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Management competencies of clinical managers at public hospitals in Gauteng, South Africa: implications for coaching

A research report submitted by

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25 May 2017

DECLARATION

I, Mperekeng Bekani Naumi Sithole declare that this research report is my own work except as indicated in the references and acknowledgements. It is submitted in partial fulfilment of the requirements for the degree of Master of Management in the University of the Witwatersrand, Johannesburg. It has not been submitted before any degree or examination in this or any other university.



MBN Sithole

Fourways
Signed at

25 May 2017
Date

DEDICATION

I dedicate this thesis to my 4 boys: Rhulani 3 years old, for giving me a reason to have a positive outlook on life. Bongani, Fumani and Akani for their special interest in my development and growth, unconditional love, presence and unwavering support.

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ABSTRACT

Introduction

Public hospitals are complex environments in which healthcare leaders are required to lead effectively in order to provide quality service delivery. The issue is: are clinical managers working in Gauteng hospitals competent to lead? This study measures the competency of clinical managers in public hospitals and considers how coaching can be used to close the competency gap in Gauteng public hospitals. Coaching has been identified as one of the appropriate developmental tools to enhance the skills' gap of top managers in organisations (West & Milan, 2001). In this study, coaching has been considered to be an appropriate learning and developmental tool to enhance skills for these managers.

Methods

A self-administered questionnaire was used to conduct the survey among clinical managers in the hospitals in Gauteng. Participants were asked to rate the required management competencies and their proficiency levels against nine management competency categories which include: leadership, communication, life-long learning, consumer responsiveness, political and health environment, conceptual skills, results management, resource management, compliance with standards and coaching in improving management competencies .Likert-scale data was used to measure the top managers' perceptions of the important competencies required for effective service delivery and their level of proficiency with those competencies.

Results

Findings show that there is significant gap in management competency of clinical managers, which indicates the need for further development of managers. Most clinical managers' have a perception that coaching has a role in enhancing their competency gap. Literature supports coaching as a leadership development tool for closing the competency gap of clinical managers.

Conclusion

There is significant gap in the public health sector managers' competency level. There is a need for appropriate and further training and development to address the skills gap. There is need to strengthen management capacity to support the strategy of improved and sustainable healthcare service delivery. Coaching is the appropriate leadership developmental and supportive tool to enhance the skills needed by clinic managers.

CHAPTER 1: INTRODUCTION

1.1 Purpose of the Study

The purpose of this research is to measure the competencies of clinical managers in public hospitals, and to consider how coaching can be used to close the competency gap in Gauteng public hospitals.

1.2 Context of the Study

This study took place in Gauteng Province, South Africa. South Africa is a developing country with a unique history of apartheid. According to Coovadia, Jewkes, Barron, Sanders, and McIntyre (2009), during that time, top managers in the public health sector were mostly white males and decision-making powers were centralised at provincial health offices. The public sector was also a designated sector for whites who were unemployed. Democracy dawned in 1994 and with this there has been an increase in community awareness about the rights and service standards that should be met by public institutions. The new government also drove the agenda of the recruitment of black people including women in the top management of the health sector. During this process, competencies were not considered as part of the recruitment. There was also a scarcity of training, development and support of staff. This South African legacy has resulted in challenges with the provision of quality healthcare service in the public sector due to the lack of competent managers.

Lately, the Minister of Health has been addressing the issue of recruitment of incompetent top managers, with competencies used as an integral part of the recruitment of top managers; hence, Coovadia et al. (2009) developed the competency framework for senior managers in health. The evident lack of management capacity in healthcare services has created an urgent need for leadership training and development.

According to Pillay (2008), the public has a view that public hospitals are under-performing and this is evidenced by the dissatisfaction echoed by patients. Lack of management capacity was found to be a key factor in poor performance. The Pillay (2008) study recommended further development and training of managers. He highlighted that there was a need to ensure that interventions were suitable to the individual and organisation.

Karsten (2010) reported that organisations were in need of effective leadership and management in order to achieve set organisational performance; however, this is currently a challenge due to limited availability of competent leaders. This challenge coupled with changes in the economy, requires a change in the acquisition of skills and behaviours which in turn requires effective development programme for leaders (Charan, Drotter, & Noel, 2010; Kaiser, 2011). The above studies support the need for improved performance in the public healthcare sector. This can be attained if competent people are recruited to top management, who are then developed and supported with suitable programmes (Coovadia et al., 2009).

Public hospitals in this study are located in an urban province with multiple universities that offer teaching of healthcare workers, which includes specialised health services. People come in droves from other parts of the country and outside South Africa to this province looking for jobs, as it is also called "The City of Gold". The influx of people leads to greater numbers of sick people seeking specialised care. The increase in the number of patients increases the demand on the allocated resources.

This was supported by MacKinnon et al. (2005) who define the healthcare setting as a complex environment to manage due to high patient demands, lack of resources, political pressures, the need for the provision of quality care, and access to healthcare service and accountability. Coovadia et al. (2009) state that 64% of the South African population use the public health system to access the health services and 44% of the healthcare budget is used in the tertiary and academic hospitals due to the complex and increased number of patients that the health public health system serves. This means that the level of care

of the hospital is also under pressure, and the higher the level of care required, the higher the challenge and the higher the need for well-capacitated management.

Clinical managers in this study are business managers, responsible for various units in the hospital. Clinical managers in this public hospital experience the challenge of a high number of patients who seek medical services. Most of these patients come from poor communities, including informal settlements and are unable to afford medical aid for private medical care. The change in disease profile, in this case HIV and AIDS, has also contributed to the increase in number of patients at these hospitals. There is an overflow of patients in the medical wards with prolonged hospital admissions (Arthur et al., 2000). This stretches the demand for available resources, and results in senior managers competing for available resources. The increase in resource demands, with limited resources being allocated, results in frustration and conflict among senior managers, which manifests in a silo mentality, lack of collegial relationships and low productivity (Patton, 2014). This observation has been reported by Mitton and Donaldson (2003) as a challenge in the healthcare setting.

The nature of work in a hospital environment as reported by Aubry, Richer, and Lavoie-Tremblay (2014), where people's lives are at stake, is stressful both physically and psychologically for clinical managers. A study by Schieman (2013) identified high job demands coupled with performance anxiety, long working hours and more engagement with activities on the ground, resulting in work to home conflict. He called it "stress of higher status" (p. 1). An added stress is that media in South Africa have put public hospitals under constant scrutiny, which adds to the stress and demotivation of top managers.

In summary, the context above provides a fertile ground for this study to be conducted. It highlights that the hospital environment is a dynamic environment and managers in it play an important role in addressing the challenges on the ground. It is critical that the important competencies for this environment are identified, and the actual and required competencies for top managers are assessed. Then the need for

support and empowerment through coaching of clinical managers must be determined, in order to enable them to cope with the current challenges in this environment.

1.3 Problem Statement

1.3.1 Main problem

To measure the competencies of clinical managers in a public hospital environment in Gauteng and to understand how coaching could play a role in closing this gap.

1.3.2 Sub-problems

The first sub-problem is to establish the competencies of clinical managers required in a public hospital environment in Gauteng.

The second sub-problem is to explore managers' perceptions of coaching in improving competencies of clinical managers.

1.4 Significance of the Study

This research focuses on the role of coaching in improving competencies to enhance the effectiveness of clinical managers, supported by existing theory and research in coaching. The findings of this research will enable the selection of an appropriate coaching model as a next step for improving competencies of clinical managers in their working environment (Ely et al., 2010). Currently, there is scarcity of coaching for clinical managers in public hospitals in Gauteng.

The method of research was quantitative, due to the nature of the topic. Data collection entailed the administration of a voluntary survey to the target group. The results of the study should provide guidance to clinical managers on how to maximise their potential and productivity within the complex environment in which they work (Ladegard & Gjerde, 2014).

Coaching improves the quality of leadership and addresses individual needs according to the work situation and personality of the manager (O'Connell, 2014; Porter & McLaughlin, 2006). This is necessary to develop effective and efficient managers, who will be creative, innovative and be able to provide quality care within the constraints of budgets and a high patient population (Gunderman & Cox, 2015; O'Connell, 2014).

This study provides information about the clinical managers' competency gaps and an indication of the need for coaching as a leadership development intervention. This should bring benefits of an increase in effectiveness to the organisation as well as personal growth for the clinical managers themselves (Wales, 2002).

1.5 Delimitations of the Study

The study was conducted in an urban environment in Gauteng province.

This research took place in the public health sector.

The population comprised all clinical managers in the Gauteng public hospital should they manage more than one unit.

1.6 Definition of Terms

Coaching: Coaching is a form of a systematic feedback intervention aimed at enhancing professional skills, interpersonal awareness, and personal effectiveness (Kampa-Kokesch & Anderson, 2001).

Executive coaching: Executive coaching is a helping relationship formed between a client who has managerial authority and responsibility in an organisation and a consultant who uses a wide variety of behavioural techniques and methods to assist the client to achieve a mutually-identified set of goals, to improve his or her professional performance and personal satisfaction, and consequently to improve the effectiveness of the client's organisation within a formally-defined coaching agreement (Kilburg, 1996).

Leadership: Leadership is a process whereby an individual influences a group of individuals to achieve a common goal (Northouse, 2015). In this study, leadership refers to clinical managers.

Organisation: An organisation is a group in which members are differentiated as to the responsibility for tasks leading to a common goal (Stogdill, 1950).

1.7 Assumptions

Top managers at public hospitals have tertiary qualifications.

This research provides a platform for information sharing to those who are interested in similar studies.

Participants will understand the research purpose and questions.

Managers have a desire to grow and develop themselves.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter consist of the literature review of clinical managers as top managers in their organisations, management competencies and executive coaching as a developmental tool of the top managers.

This research project attempts to establish the required competencies of clinical managers in Gauteng public hospitals, measures their proficiency level of management competencies and consider what role coaching can play in assisting them to be effective in the day-to-day management of the hospital, by enhancing their skills and closing the gap.

The literature review is structured in the following manner:

Firstly, it discusses background of leadership in organisations and in hospitals. It covers roles of clinical managers, required competencies and proficiency level of managers' competencies, constraints experienced by these managers and leadership and management development training.

Secondly, it incorporates the literature of executive coaching definition, its use in organisations, benefit, its component and process, various coaching types in leadership, factors contributing to its success and its outcomes to individuals and their organisations. Last, we close with conclusion of the literature review of the whole chapter.

2.2 Background discussion

Public hospitals in South Africa are faced with the challenge of improving healthcare delivery systems, to meet the public's expectations, United Nations millennium goals and the Minister of Health's service delivery contract.

Hospitals are complex structures with socio-political bodies. Effective leadership and the ability to collaborate can be challenged by power struggles, silo structure and unhealthy competition between the disciplines (Daly, Jackson, Mannix, Davidson, & Hutchinson, 2014). There is a need for cultural and structural.

Improvement in the quality of patient care has been viewed as a critical requirement to improve health outcomes (Matsoso & Fryatt, 2013). Managers in hospitals are the drivers responsible for ensuring the implementation of the vision, mission and objectives of the health department. Health management requires specific managerial competencies for the delivery of healthcare. It is important to note that studies in developed and developing countries use the concept of managerial competencies to improve effective and efficient service delivery. The gap of management capacity has been reported in the healthcare setting across the board, with the greatest gap in developing countries (MacKinnon et al, 2004; Pillay, 2008; Pillay, 2010).

Leadership development in healthcare has received attention due the complex nature of the health environment. The need to capacitate the managers where a skills gap is identified, calls for effective interventions

2.3 Studies of clinical managers' competencies

In order for the managers to perform their tasks as required in their job descriptions, they need to be competent (Pillay, 2010). Rao and Palo (2009) citing Boyatzis (1982) stated "A job competency is an underlying characteristic of a person which results in effective and/ or superior performance in a job". Competency in management refers to the acquired knowledge, skills, behaviours and attitudes that a person requires in order to be effective in various managerial jobs (Khadka, Gurung, & Chaulagain, 2013). Lastly, the definition of competency includes the standard or quality of products or services produced by employees in an organisation.

Leadership is viewed as the act of making a difference (Slavkin, 2010). It includes improving and sustaining others so that performance is optimised (Slavkin, 2010). In the past five decades, it was associated with innovating, creativity, building and being generous. Currently leaders are required to focus on reducing social and health benefits cutting the human resource and related services. Leading with allocated resources which do not meet the demands requires finding acceptable alternatives, motivating, inspiring and influencing others (Slavkin, 2010). Human and financial resources need to be co-ordinate towards a shared goal. The definition of leadership is also reflected in individual leader attributes, which includes self-knowledge, identity, clearly-articulated vision and the ability to establish trust among colleagues and through decisiveness (Slavkin, 2010).

According to Ugboro and Obeng (2000), senior managers' roles are to provide strategic direction, develop workers and create an enabling environment for them to function at their optimum level. They further highlight that in organisations that drive total quality management, senior managers are the key drivers of communicating strategy, to ensure customer satisfaction and return on investment. Communication is the key driver at this level. Similarly another study (Răducan & Răducan, 2014), emphasises the importance of leadership in an organisation. They coined the concept of "leadership in the mirror" (p. 808), to capture the importance of managers reflecting the desired behaviours, attitudes, values and skills, to provide their teams with good role models. In this way, they would fulfil the strategic vision and mission of the institution. An example is found in the study by York and MacAlister (2015) where a top manager of security at a hospital was able to mirror and change the culture of those reporting to her.

Organisations are faced with a challenge of top managers who are not correctly placed at their level of work, which could be due to lack of sequential promotion resulting in a skills gap. Each level of management demands a certain skills set and if this is not acquired by the manager, it can negatively affect the organisation's performance (Charan, Drotter, & Noel, 2010). Organisations are also faced with the problem of managers maturing in their management position for a long time; this, too, can be

detrimental to the performance of the organisations. This scenario exists in public hospitals (Karsten, 2010) where the current study takes place.

The information gathered from various studies helped Rao and Palo (2009) to develop a competency framework with seven categories: personal value system, strategic vision, leadership and decision making, conflict and negotiation management, communication and administration and technical knowledge. Rao and Palo (2009), in the consolidation of the competency approach, recommended that there was a need for further research in various industries to explore appropriate competencies and include factors such as the size of the organisation, mission and culture in those areas.

In South Africa, a competency framework has been developed in relation to senior management services for health managers (Schwella & Rossouw, 2005). It entails 11 generic competencies which are deemed important for effective service delivery. They are strategic capability and leadership, programme and project management, financial management, change management, knowledge management, service delivery innovation, problem-solving and analysis, human resources management and empowerment, client orientation and customer focus, communication and information, and honesty and integrity.

Managers need to acquire various managerial competencies in order to improve the quality of service in the public hospital. Pillay (2008) identified the various healthcare skills that are important to hospital management as follows: strategic skills which enable managers' objectives according to the needs of the organisation; task-related skills which are operational and guide managers to use the most effective and efficient processes that will improve service delivery with the limited resources allocated; interpersonal skills which enable managers to guide and influence others to achieve set objectives; and self-management which requires the managers to be able to create a work-life balance, so that they have job and life satisfaction, which will benefit the individual and organisation.

A study of health executives in Canada (MacKinnon et al., 2005) identified competencies that are important in the healthcare sector for effective and efficient service delivery. In this study, the

competencies were identified as skills and knowledge that the managers had acquired. The competencies included "leadership, results management, resource management, compliance of standards, communication, community responsiveness and relations, conceptual skills, life- long learning and political and health environment" (MacKinnon et al., 2005). The Canadian study was used to assess the competencies of clinical managers in the current study, as it was designed and used for clinical managers.

According to Daire, Gilson, and Cleary (2014), management is viewed as a process that includes planning, budgeting, organising, controlling and problem-solving whereas leadership is viewed as a process that influences others, provides strategic direction, communicates the vision to all relevant stakeholders including employees, inspires and motivates employees, and is responsible for employee alignment to organisational objectives in order to ensure success. Health leaders and managers require both leadership and management competencies in order to effectively implement health policies in a challenging and resource-constrained context. Organisational capacity is strengthened when there is strong leadership and management practice. This leads to high quality of service, success in complex environments and sustained improvement.

Developing countries' health leaders are trained as health professionals with lack of training and experience in management (Daire et al., 2014). They are promoted into management based on their clinical expertise and are expected to learn management on the job. The role of leaders and managers in the public health sector in developing countries includes management of all relevant stakeholders, resources and health services. The public healthcare sector has bureaucratic structures with limited support for innovation or creativity to meet the customers' needs. Leaders and managers still have to take responsibility to lead by motivating employees and collaborating with all relevant stakeholders.

Health leaders and managers' required competencies include knowledge, behaviour skills, attitudes and values. Daire et al. (2014) grouped leadership and management competencies into three categories: cognitive, emotional and social intelligence. The issue of a leadership identity and core values is

important for alignment with organisational values as this will enable a leader to share the organisational vision with followers. The risk for leadership development process in the health system is that managers who are capacitated might leave the system due to misalignment, e.g. inability to innovate for improved service delivery due to bureaucracy.

In developed countries, the healthcare environment is faced with challenges of increased demands, patients who are knowledgeable and know their rights, limited financial resources and concerns about the quality of care and safety of patients (Daly et al., 2014). Inefficiency in service designs and models that no longer serve the purpose for the issues of the 21st century in the healthcare environment has been attributed to lack of financial resources. Hospitals are under scrutiny globally, currently viewed as organisations that are often harmful to patients, especially vulnerable groups such as children and old people (Daly et al., 2014), compared to the past when they were viewed as places of healthcare to the community. Leaders in the hospital environment have to cope with complex demands, which requires them to have apply various leadership styles in order to offer effective leadership (Daly et al., 2014).

In summary, the review above suggests that managers should be evaluated in terms of relevant skills. Once this is done, managers can be supported and further developed appropriately as their strengths and weaknesses would have been identified.

2.4 Managerial competencies

2.4.1 Benefits of use of managerial competencies

The issue of competencies to improve managerial effectiveness has been evaluated since early in the 1970s (Kets de Vries & Cheak-Baillargeon, 2015). Rao and Palo (2009) evaluated the theories that deal with the concept of the competency approach. This approach views the benefits of use of competencies in an organisation as: firstly, an effective objective tool that assists managers to be coherent with the understanding of excellent performance; secondly, it is a strategy used by human resource units in

organisations to align the workers' skills and behaviour with that of the organisation's vision and mission; thirdly, it involves identification of managerial competencies, provides insight into the level effectiveness of managers in an organisation; and lastly, if it is effectively implemented, there will be a benefit of further development to individuals as well as the organisation as the whole.

According to (Khadka et al., 2013), key competencies for managers are a requirement for managing healthcare institutions. They further mentioned that they are enablers for sustained effective and efficient service delivery. Competency used in executive coaching refers to the contribution of knowledge that the coach and coachee share as experts during coaching process, to create new knowledge (Rostron, 2009)

2.4.2 Proficiency level of management competencies

According to (Khadka et al., 2013), low-income countries are under-performing with regard to achieving the health-related millennium goals. Limited managerial capacity has been cited as a contributing factor.

A study conducted by (Khadka et al., 2013) in a developing country, Nepal, found that managers were reasonably capacitated but were still lacking adequately-developed competencies in other areas of their work. The results of the study were a reflection of the reality of the hospital management environment and the need for further development of hospital managers.

Pillay (2008) states that managers play an important role in the provision of quality healthcare services. In SA, there is a lack of assessment of management capacity and little exposure to an appropriate development programme. The information gained from the current study may assist in identifying appropriate training and further development of clinical managers at Gauteng public hospitals.

Pillay (2008) noted that managers in the South African public health hospitals are less competent and need to be capacitated in order to address the public's dissatisfaction regarding the low quality of care of

patients. There is a need for an evaluation of the current managers' competencies in the public healthcare sector, as this will assist in further expansion of the human resource development policies, with suitable management training programmes (Lane & Ross, 1998). The same finding of lack of performance of public healthcare managers was reported by Coovadia et al. (2009), who attributed the non-performance of the current top managers to South African history, where those who are loyal to the political leadership were recruited to top positions regardless of their competencies and performance.

(MacKinnon et al., 2005) in a study on a developed country revealed high self-assessment competency scores, which is a different picture from low-income and developing countries. They caution that the results are self-reported and there was a need for further investigation; however, other studies also used a similar self-administered questionnaire. Citing one study, (MacKinnon et al., 2005) found that there were some clinical executives who identified lack of managerial capacity in their work environment which would require further development.

It is interesting to note that the issue of lack of leadership capacity is also present globally in other sectors. The concern is the critical unavailability of effective leaders. Development programmes were identified as a solution to close this gap (Maciariello, 2014).

A competency framework provides a platform to assess the individuals' current competency and the required competency. This information provides a platform for the development of supportive programmes that will enhance the performance of individuals and organisations. The main aim of this study is to identify the competencies that are deemed important by managers, determine their proficiency level and lastly, determine the association between the competency level of each manager and their individual characteristics (Karsten, 2010)**.**

2.5 Impact of challenges experienced in a hospital environment

High demanding jobs like those in hospitals and financial institutions have been found to induce stress in top managers. This impacts negatively on the physical and psychological health of this category of individuals (Lovelace, Manz, & Alves, 2007). High blood pressure and heart disease have been reported as the cause of poor health at this level of management. The health of these managers is often neglected and the disease among these managers often goes undetected and results in burn out, depression and anxiety. The negative impact for organisations, is that there is high absenteeism, particularly in healthcare organisations (Ganster, Fox, & Dwyer, 2001).

High stress levels among these managers lead to job dissatisfaction and, in turn, low productivity for organisations (Johnson et al., 2005). This is further supported by Byrne (2005) who concurs with these findings. In quality service organisations, there will be a noticeable decline in quality service and increased customer dissatisfaction (Ugboro & Kofi, 2000). Clinical managers that are included in the current study are at the theoretical business manager level. At this level, managers can use creativity, innovation and their collective skills to lead effectively. (Charan et al., 2010) show that there are three main challenges for managers at this level: poor work values, for example, inability to delegate duties; lack of maximisation of human resources, for example, no encouragement of a collegial atmosphere in the team; and lack of strategic leadership, for example, micro-managing teams. The challenges above contribute towards low productivity.

In developing countries like Nepal, a challenge that is experienced by hospital management is lack of recognition. The hospital service delivery is provided by clinicians whereas the hospital management supports the delivery. Hospital managers work in the back office, planning, controlling, monitoring and evaluating to ensure provision of sustainable service delivery. They also play a vital role in the hospital environment; therefore, they deserve investment. In South Africa, lack of management capacity has been attributed to the lack of effective service delivery (Pillay, 2010).

Developed countries like Canada are still faced with health challenges in the hospital environment due to the complexity of the healthcare system. According to MacKinnon et al. (2005), their challenges include accountability, shortage of staff, increasing demands from patients, political pressure, access, quality of care and budget cuts. Therefore, their clinical executives were exposed to a developmental programme to enable them to manage effectively despite the challenges they were faced with, in a complex, ever-changing healthcare system.

Globally there is a move towards continuing education and skills development for healthcare leaders to thrive in a challenging health environment (Hartman & Crow, 2002). The industry also faces environmental challenges to which it is not responding appropriately and timeously. Technology and regulations are forces for change that impact healthcare organisations and require rapid adaptation of systems and training for those who have to implement them.

The continuous consolidation of healthcare services in the hospital environment has resulted in a complex, rapidly-changing competitive environment. There is a need for healthcare managers to be able to balance the quality of care with the cost (Hartman & Crow, 2002). Healthcare executives require the following in order to succeed: education, but the existing education system is not effective; automation and technology, but knowledge and skills in business acumen are currently lacking; universities to provide training that is appropriate and responsive; existent healthcare administration programmes to be respected. Educators and practitioners play an important role in the education and training of clinical executives.

Issues included strategy formulation versus strategy implementation in relation to the turbulence in the industry. Many managers do not have the skill to implement strategies effectively hence there is a gap between the plan and the implementation (Hartman & Crow, 2002). A need exists for health executives to develop skills in implementation or enable them to drive and enact the vision throughout the institution. Form should follow function.

With the challenges that exist in the healthcare industry, there is a need for an appropriate and timeous response. Flexibility and emotional intelligence are required to read complex situations and respond accordingly (Hartman & Crow, 2002). Innovation has been suggested as a skill for strategic leadership. Change signifies conflict and politics which act as barriers to change in the healthcare environment. This impacts the commitment of health executives to lead change effectively.

Hence the current study looks into the issues of clinical managers' development, with the aim of devising a relevant support and developmental programme to enable them to cope with the complex issues in the hospital environment.

2.6 Leadership and management development training

2.6.1 Formal and informal training

There are three categories to leadership and management development approaches used in low- and middle-income countries: formal training, on-the-job training and action learning. Formal training is the most common training and development approach used in low- and middle-income countries for leaders and managers. The training includes master's programmes, certificates, diplomas or short courses. These are offered through lectures or on-line facilities (Daire et al., 2014).

A formal training programme focuses on cognitive intelligence. Since there is a need for leadership to be capacitated to handle human resources and to have the ability to influence others to perform (Daire et al., 2014), formal training programmes for executives are geared towards cognitive intelligence in leadership and management competence; they include finance management, human resource management, information management and current public health policies..

On-the-job training includes informal and some informal training. Approaches used are coaching, 360-degree feedback and network. This is offered by the organisation through internal mentoring programmes or external coaches or consultants.

Action learning is defined as learning by doing, participatory capacity building and collaborative learning and joint development activities. This includes formal training, informal training and support, daily activities, and perceptions of an individual about their work context through reflection as the tool for learning. This approach which is part of the work environment has been viewed as having the potential for leadership and management development.

Executive education in the healthcare environment involves mentoring relationships to augment daily work practice. Furthermore, the need for business acumen in formal education programmes was highlighted with a focus on finance (Hartman & Crow, 2002).

University training should include both classroom and workplace learning. Financial skills and acumen are lacking in the healthcare sector today, in an environment where there is pressure on financial resources and lack of integration of information technology within hospital environments (Hartman & Crow, 2002). Traditional training formats include self-directed, team training and formal training. It is suggested that the curriculum for undergraduates should include formal training in management to qualify students in management tracts in their careers (e Sonnino, 2016). In developed countries, they have a concept of dual degrees for medical professions e.g. MD/MBA or MD/MPH. However, there is also a need for public health schools to introduce leadership programmes to address leadership issues. Programmes should address attributes of a leader like values, change, team effectiveness and leading self and others. Annual development programmes geared towards women and aspiring leaders are also needed.

A comprehensive leadership development programme is required for leaders to perfect their skills in leadership roles, tailored to a broadly-skilled and value-driven leader (e Sonnino, 2016). The need for formal comprehensive healthcare leadership development at university like Duke in developed countries have developed the graduate management with a combination of formal MBA and experiential learning in leadership competencies. This may represent a new model for early leadership training in the medical

field. Business and administrative acumen is unfamiliar to clinical leaders but now it is essential. The new image of leadership differs to that of the past in that it is geared towards a shared vision and teambuilding.

In developed countries, there is still a scarcity of comprehensive leadership programmes for existing senior leaders. Those available include leadership strategies (e Sonnino, 2016). We learn from this discussion that a combination of formal and informal training yields favourable results in the organisation.

2.6.2 Strengths and limitations of current approaches

Many leadership and management developmental approaches are geared towards cognitive intelligence but lack emotional and social intelligence which assist leaders and managers to influence, develop and be change agents in the work place. Leadership competencies are achieved when the leader is clear of his identity, values and beliefs and is able to align these to values of their organisation (Daire et al., 2014). This has the benefit of the leader being able to share and drive vision, influence others towards a common organisational goal and have the passion to address barriers in the organisation. They propose that leadership skills are learned in the following sequence: through experiencing problems or observations in a particular situation followed by an increased level of awareness that influences behaviour, knowledge and social perceptions. The cognitive development that results is evidenced in the new way that the leader acts in his role and in line with his identity. Finally, the leader's competencies are incorporated with his role and identity as a leader. Lord and Hall (2005) cited in Daire et al. (2014) suggest that leadership development approach is not only a cognitive process but, if this training includes a didactic educational process, it can enable leaders to influence others positively especially when the leaders' identity, purpose and core values have been aligned with that of the organisation and are used on a daily basis. The addition of coaching or mentoring to support the leaders to succeed can be used to ensure development and enhance performance especially when integrated into the organisational culture that will provide context

for the issues to be addressed in a particular situation. This integration has the potential to channel the energy of the organisation to improve performance (Daire et al., 2014).

2.7 Coaching

Coaching was defined as "a process that provides individuals with the necessary tools, knowledge and opportunities to necessary to develop them and become effective" (Peterson and Hicks, 1995, p. 41).

2.7.1 Definitions of executive coaching

Executive coaching has been defined in different ways by various authors (Feldman & Lankau, 2005). According to Kilburg (1996) executive coaching is

> a helping relationship between a client who has managerial authority and responsibility in an organisation and a consultant who uses a wide variety of behavioural techniques and methods to help the client and a consultant who uses a wide variety of behavioural techniques and methods to help the client to achieve a mutually identified set of goals to improve his or her professional performance and personal satisfaction and consequently, to improve the effectiveness of the client's organisation within a formally defined coaching agreement (p. 142).

Hall, Otazo and Hollenbeck (1999) define executive coaching as "a practical, goal-focused form of personal, one-on-one learning for busy executives may be used. This is aimed at improving performance or executive behaviour, enhancing a career or preventing derailment and work through organisational issues or change initiatives" (p. 40).

Executive coaching was also defined as a process that unleashes the person's potential in order to maximise their performance, in enabling them to learn and grow (Kempster & Stewart, 2010), while Witherspoon and White (1996) define it as "a confidential, highly personal learning process – an organised, personal learning provided over a specified period of time to bring about the possibility effective action, performance improvement and / or growth" (p. 127).

Kampa-Kokesch and Anderson (2001) define executive coaching as "a systematic feedback intervention aimed at enhancing professional skills, interpersonal awareness and personal effectiveness" (p. 208), while Feldman and Lankau's (2005) define it as "a process of equipping people with tools knowledge and opportunities they need to develop themselves and become more effective" (p. 830) . Koo (2005, p. 468) viewed executive coaching as "a relationship between a coach and the executive with the goal of enhancing development".

After the review of the different definitions of executive coaching, the areas of focus in these definitions are highlighted in Table 1.

Table 1: The executive coaching definitions and areas of focus.

Process which has learning, growth and choice	(Kilburg, 1996, p. 142); (Hall, Otazo, & Hollenbeck, 1999, p. 40).
Relationships between a coach and coachee	
Personal growth and development	
Enhanced performance of individual and organisation	
Process which has learning, growth and choice	(Witherspoon & White, 1996, p. 127).
Personal growth and development	
Enhanced performance of individual and organisation	
Process which has learning, growth and choice	(Kampa-Kokesch & Anderson, 2001, p. 208); (Feldman & Lankau, 2005, p. 830); Koo (2005, p.468)
Personal growth and development	
Process which has learning, growth and choice	(Kempster & Stewart, 2010).
Enhanced performance of individual and organisation	

Thus, it can be concluded from the literature that the executive coaching definition includes process of learning, change and choice, relationship between a coach and executive, personal development and growth, and enhanced personal and organisational performance.

2.7.2 Uses of executive coaching in organisations

Leaders in organisations require a range of leadership skills, management skills and interpersonal skills. Leadership coaching is the most commonly used method for leadership development (Ely et al., 2010). It is the relationship between the coach and coachee which catalyses the success of this intervention as it is dynamic and relevant. Leadership coaching focuses on the needs and characteristics of an individual client, including the organisation where they work. It demands the unique skill set of a professional

coach. The leadership coaching process requires a responsive process, within the specific context, in order to achieve set goals (Ely et al., 2010). Executives will benefit from coaching because it enhances personal development and problem resolution (West & Milan, 2001).

Executive coaching is a leadership developmental tool used to improve managers' productivity and organisation performance by translating the knowledge gained into action (Kampa-Kokesch & Anderson, 2001; Wales, 2002). In the past coaching was used as an approach to fix people who had errant behaviours in leadership. This view has changed as it is now seen as a positive developmental tool and valued by senior managers (Kempster & Stewart, 2010).

Coaching is a unique development programme compared to conventional programmes which are generic, catering for a diverse audience with training being determined by trainers (McGovern et al., 2001). Leadership coaching addresses a range of individualised needs and challenges, it brings about learning of new solution based skills to issues in specific contexts in their particular organisation (Ely et al., 2010). Its elements are specific and tailor-made for issues of a particular organisation, environment, individual or team. It capacitates the executives with the capacity to achieve professional and organisational goals (GSAEC).

Coaching is a process which has a start and end date and must be linked to the developmental needs of a coachee. Coaching is a flexible developmental tool which can be used as a short-term or long-term intervention. The effects of coaching are measurable at individual and organisational level (Rekalde, Landeta, & Albizu, 2015)

There are many organisations that practise coaching in which it is reported to be part positive psychology. It is based on the idea of exploring and using individual strengths to the maximum (Linley & Harrington, 2005). This encourages positive change in the behaviour of an individual in an organisation, with the result of improved effectiveness and wellbeing (Crabb, 2011).

The emphasis in coaching is to provide a reflective space for the leader to explore specific issues and enable them to come up with solutions using available resources. Coaching is about capacity building and skills development within the work context. It includes four key dimensions which are: psychological contract between the coach and coachee; contribution of a coach; the various coaching models to be utilised in the process and the power relations between the coach and coachee (Kempster & Stewart, 2010).

A coach is utilised as a reflective board, while the executive shares his work challenges, gaps in skills and how he carries himself as a leader, with the aim of bringing about change and improvement in specific areas (Jones, 2005). The coach and executive will then develop an activity plan, based on a common goal, with the use of a myriad of resources. The executive is offered support by the coach during the phase where they have to practise set activities. The practise is followed by a review to evaluate the expected outcomes. The coaching process is built on the executives' strengths, helps them to understand their leadership styles and effects this has on followers, challenges them to step out of their comfort zone and stretches them to bring about change (Jones, 2005). Coaching brings about behavioural change in the workplace (Kempster & Stewart, 2010). Since it is tailor-made and individualised for every work context and particular leader, it can capacitate them in business, functional and personal endeavours. Successful coaching includes an assessment, challenges and the provision of support. It provides an idea of the current skills and areas in need of development. Challenges and support co-exist in order for the leaders to develop and grow according to their personal skills requirements (Kempster & Stewart, 2010). Coaching helps individuals to learn and receive feedback.

Through this discussion, it can be understood that coaching makes use of varying degrees of directedness. Coaching is underpinned by a behaviourist, psycho-dynamic, person-centred, cognitive and systems-oriented approach (Kempster & Stewart, 2010). The person-centred approach to enable leaders to construct their solutions (Rogers & Maslow, 2008). It brings about personal change in high functioning individuals (Kempster and Stewart, 2010). The coaching relationship is that of equals, each respecting

skills and knowledge of the other in a collaborative partnership. The degree of directedness of a coach depends on his/her professional choice of coaching models to be used which is derived from the agenda projected by the leader (Kempster & Stewart, 2010).

Learning through practice has become crucial in context- and situation- specific activities encouraged in coaching, mentoring and action learning. This change in leadership development practice is viewed as the best approach as it can be applied anytime, anywhere within a particular context in an organisation (Kempster and Stewart, 2010).

It is not easy for senior managers to get feedback from subordinates. In organisations with a weak culture, employees are reluctant to give feedback to management as this is perceived as a possible threat. Management has the responsibility to change a weak culture into a strong culture (Roebuck, 1996). This change is possible through feedback. Feedback is a learning tool for self-directed learners and is the only way of informing the individual about their strengths and areas for improvement (Drucker, 1999). During the coaching process, the coach is used as a source of feedback which has an influence on the development of the self-efficacy (Popper & Lipshitz, 1993). An effective feedback system encourages empowerment, commitment and total quality management (Roebuck, 1996).

Simultaneously, practice research confirms that informal leadership development has enabled leaders and allowed them to lead more effectively, as learning is coupled with the workplace. Informal training emphasises relational and contextual practice. EQ and relevance are addressed by coaching (Kempster & Stewart, 2010).

The informal approach to leadership development is a more natural way of learning and developing (Kempster & Stewart, 2010). Coaching mimics this naturalistic style of learning. It also enables the managers and leaders to become self-aware of their role in leadership. Coaching provides the necessary support for the leaders who are willing to unlearn old ways of functioning which no longer serve purpose, and learn new effective ways of solving issues (Kempster & Stewart, 2010). Coaching enables leaders to

learn in their own environment and use reflection to access more information about their daily activities, which wouldn't have been possible through formal classroom lectures.

Other studies which advocate coaching highlight that employees that are supported and developed in their work environment are more likely to produce significant benefits to the organisation Collegial relationships are formed in organisations that practice positive psychology and this yields benefits of increased productivity, job satisfaction and decreased absenteeism and attrition rates (Chan, McBey, Basset, O'Donnell, & Winter, 2004; Crabb, 2011).

There are three categories of leaders that use executive coaching: high potential managers who are unable to progress career-wise due to lack of skills in one or two areas of their work; potential managers with the need to enhance leadership skills including vision of self, ability to influence direct reports and others; and individuals such as doctors who open a new private practice and are overwhelmed by the daily management demands, which are viewed as barriers to enable successful implementation of business strategies (Judge & Cowell, 1997).

People seek leadership coaching for a variety of reasons such as enhancement of leadership skills, self-awareness or gaining clarity within a current challenge or future situation. This implies there is a need to focus on and improve leadership competencies, leader behaviour and attitudes, and to provide leaders with tools to assist in reaching personal and organisational goals (Ely et al., 2010).

According to Wise and Voss (2002), executive coaching was used to develop leadership skills of executives (86%), to develop newly promoted managers (64%), to develop management and leadership skills of their expert individuals (59%), to correct behavioural problems at management level (70%) and to capacitate leaders to effectively resolve interpersonal conflicts among employees (59%).

New leadership skills are required to deal with change management (Ely et al., 2010). Development of new capabilities for succession planning. Develop leader capabilities for career management and

employee satisfaction Coaching ensures that the executives are capacitated and that change is sustainable (Cunningham & McNally, 2003). Leadership development in order to build and position the organisation addresses organisational management (Ely et al., 2010).

In summary, coaching has various uses in organisations which are consistent with the definition of coaching as a process of learning, change and choice, relationship between a coach and executive, personal development and growth, and enhanced personal and organisational performance.

2.7.3 Benefits of executive coaching

Coaching plays an important role in work-life balance (Jones, 2005). The use of psychometric instruments is of benefit to coaching of leaders, as they provide an objective measurement (Jones, 2005), which can be used as a point of departure in the development of a leader. These instruments include, for example, the 360-degree feedback and Myers-Briggs type indicator (Jones, 2005). The benefits of coaching at individual and organisational level are divided into four areas namely: executive learning enhancement; gains in organisational performance and support for human resource development; improved interpersonal relationship; and improved leadership effectiveness. The other identified benefit was improved business results

2.7.3.1 Individual and organisational improvements:

According to Olivero, Bane, and Kopelman (1997), in their study of public health care sector managers, conventional training improved productivity by 22,4% whereas the exposure of the same managers to coaching once exposed to this training, yielded 88% improved productivity. They highlighted that the use of knowledge gained from training into practice, is influenced by factors such as work environment and the view of such training by the person exposed to it as an opportunity for learning and growth, through practice and feedback (Olivero et al., 1997). Coaching has the ability to ensure transfer of knowledge from training into practice, with the coaching process focused on the areas of development covered in training. Coaching has the ability to provide an enabling environment which is safe for learning through

practice. In their study, an increase in productivity was attributed to one-on-one interaction with the focus on goal-setting, collaborative problem-solving, practice, feedback, supervisory involvement, evaluation of the end results and public presentation (Olivero et al., 1997). They further highlighted that goal setting and public presentation, were the two areas that were key to the success of the process. Olivero et al. (1997) reported that the literature supports the view that *specific, measurable, attainable, realistic, and timely* (SMART) goal setting has the potential to enable transfer of knowledge into practice. It further brings about positive effects where managers feel confident and deliver service as expected by their organisation**.** In their study, coaching was applied as a directive intervention, which entailed setting of goals, problem-solving through engagement, practice, feedback, supervision engagement, outcome evaluation and presentation to the public. It is interesting to note that similar findings of increased productivity were reported due to exposure of managers to coaching in other studies (Cunningham & McNally, 2003; Wise & Voss, 2002). One-on-one coaching provided the managers with the opportunity to practise what they learned in training and they were able to receive feedback on that, thus improving their level of self-awareness about their knowledge gained; the positive feedback from stakeholders also had a positive effect on how they viewed themselves as managers and their responsibilities. In reference to public presentation in the (Olivero et al., 1997) study, managers and their juniors had to deliver a presentation to the leadership at the end of the coaching project. The presentations were a success and feedback from leadership had a positive effect on participants. The increased productivity results would be useful in the healthcare industry.

Executive coaching enables the executive to learn in a short period of time and offers support to the new leader while creating an opportunity to learn through reflection (Anderson, 2001). Coaching is used to increase individual and organisational learning which leads to organisational effectiveness (Judge & Cowell, 1997). The executives who are exposed to coaching sustain excellent performance, increased self- efficacy and self-regulation (Cunningham & McNally, 2003).

Holoviak (1982) reported similar findings of an increase in managerial performance in organisations where coaching has been utilised as the only developmental tool or in combination with generic programmes. There is evidence that after exposure to a coaching programme there was an 85% improvement in management performance (D. B. Peterson, 1993). A similar study by (Olivero et al., 1997) which was conducted in a public sector institution, reported an improvement of 88% in the effectiveness of managers after exposure to coaching.

Emotional intelligence is a key skill in leadership. It is crucial for leaders to understand their own feelings, be able to self-regulate and consider the feelings of others (e Sonnino, 2016). Emotional intelligence facilitates good communication and there is a likelihood that this effective communication of the vision would be shared among the leaders and followers. Ineffective communication can disrupt the functioning of the organisation. The concept of awareness and authenticity, elements of emotional intelligence, are today accepted traits of a leader.

Empathy and empowerment of followers through coaching and mentoring is a feature in leadership that differentiates a good leader from others (e Sonnino, 2016). All personal competencies are not innate in leaders, which is why training is needed. Personal competencies are best addressed by tailored coaching programmes rather than generic one-size-fit-all courses.

2.7.3.3 Gains in organisational performance and support for human resource development

There is evidence that coaching contributes to performance of organisations and growth and development of individual managers (Cunningham & McNally, 2003). Research by (Outhwaite & Bettridge, 2009) also indicates that newly acquired skills and knowledge are used to better effect in the cohesiveness and performance of cross-functional teams as they facilitate and establish harmonious culture within the managers' department. The potential for coaching to be customised to the individual manager will encourage managers to be part of cross-functional teams as opposed to functioning in silos ((Outhwaite &

Bettridge, 2009). This is desirable in a complex working environment, similarly to that experienced in hospitals, where resources are scarce.

Organisational performance refers to the influence of training on the organisational level. Coaching benefits include productivity, revenue and retention (Ely et al., 2010). A systems level perspective includes the leader, the organisation and its systems. Luthans and Peterson (2003) found that 360-degree feedback and systematic coaching improved self-awareness and management behaviour resulting in more satisfying interpersonal relationships. It improved organisational commitment and reduced attrition rates (S. J. Peterson & Luthans, 2003). Progress is made towards the transference of tools such as the goal-setting, followed by striving to achieve intrinsically-set goals, wellbeing and hope, all of which are positive outcomes enhancing productivity and effectiveness (S. J. Peterson & Luthans, 2003).

Transformational behaviour within the organisation, empowerment and intrinsic motivation helps to improve organisational performance (Tafvelin, 2013). Transformational leadership is focused on the followers' emotions, in particular those emotions that will lead followers to produce behaviours of excellence. It has been reported that workers follow transformational leaders due their capacity to impact order, security and guidance in a chaotic world (Popper & Lipshitz, 1993). Transformational leaders bring about deep awareness, which leads followers to produce behaviours that exceed expected results of high performance (Bass & Riggio, 2006). Job satisfaction will be evident from subordinates and productivity and quality of outputs and leaders' strategic activities are seen as long-term (Ely et al., 2010).

The coaching results reported by Cunningham and McNally (2003) were improved retention of staff, increased quality of service and customer service while Wise and Voss (2002) reported improved productivity, quality of service, retention of talent, improved organisational strength, customer satisfaction, reduction in complaints, increased profit and improved business results (Wise & Voss, 2002). These results would benefit the healthcare industry.

2.7.3.4 Improved interpersonal relationships

According to Jones (2005), coaching brings about development of leaders' knowledge about identity, strengths and areas of improvement, build required leadership style, enhances communication skills, interpersonal skills, accountability and responsibility, conflict management, adaptability and courage, enhances the ability of leaders to influence and develop others, assist with development of a strategic vision and the strategy on how to achieve it. It also addresses political awareness and problem-solving (Jones, 2005). Self -management and management of others is important in leadership. This could be achieved through work-life balance. According to Judge and Cowell (1997), skills that coaching focus on are interaction style, trust creation in relationships, increase listening skills and public speaking skills (Judge & Cowell, 1997). The results of McGovern et al. (2001) study in measuring the effectiveness of leadership coaching reported by executives were enhancement of interpersonal skills and management skills. The coaching results reported by Cunningham and McNally (2003) in their study was increased interpersonal relations at work with direct reports and supervisor. Similar results were reported by Wise and Voss (2002), including improved interpersonal relationship with relevant stakeholders out of the organisation.

21st Century organisations require 21st Century leaders. These are leaders who have a high level of emotional intelligence. Emotional intelligence is a set of skills that contribute to accurate appraisal and expression of emotions in oneself, in others, effective regulation of emotions in self and others, use of feelings to plan, motivate and achieve in one's life (Salovey & Mayer, 1990).Organisations consist of people who have different moods, emotions, derives and interactions. An emotional intelligent leaders should have the ability to read and respond appropriately (D. Goleman, 2003; D. P. Goleman, 1995). This self-regulation and integrity will result in building trust and followers will begin to accept this person as a credible leader. An empathic leader is sincere, authentic and sensitive to culture and diversity (D. P. Goleman, 1995). Social skill is crucial to leading change in the work place. This skill enables the leader to

be hard on results and soft on people. These leaders are self-driven, optimistic and passionate about all aspects of the organisations (D. P. Goleman, 1995). These results would benefit the healthcare industry.

2.7.3.5 Improved leadership effectiveness

According to the literature McGovern et al. (2001) puts forward three points towards executive coaching which are coaching facilitates practice, practice is translated into impacting business, with positive results, this results of coaching can be measured and maximised.

Leadership skills are skills required for interaction with the followers. This entails oral and written communication skills, provision of feedback, interviews and conducting meetings (Popper & Lipshitz, 1993). Effective leadership skills need high self-efficacy, motivation and specific skills like feedback. Self-efficacy is the belief that a person has about their capability in performing certain tasks. Leaders with high self-efficacy have the ability to influence others. Repeated exposure to successful performance is a source of self-efficacy (Popper & Lipshitz, 1993). The coach during the coaching process is viewed as a source of feedback, which has an influence on the development of the self-efficacy(Popper & Lipshitz, 1993). Increased self- efficacy is created over a period of time and coaching has been reported to be the best tool in leadership development to achieve this(Popper & Lipshitz, 1993). During coaching process, each review session has feedback which is either positive for success or negative as an area of improvement. Support is offered to redress the areas of improvement with the aim of succeeding with the next attempt (Ely et al., 2010). This process of repeated success over six months or more, creates an opportunity to build executives self- efficacy which is a requirement for effective leadership (West & Milan, 2001).

According to Judge and Cowell (1997) coaching focuses on enhancing change management skills, long-term focus, work/life balance, goal clarity and stress management skills. Executive coaching is used during in organisations to assist executives to be capacitated with psychological and behavioural skills

required for them to focus on reaching work goals while thriving during the turbulence times (Grant, 2014). According to Fugate and Kinicki (2008) reported that executives struggles with psychological and behavioural skills during change in the organisation while required to achieve goals in their organisations. The ability of a leader to build effective teams and achieve organisational goals during change is an important requirement for the leader effectiveness (Gilley, McMillan, & Gilley, 2009).

Executive coaching is used in organisations to help capacitate executives to manage change effectively and offers support to them to obtain the work related goals (Grant, 2014). This use in organisations is supported by its definition as a helping relationship between a coachee-coach, uses various behavioural and cognitive tools to capacitate the coachee to achieve her/his set of goals with the goal of improving their leadership skills, productivity and organisational effectiveness (Grant, 2014).

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According to (Judge & Cowell, 1997), coaching focus on enhancing change management skills, long-term focus, work/life balance, goal clarity and stress management skills. Executive coaching is used during in organisations to assist executives to be capacitated with psychological and behavioural skills required for them to focus on reaching work goals while thriving during the turbulence times (Grant, 2014). According to Fugate and Kinicki (2008) reported that executives struggles with psychological and behavioural skills during change in the organisation while required to achieve goals in their organisations. The ability of a leader to build effective teams and achieve organisational goals during change is an important requirement for the leader effectiveness (Gilley et al., 2009).

Executive coaching is used in organisations to help capacitate executives to manage change effectively and offers support to them to obtain the work related goals (Grant, 2014). This use in organisations is supported by its definition its definition as a helping relationship between a coachee-coach, uses various behavioural and cognitive tools to capacitate the coachee to achieve her/his set of goals with the goal of improving their leadership skills, productivity and organisational effectiveness (Grant, 2014).

Most managers accept executive and leadership coaching as a part of their development (e Sonnino, 2016). Coaching as part of a comprehensive leadership programmes is viewed as a necessary developmental tool in leaders (e Sonnino, 2016). Having coaches at senior management level has developed a culture of support for leaders.

In addition, coaching has contributed to organisational success, enhanced individuals' careers, personal growth, career satisfaction and networking. Networking is important as it creates a culture of informal

relationships which encourages creativity. This creates collaboration and synergy within the healthcare sector (e Sonnino, 2016).

In summary, it would therefore appear that executive coaching is an appropriate intervention to be used in closing the competency gaps of the managers in this study.

2.7.3.7 Quantitative Business results

The coaching results reported were return on investment of 6:1 and increased profit (Cunningham & McNally, 2003; Wise & Voss, 2002). According to the literature (McGovern et al., 2001) any development programme that yields an ROI of more than 25% is ideal and beneficial for the organisation. In the study by (McGovern et al., 2001) study 75% of participants and stakeholders reported that executive coaching had more value than monetary value (McGovern et al., 2001) to the organisation in research shows up to 545% (McGovern et al., 2001) benefit to the organisation.

2.7.4 Coaching components

There are various components of the coaching process that occur in an on-going relationship with the coachee. The following features will be used to design, implement and evaluate the coaching process: 1. A contract between the coach and coachee will be initiated to foster commitment and ownership. 2. A relationship will be established between the coach and the coachee. 3. An assessment of individual issues. 4. The information gathered from this will be used to set specific goals so that new learning takes place. 5. The coach will use evidence-based practice and research to ensure improved performance is sustainable. 6. The knowledge gained will be translated into change in the behaviour of individual. 7. Continuous monitoring and evaluation of the coaching process (Kilburg, 1996). There is, however, a need for an enabling environment in order to transfer knowledge gained into sustained action; for example, there should be encouragement of creativity and workload and management strategies implemented (Stewart & Palmer, 2009). This will maximise innovation and creativity (Stewart & Palmer, 2009).

2.7.5 Coaching process and its elements

The coaching process has three core elements, despite the type of coaching process used which are contracting, data collection and coaching.

Contract includes discussions around the coaching goal, monetary investment and time, commitment to the process, if agreement is reached then the contract is finalised (Thach, 2002). The core elements of leadership development interventions should include assessment, challenge and support. This leads to a successful leadership development (Ely et al., 2010). A coaching intervention is guided by the needs, characteristics and experience of an individual manager as well as the needs of the organisation and the attributes of an executive coach (Ely et al., 2010). Assessment provides insight into the current issues and development needs of the client in relation to the organisation (Ely et al., 2010). Data collection is done using 360 feedback assessment, personality and skill assessment (Thach, 2002).

Feedback is part of communication. It requires action or a situation for it to happen. Organisational feedback is any feedback which can be used to benefit the organisation (Roebuck, 1996).

There are two types of feedback namely soft and hard feedback. Hard feedback is used for management purposes and is derived from organisational business systems. Soft feedback is obtained from individuals and it is subjective and derived from opinions and perceptions. The involvement of a choice is used in soft feedback and it has four main areas in an organisation which are improved performance of the stakeholders and individual, improved organisational effectiveness and their view of a situation in an organisation (Roebuck, 1996).

Benefits of feedback includes: hard feedback is critical to management as it is required for effective management such as decision making. It acts as a checking mechanism and aids management learning through improvement and development. The benefits of soft feedback is found in three areas which are organisation, team and task It gives information about employee commitment, effectiveness of training

and guides managers to overcome hurdles and build on success. Feedback is a component of action centred learning or learning organisation. Employees via feedback may identify problems which they view as barriers to their work performance. This enables managers to respond appropriately and thereby increasing performance. Therefore, soft feedback is key to total quality management, teamwork, commitment and organisational culture just like in the hospital environment. Feedback is vital particularly in change management (Roebuck, 1996).

Research shows that management should seek more feedback from employees in order to gather information about the culture within the organisation. With this information, managers are able to influence the culture and issues positively, which leads to increased performance and commitment (Roebuck, 1996).

Benefits for individuals are taken to be a combination of needs, rewards and action. In turn managers benefit as they address the individual's needs, rewards and action taken. These lead to improved performance and productivity. The satisfaction gained by offering feedback, motivates and rewards the employee (Roebuck, 1996).

Managers and coaches need to be aware of the potential coast and risk to the organisation when using feedback and acting upon it. This must not impact negatively (Roebuck, 1996).

A strong culture would encourage open and transparent communication. It's relationship of communication, where managers and employees are both willing to listen to one another in a constructive paradigm (Roebuck, 1996).

An effective feedback system would encourage empowerment, commitment and total quality management. Steps for an effective feedback includes: Commitment from management to receiving feedback is key. Middle management must support the idea of feedback. Focus groups and individual one-on-one meetings (Roebuck, 1996). Action will encourage individuals to see the benefit of feedback as

it has directly affects them. Planning is a step which uses the appropriate tools to collect feedback. There are various tools used to collect the feedback which entails management by walk in, wherein managers are collecting feedback from what they see and hear and action is taken (Roebuck, 1996). Appraisal system includes 360 degree feedback. Good organisational feedback particularly from those who are unable to express themselves in teams. Feedback from appraisals can be channelled back to team briefings in the safety of anonymity. Team briefings encourage feedback and information passed up the line to senior managers. The flow of information up and down the line is encouraged. Line based feedback can be corrupted. Managers need to be aware of this and use checking mechanisms. Non-line based feedback includes attitudes, surveys, voting panels, newsletters and suggestion boxes (Roebuck, 1996).

Management has the responsibility to educate their employees about feedback and how it contributes to a better performance. Employees must feel that their feedback is valued and this should encourage them to offer feedback of better quality (Roebuck, 1996). Response to feedback initially provides management with the reality on the ground and it will help them set future objectives. Action must be taken in light of the feedback given in order to benefit the organisation (Roebuck, 1996).

Further feedback system must be seen as a continuous process of improvement as in the Kaizen model (Bond, 1999). Further feedback is crucial for further organisational development or implementation of change management in the organisation. It is also allows management to monitor progress of set objective. Achievable objectives encourage and motivate employees. This step by step approach ensures progress through monitoring and resolves problems effectively. it allows for flexibility and continuous learning and development (Roebuck, 1996).

Use of 360-degree feedback assessment is an effective tool used by coaches to enhance self- awareness of competency strength and areas of improvement. 360-degree feedback is an information gathering tool about the executives' behaviour from superiors, peers and subordinates. This tool is effective when it is

supported by senior management and aligned with strategy and is used for follow up in coaching. It is effectively used by a coach, as a supportive developmental tool during learning process (Thach, 2002). The coaching phase consumes most of the time in the process. In this phase, the coach and coachee analyse the assessment results and plan activities together to address issues that impact organisational performance (Thach, 2002). The coach will challenge the coachee with the issue on hand, so as to increase self-awareness and responsibility on the side of the coachee (Thach, 2002). Challenge is when existing skills are stretched into the zone of proximal development and new learning takes place (Ely et al., 2010). Review of the process on implementation of activities is done in this phase during follow up meetings, monitor progress on the coachee's interaction, offer support during the process (Thach, 2002). Support is manifested by various factors such as passion, motivation, resources, tools (Ely et al., 2010). End with assisting the coachee to evaluate the process results (Thach, 2002). Reward and recognition, managing obstacles successfully and creating sustainable learning practice. through assessment and giving feedback improves confidence of the coachee (Ely et al., 2010). Once the set goals are achieved the coaching process terminate (Thach, 2002). One needs to be aware of the effect of use of internal and external coaches.

2.7.6 Types of coaching

There are three types of coaching that range from training to development, namely: coaching skills, performance and developmental coaching (West & Milan, 2001). The type of coaching that is mainly used towards senior management training is performance and developmental coaching (West & Milan, 2001).

Skills coaching focuses on the client's specific developmental needs based on their skills and capability. It is directive, involves best practice advice and training for specific skills. During the coaching process the coach uses facilitation through questioning, this assist the individual to reflect on their issue and come up with a solution for implementation (West & Milan, 2001).

Skills and Performance Coaching delivers one-on-one engagement with the coach, this develops growth in self-awareness and insight which allows the client to manage their own learning. It is delivered over a brief 3-6 month period, which is beneficial for busy leaders, while at the same time achieving results quicker (West & Milan, 2001).

Performance Coaching is geared towards the current performance and role of the individual leader, but is focused on the organisational needs. It gathers information of a leader from their supervisor, peers and their subordinates, this method is called 360 Degree Feedback. This type of coaching is also referred to as Feedback coaching. It is short term in duration and uses a directive coaching style (West & Milan, 2001), to address the issues that were raised from feedback and the individual issues in their work place. It enhances change in behaviour of a leader and the ability to unlock the individuals' potential to maximise performance (West & Milan, 2001). Lack of individual commitment to their role in an organisation, is mostly due to lack of psychological contract. Lack of clarity about the leader's role and their expectations from their seniors, often impacts negatively on the individual performance. Performance coaching offers a reflective space for the leader to explore their issue, create meaning and come up with an appropriate solution to address the expectations, and engage their senior in the solution.

Kolb's as reported by West and Milan (2001) learning is maximised through an exposure to a circular process. It starts with an experience, reflection of that experience, interpretation of the experience and preparation for the next similar experience. Coaching uses the same principles in adult learning.

Developmental coaching has the most benefit when used for the senior members of staff in the organisation, as they deal with complexity and have to address a variety of issues (West & Milan, 2001). It is more clients' focused and uses a holistic approach to address the individual needs. It helps the clients to develop detailed understanding of their identity and role, communicate clearly the personal and business strategy and implement appropriate change according to the findings. The process is spanned

over a 5-year period and based on the issues the leader has to address. The objectives are more complex as they are client defined and would thus requires a long-term investment (West & Milan, 2001).

New approaches are needed for strategic development. Long-term strategic plans are no longer appropriate in a turbulent environment; thus, a more rapid and appropriate response is required. Current issues need to be addressed and managers and executives need the capability to recognise real issues including those related to change. Thereafter, they need to draw up action plans as a means of response. There is also a need to strengthen strategic implementation enactment of the vision (Hartman & Crow, 2002).

Education must stress the best practice which is gained in the workplace. It is critical for the health executives to renew their commitment to self- development and serve as mentors. Training must focus on core competencies especially basic business acumen, people skills, and the ability to lead change in a constantly changing environment.

2.7.7 Factors contributing to successful coaching

The literature looked into critical factors that are contributing to the effectiveness of executive coach as a management developmental tool (Rekalde et al., 2015)**.** They include the coach as a person who is responsible for influencing the change in the behaviour of the individual; the coachee as the person who has a managerial responsibility and has to go through the leadership process for learning and growth; the relationship between the coach and the coachee; the coaching process; and the organisational context which is the environment where the coachee is working (Rekalde et al., 2015).

Formative evaluation within the process entails the dynamic nature of coaching in that it provides customised, unique adaptable leadership learning in response to the leader and organisational needs (Ely et al., 2010). Formative evaluation in the perspectives of leadership coaching includes the client, coach, client-coachee relationship and coaching process.

Clients may vary with their level of readiness, their expectations and the competencies they need to enhance their skills (Ely et al., 2010). The coach needs to assess organisational goals and organisational climate. This information provides the coach with factors which will influence the success of coaching intervention.

2.7.7.1 Coach

Coach competency is a factor for the success of the relationship. Their competence has an effect on the ability of the coachee to implement the planned activities from the engagement.

The coach factors include the ability of the coach to create trust and ensure confidentiality during the coaching process (de Haan, Sills, Boyce, Jeffrey Jackson, & Neal, 2010). The coach must be competent in communication skills that include verbal and non-verbal communication; must be committed to the process with regard to the clients and his/ her organisation (Hall, Otazo, & Hollenbeck, 2000; Hill, 2010); and must be competent in managing a leader's emotional reactions as barrier to decision-making for change and to challenge the coachee out of the comfort zone. The ability of the coach to generate trust, create quality relation and be able to provide constructive feedback are the required competencies for successful coaching process (Rekalde et al., 2015). According to (Rekalde et al., 2015), trust is key as it generates the favourable conditions for the coachee to be ready for the process, open up and allow himself to be vulnerable, without the coach judging them but offering support.

Coupled with this, the coach must have the capability to effectively and efficiently share feedback during the reviews (McGovern et al., 2001; Rekalde et al., 2015). Coach competencies include communication, ability to motivate, credibility and expertise in coaching skills. The coach should also have business awareness and knowledge of client's industry as well as behavioural science in order for them to be competent (Ely et al., 2010).

Coaches encourage their coachee's to know themselves and their own learning styles to facilitate speedy effective problem-solving; According to (Sadler-Smith, 2001), this self-knowledge in executives can be strengthened so that they are aware of their habits and should be willing to explore them if a need arise. This knowledge will also contribute towards a coachee's ability to tap into their internal resources for problem-solving.

2.7.7.2 Coach attributes

A trained professional who is competent has a vast and adaptive set of skills. The required competencies for an effective coach include:

> effective communication skills, analytical skills, assessment and feedback skills, planning skills, goal setting skills, organisational skills, creativity and resourcefulness, ability to motivate and encourage, ability to challenge others, results oriented and accountability, integrity, empathy, caring, personable, approachable, flexible, empowering and trustworthy, establish and maintain trust, ensure accountability, be objective, be accountable and set clear boundaries for their role (Ely et al., 2010).

In active listening, effective questioning and improved self-awareness, the coachee is challenged out of his/her comfort zone and self-limiting beliefs which enables the executive to realise the need for new action and assists him/her to create a new plan of activities (Cunningham & McNally, 2003). Furthermore the coach needs to ensure confidentiality, share feedback with the coachee, channel the focus of the coachee, ensure boundary management in the relationship between the coach and coachee, and challenge and offer support throughout the coaching process (Judge & Cowell, 1997).

The role of a coach is to assist clients to clarify where they are and where they want to be, to build self-awareness and create alignment with their goals, ensure that they are held accountable and responsible, and encourage them to come up with solutions and interventions for the challenges (Maltabia, Marsick, & Ghosh, 2014).

2.7.7.3 Coachee

The results of the study by McGovern et al. (2001) in measuring the effectiveness of leadership coaching were that the executives viewed and appreciated the process as they saw it as an opportunity for life-long learning. This result is supported by Lieb and Goodlad (2005) who posit that adults learn best if they see that the coaching is relevant to their work or other areas of their life. The lesson needs to be useful so as to increase their interest in learning.

The coachee must be committed to the coaching process, must be ready to learn and grow and have cognitive adaptability (Rekalde et al., 2015). Commitment of the coachee to the process entails their loyalty, devotion and readiness which is influenced by the coach, and the passion of the coachee towards their self-development are the contributing factors related to successful coaching (Rekalde et al., 2015). The leaders needs to be motivated to learn in order to bring about change and enhance performance (Rekalde et al., 2015). Coaching results are negatively affected by executives who are unable to honour their coaching appointments due to work pressures and inability to have time to practise what they have learned from coaching (McGovern et al., 2001).

The coach-coachee relationship is important to the coaching process. It is a one-on one relationship which requires trust, rapport, collaboration, commitment, trust and confidentiality; this contributes to the coaching success (Cunningham & McNally, 2003; Ely et al., 2010; Rekalde et al., 2015).

Trust is classified as an important factor in the relationship and is a factor that contributes to the successful outcome of the executive coaching process (Armstrong, Melser, & Tooth, 2007; Rekalde et al., 2015). Trust matters because it encourages collaboration, increases engagement, encourages agility and speed of learning, improves performance and improves satisfaction (Covey, Link, & Merrill, 2012). Furthermore, it encourages the coachee to engage openly and freely in the reflective process without fear of being judged, as the coach will have created an environment where the coachee feels that there is

objectivity in handling of issues by the coach. This subsequently increases the opportunity for the manager to be willing to learn and be influenced for change (Rekalde et al., 2015).

Rapport incorporates mutual understanding which allows for respect and valuing one another (Ely et al., 2010). In coaching the relationship is one of equals between the client and coach, as they are both experts (Rogers & Maslow, 2008).

Collaboration encourages information sharing that creates shared vision. With the co-operation that occurs between the coach and client and working towards a common goal, learning will take place and desired results will be achieved (Ely et al., 2010).

Commitment reflects dedication levels of the coach and coachee towards achieving developmental goals (Ely et al., 2010).

Confidentiality refers to mutual respect for safe communication in which boundaries are established for open and transparent discussions. Coaching is viewed as a practice which offers a safe environment for leaders to explore their issues. It is critical for the coach to ensure an enabling environment for learning (Ely et al., 2010). Involvement and engagement between that the coach and coachee is critical to the relationship. This synergy creates an environment that supports the coaching process and allows for learning. According to literature (Cunningham & McNally, 2003), an executive needs to be vulnerable in order to learn; this could be facilitated in a coaching environment which is safe and allows the executive to open up without having to share their challenges and aspirations with anyone else.

For the coaching process to be effective appropriate feedback is required from coach to coachee, and the executive needs to be continuously challenged for sustained learning and change in behaviour. The process must be goal-oriented, objectives must be SMART and activities should be accompanied by agreed targets (Judge & Cowell, 1997; Rekalde et al., 2015). The feedback in the process is key to

successful coaching, as it helps the coachee to understand their issues more clearly and be willing to explore a plan of activities to address them (Rekalde et al., 2015).

Organisational context refers to the place where the process will be rolled out. It should be an enabling environment with a culture of learning and supportive leadership. People learn the best when they have the perception that their organisation invests in their development and their leaders support their development. The organisation needs to make resources available to support executive coaching. Top level support for coaching as a developmental tool as well as throughout the coaching process is required for successful coaching (Rekalde et al., 2015).

2.7.7.4 Internal vs external coaches

External coaches are viewed to provide confidentiality, objectivity, trust and expertise while the internal coaches provides knowledge, lower cost, increased accessibility (Rekalde et al., 2015). External coaches are used frequently for executives; they are preferred for confidentiality, their availability and mostly focus on relevant issues as perceived by the executives.

2.7.8 Outcomes of executive coaching

This section covers issues pertinent to leadership coaching evaluation. Evaluation efforts must use include summative and formative evaluations (Ely et al., 2010). Summative outcomes assess coaching effectiveness as an effective tool for leadership development and formative evaluation within the process entails the dynamic nature of coaching in that it provides customised, unique adaptable leadership learning in response to the leader and organisational needs (Ely et al., 2010).

Summative outcomes in the leadership coaching training evaluation includes reaction, learning, behaviour and results (Ely et al., 2010). Reaction as an outcome is subjective. It can be used to assess individuals' satisfaction with the coaching and its effectiveness. This evidence is gathered by multiple dimensions of reactions, from coach-coachee relationship and the process (Ely et al., 2010). Learning as the second

outcome will be evident in three areas which are cognition, affective learning and skill capacity. Of particular significance is that coaching identifies areas not identified in traditional learning interventions. Cognitive and affective outcomes are significant areas of observation and learning (Ely et al., 2010). Outcomes of cognitive learning in leadership coaching are self-awareness and cognitive flexibility. After gathering information and feedback, the coach should understand the goals of the client and his/her role requirements; this is often the first time any identified gaps are addressed through leadership coaching. An increased sense of self-awareness at the end of the coaching process is an outcome. This can be confirmed through comparing initial assessment ratings and final assessment ratings, and through observation of other relevant stakeholders e.g. superiors, peers or subordinates. Cognitive flexibility is a much-required leadership element for leaders to develop so they can deal with complex demands. They need repertoire of responses to help in dealing with changes successfully (Ely et al., 2010). Affective learning is defined as attitude and motivation of the leader. Assessing this is important to provide evidence of learning at an executive level. Through the leadership coaching process, the coachee is given continuous, positive and challenging feedback. When feedback is challenging, the coachee is offered support and recognises the opportunity for learning. This ability to transfer learning to the working environment empowers the leader and the feeling of empowerment brings about confidence in their role and capacity to lead effectively. In turn they are motivated and committed to the organisation. The investment of the organisation in leadership coaching make the individual feels valued and creates motivation and commitment (Ely et al., 2010). Coaching in organisational learning refers to the process whereby an individual's learning is transferred to others in an organisation through sharing to enable collective learning which results in change that achieves organisational goals (Swart & Harcup, 2013). It is embedded in the coaching school of thought that individual learning is the base for growth of collective learning, through practising new skills and sharing feedback among individuals, teams and the organisation (Swart & Harcup, 2013). This encourages and reinforces double loop learning.

There are mechanisms coaching uses to translate individual learning to collective learning (Swart and Harcup, 2013). According to the coaching philosophy, individuals are helped to learn and are not taught; hence the definition of coaching where individuals are assisted to unlock their potential to maximise their own performance (Swart & Harcup, 2013). The three mechanisms that translate individual learning into collective learning in coaching include enacting of new behaviours through practice, role modelling and information sharing, and copying of shared new learning (Swart & Harcup, 2013). It then includes understanding how coaching works as a developmental tool, sharing ideas and new ways of thinking and copying of coaching tools in leadership styles leading to changes in team behaviour. Last, collective learning should be integrated into organisational procedures and ensure improved and sustained implementation of new and existing procedures (Swart & Harcup, 2013).

Swart and Harcup (2012) reported cognitive level changes including increased self-awareness, more confidence, focused approach, flexible mindset and positive attitude. Behavioural changes included increased attention to managing people, use of strategic approach to business development, planning ahead, delegating effectively and use of an effective communication style.

The goal of leadership coaching is to enhance leaders' performance. Effective leadership behaviour involves change the ability of the manager to effectively and efficiently complete their tasks, implement change, be innovative and adaptable, and encourage trust and co-operation (Ely et al., 2010). It also includes interpersonal communication, leadership and supervision, personal behaviour and skills as well as expertise in area of management. Organisational development behaviour involves effectively searching for relevant information, the ability to structure it and use it in problem-solving and effective use human resource management and other resource use. In coaching frequency of behaviour after exposure to coaching collect evidence of behaviour of interest to all stakeholders.

Results refer to the influence of training on the organisational level. It includes productivity, revenue and retention (Ely et al., 2010). Transformational behaviour within the organisation requires empowerment

and intrinsic motivation to do it. Job satisfaction, creativity and innovation, and improved organisational performance are evident from subordinates. Productivity and quality of outputs and leaders' strategic activities are long-term (Ely et al., 2010).

Formative evaluation in the perspectives of leadership coaching includes the client, coach, client-coachee relationship and coaching process. Clients may vary with their level of readiness, their expectations and the competencies they need to enhance their skills (Ely et al., 2010). The coach needs to assess organisational goals and the organisational climate. This information provides the coach with factors which will influence the success of coaching intervention

Summary: Leadership coaching is a one-on-one, synergistic relationship, that has the ability to improve leadership effectiveness through life-long learning, and has the benefit to transform leadership as new learning is used to empower and influence the leader's followers thereby increasing productivity and quality and fostering commitment from followers. This is the catalyst which enhances organisational performance. The emphasis in organisational learning is role modelling behaviour and copying by followers, leaders' creative thinking and integration of new learning into work procedures which are important for transference and learning to occur from the individual to the collective.

2.8 Conclusion of Literature Review

The purpose of this literature review was to explore clinical managers' competencies as a requirement in their work environment, proficiency level of the management competencies in the public health care sector and executive coaching and its role in leadership development.

The first part of the review explored the concept of competency and its importance in management's role, the proficiency levels of management competencies of clinical managers and the impact of challenges experienced in a hospital environment. The literature on both developed and developing countries identified a significant gap in public health sector managers' competency levels, which contributes to their lack of management capacity in a challenging and complex hospital environment.

The literature also explored leadership and management developmental training. There was a focus on executive coaching and its use as a leadership development tool in organisations. Based on the various definitions, there was a focus on a helping relationship which is goal-oriented and a growth and developmental tool aimed at improved performance, productivity and learning. There various types of coaching in organisations, with the performance and developmental coaching style mostly geared towards senior managers. There are factors contributing towards a successful coaching process, which include the competence of the coach, coachee readiness for the process, coach-coachee relationship effectiveness and organisation context.

The benefit of executive coaching was explored and summarised into four categories namely: improved personal and organisational performance; learning; improved interpersonal relationships; and behavioural change. Lastly, the outcome of executive coaching was explored, with formative and summative outcomes identified. Summative assessment evaluates the effectiveness of coaching as a tool for leadership development and it entails reaction, learning, behaviour and results. Formative evaluation includes ongoing assessment of the coach-coachee relationship and coaching process.

CHAPTER 3: RESEARCH METHODOLOGY

This section describes the methodology that was followed to answer research questions that have been put forward as probable solutions to the sub-problems discussed in the literature review section. This study utilised a quantitative survey as the research methodology. This chapter describes the target population, the research instruments and procedures for data collection, as well as outlining tools for data analysis, limitations of the study, and measures taken to ensure validity and reliability.

3.1 Research Paradigm

This researcher preferred the use of the quantitative approach which follows the positivist research philosophy. Its key focus is on individuals' behaviour in response to stimuli. The focus is to determine the required competencies of clinical managers in the public hospital environment in Gauteng and managers' perceptions of coaching in improving the competencies of clinical managers individually. The survey study was used to capture data that occurs in a particular situation, at a particular time with the aim of explaining the current situation (Cohen, Manion, & Morrison, 2011). This methodology was used in order to capture appropriate data to achieve study objectives.

In summary, the researcher in this study used the positivist research paradigm in order to measure and generalise the findings from the sample to the population of clinical managers in Gauteng hospitals.

3.2 Research Design

The cross-sectional survey research design was used. This design allows for the quick collection of data, and it is simple and cheap to administer although it has a limitations in that it may miss some variations in participants'' perceptions over time (Bulmberg, Cooper, & Schindler, 2011)

The survey instrument was adapted from a Canadian model (MacKinnon et al., 2005). Its advantage is that it allowed the researcher to capture the perceptions of a representative sample of certain individuals

from the population, to provide accurate, numerical data and allow for generalisation of the results (Cohen, Manion, & Morrison, 2011)

3.3 Population and Sample

3.3.1 Population

The population of the study included all 80 clinical managers working at 38 public hospitals in Gauteng province, in South Africa. They are all involved in the development of the hospitals' strategic and operational plans. They organise, monitor and evaluate, as well as lead in their departments.

3.3.2 Sample and sampling method

A total population (census) strategy was utilised to identify the target group. The survey questionnaire was administered to the whole population. This sampling strategy was chosen by the researcher in order to focus on specific issues of all clinical managers in Gauteng public hospitals and to create an adequate sample for the research (Cohen et al., 2011).This would have been difficult if any other sampling strategy had been employed (Chen, 2010).

Table 2: Profile of proposed respondents

Hospital Category	Number	Number of clinical managers to be sampled
Oral	3	1 per hospital (3)
Specialised hospitals	6	1 per hospital (6)
District hospitals	8	1 per hospital (8)
Regional hospitals	8	2 per hospital (20)
Tertiary hospitals	9	2 per hospital (16)
Central Hospitals	4	4 per hospital (20)
Total	38	80

3.4 Procedure for Data Collection and Analysis

The permission to conduct the study in Gauteng hospitals was sought from the Head of the Department (HoD) of Gauteng Health (Appendix 3). Permission was granted by the Wits Business School.

The procedure for data collection started with the researcher sending a letter to brief clinical managers on the purpose of the survey. The letter described the purpose of the study and was sent out with an invitation to a meeting to familiarise and increase the buy-in of the respondents.

On the day of the clinical managers' meeting, the researcher briefly presented the purpose of the survey and allowed for any clarity-seeking questions. The researcher emphasised that participation in the survey was voluntary and that anonymity and confidentiality would be strictly maintained. All respondents were given a separate informed consent form requesting their permission to be part of the study. Then a self-completion questionnaire was distributed to all participants for completion during the allocated time slot of 30 minutes during the meeting (Faris, MacKinnon, MacKinnon, & Kennedy, 2005). This similar method of data collection was used in a study by Gorki (2014) to minimise a poor response rate which can hamper the effectiveness of surveys.

3.4.1 Research instruments

The following two survey instruments were used to collect data are as follows:

1. The demographic questionnaire with characteristics of clinical managers was used to gather data on: personal characteristics, qualifications, experience, roles, challenges, training in health management and a need for further training and development training in health management was adapted from a South African study (Pillay, 2010). (Appendix 1).

2. The Canadian Health Executives' managerial competency questionnaire was used in this survey (MacKinnon et al., 2005) (Appendix 2). It contains 31 specific managerial competencies in the following nine categories, namely: leadership, communication, life-long learning, consumer/community responsiveness and public relations, political and health environment awareness, conceptual skills, results management, resource management and compliance to standards. This tool was used to capture data about the perceived important managerial competencies in the Gauteng public hospitals and the proficiency level of clinical managers in these competencies. Liker-scale questions were used to measure the top managers' perceptions of the important competencies required for effective service delivery and their level of proficiency with those competencies. The main aim of the researcher was to be able to score the variables and draw important deduction from this data (Boone & Boone, 2012). The scale had a number of items and the scale ratings ranged from 1-5, with 1 (not important) to 5 (very important) with regards to required competencies and 1 (poor) to 5 (excellent) with regards to proficiency level. High scores on the Likert scale are associated with positive thoughts, while low scores are associated with negative opinions (MacKinnon et al., 2005).

3.4.2 Data analysis and interpretation

Data are captured differently depending on the questionnaire. Quantitative data such as demographics, important competencies and their proficiency were captured on an excel spread sheet. Thereafter the data were imported into Stata13 for analysis. Stata13 is a statistical software package that is used to perform statistical analysis and data management.

Descriptions of the socio-demographic characteristics of the respondent used frequency tables and percentages for categorical variables such as gender, qualification, ethnic group, and so on. Continuous variables such as age were summarised using mean and standard deviation or median and interquartile range depending on the underlying distribution of the continuous variables (MacKinnon et al., 2005).

A score of 3.5 and above was considered as excellent for proficiency levels. An average level of proficiency was obtained by summing up different proficiency levels for different competencies. ANOVA was used to test for equality of mean proficiency levels across different ethnic groups and qualification levels of the respondents (MacKinnon et al., 2005).

The first sub-problem of the study, to establish the competencies of clinical managers required in a public hospital environment in Gauteng, was answered using frequencies and percentages.

To answer the second sub-problem, to explore managers' perceptions of coaching in improving competencies of clinical managers, a competency score was constructed for individual respondents by summing up different scores on the Likert scale. Averages or medians of the proficiency score were compared across demographic characteristics of the respondents, depending on the underlying distribution. Therefore, independent t-tests were used to test for equality of means proficiency scores between demographic characteristics of two levels such as gender, formal training in health management, and previous exposure to coaching as a development intervention and so on. Where the proficiency scores followed a skewed distribution, then Mann Whitney was used instead of independent t-test.

For demographic characteristics of more than two levels, ANOVA was used to test for equality of proficiency levels across these variables. These included among others, race, academic qualifications, field of study, hours worked per week, and length of experience in the position.

3.6 Limitations of the study

There may be incorrect responses due to the type of issue under discussion; e.g. sensitive matters may be under-reported, or proficiency levels of respondents may be under-reported as this might pose a threat of demotion or deny respondent promotion.

With Likert-scale type data, participants have a tendency to select neutral statements, (neither positive or negative) which results in the researcher having no idea about the stand point of the respondents but it makes them feel safe (Boone & Boone, 2012)

3.7 Validity and Reliability

3.7.1 External validity

External validity refers to the extent to which the conclusions of the study can be generalised to a wider population, and across populations with various contexts. In this study, a census sample was used which included all clinical managers working in the Gauteng province in the population and sample (Cohen et al., 2011). External validity was thus ensured.

3.7.2 Internal validity

Use of unreliable instruments was minimised by using instruments that had been tested and validated in previous studies (MacKinnon et al., 2005). Open-ended questions were piloted among clinical managers in one hospital before use in the final study.

3.7.3 Reliability

A pilot study was conducted to test the data collection time and the reliability of the questionnaires, in order to ensure that the tools would yield reliable data. Identified gaps were filled in order to improve data collection.

The scale reliability was estimated by the use of Cronbach's Alpha (Norman, 2010). It measures internal consistency among variables and yields inter-item correlations (Cohen et al., 2011)

The availability of the researcher during the completion of the questionnaires, enabled her to clarify any questions and minimise any misunderstandings.

3.8 Ethical Considerations

Ethical clearance was obtained from the Wits Business School's Graduate Studies Committee. Consent for participation in the research study was obtained through informed consent forms signed by the respondents. The purpose of the study was explained. The respondents were informed about anonymity, confidentiality and the right to withdraw at any stage of the study. Those who consent to enter the study were asked to sign an informed consent form.

The researcher also explained to respondents that they were not going to be rewarded financially for participating in this research. The participants were reassured about confidentiality and anonymity in reporting the results.

CHAPTER 4: RESULTS

The study sought to describe the managerial competencies of clinical managers and the need for coaching as a mechanism for improving effectiveness of clinical managers at public hospital in Gauteng.

These results are presented in five sections. The two first sections present the participants' response rate and their socio-demographics. The third section presents participants' exposure to coaching. The fourth section is a description of managerial competencies among participants, managerial competency by category and determines the most important and the least important managerial skills. The fifth section concludes the results.

4.1 Response Rate

The study was designed to include all 80 clinical managers working in Gauteng province. Only 61 clinical managers were accessible via email. An informed consent form, the survey questionnaires and the research topic which explained to the participants coaching and its benefit as a developmental tool for managers were distributed to all the participants via email.

As described on the flow chart below, of the 61 distributed questionnaires, 35 were returned, which represents 57.38% response rate. Only one of returned questionnaires was discarded and removed from the survey population as it was incompletely filled out. In total, 34 questionnaires were returned fully completed which gives a response rate of 55,7%. Thus, the final sample consisted of 34 clinical managers who completed the two questionnaires namely; socio-demographic and competency.

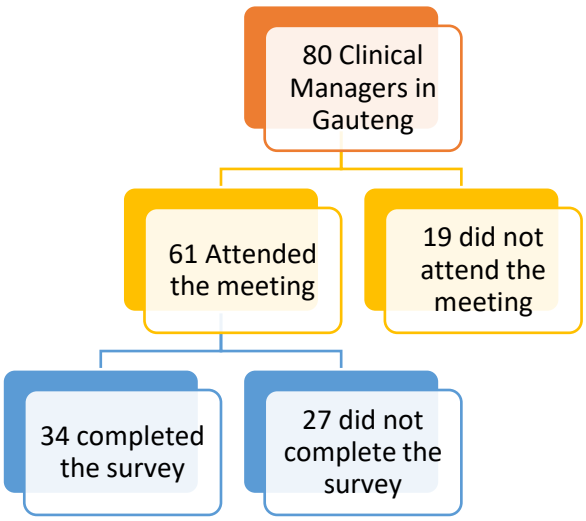


Figure 1: Flow chart of data collection

4.2. Socio-demographic characteristics of participants

Table 3 below describes the socio-demographic characteristics of participants. Males represented 52.94 of participants against 47.06% of females. Of the 34 clinical managers, 26.47% (n=9) work in central hospitals, 23.53% (n=8) work in tertiary hospitals, 20.59% (n=7) work in regional hospitals, 14.71% (n=5) work in district hospitals and 14.71% (n=5) work in specialised hospitals.

Table 3: Socio-demographic characteristics of participants

Characteristics	Frequency (n=34)	Percentage
Gender		
Male	18	52.94
Female	16	47.06
Age		
< 35 yrs	1	2.94
34 – 50	17	50.00
50+	16	47.06
Experience in 5 year brackets		
<5	12	35.29
5 – 10	10	29.51
10+	12	35.29
Level of Care		
Central Hospital	9	26.47
Tertiary Hospital	8	23.53

Regional Hospital	7	20.59
District Hospital	5	14.71
Specialised Hospital	5	14.71
Academic Qualification		
Degree	24	70.59
Masters	10	29.41
Study Field		
Medical	28	82.35
Allied	6	17.65
Formal Training		
No	9	26.47
Yes	25	73.53

Of the 34 respondents who completed the survey, 18 were males against 16 females as shown on Figure 2.

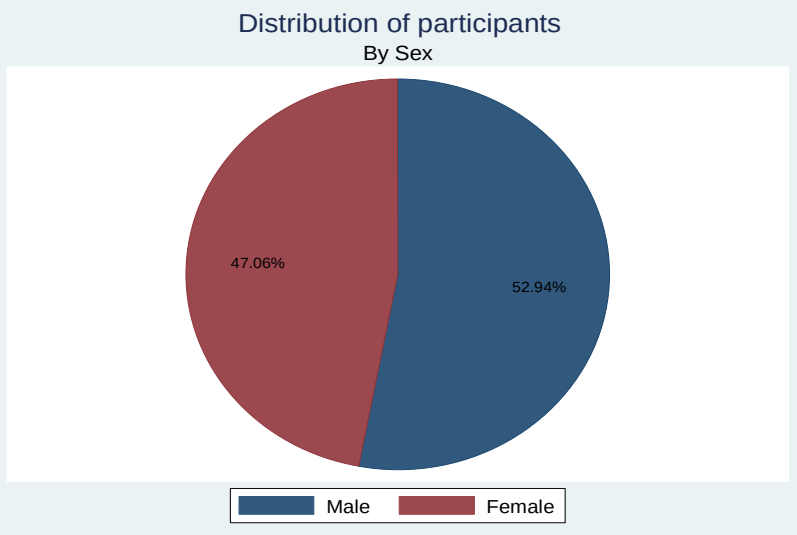


Figure 2: Distribution of participants by age and gender

Results shows that 97% of all clinical managers in Gauteng area are 35 years and older, whereas 47% of them are above 50 years of age. Sixty five percent have more than 5 years of work experience and 71% have an associate basic degree against only 29% having a master's degree and 74% have received formal training.

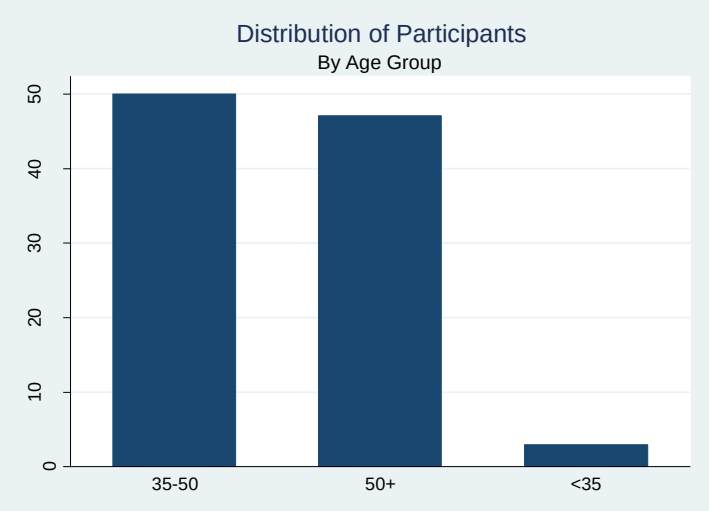


Figure 3: Describes the age group distribution of the participants in this study.

Figure 3 shows 50% of participants were between 35 and 50 years, whereas less than 5% were over 35 years of age.

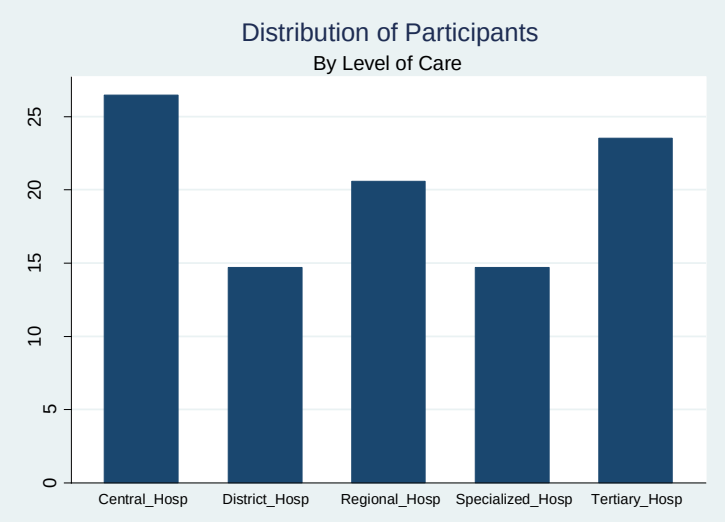


Figure 4: Distribution of participants by level of hospital

Figure 4 shows that approximately a quarter of participants (26.5) are working in central hospitals, followed by tertiary and regional hospitals with 23,53% and 20,59% respectively, whereas participants from district and specialised hospitals each represented 15% of the final sample.

4.3 Participants' Exposure to Coaching and Need for Coaching

Figure 5 describes the distribution of participants in terms of coaching exposure and the need for coaching as a developmental tool.

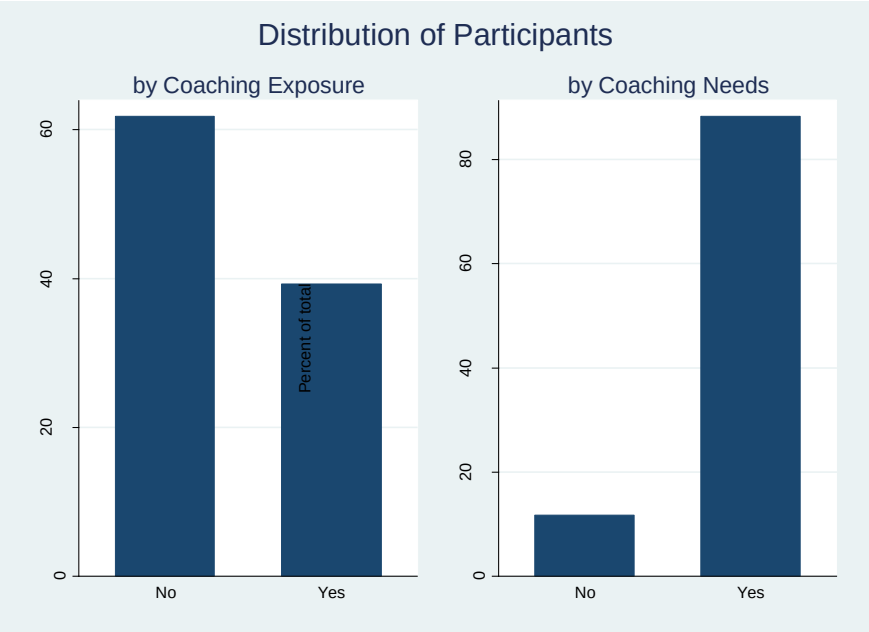


Figure 5: Distribution of participants by coaching exposure and the need for coaching

The figure indicates that only 39% of clinical managers have been exposed to coaching. It was of interest to note that 88% of clinical managers indicated the need for exposure to coaching in their workplace.

4.4 Description of Managerial Competencies: Importance seen by Participants

Managerial competencies were measured using a validated tool, the South African Clinical Manager's Self-Assessment of Managerial Competency questionnaire. Participants were asked to rate on a Likert scale (1 – 5) the importance of the core managerial competency in their current position. These included leadership, communication, life-long learning, community responsiveness and public relations, political and health environment, results management, resource management and compliance to standard.

Table 4: Clinical managers perceived importance of competency skill set and self-assessment of the skill set

Skill set	Importance score in current position	Mean score (SD)
Leadership (score out of 45)	41	4.40
Communication (score out of 15)	13.94	1.78
Life-long Learning (score out of 10)	8.76	1.39
Responsiveness & public relations (score out of 10)	8.82	1.31
Political and health environment (score out of 10)	8.68	1.30
Conceptual skills (score out of 15)	13.56	1.94
Results management (score out of 15)	13.53	2.19
Resources management (score out of 20)	17.65	2.79
Compliance with standards (score out of 15)	13.74	1.90
Total Score	135.06	15.22

We found that, on average clinical managers in Gauteng value managerial competencies on a scale of 135 out of 155. This total score includes nine core sub-skills for the competence managerial. For instance, on average, participants expressed great importance (41 ± 4.40) for leadership as a critical skill in their current position. In addition, participants valued resource management as an important managerial competence (17.65 ± 2.79).

In addition, participants were asked to self-assess their own competency using the same tool. The aim was to assess how clinical managers value these competences and to what extent they use what they value to be critical skills needed for their positions. Table 5 provides these assessments by area of competency.

Table 5: Clinical managers perceived importance of competency skill set and self-assessment of the skill set

Skill set	Self-Assessment score in current position	Mean score (SD)
Leadership (score out of 45)	36.5	5.73
Communication (score out of 15)	12.41	1.84
Life-long Learning (score out of 10)	7.65	1.30
Responsiveness & Public Relation (score out of 10)	8	1.37
Political and health Environment (score out of 10)	7.68	1.45
Conceptual Skills (score out of 15)	12.09	2.04
Results Management (score out of 15)	11.62	2.17
Resources Management (score out of 20)	15.47	2.71
Compliance with standards (score out of 15)	12.03	2.34
Total Score	119.68	18.23

In terms of self-assessment, we found that on average participants only apply leadership competency in their workplace with a score of 36.5 on a scale of 45 possible points. Overall, we also found that managerial competency was applied at the workplace at 119.68 (±18.23) out of 155 possible points. Table 5c below provides a comparison between the importance attached to the skillset by participants and their self-assessment of the aforementioned skills at their workplace.

Table 6: Clinical managers perceived importance of competency skill set and self-assessment of the skill set

Skill set	Importance Score in current position Mean score (SD)	Self-Assessment score in current position Mean score (SD)	p-value
Leadership (score out of 45)	41 (4.40)	36.5 (5.73)	0.001
Communication (score out of 15)	13.94 (1.78)	12.41 (1.84)	0.001
Life-long Learning (score out of 10)	8.76 (1.39)	7.65 (1.30)	0.001
Responsiveness & Public Relation (score out of 10)	8.82 (1.31)	8 (1.37)	
Political and health Environment (score out of 10)	8.68 (1.30)	7.68 (1.45)	0.003
Conceptual Skills (score out of 15)	13.56 (1.94)	12.09 (2.04)	0.001
Results Management (score out of 15)	13.53 (2.19)	11.62 (2.17)	0.001
Resources Management (score out of 20)	17.65 (2.79)	15.47 (2.71)	0.001
Compliance with standards (score out of 15)	13.74 (1.90)	12.03 (2.34)	0.001
Total Score	135.06 (15.22)	119.68 (18.23)	0.001

Note: All p-values in the table refer to paired t-tests. The two assessments were done by the same individuals; therefore, the two measurements are dependent. It is indicated to use paired t-tests given that the study sample is greater than 30 (according to the central limit theorem) (Drew, Evans, Glen, & Leemis, 2017).

The results reveal that there are significant differences between the perceived importance of all skills and the managers' self-assessment of their competency. For instance, on average, participants expressed great importance (41 ± 4.40) for leadership as a critical skill in their current position; however, their actual average score for leadership on their workplace is only (36.5 ± 5.73), which represents a significant 4.5 points down (p-value: 0.001) compared to the perceived importance of this skill. There was a pattern of a consistent difference of two points with regard to conceptual skills, results management, resource

management and compliance with standards, which was significant. In summary, results in Table 4, 5 and 6 shows that on average, there was a significant difference between how participants rated the importance of the required skill set (mean: 135.06 ± 15.22) and how they use these skills in their workplace (119.68 ± 18.23.

4.4.1 Managerial competency by category

Under this section, the breakdown of the managerial competencies and their ratings by participants is presented. Thereafter, they were ranked in their order of importance, according to the percentage given to individual sub-skill.

Table 7: The results of leadership sub-skills

Skills designation	Importance					Self-Assessment				
	Very High	High	Medium	Low	Very Low	Very High	High	Medium	Low	Very Low
Vision	23 (67.65)	4 (26.47)	3 (5.88)	0 (0.00)	0 (0.00)	12 (35.29)	12 (35.29)	10 (29.41)	0 (0.00)	0 (0.00)
Team Building	24 (70.59)	10 (29.41)	0 (0.00)	0 (0.00)	0 (0.00)	13 (38.24)	13 (38.24)	8 (23.53)	0 (0.00)	0 (0.00)
Flexibility in different situations	18 (52.94)	15 (44.12)	1 (2.94)	0 (0.00)	0 (0.00)	9 (26.47)	15 (44.12)	10 (29.41)	0 (0.00)	0 (0.00)
Flexibility in change management	18 (52.94)	13 (38.24)	3 (8.82)	0 (0.00)	0 (0.00)	9 (26.47)	16 (47.06)	9 (26.47)	0 (0.00)	0 (0.00)
Stress management	18 (52.94)	12 (35.29)	4 (11.76)	0 (0.00)	0 (0.00)	6 (17.65)	11 (32.35)	14 (41.18)	3 (8.82)	0 (0.00)
Commitment to the consumers	22 (64.71)	11 (32.35)	1 (2.94)	0 (0.00)	0 (0.00)	13 (38.24)	15 (44.12)	6 (17.65)	0 (0.00)	0 (0.00)
Commitment to the organisation	23 (67.65)	9 (26.47)	2 (5.88)	0 (0.00)	0 (0.00)	15 (44.12)	13 (38.24)	6 (17.65)	0 (0.00)	0 (0.00)
Commitment to stakeholders	23 (67.65)	8 (23.53)	3 (8.82)	0 (0.00)	0 (0.00)	11 (32.35)	15 (44.12)	7 (20.59)	1 (2.94)	0 (0.00)
Commitment to health service	21 (61.76)	9 (26.47)	4 (11.76)	0 (0.00)	0 (0.00)	14 (41.18)	14 (41.18)	5 (14.71)	1 (2.94)	0 (0.00)

4.2.2.1 Leadership sub-skills

Leadership was broken into nine sub-skills and each sub-skill was rated on a Likert-scale of 1 – 5 according to their importance.



Figure 6: Graphical presentation of the leadership sub-skills in order of importance

Results in Table 4 show that of the 34 participants, 23 (67.65%) said that vision was a very important contributing skill for a strong leadership. In terms of team-building as a sub-skill for strong leadership, 71% of participants believed that it is very important for good leadership. Regarding stress management, only 53% of participants believed that it was very important. This allowed for a ranking in their order of importance, based on the individual rating of each sub-skill as follows: team building, vision and commitment.

The least important skills were stress management and flexibility in different situations and change management. On the other hand, participants also rated themselves with respect to the leadership sub-skills. Results from Table 4 seem to provide a different view. Indeed, results from Table 7 above suggests that commitment (to the organisation, to the stakeholders and to the health profession) is the most used skills in the workplace among clinical managers. These results appear to contradict what they regarded as important. Figure 6 provides a graphical presentation of the leadership sub-skills of clinical managers by order of importance.

Table 8: Clinical managers' self-assessment of leadership sub-skills

Skills designation	Self-Assessment				
	Very High	High	Medium	Low	Very Low
Vision	12 (35.29)	12 (35.29)	10 (29.41)	0 (0.00)	0 (0.00)
Team Building	13 (38.24)	13 (38.24)	8 (23.53)	0 (0.00)	0 (0.00)
Flexibility in different situations	9 (26.47)	15 (44.12)	10 (29.41)	0 (0.00)	0 (0.00)
Flexibility in change management	9 (26.47)	16 (47.06)	9 (26.47)	0 (0.00)	0 (0.00)
Stress management	6 (17.65)	11 (32.35)	14 (41.18)	3 (8.82)	0 (0.00)
Commitment to the consumers	13 (38.24)	15 (44.12)	6 (17.65)	0 (0.00)	0 (0.00)
Commitment to the organisation	15 (44.12)	13 (38.24)	6 (17.65)	0 (0.00)	0 (0.00)
Commitment to stakeholders	11 (32.35)	15 (44.12)	7 (20.59)	1 (2.94)	0 (0.00)
Commitment to health service	14 (41.18)	14 (41.18)	5 (14.71)	1 (2.94)	0 (0.00)

Table 8 shows results of how participants rated themselves with respect to the leadership sub-skills. Results provide a different view. The score of commitment to the organisation and health profession scored highest followed commitment to consumers and team building. The results from Table 8 suggest that commitments (to the organisation, health profession and consumers) are the most used skills in the workplace among clinical managers. These contrasts with what they thought were important.

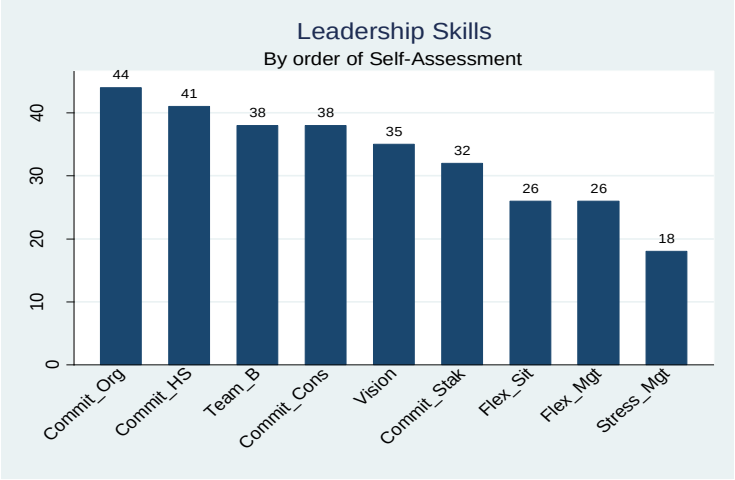


Figure 7: Graphical presentation of the leadership sub-skills: Self-assessed

Figure 7 shows that all the leadership sub-skills for self-assessed clinical managers' competencies scored lower than what managers viewed as important leadership skills.

4.2.2.2 Communication sub-skills

Communication sub-skills encompassed verbal, listening and writing skills. Table 9 provides a clear description of the rating by participants.

Table 9: : Description of communication skills: Importance vs self-assessment

Skills designation	Importance				
	Very High	High	Medium	Low	Very Low
Verbal skills	22 (64.71)	10 (29.41)	2 (5.88)	0 (0.00)	0 (0.00)
Listening skills	22 (64.71)	12 (35.29)	0 (0.00)	0 (0.00)	0 (0.00)
Writing skills	24 (70.59)	10 (29.41)	0 (0.00)	0 (0.00)	0 (0.00)
	Self-Assessment				
Verbal skills	14 (41.18)	14 (41.18)	6 (17.65)	0 (0.00)	0 (0.00)
Listening skills	8 (23.53)	21 (61.76)	5 (14.71)	0 (0.00)	0 (0.00)
Writing skills	12 (35.29)	13 (38.24)	9 (26.47)	0 (0.00)	0(0.00)

Results from Table 9 suggest that, most of the study participants said each component of communication competency is very important. Seventy one percent of participants said writing skills are very important, followed by verbal and listening skills at 65%; however, on the self-assessment, only 35% are said to be effectively using writing skills in their profession. Only 23% of the study participants are effectively using listening skills in their workplace and 12% use writing skills effectively. Figure 8 provides a graphical representation of communication skills as reported in Table 9.

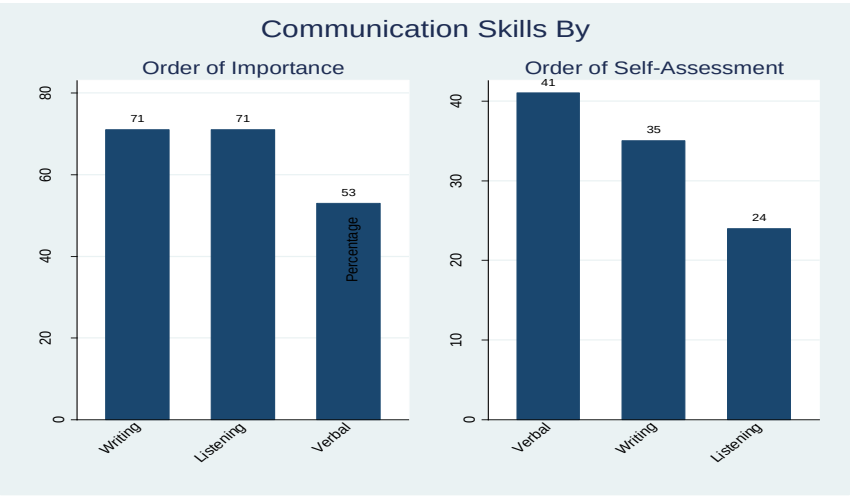


Figure 8: Description of communication skills

4.2.2.3 Life-long learning skills

Life-long core competency included self-directed learning and teaching or mentoring. Table 10 shows results of life-long learning skills.

Table 10: Description of life-long learning skills: Importance vs self-assessment

Skills designation	Importance				
	Very High	High	Medium	Low	Very Low
Self-directed learning	18 (52.94)	11 (32.35)	5 (14.71)	0 (0.00)	0 (0.00)
Teaching/mentoring	18 (52.94	12 (35.29)	3 (8.82)	1 (2.94)	0 (0.00)
	Self-Assessment				
Skills designation	Very High	High	Medium	Low	Very Low
Self-directed learning	5 (14.71)	14 (41.18)	15 (44.12)	0 (0.00)	0 (0.00)
Teaching/mentoring	9 (26.47)	15 (44.12)	9 (26.47)	1 (2.94)	0 (0.00)

Results from Table 10 suggest a huge discrepancy between the perceived importance of life-long learning skills and their use among clinical managers as depicted on the graphs below. Figure 9 presents results of life-long learning skills.

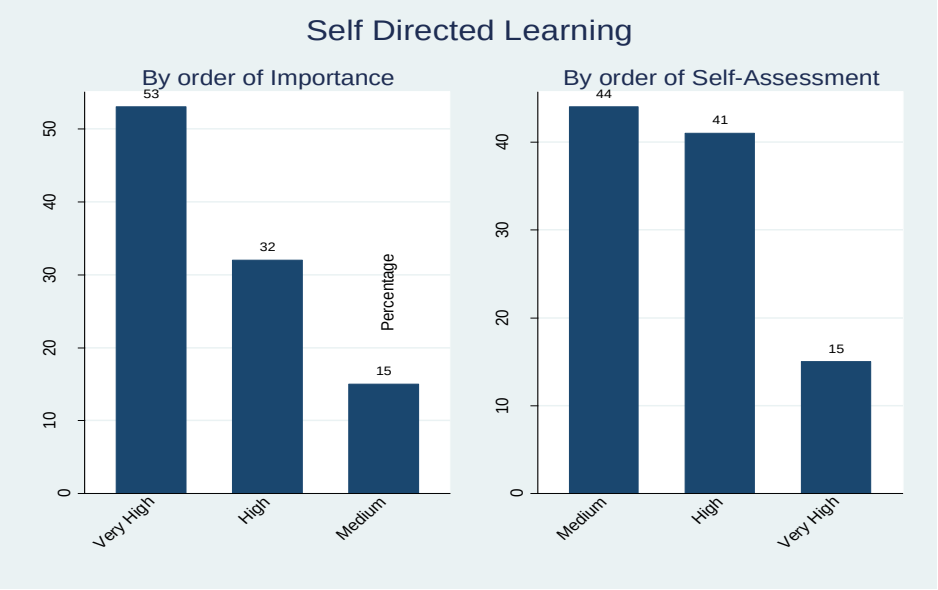


Figure 9: Self-directed learning: Importance vs self-assessment of management competencies

Indeed, the graphs show that although clinical managers (52.94%) value very highly self-directed learning skills, only 14.71% are highly using the skill at their workplace. The similar striking difference was also seen with teaching/mentoring as a life-long learning skill (Figure 10).

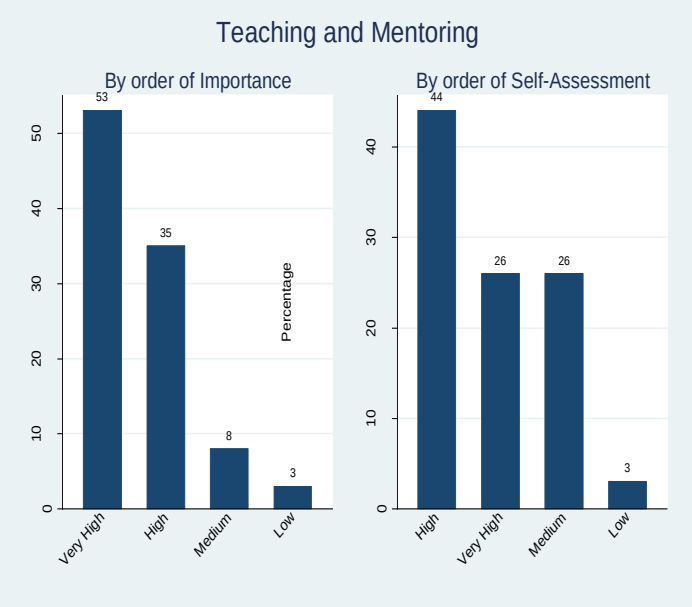


Figure 10: Teaching/ mentoring: Importance vs self-assessment of management competencies

4.2.2.4 Consumer/community responsiveness

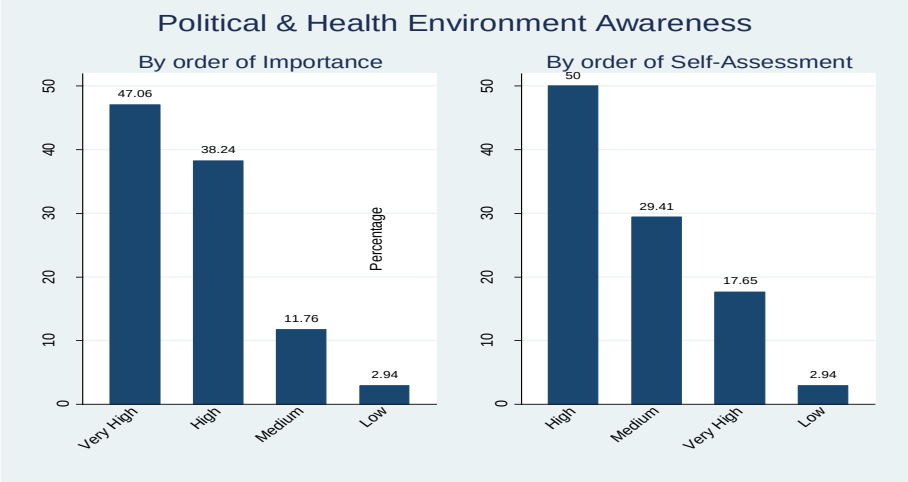


Figure 11: Community responsiveness and public relations

Figure 11 shows that although more than 50% of study participants believed that community responsiveness is very important, with only 32.35% striving to develop good relationships with the public.

4.2.2.5 Political and health environment awareness

The core competency for political and health environment awareness included political awareness and sensitivity, referring to the ability to display sensitivity to political policies and issues; actively seek information on political trends in health services issues; monitor trends in the health environment; and anticipates potential impact on the organisation. Figure 10 shows political and health environment awareness.

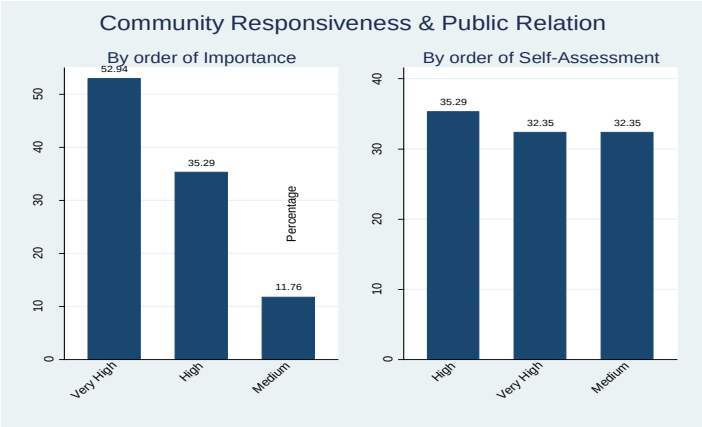


Figure 12: Political and health environment awareness: Importance vs self-assessment management competencies

Figure 12 shows that about 47% of participants believed that it is very important to develop such skill while only 17.65% are said to be applying these skills at the workplace.

4.2.2.6 Conceptual skills

The conceptual skills included analytical and synthetic skills, problem-solving capacity and system thinking inclination. Figure 13 presents the perceived importance and the actual assessment of participant for the analytical and synthetic skills.

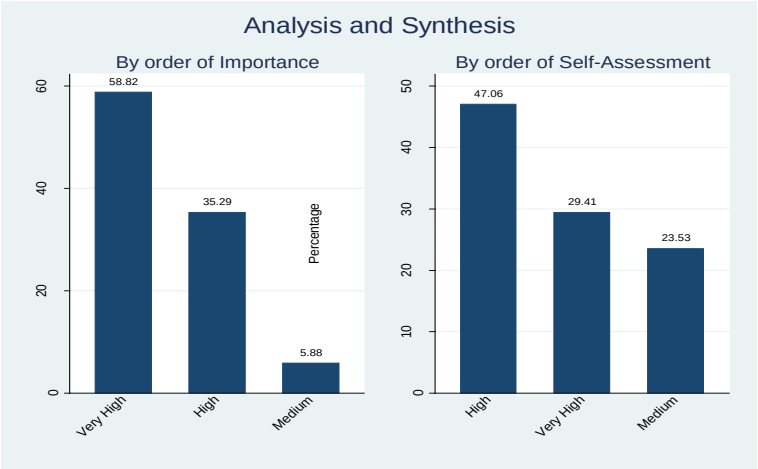


Figure 13: The perceived importance and the actual assessment of participant for the analytical and synthetic skill

Figure 13 shows that although 59% of participants acknowledge that analysis and synthesis are very important skills on the core conceptual competencies, only 29.41% are said to be very highly using them at their workplace.

4.2.3 Investigating the most important managerial skills

The mean rating was obtained for the perceived importance of each of the 31 competencies. Table 11 shows the five most important managerial competencies.

Table 11: Five most important managerial competencies

Top five Managerial competencies	Mean	SD
Team building	4.71	0.46
Writing	4.71	0.46
Ethical standard	4.68	0.59
Listening	4.65	0.49
Vision	4.62	0.6

The results from Table 11 show that out of the five most important managerial competencies, team building and writing skills were the most important, followed by ethical standards, listening and vision.

Table 12: Five most important managerial competencies by level of hospital care

Competency	Level of care					p-value
	Central Hospital	Tertiary Hospital	Regional Hospital	District Hospital	Specialised Hospital	
	(n=9)	(n=8)	(n=7)	(n=5)	(n=5)	
Team Building	4.44 (0.53)	4.50 (0.53)	4.86 (3.78)	5.00 (0.00)	5.00 (0.00)	0.04
Writing	4.56 (0.53)	4.63 (0.52)	4.86 (0.38)	4.60 (0.55)	5.00 (0.00)	0.39
Ethical standards	4.56 (0.53)	4.50 (0.93)	4.71 (0.49)	4.80 (0.45)	5.00 (0.00)	0.61
Listening	4.67 (0.50)	4.63 (0.52)	4.57 (0.53)	4.60 (0.55)	4.8 (0.45)	0.95
Vision	4.33 (0.87)	4.50 (0.53)	4.57 (0.53)	5.00 (0.00)	5.00 (0.00)	0.17

Note: p-value from Pearson Analysis of Variance (ANOVA) test considering 5% level of significance

Results in Table 12 above suggest that although clinical managers showed differences in rating the five most important managerial competencies with respect to their hospital care level, such difference was significant only for the team building competency (p-value: 0.04). This implies that competency perceived importance did not vary with hospital care level, except for the team-building. However, it should be noticed that such a difference could become significant even for other competencies with a much larger sample and may be affected by many other variables. Figure 14 is a graphical presentation of five most important managerial competencies by level of hospital care as reported in Table 12.

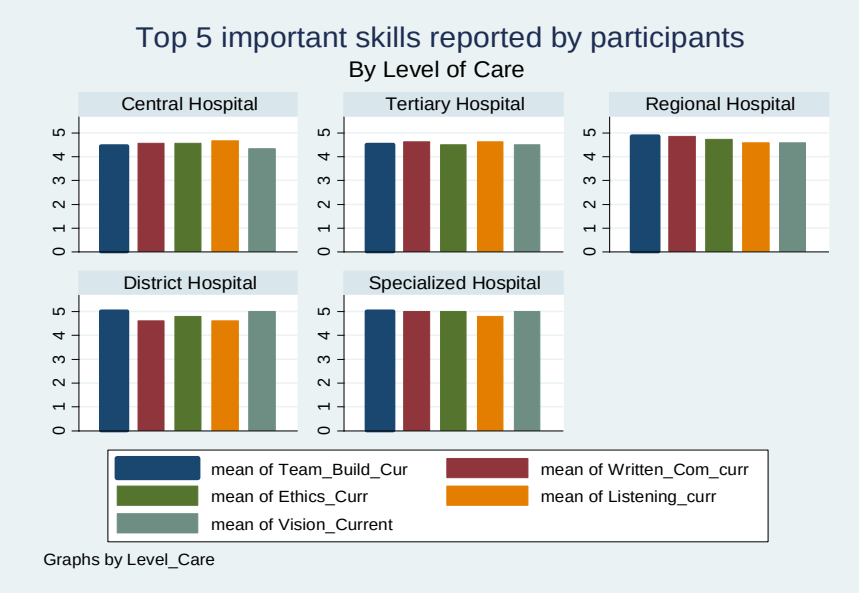


Figure 14: Five most important managerial competencies by level of hospital care

Table 13: Level of care

Competency	Level of care					
	Central Hospital	Tertiary Hospital	Regional Hospital	District Hospital	Specialised Hospital	p-value
	(n=9)	(n=8)	(n=7)	(n=5)	(n=5)	
Political awareness	3.78 (0.67)	3.13 (0.99)	4.29 (0.76)	4.00 (0.71)	4.00 (0.71)	0.08
Monitoring / evaluating	3.78 (0.67)	3.63 (0.92)	4.00 (1.00)	4.00 (1.00)	3.60 (0.55)	0.86
Learning self-directed	3.56 (0.53)	3.63 (0.92)	3.86 (0.69)	3.80 (0.84)	3.80 (0.84)	0.92
Capital/ material assets	3.89 (0.60)	3.25 (0.71)	3.86 (0.90)	4.00 (1.00)	3.60 (0.55)	0.35
Stress Management	3.67 (0.71)	3.13 (0.99)	3.71 (0.95)	4.00 (0.71)	3.60 (1.14)	0.51

Note: p-value from Pearson Analysis of Variance (ANOVA) test considering 5% level of significance

Results in Table 13 above show that there was no statistically significant difference in the least managerial competency self-assessed mean rating across different levels of care. However, given the p-value of political awareness (p-value: 0.08, which is significant at 10% level of significance), this could be a key indicator to watch, as it may become significant with a larger sample size. Figure 15 provides a graphical presentation of the five least important managerial competencies by level of hospital care as reported in Table 13.

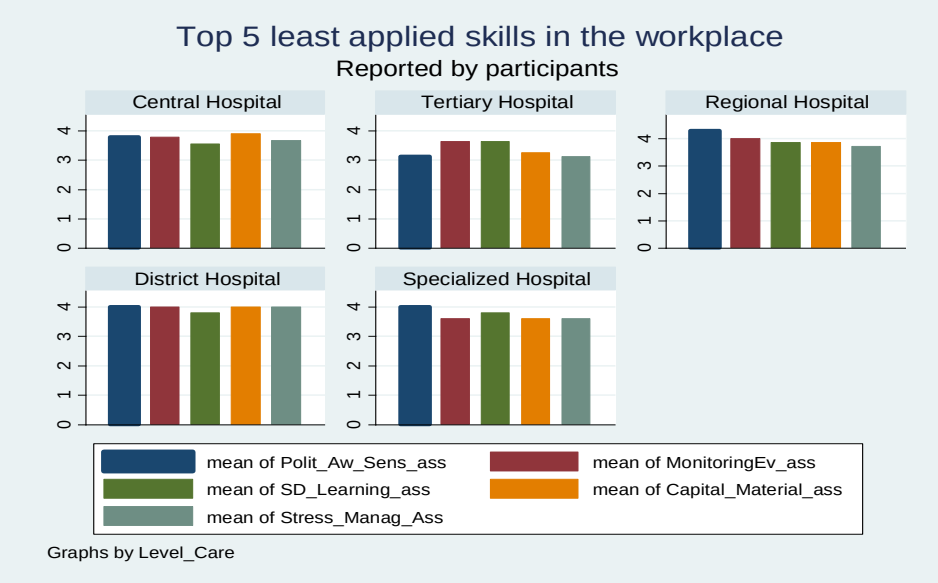


Figure 15: Five least important managerial competencies by level of hospital care

4.2.4 Additional required competencies that were identified by clinical managers

One open-ended question was asked and the clinical managers reported that the additional required competencies that were not part of the nine general competencies included: the ability to multi-task, work under pressure, effective time management, health system management, health economics, clinical skills, business process mapping and re-engineering, emotional intelligence, accountability, innovation, risk management and clinical governance.

4.5 Chapter Summary

In summary, the results show that on average, there was a significant difference between how participants rated the importance of the required skill sets and how they use these skills in their workplace. Evidence emerged from the findings suggests that most skills sets that are highly valued by clinical managers, are not widely used in their workplace. Such a disconnection between the perceived level of importance and self-assessed proficiency level provide indication for policy makers to address this gap. A critical step in filling this gap, would be to think of exposing the clinical managers to coaching as a mechanism for improving their effectiveness at public hospital in Gauteng. The highest number of them indicated the need for coaching in their work place.

CHAPTER 5: DISCUSSION OF THE RESULTS

This chapter discusses the research findings. These are reviewed, interpreted and linked to the literature or theory. The gaps, anomalies and deviations in the data are discussed. The discussion is structured using the participants' demographics and main findings of the research questions as follows: the discussion of the first question is focused on required competencies of clinical managers in the public hospitals in Gauteng, followed by measurement of clinical managers' competencies in a public hospital environment in Gauteng. The last research question explores how coaching could be used to close the competency gap in Gauteng public hospitals and the clinical managers' perception for role of coaching in closing their competency gap. This chapter concludes by summarising all the discussion areas.

5.1 Gender

In this study, the most noticeable deficit in leadership appears to run along the lines of gender. The South African study by Pillay (2010) and that of Nepal (Khadka, Gurung, & Chaulagain, 2013), in the developing countries reported a lower representation of women in health leadership. Developed countries such as Canada reported different results along gender lines with female representation being higher than that of men in health management (MacKinnon et al., 2005). In the current study, representation of women in leadership was lower than that of men. It is interesting to note that despite government transformation efforts, there are still more men than women in this study. The trend is also observed in other developing countries (Khadka et al., 2013; Pillay, 2010). The need for more women in healthcare management is still an issue that requires redress as supported by the South African Constitution.

5.2 Age

According to the South African study conducted by Pillay (2008), the current leaders in the public healthcare sector are mostly above 50 years of age. He suggested that this should be considered when exposing managers to leadership training, as there is a need to also capacitate the potential future

managers through succession planning. There is a need to create a pool of prepared managers for career management and closure of the skills gap, since many current managers are approaching retirement. As a strategic intervention, there is a need for emerging leaders such as those in academia and clinical healthcare settings who could be potential candidates for creating a pool of healthcare leaders and should be considered for specific leadership development training for succession planning (Sonnino, 2016). This would ensure preparedness for the next generation of healthcare leaders since 47% of clinical managers in the current study are over 50 years of age.

5.3 Professional Background

The majority of the health leaders and managers in undeveloped and developing countries have a health professional background, with lack of training and experience in management (Daire et al., 2014). In the current study, 100% of clinical managers have a healthcare degree. It is interesting to note the existence of similarities in the health profession background of health managers in this study and that of other developing countries.

5.4 Management Competencies

5.4.1 Required management competencies

Hospital environment is a complex environment and it is constantly changing; however, the required core skills of human resource management have not changed. This includes emotional intelligence, mentoring and communication skills. In this study, clinical managers identified with all nine of the management competencies required for a leader in a hospital environment: leadership, communication, life-long learning, responsiveness and public relation, political and health environment, conceptual skills, results management, resources management and compliance with standards. They identified leadership skills and resource management skills as the most important skills needed in their daily tasks. The two competencies under leadership skills identified were vision and teambuilding, as the most important competencies out of 31 required in the hospital environment. This was a similar finding to that of MacKinnon et al. (2005)

in his study of Canadian healthcare leaders. This indicates support for these requirements of a leader in the 21st century in healthcare organisations. Another competency that was viewed as the most important in both Canada and this country was communication; there was a skills gap this area. This similar finding is supported by the literature (MacKinnon et al., 2005).

Emotional intelligence was a competency highlighted to by clinical managers as a required skill in the hospital environment. According to MacKinnon et al. (2005), emotional intelligence is part of life-long learning and is assessed using leadership tools. Emotional intelligence is relevant as it is crucial to create and lead change and build teams. Leaders who engage staff encourage collaboration to build teams who feel valued and motivated to deliver beyond the expectation (Goleman, 1995). Any organisation that needs to increase productivity relies on emotionally intelligent leaders who serve as role models to their followers and create a conducive context wherein the workers or staff can excel.

Innovation has been suggested as a skill for strategic leadership (Hartman & Crow, 2002). It is interesting to note that the clinical managers highlighted it as an additional competency required in this study together with emotional intelligence and competence in information technology. MacKinnon et al. (2005) found similarities in their study.

This study also reveals that the required skills can be acquired by followers when leaders serve as good role models and their followers experience this in their work environment, which will be healthy and enabling for performance (coaching and mentoring article).

Strong communication is crucial for all leaders, and communication skills need to be learned or polished. All personal competencies are not innate in leaders (Sonnino, 2016). In the 21st century we can no longer have healthcare leaders who are not trained in leadership. Communication and conceptual skills were skills with the highest rating of importance and these skills can be acquired through training (MacKinnon et al., 2005).

In this study, leadership, communication and compliance with standards were management competencies considered to be the most important among clinical managers working in the Gauteng province hospitals. It is interesting to note that communication is commonly viewed as an important management competency among clinical managers in both developing and developed countries.

In developing countries like Nepal, hospital managers identified strategic capability as the most important competency in hospital management. At strategic level, they felt the need to be competent in creating a vision, sharing it with others and driving it, and the ability to influence others towards achievement of a common goal in an organisation. This was followed by effective human resource management and investment in people as assets of an organisation (Khadka et al., 2013). The three most important managerial competencies out of a choice of 31 were: leadership: teambuilding, flexibility in effectively managing change and commitment to the consumer featured highest; communication: listening and verbal communication (MacKinnon et al., 2005), and ethical standards and compliance with standards.

Most public sector organisations are creating competency frameworks required for leaders in particular industries as reported by (Jones, 2005). For example, in this study, we used the Canadian competency framework of health executives, and the required competencies used in this tool were accepted by the clinical managers in this study (MacKinnon et al., 2005). Emotional intelligence is a leadership quality required in many of the leadership roles. Executive coaching has the capacity to enhance the emotional intelligence of a leader through personal development and self-awareness. This subsequently improves the leaders' performance (Jones, 2005).

5.4.2 Skills gap

There was a probability that there was overall skill deficit in all 31 competencies, as the proficiency self-assessment was not greater than what was deemed important (MacKinnon et al., 2005). In this study, there was a gap in all the management competencies required. This was also a feature of the study in Canada so it seems likely that these gaps are universal.

It is a concern that even though communication is an important skill for managers, this is still identified as a skills gap in both developed and developing countries. Attributes of the 21st century healthcare leaders include: “listening, empathy, awareness, persuasion” (Sonnino, 2016, p.21). They must commit to integrity, altruism and authenticity. Leaders motivate, inspire, drive the vision and challenge status quo (Sonnino, 2016). Currently, ineffective communication can disrupt the functioning of the organisation. In this study, listening as a form of communication was a competency identified as one of the most important managerial skills and respondents in this study indicated a gap in their own development of listening skills. This was similar to finding in the Canadian study (MacKinnon et al., 2005).

With the challenges that exist in the healthcare industry, there is a need for appropriate and timeous responses. Flexibility and emotional intelligence are required to read a situation and respond accordingly (Hartman & Crow, 2002). A competency gap with regard to flexibility was identified and emotional intelligence was identified as an additional important competency required for leadership. In Canada, flexibility was a competency with the largest skills gap and managers highlighted the need for emotional intelligence in their work place (MacKinnon et al., 2005) as in the current study.

The literature highlights that the external factors are forces for change to the healthcare system, with regard to the quality of healthcare, its accessibility and affordability (Slavkin, 2010). If the leaders are lacking skills in areas of vision, business acumen and people skills, it will be challenging for them to bring about change (Hartman & Crow, 2002). The current study identified these skills gap and it is critical that the healthcare leaders are aware of these factors in order to respond timeously and appropriately (Hartman & Crow, 2002).

According to Daire et al. (2014), health executives are required to have both leadership and management competencies in order to effectively implement health policies in a challenging and resource-constrained context. Even though 74% of managers have been exposed to formal training in management, they still evaluated themselves significantly low in their competency levels (Pillay, 2010). This finding supports

the literature in that managers felt that a formal hospital management programme improves some of the management competencies as compared to managers with a clinical background only (Pillay, 2010).

It is interesting to note that public sector managers in this study, though they had attended formal training in management, still rated their competency levels on the low side. Health executives that are working as health administrators have been exposed to formal training programmes like Master of Business Administration (MBA) but this programme has been found to lack information relevant to the healthcare industry. There is competency gap among public healthcare sector executives globally, but the gap is bigger in developing countries than developed countries like Canada (MacKinnon et al., 2005).

Daire et al. (2014) state that formal training is the most common training and development approach used in low- and middle-income countries for leaders and managers. This generic training for leadership and management competencies is a cognitive process, which lacks elements of emotional and social intelligence required for health managers to lead effectively. Leadership and management competencies include cognitive, emotional and social intelligence. This supports the finding in this study where clinical managers have an overall skills gap even though most of them have been exposed to formal training. There is a need for leadership to be capacitated to handle human resource planning and the ability to influence others to perform. In the past, Master's in Public Health (MPH) and MBA were management programmes that were thought to be a solution as an intervention to address issues of skills gap in the healthcare leadership. They did provide knowledge in specific areas like global health and financial skills but these degrees did not address the leadership skills (Sonnino, 2016).

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The findings of Rao and Palo (2009) in the consolidation of the competency approach, recommended that there was a need for further research in various industries to explore appropriate competencies and include factors such as the size of the organisation, mission and culture in those areas. In this study, we explored the most important competencies and the skills gap in various levels of care of the hospitals. The results showed that although the clinical managers showed differences in rating the five most important managerial competencies with respect to hospital level of care, such difference was significant only for team building competency. This implies that the perceived importance of competency did not vary with hospital care level, except for team-building which was highly important in specialised and district hospitals which are small in size. There is lack of literature on studies comparing the proficiency of clinical managers' according to the level of hospital care.

5.4.3 Role of coaching in enhancing competency gap

5.4.3.1 Overall effectiveness

In the 21st century leadership development is critical for organisational success. The coaching results reported by Cunningham and McNally (2003) in their study were increased quality of service and customer service while Wise and Voss (2002) reported improved productivity, quality of service,

retention of talent, improved organisational strength, customer satisfaction, reduction in complaints, increased profit and improved business results. The above are results are good for the healthcare industry. Clinical managers in this study have an overall gap in all the competencies required of managers in the hospital. In developing countries, Pillay (2010) and Khadka et al. (2013) reported similar results. It was interesting to note that MacKinnon et al. (2005) reported the same finding in a developed country like Canada even though it was lower than in developing countries. This finding supports Play's (2008) finding that the public has a view that public hospitals are under-performing and this is evidenced by the dissatisfaction expressed by patients. Lack of management capacity was found to be a key factor in poor performance. The Pillay (2008) study recommended further development and training of managers. He highlighted that there was a need to ensure that interventions were suitable to the individual and organisation. Coaching would appear to be an appropriate leadership development tool for clinical managers.

In this study, it is interesting to note that 88% of clinical managers highlighted their need to be exposed to coaching in order to be capacitated. Coaching addresses being a leader and not learning about it, enables leaders to learn in their own environment and use reflection to access more information about their daily activities, which would be possible in formal classroom lectures (Kempster & Stewart, 2010). Its ability to capacitate the managers to experience deeper self-awareness, offers the opportunity for reflection and encourages the managers to view issues from different perspectives. It has the potential to allow leaders to recognise areas within themselves that need to be enhanced in order to grow and change so that they are beneficial to the organisation (Patterson, 2015).

Effective feedback during the coaching process can be offered by setting clear goals that need to be achieved in order to close the gap, engage the leader about the issue in a specific and relevant context and then plan the ideal way of how to improve the issue. This process needs to done with respect and objectivity. This kind of engagement, which is face-to-face, provides a better understanding of the

context, eliminating inappropriate assumptions. These engagements where the leader is engaged, create the perception that they are respected and feel valued, resulting in change in behaviour (Ely et al., 2010).

Leadership development results in capacitated managers which yields organisational success. At hospital level, capacitated clinical managers, have the potential to improve quality of care of patients through retention of good staff, improved staff satisfaction and financial results. This programme would further enable the manager to thrive through turbulent times in the organisation (Cunningham & McNally, 2003; Jones, 2005). There is reported evidence that coaching leads to increased staff retention of good talent, improved staff satisfaction resulting in improved staff morale and financial results with good patient outcomes

Leadership coaching is used as a developmental tool for executives in order to improve their leadership effectiveness in their roles. The coaching process with exposure of executives to reviews over time (a minimum 6 months - 5 years according to types of coaching) provides adequate time for the creation of self-efficacy (Ashford, Blatt, & Walle, 2003). Each review session has feedback which is either positive for success or negative as an area of improvement. Support is offered to redress the areas needing improvement with the aim of succeeding with the next attempt (Ely et al., 2010). This process of repeated success creates an opportunity to build executives' self-efficacy which is a requirement for effective leadership (Ely et al., 2010). This coaching process would capacitate the clinical managers with quality leadership skills for the 21st century.

5.4.3.2 Life-long learning

Clinical managers in this study reported a huge gap in life-long learning competency. This competency includes self-directed learning and teaching and mentoring of followers. According to Pillay (2010), in South Africa, a developing country, this skill was most lacking. However, in a developed country such as Canada, life-long learning with regards to teaching and mentoring was also regarded as the greatest area of weakness (MacKinnon et al., 2005). One could infer that this skill is not utilised in the work

environment even though it is required. According to Marsick and Watkins (1992), there are organisations that have employees who lack continuous learning skills, but are committed to assisting them in the development of skills by means of informal learning such as coaching which is used as a reflective practice in leadership development (Anderson, 2001; Marsick & Watkins, 1992). Coaching brings about deeper self- awareness and offers opportunities for reflection and thinking from different perspectives. It also assists leaders to recognise areas within themselves which need to grow and change so that they are beneficial to the leader's relationships (Grant, 2014). The reflective practice is successful when an individual receives feedback from others, superiors, peers or direct reports (Marsick & Watkins, 1992). It is important to note that feedback in leadership is a sensitive matter that requires special consideration. Leaders may have difficulty in seeking feedback from their followers due to ego and their image. If leaders need to be effective in their leadership skills, such as being visionary and charismatic, they need to seek this feedback (Ashford et al., 2003). The literature reports that senior executives, who were exposed to reflective practice, reported the benefits of reflection as availability of thinking space and the creation of an enabling environment to learn from experience and develop new understanding. They were able to reflect on the organisation as a system, that includes them as individuals, others and the organisational context. Benefits of reflection included their ability to think, have different perspectives, come up with solutions and change their behaviour (Patterson, 2015). Reflective practice requires clients to take responsibility for their own learning and development, which is a skill required for the clinical managers in this study (Marsick & Watkins, 1992). Executive coaching enables the executive to learn in a short period of time and offers support to the new leader while creating an opportunity to learn through reflection (Anderson, 2001). Public hospitals as non- profit organisations use the total quality management approach to improve performance (Matsoso & Fryatt, 2013). Total quality management cannot exist without empowerment of employees to take responsibility for daily decision-making with their allocated tasks (Marsick & Watkins, 1992). The reported skill gap of teaching and mentoring of followers, indicates a need for organisations like hospitals to create a learning culture in order to thrive in the 21st century. This change has to start and be supported by senior management as role models, if it is to

be sustainable (Marsick & Watkins, 1992). In this study, clinical managers as senior managers in hospitals will be required to bring about change of learning culture. Coaching has the capacity to provide clinical leaders with the tools to mentor their followers, so as to increase productivity in the organisation (Swart & Harcup, 2013). Organisations that were exposed to leadership coaching have reported a culture change in their leaders and commitment to empowering their staff members (Jones, 2005)

Life-long learning as an overall learning skill with greatest gap requires continuous learning to be instilled in organisations. According to Swart and Harcup (2013), coaching in organisational learning refers to the process whereby an individual's learning is transferred to others in an organisation through sharing to enable collective learning which results in change that achieves organisational goals. There are mechanisms coaching uses to translate individual learning to collective learning: enacting new behaviour, enacting coaching approach and integration of collective learning (Swart & Harcup, 2013). Clinical managers will use these mechanisms of transference of learning to empower followers through coaching.

Reflective practice is core to continuous learning for continuous development and growth of individuals to identify and solve problems in their work environment. Learning of managers through reflective practice leads to improved organisational learning and performance (Marsick & Watkins, 1992). Integration of collective learning into organisational procedures and ensure improved and sustained implementation of new and existing procedures (Swart & Harcup, 2013). Figure 16 shows the role of executive coaching in enhancement of lifelong learning skills.

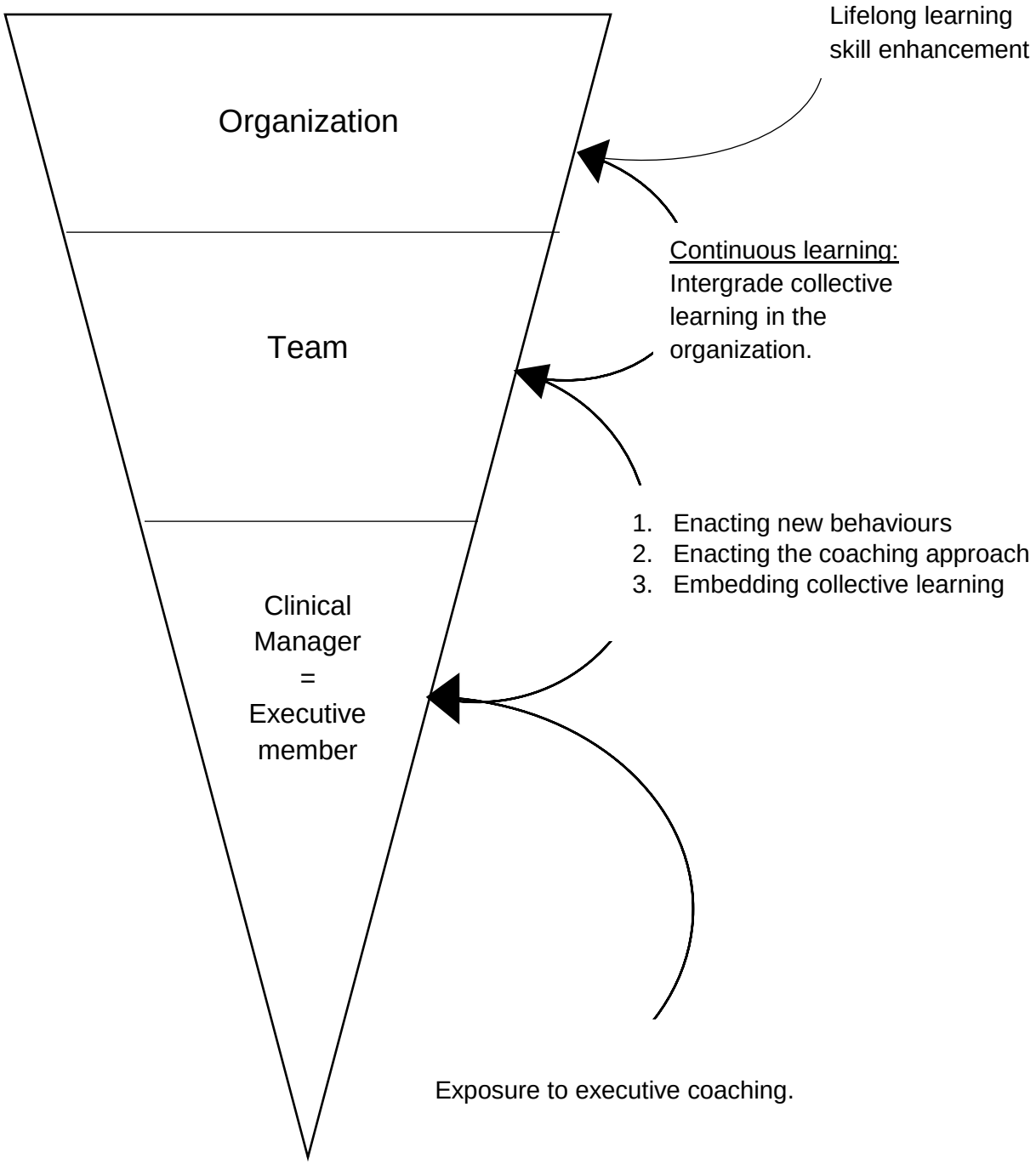


Figure 16: The role of executive coaching in enhancing lifelong learning skills

Continuous learning requires individuals with a growth mindset, who are able to use feedback as a strategic tool, and organisations to develop a learning culture without the use of bureaucratic structures as they have not been designed to support empowerment and decentralised learning (Marsick & Watkins,

1992; Roebuck, 1996; Swart & Harcup, 2013). According to (Marsick & Watkins, 1992), this yields increased organisational performance and continuous organisational development. It is worth noting that clinical managers in this study (64,8%) have work experience of more than five years; it might, therefore, be difficult for them to unlearn old ways of doing things so as to allow new sustained learning required for change.

5.4.3.3 Commitment

A gap was identified in this study with regard to commitment to organisations, health service and consumers and stakeholders, with commitment to the organisation as the highest skill gap. In Canada, (MacKinnon et al., 2005) reported commitment to the organisation and commitment to the consumer as the management competencies with greatest strength in clinical executives , a finding that differs from this current study. A study by Luthans and Peterson (2003) found that 360-degree feedback and systematic coaching, improved self-awareness and management behaviour resulting in more satisfying interpersonal relationships. This improved organisational commitment and reduced the attrition rate. According to Jones (2005), coaching of leadership in the public sector could expect an outcome of increased staff morale, reduced sick leave and absenteeism, behaviour change and effectiveness in meeting targets. Exposure of clinical managers to coaching thus has the capability to improve commitment of clinical managers.

5.4.3.4 Communication and team-building

The management culture style needs to be inclusive and supportive. In that way, feedback is seen as beneficial to the organisation and the individual. This management style encourages open and transparent communication which is required for organisational effectiveness (Roebuck, 1996). In this study, there was a reported skill gap with regard to communication skills which includes listening, verbal and writing skills. Listening as part of communication competency revealed a large gap as reported by clinical managers. Similar findings of a skill

gap in communication were reported by (Pillay, 2010). It is interesting to note that MacKinnon et al. (2005) also reported listening as one of the skill among the competencies with largest gap.

In order for the hospital environment to respond appropriately to challenges and changes, feedback as part of communication should be viewed as an essential component of an integrated strategy for development (Roebuck, 1996). According to Roebuck (1996), communication via feedback requires both parties in a relationship to be willing to listen to one another. The coaches use 360-degree feedback system, as a supportive developmental tool during learning process. This approach is supported in the literature (Roebuck, 1996). The coaching enhances self-awareness of an area of improvement and strength. It uses transference of skills from coaching to managing i.e. practice in an organisation. The reported listening skill gap needs to be addressed, if the benefit of the feedback system in coaching is to be realised. It has been reported by Roebuck (1996) that its use during coaching encourages empowerment, commitment and total quality management. It is important that clinical managers' listening skills be enhanced, and an ideal mechanism for developing these skills could be through coaching.

Continuous feedback during reviews should encourage hospitals to be learning organisations. In turn, clinical managers would enhance their communication competencies, especially listening, through self-development and commitment to empowering others. Organisations that were exposed to leadership coaching have reported a culture change in their leaders, improvement in listening skills and commitment to empowering their staff members due (Jones, 2005).

Strong communication is crucial for all leaders, and communication skills need to be learned or enhanced. All personal competencies are not innate in leaders (Sonnino, 2016). In the 21st century, we can no longer afford to have healthcare leaders who are not trained in leadership.

Coaching has the capacity to improve effective communication and build strong teams which are required for successful organisational outcome. A teambuilding skills gap was identified in this study. This was different to the Canadian study by MacKinnon et al. (2005). According to the literature, coaching provides the opportunity for leaders to be capacitated in order to build strong teams and create effective communication (Korth, 2016). Team engagement is key to organisations for effective teamwork. This could be achieved by recognition of followers, making an effort to know them, nurture them and offer support, and exploring reasons why people leave the organisation (Korth, 2016). Executive coaching can be used as a potential tool for building potential in building effective teams. This would lead to a reduction in conflict and create a strong culture of accountability.

5.4.3.5 Leadership skills

Effective leadership is a necessity for public sector organisation success (Jones, 2005). Clinical managers in this study reported a gap in leadership skills. Pillay (2010) reported a similar finding while MacKinnon et al. (2005) reported the same finding of a gap in leadership skills especially in change management and stress management. According to Borrill, West, and Dawson (2005), effective leadership is important for individual, team and organisational performance. Organisations are in need of good role models, who are capacitated in leadership. In this study, change as a leadership skill, showed a gap. It stands then to reason that self-awareness and cognitive flexibility of clinical managers could be addressed through leadership coaching. This could assist them to deal with change management and various complex situations in the hospital environment. The literature reveals that each coaching process has assessment and feedback, challenge and support. This process would contribute to the effective development of effective leaders in organisations (Ladegard & Gjerde, 2014). Leaders who were exposed to coaching in this study had increased self-efficacy and increased trust in their followers. It seems clear that if clinical managers as leaders in hospitals are exposed to the coaching process, it will increase their leadership effectiveness and their trust in their followers and thereby increase output for the hospitals. According to Cunningham and

McNally (2003), an increase in leadership competence results in an increase in accountability and self-efficacy in managers' work roles.

Improved leadership skills improve the quality of leadership. The concept of leadership embraces the ability to influence others and this could be achieved if the leaders have a high sense of self-efficacy which includes employing different ways of handling leadership issues and awareness of factors that act as barriers to success and competence in relevant leadership skills (Popper & Lipshitz, 1993). The results in this study show a competency gap in the leadership skills of clinical managers. The results show the need to improve the leadership skills of these managers, with the aim of improving their interpersonal relations with their followers as this will influence their level of motivation.

According to the literature Grant (2014), executive coaching during times of change can have a myriad of positive effects. These are attainment of goals, adoption of effective solution- focused thinking, change readiness is enhanced, self-efficacy in leadership, resilience in leadership improves mental health (Grant, 2014). In this study competency gap was identified in managers' ability to lead change. This could indicate a lack of confidence in their ability to lead change. Confidence as a core element of self-efficacy and solution-focused thinking are critical factors required in leading change (Grant, 2014). Solution-focused thinking is a fenced-in approach; there is an intention to think within a context, ignoring causal factors but more focused on finding solution. This type of thinking requires different effective communication and influencing skills in order to bring about change. Goal setting is important during change process. Literature (Grant, 2014) reveals that executive coaching builds the ability to deal with setbacks and builds resilience within the leader to influence others to be committed to solution- based thinking and bring about the necessary change (Grant, 2014). This could benefit the clinical managers in this study.

According to Rosha and Lobanova (2014), leaders who are exposed to coaching are empowered to think with relevance and strategy which brings about positive change in relationships between a leader and a

follower. This encourages collaboration and transparency which results in improved productivity and innovation.

Leadership is associated with leaders viewed as change agents with regard to organisational strategy (Slavkin, 2010). Influencing people is more persuasive when the vision becomes strategic and outcomes are concrete. According to Hartman and Crow (2002), the existence of barriers to change in the healthcare environment impacts negatively on the commitment of health executives to lead change effectively. Research shows a significant gap between knowledge and practice.

The least important competency identified in a developing country (Nepal) was change management (Khadka et al., 2013). This indicates the need for the leaders to be skilled adequately to recognise and effectively manage change within a socio-political environment such as hospital. Canadian healthcare leaders viewed change as the most important competency (MacKinnon et al., 2005). In the current study, change still did not feature as the most important competency required in the hospital environment and there was a significant gap in this competency. This finding mirrors the findings in the literature, namely that leaders are finding it challenging to implement vision and strategy in a dynamic and changing environment (Hartman & Crow, 2002). There is a need for availability of transformational leadership and change in the healthcare sector strategy (Slavkin, 2010). In the 21st century, organisations need leaders who have both task and relationship skills (Sonnino, 2016). Transformational leaders lead change, inspire and motivate others to perform and servant leaders serve their followers and empower them. The new image of leadership differs from that of the past in that it is geared towards a shared vision and teambuilding.

Stress management competency has been reported in this study as a competency with a significant gap. It was interesting to note the similar results in developed countries (MacKinnon et al., 2005). This finding according to Ugboro and Obeng (2000) reports that quality service organisations , results in a noticeable decline in quality service and increased customer dissatisfaction . Public hospitals are quality service

organisations. Exposure of clinical managers to executive coaching will provide them with the arsenal of tools to response effectively to stress. Coaching interventions enhances the stress management skills, help to minimise stress and manage it effectively, helps managers to thrive during adversity and change while they deliver organisational goals and improves interpersonal relations (Jowett, Kanakoglou, & Passmore, 2012; Kilburg, 1996; Wasylyshyn, 2003)

5.4.3.6 Political and health environment awareness

A skill gap with regard to political and health environment awareness has been reported in this study. Developing country results showed similar gap in this skill (Pillay, 2010). In a developed country, MacKinnon et al. (2005) also reported similar findings with the greatest gap in this skill. Only 17% of clinical managers reported the use of this skill in their work environment. Burke and Litwin (1992) model advocates the importance of environmental awareness as a driver for change in organisations. It requires that 21st century managers constantly scan their environment in order to respond appropriately and be prepared for change. This identified skills gap requires development and enhancement. Skills coaching focuses on the client's specific developmental needs based on each one's skills and capability. It is directive, involves best practice advice and training for specific skills. During the coaching process the coach uses facilitation through questioning; this assists individuals to reflect on their specific issues and come up with a solution for implementation (West & Milan, 2001). Skills and performance coaching will expose the clinical manager to one-on-one engagement with the coach. West and Milan (2001) reported that coaching has the ability to develop growth in self-awareness and insight which allows clients to manage their own learning. It is beneficial for busy leaders, while at the same time achieving quicker results (West & Milan, 2001).

5.4.3.7 Conceptual skills

A gap was also reported in terms of conceptual skills; they include analytical, synthetic, problem-solving capacity and systems-thinking inclination. Pillay (2010) reported a similar skills gap. In Canada,

MacKinnon et al. (2005) reported a different result in that the managers felt that they were adequately skilled. Based on the finding, there is a need to enhance these skills for effective leadership. Coaching has the most benefit when used for the senior members of staff in the organisation, as they deal with complexity and have to address a variety of issues (West & Milan, 2001). It has the ability to ensure transfer of knowledge from training into practice, with the coaching process focused on the areas of development covered in training. It further provides an enabling environment which is safe for learning through practice. According to Olivero et al. (1997), an increase in productivity was attributed to one-on-one interaction with the focus on goal-setting, collaborative problem-solving, practice, feedback, supervisory involvement, evaluation of the end results and public presentation.

5.4.3.8 Resource management skills

Management of resources in the healthcare sector is important for service delivery (Khadka et al., 2013). In this study, the clinical managers highlighted the lack of competency with regards to financial resources. The same lack of financial acumen has been highlighted as a reason for poor management in the healthcare sector in developing countries (Khadka et al., 2013). Coaching will assist with transference of knowledge gained from formal training and provide an opportunity for it to be practised, learning will take place. The issue of healthcare management and leadership capacity is critical to ensure effective financial management. Reported outcomes of capacitated leaders were accountability, improved performance and patient satisfaction. The results indicate the need for development and education of healthcare executives in order to succeed in a turbulent environment.

5.4.3.9 Participants' perception for need of coaching and exposure to coaching

Based on the reported skills gap of clinical managers, it was interesting to note that 88% of clinical managers indicated the need for exposure to coaching in their workplace. The willingness of these managers to be exposed to coaching, according to the literature is a requirement for a successful coaching

process (McGovern et al., 2001). Investment in coaching for these managers would create favourable conditions for success.

Only 12% rejected coaching as a mechanism of improving their managerial skills. Although we could not conduct such an analysis, the retrospective analysis of the past history of the participants with respect to their exposure to coaching, have shown more compelling results, which highlight the importance of coaching in improving managerial competencies at workplace among clinical managers in Gauteng. According to Cunningham and McNally (2003), the benefits as reported by participants were improved working relationships with followers and seniors, improved productivity, quality of service, organisational strength retention of talent and customer service, while Jones (2005) reported that coaching brings about development of leaders' knowledge about identity; strengths and areas of improvement; builds required leadership style; enhances communication skills, interpersonal skills, accountability and responsibility, conflict management, adaptability and courage; enhances the ability of leaders to influence and develop others; and assists with development of a strategic vision and the strategy on how to achieve it. It also addresses political awareness and problem-solving (Jones, 2005). These are benefits required in Gauteng healthcare.

5.4.4 Success factors for coaching

Even though coaching provides for leadership development for managers, it requires favourable conditions for it to be effective. Maximising the impact of executive coaching, success factors were identified as careful selection of coaching, with matching a key element of the coach-coachee relationship coupled with quality of feedback and assessment, and objectivity of the coach. Provision of strong organisational support was important, especially the support of the executive managers, highlighting the benefits of coaching. Other success factors are the alignment of organisation goals and the role of the executive; availing time for coaching; recognition and acknowledgement of effort; emphasis of coaching

as an instrument of leadership development; and commitment of the organisation towards the growth of executives.

Leadership coaching increases organisational effectiveness by increasing the self-awareness of the leaders through 360-degree feedback, accompanied by a competent coach who offers support through the process. This results in enhanced leader development especially for potential managers (Thach, 2002).

It should be noted that the study of competencies of managers was subjective as it was based on self-assessment. No validation was used. This study, nevertheless, contributes to the body of knowledge of education in healthcare management.

5.5 Chapter Summary

To conclude, this discussion chapter highlights the findings of the research, gaps, anomalies and deviations in relation to the literature theory and unique benefits of executive coaching in enhancing the leadership management competencies.

In conclusion, the research questions have been answered as follows:

5.5.1 Research question 1

There are nine management competencies required for a leader in a hospital environment. They are leadership, communication, life-long learning, responsiveness and public relation, political and health environment, conceptual skills, results management, resources management and compliance with standards.

5.5.2 Research question 2

Measurement of the management competencies of clinical managers was determined. There was a skills gap in all management competencies of clinical managers in this study.

5.5.3 Research question 3

Coaching has a role in enhancing management competency of the clinical managers and the participants' perception for need for coaching. Coaching enables leaders to learn in their own environment and use reflection to access more information about their daily activities, which would not have been possible through formal classroom lectures. Learning through practice has become key in context- and situation-specific activities encouraged in coaching. This change in leadership development practice was viewed as the best approach during the review as it can be applied anytime, anywhere within a particular context in an organisation; however, in order for the executive coaching process to be successful, coachees must actively engage, commit and take responsibility for their own learning.

Successful coaching includes assessment, challenges and support. This provides an idea of the current skills and areas in need of development. Challenges and support co-exist in order for the leaders to develop and grow their skills. Clinical managers in the current study assessed their competencies with the results indicating an overall lack of capacity and willingness to learn. Coaching would then be a suitable intervention in this context, as it addresses capacitating clinical managers in the hospital environment with the necessary support. All managers must be adept in the required competencies. The gaps, anomalies and deviations have been identified. Executive coaching is the suggested tool to address these due to its unique process.

CHAPTER 6 CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter summarises the key findings from the research with regard to clinical managers' competency level and the role of coaching in closing the competency gap. The objectives of this study were to measure the clinical managers' competencies, establish the competencies of clinical managers required in a public hospital environment in Gauteng and to explore the role of coaching in enhancement of competencies of clinical managers.

From this study, the competency gaps of clinical managers were identified. There is a need to address this with the goal of enhancing the leadership skills of these managers for effective leadership. Coaching as a developmental tool has been identified to capacitate these managers. Conditions that contribute towards its success have been explored. The section concludes with the summary of key three issues in this study, which are clinical managers' required competencies, the measurement of the clinical managers' competencies and the role of coaching.

6.2 Conclusions of the Study

6.2.1 Required competencies

Complex hospital environments are constantly changing. Highly skilled leaders are required in order to lead effectively and thrive in this challenging environment.

This study reveals the required skills identified by clinical managers in public hospitals in Gauteng. Nine categories of clinical managers' competencies were identified as required. They are leadership, communication, life-long learning, responsiveness and public relation, political and health environment, conceptual skills, results management, resources management and compliance with standards. Out of

these categories of competencies participants identified leadership skills and resource management skills as the most important skills needed. This highlights the use of these competencies in their daily tasks.

6.2.2 Measured competency level

The proficiency levels revealed significant differences between what was required and their self-assessed competencies. Managers display a gap in their competency levels. There is a need to enhance the managers' competencies.

6.2.3 Understanding executive coaching and its uses

Executive coaching has been identified in the literature to be a unique developmental tool to capacitate executives, leaders and managers. It is a formal one-on-one intervention. It is dialogical in nature and it addresses the issues of a specific leader with the intention of enhancing leadership effectiveness. Executive coaching is a tailor- made process which assists managers and provides tools for them to operate in a variety of situations. This is different from traditional methods of training and development, in that it provides the leaders with new learning and direct application in the work place. During the process, the leader is provided with opportunities to reflect, think from different perspectives, evaluate their own progress and receive constructive feedback. Over time, this facilitates learning and brings about change, confidence and sharpening of skills in a demanding, complex and changing 21st century environment.

6.2.3.1 Benefits of executive coaching

The benefits of executive coaching are improved individual and organisational performance which includes enhancement of executive learning, gains in organisational performance and support for human resource development, improved leadership effectiveness and improved interpersonal relationship. Hospital environments experience constant change. For this change to occur, they need to be learning organisations. Executive coaching culture of learning has the potential to equip leaders to execute this

vision. Top managers are role models for followers. Coaching helps them to influence followers and empower them within a culture of learning, initiated through the experience and practice.

During times of change, people are insecure and struggle with thinking on their feet to reach the desired goal. A confident leader is what they need. Executive coaching helps to build a confident leader; a leader who is a change agent who understands the dynamics of change. It facilitates this understanding and assists the leader to respond appropriately and timeously in practice. Their cognitive flexibility is improved and they learn to make use of various tools for effective change.

This study revealed a gap in communication skills. Coaching process through its feedback system demands good listening skills. This is how executives begin to improve their listening skills, as they do this with intention as well as in their practice in work environment. This improves the communication skills of leaders with others and has the ability to influence others for change. These results are favourable to the hospital environment and the clinical managers' development.

Effective leadership skills are key to clinical managers as reported in this study. An identified shows the need to enhance this and the resource management skills. These leadership skills are used on daily basis by managers in their interactions with others.

6.2.3.2 Factors contributing to successful coaching process

Literature reveals the conditions of successful executive coaching in organisations. There is need for organisations to support coaching, especially from top management. The executive needs to be ready to learn and should view coaching as a learning opportunity for their work role. The need of a competent for is a requirement for successful coaching.

6.2.4 Summary

The literature review has confirmed the need for the study. There is significant gap in the public health sector managers' competency level. There is a need for appropriate and further training and development

to address the skills gap. There is need to strengthen management capacity to support the strategy of improved and sustainable healthcare service delivery. Coaching is the appropriate leadership developmental and supportive tool to enhance the leadership skills needed. It is different from formal training because it is tailored to develop the specific individual and respond to a relevant specific situation and context. Coaching programmes are intended to improve the culture or the specific context and skills. An intervention like this is suitable for the hospital environment as there is a need for enhancement of skills, change in cultural and bureaucratic structure in the hospital environment. It stands to reason that leaders' skills should incorporate the ability to adapt to a specific context and in driving cultural change. Coaching is encouraged and there is evidence of improved performance and productivity, leadership effectiveness and improved interpersonal relationship; when coaching is used as a development tool.

6.3 RECOMMENDATIONS

- In light of the nature of the competency gap, an appropriate leadership development tool is recommended. It is recommended that executive coaching becomes a development intervention for leaders, due to its benefit to the executive and the hospital as an organisation.
- Coaching for leaders is recommended as it enhances life-long learning for continuous improvement.
- Leaders use communication skills in their daily activities either in writing, listening or verbal. The gap revealed in this area needs to be addressed.
- Coaching is recommended for the enhancement of leadership skills.
- Emerging managers, especially women, should be exposed to leadership development training programmes.
- A comprehensive leadership development model for public healthcare leaders should be created.
- A coach with a health leadership background would be most suited to enhance leadership competencies, with resulting coaching success.
- Future recruitment of clinical leaders should consider cognitive, emotional and clinical skills.

- Executive coaching can be used as a potential tool for building potential leaders and retention of good talent, build knowledge base and effective team building.
- In addition to formal training programme, coaching is important in the development of clinical leadership. Coaching has a role to play in developing existing and new managers' skills for succession planning. It should be considered as a priority in leadership development of clinical managers and is recommended as it has the ability to build cohesive teams from which all the relevant stakeholders in health will benefit.
- Leadership coaching addresses problems in traditional leadership development. It is tailored to the unique requirements and circumstances of individuals as opposed to a generic formal training programme. Recommended for busy executives, it is flexible and is offered according to the clients' needs, which can range from a short to long-term, tailored programme.
- Coaching provides opportunities for clinical managers to learn through practice. This is the preferred way of adults to learn while working.
- Feedback provides space for reflection and growth in self-awareness. Coaching is recommended to assist the clinical managers to learn and grow through reflection.
- It is recommended for effective goal setting. People who can set SMART goals, lays the foundation for success, motivation, self-efficacy and energy needed to tackle a new challenge.
- Succession planning needs to consider leadership training for the existing cohort of healthcare workers. This issue of healthcare development does not only benefit the institution but the country as a whole, as leaders are able to lead effectively and efficiently. This potentially alleviates the need for our healthcare sector to depend on other countries to supply qualified personnel and would ensure a sustainable and relevant healthcare sector in South Africa.

6.4 RECOMMENDATIONS FOR FURTHER RESEARCH

- The outcome of executive coaching process among clinical managers in public hospitals in South Africa should be determined.
- There is a need for a study in public hospitals to determine the effectiveness of coaching in enhancing the leadership skills of clinical managers.

REFERENCES

Anderson, M. C. (2001). Executive briefing: Case study on the return on investment of executive coaching. Retrieved from: http://www.empowermenttoolbox.com/ MertrixSurvey.html.

Armstrong, H. B., Melser, P., & Tooth, J. (2007). Executive Coaching Effectiveness: a pathway to self-efficacy. *unpublished paper, Institute of Executive Coaching*.

Arthur, G., Bhatt, S. M., Muhindi, D., Achiya, G. A., Kariuki, S. M., & Gilks, C. F. (2000). The changing impact of HIV/AIDS on Kenyatta National Hospital, Nairobi from 1988/89 through 1992 to 1997. *Aids, 14*(11), 1625-1631.

Ashford, S. J., Blatt, R., & Walle, D. V. (2003). Reflections on the looking glass: A review of research on feedback-seeking behavior in organizations. *Journal of Management, 29*(6), 773-799.

Aubry, M., Richer, M.-C., & Lavoie-Tremblay, M. (2014). Governance performance in complex environment: The case of a major transformation in a university hospital. *International Journal of Project Management, 32*(8), 1333-1345.

Avolio, B. J. (2007). Promoting more integrative strategies for leadership theory-building. *American Psychologist, 62*(1), 25.

Bass, B. M., & Riggio, R. E. (2006). *Transformational leadership*: Psychology Press.

Bond, T. (1999). The role of performance measurement in continuous improvement. *International Journal of Operations & Production Management, 19*(12), 1318-1334.

Boone, H. N., & Boone, D. A. (2012). Analyzing Likert data. *Journal of Extension, 50*(2), 1-5.

Borrill, C., West, M. A., & Dawson, J. (2005). *The relationship between leadership, people management, staff satisfaction and intentions to leave*. Birmingham, England: Aston University: Aston Business School.

Blumberg, B., Cooper, D., & Schindler, P. (2011). *Business research methods*. Boston, MA: McGraw-Hill/Irwin,

Burke, W. W., & Litwin, G. H. (1992). A causal model of organizational performance and change. *Journal of management, 18*(3), 523-545.

Byrne, U. (2005). Work-life balance Why are we talking about it at all? *Business Information Review, 22*(1), 53-59.

Chan, C. C., McBey, K., Basset, M., O'Donnell, M., & Winter, R. (2004). Nursing crisis: retention strategies for hospital administrators. *Research and Practice in Human Resource Management, 12*(2), 31-56.

Charan, R., Drotter, S., & Noel, J. (2010). *The leadership pipeline: How to build the leadership powered company (Vol. 391)*. London, England: John Wiley & Sons.

Chen, Y. M. (2010). Perceived barriers to physical activity among older adults residing in long-term care institutions. *Journal of Clinical Nursing, 19*(3-4), 432-439.

Cohen, L., Manion, L., & Morrison, K. (2011). *Research methods in education*. Abingdon, England: Routledge.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: historical roots of current public health challenges. *The Lancet, 374*(9692), 817-834. doi:http://dx.doi.org/10.1016/S0140-6736(09)60951-X

Covey, S. M., Link, G., & Merrill, R. R. (2012). *Smart trust: Creating prosperity, energy, and joy in a low-trust world*: Simon and Schuster.

Crabb, S. (2011). The use of coaching principles to foster employee engagement. *The Coaching Psychologist, 7*(1), 27-34.

Cunningham, L., & McNally, K. (2003). Improving organizational and individual performance through coaching: A case study. *Nurse Leader, 1*(6), 46-49.

Daire, J., Gilson, L., & Cleary, S. (2014). *Developing leadership and management competencies in low and middle-income country health systems: a review of the literature*. Cape Town, South Africa: Health Economics Unit, University of Cape Town.

Daly, J., Jackson, D., Mannix, J., Davidson, P. M., & Hutchinson, M. (2014). The importance of clinical leadership in the hospital setting. *Journal of Healthcare Leadership, 6*, 75-83.

de Haan, E., Sills, C., Boyce, L. A., Jeffrey Jackson, R., & Neal, L. J. (2010). Building successful leadership coaching relationships: Examining impact of matching criteria in a leadership coaching program. *Journal of Management Development, 29*(10), 914-931.

Drucker, P. F. (1999). Knowledge-worker productivity: The biggest challenge. *California management review, 41*(2), 79-94.

Ely, K., Boyce, L. A., Nelson, J. K., Zaccaro, S. J., Hernez-Broome, G., & Whyman, W. (2010). Evaluating leadership coaching: A review and integrated framework. *The Leadership Quarterly, 21*(4), 585-599.

Faris, R. J., MacKinnon, G. E., MacKinnon, N. J., & Kennedy, P. L. (2005). Perceived importance of pharmacy management skills. *American Journal of Health-System Pharmacy, 62*(10), 1067-1072.

Fugate, M., & Kinicki, A. J. (2008). A dispositional approach to employability: Development of a measure and test of implications for employee reactions to organizational change. *Journal of Occupational and Organizational Psychology, 81*(3), 503-527.

Ganster, D. C., Fox, M. L., & Dwyer, D. J. (2001). Explaining employees' health care costs: a prospective examination of stressful job demands, personal control, and physiological reactivity. *Journal of Applied Psychology, 86*(5), 954.

Geraki, A. (2014). Roles and skills comparison among principals in Greek schools. Application of Competing Values Framework. *Educational Management Administration & Leadership, 42*(4_suppl), 45-64.

Gilley, A., McMillan, H. S., & Gilley, J. W. (2009). Organizational change and characteristics of leadership effectiveness. *Journal of Leadership & Organizational Studies, 16*(1), 38-47.

Goleman, D. (2003). What makes a leader. In L. W. Porter, et al. (Eds.) *Organizational Influence Processes* (pp. 229-241). New York City, NY: ME Sharpe.

Goleman, D. P. (1995). *Emotional intelligence: Why it can matter more than IQ for character, health and lifelong achievement:* New York: Bantam Books.

Grant, A. M. (2014). The efficacy of executive coaching in times of organisational change. *Journal of Change Management, 14*(2), 258-280.

Gunderman, R. B., & Cox, C. W. (2015). Coaching: A key model of leadership. *Journal of the American College of Radiology, 12*(4), 327-328.

Hall, D. T., Otazo, K. L., & Hollenbeck, G. P. (2000). Behind closed doors: What really happens in executive coaching. *Organizational dynamics, 27*(3), 39-53.

Hartman, S. J., & Crow, S. M. (2002). Executive development in healthcare during times of turbulence: top management perceptions and recommendations. *Journal of Management in Medicine, 16*(5), 359-370.

Hill, G. I. (2010). *Executive coaching: perspectives of effectiveness from executives and coaches.* Queensland University of Technology.

Holoviak, S. J. (1982). The impact of training on company productivity levels. *Performance & Instruction, 21*(5), 6-8.

Johnson, S., Cooper, C., Cartwright, S., Donald, I., Taylor, P., & Millet, C. (2005). The experience of work-related stress across occupations. *Journal of Managerial Psychology*, *20*(2), 178-187.

Jones, D. (2005). Executive coaching and its role in effective leadership development. *International Journal of Leadership in Public Services*, *1*(1), 45-48.

Jowett, S., Kanakoglou, K., & Passmore, J. (2012). The application of the 3+ 1Cs relationship model in executive coaching. *Consulting Psychology Journal-Practice andResearch, 64*(3), 183.

Judge, W. Q., & Cowell, J. (1997). The brave new world of executive coaching. *Business Horizons, 40*(4), 71-77.

Kaiser, R. B. (2011). The leadership pipeline: Fad, fashion, or empirical fact? An introduction to the special issue. *The Psychologist-Manager Journal*, *14*(2), 71-75.

Kampa-Kokesch, S., & Anderson, M. Z. (2001). Executive coaching: A comprehensive review of the literature. *Consulting Psychology Journal: Practice and Research, 53*(4), 205.

Karsten, M. A. (2010). Coaching: an effective leadership intervention. *Nursing Clinics of North America, 45*(1), 39-48.

Kempster, S., & Stewart, J. (2010). Becoming a leader: A co-produced autoethnographic exploration of situated learning of leadership practice. *Management Learning*, *41*(2), 205-219.

Kets de Vries, M., & Cheak-Baillargeon, A. (2015). Leadership in Organizations, Sociology of. In J. D. Wright (Ed.), *International Encyclopedia of the Social & Behavioral Sciences* (2nd Edition) (pp. 664-669). Oxford, England: Elsevier.

Khadka, D. K., Gurung, M., & Chaulagain, N. (2013). Managerial competencies–A survey of hospital managers' working in Kathmandu valley, Nepal. *Journal of Hospital Administration, 3*(1), p62.

Kilburg, R. R. (1996). Toward a conceptual understanding and definition of executive coaching. *Consulting Psychology Journal: Practice and Research, 48*(2), 134.

Korth, J. (2016). Communication and Coaching: Keys to Developing Future Nurse Leaders. *Nurse Leader, 14*(3), 207-211.

Kumar, R. D. (2013). Leadership in healthcare. *Anaesthesia & Intensive Care Medicine*, *14*(1), 39-41.

Ladegard, G., & Gjerde, S. (2014). Leadership coaching, leader role-efficacy, and trust in subordinates. A mixed methods study assessing leadership coaching as a leadership development tool. *The Leadership Quarterly*, *25*(4), 631-646.

Lane, D. S., & Ross, V. (1998). Defining competencies and performance indicators for physicians in medical management. *American Journal of Preventive Medicine, 14*(3), 229-236.

Lieb, S., & Goodlad, J. (2005). Principles of adult learning: Best Practice Resources.

Linley, P. A., & Harrington, S. (2005). Positive psychology and coaching psychology: Perspectives on integration. *The Coaching Psychologist, 1*(1), 13-14.

Lovelace, K. J., Manz, C. C., & Alves, J. C. (2007). Work stress and leadership development: The role of self-leadership, Shared leadership, physical fitness and flow in managing demands and increasing job control. *Human Resource Management Review, 17*(4), 374-387.

Luthans, F., & Peterson, S. J. (2003). 360-degree feedback with systematic coaching: Empirical analysis suggests a winning combination. *Human Resource Management, 42*(3), 243-256.

Maciariello, J. A. (2014). *A year with Peter Drucker: 52 weeks of coaching for leadership effectiveness*. New York City, NY: Harper Collins.

MacKinnon, N. J., Chow, C., Kennedy, P. L., Persaud, D. D., Metge, C. J., & Sketris, I. (2005). Management competencies for Canadian health executives: views from the field. *Paper presented at the Healthcare Management Forum, 17*(4): 40-45.

Marsick, V. J., & Watkins, K. E. (1992). Continuous learning in the workplace. *Adult Learning, 3*(4), 9-12.

Matsoso, M., & Fryatt, R. (2013). National health insurance: the first 18 months. *SAMJ: South African Medical Journal, 103*(3), 154-155.

McGovern, J., Lindemann, M., Vergara, M., Murphy, S., Barker, L., & Warrenfeltz, R. (2001). Maximizing the impact of executive coaching. *Manchester Review, 6*(1), 2001.

Mitton, C. R., & Donaldson, C. (2003). Setting priorities and allocating resources in health regions: lessons from a project evaluating program budgeting and marginal analysis (PBMA). *Health Policy, 64*(3), 335-348.

Norman, G. (2010). Likert scales, levels of measurement and the "laws" of statistics. *Advances in Health Sciences Education, 15*(5), 625-632.

Northouse, P. G. (2015). *Leadership: Theory and practice*. Thousand Oaks, CA: Sage.

O'Connell, P. K. (2014). A simplified framework for 21st century leader development. *The Leadership Quarterly, 25*(2), 183-203.

Olivero, G., Bane, K. D., & Kopelman, R. E. (1997). Executive coaching as a transfer of training tool: Effects on productivity in a public agency. *Public Personnel Management, 26*(4), 461-469.

Outhwaite, A., & Bettridge, N. (2009). From the inside out: Coaching's role in transformation. *The Coaching Psychologist, 5*(2), 76-89.

Patterson, E. (2015). 'What are leaders' experiences of reflection?' What leaders and leadership developers need to know from the findings of an exploratory research study. *Reflective Practice, 16*(5), 636-651.

Patton, C. (2014). Conflict in health care: A literature review. *The Internet Journal of Healthcare Administration, 9*(1).

Pearce, C. L. (2007). The future of leadership development: The importance of identity, multi-level approaches, self-leadership, physical fitness, shared leadership, networking, creativity, emotions, spirituality and on-boarding processes. *Human Resource Management Review, 17*(4), 355-359.

Peterson, D. B. (1993). Measuring change: A psychometric approach to evaluating individual coaching outcomes. *Paper presented at the Annual Conference of the Society for Industrial and Organizational Psychology*, San Francisco, CA.

Peterson, S. J., & Luthans, F. (2003). The positive impact and development of hopeful leaders. *Leadership & Organization Development Journal, 24*(1), 26-31.

Pillay, R. (2008). Managerial competencies of hospital managers in South Africa: a survey of managers in the public and private sectors. *Human Resources for Health, 6*(4), 1-7.

Pillay, R. (2010). The skills gap in hospital management: a comparative analysis of hospital managers in the public and private sectors in South Africa. *Health Services Management Research, 23*(1), 30-36.

Popper, M., & Lipshitz, R. (1993). Putting leadership theory to work: A conceptual framework for theory-based leadership development. *Leadership & Organization Development Journal, 14*(7), 23-27.

Porter, L. W., & McLaughlin, G. B. (2006). Leadership and the organizational context: Like the weather? *The Leadership Quarterly*, 17(6), 559-576.

Răducan, R., & Răducan, R. (2014). Leadership and management. *Procedia - Social and Behavioral Sciences, 149*(10), 808-812. doi:http://dx.doi.org/10.1016/ j.sbspro.2014.08.322

Rao, M. K., & Palo, S. (2009). Identification of managerial competencies for establishing a conceptual framework for HRD practitioners. *Asia Pacific Business Review*, 5(4), 56-69.

Rekalde, I., Landeta, J., & Albizu, E. (2015). Determining factors in the effectiveness of executive coaching as a management development tool. *Management Decision, 53*(8), 1677-1697.

Roebuck, C. (1996). Constructive feedback: Key to higher performance and commitment. *Long Range Planning, 29*(3), 328-336.

Rogers, C., & Maslow, A. (2008). Carl Rogers. *Information Theory*, 214.

Rosha, A., & Lobanova, L. (2014). Identifying conditions to promote organisational coaching in Latvia and Lithuania. *Procedia – Social and Behavioral Sciences*, 156, 183-185.

Rostron, S. S. (2009). The global initiatives in the coaching field. *Coaching: An International Journal of Theory, Research and Practice, 2*(1), 76-85.

Sadler-Smith, E. (2001). A reply to Reynolds's critique of learning style. *Management Learning, 32*(3), 291-304.

Salovey, P., & Mayer, J. D. (1990). Emotional intelligence. *Imagination, cognition and personality, 9*(3), 185-211.

Schieman, S. (2013). Job-related resources and the pressures of working life. *Social Science Research, 42*(2), 271-282.

Schwella, E., & Rossouw, A. (2005). Competencies for the senior management service in the South African public service: an evaluative assessment. *Journal of Public Administration, 40*(4), 761-779.

Slavkin, H. C. (2010). Leadership for health care in the 21st century: a personal perspective. *J Healthcare Leadership, 2*, 35-41.

Sonnino, R. (2016). Health care leadership development and training: progress and pitfalls. *Journal of Healthcare Leadership, 8*, 19-29.

Stewart, L. J., & Palmer, S. (2009). Capitalizing on coaching investment: enhancing coaching transfer. *Development and Learning in Organizations: An International Journal, 23*(3), 14-17.

Stogdill, R. M. (1950). Leadership, membership and organization. *Psychological Bulletin, 47*(1), 1.

Swart, J., & Harcup, J. (2013). 'If I learn do we learn?': The link between executive coaching and organizational learning. *Management Learning, 44*(4), 337-354.

Tafvelin, S. (2013). *The transformational leadership process: Antecedents, mechanisms, and outcomes in the social services.* Umeå universitet.

Thach, E. C. (2002). The impact of executive coaching and 360 feedback on leadership effectiveness. *Leadership & Organization Development Journal*, *23*(4), 205-214.

Ugboro, I. O., & Obeng, K. (2000). Top management leadership, employee empowerment, job satisfaction, and customer satisfaction in TQM organizations: an empirical study. *Journal of Quality Management, 5*(2), 247-272. doi:http://dx.doi.org/10.1016/S1084-8568(01)00023-2

Wales, S. (2002). Why coaching? *Journal of Change Management*, *3*(3), 275-282.

Wasylyshyn, K. M. (2003). Executive coaching: An outcome study. *Consulting Psychology Journal: Practice and Research, 55*(2), 94.

West, L., & Milan, M. (2001). *The reflecting glass: Professional coaching for leadership development*. New York City, NY: Palgrave McMillan.

Wise, P. S., & Voss, L. S. (2002). *The case for executive coaching*. Durango, CO: Lore Research Institute.

York, T. W., & MacAlister, D. (2015). Chapter 7 - Leadership and professional development. In T. W. Y. MacAlister (Ed.), *Hospital and Healthcare Security* (6th Edition) (pp. 153-171). Boston, MA: Butterworth-Heinemann.

APPENDICES

APPENDIX 1: DEMOGRAPHIC QUESTIONNAIRE

Self-administered questionnaire
Please tick appropriate response

Personal characteristics

1 Level of hospital care				
Central	Tertiary	Regional	District	Specialised
2 Gender				
Male		Female		
3 Age				
<35		34-50		50
4 Length of experience in the current position				
<5 years		5-10 years		>10years
5 Academic qualification obtained				
Diploma		Degree		Masters
6 Specify the field of study				
Medical		Allied		Other
7 Formal training in health management in the form of certificate, diploma, degree.				
Yes		No		
8 Exposure to coaching as a developmental intervention				
Yes		No		
9 Would you like to be exposed to training on coaching for clinical managers?				
Yes		No		

APPENDIX 2: SOUTH AFRICAN CLINICAL MANAGERS' SELF-ASSESSMENT OF MANAGERIAL COMPETENCIES

The intent of this section of the questionnaire is to provide you with an opportunity to give your opinion on which management competencies are important to your position. Please answer the following questions by selecting the box that corresponds to the appropriate rank.
Managerial Competencies Assessment Part 1

Managerial Competencies Assessment	The importance of this skill in your current position				
	VERY HIGH	HIGH	MEDIUM	LOW	VERY LOW
Leadership					
1. Vision - Creates and promotes a vision for health services and encourages the organisation and community to contribute to that vision.					
2. Team Building - Acts as a team member and leader to resolve conflicts, promote team spirit, and build community partnerships.					
3a. Flexibility - Demonstrates various leadership styles appropriate for different situations.					
3b. Flexibility - Manages change effectively.					
4. Stress Management - Recognises personal and group stress signals and implements effective programs to reduce environmental stressors.					
5a. Commitment - Demonstrates commitment to the consumer.					
5b. Commitment - Demonstrates commitment to the organisation					
5c. Commitment - Demonstrates commitment to the stakeholders.					
5d. Commitment - Demonstrates commitment to the health service management profession.					
Communication					
6. Verbal Communication - Speaks articulately and persuasively.					
7. Listening - Appreciates the importance of listening and demonstrates the ability to read body language and subtle messages.					
8. Written Communication - Expresses clearly, concisely and with impact through written communication.					
Life-long Learning					
9. Self-directed Learning - Establishes goals for learning and participates in life-long learning and growth.					
10. Teaching/Mentoring - Promotes formal and informal methods and techniques for mentoring and developing staff.					

Consumer/Community Responsiveness and Public Relations					
11. Public Relations - Conveys a positive image of self and organisation to establish good relations with internal and external communities.					
12. Responsiveness - Continually improves service according to stakeholder, community and consumer expectations.					
Political and Health Environment Awareness					
13. Political Awareness and Sensitivity - Displays sensitivity to political motives and issues and actively seeks information on political trends in health service to address organisational issues.					
14. Health Environment - Monitors trends and issues in the health environment and anticipates potential impact on the organisation.					
Conceptual Skills					
15. Analysis & Synthesis - Effectively researches analyses information to arrive at a conclusion or solve a problem.					
16. Problem-solving - Demonstrates a strategic approach to problem-solving while recognising change as an important element in solving problems.					
17. Systems Thinking - Recognises the interrelationships between different systems and takes a total system perspective to improve the efficiency of the organisation.					
Results Management					
18. Planning - Uses effective planning to establish and promote corporate mission, values, goals and objectives.					
19. Implementation - Develops systems, tools and procedures that translate plans into an implementation strategy.					
20. Monitoring/Evaluating - Designs and implements methods and techniques to monitor and continuously improve delivery of service and on-going operations.					
Resource Management					
21. Human Resources - Effectively manages human resources so that organisational objectives are achieved.					
22. Financial Resources - Appropriately manages financial resources so that organisational objectives are achieved.					
23. Capital/Material Assets - Efficiently and effectively manages assigned assets to promote optimal utilisation of resources.					
24. Information - Disseminates information effectively throughout the organisation to promote generation of informed decisions.					
Compliance with Standards					
25. Accreditation - Promotes compliance with accreditation standards.					
26. Ethical Standards - Demonstrates adherence to the CCHSE Standards of Ethical conduct.					
27. Legal Standards - Promotes compliance with legal					

requirements and recognises and avoids potential legal problems.					
Coaching in improving competencies					
28. Management development intervention - Role of coaching in improving competencies					
29. Benefit - Areas in work environment which would benefit from coaching					

Managerial Competencies Assessment Part 2

Self-Assessment Questionnaire	Your assessment of your skill level in this area				
	VERY HIGH	HIGH	MEDIUM	LOW	VERY LOW
Leadership					
1. Vision - Creates and promotes a vision for health services and encourages the organisation and community to contribute to that vision.					
2. Team Building - Acts as a team member and leader to resolve conflicts, promote team spirit, and build community partnerships.					
3a. Flexibility - Demonstrates various leadership styles appropriate for different situations.					
3b. Flexibility - Manages change effectively.					
4. Stress Management - Recognises personal and group stress signals and implements effective programs to reduce environmental stressors.					
5a. Commitment - Demonstrates commitment to the consumer.					
5b. Commitment - Demonstrates commitment to the organisation					
5c. Commitment - Demonstrates commitment to the stakeholders.					
5d. Commitment - Demonstrates commitment to the health service management profession.					
Communication					
6. Verbal Communication - Speaks articulately and persuasively.					
7. Listening - Appreciates the importance of listening and demonstrates the ability to read body language and subtle messages.					
8. Written Communication - Expresses clearly, concisely and with impact through written communication.					
Life-long Learning					
9. Self-directed Learning - Establishes goals for learning and participates in life-long learning and growth.					
10. Teaching/Mentoring - Promotes formal and informal methods and techniques for mentoring and developing staff.					
Consumer/Community Responsiveness and Public Relations					
11. Public Relations - Conveys a positive image of self and					

organisation to establish good relations with internal and external communities.					
12. Responsiveness - Continually improves service according to stakeholder, community and consumer expectations.					
Political and Health Environment Awareness					
13. Political Awareness and Sensitivity - Displays sensitivity to political motives and issues and actively seeks information on political trends in health service to address organisational issues.					
14. Health Environment - Monitors trends and issues in the health environment and anticipates potential impact on the organisation.					
Conceptual Skills					
15. Analysis & Synthesis - Effectively researches analyses information to arrive at a conclusion or solve a problem.					
16. Problem-solving - Demonstrates a strategic approach to problem-solving while recognising change as an important element in solving problems.					
17. Systems Thinking - Recognises the interrelationships between different systems and takes a total system perspective to improve the efficiency of the organisation.					
Results Management					
18. Planning - Uses effective planning to establish and promote corporate mission, values, goals and objectives.					
19. Implementation - Develops systems, tools and procedures that translate plans into an implementation strategy.					
20. Monitoring/Evaluating - Designs and implements methods and techniques to monitor and continuously improve delivery of service and on-going operations.					
Resource Management					
21. Human Resources - Effectively manages human resources so that organisational objectives are achieved.					
22. Financial Resources - Appropriately manages financial resources so that organisational objectives are achieved.					
23. Capital/Material Assets - Efficiently and effectively manages assigned assets to promote optimal utilisation of resources.					
24. Information - Disseminates information effectively throughout the organisation to promote generation of informed decisions.					
Compliance with Standards					
25. Accreditation - Promotes compliance with accreditation standards.					
26. Ethical Standards - Demonstrates adherence to the CCHSE Standards of Ethical conduct.					
27. Legal Standards - Promotes compliance with legal requirements and recognises and avoids potential legal problems.					

Coaching in improving competencies					
28. Management development intervention - Role of coaching in improving competencies					
29. Benefit - Areas in work environment which would benefit from coaching					

APPENDIX 3: LETTER REQUESTING PERMISSION TO CONDUCT RESEARCH

A letter of request for permission to conduct research for clinical managers in Gauteng hospitals.
Helen Joseph Hospital
Private Bag X01
Perth road
2068
22nd February 2016
To: Dr B Selebano
The HoD
Gauteng Department of Health
Dear Sir

I am currently completing my Masters of Management in the Field of Business Executive coaching through the University of Witwatersrand Business school. I would like to request permission to conduct my research at Helen Joseph tertiary hospital. My research topic is 'Management competencies of clinical managers at public hospitals in Gauteng, South Africa: implications for coaching'.

The data will be collected using questionnaires. The areas that will be explored are the roles of the demographic presentation of clinical managers, their competencies and the role for coaching. Data collection will require 30 minutes of the clinical managers' time and will be arranged for a date and time during the Gauteng clinical managers' meeting.

Informed consent will be solicited from clinical managers participating in this study. Strict confidentiality will be observed at all times. The department of health will not incur any costs as a result of this study.

Thank you for your support.

Yours sincerely,

_____

Naumi Sithole
SA Mobile: + 27 79 899 6496 or email: naumisithole@gmail.com.

APPENDIX 4: CONSENT LETTER

Letter to respondents

The Graduate School of Business Administration
2 St David's Place, Parktown,
Johannesburg, 2193,
South Africa
PO Box 98, WITS, 2050
Website: www.wbs.ac.za

MMBEC RESEARCH CONSENT FORM

INFORMATION SHEET AND CONSENT FORM

I am Naumi Sithole. I am conducting research for the purpose of completing my MMBEC at Wits Business School

I am conducting research on 'Management competencies of clinical managers at public hospitals in Gauteng, South Africa: implications for coaching'. I am conducting a quantitative method study with clinical managers to establish their competency level and the need for support and further development using coaching.

I am asking you whether you will participate in the study. You will be briefed about the purpose of the study, if you agree, I will ask you to complete a self-administered questionnaire for 30 minutes.

Please understand that your participation is voluntary and you are not being forced to take part in this study. The choice of whether to participate or not, is yours alone. If you choose not take part, you will not be affected in any way whatsoever. If you agree to participate, you may stop participating in the research at any time and tell me that you don't want to go continue. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way.

Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including my academic supervisor/s. (All of these people are required to keep your identity confidential.)

All study records will be destroyed after the completion and marking of my thesis. I will refer to you by a code number or pseudonym (another name) in the thesis and any further publication.

At the present time, I do not see any risks in your participation. The risks associated with participation in this study are no greater than those encountered in daily life.

There are no immediate benefits to you from participating in this study. However, this study will be extremely helpful to us in understanding the need for coaching as a developmental tool for top managers.

If you would like to receive feedback on the study, I can send you the results of the study when it is completed sometime after April 2017.

This research has been approved by the Wits Business School. If you have any complaints about ethical aspects of the research or feel that you have been harmed in any way by participating in this study, please contact the Research Office Manager at the Wits Business School, Mmabatho Leeuw. Mmabatho.leeuw@wits.ac.za

If you have concerns or questions about the research you may call my academic research supervisor Dr Kerrin Myers (011- 485 3055).

CONSENT FORM

I hereby agree to participate in research to determine the competencies of clinical managers in a public hospital environment in Gauteng and to understand how coaching could play a role in closing this gap.

I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop participating at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term.

I understand that my participation will remain confidential.

Signature of participant Date:……..

Brief explanation of coaching

Coaching is an effective leadership development and helpful support mechanism in individual's leadership position. It is a helping relationship which assists an individual in achieving their goals. The aim is to address the areas of the client's life that the client has identified as the agenda, in order to achieve increase and sustainable improvement through focused learning. The coach will assist the coachee to improve their self-awareness and come up with choices that could contribute towards problem-solving and achieving the coachee's potential. Coaching is not about fixing people but helping individuals to explore their vision and focus on meaning and purpose in life.

Benefits of coaching

The table below provides the benefits of coaching at individual, team and organisational level.

Individual level	Team level	Organisational level
Better self-awareness and self-reflection	Improved team efficiency/performance	Improved organisational performance
Increased individual performance	Clearer vision development and objectives	Higher productivity
Higher motivation and	Improved team spirit and conflict	Better staff motivation and

commitment	management	retention
Better leadership skills	Better communication and relationships	Less absenteeism
Personal growth	Creating synergies	Buy-in to organisational values and behaviours
Higher quality of life/work balance	Higher motivation	Better management of change processes
Efficient implementation of acquired skills	Unleashing group potential	Open and productive organisational culture
Sustainable form of personal development		Realising the learning organisation
		Sustainable form of learning and development

APPENDIX 5: RESEARCH PLANNING

Time-table for completion of research report by November 2016

	date	date	date	date	date	date	date
Finalise proposal	29 February 2016						
Gain approval	29 February 2016						
Gather data		25 April 2016					
Do data analysis			30 June 2016				
Write report					30 August 2016		
Finalise report							28 November 2016

Consistency Matrix

Research problem: To measure the competencies of clinical managers in a public hospital environment in Gauteng and to understand how coaching could play a role in closing this gap.					
Sub-problem	Literature Review	Hypotheses or Propositions or Research questions	Source of data	Type of data	Analysis
Research problem: To measure the competencies of clinical managers in a public hospital environment in Gauteng and to understand how coaching could play a role in closing this gap.					
Sub-problem	Literature Review	Research questions	Source of data	Type of data	Analysis
The first sub-problem is to establish the competencies of clinical managers required in a public hospital environment in Gauteng.	(Pillay,2008)- Managerial competencies of hospital managers in South Africa: a survey of managers in the public and private sectors. Human Resources for Health (Pillay, 2010) –	What are the required competencies of clinical managers in public hospital environment in Gauteng?	Appendix 2 – A questionnaire with perceived required managerial competencies for clinical managers.	Ordinal. Data in a 5 point Likert scale. Ratio scale.	Percentages and frequency distribution will be used to provide summary of the items, with the focus on calculating standard deviation for variability and a mean for central tendency score of the clinical

	The skills gap in hospital management: A comparative analysis of hospital managers in the public and private sectors in South Africa. (Mac Kinnon, et al, 2006)-Management competencies for Canadian health executives: Views from the field.				managers' response.
Research problem: To measure the competencies of clinical managers in a public hospital environment in Gauteng and to understand how coaching could play a role in closing this gap.					
Sub-problem	Literature Review	Research questions	Source of data	Type of data	Analysis
The second sub-problem is to explore managers' perceptions of coaching in improving competencies of clinical managers.	(Steward Palmer, 2009)-Capitalizing on coaching investment: enhancing coaching transfer. Development and learning in organisations (Kilburg, 1996). Toward a conceptual understanding and definition of executive coaching.	Research question 2: What are the managers' perceptions of coaching in improving competencies of clinical managers?	Appendix 3 - the role of coaching in improving managerial competencies.	Ordinal	Thematic analysis will be used to interpret the content of data when it falls into the subjective nature of research. It allows for identification of themes, and patterns in the content of the text data