IMPROVING PUBLIC HOSPITALS
THROUGH EFFECTIVE CLINICAL LEADERSHIP:

LESSONS FROM SOUTH AFRICA

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Acknowledgements

Executive summary

Introduction

This report is the second part of an exploratory research project titled "The role of district hospital clinical staff in improving clinical governance in the public health sector in South Africa: possibilities and challenges." The project forms part of The Municipal Services Project which is located at the School of Government, University of the Western Cape, Republic of South Africa, and funded by the International Development Research Centre of Canada. The first part of the project was an extensive literature review of local and international literature.

This report summarises the findings of a rapid, exploratory study using a qualitative approach based on the literature review, fourteen semi-structured interviews and feedback on the review and initial findings by the initial interviewees and five additional interviewees (through written comments).

Background

The debate around public hospital management reform in South Africa tends to focus on the extent to which authority should be decentralised to the senior management team and how to strengthen general management processes. These interventions are seen as key to improving hospital performance.

However, the international literature emphasizes that, in the hospital setting, decision-making that directly affects the quality of care largely occurs at lower levels of the management hierarchy. Equally importantly, it is largely clinical staff, and not general managers, who make these decisions.

Clinical leadership is therefore vital to improving hospital performance particularly, but not only, with respect to the quality of care. Clinical leadership is the transformational leadership provided by practising clinical staff who drive improvements in the quality of care through innovation, either through formal participation in clinical governance activities or through informal role modelling and mentorship.

What makes a good clinical leadership system?

In trying to understand the potential of clinical leadership it is important to acknowledge that not all individuals are suited for – or interested in – clinical leadership. The training provided by different disciplines offers different advantages but also disadvantages. There is no in principle reason why clinical leadership should be confined to any particular discipline. Likewise, clinical leadership opportunities exist at many levels of the hospital.

In hospitals where clinical leadership systems are relatively strong, there tend to be certain common features:

- a critical mass of skilled clinical staff;
- a focus on patient needs within the context of the wider health system;
- leaders with appropriate personality traits and experience;
- collaborative leadership styles and multidisciplinary teamwork; and
- frequent, purposeful meetings.

Importantly, successful clinical leaders tend to continue their clinical work on a part-time basis: this is what allows them to keep patient care at the heart of management, understand what is needed to protect the quality of care and retain the respect of the clinical staffs and other staff that they lead.

What are the obstacles to clinical leadership?

There are many system obstacles to good clinical leadership that often stymie the best efforts of clinical staff. As one interviewee put it,

> *"Despite having often that passion and that drive, it means you have some success but sometimes that success is only limited to keeping that team together and you're still putting out fires but some of the more high quality issues, or some of the more deeper issues of clinical governance, you're not necessarily getting to those even though you've got a good team."*

These problems include:

- the failure of district and provincial offices to provide an enabling environment;
- a disjuncture between the identification of problems affecting clinical care and action by the management team;
- alienation of district hospitals from the primary care services in the district;
- poor human resources management that slows the appointment of clinical staff and places unnecessary administrative loads on clinical staff;
- the selection of insufficiently skilled clinical staff into leadership positions;
- lack of leadership and management training for all types of health professional, at undergraduate and postgraduate level, as well as insufficient mentoring; and
- burdensome and ineffectual monitoring systems.

These problems contribute to the failure of clinical governance systems in South Africa.

Conclusions and recommendations

Clinical staff already play a pivotal role in sustaining hospital services in South Africa. This is especially so in poorly-resourced areas: thus, in rural district hospitals, clinical staff shoulder enormous responsibility, not just for managing the care of individual patients, but also developing staff and services at primary and hospital level, and contributing to wider decision-making around health care priorities and resource allocation

Even within the context of limited resources, it is possible to develop clinical leadership and draw on it more effectively to improve clinical governance as well as hospital performance more generally. District hospitals are good sites to explore strategies for strengthening clinical leadership because they are small enough to overcome the traditional boundaries between different types of clinical staff, and between clinical and administrative staff, that create such obstacles to collaborative leadership in larger hospitals. District hospitals are also a key component of the District Health System and a priority for providing adequate hospital coverage under the proposed National Health Insurance system.

Certainly many lessons from the general management literature are highly pertinent to improved clinical leadership. However, while strengthening clinical leadership is partly about strengthening general management systems it is also about shifting the focus and style of some management transformation efforts. In addition, there is a dynamic interaction between strong clinical leadership and strong clinical governance systems: while it is not the task of this study to make recommendations on appropriate clinical governance systems, it is impossible to make recommendations on improved clinical leadership without touching on some aspects of clinical governance. Lastly, the recruitment and retention of clinical staff is obviously a starting point for improving the quality of care and some recommendations are designed to address this as well.

Bearing these introductory comments in mind some recommendations for consideration and further research are presented below.

Recommendations for universities

Introduce or strengthen leadership and management training for all health professionals with a focus on values-based, distributive leadership styles and teamwork in a multi-disciplinary context. Ensure that students have exposure to public health principles and a good understanding of the nature of the health system. This is essential for undergraduate training but postgraduate learning opportunities also need to be provided. The latter, in particular, should use innovative and reflective training approaches and be supplemented by on-the-job mentoring and support. Problem-solving skills need to be promoted for all disciplines.

Recommendations for the National Department of Health

Address the policy and implementation gap on the integration of the district hospital in the District Health System, particularly in view of the key roles these hospitals will play under National Health Insurance.

Acknowledge clinical leadership as a key driver of hospital performance and support provincial hospital systems in formulating clinical leadership development strategies as part of effective clinical governance.

Monitor the impact of norms and standards, not only on fundamental aspects of the quality of care as but also on the morale, workload and commitment of clinical staff.

Recommendations for provincial Departments of Health and their district and sub-district management structures

Review demands placed on hospital managers by district and provincial head offices, and create effectual delegations, so that they can be more present at the hospital and so that their time is freed up to concentrate on transformative leadership.

Galvanise human resource management at provincial, district and hospital level, with an emphasis on rapid appointment and timely payment of clinical staff, as well as effective labour relations and disciplinary support, to facilitate growing the numbers of good clinical staff, and to relieve medical managers of what is presently a large human resource management burden.

Review structures and processes for joint planning and supervision of district health services, with a view to integrating district hospital and primary health care more effectively. This should include developing a comprehensive clinical governance strategy and specialist support to district hospitals.

Make clinical governance a key function of the senior hospital management teams as well as hospital boards, in order to re-orient the focus of the hospital towards patient care and create a stronger impetus for improving clinical governance. This does not need to be inconsistent with maintaining financial sustainability and efficiency.

Recommendations for hospital managers (and senior management teams)

Clarify the different roles of clinical staff, especially those in leadership positions with a focus on building collaborative teams. Particularly important relationships are those between:

- the hospital, medical and nursing services manager; and
- the nurse and doctor in charge of a ward.

Acknowledge the key roles played by medical and operational managers and appointment credible professionals into these positions based on leadership and management prowess rather than on simply the number of years they have served.

Encourage clinical leaders to remain highly visible and accessible to the rest of the organization through such strategies as ongoing engagement in clinical work, the physical location of offices near clinical areas, an open door policy and frequent visits to clinical spaces.

Strengthen the position of the senior administrative manager (sometimes known as the systems or non-clinical services manager)*,* so that the administrative loads of the hospital, medical and nursing services managers are lightened so that they can make stronger leadership contributions and strengthen clinical governance systems. Also ensure that there are functioning computers, fax machines and photocopiers to minimise administrative chores for managers.

Recommendations for senior clinical leaders

Implement a clinical leadership development strategy that could include:

- strengthening the multi-disciplinary clinical team, especially at the level of the ward, with a special focus on strengthening the relationship between the doctor and nurse in charge of the ward;
- exploring the roles non-medical clinical staff could play in clinical leadership along the continuum from junior to senior staff, and creating incentives for them to participate in clinical leadership;
- providing supportive clinical supervision and on-the-job leadership training and mentorship for clinical leaders throughout their careers;
- promoting joint appointments with universities for key clinical staff in order to give them support and stimulation;
- finding a mechanism (such as a clinical committee) to take structured action on issues affecting clinical care that may be identified by other committees and clinical staff; and
- balancing collegial leadership with measures to ensure that clinical staff are fulfilling their roles adequately and remain accountable.

Develop clear, frequent and multi-faceted strategies for communication within and between clinical groups, and between clinical and administrative staff. Use both formal and informal opportunities for face-to-face interaction, as well as e-mail. The focus should be on identifying and addressing obstacles to good clinical care and taking accountability for agreed actions.

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PART A: INTRODUCTION TO PURPOSE AND KEY CONCEPTS

A1. Background

The debate around public hospital management reform in South Africa tends to focus on whether, and how, to decentralise authority to the hospital manager, the ideal characteristics of the hospital manager, and how to strengthen the capacity and leadership style of members of the senior management team (Doherty 2013). These interventions are seen as key to improving hospital performance. However, the international literature emphasises that, in the hospital setting, decision-making that directly affects the quality and efficiency of care, as well as resource allocation patterns, largely occurs at lower levels of the management hierarchy or at the front-line of service delivery (Doherty 2013). Moreover, it is largely clinical staff, and not managers.

This report summarises the findings of a study that hypothesized that amongst the reasons for the lack of progress in public hospital transformation in South Africa are management structures and processes that sideline or neutralise the leadership contributions clinical staff could make, and limited capacity development for clinical leadership. The study explores how to strengthen the role of clinical staff – doctors, nurses, allied health professionals and mid-level workers who are involved directly in seeing and treating patients – in helping to transform public hospitals to provide better quality of care.

A2. Objectives

The objectives of the study were to:

1. review key issues in recent international management and decentralisation literature that are relevant to the role of clinical staff in the leadership and management of public hospitals, particularly with respect to clinical governance;
2. assess the major successes and challenges related to involving clinical staff in the leadership and management of South African public hospitals with a focus on the impact on clinical governance;
3. identify the explanatory factors that account for these successes and challenges; and
4. explore, in the context of National Health Insurance, what kind of alternative leadership and management practices around clinical governance might lend themselves to more equitable and efficient outcomes.

The study focused on district hospitals both because these form part of the primary health care system, a key focus of government health policy, and because many of these hospitals are located in disadvantaged communities and are severely under-resourced.

A3. Methodology

The study was a rapid, exploratory study using a qualitative approach based on an in-depth international literature review (published separately as Doherty 2013), nineteen semi-structured interviews and e-mail exchanges, and feedback on drafts of the review and this report from ten of the interviewees. Ethical clearance for the study was obtained from the University of the Western Cape.

Interviewees were sampled through the 'snowball' method by initially approaching experts in rural health and asking them to identify individuals who fitted the criteria laid out in **Table 1**. A comprehensive list of recommended names was compiled and a sub-set of people was selected, ensuring as wide a range of people as possible. **Table 1** categorises the interviewees by discipline, role and work setting while **Annex 1** categorises them by province.

Table 1: Categorisation of interviewees

SELECTION CRITERIA	INTERVIEWEES FITTING THESE CRITERIA (number in brackets refers to interviewee interview code)
Good clinical staff (whether doctors, allied health professionals or nurses) who <u>currently</u> provide clinical care in public sector district hospitals (in rural or urban environments) and have an excellent track record of trying to improve quality of care and/or contribute to organisational development, either informally or formally (through participation in committees, some form of leadership or managerial role etc.)	• medical manager in district hospital (03, 04, 14) • head of a department in a district hospital, with an occupational therapy background (15)
Individuals who <u>used to</u> primarily be clinical staff (and therefore have a good knowledge of the clinical environment) but are now primarily involved <u>in management or training</u> (they might still continue some clinical work or they might have discontinued clinical work). They should have a good reputation in both these roles.	• local and international management consultant with medical and senior management background (05, 19) • member of district management team with medical background (10, 12) • hospital manager with nursing background (13) • academic doctor involved in training and service development (02, 07, 08, 11, 16, 17, 18)
Excellent <u>managers</u> who do not have any clinical background but have an excellent track record for leading/managing clinical staff	• district manager (09)
<u>Other individuals</u> who might be particularly good at reflecting on how to improve the manager-clinical staff	• local management consultant working in the health sector (01)

interface, how to use the strengths of clinical staff better, how to improve teamwork etc.	• international management consultant (06)

The semi-structured interviews were performed telephonically and recorded with the permission of the interviewees. In some instances it was not possible to make a recording because of poor phone lines, in which case hand-written notes were taken, and in other instances interviewees preferred to respond by e-mail (see Annex 1). Where there were recordings these were subsequently transcribed. A thematic content analysis was performed on the transcripts, written notes and e-mailed responses according to the themes identified in the literature review. Information from different sources was triangulated where possible. In the text below, numerical codes are used to identify which interview is the source of information to protect the identity of the interviewee.

The limitations of the study relate to its exploratory and qualitative nature. It is impossible to capture all the details of clinical leadership in district hospitals through only nineteen interviews. Because of the selection criteria, the viewpoints of the interviewees cannot represent those of all clinical staff, especially as the study specifically targeted the viewpoints of senior rural doctors (this was because of the prominent roles doctors play in clinical governance). While every effort was made to interview people with different disciplinary, geographic and career experiences (see **Table 1**), further research is required to elicit the opinions of non-medical clinical staff and non-clinical managers.

Nonetheless, together the interviewees represent a highly experienced set of clinical and other leaders. On most issues their viewpoints tallied well with one another and with the international literature. This suggests that the issues raised below can make an important contribution to the debate on hospital transformation.

A5. Definitions of key terms

There appears to be a lack of conceptual clarity, in both the international literature and the South African discourse, on what is meant by commonly used terms, such as "clinician," "clinical governance" and "clinical leadership" (Doherty 2013, 07). This lack of clarity contributes to difficulties in structuring constructive debate around the role of clinical leaders, especially where there are professional rivalries between different categories of health professional, or between health professionals and managers. This report avoids the term "clinician" because it is commonly associated with doctors and relies instead on the following definitions developed through the literature review:

1. **Clinical staff**: <u>any</u> health professional (from any disciplinary background) who is directly involved in diagnosing a patient's health problem, deciding upon the

treatment required, overseeing the care of the patient and participating in the care of the patient, including conducting procedures

2. **Clinical governance**: the creation of an integrated system for leading, managing and monitoring the clinical process that promotes a productive culture in which clinical excellence can thrive, whilst ensuring transparency and accountability on behalf of leaders, managers and clinical staff

3. **Clinical leadership**: the transformational leadership provided by practising clinical staff who drive improvements in the quality of care through innovation, either through formal participation in clinical governance activities or through informal role modelling and mentorship

The report focuses on the role of clinical leaders as distinct from non-clinical managers, where the latter include staff who are not health professionals <u>as well as</u> health professionals who are no longer directly involved in clinical care: this is because the study seeks to identify what contributions those directly involved in the clinical process do, or could, make to improved clinical governance as well as hospital management more generally.

PART B: CLINICAL LEADERSHIP IN SOUTH AFRICAN DISTRICT HOSPITALS

B1. The difference between leadership and management

The boundaries between leadership and management are not always clear. Yet, as one interviewee put it, *'leadership and management are two fundamentally different concepts, although they overlap, and the skills and abilities for each are different'* (16).

Interviewees understood the difference between leadership and management in much the same way as summarized by the literature review (03, 12, 13, 15):

> *'Leadership – especially transformational leadership - is about developing a values-based vision and direction for an organisation, motivating and inspiring members of that organisation to implement the vision, aligning the efforts of various members, guiding the organisation through periods of change and instability, and developing and empowering followers. Management, on the other hand, is more about achieving stability through planning and operational problem-solving, including developing concrete plans and budgets, setting targets, and marshalling and organising resources'* (Doherty 2013: 7).

A management consultant explained further that, *'management is about seeing that the thing is done properly. Leadership is about seeing what the thing is that should be done. So you can do the thing very well as a manager but it can be the wrong*

thing done extremely efficiently. Whereas if you are a leader, you aim to do the right thing' (03). One interviewee noted that there is a dearth of leaders in management systems whereas *'we've got a hang of a lot of managers, you know, people who think that it's a position to achieve, … basically seeing management as a chance to work less hard. So there are a lot of managers, and a lot of them kind of push the issues around on their desk, you know, and when there's a crisis we manage the crisis and then we carry on and we're very ineffectual'* (04).

This is why, even though most clinical leaders are required to also do management, the focus of this report is on the leadership end of the leadership-management continuum. It is leadership that is required to transform the health system and leadership can be provided by a range of people at different levels, even those who do not hold a formal management position.

B2. Why is clinical leadership important?

Problems with hospital management as well as the quality of care in South African hospitals have been raised repeatedly in the South African media and academic literature over the past two decades (Doherty 2013). As one interviewee put it, *'there's quite a big gap between management and clinical outcomes'* (07). The current Minister of Health has made renewed efforts to tackle these problems, including through new legislation that requires hospital managers to have a health background, the appointment of new hospital managers, the launch of a management training academy and the creation of an Office for Health Standards Compliance.

While all these steps are essential to improving hospital systems, they may not be sufficient to transform the quality of care. The international literature explains that health care institutions are "professional bureaucracies" where a clinical staff member's authority does not derive from his/her position in the formal management hierarchy but from his/her specialist knowledge and linkage to professional networks (Doherty 2013). In hospitals, this means that most decision-making that affects clinical care (and even some aspects of organisational efficiency) is actually out of the hands of hospital managers: it occurs in a completely different setting from the boardroom or office, namely, in the ward and operating theatre.

In addition, the clinical process is extraordinarily complex and unpredictable in nature. No one patient entering the health system is the same as another, conditions progress from day to day, and treatments vary according to an array of individual, family and contextual features. This means that it is difficult to standardise the approach to care, while the management of resources – at the ward, theatre, unit and departmental level - needs to adapt to changing circumstances. A high degree

of discretion is required of health professionals, and clinical decision-making needs to be individualised and responsive.

For these reasons, the international literature is quite emphatic that the conventional approach to managing a government bureaucracy through hierarchical, rule-governed relationships is not applicable to hospitals, at least with respect to the clinical process. In order to be effective managers of change (or even to meet regular financial and other targets), hospital managers have to bring clinical leaders into management processes, actively facilitating clinical leadership and encouraging managers and clinical staff to understand one another's viewpoints and experiences.

Leadership also has to penetrate into all parts of the organisation: this need for "distributed" leadership means that many clinical staff need to be involved, organised into teams working on specific clinical areas or "clinical micro-systems" (Doherty 2013). The international literature also shows that effective clinical leaders have specific attributes, apart from their expert knowledge, to contribute to this new approach to clinical governance. They have a "micro-level" viewpoint and use persuasion and evidence to bring about change, often acting as "opinion formers" who shape the tone of the hospital in an integral way. Good clinical staff are trained to take responsibility for decision-making and to prioritise patient care.

In combination, these characteristics make clinical staff good candidates for bringing about organisational change in support of patient care, and recent international research evidence is strong for clinical staff engagement as an essential strategy for improving clinical governance (Doherty 2013). However, the international literature emphasises that an increased influence for clinical staff needs to be balanced by greater accountability, recognition of funding constraints and adherence to national norms and standards.

This is the international argument for the importance of clinical leadership and new approaches to involving clinical leaders in management. There is also some emerging local evidence of dynamic clinical leadership bringing about change.

One interviewee in this study concurred that it is important *'to understand how the clinical care the patients receive is actually completely dependent on the discretion of the individual clinician'* (07). Another emphasised that clinical staff *'can understand what is important and what is not so important in terms of delivering the service in the ward. But I think also …, if you're still practicing, you have a degree of sympathy for the frailty of humanity. You understand under [certain] situations that people don't always achieve their best and that it doesn't necessarily mean that they're useless'* (03). Another interviewee stated that, *'at places where there is good care, people are not working to the rule. Where there is good care there is good leadership and the leadership usually is something … quite ephemeral in some ways, on some levels. On other levels I think it's something very, very visible and very concrete'* (07). Another interviewee affirmed that, *'if they [i.e. clinical staff] are involved [in decision-*

making] there tends to be ownership and I think their productivity tends to be better and obviously we need to improve clinical care, we need to go back to basics' (12).

However, one interviewee challenged the notion that the specific features of hospital services and characteristics of clinical staff necessitate a distinctive management approach, saying, *'it's irrelevant which industry you're in, good management's good management, and it has to do with managing the processes in a particularly respectful way'* (01). Certainly many of the general management lessons and principles apply equally to clinical leaders (see Doherty and Gilson 2011). Certainly, too, as described in more detail later, there are many examples of clinical staff who are bad managers or disinterested clinical leaders. Nonetheless, the rest of this report explores the possibilities for improving the impact of clinical leadership, given the mounting international evidence for its relevance (06, Doherty 2013).

B3. The current roles of clinical staff in leadership and management

Practising doctors, professional nurses and allied health professionals in the district hospital report (along with their associated mid-level health workers) to line managers within their own disciplines. Whereas doctors tend to retain their involvement in direct provision of clinical care, even as they become more senior, the system for nurse advancement tends to place experienced nurses in purely managerial or administrative roles.

The nursing hierarchy is overseen by a nursing services manager while the medical manager, in the absence of a non-clinical services manager (which is mainly the case in district hospitals) oversees all other health professionals. Both these managers sit on the senior management team chaired by the hospital manager: this team includes a human resources manager, finance manager and sometimes a systems/administrative manager.[1] The hospital manager is a non-clinical position: until recently the incumbent did not have to be a health professional.

Within these hierarchies, interviewees identified two critical formal roles for clinical leaders. The first is the nurse in charge of the ward, a position now known as the operational manager. This position receives scant attention in the South African management literature and interviewees did not immediately group them amongst clinical staff, perhaps because they belong to the nursing management hierarchy and take clinical instructions from doctors. Ward nurses tend not to have postgraduate clinical training, unlike the primary health care nurses in charge of clinics, the exception being senior maternity, theatre or outpatients department nurses.

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[1] Different provinces appear to use different terminology. Some district hospitals may also have a clinical manager who is senior to the medical manager (in which case the latter is presumably only in charge of medical as opposed to other clinical care).

Nonetheless, when pressed interviewees were unanimous that operational managers are key to organising all the activities in the ward, including clinical care (08, 13). *'I think those nurses are really critical to the successful functioning of a district hospital … They really have a significant role to play,'* said one medical manager (04).

The second critical formal clinical leadership role is that of <u>medical manager</u> who is responsible for overseeing the overall quality of care. Ideally this person has years of clinical experience but, with the shortage of staff in rural district hospitals especially, this is not always the case *(*09). In many hospitals this position is not filled and clinical staff answer to the (often non-clinical) hospital manager.

Medical managers often take on non-clinical leadership and management roles out of frustration with failures in general management systems, especially where they impact on the quality of care. Pressuring human resource administrators into completing new appointments in order to secure new clinical staff was raised frequently by interviewees as an example of an especially time-consuming activity (02, 04, 07, 08, 09, 12, 15, 16, 17). Other examples were interacting with ambulance services to improve the quality of their care, and working with foremen to sort out dilapidated sewerage systems.

Other formal leadership roles for clinical staff include membership of a host of hospital committees (such as maternal and perinatal mortality audit meetings, human resource development meetings etc.).[2] Doctors are also put in charge of wards where they are expected to work closely with the operational manager so that *'there should be elements of leadership at that level'* (12), as described in more detail in **Box 1**.

Depending on their personalities and interests, clinical staff also play a number of informal leadership roles. For junior doctors, this tends to be very much focused around patients at the ward level (02, 04). While these doctors may be confronted with health system problems, they are usually unable to address them, which prompts some to become involved in leadership roles but disillusions many others (04) (see **Box 2**). For more experienced doctors, informal leadership occurs especially through extensive training and mentoring of more junior clinical staff and visiting students, and outreach to surrounding primary care services.

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[2] Distributing the responsibility for participation on committees seems to be one of the strategies used by good medical managers, as well as a necessity in hospitals where there are only a handful of doctors (03, 04).

Box 1: The working relationship between the doctor and nurse in charge of a ward, as described by one interviewee

'What happens is that the doctor on the ward round will say what they need to be done, discuss the patients. They come together with the ward staff to discuss mortality and morbidity and clinical issues, they do nurse training in the ward on clinical issues. And they would ask the sister-in-charge, or the operational manager …

The operational manager is someone who is actually doing the job and a team leader, basically, although some people tend to emphasise the manager bit, but in fact they should be emphasizing the operational bit … This means you should spend some of your time doing the service, you know, the clinical work. If you're the operational manager in the ward you should spend some of your time seeing the patients, checking up on the drugs, so you're in touch with what's going on, and then you work on a shift basis. On part of the shift that you work on you do some clinical work shared with other clinical nurses.

Now, those operational managers are responsible for seeing that the ward is in order, and that it's staffed, and that the patients are properly controlled, and making sure that the patients are prepped, and being advocates for the patients like nurses are supposed to do. And liaising with the doctors in the ward as to what is needed in the ward and how things are going.

And in our situation …. they work together with the doctor, and there isn't an issue of who's in control of the ward because the doctor has a slightly different role. The doctor's role is to demand good clinical care for the patients and that the processes that are needed for that patient's care, the drugs given, is happening. But the nurses role is to see that the facilities are there, and that her team are doing that actual hands-on care for the patient, and make sure that the stores and supplies are coming in and going out, although sometimes she needs the doctor's support to help her against any other conflicting interests outside of that area … and sometimes she needs to come alongside of the doctor to tell her nurses to do the job properly rather than ignore it, carries responsibility for some discipline etc,, because the doctor isn't responsible directly for disciplining the nurses. The nurse is responsible for that.' (03)

Box 2: Clinical leadership by junior doctors: the perspective of one interviewee

'I think as a junior doctor … one's influence tends to be more at the patient and ward level … and depends a lot on the individual. But generally speaking, … you might be in a ward for three months or six months or whatever, and then … one tends to mould the ways things happen a little bit to your particular outlook, you know, preference, and try and get a system that's working well. A lot of that is negotiating the relationships and I think trying to keep a focus on patients and systems, getting efficient results for those patients. But I think as a junior doctor one tends to feel not really able to take on the bigger issues … I think that's one of the challenges in the public sector. Even if I look back at our … early years, there were big systems issues that were well beyond our capability to engage … That in a way makes it even more frustrating because you just feel powerless to do anything' (04).

In a district hospital these roles are played out within a "generalist" context where, unlike in secondary or tertiary hospitals, clinical staff have not chosen to specialise, either because they are still too junior or because they do not want to take on that particular sort of leadership role. The advantage of this context, noted one interviewee, is that *'there is much less of a hierarchy in district hospitals than regional or tertiary hospitals: all the clinicians are faced with more or less the same range of clinical challenges; they can relate directly to each other's experience'* (17).

B4. Who makes a good clinical leader?

Several interviewees emphasised that it is more a person's personality and experience that determines leadership competence, rather than their disciplinary background (01, 04, 15). As one interviewee put it, *'some people are very good clinicians but make shocking managers, and other people are good managers and make shocking clinicians, and sometimes you're lucky enough to get both'* (15).

Leadership skills can also be taught (see Doherty *et. al.* 2013*)* but until recently there was virtually no formal leadership training for health professionals, at either undergraduate or postgraduate level (most of the clinical leaders interviewed had learned their skills on the job or, in a few cases, enjoyed the support of a mentor). However, many interviewees noted that there are inherent differences in the general undergraduate training of different health professionals that affect their management and leadership styles.

Medical training reportedly inculcates strong problem-solving skills which can give doctors a leadership advantage. Doctors also tend to interact more informally and collegially, rather than adhering to a strict hierarchy, which makes for more flexible decision-making. Doctors are in any case formally responsible for patient care and one interviewee noted that *'trust the doctor'* is a very strong ethos in hospitals (01).

Despite this leadership potential, many doctors are not interested in leadership and management (failing, for example, to attend management meetings where issues pertinent to clinical care are discussed), or feel alienated from management systems (02, 10, 11, 13). Interviewees provided several reasons for this (see **Box 3**), including the focus in medical training on individual patient care rather than health systems, a lack of skills in team work and communication, the difficulties of working in a highly resource-constrained environment which continuously undermines the quality of care, poor management systems, a structural lack of integration of different clinical disciplines and the lack of clinical career pathways (01, 02, 07, 10, 11, 12, 13, 15). Doctors also have a reputation for arrogance, even when they are still relatively inexperienced (01, 13).

Box 3: Reasons why some doctors do not take on clinical leadership roles

'I've seen clinicians in charge of departments [in regional and tertiary hospitals] be very destructive because they are acting in terms of a very narrow interest - their patient, their ward, and to hell with the rest … They really … subvert the system, they harangue the CEO, they get onto the outside supplier themselves and demand delivery, quite often with the long-term effects that … they are just destabilizing the system' (01).

'Because of poor management, and they work so hard and they don't have time off, and poor management, they go into a downward spiral of negative motivation so in the end they don't, they just leave. So it's the conditions.' (02)

'What is quite difficult is that a lot of doctors don't want to go into management at all because … in many ways what you are constantly needing to do is take responsibility for a lot of different decisions that are being made at different levels that you don't necessarily agree with or like. And you also start to take greater responsibility for the grievous constraints that people are working under, and it really creates quite a lot of anxiety for people to constantly need to make decisions but under these circumstances …so you constantly negotiate, even at the clinical implementation level, you constantly engage and negotiate the resource limitations' (07).

'I would say that doctors are actually do not want at all to be involved in managerial issues. They are not even aware. They tend to be ignorant in my view … In most hospitals they feel a bit more excluded, you'll find in most cases the professional nurses are playing even more clinical leadership roles in the units' (10).

'Part of the problem is that people with a good clinical or patient focus, if they want to move into management, they have to throw this away and become a bureaucrat, otherwise they will never be promoted …. so the people who know best for the patient … do not have power' (11)

'They come in the ward, they're very, very narrow in terms approach. They come and just concentrate on the patient. They don't care how the patient is fed, how the systems are running in the ward. They don't really mind about that. They'll come and find their orders are not carried out, they'll not even follow it through' (12).

'They tend not to listen' and are *'in most cases very difficult'* (13).

'Our maternity operations manager, you wouldn't find her dead in a management post, she thrives on clinical, that's where she's staying, at the coalface … [In addition], some clinicians just want to be left to do clinical work and don't want to collect any more data than is absolutely the bare essential, which makes it very difficult as manager to say …, "Look, I would really like to you to collect this extra data or complete this extra form because it will really help us improve our programme"' (15).

Hospital nurses, on the other hand, are reportedly trained to operate in a more formal hierarchy and according to formal procedures. This has its advantages but can lead to a more bureaucratic approach to clinical leadership (02, 03, 04, 08, 15): as one interviewee described it:

> *'Nurses are … much more established in the kind of management structure and hierarchy … Quite often management tends to be a little bit more removed from the coalface of everyday nursing but which is not to say that they don't interact with that, but they're quite office-bound and get a bit more constrained by the paper work and things like that that often come with management … I think also they're just more often task-orientated than nursing-orientated if I can make that distinction … meaning that sometimes the papers and processes sometimes hold precedence over, you know, what's functionally happening to patients. And I think there's pros and cons to that. I think the nursing profession's reasonably well-organized as a result but … it can risk becoming a bit bureaucratic'* (04).

This was contrasted with the more dynamic leadership styles of the primary health care nurses who run clinics and have postgraduate training (15).

One interviewee summarised the different paradigms of doctors and nurses thus: *'Nurses are more hierarchical and schooled in following orders, processes etc. This [means] they are more managerial, while doctors are taught to think critically for themselves, making them better leadership material, but poorer team players (and problematic when guidelines need to be followed)'* (16). Another interviewee high-lighted the presence of *'professional cultural issues'* and power relationships that determine the way doctors and nurses interact with one another, giving a detailed example that appears in **Box 4** (07, 18).

Box 4: Professional issues that affect the interaction between doctors and nurses: the example of two quality improvement interventions in a district hospital

> *'One of them [the two quality improvement projects in the hospital] was much more nurse-driven and one of them was much more doctor-driven and both of them had lots of strengths and both of them had lots of weaknesses. So it was quite difficult to implement quite a lot of the clinical or the nursing care changes with [the one intervention] because it was perceived to be a doctors' process. And similarly the nurses couldn't find a way of challenging how doctors were making decisions, like when a [care intervention] was needed or not, or even what the process would be to challenge a junior doctor when the midwife felt it was an inappropriate decision, like all of those sort of things, they really, really struggled with, so it remained relatively unresolved … So I think that kind of fairly co-dependent relationship between doctors and nurses is … also a major issue and there needs to be shared responsibility between them …. but there are long term professional cultural issues that are determining how doctors and nurses relate to each other'* (07).

Allied health professionals and mid-level workers also do – or could – have clinical leadership roles but this study was not able to explore the strengths and weaknesses of their training.

Hospital managers do not usually play a direct clinical leadership role as their functions are more administrative in nature (12). However, as the accountable face of the hospital, they play a key role in clinical governance and are supposed to facilitate the work of the medical manager in this capacity. Their training can be a stumbling block in this regard, particularly where they are not health professionals (03, 09). As explained by one interviewee: *'the problem with a non-medical person in charge is that sometimes it gets a bit too focused on kind of the processes and the essence of business which it isn't really. So it's about trying to marry those competing interests. You want an efficient hospital where finances, supply chain, all that runs properly and buildings are maintained etc, and often doctors do that very badly, but on the other hand you want people who are primarily focused on providing the patient with good quality clinical care as doctors'* (04).

In trying to understand the potential of clinical leadership it is important, therefore, to acknowledge, first, that not all individuals are suited for – or interested in – clinical leadership. Second, there is no in principle reason why clinical leadership should be confined to any particular discipline but the training provided by each discipline has different strengths and weaknesses in terms of nurturing leadership capabilities. Third, clinical leadership opportunities exist at many levels of the hospital which means that not all clinical staff interested in leadership roles need also take on large management or administrative duties, especially if they are provided with adequate administrative support.

B5. Key features of good clinical leadership systems

<u>A critical mass of skilled clinical staff</u>

Resource constraints thwart the gains that good clinical leadership can make, especially when there are only between two and four doctors, and an equally small group of senior managers, which is often the case (04, 11). As one interviewee put it, *'the erosion of the long-term context … affects people's willingness to keep up the good fight'* (11). A particular problem is the shortage of senior medical officer posts, representing the middle level of leadership in a district hospital (02). Mid-level leaders are important because *'you need somebody who's clinically savvy enough, that can be on the shop floor, but doesn't have to do too much admin, that can actually just concentrate on doing clinical, you need that to kind of free up your time [as a medical manager] a little bit, because you can't be everywhere at once'* (15).

Where a core of experienced staff is retained for a few years, this make an enormous difference to exercising good clinical leadership and providing a context that facilitates the development of junior clinical staff (03, 5). Not only do senior staff provide mentoring but they also understand the health system and are able to address some of the frustrating issues that confront junior staff in the ward: this contributes to the retention of staff (04, 13). As one interviewee noted, *'I think that's an important recipe for longevity … in rural [practice]'* (04).

One of the strategies mentioned by interviewees for developing a core of skilled staff is to stop the practice of rotating senior nurses between wards (14). This allows them to build up expertise and become respected in their chosen field (06): *'We must stop rotating nurses within institutions … If a nurse is working in the maternity ward, and she's an advanced midwife, what logical sense does it make to take that nurse next month and put her in casualty? … In terms of holistic health care there's no way you can allow that to happen these days, it's just irrational'* (09). One international consultant clarified that the only senior nurses who should be rotated are those who have been identified through a systematic process as being capable of, and interested in, working towards senior management roles as rotation provides them with the all-round experience to equip them for these roles (06).

Another strategy to nurture a core of skilled staff is to address health system failures that exaggerate their clinical workload (such as providing gateway clinics to reduce pressure on the outpatients' department) and offer support that alleviates their non-clinical workload (06, 19). One interviewee reflected that, *'freeing up time for middle-level medical leadership to engage with colleagues, other clinical professionals and hospital management can be achieved by providing them with adequate administrative support – adequate both in terms of the skill-levels of such people (which engenders trust) and the salaries attached. Both require significant investment'* (06).

A focus on patient needs within the context of the health system

The most important contribution a good clinical leader can make is to reorient the district hospital management team away from a preoccupation with administrative issues towards responding adequately to patient needs and improving the quality of care: *'We emphasise over and over again that our primary purpose for being here is the patient and managing their care,'* said one interviewee (04) and *'everyone including the HR person should be seeing the patient at their patient'* said another (08). Another person described the tension between meeting clinical and "corporate" needs thus: *'There are people in the system who feel that they're working for the government and the government's going to check them out if they don't tick the right*

boxes, and then there are other people who feel they're working for the patient and the government is assisting them to do that. I think that's a more healthy way' (03).

Clinical staff are accountable for patient care to their professional councils which is a key difference from non-clinical staff. In addition, ongoing clinical work was identified as an essential part of understanding what other clinical staff are experiencing, tracking quality and identifying key health system problems. As one interviewee described it:

> '*I think the unique contribution is being in touch with firstly the patient but also being in touch with the needs of the community. That's why you can't just be a clinician you must also have a community-oriented approach. You must have a bit of public health background so that you also understand the population-based problems … Secondly, … I think clinicians … do have the opportunity to be change agents because they … have the opportunity to be advocates for your patients because you see the conditions they live in … So I think … clinicians, also because they're at the cutting edge or the bleeding edge of medicine, they see the problems and they can be advocates and in that sense they can be change agents'* (02).

Good clinical leaders take action on these issues and achieve a balance between caring for individual patients and strengthening the system as a whole. Most interviewees were adamant that it is essential for medical managers to continue practice in order to achieve this balance, although heavy workloads require careful prioritization of duties and some delegation to other clinical or administrative staff (see **Box 5**) (02, 03, 04, 07, 10, 12, 15, 17). Retaining clinical work could include receiving phone calls and visits from clinical staff needing clinical advice, being on call after hours, participating in ward rounds, doing outpatient sessions, doing some surgery or checking on admitted patients. One interviewee explained it thus: *'In my experience the clinical leader's credibility and therefore effectiveness as a leader depends directly on their clinical skills and judgement. If others in the clinical team do not respect a clinical leader's clinical judgement then they will not follow their lead on an improvement project or system change. So the skills of clinical leadership must be built on solid clinical skills'* (17).

Nurse managers throughout the hierarchy reportedly tend to do much less clinical work than their medical counterparts *'because of the nurse hierarchy that as soon as you leave the ward you lose contact with the patient'* (03). One interviewee said, *'with regards to the matrons, I always feel like they need to be a little bit more in the firing line of the relatives, family and friends … than sitting behind an office [desk] … so they can listen to what's going on in the wards and actually see what's going on'* (15). It was suggested that matrons should take on some shifts, not only to bring

themselves closer to patient needs, but also to monitor nursing practice in the ward as they are often oblivious to sub-standard care.[3]

One interviewee cautioned that clinical staff need to ensure that they do not focus on the patient's need to the detriment of the health system, and that clinical leaders who are trying to build a sustainable hospital system will have to challenge the habits of clinical staff who are heavily invested in their individual patients: *'We [clinical staff] essentially put the client first but that's not always good. It's very good from the client's perspective, it's not very good from a systems perspective. If you're trying to establish a system and get it … to work, sometimes some people are going to be a little bit unhappy about it. And you must just know when you can bend a system and when you can't'* (15).

Two interviewees did not agree that clinical practice is essential for senior clinical leaders, although neither of these people had worked at a district hospital themselves. They felt that the leadership and management load was too heavy (09) or feared that it would be a waste of clinical skills for a good clinician to take up a management position (02). One person noted that it might be possible for a medical manager who does not do clinical work to remain sufficiently in touch with clinical issues but he or she would have to have sufficient prior clinical experience and continually visit clinical spaces (15). These responses partly reflect the situation in South Africa where senior clinical leaders have very little administrative support and are expected to take on large daily management loads.

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[3] One interviewee gave the example that sometimes patient records are filled out by the nurses working in the ward at the end of the day rather than at the time care is given, and that some duties – such as turning patients – are not actually done although they are recorded (15).

Box 5: Reflections by interviewees on the importance of medical managers continuing clinical work

'You cannot run a hospital as a clinical lead and you don't do the work yourself … You have to do clinical work and they actually want to. I mean, if I look at the family physicians who are appointed there, they are young specialists, they want to do it, it's what they are good at. So you actually de-skill them if you don't give them time to do that … Seeing patients and being on the receiving end of the system you also get an understanding of what can make things better' (02).

'I think it's nice if you can maintain some clinical work. In some situations it's not going to work, but it helps you keep reality in check because you can sit behind a desk and command the troops, and think that the impossible can be done if you just draw enough straight lines. We find its good that people understand the ambiguities of health care because there's a lot of ambiguity in caring for a patient …That's why I like the idea that the manager remains in contact with the reality and doesn't leave it frozen 25 years ago' (03)

'So I've still got a very good idea of the systems of care within the hospital and how things are going, you know, I do a weekend ward round and that sort of thing that give me insights into how the patients are managed … There's a very real danger … that you can become so focused on the systems and the bureaucracy part and you lose sense for exactly how patients are being managed, so that's a real risk' (04).

'I think that … the good managers who are clinicians, have often used that clinical knowledge to have a focus for their decision-making. They realise if certain things are out of stock it's a disaster, even if it's a tiny little thing. On those sorts of issues they can make very good calls … A lot of medical people like to remain in clinical practice because that's where you see where the problems are, that's where you know what the shortages of nurses are in certain wards or whatever so it's a way of remaining close to where the rubber hits … whenever I got a bit frustrated about things I ended up doing a ward round in paeds and it sorted me out – real people with real issues and they don't mess you about and usually you could do something about it. It was just such a grounding experience' (07)

'I only do calls at the hospital as a sessional doctor. I pick up lots of problems by only doing calls in the hospital' (10).

'Unless you do it you not understand what your doctors are going through … I think at district hospitals the clinical manager must be very clinical, very experienced in clinical work … he should be an all-rounder' (12).

Appropriate leadership styles

Interviewees emphasised that it is not enough for a clinical leader just to have good clinical skills. Appropriate personality traits and leadership styles are also required, such as an open and respectful attitude towards others, good listening and networking skills, responsiveness and the ability to think on one's feet, flexibility and

the ability to "make a plan" rather than "work to the rule" (01, 07, 11). Other interviewees said it is important for a clinical leader to draw out people's opinions, inspire them to work with them and enable them to get on with their jobs (01, 03, 06). Another felt that good clinical leadership is *'providing context for new staff. If they have a bigger context then they can usually go with a lot of the issues. And then, you know, just remaining passionate and energetic and approachable and humble.'* (15)

One interviewee noted that hospitals begin to transform when *'there's one or two people in the hospital that's kind of a champion for the hospital, [saying] "Guys, let's pull this together" … So it's got to do with the individual motivation and leadership that pervades the rest of the team'* (02). The medical manager is a key champion in this regard because of his or her formal clinical leadership role and authority to call all clinical disciplines together: *'We've argued for years,'* said one interviewee, *'that if you don't have a Doberman-type person who has the passion and has the drive, there's no system support for it otherwise. It's personality-based, and that's been the case in a number of district hospitals'* (08). Another interviewee agreed, saying that *'there is nothing as good as sharing a vision'* with the rest of the hospital so that it *can unify initiatives'* (14).

It helps, too, if the medical manager supports multi-disciplinary teamwork, has a public health perspective and supports the primary health care approach, given that district hospital doctors are responsible for supporting clinic nurses as well as engaging with the community in which health services are located (02, 15, 17).

Finally, *'some form of moral judgment and also moral authority'* (07) is required of clinical leaders as they have conviction and persistence, and also ensure that discipline is maintained (15): one interviewee felt *'that's essentially what makes a place like that tick, that you've got people who are able to speak up and say this is the standard'* (07).

Collaborative leadership and multi-disciplinary teamwork

Interviewees also raised the importance of a collaborative and non-hierarchical style of leadership rather than applying a "command and control" approach. One medical manager learned this from his mentor*: 'I can remember one conversation early on phoning one of my mentors and saying, tell me "What to do, you know?" And he was speaking about leadership styles. He said, "You know, in a rural hospital you can be collegial or authoritarian, but authoritarian doesn't work very well, you know!"'* (04).

In engaging with colleagues from the same and other disciplines, interviewees referred to the need to build up personal relationships based on trust and respect, and to engage informally across established professional "silos" (04, 13, 15). It was a feature of the interviews that silos were generally not perceived as a problem, as they often are in less well-functioning facilities or in larger facilities with bigger staff complements (an exception is described in **Box 6**): clearly the management style of

the successful clinical leaders interviewed, and the organisational culture that had developed in these facilities, allowed structural problems in communication to be overcome. In addition, district hospitals are small enough for staff to get to know one another relatively well, including after hours, as many live on the property itself.

Box 6: Persistent problems with 'silos,' as described by a district manager

'there is still the silo concept. We're trying to break it down, where a nurse can, for instance, tell a doctor, "But doctor, I don't agree with what you're doing." You know, we had the tradition for many, many years that the doctor issues the orders and the nurse carries the bedpan: that needs to change … [Operational managers] need to be the kingpin in that particular department, the operational manager needs to be able to tell a doctor, "I think you are out of line." It's not happening yet but I think we need to move that way because nursing is a discipline in its own, clinical work is a discipline in it's own, but the two need to complement each other to the benefit of the patient, and if the nurse feels that a junior doctor is out of line I believe that that nurse should be able to open her mouth and say, "I don't agree with you," and then she needs to have the protection and the support of the hospital management' (09).

Key relationships that need to be established are between the medical and hospital managers, between the medical and nursing services manager, and between the doctor and nurse in charge of each ward (12). *'They communicate across them [silos] and they trust each other and they respect each other's ability'* said one interviewee (02) and *'if there's respect in the team for my silo, the one that I'm good at, that shouldn't be a problem'* said a second (03). A third described his hospital as '*very un-hierarchical in general. Some of our best relationships as doctors are with some of the more junior nurses … In everyday life there's not really much hierarchy at all and the junior nurses often are the best at engaging with the clinical staff'* (04).

Informants reflected that informal communication across silos allows problems to be sorted out quickly, discreetly and often at a more junior level so that they do not need to be escalated upwards (03, 04, 12, 13) (see **Box 7**). Formal hierarchies are then reserved for dealing with intractable problems that need to be addressed in a more structured way (02, 03, 04). It is important that these hierarchies do provide support to frontline staff when needed *'so senior management should find a way to act on issues raised by frontline people, but frontline nonetheless have to galvanise them'* (01).

Maintaining an open door policy and making oneself accessible to clinical staff was identified as an important way a medical manager could facilitate communication and be *'in the thoroughfare of everyday life'* (04). One interviewee gave an example of why this is important:

'So in the hospital I would be involved, well, I don't have an office, I just sit in the treatment room as well, and do my admin and then listen in on the patient consultations happening and then I kind of very gently butt in when there's uncertainty or someone's going off on the wrong track of if they ask me to help … When somebody comes to me and describes a patient to me and says, "What would you do, then I'll tell them and then half of the time I'll go through if I was in the other room, I'll go to see the patient and find out its completely different than I would have actually done … So that's where being on the shop floor is really, really useful … you really have to see the client' (15)

Box 7: Working across silos in well-functioning district hospitals

'[Silo structures are made unproblematic] by having a common vision. It's not so much your line manager but if you know where you are going to. So you can have a team of people working together and they answer to different managers but if all the managers they're answering to share the same vision, you won't have a problem' (03).

'I mean, strictly speaking they go up the nursing hierarchy but, one of the things that I appreciate about [X hospital] is there's a reasonably good relationship between the doctors and the other clinical professionals … and the nursing staff. So there's often quite a lot of engagement between the clinical staff and it works both ways. So there are times when we're struggling to engage with a nursing issue and we don't feel like we're being taken seriously, then we'll go to the nursing manager and it gets cascaded down that way. But equally speaking when the nurses are feeling they're not being listened to on the ground they'll come to us and we'll take it to nursing management, so I think there are communication channels there that actually work in all different directions … 'I think there are other hospitals where it's a lot more formal and it's quite difficult to get anything done outside of the hierarchy but we really don't believe much in the hierarchy to tell you the honest truth' (04).

Frequent, purposeful meetings

As described above, good informal channels for communication are important but most interviewees also raised the importance of frequent structured opportunities to interact: *'if you don't communicate, that's when things go wrong'* said one interviewee (04) and *'you need to have structures where you meet doctors and nurses more often'* (12) said another. Structured interactions range from ward rounds to formal committee meetings and from interactions between clinical staff to those that include administrative staff as well. Examples of important types of meeting are listed in **Box 8**: collectively they address quality of care issues but also form bridges between the clinical and non-clinical aspects of leadership and management.

Box 8: Important routine meetings to discuss quality improvement and address health system issues that compromise patient care

- Meetings of multi-disciplinary clinical teams
- Ward rounds (which should include the whole multi-disciplinary clinical team at least a couple of times a week)
- Meetings between ward doctors and operational managers
- Meetings between medical manager and doctors
- Multi-disciplinary meetings with all clinical staff
- Maternal and perinatal mortality meetings
- Senior management team meetings
- Meetings of clinical staff with administrative personnel (human resources development, finance, supply chain, cash flow, transport and maintenance etc.)
- Meetings to review indicators and progress reports
- Mass meetings including unions, cleaning staff etc.

(01, 02, 04, 12, 13, 14, 15)

To ensure the potential of meetings is fully realized, it is important that they are regular and that decisions taken are followed up: as one interviewee put it, *'I think it's about making people accountable and if you identify issues and you escalate them up, as long as you've regular meeting and getting feedback from those people, they tend to do slightly more'* (12). For clinical staff it is also important to select meetings that will have an impact on quality of care as *'some of them are more useful than others, and the trick is not to go to too many because then you are useless'* said one interviewee (15).

Some meetings need to be daily but others can be less frequent (01, 02). One medical manager had instituted a daily morning meeting with all doctors, before the ward round, which provided both an opportunity to discuss and sort out clinical and administrative problems, and to ensure that all doctors are at their posts (14): she identified this as an essential part of improving the quality of care.

Regular ward rounds were frequently mentioned as key strategies for addressing the quality of care, training and building the clinical team. One interviewee described the system at his hospital: *'We look at the way they've [the patients] been managed and we critique ourselves. That's part of our clinical governance. And actually have more senior doctors on the team. We get more value out of that. If we only have juniors, then it gets more difficult'* (03). Another recommended that, following ward rounds, the doctor and nurse in charge should have an half-hour meeting to address issues as *'they need to act hand in glove … they need to solve problems together, even before they take problems to the nursing services manager … Ward rounds will inevitably raise issues which need a separate forum to sit down … So you can't treat ward rounds and clinical work and other duties in the ward separately … The team must be able to look at all systems in the ward'* (12).

PART C: FACTORS THAT CONSTRAIN GOOD CLINICAL LEADERSHIP IN DISTRICT HOSPITALS

<u>A disjuncture between clinical problems and action by the senior management team</u>

Several interviewees said that, in their hospital, there is a gap between identifying health system problems that affect the quality of care and action to address these problems (07, 08). One interviewee described it thus: *'The service delivery which is one of the WHO building blocks is completely divorced from the finance, admin, pharmaceutical etc. and it's a real problem … nobody except the clinician, and sometimes not even the clinician, sees the patient at their patient'* (08). Another agreed that *'the system of how that problem that has been identified links up with the management system is very weak … A lot of mangers don't manage that gap very well,'* especially as senior management team meetings, where obstacles to good clinical care should be solved, tend to focus on finance and human resources or responding to memoranda from head office (07).

The possible reasons provided for the lack of action on problems identified by clinical staff is the preoccupation of administrative staff, including hospital managers, with meeting bureaucratic objectives set by the district and provincial head offices, a lack of focus on patient care as the primary function of a hospital, and the use of monitoring indicators that entrench these perspectives[4] (08, 10). Another cause is the lack of general management training of hospital managers as well as the lack of specific training on how to impact on health challenges such as the high maternal mortality rate (05, 07). This is aggravated by weak administrative support for managers which means that they are unable to progress from dealing with administrative tasks to addressing strategic issues (09, 10). One interviewee described how, as a consequence, managers *'end up hopping around doing nothing actually … The result will be you go to the meeting not prepared, you don't do your task because you're somewhere else … so you basically end up wasting time … I try to advise them but that's when you see that people, they have no clue, or they're not aware of a lot of things and that's when you get worried'* (10).

This can strain relationships between the hospital manager and senior clinical leaders: '*Well, in certain hospitals it works very, very well but in the one hospital … we had a problem because the clinical manager and the hospital manager did not … see eye to eye and they sort of undermined one another, because the hospital manager didn't understand the clinical issues … It was purely a professional issue. The hospital manager didn't understand the issues that worried the clinical manager'* (09).

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[4] For example, clinical outcomes do not feature strongly amongst indicators.

One interviewee concluded that, '*Clinical care will happen - I mean, obviously you need a strong clinical manager - but good clinical care will start to happen if you just create an enabling environment for a start. If everyone is just fighting all these like stupid red tape and processes, and just fighting to get one single thing done that's taken them like three hours, clinical care is going to suffer*' (15). One international consultant felt that a line item for 'clinical leadership and management' in hospital budgets is necessary for hospital management – and head offices – to take the concerns of clinical leaders seriously.

<u>Hospital managers overburdened by the inappropriate demands of "head office"</u>

A linked, but somewhat different, cause of the disjuncture described above is '*that management is quite distant*' – in a physical sense - from the daily life of the hospital (07). Several interviewees noted that their hospital manager, while competent, spent relatively little time at the hospital itself because of the need to attend district and head office meetings that result from the proliferation of government programmes and other initiatives (04). One interviewee estimated that his hospital manager was absent two to three days a week, and sometimes could be away from the hospital for a whole week.

A management consultant confirmed this as a major obstacle to correcting management problems at hospitals, saying that '*there's very little respect for the people who actually do the work and why I say that is that people get yanked out of their day to day work to go and "see the boss"*' (01). '*The system itself … is quite toxic and quite undermining of people*', said one former hospital manager, '*so I understood myself as a filter [between the unreasonable demands of head office and his staff]. That was my prime function as a manager*' (07). Another interviewee complained that head office staff frequently complain about the performance of hospitals but do not create an enabling environment and take joint responsibility for solving problems (10). '*People at the top, i.e. in Province and in District,*' said another interviewee, '*actually have to have a clearer vision of where we need to go together, which might help. And if they won't [be] so much swayed by the latest trend in politics and, you know, "Please do this now all of a sudden," I think it might work a little bit better*' (15).

This is partly due to insufficient delegation of authority to hospital managers, reportedly because of a fear that lack of capacity at lower levels will lead to mismanagement (18) but also, as one interviewee put it, '*there is constant oscillation between centralisation and decentralization in pursuit of power*' (05). One interviewee characterized the design of a hospital manager position as being one of '*clerical-management*' saying that*, 'if your CEO is supposed to be the chief policy director, you don't want a clerical job there. And you don't just want a manager there. You want a leader there*' (03). This leads to '*the inclination of the senior management, but particularly the hospital manager, to be essentially looking*

upwards to District rather than around him or her for solving of problems' (08). The same problem also applies to district managers who are separated geographically from their district hospitals and visit them infrequently (04, 08).

The fact that district and hospital managers are so preoccupied with extra-hospital activities and demands means that their contribution to clinical governance is much less than needed. This is particularly worrying because hospital boards are also not playing a strong governance role: said one interviewee, *'you have the clinic committee and the hospital [board], but they are toothless. It's just that they are just there to be informed and [if] the community is not satisfied about the hospital, nobody will do anything'* (10).

Poor human resource management

A common complaint by medical and other senior clinical managers was that the human resource management capacity of their hospitals – and of head offices - was very limited (07, 08, 09, 12, 15, 16, 19). This means that the recruitment of new clinical staff is very poorly implemented. A particular problem is that there is no sense of urgency around replacing clinical staff, despite chronic staff shortages. In order to hasten the process of identifying and appointing applicants, and maintain adequate clinical capability at their hospitals, these clinical leaders have to become integrally involved in the recruitment process. One person explained that, *'a large percentage of my time as a clinical manager was spent on HR issues because there was (and is) a total lack go understanding of what it takes to recruit and retain health professionals. Health professionals are treated in the same way as clerks and cleaners in terms of HR* [human resources] *processes'* (16). More generally, workforce planning, implementing retention measures, career pathing and job satisfaction measures, human resource development and disciplinary systems were all seen as functions that are poorly handled.

The fact that they have to take on so many of the functions that are in fact the responsibility of human resource managers is a great cause of frustration for clinical leaders, and a major obstacle to finding sufficient time to attend to improving the quality of care (07, 08, 09, 12, 15, 16, 19): *'we can't even get to that QI* [quality improvement] *work because a lot of these retention issues, or a lot of this workforce planning, is absent,'* said one commentator (08).

Inappropriate selection of leaders

Doctors often apply for leadership positions because they come with a substantial increase in salary that is not normally possible (16). Often they are promoted into these positions because of seniority or length of service, rather than because they possess good leadership and management skills (or even knowledge of basic

bureaucratic processes and labour relations) (07, 10, 11). However, *'experience does not equate to management skills'* said one commentator, pointing to the poor performance of many clinical leaders (08). Another interviewee elaborated:

> *'If you go to … most hospitals, the clinical managers that are there, …. I think recently it might be changing, but most people that are there are because of seniority, it's not because of leadership skills or managerial skills … They don't even know what they're supposed to do … They'll just take the feedback from the management team, they won't even interrogate some of the decisions … They don't even enforce the protocols … to see that the doctors are really following the guidelines'* (10).

Lack of leadership and management training for clinical staff

Interviewees emphasized that, until very recently, there has been virtually no leadership and management training at the undergraduate level for health professionals. Undergraduate training tends to focus on patient care, neglecting an analysis of the wider health system and discussion of key management and leadership responsibilities (09). One interviewee expressed the problem thus:

> *'Especially with the doctors' medical training, undergraduate studies, you see, it doesn't help us. In my view it doesn't help the country. You know, they just entertain academic issues and then that's it .. We're having the situation that we're not being trained to [the] public health point of view, to say when you treat a patient, "What are you trying to achieve?" You only know that when you treat patients physiologically this is what you want to achieve, to help the patient … So they're not prepared to work within the system so that's why they can't integrate with other … allied professionals and nursing'* (10).

Another interviewee felt that even the term 'clinical leadership' is not sufficiently broad to capture the community-based responsibilities of clinical staff in the South African context: *'Leadership needs to be taken not only in the clinical/curative hospital arena, but it needs to be framed by the responsibility for the health of the whole of the sub-district population in which the hospital is situated'* [as this is part of a single system] (17). Consequently, leadership training needs to be much broader than the generic management training usually provided to general managers, in the form of *'a whole series of undergraduate and postgraduate interventions around influencing and improving health systems, being a "change agent," working in teams, and taking leadership'* (17). Likewise, clinical leaders need training on clinical governance principles and quality improvement strategies (08).

Given the dearth of formal training mechanisms, clinical leaders tend to gain skills 'on the job' through experiential learning. This is made easier with a supportive manager or other mentor but many are 'thrown in the deep end,' even when they are relatively inexperienced clinically (04, 10, 15). For example, medical managers (who

are doctors) find themselves in charge of allied health professionals and pharmacists, without knowing much about the systems in which they work (10). One interviewee recalled that, *'we were thrust into a position of responsibility … that was well beyond our years'* (04).

Some clinical leaders arrange to go on short courses (such as, for example, on labour relations), sometimes in their own time (07, 15). An international consultant emphasized that Master's programmes for clinical leaders should not be the preferred option for imparting skills as *'it leads to people "learning what" rather than "learning how"* (06): a more creative mix of courses, on-the-job training and mentorship is required. Another interviewee suggested that there should be more sharing of leadership and management skills between doctors and nurses as *'the nursing side, they've developed their system more than the doctors … Their system is more compact'* (10).

Alienation of district hospitals from primary health care services

Several interviewees bemoaned an inadvertent consequence of district health system and primary health care policies and structures that has left district hospitals *'isolated'* from the rest of the district health system (01, 08, 10, 12). The government's Primary Health Care Re-engineering Strategy reportedly focuses exclusively on community-based and clinic-based activities while, at district and provincial office levels, there are separate reporting mechanisms for district hospitals and primary care services[5] (10). While there are clinic supervisors at the district level, there are not the equivalent for hospitals, while other forms of supervisor – such as those running TB or maternal and child health programmes - also tend to focus more on clinics (09, 19).

This weakens the integration of district hospitals with the rest of the district health system, of which it should be an integral part (10). District hospitals are consequently a neglected category of facility, said a management consultant: *'most of the times the hospitals are completely ignored by the district managers and the provincial managers, unless they make a mistake'* (01). *'[You] frequently get situations where the hospital would be completely divorced from the primary health care clinics and community health,'* said another interviewee (08). While not wishing the District Health System to become hospicentric, interviewees felt it would be impossible to provide comprehensive care to the district population without treating clinics and hospitals as one system (08, 12, 17).

This resonated with the experience of one international management consultant who drew attention to *'the general malaise in the district health system* [in Africa] *where poorly prepared health leaders and managers within a resource-constrained environment are expected to perform and provide quality health services. This of*

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[5] Thus, sub-district managers typically report to a PHC director and hospital CEOs to hospital director.

course impacts on clinical leadership and management within the context of clinical care which is a second priority to public health programmes' (19).

Burdensome and ineffectual monitoring systems

While interviewees recognised the importance of monitoring clinical care, they emphasised the difficulties of implementing monitoring systems in contexts of severe resource shortage. Part of the problem is the administrative demands placed on busy medical managers: *'I'm constantly sort of faced with the challenge of balancing trying to do that kind of admin with trying to problem-solve'* said one medical manager (04).

This problem is aggravated by impractical or inappropriate monitoring requirements placed on district hospitals by national and provincial head offices: these burden clinical staff when often they have no control over the many problems that affect the quality of care (08). Some interviewees felt that these problems would be aggravated by the norms and standards introduced by the new Office of Standards and Compliance.

One interviewee warned that the new standards could further disaffect staff: '*They all feel they're so overworked and they're not being looked after and supported and managed well, and now we're going to try and ask them to report on adverse events and not only adverse events but near misses'* (08). Another said, *'information gathering and leverage process critical but people have absented themselves from that'* (11). A third said, *'I think they are unrealistic and they will actually go far towards bureaucratizing everything which in the end just becomes a big stick'* (07).

Further, some clinical staff felt that the standards, because they are focused on eventual accreditation mechanisms, do not address the fundamental issues that affect the quality of care (see **Box 9** for a detailed example) whilst leaving clinical staff feeling undervalued: *'they can be quick to condemn clinical practice which is actually quite legitimate,'* said one interviewee (03). An international consultant added that, in low- and middle-income countries, the emphasis tends to be on indicators for public health programmes, especially where these are donor-driven, leaving provincial and national managers without accountability for clinical outcomes (19).

Box 9: Disaffection of clinical staff with norms and standards

Accreditation focuses *'on more structural features as well as documentation of processes, rather than on actual patient care and patient outcomes ... My stark example would be a hospital ward which scores highly because they have all the equipment, all the protocols, and all the documents in the files, but patients are not getting their medication on time, some are developing bedsores because they are not turned, and they do not "feel" care from the staff* ... [In an accreditation intervention] my experience was that doctors were alienated by the process because they could not see how it would lead to improved clinical care. They saw papers being given more importance than people and they saw institutions or sections of hospitals given higher scores when their patient care was known to be inferior' (16).

<u>Poor clinical governance systems for district hospitals</u>

Many of the problems described above, as well as some additional ones, result in a poor clinical governance system for district hospitals (where the definition of 'clinical governance' is the one summarised in **Section A.5**). As one interviewee said:

> *'I think within the health care system the way governance is conceptualized is very weak … What the mechanisms of accountability are is something which needs a lot more exploration to understand… The ideas of the corporate governance and clinical governance and that there is an accountability to the population that you serve is … still very, very poorly developed and in many ways I think that is where the key lies, that is what really needs to drive the changes within the hospital'* (07).

The lack of a clinical governance system to frame the work of clinical leaders means that it is difficult to make headway, even where clinical staff are skilled. As one interviewee put it, '*What happens though is … despite having often that passion and that drive, it means you have some success but sometimes that success is only limited to keeping that team together and you're still putting out fires but some of the more high quality issues, or some of the more deeper issues of clinical governance, you're not necessarily getting to those even though you've got a good team'* (08). **Box 10** summarises those shortfalls in clinical governance mentioned by interviewees and the level of the health system at which these problems occur.[6]

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[6] This is not an exhaustive list as the focus of the project was on one aspect of clinical governance only, that is, clinical leadership and the main factors that affect it.

Box 10: Levels of medical supervision and oversight relevant to the district hospital

LEVEL OF OVERSIGHT	PROBLEMS WITH OVERSIGHT
NATIONAL LEVEL	
National Department of Health	
Clinical guidelines, including those linked to the Essential Drugs List, are supposed to influence clinical decision-making and promote clinical and cost effectiveness.	The guidelines are not always followed at facility level and in some clinical situations they are not necessarily appropriate.
The newly created Office of Standards Compliance has developed clinical standards intended to guide and incentivise facilities to improve the quality of care over time.	In some instances these standards do not get to the heart of quality issues or create an administrative burden for under-resourced district hospitals.
PROVINCIAL LEVEL	
Provincial Department of Health	
Key decision-making authority still tends to reside with provincial Head Office staff (although in a few provinces this is less so), including hospital budgeting and human resource recruitment and disciplinary functions.	The hospital manager often has limited authority in relation to the head office. Verticalisation of many functions – such as disease programmes – creates a plethora of provincial and district managers to which the hospital manager is answerable. The hospital manager is called away to many meetings which makes it difficult to focus on hands-on management of the hospitals. Human resource functions tend to be particularly weak which hinders recruitment at hospitals.
Regional Hospital	
Specialists are supposed to fulfil a key role in clinical governance including visiting district hospitals to see complex patients, provide advice and conduct training, as well as providing telephonic advice.	Specialist support is often insufficient or absent because of staff shortages in regional hospitals or because specialists are poorly trained in fulfilling these roles. Telephonic support is not always satisfactory, especially when doctors do not know one another well or when regional doctors are inexperienced.
DISTRICT LEVEL	
District and Sub-district Management Teams	
District managers do not in effect have decentralised management authority and essentially carry out activities determined at the provincial level, including many vertical functions. Many districts do not have someone in charge of clinical care although in some districts a family physician has recently been appointed to this role.	In some contexts it is rare for district managers to visit district hospitals, or for there to be a manager devoted to district hospital coordination and support. There is therefore very little supervisory support.
District Clinical Specialist Support Teams are a new initiative linked to the government's PHC re-engineering policy although these teams have only recently been constituted across all districts. Made up of specialists these teams are specifically intended to support improved clinical governance throughout the district.	In many districts the tendency is to see these teams as supporting primary care services to the exclusion of district hospital services
DISTRICT HOSPITAL LEVEL	
Until recently the Hospital Manager did not have to be a health professional (unlike in the apartheid era and through the 1990s). This is still the case in district hospitals although the situation has changed in higher level hospitals.	In cases where the hospital manager is not a health professional, this makes it difficult for him or her to participate in clinical governance. Even some of those who are health professionals are no longer directly involved in clinical care. This is particularly a problem where there is no clinical or

	medical manager.
The <u>Senior Management Team</u> of the hospital includes the hospital manager, medical manager, finance manager, systems manager and human resources manager and has considerable say in the running of the hospital.	This team is not always effective in addressing problems affecting the quality of care that have been raised by clinical leaders.
<u>Clinical and Medical Managers</u> fill key positions in terms of clinical governance. The doctors and other health professionals in the hospital (apart from nurses) report to these managers. The medical manager (or clinical manager in a larger hospital) reports to the hospital manager and sits on the senior management team, alongside the nursing services, human resources, finance and administrative managers.	Large administrative loads often compromise clinical oversight functions. There is seldom someone who monitors clinical record-keeping or checks on whether patient care follows clinical guidelines and is clinically and cost effective. If clinical audits do happen they are often not done properly. There is seldom a clinical risk management plan.
<u>Clinical staff</u> are supposed to conduct clinical audits, ensure clinical effectiveness and manage clinical risk.	Quality improvement committees are often run by staff who do not have sufficient authority to effect change.
PRIMARY CARE LEVEL	
<u>District hospital doctors</u> provide support to primary care clinics through supervisory visits as well as telephonic advice. Doctors working at community health centres would also receive support although often these posts are not filled. There are several other outreach services provided by the district hospital.	Clinic support is often neglected due to large workloads for hospital-based doctors.

Sources: 02, 03, 04, 05, 08, 12, 14, van Rensburg book, RUDASA NHI doc, RHAP 2011

One interviewee noted that creating or strengthening the hospital clinical governance (or quality improvement) committee would go some way to shoring up clinical governance under existing constraints, but emphasised that this committee should have sufficient authority to introduce change. As he explained: *'typically the … QA manager, district hospitals have that but … that individual is not even, does not have the rank, does not have the experience to drive everybody to get on board. The reason I'm mentioning that is, unless you have senior management actually capacitating that committee, one needs to be careful to take it out of the senior management role'* (08).

Another interviewee noted the potential of family physicians to take on the medical manager role or become lead clinicians in district hospitals, given their comprehensive training that is tailored to the district hospital profile and ranges from patient care through to community diagnosis, and includes training in leadership, clinical governance and mentorship (02). However, the profession is not entirely in agreement that family physicians should take on this role as opposed to operating at the primary care level (08).

Several interviewees felt that the new District Clinical Specialist/Support Teams have potential to strengthen clinical governance but expressed disappointment that they are generally not seen as contributing to the clinical governance of district hospitals. This partly appears to be because there is a fear that these Teams, which are

relatively small and only partly constituted in some districts, would be over-burdened by the clinical demands of hospitals (09, 12), but also because of the aforementioned focus on primary health care (although the interpretation and implementation of the Teams appears to vary from province to province).

Another alternative is to encourage medical officers to get postgraduate qualifications (such as diplomas) which give them some specialist skills with which to support other clinical staff (09).

PART D: THE SOUTH AFRICAN EXPERIENCE IN INTERNATIONAL PERSPECTIVE

The interviews conducted for this study corroborate much of the international thinking on clinical leadership (as summarised in Doherty 2013). Thus, the international literature notes that, historically, the assumption has been that doctors and nurses simply look after patients, while administrators simply look after the organisations that treat them. There have also been poor relationships between different types of clinical staff, and between them and managers. This is due to different backgrounds, training, social status and perspectives. Internationally, management reforms since the 1980s have sometimes aggravated these poor relationships by elevating concerns of efficiency and financial soundness over the demands of patient care. Clinical staff have resented managers and "managerialism" for compromising the quality of their clinical practice. Managers, on the other hand, have been frustrated by clinical staffs' insistence on the primacy of their individual clinical autonomy, sometimes at the expense of the wider community.

Internationally, an understanding of the critical role clinical leadership could play in clinical governance has given rise to attempts to develop more productive relations between clinical staff and management, with most formally documented examples emanating from Australia, the European continent, the United Kingdom and the United States. Even in South Africa, where public hospital management is generally in crisis, there are examples of well-functioning hospitals, even in resource-poor areas, although relatively few examples have been documented.

The international and local examples show that, in order to restore mutual respect and a sense of shared purpose between clinical staff and managers, a "crossing over" of perspectives is required: clinical staff must contribute to organisational transformation, traditionally the preserve of general managers, while managers, in turn, must shift their focus to achieving the main purpose of hospitals, good quality clinical care. This leads to a greater willingness on the part of both clinical staff and managers to share responsibility for change, re-alignment of priorities, a dove-tailing of clinical and resource management decision-making, and a greater likelihood for

innovation in service delivery. This requires not only a "mind-shift" on the part of clinical staff and managers, and changes in their respective behaviours and training, but also the incorporation of clinical staff into management teams at different levels within the organisation, as well as greater recognition of their informal leadership contributions as role models and mentors.

Internationally, successful examples of clinical leadership are based on open and inclusive communication as well as collaborative leadership styles that rely on influence and mediation (sometimes called "influence-ship") rather than "command and control." They allow clinical input into decision-making at all levels and facilitate clinical leaders' understanding of the strategic direction of the health service. They reconcile professional aspirations with resource availability, facilitate and support clinical self-management, achieve change through motivating clinical staff, and promote a move away from a custodial role for clinical staff – where they focus on protecting their clinical practice - to creating a greater alignment between the managerial and clinical objectives of the organisation.

Almost all of the literature emphasises that successful clinical leaders continue with part-time clinical work. Clinical work is the source of clinical staffs' strength as leaders because it provides them with in-depth knowledge of the needs of the health service and, if done well, generates the respect that encourages other health workers to follow their lead. Once they take up formal leadership positions, continuing clinical work preserves clinical leaders' credibility with other clinical staff.

The international literature also points to the many barriers to strong clinical leadership. Clinical staff are often poorly prepared for leadership and there are few financial incentives to take up leadership positions, as well as limited career pathways. Organisational support is often weak and clinical leaders may encounter resistance from their clinical colleagues who sometimes judge them for having gone over to "the dark side" by participating in management processes. To counteract these problems, clinical staff need leadership training and mentorship, starting at the undergraduate level and persisting late into their careers. Importantly, this training should break from conventional business management approaches to respond to the unique features of the public health system and reflect a philosophy of shared, multi-disciplinary and transformational leadership.

The support of top-level hospital management is critical to the development of clinical leadership: hospital managers need to be willing to delegate power and responsibility to clinical leaders and nurture productive relations between clinical staff and management, creating an enabling environment for clinical leaders to function well and to assist the hospital in achieving its objectives. For this to happen adequately, hospital managers themselves need to receive appropriate delegations.

Further, clinical leaders should be valued by the organisation, including receiving adequate financial rewards and being offered career paths that allow them to

combine management with clinical work, as well as to move in and out of leadership positions. The support of their colleagues is important, as is administrative back-up.

Lastly, the international literature recognises that placing clinical staff in leadership positions is not a "magic bullet": it is very important to ensure that appropriate people fill these positions – with the necessary leadership traits and skills, and the ability to adapt their leadership styles and focus to the contingencies of local circumstances.

These, then, are the lessons from international experience that appear to resonate with the views of the interviewees in this study. What did not arise as a strong concern for interviewees was the presence of disciplinary 'silos' in their hospitals, an issue that has been raised repeatedly in the South African literature and some international literature. This is probably because most interviewees were from relatively well-functioning hospitals where these silos had been overcome through strong collegial relationships between staff from different backgrounds. In addition, it is evident from the interviews that the district hospital is an institution that is small enough to have a relatively flat management structure and for staff to know one another relatively well.[7]

Another contrast to the international literature, which mainly derives from high-income countries, is the low level of resourcing of district hospitals in South Africa. This makes the challenge of implementing appropriate clinical governance systems for South African district hospitals that much greater.

PART E: RECOMMENDATIONS FOR STRENGTHENING CLINICAL LEADERSHIP

Even within the context of limited resources, it is possible to develop clinical leadership and draw on it more effectively to improve clinical governance as well as hospital performance more generally. District hospitals are good sites to explore strategies for strengthening clinical leadership because they are small enough to overcome the traditional boundaries between different types of clinical staff, and between clinical and administrative staff, that create such obstacles to collaborative leadership in larger hospitals. District hospitals are also a key component of the District Health System and a priority for providing adequate hospital coverage under the proposed National Health Insurance system.

Certainly many lessons from the general management literature are highly pertinent to improved clinical leadership and these should be read in conjunction with this

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[7] District hospitals also appear to be too small at the present time to create decentralised clinical directorates that have responsibility for managing staff and budgets as well as meeting clinical and other targets.

report (see, for example, Doherty and Gilson 2011). However, while strengthening clinical leadership is partly about strengthening general management systems it is also about shifting the focus and style of some management transformation efforts. In addition, there is a dynamic interaction between strong clinical leadership and strong clinical governance systems: while it is not the task of this study to make recommendations on appropriate clinical governance systems, it is impossible to make recommendations on improved clinical leadership without touching on some aspects of clinical governance. Lastly, the recruitment and retention of clinical staff is obviously a starting point for improving the quality of care and some recommendations are designed to address this as well.

Bearing these introductory comments in mind some recommendations for consideration and further research are presented below: these are derived from explicit recommendations made by interviewees or implied from their comments reported earlier.

Recommendations for universities

Introduce or strengthen leadership and management training for all health professionals with a focus on values-based, distributive leadership styles and teamwork in a multi-disciplinary context. Ensure that students have exposure to public health principles and a good understanding of the nature of the health system. This is essential for undergraduate training but postgraduate learning opportunities also need to be provided. The latter, in particular, should use innovative and reflective training approaches and be supplemented by on-the-job mentoring and support. Problem-solving skills need to be promoted for all disciplines.

Recommendations for the National Department of Health

Address the policy and implementation gap on the integration of the district hospital in the District Health System, particularly in view of the key roles these hospitals will play under National Health Insurance.

Acknowledge clinical leadership as a key driver of hospital performance and support provincial hospital systems in formulating clinical leadership development strategies as part of effective clinical governance.

Monitor the impact of norms and standards, not only on fundamental aspects of the quality of care as but also on the morale, workload and commitment of clinical staff.

Recommendations for provincial Departments of Health and their district and sub-district management structures

Review demands placed on hospital managers by district and provincial head offices, and create effectual delegations, so that they can be more present at the hospital and so that their time is freed up to concentrate on transformative leadership.

Galvanise human resource management at provincial, district and hospital level, with an emphasis on rapid appointment and timely payment of clinical staff, as well as effective labour relations and disciplinary support, to facilitate growing the numbers of good clinical staff, and to relieve medical managers of what is presently a large human resource management burden.

Review structures and processes for joint planning and supervision of district health services, with a view to integrating district hospital and primary health care more effectively. This should include developing a comprehensive clinical governance strategy and specialist support to district hospitals.

Make clinical governance a key function of the senior hospital management teams as well as hospital boards, in order to re-orient the focus of the hospital towards patient care and create a stronger impetus for improving clinical governance. This does not need to be inconsistent with maintaining financial sustainability and efficiency.

Recommendations for hospital managers (and senior management teams)

Clarify the different roles of clinical staff, especially those in leadership positions with a focus on building collaborative teams. Particularly important relationships are those between:

- the hospital, medical and nursing services manager; and
- the nurse and doctor in charge of a ward.

Acknowledge the key roles played by medical and operational managers and appointment credible professionals into these positions based on leadership and management prowess rather than on simply the number of years they have served.

Encourage clinical leaders to remain highly visible and accessible to the rest of the organization through such strategies as ongoing engagement in clinical work, the physical location of offices near clinical areas, an open door policy and frequent visits to clinical spaces.

Strengthen the position of the senior administrative manager (sometimes known as the systems or non-clinical services manager)*,* so that the administrative loads of the hospital, medical and nursing services managers are relieved, allowing

them to make stronger leadership contributions and strengthen clinical governance systems. Also ensure that there are functioning computers, internet connections, e-mail, fax machines and photocopiers to minimise administrative chores for managers.

<u>Recommendations for senior clinical leaders</u>

Implement a clinical leadership development strategy that could include:

- strengthening the multi-disciplinary clinical team, especially at the level of the ward, with a special focus on strengthening the relationship between the doctor and nurse in charge of the ward;
- exploring the roles non-medical clinical staff could play in clinical leadership along the continuum from junior to senior staff, and creating incentives for them to participate in clinical leadership;
- providing supportive clinical supervision and on-the-job leadership training and mentorship for clinical leaders throughout their careers;
- promoting joint appointments with universities for key clinical staff in order to give them support and stimulation;
- finding a mechanism (such as a clinical committee) to take structured action on issues affecting clinical care that may be identified by other committees and clinical staff; and
- balancing collegial leadership with measures to ensure that clinical staff are fulfilling their roles adequately and remain accountable.

Develop clear, frequent and multi-faceted strategies for communication within and between clinical groups, and between clinical and administrative staff. Use both formal and informal opportunities for face-to-face interaction, as well as e-mail. The focus should be on identifying and addressing obstacles to good clinical care and taking accountability for agreed actions.

ANNEX 1: BREAKDOWN OF INTERVIEWEES BY GEOGRAPHIC BASE AND TYPE OF INTERVIEW

INTERVIEWEE*	GEOGRAPHIC BASE**	TYPE OF INTERVIEW
01	Western Cape	Telephonic interview with detailed transcript
02	Western Cape	Telephonic interview with detailed transcript
03	KwaZulu-Natal	Telephonic interview with detailed transcript
04	Eastern Cape	Telephonic interview with detailed transcript
05	Other country in Africa	Short e-mailed comments
06	High-income country	Detailed e-mailed comments
07	KwaZulu-Natal	Telephonic interview with detailed transcript
08	Gauteng, North West	Telephonic interview with detailed transcript
09	North West	Telephonic interview with detailed transcript
10	North West	Telephonic interview with detailed transcript
11	Other country in Africa	Telephonic interview with hand-written notes as bad telephone line made taping impossible
12	Gauteng	Telephonic interview with detailed transcript
13	Limpopo	Telephonic interview with hand-written notes as bad telephone line made taping impossible
14	KZN	Telephonic interview with hand-written notes as bad telephone line made taping impossible
15	KZN	Telephonic interview with detailed transcript
16	Gauteng, North West	Short e-mailed comments
17		
18	Gauteng	Short e-mailed comments

*Details on disciplinary background and job occupation appear in **Table 1** in the main teaxt.

**This is the province in which they currently work. Several interviewees had previously worked in other provinces or have in-depth knowledge of other provinces through their current work responsibilities.

REFERENCES

Doherty J. 2013. *Strengthening clinical leadership in hospitals: a review of the international and South African literature.* (in press)

Doherty JE, Couper ID, Campbell D, Walker J. 2013. Transforming rural health systems through clinical academic leadership: lessons from South Africa. Rural and Remote Health; 13: 2618 (online). Available at: http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=2618.

Doherty J, Gilson L. 2011. *South African health managers speak out: lessons for innovative health management in the public sector.* Cape Town: Oliver Tambo Fellowship Programme, University of Cape Town.