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Competence-Based Leadership in Indonesian Hospital Settings: A Qualitative Study of Operational Coordination and Digital Adaptation

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ABSTRACT

Hospitals industry increasingly require leaders who can integrate managerial, interpersonal, digital, and strategic capabilities with the technical demands of healthcare delivery. This study explored how competence-based leadership is understood and enacted west java in Indonesian hospital settings, particularly in relation to operational coordination, professional boundaries, and digital adaptation. A qualitative descriptive design was used. Six hospital directors or managers and ten unit heads or supervisors in participated between Data were generated through semi-structured interviews and supported by document review and field observation. The material was analysed using thematic analysis and reported with reference to COREQ and SRQR principles. Four themes were identified: (1) competence as practical work readiness rather than technical knowledge alone; (2) leadership as direction, coordination, and real-time problem solving; (3) professional boundaries and hierarchy as simultaneous sources of order and barriers to open collaboration; and (4) digitalisation as an expansion of competence requirements and leadership responsibilities. The findings suggest that competence-based leadership is best understood as a situated organisational practice through which leaders mobilise employee capabilities, translate standards into daily routines, bridge professional boundaries, and support digital workflows. Participants associated these practices with more consistent service processes, stronger coordination, and greater organisational adaptability. The study contributes a context-sensitive framework linking healthcare-context competence, operational leadership, relational coordination, digital competence, and continuous competence development. Hospitals should prioritise competency mapping, unit-based leadership development, psychological safety, digital mentoring, and performance feedback.

Keywords: Competence-Based Leadership; Hospital Management; Interprofessional Coordination; Digital Adaptation; Psychological Safety; Indonesian Hospital

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INTRODUCTION

Hospital leadership has become more demanding as healthcare organisations are expected to improve service quality, patient safety, operational efficiency, workforce capability, and digital integration simultaneously. Hospitals are therefore not only clinical institutions but also complex professional organisations that must coordinate multiple occupations, technologies, regulations, and stakeholder expectations (Figueroa et al., 2019; Spanos et al., 2024). Leadership in this environment cannot be reduced to formal authority or administrative control. It also requires the ability to interpret changing conditions, translate standards into workable routines, support learning, and coordinate people whose professional priorities may differ.

The competence required of hospital leaders is similarly multidimensional. Systematic reviews identify healthcare-context knowledge, operational management, communication, decision-making, resource management, professionalism, and strategic capability as central elements of hospital management and leadership competence (Pihlainen et al., 2016; Kakemam et al., 2020; Ndayishimiye et al., 2023). Recent scholarship further suggests that leaders must navigate complexity by fostering collaboration, building organisational capacity, and enabling continuous innovation rather than relying exclusively on fixed lists of competencies (Spanos et al., 2024). This perspective implies that competence should be examined not only as an individual attribute but also as a capability enacted through relationships, work systems, and organisational support.

These issues are particularly salient in Indonesia. Hospitals are adapting to accreditation requirements, financing pressures, electronic medical records, health-data interoperability, and the national SATUSEHAT ecosystem. The digital-health agenda requires changes in employee skills, documentation practices, data governance, and coordination across clinical and administrative units (Ministry of Health, Republic of Indonesia, 2022; Budiyanti et al., 2023). Digital transformation is therefore not merely a technical implementation project. Evidence from healthcare organisations indicates that digital transformational leadership contributes to digital intensity partly through organisational agility, highlighting the importance of leadership in aligning technology, employees, and organisational routines (Kludacz-Alessandri et al., 2025).

Hospitals are also strongly multiprofessional. Physicians, nurses, pharmacists, laboratory personnel, medical-record staff, administrators, finance staff, and support units contribute to a single service chain but operate with different knowledge bases, authority structures, and work rhythms. These differences can enrich decision-making, yet they can also create fragmented priorities and communication gaps. Hierarchy may clarify accountability during urgent situations, but excessive power distance can discourage staff from raising concerns, questioning established practices, or reporting errors. Psychological safety is therefore relevant because it supports speaking up, learning, and collaborative problem solving, although its relationship with objective patient-safety outcomes remains context dependent rather than automatically linear (Montgomery et al., 2025; Shankar et al., 2025).

Previous studies have provided valuable competence frameworks and evidence on leadership styles, but three gaps remain. First, competence is often presented as a measurable characteristic of individual managers, leaving less attention to how competence is mobilised through coordination, supervision, and everyday problem-solving. Second, evidence remains limited on how leaders in Indonesian hospital settings interpret professional hierarchy, digital adaptation, and competence development as interconnected challenges. Third, research frequently associates leadership with organisational performance without examining the practical mechanisms through which

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leaders translate policy, technology, and standards into daily service routines. Addressing these gaps requires qualitative evidence that is sensitive to context and to the experiences of leaders working at strategic and unit levels.

This study, therefore, explores competence-based leadership as an organisational practice in Indonesian hospital settings. Competence-based leadership is defined here as the set of leadership practices through which leaders develop, mobilise, and align individual and collective capabilities with service standards, organisational goals, and changing operational demands. The study addresses three research questions: (1) How do hospital leaders understand competence-based leadership in daily hospital work? (2) How is competence-based leadership enacted through operational problem solving and interprofessional coordination? and (3) What organisational conditions facilitate or constrain competence-based leadership and digital adaptation? By answering these questions, the study seeks to provide a contextual explanation of competence-based leadership without claiming causal or objectively measured improvements in hospital performance.

LITERATURE REVIEW

Competence Based Leadership in Hospital Organizations

Competence generally refers to the integration of knowledge, skills, attitudes, values, judgement, and behavioural capacity required for effective performance in a particular context. In hospitals, competence is embedded in service systems and professional relationships. Pihlainen et al. (2016) classify hospital management and leadership competence into healthcare-context-related competence, operational competence, and general management and leadership competence. Kakemam et al. (2020) similarly identify decision-making, communication, resource management, professionalism, leadership, and quality orientation as core managerial capabilities.

Competence-based leadership extends this perspective by emphasising how leaders mobilise competence rather than merely possess it. A clinically experienced professional may have strong technical expertise but still require managerial, communication, digital, and change-management capabilities to lead a unit. Leadership competence, therefore, becomes visible through practical actions: setting priorities, coordinating work, supporting staff, interpreting regulations, resolving operational problems, and creating conditions in which employees can apply their expertise consistently. This study accordingly treats competence as situated and relational, not as a static inventory of individual skills.

The distinction is important because formal training does not automatically change service practice. Sustainable competence development requires a system that connects competency mapping, work-based learning, supervision, mentoring, feedback, and evaluation. Leadership positions based solely on seniority or structural appointment may create gaps between professional expertise and leadership readiness. A competence-based approach can reduce this gap by linking development activities to role requirements and observable work practices.

Interprofessional Coordination, Hierarchy, and Psychological Safety

Interprofessional coordination is central to hospital performance because patient care depends on the timely exchange of information and action across units. Professional boundaries are not inherently problematic; they preserve expertise, accountability, and role clarity. Problems arise when units optimise their own tasks without understanding

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how delays, incomplete documentation, or different priorities affect the wider service process. Leaders, therefore, need relational competence to establish shared goals, clarify interdependencies, and support respectful cross-professional communication.

Hierarchy has a dual function. It can support discipline and rapid decision-making, yet it can also discourage questioning and upward communication. Psychological safety refers to a climate in which people can raise concerns, ask questions, and acknowledge uncertainty without fear of humiliation or retaliation. Leadership is a major influence on this climate because leaders model whether concerns are welcomed, whether mistakes become opportunities for learning, and whether junior staff can contribute to problem-solving (Shankar et al., 2025). Nevertheless, psychological safety should not be treated as a simple guarantee of improved patient-safety indicators. Higher reporting may indicate greater openness rather than worse safety, and objective effects vary across contexts and measures (Montgomery et al., 2025).

For competence-based leadership, the implication is that technical and managerial competence must be accompanied by communication sensitivity, ethical awareness, and the ability to balance authority with dialogue. Leaders must maintain clear standards while enabling staff to speak up and participate in service improvement.

Digital Transformation and the Expansion of Competence

Digitalisation changes both the content of competence and the conditions under which competence is exercised. Electronic medical records, hospital information systems, integrated reporting platforms, and digital decision support require employees to input accurate data, follow digital workflows, protect patient information, and understand how information moves between units. Digital competence, therefore, involves more than operating software; it includes data awareness, process understanding, and the ability to adapt when technology changes work routines.

Leaders play a critical role in digital transformation because employee adoption depends on communication, training, workflow redesign, technical support, and the perceived usefulness of the system. Van Wart et al. (2017) conceptualise e-leadership as the appropriate selection and use of information and communication technologies for individual and organisational purposes. More recent evidence in healthcare shows that digital transformational leadership is associated with digital intensity through organisational agility (Kludacz-Alessandri et al., 2025; Efawati et al., 2025). These insights support the view that digital adaptation should be integrated into leadership development rather than delegated exclusively to information-technology units.

Conceptual Positioning

Drawing on the literature, the study positions competence-based leadership as an interaction among five elements: healthcare-context competence, operational leadership, relational and coordination competence, digital competence, and a continuous competence-development system. These elements are expected to shape how leaders and employees respond to service demands. Because the present study is qualitative and does not objectively measure organisational outcomes, hospital performance is treated as a perceived consequence described by participants rather than as a causal dependent variable.

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RESEARCH METHODS

A qualitative descriptive design was selected because the study sought a practice-oriented account of how hospital leaders understood and enacted competence-based leadership in everyday work. This design was appropriate for examining participants' interpretations of operational coordination, professional hierarchy, employee development, and digital adaptation without imposing a highly abstract theoretical model. The report was revised with reference to the Consolidated Criteria for Reporting Qualitative Research (COREQ) and the Standards for Reporting Qualitative Research (SRQR) (Tong et al., 2007; O'Brien et al., 2014).

Data were collected through semi-structured interviews, supported by document review and field observation. The interviews explored participants' understanding of competence, leadership practices, barriers to competence development, interprofessional coordination, digital adaptation, and the relationship between leadership and hospital performance. The data were analyzed using thematic analysis. The analysis involved repeated reading of interview transcripts and field notes, initial coding, grouping similar codes, developing themes, reviewing themes, defining themes, and writing thematic interpretations. Trustworthiness was strengthened through source triangulation, method triangulation, member checking, and peer debriefing. Ethical principles included voluntary participation, informed consent, confidentiality, anonymity, and the right of participants to withdraw from the study.

The participants consisted of hospital directors and heads of units/supervisors. These participants were selected because they had direct responsibility for leadership practice, employee competence development, service coordination, and digital work system implementation. Furthermore, data were collected through semi-structured interviews, supported by document review and field observation.

Table 1. Informant Composition for Qualitative Data Collection

Informant Group	Number of Participants	Role in the Study	Data Contribution
Hospital directors/managers	6	Strategic leaders	Policy direction, organizational strategy, leadership challenges
Heads of units/supervisors	10	Middle-level leaders	Daily coordination, supervision, and performance control

Source: Own preparation (2026)

Interview Guide

The semi-structured interviews were guided by several open-ended questions. The questions were designed to explore how hospital leaders understand and practice competence-based leadership in daily hospital operations. Follow-up questions were used flexibly depending on the participants' roles and responses. The interview guide consisted of open-ended questions covering several key areas: the meaning of competence in hospital work, competence as practical work readiness, leadership practices, implementation of service standards, interprofessional coordination, digital adaptation, employee development, leadership challenges, and the contribution of competence-based leadership to hospital performance. The questions were followed by probing questions to obtain deeper explanations of participants' experiences, examples of daily leadership practices, and challenges faced in Indonesian hospital settings.

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Table 2. Semi-Structured Interview Guide

Research Focus	Main Interview Questions	Probing Questions
Understanding of competence	How do you understand employee competence in hospital work?	Is competence only related to technical skills, or does it also include communication, coordination, documentation, digital system use, and service readiness? How can you identify that an employee is competent in daily hospital service?
Competence as practical readiness	In your experience, what kinds of competence are most needed when hospital services are busy or under pressure?	How do employees respond when patients are waiting, service demand is high, or coordination between units is needed? What makes an employee ready to handle unexpected service problems?
Leadership practice	How do hospital leaders support the development of employee competence?	What forms of direction, supervision, coaching, mentoring, or feedback are usually provided? How do leaders ensure that employees apply their competence in daily work?
Interprofessional coordination	How do leaders manage coordination between different professional groups and units in the hospital?	What coordination problems commonly occur between clinical, administrative, and support units? How do leaders handle communication gaps, role differences, or conflicts between units?
Digital adaptation	How do hospital leaders support employees in adapting to digital work systems?	What challenges do employees face in using digital systems? How do leaders reduce resistance, improve digital literacy, and ensure that digital documentation is completed properly?
Employee development	What strategies are used to improve employee competence in the hospital?	Are competency mapping, unit-based training, mentoring, coaching, supervision, or performance evaluation used? Which strategy is considered most effective?
Leadership challenges	What are the main challenges faced by hospital leaders in strengthening employee competence?	Are these challenges related to workload, staffing, hierarchy, communication culture, limited training, digital readiness, or resistance to change?
Hospital performance	How does competence-based leadership contribute to hospital performance?	In what ways does leadership influence service quality, patient safety, employee performance, coordination, digital readiness, and operational efficiency?
Future improvement	What improvements are needed to strengthen competence-based leadership in Indonesian hospitals?	What were improved in leadership development, training systems, supervision, work culture, digital support, or performance evaluation?

Source: Own preparation (2026)

Document review includes training documents, competency standards, organizational structure, work procedures, and internal policy documents. The data were analyzed using thematic analysis. The analysis begins with repeated reading of interview transcripts and field notes, followed by initial coding, grouping similar codes, developing themes, reviewing themes, defining themes, and writing the thematic interpretation. To strengthen trustworthiness, the study should use source triangulation, method triangulation, member checking, and peer debriefing. Ethical considerations include voluntary participation, informed consent, confidentiality, anonymity, and the right of participants to withdraw from the study. Important note for finalization: this qualitative version was completed with actual interview transcripts, verified participant information, and real institutional context before journal submission.

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RESEARCH RESULTS

The analysis generated four themes that describe competence-based leadership as a practical and context-dependent organisational process. The themes were evident across strategic and unit-level participants, although the emphasis varied according to role. Senior leaders focused more on policy translation, organisational priorities, and system readiness, whereas unit heads and supervisors emphasised coordination, workflow disruption, and day-to-day support.

Table 3. Summary of themes and their organisational relevance

Theme	Indicative subthemes	Leadership mechanism	Perceived organisational relevance
1. Competence as practical work readiness	Technical knowledge in context; responsiveness; documentation; cross-unit coordination	Enabling employees to apply knowledge under real service conditions	Service continuity and consistent execution
2. Leadership as direction, coordination, and problem solving	Priority setting; policy translation; visible support; real-time decisions	Connecting strategic expectations with daily routines	Operational clarity and adaptability
3. Professional boundaries and hierarchy influence collaboration	Role differences, authority, speaking up, shared goals	Balancing accountability with dialogue and psychological safety	Cross-professional coordination and learning
4. Digitalisation reshapes competence needs	Digital literacy; data quality; workflow integration; resistance and support	Training, mentoring, technical support, and workflow redesign	Digital readiness and information continuity

Source: Own preparation (2026)

Theme 1: Competence Is Practical Work Readiness, Not Technical Skill Alone

Participants described competence as the ability to perform reliably within the actual conditions of hospital work. Technical knowledge remained essential, but it was not considered sufficient when services were busy, information was incomplete, or multiple units had to act in sequence. Competence became visible through readiness to communicate, document, coordinate, prioritise, and respond to unexpected problems. This understanding locates competence within the service system. Employees could know a procedure but still struggle to apply it if roles were unclear, digital systems were difficult to use, or coordination was weak. Participants, therefore, associated leadership with creating the conditions that allow employees to convert knowledge into consistent practice.

"In hospital work, competence is not only about knowing the procedure. Staff must be ready to communicate, coordinate with other units, complete documentation, and respond quickly when the service situation is busy." (P01)

"For me, competent staff are those who are ready to work in daily service conditions. They understand their task, but they also know how to coordinate with other units. In a hospital, one unit cannot work alone." (P02*)*

The theme indicates that competence was understood as a contextual capability enacted through the interaction of individual knowledge, leadership support, procedures, technology, and interdependent work. This interpretation underpins the remaining themes

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because participants repeatedly linked competence to the conditions in which work was performed.

Theme 2: Leadership Is Experienced as Direction, Coordination, and Problem Solving

Participants did not define leadership primarily through formal position. They described effective leadership as visible action: clarifying what should be prioritised, interpreting policies and accreditation requirements, supporting employees during service pressure, coordinating units, and resolving operational problems before they disrupted care. Unit-level leaders were especially important because they connected senior-management decisions with frontline realities. Clear direction was not understood as a constant command. Rather, it involved explaining why a procedure mattered, helping staff identify the immediate priority, and ensuring that responsibility was coordinated across units. When this translation was absent, procedures risked becoming administrative obligations separated from their purpose in service quality and patient safety.

"Effective leadership in a hospital is not only about position. A leader must be present in daily service activities. Staff need direction, especially when the service situation is busy. If the leader can explain what should be prioritised, the staff will work more confidently and the service flow becomes clearer." (P03)

"Leadership is seen from how leaders help the unit work properly. In the hospital, problems can happen every day. Sometimes the issue is patient flow, sometimes documentation, and sometimes communication between units. A good leader must identify the problem and help the team find a practical solution." (P04)

The findings suggest that competence-based leadership operates through translation and orchestration: leaders translate standards into practical expectations and orchestrate people, information, and resources across an interdependent service process.

Theme 3: Professional Boundaries and Hierarchy Influence Collaboration

Participants described professional diversity as necessary but potentially fragmenting. Clinical, administrative, pharmacy, laboratory, medical record, and support units contributed different expertise and priorities. Coordination problems emerged when each unit focused on its own task without recognising how its actions affected the next stage of service. Hierarchy also had a dual role. It supported clear authority, discipline, and accountability, especially in urgent situations. At the same time, participants indicated that respect for seniority and the wish to avoid conflict could make employees hesitant to ask questions, correct a senior colleague, or report a problem early. Delayed communication could produce repeated work, incomplete information, or service delays. Competence-based leadership, therefore, required both clear authority and a climate in which staff could communicate concerns respectfully.

*"*Hospitals consist of many professional groups, and each group has its own way of working. Doctors, nurses, administrative staff, pharmacy staff, laboratory staff, and medical-record officers have different responsibilities. Sometimes collaboration becomes difficult because each unit focuses on its own task and does not always understand the pressure faced by other units." (P05)

"Professional boundaries are common in hospitals. Clinical staff usually focus on patient care, while administrative staff focus on documentation, reporting, and service flow. Both are important, but the priorities are sometimes different. If there is no good communication, misunderstanding can happen." (P06)

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This theme highlights relational competence as a central component of hospital leadership. Leaders must create shared goals, clarify interdependencies, and distinguish respectful challenge from insubordination. Psychological safety is therefore relevant as a mechanism for learning and coordination, while accountability and professional standards remain essential.

Theme 4: Digitalisation Reshapes Competence Needs

Participants reported that electronic medical records, hospital information systems, digital reporting tools, and integrated health platforms had broadened the meaning of competence. Employees were expected not only to deliver clinical or administrative work but also to complete digital documentation accurately, follow system-based workflows, protect patient information, and understand how delays or errors in data entry affected other units. Digital adaptation created pressure when employees received insufficient training, systems were difficult to use, or digital documentation was perceived as an additional burden. Participants therefore emphasised leadership support through explanation, training, supervision, peer assistance, and technical escalation. Digital competence was seen as both an employee capability and a leadership responsibility to align technology with work processes (Nurain et al., 2024; Efawati & Rinawati., 2026).

"Digitalisation has changed the way hospital employees work. In the past, competence was often seen from clinical or administrative ability. Now, staff must also be able to use electronic medical records, hospital information systems, and digital reporting tools. If they cannot adapt to the system, the service process can be delayed." (P07).

"Digital competence is now part of daily hospital work. Employees are expected not only to serve patients, but also to input data correctly, complete documentation, and follow digital workflows. This means competence is broader than before." (P08).

The theme shows that digitalisation does not simply add a technical skill to existing roles. It changes task sequences, information dependencies, supervision requirements, and the criteria by which work readiness is judged.

DISCUSSION

Competence as a Situated Organisational Capability

The first contribution of this study is to move competence-based leadership beyond a static list of managerial attributes. Participants understood competence as practical readiness that became visible under real service conditions. This finding aligns with hospital competence frameworks that integrate healthcare context, operational, and general management capabilities (Pihlainen et al., 2016; Kakemam et al., 2020), but it adds a stronger organisational interpretation. Knowledge and skill did not automatically produce effective practice; their application depended on procedures, coordination, supervision, technology, and access to timely information. This situated interpretation helps explain why training alone may have limited effects. A leader can send employees to formal courses, but transfer to practice will remain weak if workloads, digital systems, role boundaries, or feedback mechanisms are not addressed. Competence development should therefore be embedded in work design and leadership routines. The relevant question is not only whether an employee has attended training, but whether the work environment enables competent action when service demands change.

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Leadership as Translation and Orchestration

The second contribution is the identification of translation and orchestration as practical mechanisms of competence-based leadership. Leaders translated regulations, accreditation standards, and organisational objectives into priorities that employees could apply in daily work. They also orchestrated people, information, and resources across units. This interpretation is consistent with evidence that future healthcare leaders must navigate complexity, build collaborative capacity, and promote continuous innovation (Spanos et al., 2024). Translation is especially important in regulation-driven organisations. Compliance may remain ceremonial when employees understand what a document requires but not why it matters or how it should shape service routines. Leaders at the unit level become a critical bridge because they can connect abstract standards with patient flow, documentation, staffing, and immediate operational decisions. Their competence, therefore, includes both managerial control and developmental support.

Professional Hierarchy, Coordination, and Psychological Safety

The third theme demonstrates that hierarchy cannot be classified simply as beneficial or harmful. Clear authority supports accountability and rapid response, but excessive deference may inhibit speaking up and cross-professional learning. The leadership challenge is to preserve role clarity while allowing respectful questioning and early problem reporting. This finding strengthens the argument that competence-based leadership must include relational and cultural capabilities rather than focusing only on decision-making and resource management. Psychological safety offers a useful explanatory mechanism because it concerns whether employees believe that interpersonal risk-taking is acceptable. Leaders influence this belief by how they respond to questions, errors, dissent, and requests for help (Shankar et al., 2025). However, the present study avoids treating psychological safety as an automatic predictor of objective patient safety. Recent review evidence shows that the relationship is complex, partly because higher incident reporting can reflect greater openness rather than poorer safety (Montgomery et al., 2025). Future studies should therefore examine communication climate, reporting behaviour, and objective service outcomes separately.

Digital Adaptation as a Leadership Process

The fourth theme confirms that digital transformation expands the competence required of both employees and leaders. Digital workflows create new dependencies: inaccurate or delayed data entry may affect clinical continuity, reporting, accreditation, billing, and managerial decisions. Competence, therefore, includes understanding the consequences of digital actions across the service chain. Leadership support was important because resistance could reflect inadequate training, poor system usability, duplicated work, or uncertainty about the purpose of documentation, rather than a simple unwillingness to change (Chaniago & Efawati, 2026; 2024). This interpretation is consistent with research showing that digital transformational leadership contributes to digital intensity through organisational agility (Kludacz-Alessandri et al., 2025). Hospitals should consequently integrate digital competence into leadership assessment, workflow redesign, and continuous learning rather than treating it as a one-time software-training issue.

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Theoretical Contribution and Proposed Framework

The study proposes that competence-based leadership in hospital settings consists of five connected components: healthcare-context competence, operational leadership, relational and coordination competence, digital competence, and a continuous competence-development system. The framework contributes to the literature by reframing competence as a system-embedded capability. Leaders do not merely display competence individually; they create or constrain the conditions under which collective competence can be exercised. Perceived organisational outcomes emerge through the mechanisms of translation, orchestration, psychological safety, and digital support rather than through competence as an isolated personal characteristic.

The findings support five practical priorities. First, hospitals should map leadership competencies by organisational level and unit context rather than use a single generic profile. Second, leadership development should be unit-based and combine formal learning with mentoring, coaching, case review, and supervised problem-solving. Third, cross-professional coordination should be strengthened through shared service goals, structured huddles, clear escalation pathways, and feedback across clinical and administrative units. Fourth, leaders should cultivate psychological safety by inviting questions, responding constructively to reported problems, and distinguishing accountable learning from blame. Fifth, digital implementation should include workflow redesign, peer mentoring, usability feedback, data-quality monitoring, and accessible technical support. Evaluation should focus on changes in practice and service processes, not only attendance at training.

CONCLUSION

Competence-based leadership in Indonesian hospital settings is best understood as an organisational practice rather than merely a set of individual attributes. Participants described competence as readiness to act within complex service conditions, while leadership was experienced through direction, policy translation, coordination, and practical problem solving. Professional hierarchy supported accountability but could also constrain open communication, making relational competence and psychological safety important. Digitalisation further expanded competence requirements by changing workflows, documentation, information dependencies, and employee-support needs. The study proposes an integrated framework comprising healthcare-context competence, operational leadership, relational and coordination competence, digital competence, and continuous competence development. These components were perceived to support service consistency, coordination, and adaptability, but the study does not establish causal improvements in hospital performance. Hospitals should therefore develop leadership through systematic competency mapping, work-based learning, cross-professional coordination, digital mentoring, and feedback focused on observable practice.

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