frameworks) are identified as characteristic of an interpretive descriptive methodology (Thomas, 2006; Thorne et al., 2004).

I then used thematic analysis as the coding methodology, assuming the reflexive thematic analytic approach as described by Braun and Clarke (2013) , who proposed a six-phase process that is sequential but allows for recursive movement back and forward between the phases as required to support the in-depth analysis. The six steps are: familiarisation with the data, coding, generating initial themes, reviewing themes, defining, and naming themes, and writing up. This process creates a focussed and systematic approach to data analysis, data interrogation, and knowledge construction, to ensure a deep understanding of the data and to gain insight into the research question.

As a novice researcher, I was aware of the need to keep working to lift the data interpretation from a descriptive to a conceptual level, while holding onto the richness of the data (Stanley, 2015; Thorne, 2016). As Thorne (2016) advised, the participants should recognise themselves in the analysis and summary discussion. Thorne supported the value of testing and checking against an experienced practitioner and saw that it added to the depth of the analysis and power of the findings. I discussed my progress in the data analyses with my supervisors, and with individual peer advisory group members, to receive feedback to inform the subsequent recruitment process, and on the thinking and actions to date. As a final check, I re-read the transcripts with my data interpretations and the summary of recommendations in mind to see how they sat together.

Following on from the initial analysis and identification of the competencies employed by and required of participants, I continued with what I described as the second level of the analysis to answer the questions, what is happening here and what am I learning about this? This next round of analysis resulted in an understanding of the experiences of the work environment and the competency assurance requirements of the profession on the competencies to be developed, and the engagement by the individuals in competency development, both planned and ad hoc. This second round also raised questions of how occupational therapists viewed their connection with the profession, and the contribution of the currency of their professional competencies where professional registration was a choice.

Academic Rigour and Trustworthiness

Rigour, trustworthiness, and integrity refer to the way the study is conducted (Noble & Smith, 2015; Patton, 2015; Sandelowski, 1986; Thorne, 2016). I considered these values regarding the appropriateness and application of the research approach, research method and design, to the research question as well as my inherent bias.

The lack of pre-defined processes within interpretive description as a platform for research makes comprehensive documentation of process important for the credibility of the research findings (Patton, 2015; Sandelowski, 1986; Thorne, 2016). Comprehensive documentation allows for clarity of the processes, making the journey from design to data collection and analysis to the findings transparent. This documentation is a record of the research as it progresses and acknowledges and accounts for bias; provides for the checking of the data with the participants; outlines the data analysis process; and the creation, role, and utilisation of the research peer advisory group.

Research Journal

To ensure the reliability of my research, I recorded the decisions I made throughout the planning, gathering, and analysis of data. The purpose was to ensure that each decision I made was consistently applied, and able to be defended in relation to the research findings (Thorne, 2016). My journal contains a record of my actions and decisions, including notes on methodological decisions, contacts, and interviews, and communication with the peer advisory group and research supervisors. This information documents the academic rigour of my research, including reflexivity, and creates a trail that could be followed to review the study processes.

Summary

In this chapter, which was informed by the literature review, I outlined the decisions and rationale of the research philosophy, methodology, and methods utilised in the research. Central to this study was the desire to hear first-hand, and not be constricted by prior models or theories, from those who had made this career transition, while

allowing for the contribution of my knowledge and experience to the data collection and analysis. I selected the qualitative non-categorical interpretive descriptive methodology, which gave flexibility in the methods utilised. The lack of predefined processes within interpretive descriptive is identified as a risk. To counter this risk, the research processes implemented were described in detail to ensure academic rigour and trustworthiness are achieved.

The following three chapters will present the findings from the data analysis. Chapter Five presents the competency domains developed from the skills, knowledge, and attitudes (competencies) the participants identified that they employed and were least prepared for. Chapter Six discusses the alignment of the competencies, described in Chapter Five, with existing occupational therapy and management competency frameworks. Additionally, this chapter discusses the relationship between the findings and the collateral data of position descriptions and individual performance plans in relation to competencies required for management roles, and the planned competency development activity. Lastly, Chapter Seven will present the key contextual findings of the career journey and ongoing competency development.

Chapter 5. Findings: Competencies – Employed and Least Prepared For

The purpose of this study is to identify management competencies that the participants perceived they brought to the role, discern the influences an occupational therapy professional education and experience has on the development of management competencies, and identify the competencies participants were least prepared for and needed to develop. These findings are presented narratively, with participant quotes included. Utilising quotes in the narrative was chosen as a method to bring participants' voices to the fore in this exploratory study, and to capture detail and attitude expressed. All the participant quotations used are italicised. For improved comprehension and confidentiality some quotes are edited, and no quotes are attributed to specific participants or organisations.

Participant Profiles

For this study, data were collected from 12 participants. In line with the selection criteria outlined in Chapter Four, all participants had completed the occupational therapy qualifications required for professional registration, with three-quarters being New Zealand-educated and qualified. The span of the initial professional registrations was from the 1970s to the 1990s, with a majority in the 1980s and 1990s. Predominantly, participants transitioned into health service management positions after gaining 5 or more years of clinical experience, with two making the transition earlier in their careers. Most participants had worked in larger metropolitan DHBs, the balance in smaller rural DHBs. The range of position titles and levels spanned from team leaders/first-level managers to middle managers (Robbins et al., 2000). A quarter of the participants had experience in professional leadership positions and some in conjunction with operational management positions. Most participants described having several clinical and management positions throughout their careers, driven by personal interests, ambition, or organisational need.

Occupational Therapy Competencies Employed in Health Service Management

All the participants identified occupational therapy competencies (skills, knowledge, and attitudes) that they perceived originated with their occupational therapy education, training, and clinical experience, which they had subsequently applied in their management positions, "*[I] worked in operational management positions, you know that the roles are quite similar, and the skills are completely transferrable*". Not all participants mentioned every competency identified in the OTBNZ competency document, but analysis supported the opinion that at least one participant described each competency domain.

To support the evident linkage between participants' competencies and the competencies required of registered occupational therapists, participant quotes are annotated with the number of the relevant competency and performance indicator in the Occupational Therapy Board of New Zealand's 2015 CRCPOT (OTBNZ, 2015a). For example, a participant's claim that "All is looked at in context, not in isolation" aligns with OTBNZ competency domain 1 (Applying occupational therapy knowledge, skills and values), and performance indicator for competency 1.1, which reads "you apply an occupational perspective to your practice" (p. 4). A copy of the OTBNZ framework is provided in Appendix D.

In this study, the competencies described were collated, with three overarching competency domains identified: Perspective, approach, and attitude; clinical and technical skills; and cultural and sector knowledge, of competencies employed in health service management. Table 1 provides a visual representation of the domains and competencies developed in this study.

Table 1

Occupational Therapy Competencies Employed

Competency domains	Sub-domain competencies: Skills, knowledge, attitudes
Perspective, Approach, and Attitude	Holistic Enable and enabling The "doing profession". Solution and action-orientated Informed and guided by theorists, models, and evidence
Clinical, Technical, and Operational Skills	Leadership, people, communication, and teamwork Assessment and planning: A systems approach Documentation, Implementation, and Reflection
Culture and Sector Knowledge	Bicultural New Zealand Health sector

Perspective, Approach, and Attitude

The competency domain of perspective, approach, and attitude encapsulates the underlying values and actions employed by occupational therapists when engaging with and supporting people and communities in their everyday activities. Occupational therapists bring to management a holistic perspective. "*All is looked at in context, not in isolation*" (OTBNZ 1.1, 1.10), considering social and cultural aspects and the individual's health and care needs. "*I think that occupational therapists are good at understanding that holistic approach. I refer to it as the two sides to every story, and you have to understand the other side*". In management, this holistic perspective supports a wider view of "*understanding the importance of the individual within the whole*" and using this perspective to recognise the many elements to be considered in delivering health services and "*look to where they can do things better*" (OTBNZ 1.4, 1.9, 1.11).

The desire to improve, enable, or re-able is a perspective and attitude occupational therapists contribute to health service management.

> *When you're working with patients, you look at different ways of them being able to do things, you analyse the patient's strengths and weakness, look at*

> *what they are trying to achieve, and you work with them to modify the activity to enable them to be able to achieve it*. (OTBNZ 1.11)

This desire to find ways to improve and develop was expressed by all participants and often referred to as competency in "*change management*"; for some, it was seen as one of the points of difference occupational therapists brought to the management table, "*I can see how we can do things better, how we can change*". This drive to enable and improve and to get things done is core to occupational therapy and management competencies, with interventions employed with a person, group, service, or community.

Being solution, action, and outcomes focused is a central core to the occupational therapy perspective and attitude. The ability to be motivated and proactive and "*get on and get the job done*" (OTBNZ 1.11) was identified. This focus on action can also be clearly linked to the systematic process of Plan, Do, Study Act (PDSA), a quality improvement approach developed by Demming (1950), that is used by occupational therapists (occupational therapy process). Experience of care delivery in the real world, finding solutions, and implementing and adjusting if required to complete the tasks, "*so, we are at this point now, [and] we need to get to that point, and how do we do that? That is just being flexible and adaptable, and we can make this work*" (OTBNZ 1.4, 1.11). This ability to develop and implement a plan was emphasised as central to the profession's practice. Occupational therapy is a profession which knows how to get things done, and uses methodical approaches; this aligns directly with the purpose of management.

The approach of occupational therapists is informed and updated by evidence and best practices, theories, and models. This method was claimed by many participants as guiding their approach to clinical interventions and to management perspectives and actions. Occupational therapy practice is informed by many models (Truskowski, 2017). Some identified Kielhofner's *Model of Human Occupation* as guiding their approach to care delivery and care provision. Others referred to using "*strengths-based model*", "*enabling practice*", "*psych rehabilitation approach*", "*emotional*

intelligence", "*supervision models*" (OTBNZ 1.7), and often in combination as the situation required. The application of evidence, models, and theories was also considered from a practical and applied perspective, with the warning of the risk of losing the holistic perspective: "*we do look for the evidence too much, to the point that you know you get stuck in the evidence without thinking outside of the square*". The inclusion of evidence and best practice, theories, and models in occupational therapy practice was seen as a strength, "*as occupational therapists we think in a different way, and I think those theories underpin our practice* (OTBNZ 1.7) *and I think that fits really nicely with working out what's important for people and helping them to achieve that*" (OTBNZ 1.4). The ability to apply relevant and appropriate models while keeping a focus on what is important demonstrates agility and flexibility in thinking, an approach that fits with the competencies required of managers.

In addition to understanding the models and perspectives of occupational therapy, occupational therapists have knowledge of models used within the health system and by other health professions. The ability to practice in conjunction with many different care delivery and practice models was seen as a strength occupational therapy brings to management: "*[We] sit on the fringe of and understand the medical model, this is a strength of knowledge and perspective*" (OTBNZ 1.8, 2.11, 3.5). As summarised by one participant, their knowledge of the models occupational therapists utilise, and those of other professions, supports the ability to "*navigate the medical model, but practice in an occupation-based way*". The knowledge of the models of care used within the health system, and the experience of successfully working within and alongside these models, adds to the understanding of how the health system operates that occupational therapists' bring to health service management.

Clinical, Technical, and Operational Skills

This competency domain captures the competencies occupational therapists hold and employ of occupational therapy tools techniques and skills, interpersonal relationships, and reflective practice. All participants identified clinical, technical, and operational competencies from their professional education and experience they employed in their management roles. Their competencies and level of knowledge varied depending

on each participant's areas of clinical expertise and experience. The identified occupational therapy competencies employed in management are grouped into: leadership, people, communication, and teamwork; systems approach to assessment planning and implementation; and documentation and reflection. These groups of skills, knowledge, and attitudes are interconnected and fundamental components of both occupational therapy and management practice.

Leadership, People, Communication, and Teamwork

Occupational therapists demonstrate collaborative leadership in their practice and interactions with clients and colleagues. Although leadership is not specified in the 2015 OTBNZ CRCPOT competency framework, the competencies of being people and outcomes focussed, collaborative, ethical, skilled in communication, and experienced in working in various clinical areas are present and support the development of leadership competencies. These were described by the participants; for example, "*the fundamental always comes back to building trust and connection and relationships with people, and to me that's fundamental in any leadership and management role*".

Central to the leadership experiences identified by participants was the satisfaction gained through leading the development of the services they managed. They described the ability to see what change is needed, to see "*how we can add value, how we can improve the service*". There was a desire to "*drive the service forward*", *to* grow, to improve and to inspire, and to "*lead by example*". In line with the purpose of management to make an organisation or service efficient and effective, participants described a drive to add value and make a difference; for some, this drive resulted in less interest in accepting or maintaining the status quo and being a "*caretaker manager*" and led them to look for new challenges and management roles.

Keeping the person at the centre of all activity is fundamental to occupational therapy and to leadership and management, "*I really do think that it comes back to looking at the whole person in the environment that they're in, understanding the importance of that particular occupation*" (OTBNZ 1.1, 1.9). From the management and leadership perspective, taking into consideration "*what's important to them in terms of*

occupations and that's not just about the work that they're employed to do, but what makes them happy" (OTBNZ 1.10).

Communication competencies are employed in occupational therapy interventions and in management and leadership. That was evident in the self-awareness and ability to intentionally change communication approaches and methods to facilitate communication and build rapport. "*I definitely change the way I approach different people, and I think that is definitely something I've learnt from my occupational therapy training*". The participants used the term "*therapeutic use of self*" to describe the conscious efforts to optimise their interactions with clients, "*if you link that back to occupational therapy, you're always having to flex your style with the client or patient and flex your professional behaviour to match; you know to keep the communication and the road going forwards*" (OTBNZ 1.3). The participants identified this flexibility, informed by self-awareness, in communication as a competency they used in their management positions and saw the ability to be agile in their communication approach as one of their strengths. Establishing effective communication aligns with the underlying enablement approach to their leadership and management.

In addition to communicating one-to-one, the application of occupational therapy is fundamentally based on being part of a team and working together to achieve the desired outcomes. The participants identified that the success of both occupational therapy and management lies in the importance of establishing a relationship with the people they are working with and using the ability to work alongside, facilitate, negotiate, engage, and develop solutions together (OTBNZ 1.5).

> *I think I've got strong relational skills and that's a lot about the learning that I've had as an occupational therapist around bringing people together* (OTBNZ 1.8), *being strengths-based* (OTBNZ 1.9*), looking at how people fit together, how we complement each other all of those, all that kind of group work systems skills that you kind of see people rather than processes*. (OTBNZ 1.16)

In the clinical setting, occupational therapists often work as part of a multi-disciplinary team. They are skilled in collaboration and cooperation required for them and the

team to succeed, "*I've spent my career working with different professions*". These competencies are also needed when leading interconnected and co-dependent services in DHBs; "*figuring out how we fit, and how we cross [over], and that also works in management*" (OTBNZ 1.3, 1.4). One participant described proactively using occupational therapy competencies to facilitate team cohesion, "*it's understanding that people [are] more than just workers and more than just colleagues. What …skills do we bring? Mediation. I think occupational therapists are really good at mediating*" (OTBNZ 1.3). Skills and confidence in leading teams and working in a team are core competencies occupational therapists bring to management roles. Health management is a collaborative and cooperative endeavour and cannot be achieved without the knowledge of how to work with a range of groups, perspectives, and competing priorities.

Assessment and Planning: A Systems Approach

"*Occupational therapists [have the] ability to solve complex problems and simultaneously juggle lots of complex issues to develop a patient-focused plan*".

The occupational therapy process guides the steps and sequencing of clinical intervention steps, which is applicable in many problem-solving situations. "*The occupational therapy* [process] *is an incredibly efficient* [way to think] *through the task*" (OTBNZ 1.6). Assessment using activity, task, and systems analysis was identified by all the participants as a core competency of occupational therapists "*whole activity analysis and synthesis, which is a core occupational therapy skill set, I see this as kind of at the core of a lot of things*" (OTBNZ 1.6). Participants utilised these competencies in management roles:

> *assessment as a common tool in being able to analyse what actually is going on, what activity, what are we are looking at, what is the actual core problem here and then looking to actually what potentially could some of the solutions be*. (OTBNZ 1.6, 1.7)

Many participants acknowledged they enjoyed the work of analysing systems and processes and applied this skill in every position they were in:

> *it was the kinesiology where we learnt to break things down to the smallest detail to understand what it was that needed to be changed to get to the long-term goal so* [used in] *my problem solving and my project planning [abilities].*

Confidence was expressed in the skills of analysis and synthesis of information as a basis for decision-making and its applicability in management.

Planning is aligned with the systems approach and action focus of occupational therapy and of operational management (OTBNZ 1.13, 1.14). "*[I used a] sort of goal planning and reviewing and Plan, Do, Study, Act Cycle*" and used these competencies "*for getting things [done], rather than just planning and thinking*". Aligned with the expertise in using PDSA models is the ability to synthesise information, "*you get bombarded with lots of information, think it all through and devise a plan*". One participant described an early experience as a clinician and the expectation as an occupational therapist that a plan was in place, "*[my] first ward round, and I got asked, 'What are your plans for this patient?'*". PDSA cycles are utilised in clinical and managerial activity to ensure quality and to learn from practice, and are not specific to occupational therapy, although occupational therapists perceive they are skilled in the application of this model and taking a person-centred and collaborative approach with this process. Planning is core to both the occupational therapy process and management. It ensures clarification of the path forward and the focus remains on the steps to the desired outcome.

Documenting, Implementing, and Reflecting

A direct link was made between the requirement for and importance of clinical notes to the documentation of plans and decisions taken in management positions. "*If you do not write it down, somebody else comes along, there is no history, and you have to start all over again. I learnt that from progress notes writing*" (OTBNZ 1.13, 1.14). Another described how the documentation was used in service planning: "*It was like my blueprint for how I wanted things to be going forward*". The documentation provides clarity for the way forward, as a reference for evaluation and review, and accountability for both clinical and managerial actions.

Essential competencies are involved in the ability to implement a plan. "*I am visionary and strategic, but I can operationalise, and that's something I've not come across in other people*" (OTBNZ 1.13, 1.14). The implementation of a care plan is often described as case management, and the competencies to manage care intervention are central to successful care outcomes. "*I think what occupational therapists probably underestimate is their case management*". The knowledge and skills involved in implementation and case management have been identified as competencies employed by occupational therapists in their practice of management.

Reflection on the past and understanding the potential impact of future decisions is both a clinical discipline and a managerial competency. Occupational therapists use supervision and reflection as part of the competency assurance, development, and continuous improvement process. Many participants continued to participate in this process when in leadership and management positions, and identified the value of these actions and the links back to occupational therapy: "*I use supervision, reflection, I do plan a lot, and again I think that comes from the occupational therapy work*" (OTBNZ 1.12, 3.6, 5.1, 5.7). The process of reflecting on actions and outcomes before making the next step is seen in the occupational therapy process, "*we [can] come up with another plan*" if this one is not fit for purpose, or the challenge has changed, or new challenges are to be faced. This constant process of reflecting, reassessing, and adjusting was linked strongly to occupational therapy, to activities within their management position, and was seen as a strength occupational therapists brought to their management.

Cultural and Sector Knowledge

This domain pulls together the competencies employed relating to cultural knowledge and responsibilities, the knowledge of the health sector and as one of many health professionals working together in the sector. Occupational therapists have competency in working in bicultural New Zealand and working within the cultural norms of New Zealand society. Participants discussed the competencies related to bicultural New Zealand and te ao Māori concepts of rangatiratanga (leadership philosophy) as they were applied in their management positions from two

perspectives. First, was the use of tikanga (Māori concept based on customary practices or principles) as the guidance for behaving in a culturally appropriate manner. This was demonstrated in the importance placed on welcoming and greeting and establishing safe and respectful relationships, "*whakawhanaungatanga is so crucial*" (OTBNZ 2.2, 2.8, 4.3, 4.5). Second, was the development of partnerships in the provision of healthcare, bringing other knowledge and experience and, thereby, acknowledging that health is based on more than medical interventions. "*We have a tripod leadership, so there's me, a clinical director, and we have a kaumatua, so we meet weekly, and we discuss the things that come up or the direction of the service*" (OTBNZ 2.1, 2.2, 2.4, 2.6, 2.8, 3.5, 3.6, 3.7, 3.9). The occupational therapy cultural knowledge and competencies were employed with individuals, groups, and services, both in clinical and managerial positions.

Sector knowledge was seen as both a personal and organisational advantage. One participant's feedback when applying for a new position was that their sector knowledge and prior experience as a clinician was an advantage, "*having been part of a clinical team is a strength. I know clinically what the right thing is to do*" (OTBNZ 1.7, 1.8, 1.14, 4.11). This knowledge was described as giving "*credence to their leadership roles within a service*" and inspired confidence in others that they understood the sector and, as a manager, they "*knew what they were doing*". This feedback supported the participant's belief that their occupational therapy knowledge and experience benefited the organisation. In contrast, one participant expressed concern that their clinical experience and limited sector knowledge would be seen as limiting their career options. However, background clinical experience and sector knowledge did not preclude transitioning into specialist leadership and management positions.

> *I had only ever worked clinically in mental health, so it was a real step for me to understand that… I didn't need to be clinically knowledgeable about an area to be able to manage an area effectively; I think that was another big learning for me.* (OTBNZ 4.4, 4.11)

Overall sector knowledge was experienced as contributing to the awareness of others and themselves of the competencies they brought to health service management. It also contributed to self-confidence and readiness for managerial roles.

In summary, the findings of this study supported the position that all participants, whether they had remained engaged with the profession or not, employed competencies that they developed through their professional education and experience in their roles as health service managers. Analysis indicated that a wide range of competencies were employed across the career steps and positions, and the participants were aware they were employing occupational therapy competencies in their practice as managers and leaders. The ability to employ existing competencies supports those occupational therapy competencies that are transferable and adaptable, and that the individuals with their knowledge of the health sector understand when this is appropriate, and when existing competencies require further development and new ones are needed.

Competencies Least Prepared For

"*When I came into the role, I thought I did not have skills, [I] reflected on the skills I did have projects, supervision, supporting others, so though I had those skills, I didn't have management skills. I had to learn them*".

This section outlines the findings from the data analysis of the secondary research question: "*What were the competencies required in their management role that participants were least prepared for?*" This question sought to understand if participants identified gaps in their competencies; and, if so, what were these, and when were they identified? After identifying competency gaps, consideration was given to the actions taken to address these gaps. In line with the previous section, the participant quotes utilised as examples of the competencies employed are referenced to the ACHSM (2016) Master Health Service Management Competency Framework.

In response to questioning and probing their responses, all the participants identified management competencies they were least prepared for from their occupational

therapy education and experience and needed to develop: "*I recognised I needed a tool kit of different skills*". Further experience in health service management resulted in increased awareness of the actual and potential range and depth of knowledge and skills required; "*The basic [competencies] that you have in your first few years as a manager, and then what's the next level up, because you are exposed to different things at different points [in your career]*". As a result, there was an understanding that competency development would be an ongoing process throughout the career journey because the competencies they required changed in response to the diversity of health service management positions and the ever-changing demands within the health sector.

Although each participant's career journey was unique, they identified many similarities in the competencies they were least prepared for. The analysis of data identified four competency domains: leadership, business and administration, managing within the healthcare environment, and developing self-confidence and resilience. These domains and accompanying competencies are presented in Table 2.

Table 2

Competencies Least Prepared For

Competency domains	**Sub-domain competencies: Skills, knowledge, and attitudes**
Leadership	Understanding team dynamics Understanding self Developing leadership approaches
Business and Administration	Human resource management Service management and development Business and communication skills
Managing within the Healthcare Environment	Managing 24/7 services Managing and Leading regional and national services.
Building Self-Confidence and Resilience	Working outside comfort zone Support networks

Leadership

This competency domain encapsulates the competencies required for team leadership, understanding of self as a leader, and of developing leadership approaches. Although the participants in this study had confidence in their leadership (ACHSM Domain 1) for therapeutic care and case management, which they subsequently employed in their management career, a lack of advanced leadership knowledge and skills required to lead a team, service, or project was identified. This section describes three competency performance areas: understanding the dynamics and responsibilities of team leadership, understanding of self as a leader, and developing leadership approaches appropriate to the situation and environment.

The responsibility and competencies required for leading and managing a team were experienced as being a step up from the leadership skills utilised in the coordination of clinical care and case management. Participants identified that in the step to leadership, they needed to develop a more in-depth understanding of "*people management*" (ACHSM 1.1, 3.3), such as team dynamics and expertise in how people are approached and respond to being led and managed. For example, "*[learning] the psychology of people and groups… that would have been really useful*" (ACHSM 4.1). For those leading changes in service structures, the ability to "*understand how people and staff see things from a different perspective, what is in it for them, why should they change?*" (ACHSM 1.1, 4.1, 4.3), was highlighted as a required skill. Associated with the importance of understanding people and teams was developing an understanding of oneself and the attitudes and understandings that influenced leadership approaches.

An understanding of how personality impacts interactions and behaviours as a leader was described as a competency gap, and many participated in formal leadership education and training. Some used psychological models to understand the relationship between personality types and leadership: "*I have consciously developed EQ* [Emotional Intelligence]; *that was the one thing I had to work on as a leader*" (ACHSM 1.1). Others had experience with the "*Myers* Briggs [The Myers-Briggs Type Indicator ®, a personality instrument]". The emphasis placed on this knowledge was demonstrated in the comment, "*I would have done that EQ work sooner*" (ACHSM 5.2).

These steps to understand self and others highlight the importance of such knowledge in the desire to be successful as a leader, to develop further understanding of leadership models, and the impact of leadership approaches.

In addition to using models to develop an understanding of personality and leadership, developing leadership skills and approaches appropriate to the situation was described as an iterative informal process through observation, trial and error, feedback, and reflection. Some observed, "*I have taken the bits from leaders that seem to work*". Others have built on their own experiences of how they were led. "*My management and leadership style has been informed by experiences… good and bad*" (ACHSM 5.2, 5.3). Some talked about testing their leadership approaches and described developing a style; one participant described the deliberate change in their leadership approach and unsuccessfully applied a different approach. "*I thought a leader should be authoritarian, and that just didn't work*". Experience and reflection informed managers of effective leadership styles, "a*s a junior …there would be a lot of leadership that was a dictatorship rather than any kind of partnership*", and "*that's been the thing in the back of my mind whenever I've led a team, how do we do this together and be part of one team*" (ACHSM 1.1). The practice of leadership is inherently individual and develops over time in response to education and various experiences and situations. Overall, the analysis suggested that all participants partook in leadership competency development.

Business and Administration Competencies

This domain describes the business and administration competencies least prepared for including human resource management, service management and development, and communication. A common experience among the participants was the need to develop business and administration competencies and to develop further existing competencies to have a business focus (ACHSM Domain 2, 3, 4). Analysis of the career journey highlighted the sequencing of the required competency development; some of the competency gaps needed to be addressed immediately, others had less urgency, and others were addressed when required over the career journey.

Not unexpectedly, with the step up to managing teams, human resource management was identified as a competency gap to be addressed early in the management career. One example was the "*staff left before I came, so we were very short-staffed*" (ACHSM 3.3). The manager identified "*there was work that I had to do to up-skill*", such as "*how to write a job description*" (ACHSM 4.2), and "*I had much to learn in the legal skills of managing human resources*". In addressing knowledge gaps, most of the participants worked alongside the organisational specialists. In this example, they "*worked very closely with the recruitment team*" (ACHSM 2.1, 2.2, 3.3, 4.1) to address the recruitment and employment needs; and, because of working with the subject matter expert, developed new understanding and competencies required for human resource management.

Others described the importance of understanding and managing day-to-day service delivery, budgeting, and presenting financial reports, "*you need to do a financial orientation*", and legal "*understanding of contract law*" (ACHSM 2.1. 4,3.2, 3.9). Again, collaboration with the subject matter experts was emphasised, "*I sit with the finance manager, and he'll help me*" (ACHSM 4.1). Occupational therapists' competencies in teamwork and collaboration can be considered to contribute to this collaboration with the organisation's specialist teams, and contribute to the identification of competency gaps, subject matter experts, and learning opportunities.

The knowledge of national strategies and related legislation was an area that many identified as a knowledge gap that needed to be addressed. This information was described on a need-to-know basis across careers, compared to gaining prior knowledge of the responsibilities and accountability of public service in the health sector. For example, "*I've no specific training with the new [health] strategies*", and "*[there] was a huge amount of work that I had to do to up-skill about roles and requirements under the mental health law. It was quite different to what I had [done previously]"* (ACHSM 2.1). Furthermore, a lack of knowledge was identified relating to the State Sector Act 1988 (Public Service Act 2020). These Acts outline the responsibilities of public servants and of DHBs for ensuring managers are aware of the requirements of this legislation.

The knowledge and skills required for the ongoing maintenance and development of services were also identified. An example is the writing and presentation of business plans, including applications for additional funding. "*I had to write a business case for a facilities development, …trying to work alongside people to learn those skills because it's a real skill to write a board paper*" (ACHSM 3.5). In addition to writing plans, was the ability to manage and assign human, physical, and financial resources. "*I did not understand strategic planning, the use of capital, how you make those sorts of fundamental decisions about the allocation of resources and managing the difficult decisions*" (ACHSM 3.5). These are higher-level competencies required by managers in senior roles. In addition to developing service plans are the competencies required to implement organisational directives. "*I was basically told there was not an option*" (ACHSM 1.1, 2.1, 5.2) said one participant when questioning a directive, and who then had the responsibility to translate and communicate the plans and impacts to the services they manage while holding the organisation's position and decisions. For most, the level and complexity of this work required additional education and training.

The participants described their confidence in the competencies they held in establishing rapport, and verbal and written communication. However, they also identified that further development was required of these communication competencies; for example, in relation to producing and presenting formal planning documents. This was a step up from occupational therapy communication skills to those required in a business setting. "*Marketing, I understood it was about communication; I didn't necessarily have the communication skills in terms of selling the vision",* and *"my verbal skills were good, but translating that into a message that you had to get across in a nonverbal way wasn't always so good*" (ACHSM 3.5, 4.1, 4.2). The importance of further developing the communication competencies needed to support the planning of a long-term vision for a service or organisation was identified by participants who had held senior roles in the DHBs or had experience in change management and projects.

In summary, the business and administrative competencies least prepared for were diverse, from core administrative tasks and roles to financial, legal, human resource

and contract knowledge, and on to planning and communication. Some of these were technical knowledge and needed early in the transition into management. Others were identified as required in more senior positions and necessitated an understanding of the context, as well as advanced competencies in planning, communication, and collaboration. It was noted that although the manager held the operational responsibility for these business and administration tasks, the structure of organisational support services, such as human resources, finance, and legal, required collaboration with subject matter expertise to achieve the tasks. There is also a skill in understanding that as a manager, you cannot know it all, "*I know where my strengths and gaps are… so I need to make sure I've got people around me who are good at that*" (ACHSM 5.3). There is a competency required to delegate to and trust the subject matter experts while continuing to hold the operational responsibility.

Managing Within the Health Environment

Within the competency domain of managing within the health environment, two competency groupings were developed to highlight the diversity and wide span of management responsibilities and, therefore, the operational management competencies required. These are the management of 24/7 services and the management and leadership of regional and national services.

Managing 24/7 Services

Managers within a DHB are often required to undertake organisation-wide management responsibilities. The competencies required for these roles include knowing the systems and processes of the workflow and operational activity of the DHB. In addition, developing awareness that managers did not control all the resources required to be successful, and that many players within and outside the DHB and health sector would need to collaborate and cooperate to succeed was necessary.

For some managers, their roles include the requirements to provide management outside of business hours and for incident and event management. Examples participants described were on-call management responsibilities for patient flow, "*working with the duty managers and having to manage [patient] flow, that was a*

really big learning curve for me", and critical incident management, "*I needed to understand more about disasters, I did Serious Incident Management (SIMs) training*" (ACHSM 5.2). Another example is the management of workforce strikes, *"I cut my teeth on unionised dynamics*", "*We had strikes during that time, so that was another big learning thing for me, for being involved in incident control and incident management teams during strikes*" (ACHSM 1.1, 1.2, 3.1, 4.1, 4.3). In addition to knowing the DHB systems and processes, the importance of organisational connectedness and interdependence was identified, "*I think that was a biggie about knowing the process for everything and the connections of who you need to contact about this and that*".

These examples of management actions required a high level of competency, including knowledge of legislation and standard operational processes, DHB structures systems, communication and negotiation skills, interconnections and building trusting relationships, and knowing how to hold one's nerve under pressure. This knowledge was gained over time with the support of mentors, role models, colleagues, line managers, internal experts, and internal and external courses. The management and leading of interventions provided real-time and real-life experiential learning opportunities, often in urgent and unpredictable situations, and were described by participants as a "*big learning curve*".

Managing and Leading Regional and National Services

The distribution of clinical services and resources across New Zealand, including specialist clinical services, requires some managers to hold responsibility for regional and national services, and for DHB managers to work together to provide these services. "*I am the link nationally and internationally, and I have relationships that I can call on and do call on in the middle of the night*" (ACHSM 4.1). The key aspect here is the ability to develop working relationships outside hierarchical management structures and across organisations, and participants noted that these relationships developed over time. The competencies identified included the ability to create "*trust and partnership*" and thereby to "*build personal relationships [so] you can get stuff done really quickly*" (ACHSM 4.1). The role requirements make organisation and sector

knowledge, and the ability to connect and collaborate, an essential competency. As regional and national service, there is a need to look beyond the immediate and the services managed to the needs of the service beyond that of the individual DHB. The ability to take a holistic perspective and consider the bigger picture, also described as boundary-spanning (Aungst et al., 2012), is a core competency of occupational therapy (OTBNZ 1.1) and management (ACHSM 5.4), and essential for those managing regional and national services.

Another area of competencies to be developed was when there was a need to step up and take a leadership role in the planning for regional and national services in conjunction with the Ministry of Health. This example involved working to develop a strategy document to inform the planning for a national service and identifying as the service provider "*we needed to drive the narrative*" (ACHSM 5.1) and to get buy-in from the sector. This participant described developing competency in communicating with their manager and colleagues and developing confidence to undertake this task. "*It took [time] to get everybody's thoughts and to have a plan that took into account complexity*" (ACHSM 3.5, 4.1), and "*some of those skill sets kept me in good stead because I [know I] can navigate through that, and I learnt about the politics*" (ACHSM 2.1, 4.1, 4.2, 4.3). The awareness of the internal and external politics and requirements of organisations can be seen as a higher-level competency, as they are based on the ability to work with and understand the hierarchy within the organisation, taking into consideration service provision, strategies, and organisational priorities, and proactively taking responsibility to develop these services. This is a complex integration of operational and sector knowledge, people, and communication competence, and stepping up to these challenges requires knowledge, skill, self-confidence, and resilience.

Building Self-Confidence and Resilience

The fourth domain, within competencies least prepared for, captures the competencies required that support confidence and resilience. Many described the feeling of being underprepared and overwhelmed at times in their managerial careers. There were experiences of working outside of their comfort zones and learning to

manage events and emotions, while developing awareness of the importance of support networks to sustain and nurture health service managers in a complex and ever-changing environment.

Working Outside Their Comfort Zone

The feeling of being out of their depth, lonely, doubting abilities, feeling like a fraud "*My imposter syndrome is well embedded*", and not as competent as others perceive you to be, was often experienced in the early stages of management careers: "*the management role pushed me out of my comfort zone*". These emotions were also experienced further on when confronting new challenges "*You are in an unpredictable [environment]*". However, the managers described that they "*became more confident over time*" as their competence developed.

Another challenge to self-confidence and resilience was holding the responsibility for resource management, care delivery, and working within resource constraints. DHBs are large and complex organisations with many competing priorities within and between DHBs and, at times, with the Ministry of Health. The importance of understanding and being able to navigate internal and external politics was identified by many participants. One example of internal politics is described as the tension between maintaining services, meeting targets, and demonstrating the ability to work within the budget. Sometimes, these are "*no-win situations because there's not enough money in the system*". One participant described developing strategies to manage this situation "*because I can't do [both] these two things*" (ACHSM 4.3, 5.4); they maintained their manager's confidence by demonstrating their understanding of the challenges and the ability to lead the service. Successfully developing operational strategies to work within these expectations are essential management competencies.

A small number of participants raised the experience of burnout and stress and the impact on their career and career decisions; "*I think for me, looking after yourself has always been problematic because I veer more towards 100% commitment and did burn myself out*". Another reflected on a missed opportunity for support at a time of stress, "*on reflection, I should have sought formal coaching and counselling in my time as*

manager". Both responses convey the emotional impact of managing in a complex and demanding environment. What was also noted was the impact of work pressures on self-confidence and resilience, which often becomes evident after the effects are experienced. This was a very individual experience that occurred at times across a career.

The competencies required were to develop and implement strategies to identify workplace stressors and manage the stress responses. For example, strategies were developed that "*challenged the inner negative voice with positive examples of success*", which included acknowledging and reflecting that "*I was exposed to tricky challenges, and I found I could do it, and [that] gave me confidence*". Another reflection that supported their growing self-confidence was developing "*the skill to hold my nerve, to be able to operate in the shades of grey and hold multiple tensions and conflicting views*" (ACHSM 5.3). Finally, support networks were highlighted as important to creating an environment to sustain and bolster self-confidence, when required, by providing peer support and a safe environment to express and discuss concerns.

Developing Support Networks

The final competency least prepared for is recognising the importance of, and then developing, support networks. These networks met the need for professional alliances within the workplace, and for a network of trusted colleagues outside of the work environment to talk through events and challenges. "*I have always looked for whom I can connect with and have a bit of safe space to say, 'Oh, I'm not quite sure how to do this'*" or "*I am really struggling with this bit*" (ACHSM 5.2, 5.3). These support networks provided an opportunity to reflect and consider another perspective; thus, supporting the identification of strengths and gaps in performance and competencies and providing awareness of development needs.

In summary, analysis of the responses to this research question led to a broad view of the competencies participants felt least prepared for. Their responses to this question included competencies required in the initial transition into health service

management, and which would not be included in under-graduate training. In addition, competencies least prepared for were identified by participants as those required for a specific role and across the career journey. Another set of responses to the question of those competencies least prepared for were those concerning the development of intangible competencies such as self-confidence, resilience, and the importance of support networks. The findings identified many similarities across the participants of the competencies they were least prepared for. As expected, the competency gaps identified were initially in the areas of people management, administration and business skills. The more complex competencies relating to internal politics, working in complex environments, self-confidence, resilience, and self-care became more evident as their careers progressed. These insights are valuable for those choosing this career option, and those who hold the responsibility to support their competency development.

The next chapter presents the findings from the abductive analysis (Patton, 2015) to match the competencies employed and least prepared for, described above, with the existing industry competency frameworks. This analysis is followed by the findings from analysis of the collateral data (position descriptions, and individual performance review and performance planning documents) provided by participants.

Chapter 6. Findings from Abductive Analysis

This chapter summarises the findings from two analytical processes. The first matched claims made by the participants of the competencies employed and least prepared for with two existing published competency frameworks to confirm these were indeed agreed professional and management competencies. The second analytical process used the collateral data, collected from the participants, to provide subjective and objective knowledge not generated by me and some triangulation of primary data (Hunt, 2009; Thorne, 2016).

Abductive Analysis using OTBNZ and ACHSM Competency Frameworks

Following the inductive analysis, a three-step abductive analysis process was applied, utilising existing competency frameworks to ascertain a match between those and the competencies participants claimed as employed or required. The first step matched the occupational therapy competencies that participants identified they employed with recognised professional competencies, as delineated in the 2015 OTBNZ competency framework. The second step used the 2016 ACHSM competency framework to confirm if these occupational therapy competencies employed were also recognised management competencies. The third abductive step used the 2016 ACHSM framework to match competencies identified as least prepared for with recognised management competencies.

Alignment with OTBNZ Competency Framework

In conducting the analysis, some interpretation was required to match the competencies employed to the domains and performance indicators in the 2015 OTBNZ competency framework, as terminology and descriptors varied between participants. The OTBNZ competency framework performance indicators are clinically focussed, with the use of the term client as the recipient of the intervention. Therefore, particularly in Domain 1, I applied a broader interpretation of the word

'client' as also referring to colleagues, team members, staff within the management position, or members of the organisation. This decision is in line with the OTBNZ including management within the general scope of practice.

Competencies identified by participants as being employed in their health service management roles aligned with all five domains of the OTBNZ (2015a) CRCPOT, and with most of the performance indicators. Those performance indicators not matched, were the requirements for working within occupational therapy professional boundaries (OTBNZ 1.23) and contributing to occupational therapy research (OTBNZ 5.3).

This close alignment between the competencies identified and the OTBNZ competency framework led to further reflection on whether I was 'forcing' a match. Occupational therapy provides for interventions across all age groups and many therapeutic milieus. Therefore, it is appropriate that the competency framework performance indicators are structured to be flexible to meet the competency requirements of these many environments, including those positions that are more advisory, managerial, or educational. The performance indicators within competency domains that were not mentioned by participants pertained to clinical interventions and specific knowledge, although these may have been identified through more directed questions when collecting the data.

Alignment with Occupational Therapy Competencies Employed and ACHSM Competency Framework

The next abductive step was employing the ACHSM (2016) competency framework Master Health Service Management Competency Framework to ascertain if there was a match with the occupational therapy competencies participants claimed to employ in management; thereby, confirming they are recognised management competencies. The 2016 ACHSM competency framework consists of five competency domains: leadership, health and healthcare environment, business skills, communication and relationship management, and professional and social responsibility.

The findings of this analytical step confirmed numerous matches of the occupational therapy competencies participants identified they employed with those in the ACHSM competency domains of leadership, health and healthcare environment, communication and relationship management, and professional and social responsibility, supporting the position these are competencies employed within the practice of occupational therapy and in health service management. In addition, analysis found there was minimal alignment with the occupational therapy competencies participants employed in health service management roles and the ACHSM Domain 3 business skills. ACHSM domain 3 contains competency statement categories covering: financial and resources, IT, human resources, risk and clinical governance, and planning and marketing. This result is not unexpected and matched with the business competencies identified by participants as least prepared for and described in the following section.

Alignment with ACHSM Competencies Least Prepared For

The third abductive step used the 2016 ACHSM framework to identify if there is a match between the competencies identified as least prepared for with recognised management competencies. The inductive analysis identified competency domains of leadership, business and administration, knowledge of the healthcare sector, and self-confidence and resilience as competencies least prepared for. In this abductive step, these domains and identified skills, knowledge, and attitudes matched elements contained in all five ACHSM competency domains and sub-domains, with the business skills domain receiving the greatest match of areas identified for competency development. This analytic step supports the position these competency areas identified as least prepared for match the recognised competencies required of health service managers.

In summary, occupational therapy competencies described as employed in management roles matched OTBNZ and ACHSM competency frameworks. Additionally, the competencies identified as least prepared for also matched the ACHSM framework. These analytic steps highlighted some overlap between the competencies required of occupational therapists and health service managers competency domains

of OTBNZ and ACHSM. An example is that the ACHSM competency sub-domains of relationship management (4.1), communication skills (4.2), and conflict and problem management (4.3), align with the OTBNZ competency performance indicators of building partnership and collaborating (OTBNZ domains 1 & 3). Although there is overlap in the competency domains, sub-domains, competency statements (ACHSM), competency domains and performance indicators (OTBNZ), these frameworks are for different roles within the health workforce; therefore, the focus of the competencies and the required performance vary.

This abductive analytical process has developed new knowledge of the match between what has been claimed by participants and recognised competencies. This process also developed new knowledge of competency overlaps with occupational therapy and health service management, which supports the initial positions of this study that health professionals have discipline-specific knowledge that can be employed in health service management.

Analysis of Collateral Data

The collateral data collected at the time of the interviews were the position descriptions and their individual performance review and performance development plans. Most participants provided one or both documents.

Position Descriptions

The position descriptions were reviewed to identify competencies required for the positions and to cross reference with the data and findings of competencies employed and required. As advised by Hunt (2009) and (Thorne, 2016), these documents provided objective data with which to triangulate the subjective data from the participants. The position descriptions varied in age, format, and level of detail.

This abductive analysis of the position descriptions supported the participants' portrayal of competencies required for the positions they held, including those they employed from their occupational therapy education and those they identified they were least prepared for. Competencies that aligned closely with OTBNZ competencies

included leadership, systems thinking, coaching, collaborative approach, planning, and implementing, further reinforcing the claim that occupational therapy education positions therapists for career transition into management.

Some competencies identified in the position descriptions aligned with those identified by participants as least prepared for. These competency gaps included strategic planning, financial and legal knowledge, organisational change management, political acumen, project management, human resource management, and advanced communication and presentation skills. Competencies that were less evident or missing in the position description and which are fundamental to service provision were the knowledge of statutes, national policies, and contracts. Finally, there was no indication that the position descriptions were based on a competency framework or regularly reviewed and updated.

Individual Performance Plans and Performance Development

The review and analysis of these documents were limited by the small number provided by the participants. Some did not have current plans as they were in new roles or secondments, or the plans were service-focused and did not contain individual performance development activity. The templates utilised by the DHBs varied in format, and not all contained sections for performance feedback or future development, although those with these sections were completed by the participant and their manager.

Analysis of the documents supported the participants' reports that these plans were primarily focused on service development and the tasks to be completed over the year. Some included development planning for foundational organisational operational competencies such as emergency response, fire, privacy, and occupational health and safety training. The little development planning for individuals included self-care for a new manager in a senior role, another was enrolled in an external course on leadership, and a third had a non-specific action to identify development opportunities they required. With little data, it was not feasible to match the planned development to a competency assessment or framework. In summary, these plans were limited in

their competency feedback and development actions for the individual manager were primarily focussed on actions required for service development. Of note, the plans of participants who described a positive approach to this annual process contained more detail of the developmental activities.

The following chapter presents the next two significant findings of this study. The first is the contribution and influence of the career journey on being supported and encouraged towards health service management as a career option. The second is the experience of ongoing competency development, including the processes for performance feedback, assessment, and development planning.

Chapter 7. Findings: Career Journey and Competency Development

The Career Journey

The theme of the career journey arose from the many career pathways described; the impact of the workplace environment, opportunities, guidance, and support experienced on competencies employed and those needed to be developed, and on career decisions. The data analysis identified four sub-themes: an enabling workplace environment; the importance of being encouraged, supported, and stretched; enablers and barriers; and professional registration. Overall, participants described a workplace environment that facilitated ongoing competency development and career aspirations beyond that of a clinician.

An Enabling Workplace Environment

"*A varied career path set me up with skills and perspective. [That I] carried forward into leadership and management roles*".

The opportunities available within occupational therapy services and departments were identified as contributing to the development of leadership and management competencies and confidence. The benefit of progressing through the occupational therapy service structure from junior to senior positions were identified. "*I had taken on more senior clinical roles and had started to provide some form of supervision to junior staff*". Also identified was the knowledge and experience gained working in various clinical areas, "*I had done a lot of senior rotations… and recognised that I thrived on that change and continued learning*". Overall, departmental structure and support and the encouragement of colleagues resulted in the development of clinical competence, self-confidence, and organisational understanding, and contributed to their confidence to consider management as a career option.

The Importance of Being Encouraged, Supported, and Stretched

[Confidence] "*Where did I get it? I guess from my experience, the route I travelled, and I had been in tricky, challenging roles and thought, this is OK, I can do this*".

Being encouraged, supported, and offered opportunities to stretch and grow professionally and personally was a consistent theme in the career journey and commenced early in careers. Mentorship by line managers and senior clinicians (e.g., formal mentoring) supported a learning environment, as did being provided with encouragement and opportunities such as secondments or projects as a learning opportunity. In addition, an informal mentoring relationship was often developed where the role models were identified by participants, along with the development of peer support groups which supported further growth in competencies and confidence. This support and encouragement were focussed on the individual and tailored to their interests and abilities and then matched with the needs of the service and organisation.

A common experience, early in clinical career, was the direct line manager who "*saw potential in me*" to be stretched, to develop skills, knowledge, and attitudes that would grow into leadership and management competencies. "*[My manager] said to me right from the get-go, you're going to be my replacement, so I'm going to start training [you]*". This commitment resulted in being "*connected with opportunities when they came up*". Overall, the experience of being encouraged, supported, and stretched was positive, with one participant recalling "*[the manager] to be incredibly good at just getting that stretch right, so would not throw me in at the deep end, just stretch it enough*".

Another example of a line manager's contribution of support and guidance was a time in one participant's career when "*[my manager] recognised that I was stagnating where I was*" and looked to support further growth by supporting stretch activity "*and wanted to encourage me to work outside my comfort zone*". As a result, the participant gained an understanding of their capacity for and enjoyment of growth and development. Providing the right level of encouragement, support, and stretch

enabled participants to feel safe, respected, and trusted; and, in turn, it encouraged participation and the development of competence.

The value of mentoring was identified as being key in the development of skills, knowledge, and self-confidence, particularly in the early stages of their occupational therapy, leadership, and management careers. Some recognised the value and impact in retrospect, after gaining more managerial experience, and this experience and understanding of the value of mentoring influenced their support for new managers. "*Now I see it, but I did not at the time, …she was a good mentor*". Some identified that they so valued the mentoring they received that they have actively provided mentorship to the next generation of leaders and managers. "*I am cascading the learning. We have recruited a senior who is quite inexperienced in leadership, …starting to learn leadership skills, and it's giving the challenges but also making sure that I'm there to listen*". The decision to provide mentoring to the next generation of managers supports the value placed on mentoring as a key element in building a learning and supportive environment in the development of management competencies in the health sector.

The support of line management and mentors was not the experience of all participants. One participant, who was new to a position and did not receive support and guidance, described being overwhelmed and not seeing a pathway to move towards developing leadership and management competencies.

> *I've had no orientation to this role. I've got nobody to tell me how to do it or who to go to …there's a whole load of things I don't know how to do, and I don't necessarily have the networks to help me do that.*

Managers who did not receive their manager's support and mentoring described how this gap had impacted their ability to quickly develop the competencies required for the role, which initially had a negative impact on their confidence and perception of their performance.

In situations where there was a gap in mentoring availability, two participants described the development of a peer support network, also known as a community of interest, that included peer supervision, mentoring, and opportunities for managers to share the competencies across the group. They reported, "*seasoned managers buddy up and teach, and so that group is gelled well, there's a really nice vibe in that group; they'll coach and mentor each other*". Peer support groups may not be a substitute for individual mentoring and coaching; however, in the absence of an alternative and to meet an identified need, did provide some support and guidance for competency development within the workplace.

Secondments and involvement in projects (often referred to as stretch assignments) were common opportunities offered to participants. Secondments and projects are temporary role assignments and provide an opportunity to try out the role, understand what skills and knowledge are required, develop new skills, confidence, and understanding, and decide if this is a career step individuals want to make. The reasons for them being offered spanned from providing opportunities for new learning and competency development, service leadership gaps, establishing new roles, pilot projects, and a response to major events. Many had this first opportunity within the occupational therapy departmental structure and were encouraged to take these opportunities to prepare to take over from their clinical manager as a first step into leadership and management, "*my manager had a secondment for a year, and I stepped into the acting role, so for a year, I was acting Head of Occupational Therapy role*". Other opportunities for secondment were outside any clinical or current experience, "*I got seconded to do a management role to cover parental leave. That was an incredibly eye-opening experience*". Another experience was stepping up into a more senior role, which resulted in a permanent career step, "*I did General Manager [role] …for a year as a secondment and then got a permanent role*". Some secondments were responses to catastrophic events, including the COVID-19 pandemic, and these provided exceptional learning environments for growth in the development of management competencies, "*I was asked, how would you like to come and set up a management team?*".

A common participant reflection on the experience of secondment or stretch assignments was the extent and value of the learning gained during the time, "*Oh my goodness that was learning, that was a whole new learning experience*". Another participant said, "*It was an interesting change because I was at the table, and it was my responsibility, and I think I probably spent the first 3-months wide-eyed*". These experiences demonstrate the value of secondments as an effective means of competency development in the complex and fast-moving health sector, where there are many variables in roles and responsibilities to understand and work with. Secondments and special projects provided learning experiences, as participants required competencies beyond the ones they already had from their professional education. These opportunities and the confidence gained were often the trigger for the next career step and were more often self-directed, but not always. Secondments and being requested to pick up management roles were most often serendipitous opportunities compared to self-directed and planned career direction and steps. Nevertheless, they were experienced as an important part of the career journey and contributed to competency development within the workplace learning environment.

The next sub-theme of the importance of being encouraged, supported, and stretched was the transition to self-selection of role models, mentors, and support groups. For some, the manager was identified as a role model to observe and learn from as they identified and developed management competencies. "*I've sort of taken the bits from [my manager] that seem to work*". An example was a manager role-modelling interpersonal communication to develop alliances and influence. "*My boss would disappear, and then I'd sort of see her in the canteen having coffee, and it took me a while to work out the people she was having coffee with were the influencers*". With experience, the participants understood their competency development and support needs. They became more self-directing rather than always or necessarily tied to their line manager, "*I had a connection to... number of people I could learn from, so it was the Director of Security and the Director of Nursing*". Another example was self-identifying mentors outside the organisation who would support their competency development needs. "*[My manager] suggested a particular coach. I didn't feel that*

coach was going to be the right person for me". In this situation, a mentor outside the health field was engaged, "*I have an external mentor who comes from a [non-health] background*". Another example was recognising the importance of continual support, growth, and development as a manager, reinforcing decisions for the career-long maintenance of a group of mentors and trusted advisors. The supportive and trusting relationships were valued as their career progressed into more senior roles. Some of these relations were career-long, "*I am still in contact now, like 25 years later, really a mentor for me and pushing me to try different things*"*.* Others described the maturing of some mentorship relationships to that of a trusted friend and colleague.

> *I've got a couple of mentors that are now friends that I check in with. Just make sure that you pull around you some people whom you trust, who inspire you, whom you feel open to being quite raw with and open to change and development.*

In summary, the support and guidance provided early in their careers was highly valued by the participants and was seen as core to developing competencies for health service management. It is to be noted that competency development supported by a mentor, secondments, role models, and peer support is a person-specific process and, therefore, is influenced by interpersonal relationships, the opportunities available, and the voluntary nature of mentoring relationships. Central to the success of this experience is the openness to be mentored, encouraged, and stretched, and use the opportunities that arise to enable and enact this growth. Inherently, the learnings and the benefits of the mentorship have elements of chance based on the availability, skill and knowledge of mentors, the opportunities offered and accepted, and the organisation's commitment and support for development opportunities for aspiring, and new managers.

Career Journey: The Enablers and Barriers

The final theme within the career journey were enablers and barriers that impacted a decision to step up to the challenges, and the variety of career directions, steps, and the number of role changes described. The drive to make a difference and the interest

in stretching and testing what could be achieved were noted, as well as the international opportunities open for employment as a manager. The deliberate actions to self-direct their career direction and the development of competencies were seen with a clearer understanding of areas of interest and the opportunities available. Also noted was the self-confidence to make their own career decisions to see if they could successfully achieve the next career step. "*I actually want to try doing something on my own bat, rather than feeling like I have been mentored and supported and grown up in a service*".

All the participants of this study had management experience in more than one leadership and management role, some of which were external to New Zealand. The sub-themes presented in this section include the thirst for new workplace experiences and skills development; the belief that they could make a difference to the system by stepping into management positions; family and parenting responsibilities; and the impact of holding positions with a high level of responsibility on career decisions. Overall, the study revealed a positive mindset and ambition to test what they could achieve, and to make a difference, and that many factors influenced the decisions taken across career journeys.

A common thread for many participants in their management career was that their early management steps were in an area of clinical interest and expertise, which often carried on through their career: "*I realised that this is the group that I like to work with*". Having clinical and leadership experience, competence, and confidence led to success in gaining more senior management roles, "*I then managed to break into quite senior roles through that experience*".

The desire for new work experiences and skills development to support competency development and, therefore, career options led some to explore what was available outside of the country or the health sector. "*I went to the UK and specifically wanted to look for work that enabled me to have a more direct line management role*". These additional competencies and work experience could then be utilised in management roles. "*I had roles in the private NGO sector*". "*I worked… doing medico-legal and rehab*

programmes. The insurance world was way outside my comfort zone… I learned a lot from it". The opportunities for personal growth, career experiences, and contributing to the health sector were highlighted and celebrated. "*I was so energised by all the new learning and excitement, and what we were doing was creative, and it was exciting*".

An interesting finding for me was participants' self-awareness that they were not a "*maintenance manager*" and *"liked a challenge*", which drove the career moves beyond "*day-to-day management*" to more "*strategic roles*". An example was the desire for new challenges and career steps following experiences gained from secondments, *"I just couldn't settle back [after a secondment] in that [previous] role after being in that real kind of fast-paced [project] environment… I just kind of felt like I had been there and needed something new*". The challenge of developing and improving services was an attraction for many. The maintenance of services as the status quo was not challenging enough and contributed to the decision on the next career step. The advice expressed was, "*We should go for those roles; some of those roles make a bigger difference and also know that they are hard roles, they're not easy roles*". The need for a challenge, to be stretched and to have the opportunity to develop new competencies was identified by many.

A desire expressed by most was to use their knowledge and experience in the delivery of care to make a difference in the development of health services and systems. "*I love working directly with the individuals, but you can see straight away the systemic things that don't work*", and they choose career steps to "*influence change in health*". The desire to contribute was also linked to job satisfaction by taking a broader and more holistic view from the clinical care delivery perspective. "*I get the most job satisfaction out of stuff where I feel like I am making a difference for a group of people*". Their belief in themselves and their competencies contributed to the confidence that they could step up to address service gaps. For example, "*[My manager said], can you look at this plan and tell me what you think? …I just thought, I could do it better*".

The opportunities to step into management roles occurred across the career and sometimes these came up earlier than expected, "*I was in a deputy head occupational therapist role in the first 6-months*". "*Why did I take that on? Well, probably a bit naïvely*". It may also reflect a confidence to develop the competencies required and those they already had. In contrast, one participant identified transitioning into management roles well into their career when they were asked to cover service management gaps, "*I was told by my manager that there was not an option and I needed to step in*". A responsibility for the service and the team was described, "*I realised that it was actually damaging the team thinking that I was only temporary, the team needs to know that they've got that stability*". This experience stretched them into assuming management responsibilities for which they had not prepared or planned; however, they stepped up to the challenge and worked to transition into this next role successfully.

Barriers that influenced how career decisions were made included consideration of their family's needs, primarily their availability to provide care for family members, both children and parents. "*[The] role was on the opposite side of [city] to where I lived, but then I had a child. So, I took a job half an hour from my door*". Others made the decision to place career progression on hold, "*I am ready for a change, but that does not fit with the needs of my family at this time*", another said "*[I came] back to look after [a family member]*". Others made decisions to step back from senior management roles based on being the primary caregiver for children. The impact of prioritising family also resulted in deferring learning and development: "*I feel like I've become a bit stagnant*", but "*I just can't commit to studying outside of work at the moment. I just think it will be unfair to the kids and my husband*". The decision to place a priority on family first before career and sometimes study was, for some, considered detrimental to career opportunities and self-confidence.

Additional barriers identified that impacted career decisions included workload, budget pressures, overwhelming responsibility, and lack of organisational support. For some, these barriers resulted in the decision not to step into more senior roles or to transition out of a managerial role for a period. The reasons described included

workload "*It's not attractive, partly because I've seen four service managers burn out*"; tight budgets to manage, "*I was very much feeling the weight from the top to save money*"; and responsibilities of duty of care, "s*omebody is going to get significantly injured*". For one participant, these concerns resulted in the decision that it was a risk they did not want to bear and they resigned from the role, "s*o I left, and then I went back to being a clinician for a while*". Another concern was raised regarding the expectation to transition from union membership and collective employment agreements to individual employment agreements and the reduction in terms and conditions. "*The organisational support for senior managers is not sufficient. We should stay on the MECA (Multi Employer Collective Agreement). You'd be stupid to go onto individual employment [agreement]*". Although decisions to leave roles or decline promotion opportunities may be viewed as missed opportunities, an important competency is the understanding of the impacts of workplace environments, terms, and conditions, the impact of stress, and being proactive in looking after oneself physically, emotionally, and financially.

The journey from clinician to manager was often a winding one, influenced by opportunity, responsibilities, areas of interest, and self-awareness. Overall, and despite the challenges, all the participants continued as health service managers, and held numerous roles in their careers to date, "*I've had an amazing career*". Starting a career in health and training as an occupational therapist was a good foundation. They saw they could contribute their professional competencies to achieve services and systems improvement. "*I would encourage anyone to do their occupational therapy training because it gives you such a good basis for whatever direction you might want to go. I don't think you're limited*". "*I have always said it is a career with an amazing basis. If you look at where occupational therapists end up, you just have endless opportunities*".

In summary, the decision to transition into health service management from a clinical role and make subsequent career steps was for many reasons; there was a realisation that clinical occupational therapy was a good foundation but was not their career destination. There was a desire to use their occupational therapy competencies for the

improvement and growth of services to meet the needs of the individual and the community. Each career step led to exposure to opportunities for stretch and the development of additional managerial skills and knowledge. What was also noted was that these experiences led to preparedness for future positions as they arose or were offered. All participants had experienced enablers and barriers that impacted career directions, role choices, and the timing of career steps. A key factor demonstrated was the confidence to accept opportunities as they arose, and the awareness that they had competencies relevant to the roles, and the new competencies required could be developed.

Professional Registration

Central to this study are the competencies associated with being educated and registered as an occupational therapist. All participants had been New Zealand registered occupational therapists, and at the time of the data collection half held current professional registration (see Table 3). The decision to maintain or relinquish registration as an occupational therapist was often described as a critical point in their career journey. For those who required professional registration as part of a position such as clinical leadership, there was no choice. Overall participants chose not to maintain registration where their positions did not require it.

Table 3

Profile Participants Occupational Therapy Registration and APC

Registration Status *	**Yes**	**No**
OTBNZ Registration	6	6
Role required Registration and APC	6	6

*Data as at the time of interview.

Professional registration was held in high regard by some who fully supported maintaining registration whatever the position they held. Being registered and the competency assurance activity associated with registration was core to their self-identity and professional performance. For instance, one participant said, "*Registered*

all the way through; I'm still registered now". Others chose to retain registration early in management career and then reviewed the decision as their career progressed. One participant said, "*my first role was stepping out of being clinical, so I went through that whole do I want to give up my practice at this point in time? Is it too soon?*" and decided to maintain registration at that time, "*I stayed registered … for about 5-years*". Deciding to no longer hold registration and the link to professional practice, knowledge, and competency assurance activity was often not an easy decision; and for some, it was a decision revisited through their career.

Career journeys led some back to positions that required professional registration; most commonly, this action was due to a career decision to return to profession-specific leadership or management roles (e.g., Professional Advisor Allied Health) that required professional registration. "*When I came back into allied health, I… decided at that point in time there to get it [OT registration] back… it turned out to be the right thing to do*". Regaining registration after a time was raised as a possibility by another two participants. "*I was registered… I need to just do that again, still on my list but not practising*", and "*I guess the role I'm in here doesn't require me to have a professional registration*". This explanation perhaps indicates that holding professional registration was viewed as open for reconsideration when interest or career options arose.

Half of the participant group had decided to cease holding professional registration. The reasons behind this decision can be summarised into the following four themes: choosing to no longer pursue a career as a clinician, incurring annual costs to maintain the APC, questioning the relevance of occupational therapy to their career as a manager, and finding it a challenge to commit the time required for completing annual competency assurance requirements.

The decision to no longer pursue a career as a clinician and transition into management resulted in actions to signal and protect this career step. Two participants explained their rationale for stepping away from maintaining clinical competency. "*I didn't want to get called back into the clinic when they were short*", and "*I didn't want to be pulled out of this [management] role*". The step away from

being a clinician was one way of signalling they were on a "*separate pathway that I was choosing*", and that this was a deliberate act, "*it was a very planned exit [from clinical work]*". The perceived risk of being identified with their clinical profession, and the collegial and organisational expectation to slip back into the clinical role when needed, influenced the decision not to maintain clinical competence.

Where there was no requirement to maintain registration, the decision for some was based on the financial investment for the participant and the DHB. "*I dropped my registration because it was really expensive to maintain it*". Where holding registration was not required for the management positions, the funding may not be provided by the DHB or the justification for funding was not seen. "*I couldn't justify work paying for my registration because I wasn't required to be registered for my job*". This left the decision to the individual and the value they placed on the perceived benefit gained from the time and money required to complete the competency assurance and development activities required to maintain registration.

Many experienced completing registration requirements, which requires engagement with the annual e-Portfolio process, as time-consuming and awkward to apply to a non-clinical management position. "*When I got into the operations manager role, it became really hard to maintain it because I… [was] not practising within my profession*". The result of this perceived mismatch between the operational position and the annual competency assurance activity required to maintain a practising certificate resulted in the decision to step away from holding registration. "*To maintain my registration, the e-Portfolio requirements were too cumbersome for me [so] I did let it lapse*". These comments were interpreted to reflect the participant's perception of the lack of relevance and benefit gained from the time and effort required to demonstrate maintenance of competencies focussed on clinical practice while working in demanding managerial positions. The shift away from registration also triggered disengagement with the profession, "*once I left clinical practice and moved into the general management field after about 5-years, I basically lost contact with the profession as a whole*".

Of those participants in management and leadership roles who were required to hold professional registration, many found it challenging to align their role requirements with the OTBNZ competency framework and e-Portfolio. Additionally, they struggled to transition from a fast-paced, multifaceted, and operatically focused perspective to a reflective and clinically focused mindset. One admitted, "*my e-Portfolio, I'm guilty in not engaging with that as much as I should, and I do find that hard to go back into the occupational therapy world*". They struggled to see the relevance of the process to their current position which affected their motivation and engagement, with one participant saying, "*It's too OT [occupational therapy]-specific, and it's not my world at the moment*".

Overall, the decision of whether to hold registration or not was linked to the value of belonging to a professional group and maintaining professional competence, and the DHB's position requirements. Many participants expressed reluctance to use the e-Portfolio system because it did was not seen to align with the competency development required for their management roles and added more work to already busy workloads. Interestingly, the supervision and reflection which underpin the competency assurance process were not identified as a benefit or deterrent to holding professional registration. The decision not to maintain registration where it is not mandated may reflect the value the participant and the DHBs place on the application of occupational therapy clinical knowledge in managerial positions, and of the benefit gained from ongoing competency assurance and development the annual certification process provides.

Ongoing Competency Development

Throughout the analysis there was a strong drive to experience more, to see what they could achieve, and to learn more. Some specifically acknowledged "*a thirst for learning*" and another described "*wanting to be part of making a real difference to people's lives*". These ambitions led to identifying "*an area I would have loved to work in*"; and to do so, "*I had to upskill in regard to roles*". The desire to develop more knowledge and understanding was evident in all participants and throughout career

journeys. This section focuses on the DHB processes supporting ongoing competency development. Within the theme of ongoing competency development, four subthemes were developed: informal learning opportunities and competency development, formal learning opportunities and competency development, DHB process for performance review and performance development, and the experience of competency development.

Informal Competency Development

Most participants identified their early management competency development as learning by observing others, and they acknowledged the input of mentors and role models they observed and based their developing competencies on, "*I think most of my management skills I learnt observing other people*". They described the experience of learning leadership and management competencies where they observed others, tried out, received feedback, and embedded the competency in daily occupation, "*my business acumen is very much experiential learning, and I've picked up along the way*". This learning experience was described as "*on-the-job*" learning, and an apprenticeship model of learning, and involved working with the learning opportunities provided in the everyday activity, as compared to a formal, academic learning programme, "*it has been very much that apprenticeship base model; I don't have a Master's degree for example*". In summary, informal competency development was not based on a formalised learning programme or informed by competency frameworks as are apprenticeship models. It was guided by line managers, mentors, or following areas of interest, and taking up learning opportunities when they were needed or as they arose. This was not often a planned process but contributed greatly to competency development.

Formal Competency Development

All participants described formal competency development opportunities provided by the DHB and NHS in the UK, such as in-house programmes: "*I've kind of taken advantage of internal opportunities to try to build my skills and knowledge*", programmes at tertiary providers, and programmes offered by other companies and organisations. The in-house programmes provide some of the competencies required

early in the management career. For example, "*We have got quite good infrastructure around training and people who've got expertise. We had an analyst who did a guide to understanding WEIS (Weighted Inlier Equivalent Separations) and costing*". Participants who had worked in the UK supported the NHS leadership programme, *"The NHS [programme], was a 2-year programme run through one of the universities. It was a game changer*". Another internal DHB programme was described as: "*it wasn't a great in-depth thing, but it was few basics. You needed to have a certain number of things ticked off, like finance, people management, supervision, [and] around bullying, harassment*".

As careers progressed, participants realised they needed to develop their operational management skills and knowledge further from what was available in the in-house programmes, "*I recognised the courses that were available to me within the organisation, while they were great, they were very basic*" and had limitations for those needing to learn more. "*I'm not going to any more management courses; that's the stuff that I already know*". This was a point of realisation that "*I probably needed a skill at a different level*". In summary, the in-house education and courses were valued as a first step in developing the skills and knowledge required; however, for many, this knowledge and new career challenges developed an awareness that a different approach to competency development was needed and that could involve commencing postgraduate study.

The transition into management roles triggered the consideration of an appropriate postgraduate study programme to follow. The choice was between continuing along a profession-specific pathway and doing postgraduate study with an occupational therapy focus, or a path that led to more generic management competencies. The opportunity to participate in postgraduate study was available, and many completed postgraduate certificates and Master's degrees with a health science or managerial focus, "*I needed to expose myself to different ways of thinking from different business minds*". This step into postgraduate education was often a pivot point in some careers; for example, a generic course of study was chosen and was influenced by the awareness of ongoing health reforms and potential changes to management

structures, “*I deliberately tried to do a generic MBA so that I didn’t get pigeonholed into health long term in my career. Who knows what’s going to happen in the next year?*”

Others described planned development activities to prepare for more senior positions when they became available. Although the managerial career pathway is not often a linear process, preparation in the form of competency development was seen as a good investment for when opportunities arose. The benefit of completing an MBA was “*that it provided a management framework for hanging a lot of the things that I had learnt before*”. A common reflection was the consequence of indecision over the career pivot from clinician to manager and the impact on competency development. For example, “*I completed my MBA*”; another participant reflected “*I completed my master’s in occupational therapy, although [on reflection it] should have been in management*”. Sometimes, choices were described as made to continue with profession-based academic study or performance development when career steps were leading towards a managerial career pathway. This indecision, or gap in career planning, resulted in delays in competency development, “*I should have accepted I was going to be a professional career person and got on with it*”.

Opportunities for competency development and collegial support came from other educational institutions. For example, some DHBs provided the opportunity to participate in national or Australian-New Zealand facilitated learning sets. ACHSM membership and fellowship programme was identified as one method utilised to gain relevant competencies, “*I am a fellow of the …College*”. Other options included participating in self-development programmes such as “*structured assessment and leadership development workshops with opportunities for self-reflection*” and “*work-life, career development workshops that look to the future*”. Thus, what was seen was that many options and opportunities to participate in competency development were available.

Aspects of completing the postgraduate study supported by the DHB were financial, time, and bonding commitment on top of a full-time role. The fees for the papers were

reimbursed on successful completion and there was the time commitment, "*I still had to do 40-hours a week for the organisation*", plus being bonded to the individual DHB, "*I was bonded for 2-years at the end of it to the organisation*", meaning that the funding was required to be repaid if the individual left the DHB before the end of the 2-year bond period. These conditions may have influenced the decision to enrol in postgraduate study. There was a perceived unfairness in working full time and carrying the risk of having to refund the course costs if a career step out of the DHB arose, even if it was to another DHB. This cost burden was questioned, as other groups within the DHB on collective agreements had dedicated education funding and study release time.

In summary, participants identified the need for ongoing competency development and accessed formal competency development opportunities. Opportunities were available to participants across their careers in the DHBs. The challenge was the access to learning opportunities that met their individual learning needs, and when they needed it. Also discerned from the data was the potential benefit of career counselling and advice to guide career directions and the level and subject of postgraduate study. Finally, there was a feeling of injustice of having to carry financial risk and employment bonding, which may not be required of other occupational groups. The following section carries on the discussion of ongoing performance development, by considering the DHB process for individual performance review and performance development, and how this contributes or not to competency assessment and competency development.

DHB Performance Review and Development

The annual performance review and development plan is a formal process where performance can be reviewed, and competency development activities and resources can be agreed upon. The transition from the clinical to the managerial role resulted in a change in focus to where the service and the manager are reviewed using one tool. The DHB sector uses the *Individual Performance Review and Performance Plan* (IPRandPP), or similar tool, conducted with the line manager. In this study, half of the participant group had current performance development plans, and the balance of

participants were in new or seconded positions where the IPRandPP was yet to be developed or were in roles an IPRandPP was not required at that time. For the participants who held joint roles, it was standard practice to complete both the OTBNZ e-Portfolio and the DHB IPRandPP.

Reviewing performance and receiving feedback is identified as a key component of a review process in planning for development, and the experience of this step varied across the participants. Some received little feedback; therefore, this step contributed little to the awareness of competency gaps, "*I've not been in that process where people have said I think this is a gap for you that you need to go and learn*". Where feedback was not provided by their line manager, some, recognising its importance, sought it out from colleagues, "*annual review time, we've never been asked for formal feedback, but I make sure I seek that out*". Performance feedback and opportunities for reflection are professional norms for occupational therapists, and this gap in the review process could contribute to reducing the opportunity to identify what development activities to focus on.

The application and, therefore, the benefit of the performance planning processes varied between the participants. Those who completed the DHB IPRandPP described the process as primarily focussed on the service needs and directions, with less planning completed for the career development needs of the individual manager. "*It's probably more weighted more towards service development than personal development*". However, of the plans completed, some did include development activity, "*my manager ensures that I get the skills and the personal development to do the service development*". Another participant described preparing for competency development activities they wanted to complete, "*It's been more me thinking about what areas I'm finding difficult, what do I think I need to learn… it's been more self-directed, …a lot of that's setting your own objectives*". The experience was not as positive for others and was an area of concern for them, "*there's no point in sharing that [PDP] plan because it really just saves money, you've got to dig hard to get sort of training*", another described, "*I have written a plan, and I'm supposed to review that with my manager*".

The utilisation of the DHB IPRandPP process spanned the spectrum between being well used to other participants seeing it as adding limited value to the awareness of their performance and supporting their management competency development requirements. The variable quality of the feedback from line managers leads to questions about the competence of line managers to provide useful feedback. The lack of planned development activities also raises questions about participants' and the organisation's commitment to ongoing competency development. However, regardless of the often-meagre planned developmental activities, all participants described participating in ongoing self-development activities during the year, whether planned or taken up opportunistically when available.

Competency Development Experience

Most participants emphasised appreciation of the development opportunities available over their career, "*I had many opportunities… to participate in structured assessment, and leadership development workshops, [and] opportunities for self-reflection*". Each participant described examples of career choices or aspirations that led them to identify competency gaps, and to initiate competency development activity, "*it was self-directed*". Others were guided by mentors, colleagues, and managers to participate in ongoing development, and not all the competency development activity was New Zealand-based.

Gaining experience and education outside New Zealand, in the Australian, UK, and American health systems was described, and enrolment in postgraduate study in Australia and the UK, *"[UK] Master's, consolidating some academic understanding and to learn broader innovation and system development*". Early learning activity was often clinically focused, "*Masters of Health Science*"; later, this was more focused on managerial competence, such as a "*generic MBA*". Overall, the study participants described self-directed learning, and continued to identify opportunities within and external to the organisation to grow their skills and knowledge.

Summary

The data analysis confirmed that occupational therapy competencies were employed in management and provided details of which were employed. The analysis of the data relating to the second research question also confirmed that professional education and experience did not fully prepare occupational therapists for the transition from clinical to management roles, and competencies that needed to be developed were identified. Furthermore, the analysis identified two contextual elements—the career journey and ongoing competency development. The career journey impacted the competencies employed and those needing to be developed; and ongoing competency development was influenced by workplace learning environments, including the support, mentoring, and resources available, offered and pursued. In the next chapter these findings are summarised, then put into context in terms of what is known in the literature and practice within the health sector. This is followed by my personal learnings, the limitations and strengths of the study, implications for practice, and recommendations for future research.

Chapter 8. Summary of Findings and Discussion

This final chapter is divided into eight sections. In the opening section the programme of study and the research questions are restated, followed by consideration of the findings in relation to its Deweyan underpinning and my personal reflections. The second section presents the key findings and contributions of this study. The next section returns to the literature to ground and compares the findings with what is already known. The fourth section considers this study's strengths and limitations, and their impact on the trustworthiness of the findings. The fifth section outlines the implications for the practice. Sections six to eight present recommendations, suggestions for future research, and the concluding statements.

Programme of Study

The DHSc programme is applied research with a focus on developing new knowledge that advances professional practice. In this study, the focus has been on occupational therapists who transition from clinical practice to health service management in New Zealand's publicly funded health services. In New Zealand's recent history, a series of health reforms decentralised the responsibility and accountability for publicly funded healthcare provision. The implementation of these reforms also saw the introduction of managerialism and the opportunity for health professionals, including occupational therapists, to hold health service-specific management roles. However, little was known about the competencies they employed from their prior professional education and experience, and those competencies for which they believed they were least prepared. This study was based on two premises. First, occupational therapists have transferable, discipline-specific knowledge, skills, and attitudes (competencies) to be employed in health service management. Second, that their professional education and experience may not fully prepare them for management roles and responsibilities, and additional competency development may be required. Two research questions were developed: "*What do occupational therapists employed in health service management roles in the New Zealand DHBs identify as the core management competencies they developed through their professional training and experience?*";

and, "*What were the competencies required in their management role that they perceived they were least prepared for?*"

While the study was profession specific, addressing these questions has generated insights into the competency requirements of health professionals transitioning into health service management, along with the benefits and risks to the individuals who take up the opportunities the health sector reforms created.

Dewey and Pragmatism

The beliefs of Dewey (1859-1952) underpin the approach taken to this study and the selected research methodology. Dewey (1929) held a philosophical belief in a human's ability to adapt to the environment, and to have the insight and capacity to share their understanding of this adaption. Therefore, Dewey would not be surprised by my decision to gather data directly from the individual participants or by the inclusion of their comments in the findings to reinforce the importance of the knowledge they brought from their career experiences. Nor of the findings that each person's career experience was unique, that learning occurred primarily in the work environment, and that experiences supported ongoing learning and development throughout careers. Participants described employing their occupational therapy competencies and, as a result of the engagement within their management role, of further refinement and development of these; for example, communication skills were extended to include strategic documents and marketing. Others applied competence in working in bicultural New Zealand to the development of services that include collaborate leadership structures and better meet the needs of clients, as examples of their knowledge changing the environment. The concept of habit and subconscious patterns of thinking was noticed throughout the interviews and data analysis; and, in particular, the occupational therapy concepts and practice of therapeutic use of self, holistic and systems approach to situational assessment, problem definition, planning and reflection. Whether or not the participants had retained a connection with the profession, these habits of thinking were carried forward into managerial roles. Dewey also believed that habits of thinking and actions can be challenged through intelligent enquiry. What is suggested in this study is that occupational therapy competencies are

not limited to clinical domains and are applied in management. This change in thinking potentially opens awareness of a broader employment context, as many of the competencies employed are generic to management and leadership.

Personal Reflection

Now that this programme of study is completed, I can see that, true to the study's roots in Dewey's (1929) pragmatism, my initial mindset and approach were transactional. I was looking to discern the influences a health professional education and experience has on the development of management competencies, and to identify the competencies they acknowledge they were least prepared for and needed to develop to fulfil the requirements of the role and as part of career progression. This is valuable new knowledge for educational programmes for both health professionals and health service managers. However, I think the finding that attitudinal aspects, the hard-to-describe intangible facets, are not well captured in competency frameworks is also valuable. The supportive and nurturing learning environments and systems that facilitate competency development, and which rely on the attitudes and commitment of others across organisations and the sector, are core to competency development of the individual and a key finding of this study. Overall, health service management plays a vital role in providing healthcare services in New Zealand. The results of this study can contribute to supporting health professionals who bring their professional competencies and knowledge of the health sector into these roles.

Contributions of this Study

Firstly, this study found that participants did employ competencies developed through their occupational therapy education in their roles as health service managers. The competencies employed were categorised into three competency domains: perspective, approach, and attitude; clinical, technical, and operational skills; and culture and sector knowledge. These competency domains are positioned as core to occupational therapy and competent management in the health sector. Perspective, approach, and attitude capture the holistic, enabling and evidence-based approach to healthcare. Clinical, technical, and operational skills, capture the interpersonal and

leadership skills that are core to collaborative work practices. The technical and operational skills of assessment, planning, documenting, implementation, and reflection are fundamental to effective operational management activity. Culture and sector knowledge are invaluable in the complexity of healthcare delivery. Overall, the study findings support the position that occupational therapy is a health profession that can partially prepare people to be competent health service managers and leaders.

Secondly, occupational therapy education and experience alone would not fully equip occupational therapists for management; and four competency domains were identified for which the participants were least prepared. These are: leadership; business and administration; managing within the healthcare environment; and building self-confidence and resilience. In addition to developing new competencies, the analysis highlighted the importance of refining and developing existing competencies to meet role demands as careers progressed, and to remain current in the healthcare environment.

The third finding of this study supports the first two findings by matching the competencies employed and those least prepared for with published competency frameworks. This analytical step confirmed that the occupational therapy competencies the participants claimed they employed matched with all five OTBNZ competency domains, and matched with elements of the ACHSM domains 1, 2, 4, and 5, confirming they are also accepted management competencies. This finding is unique to the study and provides support to the position of this study that occupational therapy education provides a basis for a career in health service management. The competencies identified as ‘least prepared for’ were then matched to all five competency domains, although the competency gaps mainly matched with elements of Domain 3: Business skills. The analytical process used to match the competencies identified with existing competency frameworks is unique to this occupational group and, therefore, is new knowledge in this area of interest.

The fourth finding of career journeys was considered from the individual's perspective and arose from the numerous pathways described, and of the enablers and barriers experienced. Most important was the experience of an enabling and nurturing workplace environment, and of being encouraged and supported by mentors, line managers, and colleagues who identified, facilitated, and provided learning opportunities. Barriers were experienced on the journey, including making career step decisions that considered the needs of the family, financial security, and workload management. A pivotal point in the career journey was the decision to maintain, or not, professional registration; for some, this decision signalled a deliberate career shift away from clinical work, while others considered this professional link as central to their career and to their competency assurance and development. Overall, the participants viewed occupational therapy as a strong foundation for a career in health service management, and described having access to many opportunities and an overall fulfilling career where they felt they were making a difference and influencing change in healthcare.

The fifth noteworthy finding related to ongoing competency development is that health service managers experience both informal and formal learning in the workplace. Although participants described numerous opportunities, the limitations, and barriers to learning included reliance on the goodwill and contribution of individuals rather than a systems or organisational approach to competency development, including the lack of competency development guidelines in preparation for career steps and ongoing skills development. This knowledge suggests a need for further understanding of the supports and learning structures that would be of benefit to health service managers in New Zealand's health sector environment.

The sixth finding concerns the formal structures and processes to assess and review performance and plan for competency development in the workplace and professional practice. Participants identified that the DHB individual performance review and performance planning and the OTBNZ e-Portfolio competency assurance and competency development systems were often not helpful for the planning of competency development. The impact of this knowledge is noteworthy as these two

processes have a central role in the formal processes to review performance and plan for further performance development that meets the needs to the individual, the organisation and, in the case of the e-Portfolio, the professional competency assurance requirements.

The final contribution made by this study consists of the methods employed to gather and analyse the research data, and the underpinning philosophy and methodology of the study. The New Zealand health sector is complex, fast-paced, and in a constant state of change. In this environment no role, position, or experience is the same. The individuals who work in the sector bring a unique set of competencies to a role because of their professional education and experience. This study contributes a research methodology and methods that may be utilised by other professional groups looking at this career and sector phenomenon.

Alignment of Key Findings with the Literature

The findings of interpretive description are constructed truths, developed through intellectual inquiry of the data, considering the possibilities and developing conclusions (Thorne et al., 2004). As human experience is unique, these constructed truths are viewed as relative and reflect the richness and diversity of the experiences described by the participants (Sandelowski, 1986; Thorne, 2016).

While no studies were identified on this research topic of occupational therapy competencies employed and the competencies least prepared for in the New Zealand health sector, the study findings resonated with a range of international research of occupational therapists transitioning into leadership roles. In addition, various academic texts, journal articles, and publications from the WFOT describe occupational therapy competencies that are employable or required in the practice of leadership and management. Finally, published experiences of three New Zealand occupational therapists (Azuela, 2023; Muir, 2023; Silcock, 2023) describe the competencies of occupational therapy that are applicable and employable in the practice of management and leadership.

Furthermore, research studies and literature from other health professions and industry texts were reviewed to determine whether or not the findings of this study align with those of other studies. In the sections that follow, each of the competency domains identified as employed and least prepared for in the current study is discussed, along with their alignment with published literature.

Occupational Therapy Competencies Employed in Management

The findings of occupational therapy competencies employed in health service were grouped into three competency domains: perspective, approach, and attitude; clinical, technical, and operational skills; and culture and sector knowledge.

Perspective, Approach, and Attitude

The first domain—perspective, approach, and attitude—encompasses the skill, knowledge, and attitudes necessary to approach situations holistically, with an enabling, solution-oriented, and evidence-based mindset guided by models and evidence. Each of these aspects has previously been identified in the professional literature. The ability to think about situations in a diverse manner, using a holistic perspective, has been noted by Heard (2014) and Shams et al. (2019) as a management competency, and is supported in recent personal account (Silcock, 2023). This perspective is seen as unique to occupational therapists, setting them apart from other health professionals (Shams et al., 2019). An enabling approach was identified as employed by Silcock (2023), and as a core occupational therapy competency (OTBNZ, 2015a; E. A. Townsend et al., 2013). Being solution and action-orientated was also identified in personal accounts describing identifying service gaps and developing an innovative solution (Azuela, 2023; Muir, 2023; Silcock, 2023), and being guided by models and utilising systems theory is a finding by Truskowski (2017). Previous research of other health professions identified the employment of a caring approach (Hughes et al., 2018; Lawson, 1994), and of practice informed by evidence (Hughes et al., 2018; Pilling & Slattery, 2004).

Clinical, Technical, and Operational

The second competency domain within competencies employed is clinical, technical, and operational. It contains three competency sub domains; leadership, people, communication, and teamwork; assessment and planning and systems approach; and documentation, implementation, and reflection. Competencies in these sub-domains have been identified in previous research as management and leadership competencies of occupational therapists in managerial positions. Leadership was described as practical skills developed in clinical practice (Shams et al., 2019). A study of leadership practices suggested that occupational therapists believe they have distinct qualities that contribute to their success as leaders (Fleming-Castaldy & Patro, 2012), and that having a broad base of clinical knowledge and experience working with other health professionals sets occupational therapists up for various leadership positions (Shams et al., 2019). The employment of visionary and practical leadership skills was found in studies (Heard, 2014; Truskowski, 2017), and in personal accounts (Azuela, 2023; Muir, 2023; Silcock, 2023). Leadership was identified as a key role of occupational therapy managers (Guo & Calderon, 2007). Keeping the people at the centre of all activity is fundamental to occupational therapy and to leadership and management. Keeping the person at the centre aligns with leadership and relationship building noted by Heard (2014) and Truskowski (2017). Townsend et al. (2011) identified the competencies of collaboration and partnership that are key person-centred activities. Communication skills were identified as applied in managerial and leadership roles (Heard, 2014; Truskowski, 2017), and in the personal accounts by Azuela (2023), Muir (2023), and Silcock (2023), and were seen as a strength occupational therapists brought to management.

Although little research was identified that related to the employment of skills associated with assessment, planning ,and implementation competencies, the work of Truskowski (2017) linked being a good leader to being a systems thinker, and employing skills of activity analysis. Academic literature identifies data-driven decision-making (Townsend et al., 2011) and using systems knowledge to understand how work areas function and can be improved (Guo & Calderon, 2007). Furthermore, the opinion

literature suggests that the application of the occupational therapy process aligns with the key management tasks of planning and controlling (Braveman, 2019). Lastly, personal accounts described the employment of task analysis, assessment, and planning in non-clinical roles (Azuela, 2023; Muir, 2023).

The final groups of sub-competencies within this competency domain pertain to documentation, implementation, and reflection. The employment of documentation and implementation competencies can be assumed from actions to ascertain how areas can be improved (Guo & Calderon, 2007), key tasks of organising and directing (Braveman, 2019), and the competencies described of planning activity in personal accounts employed in leadership roles (Azuela, 2023; Muir, 2023). Reflection is the last of the competencies the participants of the current study identified they employed. The importance of evaluation (reflection) by middle managers was emphasised in opinion literature (Guo & Calderon, 2007).

Previous research conducted with other professional groups also identified many of the clinical, technical, and operations competencies identified in this study. Teamwork, communication, and interpersonal skills were identified by multidisciplinary allied health managers (Cowan, 2010), nursing (Hughes et al., 2018), and speech pathologists (Pilling & Slattery, 2004). Also identified as employed were planning and evaluation (Hughes et al., 2018; Pilling & Slattery, 2004), problem-solving and decision-making (Cowan, 2010; Hughes et al., 2018; Pilling & Slattery, 2004; Prideaux, 1993), and evaluation (Hughes et al., 2018; Pilling & Slattery, 2004).

Culture and Sector Knowledge

The third competency domain pertains to culture and sector knowledge employed in health service management in bicultural New Zealand and the wider health sector. Participants of this study described employment of competencies related to tikanga (practices and values from Māori knowledge), manaakitanga (support, care, and hospitality), and kaitiakitanga (guardianship and protection). The importance of competence in cultural knowledge to achieve equitable health care is recognised (Curtis et al., 2019). From the broader healthcare sector perspective, the importance

of leaders' and managers' understanding of the wider healthcare environment and the cultures of other professional disciplines is known (Heard, 2014; Shams et al., 2019). Finally, the employment of knowledge of the health sector and community culture was found by Hughes et al. (2018), indicating this is not always profession-specific knowledge.

Summary

Overall, there is some alignment with occupational therapy competencies participants described they employed in management and leadership and those in published literature, and with some of the findings of research of other health professionals. This knowledge supports the position that competencies developed through occupational therapy education are transferable and provide a partial basis for the competencies required for a career in health service management. The presentation of these competencies into three integrated competency domains was not located in existing research and literature and is, therefore, unique to this study.

Finally, some competencies employed in leadership and management were claimed as specific to a health profession. Nursing claimed competence in directing as a critical skill transferable to management (Hughes et al., 2018). Prioritisation and conflict management skills were identified in studies of medical clinicians (Lawson, 1994). Advanced written and verbal communication skills were identified by speech pathologists as well as developed competencies they brought to management (Pilling & Slattery, 2004). The findings of my study and literature review identified two competencies that were not described as employed by other health professional groups but which were identified by the participants in the current study. These were the underpinning of holistic and enabling perspectives and approaches to their management and leadership; and the wide range of experience and sector knowledge gained from working in many clinical areas (i.e., mental and physical health, community and hospital settings). As a consequence of this experience, the participants had knowledge of the continuum of care and service interdependencies. While the first can readily be understood as an occupational therapy-specific

competency, the absence of recognition of competency developed across diverse practice areas was not expected.

Limited research was located that identified the profession-related competencies employed in management; however, more information was located on the competency gaps identified by health professionals who had made this career transition (see next section). As summarised by Pilling and Slattery (2004), although health professionals bring a core set of competencies, this does not preclude the need for further education in the areas of management and leadership.

Competencies Least Prepared For

The competencies least prepared for were categorised into four competency domains: leadership; administration and business; healthcare environment; and developing self-confidence and resilience. In addition, the analysis aligned with existing research which found that the competencies least prepared for were linked to the career pathway, experience and management level (Liang et al., 2013). Leadership, and the day-to-day administration and business competencies, were required from the beginning of the management career. Competencies required for working in the healthcare environment, and building self-confidence and resilience, often emerged as competency gaps as careers progressed. Although no previous research was located on competencies 'least prepared for' by occupational therapists transitioning into management roles in New Zealand DHBs, international research found many occupational therapists present with limited management training or experience (Wilson, 2004).

Leadership

The first competency domain of leadership as an area least prepared for included understanding team dynamics, understanding self as a leader, and developing leadership approaches. No relevant research was found relating to the knowledge gap in understanding team dynamics. Understanding of self as a leader is consistent with the findings of the iterative nature of leadership competency development, which occurs over time (Truskowski, 2017). Developing leadership approaches was seen in

the necessity of communication skills, building relationships, and emotional intelligence (Heard, 2014). Developing a leadership style and a situational approach to leadership was described by Truskowski (2017). Overall, the findings of the current study are consistent with previous research that trial and error in leadership competency development in both clinical and management roles involved stepping up to leadership and trying out skills (Heard, 2014).

Research of other professional groups also identified that leadership competency development was required. These included leading and directing a team (Cowan, 2010; McCallin & Frankson, 2010; Prideaux, 1993), understanding leadership in the cultural context of an organisation (Hughes et al., 2018), and developing and understanding team dynamics (North & Park, 2014). An underpinning aspect of not being prepared for health services leadership is role clarity, including the decision-making process and authority (Cowan, 2010). Research conducted in New Zealand by North and Park (2014) identified leadership and management competencies as the extensions of existing knowledge and skills to meet the requirements of the management roles and responsibilities. This change in focus from clinical care to service management supports the findings that leadership can be a competency brought to management and is an area for further development; but, it is a personal competency and responsibility that cannot be outsourced.

Business and Administration

The second competency domain in this section of business and administration competencies encompasses human resource management, service management and development, and business and communication. Although no occupational therapy research was located on business and administration competencies, an academic text identified the management competency areas required of occupational therapy managers as human resource management; planning, organising, directing, and controlling; financial management; and technology (Braveman, 2019). A 1980s management training course for occupational therapy managers included planning, documentation, human resource management, decision-making and managing conflict, time management, finance and purchasing (Ross & Barker, 1988). Although

this article is old, the areas for competency development align with the findings of this study and recent academic writings, indicating that these competency gaps are known.

The findings of my study are consistent with previous research. Human resource management was identified as a gap in knowledge across the professional groups, and included supervisory (Lawson, 1994; McCallin & Frankson, 2010), recruitment (Cowan, 2010), and employment relations (North & Park, 2014). The findings of the gaps in financial knowledge and budgeting were also previously identified as areas requiring development (Lawson, 1994; McCallin & Frankson, 2010), along with communication (Cowan, 2010; North & Park, 2014; Thompson & Henwood, 2016), and change management (Liang et al., 2020). Competence gaps in information technology (North & Park, 2014) were identified in published research but not in the findings of my study. A competency gap in marketing was identified in the current study but not in the published research.

Managing Within the Healthcare Environment

The third competency domain within competencies least prepared for are presented within two operational scenarios: managing 24/7 services and managing and leading regional and national services. Unsurprisingly, no research was located on this aspect of health service management. One personal account identified competencies to work across departments and organisational boundaries, and that communication and interdisciplinary collaboration and partnership is required (Azuela, 2023). Other studies identified strategic planning, coordination, and negotiation as key competencies for managers (Guo & Calderon, 2007), plus a knowledge of the healthcare environment (Ayeleke, 2018). Overall, the requirement for the integration and extension of skills is seen in these more senior roles (Liang et al., 2013).

Building Self-confidence and Resilience

Building competence in self-confidence and resilience was in response to the pressures of the management role and tasks, the experience of working outside comfort zones, and the importance of developing support networks. The findings of this study, specifically the stressors identified, are in line with the literature and included being

overwhelmed due to a lack of role preparation (Lawson, 1994), limited orientation (Thompson & Henwood, 2016), changes in interpersonal relationships (Lawson, 1994), and the underlying stressors of balancing work and home (Shams et al., 2019). The finding of the importance of developing support networks was consistent with previous occupational therapy research which identified that support systems that include colleagues, family, and mentors, (Shams et al., 2019), and supportive communities of practice (Heard, 2014), were an integral part of the support networks required for the process of transition into management.

The study's central focus on the competencies that participants felt the least prepared for is a valuable contribution to the existing knowledge of individuals making a career transition. This information can be used to inform individual, organisational, professional, and educational development activities in both formal and informal settings. The scarcity of research on occupational therapists in health service management underscores the significance of the unique findings from this study.

Alignment with Existing Competency Frameworks

An analytical process utilising two pre-existing competency frameworks revealed that the occupational therapy competencies employed in management aligned with the domains in the OTBNZ competency framework and competency statements in the ACHSM competency framework. Furthermore, competencies that were identified as least prepared for matched with competencies in the ACHSM framework. This matching step was not located in published literature and is, therefore, positioned as new knowledge developed from this study.

Career Journey

The theme of the career journey from clinical occupational therapist to a health service management role arose to acknowledge the importance of the many career pathways and the impact of the workplace environment, opportunities, guidance, and support experienced made on the career decision, competencies employed, and those competencies that needed to be developed. Four sub-themes were identified: the enabling environment within the occupational therapy departmental structure; the

importance of being encouraged, supported, and stretched; the enablers and barriers experienced; and the decision to retain or not professional registration.

Enabling Workplace Environment

The first theme of the career journey is the positive impact of a supportive and enabling occupational therapy department environment. Existing research has found that fostering a culture of mentorship and creating a supportive workplace can have a positive impact on individuals (Heard, 2014; Shams et al., 2019; Truskowski, 2017). It highlighted the support and encouragement provided by senior occupational therapists and managers (Heard, 2014), and that clinical supervisors supported the preparation for leadership roles (Cowan, 2010). Although no research on the impact of the departmental structures within DHBs was located, the scarcity of occupational therapy departments in Canada was associated with reduced opportunities for competency development, and made the step from clinician to leadership more challenging (Shams et al., 2019).

Being Encouraged, Supported, and Stretched

This theme is an extension of the enabling environment to recognise the pivotal role that individual line managers, mentors, and role models played in participants' career journeys. Although no occupational therapy-based research was located, research of health professionals (including occupational therapists) found the importance of mentors in helping mentees attain a clearer understanding of their existing abilities and awareness of the competencies that need to be enhanced and developed (Cowan, 2010; Thompson & Henwood, 2016), and assisting those who were struggling (Prideaux, 1993). The value of workplace stretch projects or secondments was experienced by most participants. The objective of stretch projects (McCauley et al., 1995) is to support ongoing learning and competency development by providing opportunities to extend beyond current capacity and capability to work with others with different perspectives and hold new responsibilities (Boak & Crabbe, 2019).

Enablers and Barriers

The third theme pulls together enablers and barriers to competency development and career decisions. A positive mindset, ambition, and deliberate actions to self-direct their career were intrinsic enablers contributing to competency development and career decisions. The desire and drive for new opportunities and career steps identified in this study are consistent with previous research on occupational therapists (Shams et al., 2019; Truskowski, 2017). Barriers experienced in the career journey most often identified were considerations of family, financial security, and workload management, with these impacting career choices and timing. The research by Shams et al. (2019) identified the importance of family support in career decisions, and Heard (2014) noted concerns related to workload and workplace stressors that impacted career decisions. The perception barrier of limited leadership positions for occupational therapists due to the health system leadership and management structures (Gauld & Horsburgh, 2012; Shams et al., 2019) was not a finding of my study, nor the impact of a smaller professional group on career progression leadership and management opportunities (Pilling & Slattery, 2004).

Professional Registration

The fourth theme concerned the decision to retain registration as an occupational therapist once they were in management roles. Those who described challenges in matching their management roles into the OTBNZ competency framework and e-Portfolio system are in line with the 2013-15 OTBNZ review of the competencies for registration, which noted that professionals not directly providing clinical care, such as managers, were not engaged with the profession (OTBNZ, 2015b). In addition, Penman (2013) asked if occupational therapists knew how to apply the learning process to maintaining competence postgraduation. This suggests there is more to be understood about the reasons for the drop in engagement with the e-Portfolio system and maintaining registration.

Ongoing Competency Development

The analysis in this study identified key components of ongoing competency development: the role both informal and formal learning played in addressing the

competency gaps, and the experience and value of the DHB annual performance review processes.

Informal Competency Development

Learning opportunities described by study participants were predominately informal, occurred in the workplace, and were self-initiated or guided by line managers, mentors, and colleagues. These findings are consistent with previous research with allied health clinicians, including occupational therapists, transitioning to team leadership, which identified on-the-job training was employed (Cowan, 2010). New Zealand nurse managers identified management skills were learnt through seeking assistance from others (McCallin & Frankson, 2010) and observing more senior managers (Thompson & Henwood, 2016). Previous research on leadership found that informal learning was an essential developmental strategy in changing environments (Becker & Bish, 2017), considered to be more effective than classroom-based education (Gonin et al., 2011), and can often be an area of missed opportunities (Boak & Crabbe, 2019).

Formal Competency Development

Opportunities for formal learning were available to most participants of this study and were recognised as contributing to competency development. Formal development programmes can build on experience and enable managers to learn from it (Legge et al., 2006), and complement informal learning (Becker & Bish, 2017); however, the gap in access to formal resources was seen as a systemic barrier and added to the challenge of transition into leadership roles (Shams et al., 2019).

Performance Review and Development

In this study, the utilisation by DHBs of the individual performance review and performance planning process spanned from being well used to other participants seeing it as adding limited value. No research was located on the experiences of the individual performance review and performance planning process; however, the concerns raised in this study are in line with what has been described in opinion-based literature. That is, that an individual’s performance development is often overlooked in

the process (Stone, 2002), and that poorly implemented performance appraisal systems lead to low morale, decreased employee productivity, and reduced support for the organisation (Isouard et al., 2006; Stone, 2002). Overall the research supports the position of my study that to maintain high levels of performance, processes such as performance appraisal and career development are essential (Islam & bin Mohd Radsad, 2006; Robbins et al., 2000).

Competency Development Experience

Throughout this study analysis revealed the absence of a sector-wide approach to learning and development for health service managers in New Zealand, and that managers new to the role had substantial learning needs to be met. Previous studies have found the benefit of having management development programmes available early in management careers (Hughes et al., 2018; Ross & Barker, 1988), but there is a lack of coordinated leadership and management development in healthcare (Ayeleke, 2018; North & Park, 2014; Turato & Oprescu, 2020). Encouragingly, the current New Zealand Health Workforce Plan 2023/24 includes competency development for health service managers and for a Pae Ora (Healthy Futures) Leadership Institute to be established (Te Whatu Ora-Health New Zealand, 2023b) which may address some of the concerns raised in this study.

Strengths and Limitations of the Study

As with any research, this study has strengths and limitations. This section considers these aspects and their implications for the trustworthiness of the findings. Aspects considered are the methodology utilised for the study, and the impact of sector-wide restructure during the period of data collection.

Interpretive description is a non-prescriptive methodology that allows for customisation to include aspects relating to the study area and the disciplinary orientation of the researcher and participants. This methodology was utilised to gain valuable new knowledge through the interpretation of the data rather than to develop theories. This methodology provides flexibility to meet the needs of the problem to be

investigated and incorporates the knowledge of the researcher (Thorne, 2016). While the study offers valuable insights, it is important to note its limitations.

All data collected were self-reported, and subjective interpretation in developing findings holds a risk of confirmation bias by the researcher. This is a small study and participants were invited to participate, which may add selection bias. Therefore, as naturalistic research and using a transactional approach, these findings are context-specific, and cannot be applied universally to all occupational therapists or work environments. Future studies could benefit from conducting a second interview with more specific questions and widening the pool of potential participants to address selection bias. Overall, while the methodology provides valuable insights, it is important to interpret the findings within the context of their limitations.

The two competency frameworks (OTBNZ, ACHSM) utilised in the analysis of the data have subsequently been refreshed and both were republished in 2022. OTBNZ core documents which include the competency framework are considered as living documents and are updated regularly to ensure they keep pace with the changing health and disability system. The 2022 competency framework refresh included changes in Domain 2 emphasising competence in responsiveness to Te Tiriti o Waitangi – The Treaty of Waitangi, with the objective of making it easier to apply in practice. Changes were also made in Domain 1 to include digital technology and Domain 4 to reflect the practice of sustainability and the environment impact in the use of resources (OTBNZ, 2022a). None of the findings from my study are out of step with the refreshed version, although competency may not yet fully reflect the emphasis placed on sustainability, Te Tiriti responsiveness, and digital technology.

The refreshed version of ACHSM competency framework was also published in 2022 following member consultation (ACHSM, 2022a). This document replaced the five competency domains in the 2016 version with six enabling domains and seven action domains. This refreshed framework is built on the work the Global Consortium and the 2016 ACHSM competency framework and provides a "contemporary and comprehensive list of competencies required of health leaders and managers"

(ACHSM, 2022a, p. 1). Although the refreshed framework covers the same ground, a noteworthy addition to the framework included Domain G: Digital Management (ACHSM, 2022b) which was also added to the 2022 OTBNZ framework. Again, as with the refreshed OTBNZ framework, the findings of my study are not out of step with the changes and, therefore, does not substantially change the importance of the study findings.

Implications for Practice

During this study the structures of New Zealand DHBs were disestablished, and the functions and services providing health care were integrated within Health New Zealand – Te Whatu Ora. Some of the proposed changes were to management structures, functions, and accountability. As a result, it is conceivable that this restructuring could have impacted the shared data, the experiences of participants since the time of the interviews, and the application of research findings and recommendations.

The findings of this study confirm competencies occupational therapists take forward into the career of health service management, and these align with many of the health management competencies; thus, they are well-positioned to make a career step in health service management. This knowledge supports the position that occupational therapy is a health profession that can partially prepare people to be health service managers and leaders, and that promotion of the competencies occupational therapists bring to leadership and management is required. Based on the findings of this study there are three implications for practice:

There is value in recognising that occupational therapy skills, knowledge, and attitudes are employed in practice areas outside of clinical care, that health service management is a career option, and that many have already successfully followed this career path. However, their professional education does not fully prepare them for all the competencies required of health service managers.

Participants demonstrated a mix of self-initiated and opportunistic competency development strategies. This study generates insights that may inform and guide targeted competency development in identifying areas of competence that occupational therapy managers identify they lack. It also gives guidance on which competency gaps may emerge. Considering these findings, individuals should proactively curate their competency development by utilising the structures, processes, and resources available through the DHB.

Occupational therapy managers should identify and communicate the competencies they possess from their professional education and experience and which they bring to health service management. Recognising these competencies can provide confidence in career choices. Articulating them contributes to a better understanding of the profession and its potential within the health sector. Acknowledging the competencies of occupational therapy strengthens the claim that they are prepared for managerial roles.

Recommendations

The research study gives rise to a range of recommendations to the profession, individual practitioners, the New Zealand health sector, tertiary education providers, academic institutions, and researchers as follows.

Occupational Therapy

Given that health service management sits within the OTBNZ general scope of practice, and that occupational therapists transition into health service management positions and employ professional competencies in their practice of management, it is recommended that:

1. Where competencies relevant to clinical practice are also relevant to management and leadership, these are identified throughout education and clinical practice prior to and after graduation. This action would highlight and reinforce the transferability of occupational therapy competencies between

roles, and that health service management is a recognised occupational therapy career option.

2. The annual e-Portfolio systems should be reviewed for application, acceptability, and effectiveness for those in health service management roles. It is highly recommended that OTBNZ consider developing a competency domain to add to the existing competency framework for managers and leaders.

Health New Zealand – Te Whatu Ora

Based on the findings of the organisational competency development processes, occupational therapy education should be recognised as a significant contribution to the competencies required for health service management.

The findings of this research of the competencies least prepared for, and the alignment of these competencies with previous research, including from a range of health professions, have sector wide implications. It is recommended that a sector-wide competency-based educational programme be developed for health service managers. Highly recommended is a mandated comprehensive orientation programme to be commenced on appointment to a management role which includes the competencies identified in the current and previous research studies as knowledge and skills least prepared for.

Based on my study's findings, it is also recommended that the annual individual performance review and performance planning systems be reviewed for purpose, application, and effectiveness. Separating the annual processes of reviewing the individual's performance and development from the process of planning the annual activity and targets for the area managed is highly recommended to allow for appropriate time for considering the individual's performance and ongoing competency development. To address the findings of limited or insufficient feedback on performance, it is recommended that line managers are trained to give consistent

and actionable feedback according to best practice guidelines (Burgess et al., 2020; Clarke et al., 2013; Ministry of Business Innovation & Employment, 2023).

Based on the findings, informal work-based learning is a primary method and location of competency development for health service managers. The recommendation is to develop an understanding of how this occurs in the workplace, with a view to improved and equitable accessibility to relevant informal and formal opportunities, and to support those who facilitate, oversee, and provide this learning environment.

Academic Institutions

The findings of this study may be useful when preparing graduates for career opportunities and role responsibilities. For example, discussions on how the employment of occupational therapy competencies is not restricted to clinical practice and can be applied in other roles within the health sector, such as management and leadership. Another example is the knowledge occupational therapists bring of their responsibilities under Te Tiriti o Waitangi – The Treaty of Waitangi and the application of this knowledge in the health environment. Overall, the findings from this study may inform course curriculum of postgraduate programmes on management and leadership by building on existing knowledge and addressing the gaps in knowledge clinicians most often identify.

Implications for Future Research

Many occupational therapists who transition into management positions choose not to retain professional registration or association membership. The recommendation is to build on the insights from this study with further research to gain an understanding of these views within the occupational therapy workforce, plus any others not raised in this study. Studies that further identify the merits of profession-based competency development in developing management competencies should be pursued.

Throughout this study, the lack of a health service management competency framework developed within and validated for New Zealand's bicultural context has been noted, with the inference that this may impact competency assessment and

planning and access to appropriate competency development activities. Studies that investigate the value and potential content of a competency framework for this section of the workforce would generate knowledge on which to base competency development, core documents such as position descriptions, and annual processes such as performance reviews.

There is little information available on the experience in New Zealand of other health professionals choosing health service management as a clinical career option, nor on how their experience of professional development and organisational support impacts their commitment within the organisation. Although this study focuses on participants with experience as occupational therapists, other researchers may see the value in this research topic and design for studies with other health professions.

Concluding Summary

Some occupational therapists choose health service management as a career option in New Zealand's publicly funded health services. This research is the first conducted in New Zealand to gain an understanding of the competencies they employed in their management roles which they had developed through their professional education and experience, and those they were least prepared for.

This research contributes to the understanding of the occupational therapy competencies employed and the alignment with the competencies required of health service managers. This knowledge recognises that occupational therapy is a health profession that provides some grounding for a career in health service management. The proposed extension of this position is that health service management is a practice option for occupational therapists other than a direct clinical role. Such knowledge can underpin and inspire management career aspirations for occupational therapists and inform proactive competency development. Health system organisations using this knowledge can be confident that occupational therapists bring strengths in core management competencies and knowledge, and of areas in which to invest for further competency development.

In addition to the new knowledge of the competencies employed and required, the current study's findings highlighted the importance of the workplace in ongoing competency development. Both informal and formal learning occurred in the workplace, and the participants emphasised the pivotal role played by line managers, colleagues, and mentors in supporting, nurturing, and guiding the learning process.

Existing individual performance review and performance planning processes and occupational therapy professional competency assurance processes have the potential to be enablers given the opportunity for the individual to grow professionally through structured feedback and planned development activity. Equally, they may pose a barrier if these processes are not conducted effectively and consistently. In the New Zealand publicly funded health system, the process for an individual manager's competency assessment and development is poorly implemented. Although resources and training opportunities are available to support ongoing development, it is strongly recommended that the individual takes proactive measures to guide their own competency development.

Competent health service management is essential for operational performance in the publicly funded health sector. The findings support the position that occupational therapists, with their knowledge of the sector and the complexity and interdependencies involved in care provision, bring skills, knowledge, and attitudes to health service management and, therefore, are already equipped with some of the competencies that underpin health services management as a career option. While the sector appears to be well served by the competencies managers bring with them from their undergraduate education and clinical experience, there are sizable gaps in the structure and process to support their ongoing competency development. The importance of effective management in the provision of health services supports the call for a comprehensive competency assessment and development system for all health service managers.

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Appendices

Appendix A. Ethics Approval

22 March 2021

Clare Hocking

Faculty of Health and Environmental Sciences

Dear Clare

Re Ethics Application: **21/58 The core management competencies occupational therapists who manage District Health Board health services identify as coming from their occupational therapy training and experience**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 22 March 2024.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which

your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

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

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

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

Appendix B. Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced: 31 March 2021.

Project Title:

The core management competencies occupational therapists who manage New Zealand District Health Board health services identify as coming from their occupational therapy training and experience.

Project Supervisor: Professor Clare Hocking

Researcher: Jennifer Coles

An Invitation

Kia ora/ Greetings, my name is Jennifer (Jenni) Coles.

I would like to invite you to participate in this research study as part of the Auckland University of Technology, Doctor of Health Science (DHSc) programme. I have experience as an occupational therapist and as a health services manager in a New Zealand District Health Board, and I am enrolled as a doctoral student in the AUT DHSc programme.

My decision to choose AUT and this programme of study was based on the desire to pursue research that is directly relevant to the health care workplace and to support occupational therapists in their management career journey.

What is the purpose of this research?

This study looks to gain insight into the competencies (skills, knowledge, and attitudes) and mindset occupational therapists identify they “bring with them” when they transition into health services management roles, and the competencies they identify they needed to

develop. This study takes the position that health professionals transitioning to health services manager roles do have transferable, discipline-specific knowledge, that can be deployed in their managerial role, while also acknowledging that their professional backgrounds, education, training may not fully prepare them for management roles.

Health services management and the development of competence of the managers has been identified as a significant issue for the Aotearoa-New Zealand health system. Previous studies have recommended the provision of additional competency development to support health professionals to transition into health services management roles.

The focus of this study is on the individual occupational therapists and asks, “What do occupational therapists employed in health services management roles in New Zealand District Health Boards identify as the core management competencies they developed through their professional training and experience?” A second question asks, “What were the competencies required in their management role, that they perceived that they were least prepared for?”

This study looks to generate new knowledge that will be useful to occupational therapists, their professional associations, the health services who employ them, and under-graduate and postgraduate educational providers, by informing initiatives for competency development. The findings of this research may also be used for academic publications and presentations.

To ensure the cultural safety of the participants, researchers and the study, a Kaumatua with experience in the provision of health and cultural services in DHBs, will provide cultural support and guidance for the period of this study.

For this study an advisory group of four members, all with experience as occupational therapists, has been established. The role of the advisory group is to bring their knowledge of occupational therapy and the complexities and demands of managing DHB health services provision to the study, to protect against researcher bias by challenging initial findings, and to support recruitment to the study by identifying potential participants.

The individual members of this advisory group will act as intermediary’s in this study and will make the initial contact with you, as a potential participant, and provide you with this information sheet and my contact details.

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

This research study plans to interview 15 health services managers in New Zealand District Health Boards who have a background as a registered occupational therapist.

The participants will all be occupational therapists with current or recent experience as a health services manager within NZ DHB services/ functions - for more than six months. Current registration as an occupational therapist is not required.

You have been identified, through professional contacts, as meeting these criteria and that your career journey and insights would contribute to this research topic.

You will have been contacted by one of the advisory group and advised of this research, invited to participate and provided with this information sheet to inform your decision to participate.

How do I agree to participate in this research?

If you are interested in participating in this research study, please contact me, Jennifer Coles, by phone or text or email. Two weeks after the initial contact by the intermediary, all the potential participants are sent a reminder message to contact the researcher, if they have not already, and are interested in participating in this research.

When you contact me and advise of your interest, we will set up a mutually agreed time and location for the interview.

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. You are also able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed from the study or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

This research will involve one (1) interview which will be arranged at a mutually agreed time and place, and will be at a minimum, two weeks from your initial contact. The interview may/ can occur in an office, meeting room or quite public space, or using Zoom. Participants may choose and are welcome to bring a support person to the interview.

It is estimated the interview will take approximately 60 minutes. Prior to the interview commencing you will be asked to sign a consent form.

In the interview you will be asked questions that look to identify and explore the knowledge and insights you have gained in your health services management journey. The areas of interest for this study are the skills, knowledge and attitudes you developed as an occupational therapist, that you found were transferable to your health services management roles, and those you have identified you needed to develop.

To gain insight into these matters, I will ask broad questions about your career journey, qualifications, registration, role demands, and the broad socio-cultural factors that impact you as a health services manager.

The interview will be audio recorded and will be transcribed verbatim by a transcriber, who has signed a confidentiality agreement. To ensure transcription accuracy the verbatim interview transcript will be sent back to you. This will provide the opportunity for you to add, clarify or remove content.

To provide helpful context, a copy of your job description and personal development plan is also requested. If you are not able to provide these documents, this does not preclude you from being part of this study.

I will analyse the information from the interview and supporting documents looking for themes and patterns related to competency development and linked to occupational therapy and health services management.

Members of the advisory group and Kaumatua, will not have access to the interview transcripts or documentation, and will not be informed of the identities of any of the participants.

The information collected and used in the study is for the purposes described only and will remain confidential. The information collected, including recordings, transcripts and researcher notes will be securely stored and then destroyed in accordance with Auckland University of Technology (AUT) policies.

What are the discomforts and risks?

We do not anticipate any risks to participants from taking part in this study. However, sometimes sharing thoughts, opinions and experiences may make a person feel emotionally uncomfortable. If you do feel uncomfortable, you can choose not to answer any question or stop the interview at any time.

How will these discomforts and risks be alleviated?

Should counselling be required this will be available through AUT University. The AUT Health Counselling and Wellbeing service is able to offer three (3) free sessions of confidential counselling support for adult participants in an AUT research project.

These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services in Auckland, you will need to:

- drop into our AUT centres at WB219 or AS104 or phone 09 921 9992 City Campus or 09 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 09 921 9992.
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this information sheet.
- You can find out more information about AUT counsellors and counselling on https://student.aut.ac.nz/support-services/counselling-and-mental-health-support

If outside of Auckland, then access to counselling will be available at your DHB from the Employment Assistance Programme (EAP).

What are the benefits?

The anticipated outcome and benefit of this study is to discern the influences (or not) that an occupational therapy background has on the development of management competencies, and to support ongoing career skills development by presenting information that will be useful to individuals, employers, professional organisations, pre- and post-graduate education providers.

The benefit to you as a participant, is the opportunity to contribute to an investigation into the competencies which occupational therapists bring, or not, into health services management. The interview process may illuminate or provide some insight into your health services

management journey. The findings of this study may provide you with information to support your ongoing management career journey, and to inform your professional development planning.

The benefit to the researcher is the opportunity to investigate and develop new knowledge in an area of interest and contribute to the successful completion of the AUT Doctor of Health Science programme and qualification.

How will my privacy be protected?

The intermediary who approached you to invite your participation in the study will not be told whether you did or did not accept the invitation.

Your identity, and that of your DHB and other people you my mention in interviews will remain confidential, with all names replaced with pseudonyms and any identifying information removed from transcripts. Digital audio recordings and original transcripts will be stored securely. All records will be password protected and destroyed after 6 years.

What are the costs of participating in this research?

The interview is estimated to take 60 minutes of your time.

Further time of about 10– 15 minutes will be required for you to read through the verbatim transcripts, and to let me know if you are happy with them.

What opportunity do I have to consider this invitation?

Following your initial contact with me, I will contact you in two weeks, to reconfirm your interest in participating this study. You may choose to contact me earlier, using the contact details on this information sheet, if you have questions.

Will I receive feedback on the results of this research?

The contribution of the participants to the research will be acknowledged as a non-identifying statement of thanks in the final study document, and I will provide the participants with a summary of the study.

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

Any concerns regarding the nature of this research study should be notified in the first instance to the Project Supervisor, Professor Clare Hocking. Contact: clare.hocking@aut.ac.nz, Ph: 09 9219162

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

Whom do I contact for further information about this research?

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

Researcher Contact Details:

Jennifer Coles. Ph 0273122158. 0273122158 Email: jyg2467@autuni.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 22 March 2021, AUTEC Reference number*21/58*.

Appendix C. Interview Questions

Indicative Interview Questions

Project title: The core management competencies N.Z occupational therapists who manage District Health Board health services identify as coming from their occupational therapy training and experience

Project Supervisor: Professor Clare Hocking

Researcher: Jennifer Coles

1. Please tell me about your career journey to this management role, from when you graduated as an occupational therapist? Why? When? Supports? Barriers? Length of time as a therapist.
2. What formal qualifications do you have?
3. Tell me about your current role, Why did you move to this role
4. How does being an occupational therapist influence how you do this or previous management roles? How? Why? Has it changed over time?
    a. Were there any management or leadership skill you learnt in the OT dept.
5. What occupational therapy skills, knowledge, attitudes (competencies), (if any) have you applied in your health management role? What was a time that you identified you needed these skills?
    a. Were there times you deliberately chose a personal communication approach?
    b. Why did you decide to use a specific approach?
    c. How / why did you decide? Reflection??
    d. Therapeutic use of self is seen as an OT skill in the therapeutic environment. Do you see that this could be applied management environment? When was this? What situation? How did you apply this skill?
6. What skills (if any) have you needed to develop to fulfil the managerial role/s you hold/ have held? What, how?
    a. What was a time that you identified you needed new skills?
7. What is different today from when you stared this role, how, why, what have you had to change/ develop?
8. Reflecting on the demands of your current role, what skills, knowledge, attitudes (competencies) will be most important to develop?
    a. Top 5 skills?
    b. What were you least prepared for
9. Thinking about roles you would like to move into in the future, what skills, knowledge, attitudes (competencies) will be most important to develop?
10. Can you think of an example of when you realised or were advised you needed new skills?
11. Tell me about coaching yourself and others? What concepts did you use?
    a. Have you given out a stretch project?
    b. How did you decide who to give it to?
    c. What were the critical points in the project?
    d. What are your reflections on your actions / role supporting and guiding in this project?

  e. What would you change and why?
  f. What is a stretch project you led?
  g. Why did it stretch you?
  h. What did you learn?
  i. What was your proudest achievement and why?

12. How has your workplace environment, culture, expectations, influenced or not your decisions about identifying and developing skills you required as a manager, and the resources available to you to use in your self-development?
    a. What is your position on remaining up to date on current management and OT theory and practice?
    b. How/ do you prioritise this learning? How does your organisation encourage and support this learning?
13. What was helpful, what would have been helpful? Why?

14. Was there a difference in when you moved from a professional group to the role of manager?

15. What legislation, treaties, or cultural aspects are you aware of that impact on your role as a manager in the health sector? Why? How? When?
    a. What is your experience of cultural diversity in your team/ workplace?
    b. What is your understanding of cultural safety in your workplace?
    c. How do you apply this in your workplace?
16. Do you have a job description and a professional development plan? How do you develop and use these documents?
17. Have you maintained professional registration as an occupational therapist or a health services manager? How? Why?

<u>Updated 2021 September 13th</u>. Adding conscious use of self, stretch projects, cultural diversity and safety.

<u>Updated 2022 February 13th</u>. Early skills development and role of OT dept. Demonstrating competencies and competence when PDP appear not to be used for this. More clarity behind the motivation to change role.

Approved by the Auckland University of Technology Ethics Committee on 22 March 2021, AUTEC Reference number*21/58*.

Appendix D. OTBNZ 2015 Competencies for Registration and Continuing Practice

(Occupational Therapy Board New Zealand, 2015a)

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Occupational Therapy
Board of New Zealand

TE POARI WHAKAORA NGANGAHAU O AOTEAROA

FOSTERING FAITH AND CONFIDENCE IN THE PROFESSION

Competencies for Registration and Continuing Practice

WRITEMARK
PLAIN ENGLISH STANDARD

APRIL 2015

Staying competent and registered as an occupational therapist

This document describes the actions and abilities you need to stay competent as an occupational therapist, and registered with the Occupational Therapy Board of New Zealand. The document sets out:

- the five broad things you must be competent in
- the outcomes you must achieve
- the specific actions and abilities you must demonstrate

The Occupational Therapy Board is responsible for setting these threshold competence standards under the Health Practitioners Competence Assurance Act 2003.

Your role as an occupational therapist in Aotearoa New Zealand

As an occupational therapist in Aotearoa New Zealand, you work with individuals, families, whānau, communities, organisations, and populations. Your role is to increase and transform people's participation in occupation. This helps to promote and improve wellbeing, health, and social outcomes. You aim to enhance tino rangatiratanga (self-determination), ensure equity, and enable occupational justice.

You practice professionally, with a commitment to addressing both individual and systemic barriers to people's participation in occupation. These barriers can be cultural, educational, environmental, or social, or related to health, disability, or spirituality.

Te Tiriti o Waitangi is the founding document of Aotearoa New Zealand. It shapes the diverse historical and sociopolitical realities of Māori and all other settlers and their descendants. Understanding how Te Tiriti affects all our lives is essential for helping people participate in their desired occupation. Such understanding helps you see how systemic and individual issues can breach people's rights and limit their opportunities to participate in their chosen occupations.

The five broad things you must be competent in

AS AN OCCUPATIONAL THERAPIST, YOU MUST BE COMPETENT IN THE FOLLOWING FIVE THINGS.

1. Applying occupational therapy knowledge, skills and values
2. Practising appropriately for bicultural Aotearoa New Zealand
3. Building partnerships and collaborating
4. Practising in a safe, legal, ethical and culturally competent way
5. Engaging with and being responsible for your profession

THESE FIVE THINGS ARE REFERRED TO AS YOUR 'COMPETENCIES'.

The outcomes you must achieve

Each competency has a desired outcome. You must achieve these outcomes in your daily practice, regardless of the setting or your level of experience.

1. APPLYING OCCUPATIONAL THERAPY KNOWLEDGE, SKILLS AND VALUES

   You apply what you know. You engage with people and communities to enable occupations based on rights, needs, preferences and capacities. You work within the context of each client's* environment to optimise their participation and well-being.

2. PRACTISING APPROPRIATELY FOR BICULTURAL AOTEAROA NEW ZEALAND

   You treat people of all cultures appropriately. You acknowledge and respond to the history, cultures, and social structures influencing health and occupation in Aotearoa New Zealand. You take into account Te Tiriti o Waitangi The Treaty of Waitangi and work towards equal outcomes for all your clients.

3. BUILDING PARTNERSHIPS AND COLLABORATING

   You collaborate. You work well with other individuals, groups, communities and organisations. You use your own and others' resources, environment and skills to benefit your clients.

4. PRACTISING IN A SAFE, LEGAL, ETHICAL AND CULTURALLY COMPETENT WAY

   You act with integrity. You include safety, legal, ethical, and cultural requirements and expectations in your professional practice, and apply them to your work.

5. ENGAGING WITH AND BEING RESPONSIBLE FOR YOUR PROFESSION

   You engage with your profession. You ensure your practice is professional, current, responsive, collaborative, and evidence-based.

*'Client' refers to any individual, family or whānau, community, organisation or population you provide a service to.

The specific actions and abilities you must demonstrate

You will achieve each competency and its outcome by demonstrating specific actions and abilities. These are referred to as your 'performance indicators', because they indicate whether you are performing to an acceptable standard.

You are not required to demonstrate all the performance indicators all of the time.

PERFORMANCE INDICATORS FOR COMPETENCY

1. Applying occupational therapy knowledge, skills and values

You apply what you know. You engage with people and communities to enable occupations based on rights, needs, preferences and capacities. You work within the context of each client's environment to optimise their participation and well-being.

To achieve this competency and its outcome, you must demonstrate the following abilities and actions:

1.1 You apply an occupational perspective to your practice.

1.2 You work within the scope of occupational therapy practice. You identify the boundaries of the service you can provide, and make appropriate referrals.

1.3 You use a range of strategies for communicating. You adapt how you communicate to each context, acknowledging and respecting the values, beliefs, attitudes and practices of your clients / tangata whaiora (Māori clients).

1.4 You enable and empower your clients / tangata whaiora to improve their own occupational performance and participation.

1.5 You collaborate with people and communities to establish priorities and goals that you all agree on.

1.6 You select the appropriate assessments and evaluations when planning your practice.

1.7 You use current theory and evidence, as well as sound clinical reasoning, to help you make decisions and use the best processes in your practice.

1.8 You identify the individuals, organisations or sections of the community that help, hinder or pose risks to your practice.

1.9 You recognise and respect that each individual is unique, and you practise in a way that respects mana (status) and wairua (spirit).

1.10 You help your clients live ordinary lives within their natural environments. You engage them in sustainable occupations that they find meaningful and valuable.

1.11 You choose and use a range of strategies, including: helping clients to adapt, modifying their environments, developing their skills, and teaching them processes for learning. You consult, advocate, and coach.

1.12 You evaluate your practice using appropriate measures and client feedback. You review, modify or complete your practice based on this evaluation.

1.13 You identify, express, document and justify the strategies you choose as appropriate for your clients, based on the results of your assessment.

1.14 You keep appropriate records of the services you provide. These records are suitable for evaluating your services, your professional performance, and your business.

1.15 You promote healthy practices, attitudes, and environments that contribute to occupational well-being.

1.16 You understand and recognise key Māori concepts, and you include appropriate tikanga (Māori customs) in your practice.

1.17 You facilitate and advocate for occupational justice.

2. Practising appropriately for bicultural Aotearoa New Zealand

You treat people of all cultures appropriately. You acknowledge and respond to the history, cultures, and social structures influencing health and occupation in Aotearoa New Zealand. You take into account Te Tiriti o Waitangi The Treaty of Waitangi and work towards equal outcomes for all your clients.

To achieve this competency and its outcome, you must demonstrate the following abilities and actions:

2.1 You understand the effects of Te Tiriti o Waitangi The Treaty of Waitangi on Māori health and social outcomes.

2.2 You recognise your responsibility as a health professional to ensure equal health outcomes for all your clients / tangata whaiora (Māori clients).

2.3 You recognise the effect of structural, systemic and historical decisions on individuals, as well as on their choices and their occupational possibilities.

2.4 You understand the factors contributing to rates of Māori mortality, imprisonment, health and social participation. You understand why Māori outcomes differ to those of non-Māori.

2.5 You understand the factors contributing to the occupational and health needs of specific clients, including Māori, tau iwi (non-Māori), Pacific peoples, refugees, new settlers and others.

2.6 You develop strategies and practise in ways that promote equal outcomes for Māori and other groups that are occupationally compromised.

2.7 You recognise that different communities need different resources. You make sure these resources are available or developed.

2.8 You adapt your services to each client. You acknowledge and respect that a client's culture or ethnicity may affect how they wish to be treated.

2.9 You acknowledge diversity across and within all groups, whether Māori or tau iwi.

2.10 You identify your own cultural values, beliefs, attitudes and assumptions about what people are entitled to. You understand the effect these ideas have on the decisions you make in your practice.

2.11 You recognise that your peers, colleagues and clients all bring different realities and identities to your practice.

2.12 You understand sociopolitical, governmental and organisational processes for making decisions and setting policies. You understand the effects of these decisions and policies on services for different cultural groups.

2.13 You take your responsibilities under Te Tiriti o Waitangi The Treaty of Waitangi seriously. You meet and develop relationships with local iwi and with people who work in Māori health, welfare and education.

2.14 You identify your own role in building and sustaining relationships with whānau, hapū, iwi, Māori organisations and tangata whenua as a whole.

2.15 You understand power imbalance between different cultures. You negotiate appropriately when collaborating, consulting or partnering with Māori.

PERFORMANCE INDICATORS FOR COMPETENCY

3. Building partnerships and collaborating

You collaborate. You work well with other individuals, groups, communities and organisations. You use your own and others' resources, environment and skills to benefit your clients.

To achieve this competency and its outcome, you must demonstrate the following abilities and actions:

3.1 You work well both alone and with others to ensure the best outcomes for your clients / tangata whaiora (Māori clients).

3.2 You act with integrity, building and maintaining respectful relationships with your clients, colleagues, peers and other professionals.

3.3 You recognise when the boundaries between personal and professional relationships are not clear enough, and how this affects your team or your clients.

3.4 You contribute to developing and achieving the objectives of your team.

3.5 You work well with people in other professions, making sure you treat clients consistently to achieve common goals.

3.6 You engage with the principles and processes of quality improvement.

3.7 You practise within the established standards, policies, guidelines, procedures and expectations of the organisation, agency or funding body you work for.

3.8 You create, monitor or challenge standards, policies and procedures to ensure they meet professional competencies.

3.9 You work with your colleagues to recognise and address any cultural assumptions that affect the quality of your services.

3.10 You contribute to supporting, guiding, and developing your team members.

3.11 You look out for legitimate, evidence-based developments in the field of occupational therapy that could be applied to your practice.

3.12 You promote occupational therapy to services, organisations, communities and agencies.

PERFORMANCE INDICATORS FOR COMPETENCY

4. Practising in a safe, legal, ethical and culturally competent way

You act with integrity. You include safety, legal, ethical, and cultural requirements and expectations in your professional practice, and apply them to your work.

To achieve this competency and its outcome, you must demonstrate the following abilities and actions:

4.1 You understand, justify and promote that all clients deserve equal services.

4.2 You understand, explain and promote personal choice and control for your clients.

4.3 You practise in ways that show you appreciate the complexity of cultures, identity, ethnicity and how people relate to and connect with their natural environment.

4.4 You recognise your own level of safety, and your legal, ethical and cultural competence, and address any weaknesses.

4.5 You acknowledge, identify and safely respond to the values, beliefs, attitudes and practices of your clients / tangata whaiora (Māori clients).

4.6 You identify cultural differences and how these might affect communication.

4.7 Your relationships with your clients are ethically sound and culturally safe.

4.8 You use reasoning and reflection to make and justify your decisions on ethical issues.

4.9 You promptly identify, explore and address potential conflicts of interest.

4.10 You recognise and address issues that compromise your own or others' safety.

4.11 Your actions comply with the legislation, regulations, service standards, and professional and ethical guidelines relevant to your area of practice. You can justify your actions.

4.12 You develop and maintain a safe environment. You balance safety, risk and participation when treating your clients.

4.13 You manage your own health and well-being so that you are fit to practice.

5. Engaging with and being responsible for your profession

You engage with your profession. You ensure your practice is professional, current, responsive, collaborative, and evidence-based.

To achieve this competency and its outcome, you must demonstrate the following abilities and actions:

5.1 You take responsibility for your own professional development.

5.2 You critically appraise and use professional literature to update your knowledge of current theories, techniques, technology, outcomes and practice. You use current developments in your practice.

5.3 You understand and contribute to research that furthers occupational therapy practice.

5.4 You help to improve occupational therapy knowledge, resources, practices and services. This includes networking with your peers and supervising or mentoring your colleagues or students.

5.5 You assess how well your colleagues are supervising, supporting and guiding others. You suggest changes when needed.

5.6 You reflect on your own and others' competence, knowledge, skills and attitudes, and work to improve them.

5.7 You identify gaps in your skills or knowledge. You find a way to learn what you need to know.

5.8 You reflect on how your professional abilities, attitudes, strengths and limitations affect your practice and the services you provide.

5.9 You support new areas of practice and knowledge.

5.10 You are aware of how sociopolitical trends – including funding, delivery, education, staffing and career choices – affect occupational therapy services.

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Appendix E. ACHSM 2016 Master Health Service Management Competency Framework

(Australasian College of Health Service Managers, 2016)

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MASTER HEALTH SERVICE MANAGEMENT
COMPETENCY FRAMEWORK

ACHSM Australasian College of Health Service Management

Better leadership. Healthier communities.

ACHSM MASTER HEALTH SERVICE MANAGEMENT COMPETENCY FRAMEWORK

Introduction

The Australasian College of Health Service Management has developed this Framework for the guidance of all of its programs, to inform members of the College on the competencies[1] they need to master and to guide employers and policy makers on the competencies they should consider when employing, leading, managing and mentoring health service managers. This Framework builds on the work of the Global Consortium hosted by the International Hospitals Federation (2015). This version was approved by the ACHSM Board at its meeting on August 31, 2016.

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Background

Why a Competency Framework is necessary

Due to rapid developments in healthcare knowledge, methods and technology over the past half century healthcare organisations have increased considerably in size and complexity and are now capable of achieving a very wide range of favourable outcomes for consumers. Healthcare now consumes a greater proportion of national expenditure than ever before and healthcare providers are required to achieve compliance with complex sets of regulatory and care standards. As a consequence governments, the community and health service funders are rightly demanding a high level of competency from the professional managers charged with the responsibility of leading and managing individual healthcare services, large healthcare organisations and the overall health system. To meet these demands leaders and professional managers of healthcare services must achieve and demonstrate a high level of competency in their practice. The range of competencies required by leaders and managers can alter quickly in the rapidly changing healthcare environment and this necessitates frequent review of the competencies they are required to demonstrate by consumers, funders and, governing and regulatory bodies. This framework provides a contemporary and comprehensive list of competencies required of healthcare leaders and managers.

In recognition of the complexity and cost of healthcare a Global Consortium, under the guidance of the International Hospital Federation (IHF), is urgently calling on governments and the international healthcare community to recognise that healthcare performance and improvement are significantly dependent on the existence and quality of professional management of healthcare organisations. To assist this recognition the Global Consortium developed and released a set of competencies for health service leaders and manager which recognise the contemporary nature of health services management (International Hospital Federation, 2015).

This Framework

This framework is based on competencies compiled by the Global Consortium. It articulates the competencies necessary in those persons charged with the management and leadership of contemporary health services within Australia, New Zealand and Hong Kong. It contributes to the professionalisation of health service management by providing an authoritative, convenient and comprehensive description of the competencies health service managers and leaders need to be effective in their role. The modifications to the Global Consortium framework have

been made to reflect local and national priorities in relation to healthcare management and to change language and expression to suit users in the countries from which the ACHSM draws it members.

Figure 1 Relationship between Domains

The ACHSM Master Competency Framework captures the core competencies that are considered important for health service managers and leaders. This Framework, summarised in Figure 1, uses the five Domains of health service management competency adopted by the Global Consortium and the IHF. Figure 1 illustrates the relationship between the five Domains and highlights that the Domain of Leadership is associated with all the other domains. This framework is based on work by Stefl (2008).

In this paper there is one table for each Domain. These tables include a number of sub-Domains. Each of the proposed competency statements (column 2) in the tables are either adopted unchanged from the IHF competency, modified to capture contemporary or local concepts or are new competencies based on the ACHSM Competency Framework Committee's identification of gaps in the IHF list of competencies.

The statements include a description of the elements that make up often complex competencies and may include references to *knowledge, skill, ability, and personal characteristics.* Because of these complexities, some statements may need to be separated into their individual elements in the development of assessment tools. In addition, a competency statement in one Domain that has a particular focus, may consist of similar skills, abilities and knowledge to a competency statement in another Domain with a different focus. Consequently, in a number of cells cross-references are provided to identify similar competency statements. These cross-references may not be exhaustive in all circumstances where similarities occur.

In the interests of brevity and clarity words such as 'health service manager', 'manager', 'leader', 'health', 'healthcare', 'aged care', 'hospitals', etc., are not included in many of the competency statements as the reference to these concepts are assumed. While many of the competencies are generic to managers and leaders in other industries, the unique contribution of this framework is to bring together the combination of competencies and the emphasis within these competencies of the skills, knowledge and attributes necessary for leaders and managers in the health industry.

The intended use of the competency framework

The ACHSM Master Competency Framework is intended for use within, and by, health services, organisations and systems in Australia, New Zealand and Hong Kong. It is intended to be the basis from which individual competency tools can be developed by the ACHSM for use across the different works of the College. It is not, in itself, a measurement tool.

In the documents reviewed during the development of this Draft Master Competency Framework, a number of competency statements appear to apply to, and are worded for, a specific level of management.[1] The competency statements in this draft are intended to apply across all levels of management and for a range of applications with the College. For this purpose, the term 'health unit/organisation/system' (U/O/S) is included in several competency statements. This enables individual tools to be developed, based on this Master, which will be applicable to a specific level of management. For example, a competency statement used at the Fellowship level within the College may make reference to the health 'system' whereas a competency tool used at the emerging manager level may make reference to the health 'unit'.

Individual tools will be developed to target specific ACHSM groups (e.g., emerging leaders, middle managers, Fellows etc.) in the future. Where these individual tools are developed within the College they will:

- be approved by the appropriate Committee of the ACHSM Board;
- maintain the established ***Domain*** and ***Short Title*** framework;
- contain individual behavioural statements worded appropriately for the particularly management level, which may mean that some competencies in the Master Framework could generate more than one behavioural statement in an individual tool; and

[1] For example, the Global Consortium (International Hospital Federation, 2015) framework makes references to the 'health system', the ACHSM tool (Australasian College of Health Services Management, 2010) to the 'unit' and the MCAP tends to refer the 'organisation'. This suggests that the IHF competency statements are intended to apply to very senior management; for example, it includes the statement 'Create and maintain a system of governance that assures appropriate oversight to the organisation'. On the other hand the competency statements developed by the Management Competency Assessment Project (MCAP) (Liang & et al, 2015) tends to apply to junior or middle management; for example it includes the competency statement 'Interprets basic financial statements (C2.3)'.

- use qualifying words such as 'basic', 'moderate', 'comprehensive', 'expert', to apply to the specific target group, for example, 'demonstrates **basic** budgeting skills', 'demonstrates **comprehensive** understanding of all organisational governance processes' so as to reflect the focus of the manager/leader that that level.

The following five tables each contain the sub-Domains, short title and competency statements for each of the five Domains.

Table 1 Leadership Competency Statements

COMPETENCY DOMAIN: 1. LEADERSHIP	
Short title	**Competency statement**
Sub-Domain	**1.1. Leadership Skills and Behaviours**
Articulates mission	1.1.1. Articulates and communicates the mission, vision, objectives, values and priorities of the Unit /Organisation /Sector (henceforth U/O/S) to internal and external entities [see also 4.2.2, and 4.2.3]
Encourages staff commitment	1.1.2. Encourages a high level of commitment from staff to the U/O/S's mission, vision, objectives, values and priorities
Balances competing organisational priorities	1.1.3. Achieves a balance between potentially competing U/O/S and professional values and priorities [see also 2.1.5]
Exhibits flexible leadership style	1.1.4. Exhibits collective and collaborative leadership by adapting leadership style to suit the situation
Exhibits leadership qualities	1.1.5. Demonstrates leadership qualities (for example: focus, perseverance, energy, commitment, enthusiasm, tolerance of ambiguity and calmness under pressure)
Encourages decision-making	1.1.6. Encourages decision-making through consultation, problem analysis, promotion of solutions and new ideas [see also 4.1.2, 4.1.3]
Sub-Domain	**1.2. Influences Organisational Climate**
Creates trust, transparency and service improvement	1.2.1. Creates an **organisational climate** built on respect, mutual trust and transparency [see also subdomain 3.8, 4.1.2 and 4.1.4]
Influences decision makers	1.2.2. Favourably influences decision makers [see also 4.1.1]
Demonstrates accountability	1.2.3. Holds self and others accountable to achieve and surpass U/O/S goals
Sub-Domain	**1.3. Leading Change**
Promotes learning and improvement	1.3.1. Promotes ongoing learning and improvement in the U/O/S
Leads change	1.3.2. Responds to the need for change and leads the change process using evidence-based methods
Encourages diversity of thought	1.3.3. Encourages diversity of thought to support innovation, creativity and improvement

Table 2 Health and Healthcare Environments Competency Statements

COMPETENCY DOMAIN: 2. HEALTH AND HEALTHCARE ENVIRONMENT	
Short title	**Competency statement**
Sub-Domain	**2.1. Health Systems and Organisations**
Understands the regulatory environment	2.1.1. Understands and considers the role and function of government and of regulatory, professional and accreditation agencies
Understands political and social environment	2.1.2. Understands and considers the impact of external factors (political, social, technical and economic) on the U/O/S
Understands how the health system works	2.1.3. Understands and considers the impact of the wider health system structure, funding and organisation on the health U/O/S
Understands and abides by relevant legislation	2.1.4. Understand and abides by relevant legislation and regulations that apply to the U/O/S
Balances competing health system priorities	2.1.5. Effectively balances the competing healthcare priorities and interrelationships across issues such as access, quality, safety, cost, resource allocation, accountability, competition, care setting, community need and professional roles [see also 1.1.3]
Assesses healthcare trends	2.1.6. Assesses the current performance of the U/O against benchmarks and best practice and compared to the wider health system
Uses quality monitoring systems	2.1.7. Understands and uses monitoring systems, that incorporate quality indicators, to identify opportunities for continuous improvement, to set and monitor performance standards and to improve quality [see also 3.8.1, 3.8.2, 5.1.4]
Encourages community participation	2.1.8. Encourages/establishes engagement and networks to enable community and network participation in the health U/O/S
Sub-Domain	**2.2. Health Workforce**
Manages health workforce	2.2.1. Manages the health workforce (volume, supply, skill mix, scope of practice) to deliver high quality healthcare for the U/O/S
Manages inappropriate behaviours	2.2.2. Manages the workforce to protect staff from bullying, harassment and other inappropriate behaviours
Sub-Domain	**2.3. Partnering with consumers**
Promotes cultural safety and Indigenous rights	2.3.1. Promotes cultural safety and Indigenous rights with respect to all treaty and/or partnership arrangements
Partners with consumers	2.3.2. Partners with consumers (including family and carers) in the planning, designing and monitoring of care
Promotes the preferences of population groups	2.3.3. Promotes the preferences of both majority and minority communities, particularly Indigenous groups, in relation to health practices and priorities
Responds to diverse health needs	2.3.4. Creates initiatives and approaches that appropriately reflect the diverse health needs of the community

COMPETENCY DOMAIN: 2. HEALTH AND HEALTHCARE ENVIRONMENT

Short title	Competency statement
Sub-Domain	**2.4. Population Health**
Demonstrates commitment to improving the health of the community	2.4.1. Pursues goals and objectives for improving the health of the community; which demonstrate an understanding of the social determinants of health and of the socioeconomic environment [See also sub 5.4.1 and 5.4.2]
Uses data to control threats to health	2.4.2. Uses organisational, community, national and global public health data for surveillance and control of threats to the health of the community.

Table 3 Business Skills Competency Statements

COMPETENCY DOMAIN: 3. BUSINESS SKILLS	
Short title	**Competency statement**
Sub-Domain	**3.1. Evidence Informed Decision-Making**
Anticipates the need for evidence	3.1.1. Anticipates the need for evidence and data (including new information) for healthcare and business decisions [see also 3.2.1, 3.2.2]
Uses data for decision making	3.1.2. Sources, understands and evaluates a variety of data and information (both quantitative and qualitative) *from internal and/or external sources* to support effective business, and healthcare decisions [see also 3.2.1, 3.2.2]
Sub-Domain	**3.2. Financial and Resource Management**
Uses financial management	3.2.1. Understands, effectively uses and effectively communicates financial data, statements and reports [see also 3.1.1, 3.1.2]
Uses financial principles	3.2.2. Understands and effectively uses key accounting principles and financial management tools such as financial plans and measures of performance (e.g. performance indicators) [see also 3.1.1, 3.1.2]
Creates and controls budgets	3.2.3. Creates and controls operational and capital budgets to meet health U/O/S goals
Manages resources	3.2.4. Plans, organises, effectively uses and monitors the [non-financial] resources of the organisation to ensure optimal health outcomes and effective quality and cost controls [see also 5.1.2]
Sub-Domain	**3.3. Human Resource Management**
Plans workforce	3.3.1. Plans for an appropriate workforce at the health U/O/S level, within available resources
Manages human resources	3.3.2. Manages U/O/S human resource functions and processes within the strategic operational framework
Promotes staff performance	3.3.3. Promotes staff performance through recognition of staff development needs and working conditions
Manages staff well-being	3.3.4. Creates an environment that monitors and supports staff health, wellbeing and satisfaction and responds appropriately to stress in the workplace
Sub-Domain	**3.4. Organisational Dynamics And Governance**
Uses relevant theory	3.4.1. Effectively applies knowledge of organisational systems theories and behaviours
Manages external changes	3.4.2. Interprets public policy, legislative and advocacy processes within the U/O/S
Understands governance	3.4.3. Understands, effectively navigates and manages within the corporate governance structure and responsibilities of the health U/O/S
Understands leadership within governance	3.4.4. Understands the role of leadership within the U/O/S governance structure
Creates appropriate governance structure	3.4.5. Creates and maintains a system of corporate governance that assures appropriate oversight of the U/O/S
Sub-Domain	**3.5. Planning and Marketing**
Leads strategic and business	3.5.1. Leads the development of key planning documents,

COMPETENCY DOMAIN: 3. BUSINESS SKILLS

Short title	Competency statement
planning	including corporate and strategic plans, business plans, service plans and business cases for new services
Develops strategic objectives	3.5.2. Develops and monitors operating unit strategic objectives that are aligned with the mission and strategic objectives
Evaluates actions against plans	3.5.3. Evaluates whether a proposed action aligns with the U/O/S business/strategic plan
Plans for business continuity	3.5.4. Plans for business continuity in the event of disasters [See also 3.7.3]
Sub-Domain	**3.6. Information Management**
Uses data to assess performance	3.6.1. Uses data sets to assess performance, establish targets, monitor indicators and trends, and determine if deliverables are met
Applies privacy protection	3.6.2. Understands and applies privacy and security requirements to protect private information
Uses health information	3.6.3. Promotes the effective management, analysis and communication of health information [see also 4.2.2]
Sub-Domain	**3.7. Risk Management and Clinical Governance**
Manages corporate risk	3.7.1. Effectively applies risk management principles and programs (such as risk assessment and risk mitigation) for corporate risk management and business continuity.
Manages clinical risk	3.7.2. Effectively applies risk management principles and programs (such as risk assessment and risk mitigation) for risk management within clinical care
Manages workplace risk	3.7.3. Effectively applies risk management principles and programs (such as risk assessment and risk mitigation) for workplace risk management [See also 3.5.4]
Understands insurance management	3.7.4. Understands the principles of, and manages the U/O/S need for, insurance
Sub-Domain	**3.8. Quality and Safety**
Implements quality and safety programs	3.8.1. Develops, implements and evaluates quality improvement and patient safety programs within the U/O/S according to national/state/local initiatives [see also 5.1.4, 2.1.7]
Measures consumer satisfaction	3.8.2. Apply tools to measure consumer (patients and carers) experience for continuous improvement U/O/S [see also 5.1.4, 2.1.7]
Sub-Domain	**3.9. Project, Supply Chain and Facilities Management**
Manages supply chain	3.9.1. Effectively manages supply chain from suppliers to end users to achieve timelines and efficiency of delivery, warehousing, and distribution in a cost effective manner
Manages projects	3.9.2. Manages U/O/S projects within budget and timelines
Manages supply contracts	3.9.3. Understands how to manage contracts with external suppliers (includes the preparation and evaluation of tenders) that comply with organisational policy and legal requirements
Manages facilities	3.9.4. Ensures that facilities are fit for purpose (including an understanding of the role of the environment of care in promoting wellness) and are legislatively compliant

Table 4 Communications and Relationship Management Competency Statements

COMPETENCY DOMAIN: 4. COMMUNICATIONS AND RELATIONSHIP MANAGEMENT	
Short title	**Competency statement**
Sub-Domain	4.1. Relationship Management
Maintains effective stakeholder relationships	4.1.1. Establishes, develops and maintains effective interpersonal relationships, using collaborative techniques, with internal and external stakeholders [see also 1.2.2]
Works effectively in a team	4.1.2. Builds teams and works collaboratively, and effectively, with people from a wide range of professional and social backgrounds and who are both internal and external to the organisation [see also 1.1.6, 1.2.1]
Delegates effectively	4.1.3. Delegates effectively by empowering others
Values diversity	4.1.4. Values and respects diversity within individuals and groups [see also 1.2.1]
Sub-Domain	4.2. Communication Skills
Listens and responds	4.2.1. Listens with understanding and empathy and responds appropriately, both verbally and non-verbally, with confidence
Demonstrates appropriate verbal and presentation skills	4.2.2. Verbally and visually communicates data and information that is factual, credible and understandable to the target audience (both internal and external) [see also 1.1.1, 3.6.3, 4.2.1]
Demonstrates effective writing skills	4.2.3. Communicates succinctly, clearly and appropriately (in language, style and format) in a manner that is appropriate for both audience and purpose [see also 1.1.1, 3.6.3]
Demonstrates effective public relations skills	4.2.4. Demonstrates effective public relations skills through appropriate communications with the media and external organisations
Applies marketing tools and principles	4.2.5. Applies marketing principles and tools to develop marketing strategies that are appropriate to the needs of the community and the organisation
Sub-Domain	4.3. Conflict and Problem Management
Manages conflict	4.3.1. Manage conflict through mediation, negotiation and other dispute resolution techniques
Manages conflict of interest	4.3.2. Manages **conflict** of interest situations as defined by organisational bylaws, policies and procedures
Demonstrates problem solving skills	4.3.3. Demonstrates problem solving skills

Table 5 Professional and Social Responsibility Competency Statements

COMPETENCY DOMAIN: 5. PROFESSIONAL AND SOCIAL RESPONSIBILITY	
Short title	**Competency statement**
Sub-Domain	**5.1. Professionalism**
Demonstrates commitment to policy advocacy and capacity	5.1.1. Advocates for policy changes, at the government, professional and organisational level that will enhance outcomes for individuals and communities [see also 5.1.1, 5.4.1 and 5.4.2]
Practices fiduciary responsibility	5.1.2. Practices due diligence to meet fiduciary responsibilities [see also 3.2.4]
Demonstrates commitment to competency, integrity and altruism	5.1.3. Demonstrates a commitment to competence, integrity, altruism and the promotion of the public good
Demonstrates commitment to quality and safety	5.1.4. Understands and promotes quality, safety of care and social commitment, in the delivery of healthcare [see also 3.8.1, 3.8.2, 2.1.7]
Sub-Domain	**5.2. Profession and Professional Development**
Demonstrates commitment to personal development	5.2.1. Demonstrates commitment to self-development including continuing education, networking, reflection and personal improvement
Demonstrates commitment to profession development	5.2.2. Demonstrates a commitment and contribution to advancing the profession of health management by sharing knowledge and experience [see also 5.1.1]
Demonstrates a commitment to developing others	5.2.3. Demonstrates a commitment to developing others by mentoring, advising, coaching, teaching and serving as a role model
Balances professional and personal accountability	5.2.4. Maintains a balance between personal and professional accountability, recognising that the central focus is the needs of the patient/ community
Sub-Domain	**5.3. Self-Awareness**
Knows own attributes	5.3.1. Uses self-assessment and feedback from others, to develop an awareness of one's own assumptions, values, strengths and limitations, and the impact these attributes have on communication and decision making, and on others
Displays emotional intelligence	5.3.2. Demonstrates self-control over own emotions and impulses
Sub-Domain	**5.4. Social Responsibility**
Understands social responsibility	5.4.1. Understands and considers the impact the U/O/S has on the wider community and environment [see also 2.4.2, 5.1.1]
Balances corporate and social responsibility	5.4.2. Balances the needs of the U/O/S with those of the wider community and the environment [see also 2.4.2, 5.1.1]
Demonstrates a commitment to ethical conduct	5.4.3. Demonstrates high ethical conduct, a commitment to transparency, and accountability for one's own actions and uses established structures to resolve ethical issues

Appendix 1: Table of Acronyms and Table of Definitions

Table 6 Acronyms

ACHSM	Australasian College of Health Service Management
IHF	International Hospital Federation
MCAP	Managerial Competency Assessment Partnership Confirmation Study – Australasia lead by La Trobe University
U/O/S	Health Unit/ Organisation/ System

Table 7 Definitions

Term	Definition
Business skills	The ability to apply business principles, including systems thinking, to the healthcare environment. (American College of Healthcare Executives, 2015)
Communication and Relationship Management	The ability to communicate clearly and concisely with internal and external customers, establish and maintain relationships, and facilitate constructive interactions with individuals and groups. (American College of Healthcare Executives, 2015)
Competency	Competence is context-dependent and is a statement of the relationship between an ability (in the person), a task (in the world), and the ecology of the health systems … in which the tasks occur. (Epstein & Hundert, 2002)
Health and the Healthcare Environment	The understanding of the healthcare system and the environment in which healthcare managers and providers function. (American College of Healthcare Executives, 2015)
Health System/ healthcare system	This includes national, state, province, district or local health system. It applies to primary, acute, rehabilitation and long term care health services delivered as inpatient, residential or home based care. It applies to both health and the aged care systems and to parallel systems such as defence, immigration, justice and veterans.
Leadership	Health leadership has been defined in Australia to have five components: leads self, engages others, achieves outcomes, drives innovation and shapes systems. (Health Workforce Australia, 2013)
Professional and Social Responsibility	The ability to align personal and organisational conduct with ethical and professional standards that include a responsibility to the patient and community, a service orientation, and a commitment to lifelong learning and improvement (American College of Healthcare Executives, 2015). Social responsibility gives consideration to the impact of organisational decision making and behaviour on the wider community and environment (Brandao, Rego, Duarte, & Nunes, 2012).

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