TOWARDS ‘A PEOPLE’S HOSPITAL’

LESSONS FROM THE
CHRIS HANI BARAGWANATH HOSPITAL
TRANSFORMATION PROJECT

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Independent researcher

FINAL REPORT
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Acknowledgements

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>TABLE OF CONTENTS</td>
<td>i</td>
</tr>
<tr>
<td>ACRONYMS</td>
<td>iii</td>
</tr>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>iv</td>
</tr>
<tr>
<td>TOWARDS A ‘PEOPLE’S HOSPITAL:’</td>
<td>1</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2. Methodology</td>
<td>3</td>
</tr>
<tr>
<td>2.1. Study design</td>
<td>3</td>
</tr>
<tr>
<td>2.2. Analysis</td>
<td>5</td>
</tr>
<tr>
<td>2.3. Limitations</td>
<td>6</td>
</tr>
<tr>
<td>3. History of the Transformation Project</td>
<td>8</td>
</tr>
<tr>
<td>3.1. Identifying Chris Hani Baragwanath Hospital as a site for transformation</td>
<td>8</td>
</tr>
<tr>
<td>3.2. Building consensus on the key challenges facing the hospital</td>
<td>9</td>
</tr>
<tr>
<td>3.3. Funding</td>
<td>15</td>
</tr>
<tr>
<td>4. Principles under-pinning the design of the Project</td>
<td>18</td>
</tr>
<tr>
<td>4.1. Decentralisation</td>
<td>18</td>
</tr>
<tr>
<td>4.2. Clinician leadership</td>
<td>18</td>
</tr>
<tr>
<td>4.3. Integration</td>
<td>20</td>
</tr>
<tr>
<td>4.4. Re-orientation of management towards patient care</td>
<td>21</td>
</tr>
<tr>
<td>4.5. Increased resources and skills</td>
<td>22</td>
</tr>
<tr>
<td>5. A transformed management system: progress so far</td>
<td>24</td>
</tr>
<tr>
<td>5.1. Transformation of the overall structure of the Surgery Division</td>
<td>25</td>
</tr>
<tr>
<td>5.2. Transformation of nursing management</td>
<td>30</td>
</tr>
<tr>
<td>5.3. Transformation of medical management</td>
<td>36</td>
</tr>
<tr>
<td>5.4. Transformation of human resources management</td>
<td>39</td>
</tr>
<tr>
<td>5.5. Transformation of financial management</td>
<td>46</td>
</tr>
<tr>
<td>5.6. Transformation of systems management</td>
<td>50</td>
</tr>
<tr>
<td>5.7. Transformation of the pharmacy</td>
<td>55</td>
</tr>
<tr>
<td>6. The impact of the Project on key problems</td>
<td>55</td>
</tr>
<tr>
<td>6.1. Improvements in efficiency</td>
<td>56</td>
</tr>
<tr>
<td>6.2. Improvements in staff morale</td>
<td>57</td>
</tr>
<tr>
<td>6.3. Improvements in the quality of care</td>
<td>61</td>
</tr>
</tbody>
</table>
7. Factors facilitating the progress of the Project.................................................................64
  7.1. Building consensus around the need for transformation........................................64
  7.2. Providing strong and consistent leadership............................................................65
  7.3. Involving organised labour in an integral way.........................................................67
  7.4. Empowering Divisional managers........................................................................67
  7.5. Making management accessible............................................................................68
  7.6. Engaging in a slow, thorough process..................................................................68
8. Factors constraining the progress of the Project..........................................................69
  8.1. Postponement of Project roll-out............................................................................69
  8.2. Weaknesses in the linkage between the Project and the provincial head office........71
  8.3. Inability of the CEO to drive through change.........................................................73
  8.4. Resistance to decentralisation................................................................................74
  8.5. Declining vigour of the consultative processes within the hospital .......................76
  8.6. Inability of the Project to create a lasting coalition of allies..................................77
9. Stakeholder concerns with the design of the Project......................................................79
  9.1. The concept of a practicing clinician as Divisional Head .......................................79
  9.2. Eliminating silos through consolidating reporting lines under the Divisional Head ....81
  9.3. Attributing impacts to the model design..................................................................83
  9.4. Lack of a monitoring and evaluation framework....................................................83
10. Conclusions and recommendations.............................................................................84
  10.1. Re-invigorate consultative processes ....................................................................86
  10.2. Restore relationships with central hospital and provincial management...............86
  10.3. Measure the impact of the project.........................................................................87
  10.4. Debate the prospects for roll-out widely..............................................................88
Appendix A: Abbreviated Curriculum Vitae of Jane Doherty.............................................91
REFERENCES.........................................................................................................................92
### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>African National Congress</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>CHB/CHBH</td>
<td>Chris Hani Baragwanath Hospital</td>
</tr>
<tr>
<td>COSATU</td>
<td>Congress of South African Trade Unions</td>
</tr>
<tr>
<td>CSU</td>
<td>Clinical Service Unit</td>
</tr>
<tr>
<td>DENOSA</td>
<td>Democratic Nursing Association of South Africa</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
</tr>
<tr>
<td>ENA</td>
<td>Enrolled Nursing Assistant</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear, Nose and Throat (specialist/specialty)</td>
</tr>
<tr>
<td>ExCo</td>
<td>Executive Committee</td>
</tr>
<tr>
<td>GDOH</td>
<td>Gauteng Department of Health</td>
</tr>
<tr>
<td>GSSC</td>
<td>Gauteng Shared Service Centre</td>
</tr>
<tr>
<td>HoDIV</td>
<td>Head of Division</td>
</tr>
<tr>
<td>HOSPERSA</td>
<td>Health and Other Service Personnel Trade Union of South Africa</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>IR</td>
<td>Industrial Relations</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>MEC</td>
<td>Member of the Executive Committee (i.e. provincial equivalent to national Minister)</td>
</tr>
<tr>
<td>ManCo</td>
<td>Management Committee</td>
</tr>
<tr>
<td>Mx</td>
<td>Management</td>
</tr>
<tr>
<td>NALEDI</td>
<td>National Labour and Economic Development Institute</td>
</tr>
<tr>
<td>NCSU</td>
<td>Non-clinical Service Unit</td>
</tr>
<tr>
<td>NEHAWU</td>
<td>National Education, Health and Allied Workers’ Union</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>SCMU</td>
<td>Supply Chain Management Unit</td>
</tr>
<tr>
<td>SD</td>
<td>Surgical Division</td>
</tr>
<tr>
<td>SLA</td>
<td>Service Level Agreement</td>
</tr>
<tr>
<td>STP</td>
<td>Surgical Transformation Project</td>
</tr>
<tr>
<td>T&amp;D</td>
<td>Training and Development</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

What is this report about?

This report documents an independent evaluation of the Chris Hani Baragwanath Hospital Transformation Project that was commissioned by the Project and funded by the Friedrich Ebert Stiftung and the Development Bank of Southern Africa.

The Transformation Project was coordinated by the National Labour and Economic Development Institute (NALEDI), a think-tank of the Confederation of South African Trade Unions (COSATU), in conjunction with the Head of Surgery. It was implemented in the Surgery Division which was intended as a pilot site prior to roll-out to the rest of hospital.

The Transformation Project was carried out in response to a Gauteng Department of Health tender. Officially the Project lasted from August 2006 to January 2008. However, the Project grew out of many years of research and debate, starting in the late 1990s, while several of the Project’s interventions were only implemented in the course of 2008 and 2009. This evaluation therefore reflects on the whole period from the late 1990s to August 2009 when the last consultant stopped working on the Project.

The evaluation itself was undertaken between October 2009 and February 2010. The goal of the evaluation was to derive lessons that may be applied to other settings as well as serve to enhance implementation within the Surgery Division. The objectives were to:

1. detail the conceptual framework underlying the Transformation Project, with a particular focus on showing how management change was intended to lead, through a variety of pathways, to improved patient care, efficiency and labour relations;
2. develop a set of preliminary indicators of successful change;
3. assess progress against these indicators;
4. identify factors that explain progress (or lack of progress); and
5. develop lessons and recommendations to inform further implementation.

The evaluation drew from, and built on, earlier assessments of the Project’s progress to provide a more detailed account of the Projects’ activities, achievements and weaknesses. Given the amount of money and effort invested in the Project, it is essential to document the experience of the Project – both positive and negative – so that it is available to a wider audience. Within South Africa, management transformation of public hospitals is again high on the policy agenda as a result of discussions around National Health Insurance. Internationally, case studies are sorely needed on management transformation in the public sectors of low- and middle-income settings.

What methodology did the evaluation use?

The evaluation was a rapid assessment that used a qualitative approach. It reviewed existing documentation and conducted 13 key informant interviews with designers of the Project, senior managers within the Division responsible for implementation as well as external commentators.

The evaluator had also wanted to interview senior hospital managers and heads of other clinical departments as well as conduct focus group discussions with Divisional shop stewards, nurses and
doctors, but was not allowed to do so by senior hospital management. This is unfortunate because the evaluator was not able to test the findings generated by the initial round of interviews against the viewpoints of several other stakeholders. However, the interviews with external commentators, as well as views captured in an earlier independent evaluation by Khalvest Consulting, enabled the evaluator to capture alternative viewpoints that explain some of the tensions that surround the Project. Hopefully, stakeholders who have not been able to contribute to the evaluation to date will feel able to comment on this report.

**What problems was the Transformation Project trying to solve?**

*Figure A* presents the Project’s analysis of how the chronic problems besting Chris Hani Baragwanath Hospital led to the management crisis it experienced in the 1990s, with dire consequences for efficiency, staff morale and patient care. In some ways these problems were typical of many public hospitals in South Africa that have suffered from underfunding, understaffing and ineffectual management systems. In other ways these problems were peculiar to the hospital because of its enormous size (3,000 beds), history of conflict and iconic status during the apartheid era.

The Project set out to reconfigure management systems within the Surgery Division and populate a new organogramme with skilled managerial and administrative staff. As one commentator said, the Project’s new management structure was ‘very innovative in design’. The ultimate objective was to address the problems of the past and improve efficiency, staff morale and the quality of patient care.

**What principles guided the Project?**

1. **Decentralisation:** A central tenet of the Project was that substantial managerial authority should be decentralised first to the hospital CEO and then to the Head of Division. Under the Head of Division is a flattened hierarchy of one or two levels (on the nursing, medical and administrative sides), each enjoying decentralised authority and accountability for a set of operational matters. This allows rapid decision-making that is responsive to the needs on the ground. Under this model, central hospital management relinquishes control of operational matters in order to focus on policy, strategy, resource allocation, support and monitoring and evaluation.

2. **Clinician leadership:** Crucial to achieving the objectives of management transformation, in the view of the Project, is that leadership of the Division should be invested in a practising clinician. The role of the Head of the Division is to provide leadership and assume accountability for the Division, rather than to be an administrator. Administrative competency is provided by a strong, integrated management team that supports the Head. A Divisional manager, called the Systems Manager, is responsible for coordinating the daily activities of the Division.

3. **Integration:** Each manager (nursing, medical and administrative) should report to the Head of the Division, rather than their counterparts in central hospital management. They should also work cooperatively in joint committees. This breaks the pattern of working in silos and integrates all functions under the leadership of one person, the Head, who then reports to the CEO. Likewise, in the wards, the ward managers (called ‘Unit Managers’ by the Project) assume full responsibility for coordinating activities with the wards, from those carried out by cleaners to those carried out by doctors.
Figure A: The Project's conceptual framework of problems besetting CHB Hospital

**OUTDATED MANAGEMENT STRUCTURE AND STYLE**
- Authority overly centralized in Provincial DOH and Hospital CEO
- Traditional management structure of working in silos (i.e. by profession and department)
- Bureaucratic culture focused on administrative goals rather than health outcomes
- Management through directives (i.e. ‘commandism’)

**MANAGEMENT VACUUUM**
- Fragmented management structure
- Insufficient delegation to operational level
- Blurred and ambiguous lines of authority and accountability
- No locus of control for decision-making
- Poor management systems
- Stifling of innovation and risk-taking
- Lack of coordination and cooperation
- Poor communication
- Focus on rules and regulations rather than people and systems
- Disempowerment of managers

**INEFFICIENCY**
- Inability to hire and fire staff
- Doctors and nurses working independently
- Wards dirty because nurses unable to supervise cleaners
- External providers not paid on time
- Breakdown in supply chains
- Cancellation of operations because of problems in Theatre
- Squandering of resources
- Ineffectual discipline

**POOR ACCESS TO CARE**
- Beds full due to inappropriately long lengths of stay

**POOR STAFF MORALE**
- Frustration and demotivation
- Poor interpersonal relationships
- Insubordination, theft, drunkenness on duty, absence without leave etc.
- Labour unrest

**POOR HEALTH OUTCOMES**
- Avoidable deaths and illness

**POOR QUALITY OF CARE**
- Delayed care
- Inappropriate care
- Unhygienic conditions
- Hospital-acquired complications
- Lack of privacy
- Patients not treated with dignity

**UNDER-RESOURCING**
- Under-funding
- Under-staffing, including too few managers
- Lack of investment in staff development, including...
4. **Reorientation of management towards patient care:** The rationale behind decentralisation, clinician leadership and integration is to reorient and enable decision-making in the service of patient care. Apart from having a clinician leader, a re-orientation towards patient care is effected by bringing administrative staff into close contact with the process of health care delivery, through participation in committees that include health professionals and by sending administrators out to the wards.

5. **Increased resources and skills:** The Project argued that the hospital is under-staffed not only in terms of clinical staff but also in terms of skilled managers. The Project highlighted the fact that the Surgery Division, which has almost 800 beds is, in itself, the size of a large regional hospital and almost the size of Johannesburg Hospital: this in itself justifies a substantial management team.

**What management structures and systems did the Project put in place?**

*Table A* shows the broad steps the Project took in setting in place new management structures and systems (considerably more detail is presented in the main report). The Table also indicates which steps were fully achieved (✓), partially achieved (±) or not achieved at all (✗). The latter two categories resulted because funding and delegations promised by the Gauteng Department of Health and the hospital did not materialize. The biggest blow to the Project was that the first new managers were only appointed one year into the life of the Project (rather than close to the start as initially intended): this threw out the timetable for implementation completely. Equally problematic for the Project was that these staff were appointed from the hospital budget rather than an extra-budgetary source as originally promised: this had repercussions for the rest of the hospital and jeopardized trust in the Project that had been built up over the several preceding years.

Nonetheless, the Project eventually managed to implement most of its model, barring greater financial delegations and implementation of a fully functional information system (for financial, human resource and health-related data). Plans to create a Surgical Pharmacy were shelved by a decision of the then CEO.

The elements of the management model that are controversial in some quarters are:

1. having a practicing clinician – rather than a senior bureaucrat - as the head of the Division; and
2. making the managers in charge of nursing, finance, human resources and systems management accountable to the Head of Division rather than their counterparts in the central hospital administration.

These two changes challenge the traditional style of managing public hospitals in South Africa but the designers and implementers of the Project argue that they are absolutely critical to the achievement of the Project’s objectives. The Project was mandated to implement these changes through the Gauteng Department of Health who awarded the tender and by the MECs who championed the Project. Nonetheless, they seem to lie at the heart of resistance to the Project by some senior hospital managers.
Table A: Summary of the activities undertaken by the Transformation Project

<table>
<thead>
<tr>
<th>OVERALL STRUCTURE AND MANAGEMENT OF SURGERY DIVISION</th>
<th>NURSING MANAGEMENT</th>
<th>MEDICAL MANAGEMENT</th>
<th>HUMAN RESOURCES MANAGEMENT</th>
<th>FINANCIAL MANAGEMENT</th>
<th>SYSTEMS MANAGEMENT</th>
<th>SURGICAL PHARMACY</th>
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<tbody>
<tr>
<td>Development of new management model based on situation analysis</td>
<td>✓ Creation of new Nursing management structure plus appointments</td>
<td>✓ Integration of Surgical specialties under Head of Division</td>
<td>✓ Creation of HR Management Section within Surgical Division plus appointments</td>
<td>✓ Creation of Financial Management Section within Division plus appointments</td>
<td>✓ Creation of Systems Management Section plus appointments</td>
<td>✓ Development of policies &amp; plans</td>
</tr>
<tr>
<td>Negotiation of appropriate delegations and lines of accountability for Head of Division and heads of sections</td>
<td>✓ Transformation of Nursing management approach with flattened hierarchy</td>
<td>✓ Institution of regular review of morbidity and mortality</td>
<td>✓ Transformation of HR management approach with flattened structure &amp; culture of service to health workers</td>
<td>✓ Negotiation of financial delegations to Division</td>
<td>✓ Creation of Communications sub-department and development of policies, hardware and networks</td>
<td>± Implementation of plans</td>
</tr>
<tr>
<td>Creation of new organisational structure with new job descriptions</td>
<td>✓ Empowering of unit managers, including skills development</td>
<td>✓ Action to address problems of clinical organisation, incl. creation of Trauma Unit</td>
<td>✓ Development of needs-based staff establishment for Division</td>
<td>± Transformation of financial management approach</td>
<td>✓ Creation of logistics sub-department to manage facilities &amp; assets &amp; liaise with Public Works</td>
<td>±</td>
</tr>
<tr>
<td>Appointment of managerial and administrative staff</td>
<td>✓ Development of Standard Operating Procedures</td>
<td>✓ Formal engagement between nursing and medical staff</td>
<td>✓ Recruiting and retention of high calibre managers for the Division</td>
<td>✓ Development of zero-based budget system</td>
<td>± Creation of procurement sub-department for supply-chain management</td>
<td>✓</td>
</tr>
<tr>
<td>Implementation of new management committees with clear roles and responsibilities</td>
<td>✓ Implementation of specific processes to improve patient care</td>
<td>✓ Improved salaries administration for Division</td>
<td>✓ Monitoring of expenditure against projected budget</td>
<td>± Creation of Information Technology sub-department</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Relocation of clinical, nursing &amp; support functions into offices near surgical wards</td>
<td>✓ Improved liaison between doctors and nurses</td>
<td>✓ Improved handling of queries about conditions of employment</td>
<td>✓ Development of Debtors’ System to recoup user fees</td>
<td>✓ Coordination &amp; monitoring of different Sections within the Division</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Establishment of Linen Management Committee to develop linen policies</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Improved performance assessment</td>
<td>✓ Cost Centre Accounting System</td>
<td>✓ Development of service level agreements with internal entities and external agencies</td>
<td>✓</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Skills development and career pathing</td>
<td>± Procurement and supplier payment system, including big-ticket items</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved labour relations, including disciplinary process</td>
<td>✓</td>
<td></td>
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viii
What are the outcomes of the Project?

The left-hand column of Table B lists the achievements of the Project that can be characterized as ‘intermediate outcomes’ (i.e. those that contribute to improved management effectiveness). The remaining two columns show how these interventions resulted in the ‘final outcomes’ of improved efficiency and staff morale. The Table shows that the Project has made significant advances on a host of issues, especially if one keeps in mind the extremely difficult context in which the hospital operates (see, for example, Box A and Box B).

Box A: Examples of improvements in efficiency

- The time it takes to appoint a new staff member after identifying a need has been reduced to 2 months (as opposed to 4 months or longer).
- Documents received by Human Resources section are now processed within 24 hours whereas before there were lengthy delays.
- Most suppliers are paid within 30 days, unlike other parts of the health system where suppliers can wait for months and then refuse to deliver.
- The number of queries around conditions of employment has dropped by around 65%.

Box B: Examples of improvements in staff morale

- 88% of staff feel they have a positive relationship with co-workers
- 79% of staff feel that they regularly share and exchange ideas
- 79% of employees feel that they work together as a team

Source: (Khalvest Consulting 2009)

Some of these achievements introduced new capabilities into the Surgery Division (such as joint budget planning between clinicians and financial managers) while some restored practices that eroded long ago (such as joint ward rounds between doctors and nurses). There seems to be a new spirit of collegiality: as an administrator commented in relation to working with doctors, ‘We are seen here ... I feel much better respected but the feeling is mutual.’ A nurse noted that, ‘It is a nice feeling. I look forward to coming to work.’ Very striking is the close cooperation between management and unions. As one manager said, ‘It’s worked fantastically. I mean, the cooperation here from NEHAWU and these other unions has been amazing because they’re now partners in a small group of people who know each other and can actually talk to each other and resolve issues.’ A trade unionist confirmed that ‘There is in fact a completely new level of trust, cooperation and respect.’

Critics of the Project argue, however, that these achievements followed simply from the injection of resources rather than from transformed management systems and leadership style. This evaluator assesses that, although additional resources are clearly a contributing factor, it is unlikely that they explain the full extent of the changes experienced by the Division.
**Table B: Improved management effectiveness, efficiency and staff morale**

<table>
<thead>
<tr>
<th>INTERMEDIATE OUTCOMES:</th>
<th>FINAL OUTCOME:</th>
<th>FINAL OUTCOME:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IMPROVED MANAGEMENT EFFECTIVENESS</strong></td>
<td><strong>IMPROVED EFFICIENCY</strong></td>
<td><strong>IMPROVED STAFF MORALE</strong></td>
</tr>
<tr>
<td>Greater understanding of management strategies to address inefficiency, poor staff morale and poor quality of care</td>
<td>Reduced bureaucracy, freeing staff to focus on management</td>
<td>Improved competency of managers in managing the staff under them</td>
</tr>
<tr>
<td>Dismantling of inefficient silo structures</td>
<td>Improved liaison with wards</td>
<td>Good communication with staff and participatory, user-friendly management style</td>
</tr>
<tr>
<td>Integration of all functions through joint committees</td>
<td>Early identification of critical events and ability to respond rapidly</td>
<td>Increased support and supervision of (including staff development)</td>
</tr>
<tr>
<td>Decentralisation of decision-making authority to the appropriate level</td>
<td>Alleviation of administrative burden on CEO and central hospital management</td>
<td>Better understanding of the needs of Division employees</td>
</tr>
<tr>
<td>Creation of clear, single lines of accountability, culminating in the Head of Division</td>
<td>Direct communication with GSCC</td>
<td>Reduction of frustration, miscommunication and delays</td>
</tr>
<tr>
<td>Strengthening of the management team, both in terms of size and skills (and including provision of strong administrative support to the Head)</td>
<td><strong>Human resources management</strong></td>
<td>Rapid filling of posts</td>
</tr>
<tr>
<td>Greater clarity on roles and responsibilities, together with the development of management guidelines</td>
<td>Overall time between identifying need for more staff to hiring reduced from 4 months or more to 2 months</td>
<td>Better staffing of wards</td>
</tr>
<tr>
<td>Improved monitoring, supervision and support systems</td>
<td>Staff employed within 10 days of interviewing them</td>
<td>Managers of wards empowered to coordinate activities of all staff in ward, including acting against poor quality care</td>
</tr>
<tr>
<td>Team-building and participatory management techniques</td>
<td>In ward, dynamic daily adjustment of staffing according to bed needs</td>
<td>Improved career paths for nurses</td>
</tr>
<tr>
<td>Increased professionalism of managerial and administrative staff</td>
<td>Almost 100% compliance with performance assessment requirements</td>
<td>Improved pride in the ward and sense of motivation</td>
</tr>
<tr>
<td>Greater accessibility of managers to other staff, especially those directly involved in patient care</td>
<td>Accurate salary payment</td>
<td>Clear mechanisms for engagement with unions</td>
</tr>
<tr>
<td>Improved communication and trust between managers and clinical staff, between different types of health professional and between the Division and external agencies (e.g. Public Works, GSCC)</td>
<td>Pay-slips delivered to ward (staff do not need to leave the ward to collect them)</td>
<td>Rapid responses to complaints by staff (and elimination of historical backlogs)</td>
</tr>
<tr>
<td>Reduction of miscommunication and delays</td>
<td>Reduction of queries made by staff by 65%</td>
<td>Culture of improved discipline</td>
</tr>
<tr>
<td>Improved co-ordination and responsiveness to problems, including the fostering of innovative solutions</td>
<td>Culture of improved discipline within the Division</td>
<td>Management seen to act against wrong-doers fairly and swiftly</td>
</tr>
<tr>
<td>Reorientation of management systems to support the achievement of quality care</td>
<td>Elimination of historical backlog of labour relations queries/grievances</td>
<td>Noticeable improvement in nursing morale</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>Current grievances dealt with immediately (usually within a few days)</td>
<td></td>
</tr>
</tbody>
</table>
Critics also contest whether there has been an improvement in the third ‘final outcome’ - improved quality of care - especially as the Division is unable to produce statistics supporting their claims. It is indeed a weakness of the Project that it was not able to get an information system up and running that was able to measure the Project’s impact in quantifiable terms. However, Project designers and implementers are adamant that quality has improved through the many interventions they have put in place (see Box C). The link between these interventions and improved quality of care seems plausible. As one nurse said, ‘if there had not been this Project, things would have blown out’. As a result of improvements, the Division is now seen as a very good training environment for medical students and registrars.

**Box C: Strategies to improve the quality of care**

- unlike in the past, getting doctors and nurses to do ward rounds together so that instructions for patient care are clear and good communication is fostered - this is supplemented by other practices that encourage a team-based approach;
- ensuring that instructions for patient care are carried out by creating clear lines of accountability for all nursing staff, with final accountability for the ward resting with the Unit Manager;
- through the same strategy, improving pride in the ward and motivation;
- clarifying standards of patient care including the development of Standard Operating Procedures that guide nursing staff and have their buy-in - this is especially important now that there are more enrolled than professional nurses in the wards;
- more rapid and innovative solutions to problems of clinical organisation, including improved cooperation between sub-specialties and between Surgery and Theatre;
- empowering nurse managers to solve patient care problems themselves and raise concerns about medical care and ethical issues;
- identifying instances of poor patient care and implementing remedial action, including formal, regular reviews by doctors and nurses of adverse incidents;
- implementing a system in the general and Trauma wards whereby a consultant is permanently on-call for intakes (this is an unusual arrangement in South Africa);
- creating a high care Trauma Unit within the Division so that these patients can receive more intense care (one nurse cares for one patient, rather than the more usual ratio of one to five or six);
- responding rapidly to concerns raised by patients and their families;
- improving the hygiene of the environment by keeping wards clean, attending to leaking toilets and ensuring that paper towels and disinfectant are available in the wards for cleaning hands;
- ensuring that supplies and equipment are ordered and received promptly;
- improving staffing levels, including filling vacant posts rapidly;
- interviewing staff for specific posts so that staff are able to choose jobs that they find interesting and are committed to; and
- freeing staff from administrative burdens so that they have more time to spend at the bedside.

*What features of the implementation process accounted for success?*

The achievements described above resulted in part from the management model adopted by the Transformation Project (i.e. what was done). In part they were also due to the Project’s particular style of implementation (i.e. how it was done). This style is in itself innovative and includes:

- **building broad-based consensus** at the hospital around the need for transformation through intensive engagement with all categories of health worker, especially in the early days of the Project;
- **providing strong and consistent leadership** in the form of the main NALEDI consultants, the Head of the Surgery Division and, for a time, one of the CEOs who acted as a champion for the Project;

- **involving organized labour in an integral way** so that, within the hospital, human resource management decisions were approved and conflict was avoided while, outside the hospital, unions’ political clout was brought to bear in accessing funding for the Project;

- **empowering Divisional managers** through mentorship and real (as opposed to notional) inclusion in decision-making processes so that they were able to become agents for change;

- **making management accessible to health workers**, both literally (through offices being located next to wards and managers making it a practice to visit the wards) and figuratively (through building trust and placing management at the service of patient care);

- **engaging in a slow, thorough process** so that the innovations introduced are accepted, understood and embedded in the new management system.

These strategies were particularly successful within the Division and, in terms of the rest of the hospital, during the early stages of the Project.

**What factors constrained the progress of the Project?**

During its lifespan the Project faced a number of severe obstacles, chief amongst which are:

- **the failure of funding and other resources to materialize**, contrary to promises made by the Gauteng Department of Health at the start of the Project: this made it difficult for the Project to achieve all its objectives, delayed implementation for a year or more and eroded the hospital-wide support that had been nurtured by NALEDI during the build-up to the Project;

- **faltering oversight of the Project by senior provincial and hospital managers** which was aggravated by the high turnover of MECS, hospital CEOs and senior hospital administrators: this meant that there was not a clear process for monitoring the Project’s progress, managing debate within the hospital and province around lessons learned, and planning a clear process for roll-out of relevant aspects of the Project;

- **resistance to decentralization** of authority to the Divisional level and the breaking up of silos: this was probably partly born out of bureaucratic constraints placed on senior managers by the Department of Public Service and Administration and the Public Finance Management Act and lack of clarity on the roles and accountability of senior hospital administrators in the face of decentralization; importantly, though, the new management model also challenged the power base of senior hospital managers, sparking resentment that was aggravated by personality clashes with Project leaders;

- **declining vigour of the consultative process within the hospital** as the Project became absorbed in the nitty-gritty of implementation; and
• the inability of the Project to sustain a lasting coalition of allies who could push through change: in particular, the CEO who was the main champion of the Project was redeployed at a critical point in the Project’s development.

As a consequence of these constraining factors, the Project has become increasingly embattled. This has placed in jeopardy full implementation of transformed management systems within the Division as well as roll-out to the rest of the hospital.

**How much would roll-out of the Project to the rest of the hospital cost?**

In 2008 NALEDI proposed that, over the next three years, the Project model be rolled out to each of the remaining three clinical divisions in sequence (i.e. the Clinical Support, Women and Child, and Medical Divisions). The Non-Clinical Support Division would be rolled out concurrently over these three years. For each of the divisions, additional managerial and administrative staff costs per annum would amount to R9.7 million in 2009 prices. Once-off costs – for refurbishment of facilities, purchase of office equipment and installation of computer systems etc. - would be R11.6 million for each of the four divisions. If a proper pharmacy service were to be provided, the annual additional cost per clinical division would be R4.8 million (again, this cost could be partially offset against vacant pharmacist posts in the central pharmacy, only 25 percent of these posts being filled at any one time). Over the three-year period of roll-out, it was suggested that external consultancy support would be needed, costing R5.8 million per year (in 2009 prices).

In considering these costs it is important to remember that:

- Chris Hani Baragwanath Hospital is generally severely underfunded and understaffed as a result of apartheid era practices - even so, the new proposed cost per bed at the hospital will still be far less than the cost of a bed at Johannesburg Hospital;

- the Divisions are very large, practically the size of regional hospitals in themselves;

- roll-out should reduce the burden on the Gauteng Shared Service Centre substantially and therefore cut costs at that level;

- roll-out could possibly be made cheaper by appointing staff at a lower level than the pilot because systems have already been established (provided these staff were provided with initial support, possibly from Surgery Division managers); and

- efficiencies introduced by the new model saves costs and also improves the quality of care - it is impossible to measure this in monetary terms.

With respect to whether provision needs to be made for external expertise to support further implementation and roll-out, the Surgery Division Head reflects that it would have been extremely difficult to effect such substantial management change in his Division without such support. This is because of the enormous workloads faced by managers within the public system which makes it difficult for them to engage in activities directed at longer-term goals. Expertise in change
management would certainly be useful to facilitate constructive engagement with stakeholders, especially those to whom management transformation poses a threat.

**What should the next steps be?**

A lot of money and effort has been invested in the Transformation Project. It has introduced a management system and style that is innovative in the context of the South African public hospital sector. There are some concerns around elements of the Project’s design and process of implementation. However, there is enough evidence that the Project has impacted favourably on efficiency, staff morale and the quality of care to warrant the Provincial Department of Health and the hospital embarking on a structured process to examine the lessons for roll-out of management reform to other parts of the hospital or other hospitals. For this, it is important to:

1. restore the relationship between the Project, central hospital management and provincial management;
2. clarify the roles of senior hospital administrators in the context of decentralisation of operational responsibility to Divisions;
3. reinvigorate the consultative process; and
4. develop a methodology for monitoring the impact of management reform on efficiency, staff morale and the quality of care, using both quantitative and qualitative approaches.
1. Introduction

This report documents an independent evaluation of the Chris Hani Baragwanath Hospital Transformation Project that was undertaken between October 2009 and February 2010. The evaluation was commissioned by the Project and funded jointly by the Friedrich Ebert Foundation and the Development Bank of Southern Africa. It was conducted by Jane Doherty, an independent health systems and policy researcher (see abbreviated curriculum vitae in Appendix A).

The overall goal of the evaluation is to derive lessons from the Transformation Project that may be applied to other settings as well as enhance implementation within the Surgery Division which serves as the pilot site for the Project.

The overall objectives of the evaluation are to:

1. detail the conceptual framework underlying the Transformation Project, with a particular focus on showing how management change was intended to lead, through a variety of pathways, to improved patient care, efficiency and staff morale;
2. develop a set of preliminary indicators of successful change;
3. assess progress against these indicators;
4. identify factors that explain progress (or lack of progress); and
5. develop lessons and recommendations to inform further implementation.

In agreeing the brief for the evaluator, the Project made it clear that the evaluation should be independent and impartial: the evaluator has tried, as far as possible, to reflect the views of all stakeholders.

The evaluation draws from, and builds on, earlier formal assessments of the Project’s progress, namely:

1. a self-assessment in June 2008 by the consultants supporting implementation (NALEDI 2008) and by the Surgery Division in August 2009 (Surgical Division 2009);
2. an evaluation in March 2009 by external evaluators commissioned by the Gauteng MEC for Health (Khalvest Consulting 2009); and
3. a presentation by senior hospital management at a hospital-wide Transformation Forum meeting on 16 July 2009 (Billa 2009).
Given these earlier assessments, why is a further evaluation necessary? Table 1 compares the earlier assessments in terms of their approach, main findings and limitations. While all sources contribute towards an understanding of the Project, the Table shows that, as a whole, they do not provide sufficient detail for people outside the implementation team to get a good grasp on the actual activities that make up the transformation process, as well as the strengths, weaknesses and implications of the Project. In addition, none of the sources makes explicit the reasons for conflict between some of the different stakeholders involved in the Project and how this conflict affects interpretation of the Project’s impact.

Table 1: Previous evaluations of Chris Hani Baragwanath Hospital Transformation Project

<table>
<thead>
<tr>
<th>Methodology</th>
<th>FINAL REPORT BY NALEDI TO MEC (June 2008); SURGERY DIVISION SWOT ANALYSIS (August 2009)</th>
<th>EVALUATION BY KHALVEST CONSULTING (March 2009)</th>
<th>PRESENTATIONS BY STAKEHOLDERS AT HOSPITAL-WIDE MEETING (July 2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• reflected on own experience</td>
<td>• conducted key informant interviews and conducted a survey of all categories of Surgery Division staff (in November 2008)</td>
<td>• range of presentations by key stakeholders</td>
</tr>
<tr>
<td>Main findings</td>
<td>• noted severe obstacles faced by Project</td>
<td>• noted high staff satisfaction</td>
<td>• the evaluator was not present at this meeting and could only draw on one presentation that was produced in written form</td>
</tr>
<tr>
<td></td>
<td>• described main achievements</td>
<td>• criticised NALEDI quite strongly for the slow pace of implementation and for not writing up a ‘blue-print’ for the Project</td>
<td>• this noted problems with the engagement of the Project with senior management, as well as concerns with the cost of the Project and lack of outcome measures</td>
</tr>
<tr>
<td></td>
<td>• assessed progress against initial objectives in contract</td>
<td>• acknowledged that the necessary support, cooperation and resources had not been forthcoming from the Gauteng Department of Health and the central administration of the hospital</td>
<td>• urged that the Project continue (but not under the leadership of NALEDI) and that more resources be made available</td>
</tr>
<tr>
<td>Main limitations</td>
<td>• represented the view of the designers only</td>
<td>• provided little detail on the actual activities of the Project</td>
<td>• conclusions were not written up in a consolidated format</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• did not explain what led to the high staff satisfaction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• designers of the Project did not feel that their perspective was represented in the report</td>
<td></td>
</tr>
</tbody>
</table>

Sources: (NALEDI 2008; Billa 2009; Khalvest Consulting 2009; Surgical Division 2009)

This evaluation therefore collates pre-existing information, addresses some gaps, makes explicit differences of opinion and draws out lessons for this and other settings. Given the amount of money and effort invested in the Project, it is essential to document in sufficient detail the experience of the Project – both positive and negative – so that it is available to a wider audience. Within South Africa management transformation of public hospitals is again high on the policy agenda as a result of discussions around National Health Insurance. Internationally case studies are sorely needed on management transformation in low- and middle-income settings.

Strictly speaking, this report assesses a particular time period, starting in August 2006 and ending roughly in February 2008: this was the period of intense implementation of management transformation in the Surgical Division through a tender that was won by NALEDI. However, the
Project was the culmination of many years of research and debate, starting in the late 1990s, while several of the Project’s interventions were only implemented in the course of 2008 and 2009, for reasons discussed later. In the minds of key informants, these periods are not strictly delimited, especially as events before and after the formal tender have a major bearing on the perceived impact of the project. This report therefore reflects on the whole period from the late 1990s to August 2009, at which time the Head of the Surgery Division went on sabbatical and the last NALEDI consultant stopped work at the hospital. Beyond this period the acting CEO – who was appointed CEO at the beginning of 2010 - appears to have chosen not to continue with the Project or replicate it in other parts of the hospital. Even during the study period, different circumstances prevailed at different times (for example, senior hospital managers came and went, influencing the project in different ways): this report tries to differentiate these changing influences.

2. Methodology

2.1. Study design

The evaluation was a rapid assessment that used a qualitative approach. The assessment was intended to be made up of several parts (see Table 2). Unfortunately only Parts I to IV – which deal mainly with the viewpoints of the designers and implementers of the Project - could be fully implemented. This was because the senior management of the hospital expressed unhappiness with the evaluation, seemingly because of suspicions regarding the motivations underlying the evaluation. The evaluator was therefore not allowed to conduct interviews and focus groups with hospital stakeholders beyond the designers and implementers of the Project. This is unfortunate because, as a consequence, the evaluator was not able to test fully the findings generated by the initial round of interviews against the viewpoints of several other stakeholders (as intended in Part V). However, interviews were conducted with some external commentators who had worked in government previously and have an intimate knowledge of the Project, while some of the earlier evaluations referenced in Table 1 relay certain stakeholder positions: these sources enabled the evaluator to capture alternative viewpoints that explain some of the tensions that surround the Project and provide valuable lessons for people working in other settings. The evaluator would welcome stakeholders who have not been able to contribute to the evaluation commenting on this report.

Key informants were originally selected through a process of identifying key stakeholders and prioritising those stakeholders who were most intimately involved in the Project or on whom there would have been the most direct impacts. Not all stakeholders could be selected because of considerable resource and time constraints. Representatives of selected stakeholder groups were identified through a ‘snow-balling’ process. That is, initial key informants were asked to identify other individuals who they thought could contribute meaningfully to the evaluation. Table 3 summarises this process and indicates which stakeholder groups are represented in the present version of this report.
In the end, 13 individuals were interviewed. Before each interview, the evaluator explained the purpose of the evaluation, emphasising that the aim was to develop constructive recommendations. Interviews were voluntary. Notes were taken or, where key informants were comfortable, a tape recording was made: this was later transcribed. The evaluator assured key informants that their names or other identifying features would not be reported or associated with any information in order to preserve anonymity.

Table 2: Component parts of this evaluation

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part I</td>
<td>Reviewing and summarising documents from the Transformation Project itself and on hospital management in South Africa, where relevant</td>
</tr>
<tr>
<td>Part II</td>
<td>Conducting semi-structured interviews with key informants who were responsible for designing and implementing the Transformation Project.</td>
</tr>
<tr>
<td>Part III</td>
<td>Based on the findings of Parts I and II, presenting a detailed conceptual framework that shows how the management transformation activities of the Project are intended to lead, through a variety of pathways, to improved patient care.</td>
</tr>
<tr>
<td>Part IV</td>
<td>Based on the findings of Parts I and II, assessing the extent to which these activities have been achieved (from the perspective of designers and implementers) and identifying facilitating and constraining factors.</td>
</tr>
<tr>
<td>Part V</td>
<td>Conducting semi-structured interviews with key informants who were impacted upon by the project (i.e. stakeholders within the hospital and from provincial structures).</td>
</tr>
<tr>
<td>Part VI</td>
<td>Based on the findings of Part V, modifying or adding to the findings generated in Part IV.</td>
</tr>
</tbody>
</table>
| Part VII  | Peer reviewing findings through two processes:  
- engaging the services of a senior hospital management consultant to review the conceptual framework, indicators and lessons; and  
- presenting the findings at a workshop that involves senior managers and policy-makers, with a particular focus on debating contentious issues. |

Table 3: Stakeholders relevant to the Transformation Project

<table>
<thead>
<tr>
<th>ACTOR</th>
<th>IDENTIFIED FOR INTERVIEW (I) OR FOCUS GROUP (FG)?</th>
<th>INTERVIEW OR FOCUS GROUP CARRIED OUT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>National and Provincial political structures</td>
<td>No: Resource constraints prevented interviewing these stakeholders, even though MECs were highly influential with respect to the Project</td>
<td>not applicable</td>
</tr>
<tr>
<td>- National political structures (senior ANC and trade union leadership (especially NEHAWU), Cabinet, Office of the Presidency)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Former and current Provincial MECs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Provincial Portfolio Committee on Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National and Provincial executive structures</td>
<td>No: Did not seem to be involved in any integral way in the Project although has interest in decentralisation and transformation of hospital management</td>
<td>not applicable</td>
</tr>
<tr>
<td>- National Department of Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Provincial Department of Health</td>
<td>Yes (I): Critical to get input of Head of Department as well as others engaging with the hospital and the Project, given the potential impact of the Project on the achievement of the Province’s objectives</td>
<td>No: Did not pursue because of unhappiness with evaluation amongst senior hospital management</td>
</tr>
</tbody>
</table>
## Hospital stakeholders

<table>
<thead>
<tr>
<th>Hospital stakeholder</th>
<th>Response</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Board</td>
<td>Yes (!)</td>
<td>Critical to get input, given the potential impact of the Project on the achievement of the Hospital’s objectives</td>
</tr>
<tr>
<td>Hospital CEO</td>
<td>No</td>
<td>Did not pursue because of unhappiness with evaluation amongst senior hospital management</td>
</tr>
<tr>
<td>Senior hospital administrators</td>
<td>Yes (!)</td>
<td>Key designer and implementer of Project</td>
</tr>
<tr>
<td>Clinical directors</td>
<td>Yes (FG)</td>
<td>Critical to get input from this group because their role and status is changed considerably by the Project model</td>
</tr>
<tr>
<td>Head of Surgery Division</td>
<td>No</td>
<td>Did not pursue because of unhappiness with evaluation amongst senior hospital management</td>
</tr>
<tr>
<td>Senior Divisional administrators (i.e. Nursing, Medical, Human Resource, Finance, Systems)</td>
<td>Yes (!)</td>
<td>Key implementers of Project</td>
</tr>
<tr>
<td>Divisional Nursing staff</td>
<td>Yes (FG)</td>
<td>Critical to understand impact of Project on this group</td>
</tr>
<tr>
<td>Divisional Medical staff</td>
<td>No</td>
<td>Did not pursue because of unhappiness with evaluation amongst senior hospital management</td>
</tr>
<tr>
<td>Other Divisions (Divisions closely linked to Surgery in terms of providing clinical support services (Anaesthesiology &amp; Theatre, ICU, Radiology); other major Divisions (e.g. Medicine))</td>
<td>No</td>
<td>Did not pursue because of unhappiness with evaluation amongst senior hospital management</td>
</tr>
<tr>
<td>Trade unions at hospital level (especially NEHAWU)</td>
<td>No</td>
<td>Did not pursue because of unhappiness with evaluation amongst senior hospital management</td>
</tr>
<tr>
<td>Patients</td>
<td>No</td>
<td>Resource and methodological constraints prevented surveying this level</td>
</tr>
</tbody>
</table>

**OTHER**

| Former government employees with in-depth knowledge of the Project | Yes       |

### 2.2. Analysis

This report collates the experience of people familiar with the Project, using thematic content analysis. Key conclusions are corroborated through triangulating data from different sources, including documents and other reports.

Health systems change is a complex process and hence it is difficult to establish causality between an intervention and its impacts (Doherty, Gilson et al. 2006). In a case like this, one could even argue that, just because there had been intensive debate over the last decade around the management problems at CHB Hospital, improvements in management would have ensued to some degree (that is, separately from the direct impacts of the Project itself). To address these difficulties, the analysis looks at what was done by the Project and records people’s admittedly subjective opinion of the impacts of these actions. As discussed later in the report, more objective measures are not readily available at present; in any case, recent literature has shown the value of tapping into the
experience and ‘tacit knowledge’ of implementers (Doherty, Gilson et al. 2006). This is especially important when one wants to understand how change is achieved in order to generate lessons for other contexts. Thus, the report provides ‘stories’ of people’s experience based on detailed quotes. It is hoped that this will make a complex and somewhat opaque process of implementation more ‘visible’ to readers and also provide concrete examples of issues faced by the Project.

In the master version of this report, specific interview codes (01, 02, 03 etc.) are used to reference information and quotes: this is to preserve ‘the chain of evidence.’ However, this version of the report replaces specific codes with broader codes (see Box 1). This is so that a specific quote cannot be associated with a specific management function (e.g. financial management), thereby making it possible to work out the identity of the key informant. This makes it difficult for readers to check whether the full range of key formants has been quoted, or whether the appropriate person has been quoted with respect to a specific management function (e.g. is it a nurse manager who has reflected on nursing morale as opposed to an external consultant?). To address this problem, the evaluator has tried to ensure that information on any one topic is taken from as wide a range of informants as possible (thus, if several quotes in one paragraph have the same code (e.g. ‘D’), this means that several individuals from category ‘D’ have been quoted). In addition, the evaluator has tried to ensure that only people qualified to talk on a certain issue are quoted. Further, a first draft of the report was sent to all key informants for feedback which has subsequently been incorporated.

Box 1: Key for interview codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>'D:'</td>
<td>Designers of the Project (i.e. people who were instrumental in shaping the nature of the Project and providing expert support to implementers): 4 people fell into this category; the NALEDI consultants and Head of the Surgery Division are included in this category</td>
<td>Designers</td>
</tr>
<tr>
<td>'I:'</td>
<td>Implementers of the Project (i.e. senior administrators within the Division): 5 people fell into this category</td>
<td>Implementers</td>
</tr>
<tr>
<td>'C:'</td>
<td>Commentators on the Project (i.e. people who were not directly involved with design and implementation but who knew the Project – and the local health system - well): 4 people fell into this category</td>
<td>Commentators</td>
</tr>
</tbody>
</table>

2.3. Limitations

First, this assessment was performed rapidly and therefore suffers from the limitations associated with time constraints.

Second, as already described, the evaluator was not given access to key stakeholders within the hospital, apart from the designers and implementers of the Project (the latter being the senior managerial staff within the Surgery Division). As the evaluator had very good access to designers and implementers, there is a risk that the experiences of this group predominate in this report. This is especially so as the evaluator judged that implementers might not feel comfortable being taped because of tensions in the wider hospital and so, although some verbatim written notes have been quoted, it is predominantly designers from whom lengthy quotes are available. This set of limitations introduces the problem of bias, especially as all of the designers and implementers...
showed a strong commitment to the model they were implementing and to the leadership of the Project.

The evaluator has attempted to modify this bias by inferring the opinions of senior hospital and provincial managers from what key informants reported and, more importantly, from other sources, especially the Khalvest Report that was conducted by another set of independent evaluators (Khalvest Consulting 2009). Whereas this evaluation draws on as many sources as possible, triangulation of data is more limited than had originally been planned. However, it is the opinion of the evaluator that the commentators interviewed were aware of the main issues that concern senior hospital and provincial managers and other clinical departmental heads and that therefore it has been possible to represent these views to some extent, even though it was not possible to interview these people directly. In particular, the evaluator has been especially careful to reflect negative views emanating from these groups. Where the report does fall short is that it cannot reflect in any depth on the experience of ordinary nurses and doctors working in the wards (although the survey quoted in the Khalvest Consulting report does provide information on staff satisfaction), nor the experience of shop stewards (although one of the key informants is a trade unionist with some relevant knowledge).

Third, due to a number of constraining factors that are detailed later, the Project was not able to implement the final component of its management model. It is therefore not possible to evaluate fully the model on which the Project is based, especially as some of the prerequisites identified by the designers of the model are not yet in place.

Finally, during the course of the evaluation the researcher became aware that one of the reasons for some senior hospital staff (and a couple of the external commentators interviewed) being suspicious of the Project is that all of the consultants who designed the Project (except the expert on unions and labour issues), as well as the Head of the Surgery Division, are white. As discussed later, Chris Hani Baragwanath Hospital has long experienced racial tensions (as well as tensions between different categories of health professional), largely because of its apartheid history. Being white herself, the evaluator understands that this might affect readers’ level of trust in the findings of this report. This loss of trust is difficult to address but the evaluator has tried to do this to some extent by: providing sufficient detail on the content of the Transformation Project to allow readers to form their own opinions; focussing on findings that relate to the appropriateness of the content and the implementation of the Project rather than personality clashes and resentments; and checking findings against those of the Khalvest Report. To the evaluator it is notable that none of the key informants working within the Surgery Division identified race as a problematic issue, although it is impossible to determine whether this was because the race of the Project designers was, for them, truly not an issue or whether these key informants did not feel in a position to reflect on race issues during the interview process.
3. History of the Transformation Project

The intense implementation phase of the Transformation Project began in August 2006: this was the starting date for a tender that was won by a group of consultants, the National Labour and Economic Development Institute (NALEDI). However, the idea for the Project had its roots many years earlier, starting with discussions in the late 1990s. Considerable research and stakeholder engagement occurred before 2006 and was critical in shaping how the project unfolded. This section reflects on this history.

3.1. Identifying Chris Hani Baragwanath Hospital as a site for transformation

One of the defining features of the Transformation Project is that it was initiated by the union movement. This makes it unique in the South African public health sector. As one respondent said, ‘this was a huge strength of the project: so management didn’t need to sell the idea to workers – it was the workers who were selling the idea to management’ (C).

Union engagement began through an initiative of COSATU. COSATU is the most powerful federation of trade unions in South Africa. It is a member of the tri-partite alliance that has won all three of the national elections since the advent of democracy in 1994. In 1997 it set up what became known as ‘the September Commission’ to propose the way forward for trade unions under the new democracy. A chapter of the Commission’s report analysed problems in the public sector and proposed that ‘COSATU should adopt an active strategy for transforming the public sector’ (COSATU 1997: p1). This was not only because the public sector was seen as a major employer and economic force, but because ‘it is where social goods are produced and public rights are exercised’ (COSATU 1997: p2). The Commission argued that unions should be concerned not only with their own bread-and-butter issues, but also with working towards social justice (through a process of what the Commission called ‘social unionism’). This was particularly important as government did not appear to have an effective strategy for achieving institutional change. The Commission’s vision for a transformed public sector appears in Box 2. A commitment by unions to combat corruption and theft in the workplace was identified as part of the commitment to transformation.

Box 2: COSATU’s vision for a transformed public sector

‘The public sector uses public money – it belongs to all citizens. It should be characterised by an ethos of service to the public, of fairness and administrative justice. It should be efficient, transparent and responsive. Achieving these goals requires that public sector workers work in fair, democratic workplaces, with reasonable pay and conditions, with access to training, under effective management.’ (COSATU 1997: p2)

Taking guidance from this position, NEHAWU, one of COSATU’s member unions, put forward Chris Hani Baragwanath Hospital (CHB) as an institution where it could take joint responsibility, with government, for providing leadership and ‘co-managing transformation’ (COSATU 1997: p4). NEHAWU is the National Education, Health and Allied Workers’ Union and is one of the biggest in
the public sector. It had been influential in the September Commission, raising issues around hospital management in the Commission’s chapter on the public sector. Its branch at Chris Hani Baragwanath Hospital in Soweto is a particularly large and influential branch (D) and the shop steward chairperson of this branch had made a visit to Cuba and been inspired by hospital care there (D). The hospital itself had an iconic status, partly because of its massive size of almost 3,000 beds, partly because of the poor care that had prevailed there during the apartheid era and made media headlines, and partly because of its commitment to improving the health of the poor, even under the most difficult of circumstances. As one respondent said, ‘it’s got a strange quality about it of having been an apartheid hospital but having this kind of aura attached to it as well’ (D).

Discussions within NEHAWU led to the development of an early concept paper that identified the challenges faced by the hospital from the point of view of the general workers who make up NEHAWU’s membership (NEHAWU date unknown). The bulk of the paper dealt with labour relations issues and it did not yet present a clear strategy to effect change. Importantly, though, it introduced the notion of a ‘people’s hospital:’ as one informant explained, ‘what they meant by a people’s hospital was a hospital that delivered good services to the community and a hospital that was a good place to work’ (D). It cemented NEHAWU’s position as the key sponsor of the Transformation Project and, in turn, led to the Project becoming one of the main political programmes of the union (D).

3.2. Building consensus on the key challenges facing the hospital
In the mid-1990s, the Hospital Strategy Project had been a major initiative of the National Department of Health to assess the state of South African hospitals and suggest priorities for transformation. This identified five major problems facing hospitals, one of which was poor labour relations policy and management, another of which was over-centralised management at the provincial level which led to ‘severe underdevelopment of management systems, structures and capacity at hospital level, and to a distorted management culture’ (Monitor Company, Health Partners International et al. 1996: pii). Occurring in a context of inadequate funding, these problems ‘resulted in the isolation of both hospital management and workers from policy making and negotiations, and ... created ignorance, a lack of trust, [and] a culture of adversarialism. The overall effect is a cycle of poor labour relations, which overwhelms the machinery set up to deal with these problems, further worsening conflict, morale and productivity’ (Monitor Company, Health Partners International et al. 1996: pii).

This analysis was pertinent to the situation at Chris Hani Baragwanath Hospital where problems with the quality of patient care had led, in the 1990s, to extensive media coverage and public debate. This, together with problems faced by other hospitals in the province of Gauteng, led to the Commission of Inquiry into Hospital Care Practices that was instituted by the Premier of the province. The Commission documented the main complaints made by patients (see Box 3) and identified funding constraints, management problems and staff behaviour as the main underlying problems (Commission of Inquiry into Hospital Care Practices 1999). Other research in Gauteng, funded by the European Union, explored problems in implementing hospital reform, pointing to similar explanatory factors (Stack and Hlela 2002). All these sources highlighted the dire state of human resource management, including labour relations.
NEHAWU’s contribution to these debates between 2000 and 2001 was: first, to link the need for improved patient care at CHB Hospital to the need for improved labour relations; second, to provide the perspective of general workers in a debate that had hitherto been dominated by health professionals; and, third, to bring the other unions represented at the hospital – which had initially been suspicious of a NEHAWU-led initiative (D) - into a broad consensus on the need to transform management at the hospital. To achieve this, NEHAWU had approached NALEDI, COSATU’s think-tank, to assist in identifying priorities for action at CHB Hospital. NALEDI is the National Labour and Economic Development Institute which had, itself, been influential in the September Commission, including involvement in writing the chapter on the public sector. NALEDI had also been involved in the Hospital Strategy Project of 1996. Accordingly, NALEDI conducted many workshops with shop stewards and met frequently with other union staff. This period culminated in an important union workshop which generated a ‘lot of enthusiasm’ (D) and led to an in-principle proposal to embark on management transformation at the hospital.

Box 3: Main complaints by patients at Gauteng hospitals

<table>
<thead>
<tr>
<th>Complaints by Patients at Gauteng Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long waiting times</td>
</tr>
<tr>
<td>Uncaring attitude of staff</td>
</tr>
<tr>
<td>Dirty facilities</td>
</tr>
<tr>
<td>Shortage of linen leading to:</td>
</tr>
<tr>
<td>• cancellation of operations</td>
</tr>
<tr>
<td>• patients using dirty linen</td>
</tr>
<tr>
<td>• patients being requested to bring their own linen</td>
</tr>
<tr>
<td>Poor quality and inadequate quantities of food</td>
</tr>
<tr>
<td>Family members being required to feed and bathe patients</td>
</tr>
<tr>
<td>Long waiting times for medicines (including having to return for a second day)</td>
</tr>
<tr>
<td>Security risks for patients and theft of their belongings</td>
</tr>
<tr>
<td>Poor communication with patients on the part of professional staff and management</td>
</tr>
</tbody>
</table>

Source: (Commission of Inquiry into Hospital Care Practices 1999)

The CEO at that time, Reg Broekman, was responsive to the idea of management transformation and suggested that a pilot should be conducted in the Department of General Surgery. There were several reasons why this department was chosen: first, the wards had just been renovated; second, it was one of the largest sections; and, third, it was headed by Prof. Martin Smith who was ‘dynamic, progressive, had ideas [and] had energy ... Martin was dead keen and he’s got a history that made him very keen on the idea of working with the unions as well’ (D). ‘So the Surgical Division got chosen ... because there was a willing partner,’ said one key informant (D).

In early 2002, NALEDI began an in-depth analysis of the problems experienced by the Department of General Surgery, conducting a series of interviews and focus group discussions with all levels of workers, including nurses. Out of this research – which was in essence a perspective that ‘emerged really from below’ (D) - they developed their key analysis of why health care services were dysfunctional at the hospital: ‘the most striking thing that emerged out of all that was what we called a management vacuum, that there quite literally just wasn’t any management. You know, endlessly people would talk about their problems and there was no-one to solve them, there was no-one to go to. They’d complain to management which is what happened in the admin block, and there would be no solutions’ (D).
This analysis was presented to all the staff in what was to become the Surgical Division. It was well-received by staff. It also challenged unions to think beyond their own more narrow interests: said one respondent, ‘there were issues that were quite difficult for shop stewards, like discipline. And ... they were always fighting for the cleaners not to be managed by the nurses and we said [the opposite]’ (D). At this time the main nursing union, DENOSA, became quite closely involved in conceptualisation of nurse managers’ roles (D). Meetings with the hospital’s leadership were also happening at this stage. As one respondent said, ‘So I think that there was a real sense of it being empowering and it being exciting. You know, there was a kind of energy, in a sense. Because Bara’s always got this feeling that nothing will ever change. And it was a sense that things can change. And I think that’s what also’s kept us there through the years ... and it was also that sense that there was this hope’ (D).

The main causes and consequences of the management vacuum, as analysed by NALEDI, are organised into the conceptual framework presented in Figure 1. As NEHAWU was later to encapsulate in a memorandum to the then Gauteng MEC for Health, ‘Chris Hani Baragwaneth Hospital, like many of our public hospitals, is a highly stressed institution. In other words, the hospital itself is sick. The stressful situation in the hospital is due to staff shortages, unmanageable workloads and management failures. By a stressed hospital we mean that the hospital operational functions are defective and weak, operational problems and breakdowns are not addressed, management is disfunctioning, systems are deficient, staff is suffering from burnout, levels of conflict are high, labour relations are poor, public health service delivery outcomes are poor’ (NEHAWU 2006).

The framework in Figure 1 shows how the management vacuum had arisen for historical reasons: an outdated and fragmented management approach based on management silos had been combined with a chronic shortage of resources and skills and superimposed on poor relations between management and workers - and between the different health professionals - as a result of bitter strikes and ‘very, very violent relations’ (D) stemming from the apartheid era. As the ‘double arrows’ show in the diagramme, the inefficiency and poor staff morale that resulted from failed management systems interacted with each other, and perpetuated an environment of distrust and confrontation. The fact that it was difficult to provide good patient care under these circumstances also had a negative impact on staff morale. As illustrated in Story 1 by an informant closely involved with trade unions, restoring trust between management and labour was therefore a crucial element of management transformation at the hospital.

**Story 1: Hostile labour relations and poor management under apartheid**

> ‘[One of the main problems in the early 1990s was] ill-discipline where workers basically were alienated from the hospital. They never saw the hospital as their own because at that time there was no real distinction between decisions made in the hospital by management and decisions made by the Transvaal Provincial Administration [of the apartheid state] ... Now, workers would respond in very different ways: ill-discipline was one of those. If they could stay for a week without getting to work that would be part of the Struggle: you know, hitting at management ... So all these bad things that would be seen as affecting the management were embraced as methods of Struggle against what was defined as ‘the enemy’ ... And there’d always be excuses or reasons why things are not done, so people would always look for spaces not to do work and, you know, in part it was relatively easy because of the size of the hospital but also the general problem of management incapacity.’ (D)
**Figure 1: The Project’s conceptual framework of problems besetting CHB Hospital**

**OUTDATED MANAGEMENT STRUCTURE AND STYLE**
- Authority overly centralized in Provincial DOH and Hospital CEO
- Traditional management structure of working in silos (i.e. by profession and department)
- Bureaucratic culture focused on administrative goals rather than health outcomes
- Management through directives (i.e. ‘commandism’)

**MANAGEMENT VACUUM**
- Fragmented management structure
- Insufficient delegation to operational level
- Blurred and ambiguous lines of authority and accountability
- No locus of control for decision-making
- Poor management systems
- Stifling of innovation and risk-taking
- Lack of coordination and cooperation
- Poor communication
- Focus on rules and regulations rather than people and systems
- Disempowerment of managers

**POOR ACCESS TO CARE**
- Beds full due to inappropriately long lengths of stay

**INEFFICIENCY**
- Inability to hire and fire staff
- Doctors and nurses working independently
- Wards dirty because nurses unable to supervise cleaners
- External providers not paid on time
- Breakdown in supply chains
- Cancellation of operations because of problems in Theatre
- Squandering of resources
- Ineffectual discipline

**POOR STAFF MORALE**
- Frustration and demotivation
- Poor interpersonal relationships
- Insubordination, theft, drunkenness on duty, absence without leave etc.
- Labour unrest

**POOR HEALTH OUTCOMES**
- Avoidable deaths and illness

**POOR QUALITY OF CARE**
- Delayed care
- Inappropriate care
- Unhygienic conditions
- Hospital-acquired complications
- Lack of privacy
- Patients not treated with dignity

**UNDER-RESOURCING**
- Under-funding
- Under-staffing, including too few managers
- Lack of investment in staff development, including...

**HISTORY OF CONFLICT**
- Hostile relations between:
  - unions and management
  - health professionals
  - racial groups

*Sources: D, D, D, (Tapson and Baker 2002; NALEDI 2002a; NALEDI 2002b; Tapson, Eisenstein et al. 2004; NALEDI 2004a; van der Walt 2005; von Holdt and Maserumule 2005)*
Importantly, the consensus generated amongst stakeholders at this stage was that the problem was structural: as one respondent relayed, ‘That’s what we always said. We said it’s not a case of people working harder - it’s a case of changing the way things are structured and the accountabilities and functions of everybody’ (D). This tallies with the Hospital Strategy Project’s conclusion that, ‘Over-centralisation ... leads to systematic underdevelopment of management skills and operational systems, especially in areas such as personnel, financial and labour relations management, and to a culture of action after permission, rather than one in which individuals take initiative and are rewarded for doing so’ (Monitor Company, Health Partners International et al. 1996: p29).

Another exciting feature of this stage was ‘to realise that right across the institution, shop stewards, workers, everyone, wanted to be able to say that they were proud of the hospital. You know, it was a very real feeling’ (D).

NALEDI’s analysis was initially received well by the Gauteng Department of Health and, in 2003, CHB Hospital agreed that implementation of a management transformation pilot should proceed in the Department of General Surgery. Importantly, the intention was that this pilot would be rolled out to the other surgical departments and then to other parts of the hospital. It was therefore crucial that the management model being implemented should have the buy-in of the whole hospital.

In preparation, NALEDI employed a human resources consultant to explore the human resource problems besetting the entire institution in more detail, and conducted further focus group discussions with a wide range of stakeholders (including different groups of health professionals and the Board). Finally, in 2004, it organized a large strategic planning workshop of all stakeholders to build hospital-wide consensus on critical problems and potential solutions. This workshop was mandated by the then MEC.

Key informants identified this workshop as pivotal in building support for the project and developing a shared understanding of the management transformation model that needed to be implemented (D). The support of the Clinical Director at that time, Arthur Manning, was seen as critical to the success of the workshop (C) and as ‘a champion of progressive change’ (D). When he eventually became CEO in 2006, he played a large part in the Project’s implementation.

It was at this stage that preparations were begun to lay the ground for implementation of the project: funding was sought from the Gauteng DOH through the MEC as the workshop had raised the possibility of R10 million; delegations to the CEO to enable decentralized management were indentified although only implemented to a limited extent; and the hospital was divided notionally into five main divisions to create clear operational units (the Surgery Division being one of these). By the middle of 2006 there had not been much progress, however. The MEC who had mandated the workshop had taken many months to consider its report and provided no decisive direction thereafter. Eventually, in mid-1996, NEHAWU coordinated a high-profile march that presented a memorandum to the new MEC, who had been appointed a couple of months earlier, objecting to this state of affairs (NEHAWU 2006). The marchers also pushed, unsuccessfully, for the removal of the provincial DOH’s Chief Operating Officer who was seen as the main obstruction to progress and insisted, successfully, on the appointment of Arthur Manning as the new CEO following the previous CEO’s retirement. Many doctors, including senior hospital specialists, academics from the Health Sciences Faculty of the University of the Witwatersrand and the Faculty’s Dean, participated in this march, alongside union members.
While this reportedly elicited anger amongst staff of the Gauteng Department of Health (GDOH) and the new MEC, the political pressure that NEHAWU was able to bring to bear resulted in the issuing of a tender to implement what had now become known as the Chris Hani Transformation Project. This tender was won by NALEDI and implementation began on 1st August 2006. The long journey towards this point from the September Commission in 1997 is reflected in Table 4.

While NEHAWU was consistently involved in pushing the agenda of transformation, its participation only became formally structured once it seconded a former union spokesperson to the NALEDI team at the time it won the tender. This ensured that ‘a labour vision for the public sector’ (COSATU 1997) was integrated into implementation; it also raised the level of union participation in decision-making because of the competency of the union representative involved (D).

Table 4: Timeline of events leading up to the implementation of the Transformation Project

<table>
<thead>
<tr>
<th>DATE</th>
<th>PERIOD</th>
<th>EVENT</th>
<th>SIGNIFICANCE FOR PROJECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>BROAD CONSSENSUS DEVELOPED AMONGST UNIONS</td>
<td>Report of COSATU’s September Commission.</td>
<td>Lays out a vision for a transformed public sector. Urges public sector unions to engage actively in transformation, including at the micro-level (i.e. institutions). Identifies management failure as a key problem and recommends decentralisation.</td>
</tr>
<tr>
<td>2000-2001</td>
<td>On behalf of NEHAWU, NALEDI engages in internal research and workshops around its vision for CHB Hospital, later extending this to engagement with other unions represented at the hospital, and the Board.</td>
<td>Perspective of general workers is introduced into debates about challenges facing the hospital. Introduces the notion of ‘a people’s hospital.’ Brings other unions on board. Reaches agreement that NALEDI should develop a plan.</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>NALEDI conducts research in Department of General Surgery, including a review of human resources management (Tapson and Baker 2002), and feeds it back to all surgical staff. NALEDI makes presentations to GDOH.</td>
<td>Crucial support from the then CEO. General Surgery Department suggested as pilot. Detailed analysis uncovers the ‘management vacuum.’ Sense of empowerment amongst surgical staff and unions. Initially, apparent enthusiasm for the Project in the GDOH but support appears to wane thereafter.</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>CHB Hospital agrees to support implementation of the project. Funding and new delegations sought.</td>
<td>Building of hospital-wide consensus around approach to transformation. R10 million promised for implementation. Support from hospital’s Clinical Director (and future CEO) critical. A situational analysis of the Nursing Division, including training needs and staff turnover (van der Walt 2005).</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>Hospital management under new CEO perceived by future Project leaders to be less supportive. Series of workshops with stakeholders at hospital to produce situational analysis (NALEDI 2004a; NALEDI 2004b; NALEDI 2004c; NALEDI 2004d; NALEDI 2004e; NALEDI 2004f; NALEDI 2004g). MEC mandates crucial 2-day strategic planning meeting at Helen Joseph Hospital (Tapson, Eisenstein et al. 2004).</td>
<td>Funding mobilised from GDOH to issue tender and employ NALEDI as consultants but full buy-in from GDOH not achieved.</td>
<td></td>
</tr>
<tr>
<td>Mid-2006</td>
<td>Community and labour march organised by NEHAWU to complain about lack of progress in funding the Transformation Project, remove the GDOH’s Chief Operating Officer as he was seen as main obstruction to progress, and insist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Month</td>
<td>Event Description</td>
<td>Details</td>
</tr>
<tr>
<td>--------</td>
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<td>--------------------</td>
<td>---------</td>
</tr>
<tr>
<td>2006</td>
<td>August</td>
<td>Implementation of Transformation Project starts.</td>
<td>NALEDI consultants analyse management systems in-depth and develop detailed plans for implementation. Reports produced on: - training needs and nurse turnover (report by Lyson Mutinhidzo) - pharmacy and dispensing - information technology infrastructure and support - a review of the need for a High Care Trauma Unit (Eisenstein 2006) - a transformed relationship between the hospital and the Public Works Department (Eisenstein 2007) - a service level agreement with the Department of Theatre Services (NALEDI 2007) - a new linen policy (Smith 2007) - a proposal for a communication strategy for the Project (Spent Arrow Communications and Public Relations 2007)</td>
</tr>
<tr>
<td>2007</td>
<td>February</td>
<td>NALEDI feels unable to continue Project because GDOH has not provided promised funding to populate the new organogramme developed by NALEDI for the transformed Surgery Division; no new managers or administrative staff have been appointed. CEO convinces NALEDI to continue.</td>
<td>No counterparts employed into the Division with which the consultants can work: implementation of plans has to be delayed. NALEDI lays off most of its consultants.</td>
</tr>
<tr>
<td>2007</td>
<td>September</td>
<td>First new manager appointed to Surgery Division. Project supposed to end but NALEDI agrees to extend work for a further six months (using same budget). New managers employed very slowly.</td>
<td>NALEDI implements plans as and when new managers are employed: progress is consequently slow.</td>
</tr>
<tr>
<td>2008</td>
<td>March – late 2009</td>
<td>NALEDI consultancy comes to an end. Hospital continues to employ one of NALEDI consultants on a contractual basis to progress implementation.</td>
<td></td>
</tr>
</tbody>
</table>

### 3.3. Funding

Table 5 summarises the sources and phasing of the funding used by the Transformation Project over time. As the Table shows, implementation was preceded by several years of in-depth research and consensus-building that was funded by money derived from the Friedrich Ebert Stiftung (one of the funders of this report), the US Embassy and NALEDI (which is funded by COSATU). This phase, which lasted from around 2001 to mid-2006, was crucial to building consensus within a community of hospital health workers whose inter-personal relationships had been ravaged by historical conflict.

Formal implementation of the Project began on 1st August 2006 after NALEDI successfully competed for a tender that had been issued by the Gauteng Department of Health. Initially the Project was intended to run for one year. Half-way through this period NALEDI felt unable to continue with the
Project as the prerequisites it had set had not been met by the Gauteng Department of Health. In particular, not a single person had been appointed into the new managerial and administrative organogramme designed by NALEDI for the Surgery Division, apart from the Head who had been an existing staff member. This was because the promised funding from the provincial head office had not materialised. Up to this stage, NALEDI had used a set of expert consultants to analyse all aspects of the Division’s management system. This included a situation analysis of the nursing section (including an assessment of acuity levels and development of staffing norms), an analysis of training needs and staff turnover, development of a proposal for pharmacy and dispensing, and an assessment of existing and required information technology infrastructure. However, now there was no further work for these consultants and NALEDI had to let them go. As the Project designers commented, this was a missed opportunity as NALEDI had initially planned that these consultants work alongside counterparts in the Division.

The CEO of the hospital responded to this crisis by deciding to fund the new managerial posts from within the hospital budget, thereby convincing NALEDI to continue with the Project. Using funded but vacant posts, managers began to be appointed to the Division: even so, the first was only appointed on 1st September 2007, the day after NALEDI’s contract was supposed to have come to an end. As NALEDI had not spent all of the R5 million it had won through the tender, it agreed to spend a further six months supporting the new managers who were subsequently slowly appointed into the new organogramme. When NALEDI’s money finally ran out, one of its main consultants, Colin Eisenstein, agreed to worker at reduced rates and was funded out of the hospital budget to ensure that implementation could continue until the main management systems were in place. This arrangement terminated around the third quarter of 2009 following a directive from the acting CEO who had succeeded Arthur Manning in 2008. As described in the following section, implementation is still not fully complete because the Gauteng Department of Health and the hospital have not yet funded what the Project designers characterise as crucial financial, human resource and information system software for the Division, as well as because of incomplete decentralisation of authority to the Divisional Head.

**Table 5: Sources of funding for the Transformation Project in the Surgery Division**

<table>
<thead>
<tr>
<th>DATE</th>
<th>AMOUNT</th>
<th>SOURCE</th>
<th>PURPOSE</th>
<th>COMMENT</th>
</tr>
</thead>
</table>
| Early to mid-2000s | R50,000- R120,000 per year from 2001-2005 | Friedrich Ebert Stiftung | Preparatory work with unions  
  • part-time secondment of Bethuel Maserumule from NEHAWU  
  • intermittent employment of 2 part-time consultants  
  • funding of shop steward workshops  
  • half-time employment of NALEDI expert, Karl von Holdt | Funding of external expertise and support (i.e. once-off costs for consultants) |
|              | Salary in kind    | COSATU                | In-depth research into the problems facing the hospital  
  • many focus group discussions and meetings with stakeholders  
  • analysis by two expert consultants |                                |
|              | Small amounts of funding in 2004 | CHB Hospital and GDOH |                                                                        |                                |
As Table 5 shows, inserting a new and expanded management structure into the Surgical Division cost approximately an additional R7 million per annum (in 2008 prices and excluding management consultants’ fees). This amount could possibly rise to R9 million if the entire organogramme, as shown in were populated, which is not yet the case. This amount is over and above the administrative staff establishment that used to exist in the Division before implementation of the model. However, approximately 80 percent of this amount is represented by funded posts that already existed elsewhere in the hospital establishment; thus one could say that, if the management model had been fully implemented, the additional financial burden faced by the hospital would have been under R2 million per annum.

Project designers argue that these figures represent the realistic cost of restoring functional management to a Division that has suffered decades of underfunding and is already the size of a regional hospital (the range of activities required to restore functionality is described in Section 5) (D, D, D, I). They argue that an investment of this nature reduces the wastage of resources and improves both patient care and staff morale (this is discussed further in Section 6). It also has the potential to reduce costs higher up in the management chain (especially at the Gauteng Shared Service Centre (GSCC) and Gauteng DOH head office). This is because, if full decentralization were to be achieved, Divisions could take on many tasks which currently burden higher levels of the management hierarchy; this would reduce the need for staff at higher levels. These points are discussed later in more detail with regard to rolling out the pilot to other Divisions or other hospitals.
4. Principles under-pinning the design of the Project

The broad objectives of the Project are to improve, through increased management effectiveness (Bodibe 2006):

- the working conditions and job satisfaction of staff (i.e. staff morale);
- the efficient use of scarce resources; and
- the quality of patient care.

This is to be achieved through creating ‘single centres of management accountability and authority’ which are supported by the appropriate management and information systems (von Holdt 2008: p1). This section describes the principles that underlie this approach. Of necessity, it mainly presents the views of designers and implementers. Later on in this report, Section 9 returns to the issue of Project design, presenting some of the concerns raised by stakeholders outside the Project.

4.1. Decentralisation

The Project argues that health care delivery is extremely complex (D). First, patients present with a wide variety of conditions that, in themselves, progress in a varied and unpredictable way during the hospital stay. This is affected by the patient’s own subjective experience of ill-health and the care that he or she receives. Second, a variety of inputs and processes are required to address the conditions that present: not only do these need to be made available at the right time and in a coordinated way, they also need to take account of the relationships between different categories of staff. As one key informant said, ‘because of the large variability involved in so many things, you keep tipping into chaos. Health [services] live on the edge of chaos. And if you want to control that chaos - this is where the fundamental principle comes in – you’ve got to break it down into its smallest pieces’ (D).

The Project argues that it is impossible to manage this kind of complexity centrally, even less so in a hospital the size of CHB (D). A central tenet of the Project, therefore, is that substantial managerial authority should be decentralised to the lowest possible level, in this case to the Head of Surgical Division supported by a senior management team. Under the Head is a flattened hierarchy of one or two levels (on the nursing, medical and administrative sides), each enjoying decentralised authority and accountability for a set of operational matters. This allows rapid decision-making that is responsive to the needs on the ground and is able to take account of local sensibilities (D). Under this model, central hospital management relinquished control over operational matters in order to focus more on policy, strategy, resource allocation, support and monitoring and evaluation (von Holdt 2008). In turn, to be able to function properly, central hospital management requires substantial delegations from the provincial head office.

4.2. Clinician leadership

Crucial to achieving the objectives of management transformation, in the view of the Project, is to have leadership of the Division invested in a practising clinician. The role of the Head of the Division is to provide leadership and assume accountability for the operation of the Division, rather than to be an administrator. Administrative competency is provided by a strong, integrated management team that supports the Head and is engaged actively in running the Division. In particular, a Systems
Manager works closely with the Head, acting in effect as a General Manager and taking care of day-to-day operational issues.

The current Head of the Surgery Division is a very senior individual, but some respondents made the case that this does not need to be so in every Division. Thus, the clinician who takes on the leadership of the Division and therefore the responsibility for service delivery need not be the same as the academic head who takes on responsibility for academic leadership. All the Surgery Division staff interviewed were adamant that the Head of the Division should be a practising clinician. For example, one person said, ‘A clinician is a person who understands. It must be a clinician’ (I) and another said, ‘I think that is very vital’ (I).

The reasons advanced by respondents for a clinical leader rather than a primarily administrative one were:

1. **A clinician has a deep understanding of the clinical process:** The Head needs to understand clinical issues in-depth, including ethical issues, in order to direct all efforts towards good patient care. This is particularly important when problems need to be resolved urgently (such as a lack of antibiotics or blocked toilets)(D, I). As one respondent said, the Head cannot be ‘a non-practising bureaucrat, he’s long forgotten what it’s like to be at the bedside … Because the moment you become isolated from the reality of clinical practise, you lose the sympathy and insight required to understand what your clinicians are asking for’ (D). As another respondent stated, ‘So they [administrators] … don’t see things from the floor. The clinician sees what’s happening … The clinician also comes into contact with the nurses, sees them every day, with the cleaners … The administrator is at the back of the desk … He loses contact with reality … He does not understand what it means, what it is not to have a ventilator. For him a ventilator is a number. For us a ventilator is a patient. So he says, “Yes, there is a patient,” but he doesn’t see the patient. So it’s a different approach to everything’ (I). It is this insight that ensures that prompt action is taken to avoid compromising patient care: this contrasts with the former system where relatively minor problems take months to resolve.

Respondents felt that central management favours the concept of an administrator (in the form of a clinical executive) rather than a clinician leader (I), but felt that administrators – even when they have a medical background – do not know the clinical process, do not have sufficient ‘clout’ (C, C) and, as ‘career bureaucrats’ (C), are answerable to bureaucratic rules rather than patient care: ‘they have lost contact with the patients … If it had been an administrator then it would never have been done. He does not know people, he does not come close to people to talk to them, can you do that, can you help …. It’s going to never happen with an administrator, never’ (I). In conclusion, one respondent said, ‘the clinician is the senior guy, he’s the one whose got the expertise, he knows everything, he’s on top of the teaching, the clinical process. If you want a management system that directly reflects the core work of the department or division, it has to be under clinical leadership, and that way you get this clear line … The superintendent, the clinical executive, has to fall under him and deal with organisational matters, systems matters’ (D).

2. **A clinician is able to assume accountability for patient care.** Once the silo structure is broken, it is important to replace it with a senior person who can take over accountability for all the functions of the Division (D). This enables ‘personal trust at the operational level’ and protects
people under the Head, should any of their actions be queried, because it is the Head that provides the authorisation. It is also important to put someone at the helm who is able to over-ride petty rules when patient care is at risk (D, D). ‘So it’s all these little bricks that build up to make esprit de corps, confidence [and] eliminate the fear of accountability, and you can only do that in the model that has been presented’ (D).

3. **The model legitimates the existing role of clinical head:** Clinical Heads have always had to take responsibility for ensuring patient care but have never had the authority to ensure that functions are carried out to achieve this. This model invests them with this authority so that people working in the Division are answerable to them and can therefore be monitored directly. This avoids the situation in the past where no-one in the ward was responsible for anything and there was no single ‘locus of authority’ (D). The Head now has the power to ensure that instructions are carried out.

Another dimension of this issue is that Clinical Heads at CHB Hospital have always tended to bypass superintendents (now called clinical executives) on important matters because they do not perceive them to have sufficient knowledge and seniority (D, 11).

4. **The model enables different interest groups to work together:** The role of the Head is to ensure patient care, rather than exercise an administrative role or advance a specific management agenda. This allows different interest groups to trust the person in this position. In reflecting on this, one respondent gave the example of unions’ willingness to engage with management on decisions regarding conditions of employment: ‘They can only do that if organized labour believes there’s an honest broker somewhere in all of this and the honest broker is the clinician manager, because why, he’s concerned with patient care, he doesn’t kowtow to managers, he doesn’t kowtow to the unions, he says, “You come here as my assistants, as one of the tools that I use, for patient care”’ (D).

**4.3.Integration**

Decentralisation needs to be accompanied by clear lines of accountability (and checks and balances) so that central management can remain confident that decentralized units still meet the overall goals of the health system. Typically under the highly centralized system that characterizes CHB, there are multiple, conflicting and ambiguous lines of accountability: this results in the ‘dispersal of management authority’ (von Holdt 2008) and crossed lines of reporting that one respondent characterized as ‘spaghetti’ (D). For example, while a senior specialist may have some authority over a nurse manager in terms of clinical care, the nurse is formally accountable through a long hierarchy to the Head of Nursing Services in the central administration of the hospital. This makes it difficult to make decisive decisions and coordinate care effectively. As one respondent put it, agreements have to be continually negotiated (D). As another said, if one thinks of the multiple inputs required to effect good patient care, ‘how can you possibly do these very difficult things without talking to each other except, maybe once a month, the heads would meet in a kind of senior management meeting? But those would never address the nitty-gritty issues that are required in terms of patient care’ (D). This tallies with a conclusion of the Hospital Strategy Project that ‘existing management structures, which separate the accountability structures of nurses, medical staff and general workers, prevent appropriate and efficient general management by a single management team’ (Monitor Company, Health Partners International et al. 1996: p29).
Thus, the Project untangled the complex lines of reporting so that each manager (nursing, medical and administrative) now reports ultimately to the Head of the Division, rather than his or her counterpart in central hospital management. This breaks the pattern of working in silos and integrates all functions under the leadership of one person, the Head, who then reports to the CEO: ‘the structure integrates clinical, nursing and support functions into a single locus of accountability’ (von Holdt 2008: p4). The ‘severing’ of the link between, say, the Divisional Head of Nursing and the central Head of Nursing is a dramatic and critical change within the public health sector environment, as will be discussed later.

Changing lines of reporting was accompanied by the creation of a number of formal committees representing the spectrum of functions in the Division and responsible for taking decisions on various matters (as detailed later). In addition to this structural intervention, the Project introduced participatory management as a core value of the project. This reflects not only the desire to create a democratic workplace but also the belief that this is in the best interests of health care as it contributes to effective integration. As discussed later, this approach has been crucial to effective engagement of unions in the transformation process which itself has contributed to the success of transformation. In addition, it has contributed towards a common vision amongst senior Divisional managers and a sense, expressed by all Divisional informants that they are able to participate freely in management decisions. As one nurse respondent put it, being able to participate in decision-making that had formerly been the preserve of one staff category or another ‘has been beyond my dreams’ (I).

4.4. Re-orientation of management towards patient care

The Project believes strongly that the objective of decentralisation and integration is not so much to gain tighter administrative control over operational matters, as to enable decision-making in the service of patient care. There has been a steady drive over the lifespan of the Project to re-orient management in this way, so that clinical issues are no longer ‘at the margins of management decision-making’ (von Holdt 2008 :p2). The Project believes that, paradoxically, in the public health sector, ‘meeting administrative goals is way above meeting health goals [in the eyes of senior hospital management], hence the failure to effect health care delivery’ (D). The aim is to turn this situation around so that, at the very least, when administrative decisions are made counter to the needs of patient care, this has to be an explicit policy decision (D) (see Story 2).

Apart from having a clinician leader, a re-orientation towards patient care is effected by bringing administrative staff into close contact with the process of health care delivery, through participation in committees that include health professionals and by sending administrators out to the wards. This creates a culture where ‘management [is] being engaged in the clinical process in the most intimate ways’ (von Holdt 2008).

Story 2: Making administrators accountable for decisions that affect patient care

“[Instead of an administrator dictating that here’s X rands to buy a drill] you reverse it. You have the clinician now saying, “I need six drills - you must find six drills. Here’s the data, here’s the patient load, here’s the backlog. It must be supported.” So Martin Smith as a clinician manager is impressed enough by a submission made by the Professor of Orthopaedics as to why he needs six drills. He takes it up and says, ... “Here’s the evidence.” On that basis nobody can deny the clinical need to effect service delivery because it’s been presented, a solid case. It would still go to an administrator and he would say, “Are you mad? I’ve got no money!” Then the clinician may say, “You can say what you like but when, as a clinician manager I am asked why there’s a waiting list of three years to have your hip done, I can say, you, Chief Financial Officer, chose it to be like that!”’ (D)
4.5. Increased resources and skills

The project argues that, not only is CHB under-staffed in terms of clinical staff, it is under-staffed in terms of skilled managers. The importance of the shortage of resources in accounting for the collapse of management at CHB is a realisation that has emerged during the lifetime of the Project and is an issue that had originally not been sufficiently appreciated by the union movement (personal communication D). The Project highlights the fact that the Surgery Division, which has almost 800 beds, is, in itself, the size of a large regional hospital and almost the size of Johannesburg Hospital: this in itself justifies a substantial management team. Part of the Project’s approach is to appoint sufficient staff into new management posts and to provide them with appropriate training so that they are able to perform their tasks competently. This is particularly important for middle management, including at the level of the wards.

Together these principles are intended to transform the ‘vicious cycle’ that was evident in Figure 1 into the ‘virtuous cycle’ presented in Figure 2 below. As shown by Box 4, the principles dovetail very closely with the vision of the Hospital Strategy Project for transformed hospital management.

**Box 4: Changes in hospital management structures recommended by Hospital Strategy Project**

- ‘A general management system will be introduced to unify and integrate management, and also to enable decentralisation within the hospital.
- Each hospital will have a chief executive officer as the single focus of authority. This will replace the current ‘hierarchical silo’ model, in which medical staff, nursing staff and administrative staff are each accountable to different authorities within the hospital and, above them, within the provincial administration ...
- Within hospitals, management structures will be based on cost centres and functional units. Each will have a single focus of authority and significant managerial authority, preferably including their own budgets, staff and other resources.
- Clear lines of responsibility and accountability will be maintained, but these will concentrate on creative use of team work and encouraging decision-making and problem-solving, that is as close to the operational level as possible. The number of levels of authority within hospitals will be significantly reduced.
- There will be a shift from a culture of “rules and regulation” to one of accomplishing tasks, meeting needs and reaching targets. This will be accompanied by a strong emphasis on continually reorienting the hospital to the needs of patients and other clients ...
- Appropriate internal governing committees and fora will be introduced to ensure adequate participation, consultation and communication.’

*Source: (Monitor Company, Health Partners International et al. 1996: pp53-54)*
Figure 2: Conceptual framework for addressing problems at Chris Hani Baragwanath Hospital

**CREATION OF NEW MANAGEMENT STRUCTURES AND STYLE**
- Decentralization of certain powers to Divisional Head
- Integrated management (i.e. severing of silos)
- Participatory management, including involvement of unions
- Reorientation of management towards patient care

**DYNAMIC MANAGEMENT**
- Single, clear lines of authority and accountability
- Appropriate delegation to operational level
- Empowerment of managers
- Implementation of systems and procedures
- Good communication and coordination
- Building of trust and cooperation
- Fostering of innovation and risk-taking
- Decisive and timely problem-solving

**GOOD QUALITY OF CARE**
- Timely care
- Appropriate care
- Good infection control
- Privacy
- Patients treated with dignity

**GOOD STAFF MORALE**
- Staff motivated
- Good interpersonal relationships
- Structured, respectful labour relations

**EFFICIENCY**
- Effective use of resources
- Good discipline

**ADEQUATE RESOURCES**
- Additional funding
- Additional staff, especially managerial and administrative
- Investment in staff development, including management skills for senior and middle management

**IMPROVED ACCESS TO CARE**
- Decrease in length of stay

**IMPROVED HEALTH OUTCOMES**
- Deaths avoided, improved health

Sources: D, D, D, (Tapson and Baker 2002; NALEDI 2002a; NALEDI 2002b; Tapson, Eisenstein et al. 2004; NALEDI 2004a; van der Walt 2005; von Holdt and Maserumule 2005; Bodibe 2006)
5. A transformed management system: progress so far

This section is based on qualitative information provided by key informants interviewed by this evaluator as well as the earlier assessments by NALEDI and Khalvest Consulting (NALEDI 2008; von Holdt 2008; Khalvest Consulting 2009). The NALEDI reports assess the percentage of intended activities that were achieved within the initial timeframe of the extended contract (i.e. from August 2006 to February 2008); this section looks at progress over the whole period until August 2009.

The information is summarised in tables which indicate which outputs and intermediate outcomes were achieved by each of the main steps undertaken by the project. ‘Outputs’ are the interventions undertaken, whereas ‘Intermediate outcomes’ are the changes that resulted directly from these interventions (see Figure 3). For the purposes of this report, ‘Final outcomes’ are the changes in management effectiveness, efficiency, staff morale and quality of care that eventually followed from ‘Intermediate Outcomes’, as improvements in all of these are the objectives of the Project, as discussed earlier and shown in Figure 2. However, ‘Final outcomes’ are discussed in a subsequent section looking at the impact of the Project. It should be noted at this stage that implicit in the objectives of the Project was the desire to improve health outcomes although the Project never undertook to demonstrate such an improvement. It is beyond the scope of this evaluation to examine changes in health outcomes.

**Figure 3: Categorisation of indicators of change as used in this report**

<table>
<thead>
<tr>
<th>OUTPUTS</th>
<th>INTERMEDIATE OUTCOMES</th>
<th>FINAL OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventions to achieve transformation of:</td>
<td>Changes in:</td>
<td>Changes in health outcomes</td>
</tr>
<tr>
<td>• overall structure of Surgery Division</td>
<td>• Efficient use of scarce resources</td>
<td></td>
</tr>
<tr>
<td>• nursing management</td>
<td>• Job satisfaction and working conditions (staff morale)</td>
<td></td>
</tr>
<tr>
<td>• medical management</td>
<td>• Quality of care</td>
<td></td>
</tr>
<tr>
<td>• human resources management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• financial management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• systems management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• surgical pharmacy and warehousing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In compiling the tables that follow, cognisance has been taken of the original document on the basis of which NALEDI won the tender for the Transformation Project. Where any step has not been achieved, this is indicated. As transformation is an ongoing exercise, some achievements were realised later than others while others are under threat because appropriate resources, such as staff and financial, human resource and information systems have not materialised. The tables also try to indicate this where relevant.

5.1. Transformation of the overall structure of the Surgery Division

The Project began by designing an overall management structure that would address the management vacuum at CHB (see Table 7). One commentator characterised the structure as ‘very innovative in design’ (C).

The first step was to divide the hospital into five Divisions, with the intention that they would all eventually receive decentralised authority (Medical, Women and Child, Surgical, Clinical Support and Non-clinical Support Divisions) (see Figure 4). The Project was implemented in the Surgery Division as the pilot site.

Figure 4: Proposed Divisions for Chris Hani Baragwanath Hospital

The next step was to design the management structure of the pilot site (see Figure 5), identify the delegations that this new structure would receive and create new roles and job descriptions for the senior managers that would populate this structure. This was a lengthy process as it entailed not only negotiating the dissolution of traditional silo management structures, but also the delegation of some authority from the Gauteng Department of Health to the CEO so that he could in turn make delegations downward. Importantly, while delegations to the CEO were approved in principle, several of them were clawed back in practice by the GDOH (D). Thus, for example, Arthur Manning...
was never able to appoint his own senior management team, a factor that was eventually to place severe constraints on the Project, as discussed later.

**Figure 5: Organogramme of Surgery Division**

Source: Extracted from (von Holdt 2008)

Once political support had been achieved for downward delegation to an agreed management structure, senior management posts had to be filled. This was a second lengthy process that set back the implementation of the new model considerably (von Holdt 2008). Nonetheless, the management structure is now fully functional allowing the Project to achieve ‘a functionally independent Surgical Division integrated within [the] broader hospital under the purvey of the CEO, delivering acceptable clinical care within the CBH Hospital complex’. Most respondents felt that there is considerable buy-in to the new system within the Division, although one informant commented that ‘even when change is for the better, there’s no guarantee that everyone who is involved will buy in’ (I).

Key to restructuring has been the creation of a single line of reporting. The Heads of the Divisional sections report to the Head who, in turn, reports directly to the CEO and sits on the hospital-wide Executive Committee. This ensures that the Head has not only accountability for patient care but also the authority to exercise control over all the functions that contribute towards patient care, including nursing (D). At the same time, the single line of reporting ‘permits the necessary financial accountability and governance assurance to the Director Finance, CEO and Board of the hospital’ (von Holdt 2008).

The section heads collaborate in running the Division through a number of committees (see Table 6). These committees ensure that the different functions within the Division work in harmony towards a common goal and do not, as was the tendency in the past, make decisions that meet their own interests only. This new way of working is reportedly still a contested area within the Division as it
subjects individual managers to the discipline of a collective (D, I). Nonetheless, the opportunity to have formal structures through which to address issues quickly, and where it is possible to speak openly, was raised by almost all the people interviewed as underpinning the Division’s ability to manage effectively. As one respondent said, ‘when we meet we have an opportunity to talk about problems. We talk about problems every day but a lot of times you don’t meet the right person every day to talk about problems or it’s not the right time. So if a problem is a serious problem but not a urgent one, this is the opportunity to discuss it. And we have doctors and sisters, and they are sitting together’ (I).

The new management structure also alleviates the CEO and central hospital administration of an enormous operational burden: for example, one Head reports from Surgery in place of the nine clinical heads of surgical departments that reported in the past. In theory, this should allow central administration to focus more on strategic and supportive functions. However, as discussed later, there is reportedly some discomfort in central administration with the degree of delegation that has been achieved. This is one reason why the designers of the Project are concerned that elements of the Project run the risk of being ‘rolled back’ and that ‘the many successes are not cherished’ (D, D, D, I, I), as will be discussed later.

Table 6: Key management committees

<table>
<thead>
<tr>
<th>COMMITTEE NAME</th>
<th>FUNCTION</th>
<th>MEMBERS</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Executive Committee (ExCo)</td>
<td>Manages the operations of the entire Division. Is the locus for financial control, procurement decisions, HR decisions.</td>
<td>Head of Division, Clinical Sub-specialties (general surgery, orthopaedic surgery, neurosurgery, paediatric surgery etc.) Nursing management Heads of support functions (HR, Finance, Systems)</td>
<td>Monthly</td>
</tr>
<tr>
<td>Management Committee (ManCo)</td>
<td>Drives the Division. Plans and implements day-to-day operations of the Division.</td>
<td>Head of Division, Head of Nursing, Heads of Support Functions</td>
<td>Weekly</td>
</tr>
<tr>
<td>Clinical Heads of Department Committee</td>
<td>Deals directly with clinical issues and practices (e.g. suture protocols, equipment needs, service level agreements with clinical support services).</td>
<td>Clinical Heads of Department</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

One respondent commented on how well the new managers responded to changed management structures and systems: ‘I felt that right through ... Even when you looked at your clinical execs, you know all these people, the superintendents, the financial manager, the HR manager, all people when you throw them into this kind of formless, badly structured system can never deliver and don’t deliver, have poor performance. You put them into a thing where the job has clear responsibilities and accountabilities and controls, so they know what they have to do. Okay, you see some people who just don’t want that, you know, they leave fast, but the others just grow because it’s a job they can get their teeth into’ (D).
Table 7: Creation of the overall structure of the Surgery Division

<table>
<thead>
<tr>
<th>BROAD ACTIVITY</th>
<th>SPECIFIC OUTPUTS</th>
<th>OUTCOMES</th>
<th>EXTENT ACHIEVED</th>
</tr>
</thead>
</table>
| Development of new management model based on situation analysis | • New management model developed to address management problems based on:  
  o Situation analysis conducted by NALEDI and worked with all hospital stakeholders  
  o Human Resource Survey conducted by NALEDI  
  o Principles discussed in previous section | • Clarification of how management issues are related to efficiency, quality of care and staff morale at the Hospital  
  • Hospital-wide buy-in to the implementation of the model in Surgery Division | ACHIEVED under the CEO Dr. Manning with buy-in of important stakeholders like Labour, but buy-in faltering in more recent times (see later discussion) |
| Negotiation of appropriate delegations and lines of accountability for Head of Division and heads of sections | • Identification of delegations appropriate for CEO  
• Approval of these delegations by GDOH and decentralisation to CEO  
• Identification of delegations appropriate for Head of Surgical Division e.g. HR functions up to Level 12, financial delegations, procurement delegations  
• Approval of these delegations by CEO and decentralisation to Surgical Head  
• Surgical Head reporting directly to CEO and sitting on Hospital Executive Committee  
• Functions under Head (i.e. nursing, clinical, HR, financial, logistical) reporting directly to Head and not to central administration | • Decentralisation of bulk of authority to Divisional Head  
• Dismantling of inefficient silo structure within Surgery Division  
• Clear, single and simplified lines of accountability established  
• Alleviation of burden on CEO and central administration of operational matters and multiple lines of accountability | ACHIEVED but some important delegations outstanding and, reportedly, ongoing discomfort on the part of central administration with some delegations and breaking of silo (see later discussion) |
| Creation of new organisational structure with new job descriptions | • New organogramme designed for managerial staff in Surgery Division  
• Development of new job descriptions  
• Acceptance of new job descriptions by CEO | • Greater clarity on roles and responsibilities | ACHIEVED |
| Appointment of managers and administrative         | • Conversion and creation of posts  
• Advertising of senior managements posts (Divisional Head, Heads of Nursing, Financing and Procurement), | • Injection off additional human resources and skills into Division management structure | ACHIEVED but very lengthy process leading to delays in |
<table>
<thead>
<tr>
<th>staff to new posts</th>
<th>Implementation of new management committees with clear roles and responsibilities</th>
<th>implementation of aspects of the Project</th>
</tr>
</thead>
</table>
| staff for support functions and unit managers  
- Interviewing of applicants and appointment  
- New organisational structure populated with new staff |  
- Implementation of key Divisional management structures with regular meetings:  
  - Executive Committee (ExCo)  
  - Management Committee (ManCo)  
  - Clinical Heads of Department Committee  
  - Keeping minutes from the above meetings which are sent to the Head  
  - Participation in multi-lateral and bi-lateral meetings with unions |  
- Functional and integrated executive and operational management committees  
- Functional accountability of unit heads to Divisional Head  
- Clear mechanisms for engagement with unions | ACHIEVED |

| Relocation of clinical, nursing and support functions into offices near surgical wards |  
- Identification of office space near to wards  
- Refurbishment of office space  
- Procurement of furniture, office equipment etc. |  
- Greater accessibility of managers to other staff, especially those directly involved in patient care  
- Improved communication, coordination and team-building between different functions | ACHIEVED |

Sources: D, D, D, (NALEDI 2008; von Holdt 2008; Khalvest Consulting 2009; Surgical Division 2009)
5.2. Transformation of nursing management

While nursing is the backbone of the service provided by the hospital, it used to be organised into a long, rigid hierarchy that operated as a silo separate from other health professions and the administrative functions. So, as one respondent said, ‘the only real meeting place between the nursing tradition and other health professionals was maybe at the bedside’ (D): at CHB even this practice had broken down due to strife between the different health professions so that doctors and nurses were no longer even doing ward rounds together. This system of silos meant that ‘if you looked at a ward, it’s not clear who runs the ward’ (D).

The aim of the Project was to integrate nursing management into a single management team within the Division and to ensure a ‘nursing function forming the platform for patient care which integrates all individual management units ..., their inputs and outputs, into a co-ordinated patient care capacity whose effectiveness is integrated with the necessary support services’ (Bodibe 2006: p12). The Project also reduced the number of levels in the reporting hierarchy from six to three (Khalvest Consulting 2009).

The Division was fortunate in employing a Head of Nursing who had years of experience in the traditional hierarchy but, despite initial reservations, was able to see the potential of the new management philosophy and make it work (see Table 9). This person was able to introduce innovative changes and was characterised by one respondent as ‘an absolutely remarkable person’ (D).

The role of NALEDI consultants was to work closely with nursing management, workshop concepts and support the initial development of Standard Operating Procedures in order to empower the new nursing managers to actively transform the wards themselves (D, D). The most significant innovation has been the creation of a new type of ward manager (now known as a ‘Unit Manager’) who is one notch higher than his or her earlier counterpart, has additional skills and training and has authority over, and responsibility for, all activities that occur within the ward. This means that, on the one hand, cleaners are directly answerable to the Unit Manager and, on the other hand, medical staff are encouraged to work through him or her when visiting the ward and issuing instructions. The introduction of Unit Managers has meant that ‘an integrated management capacity has been taken down to the level where patient care takes place’ (von Holdt 2008: p6).

As one key informant emphasised, it is important that the Divisional Head of Nursing not mimic the old style of nursing management: her role is supportive and she should not be involved in minor operational matters such as giving direct instructions to nurses in the ward (D). So the rule in the wards is that ‘no-one goes into a Unit Manager’s domain and tells her what to do because if you do it that way you get split accountability. You want singular accountability ... So now we’ve created a system where it’s very clear whose domain it is. This is a nurse domain and everybody else is a visitor ... Unless you give absolute, singular accountability and authority, as low down as you can, you will never run health care, you can’t do it, it’s just not going to work out’ (D). As a key informant involved in nursing reported, nursing staff have ‘welcomed [this change] with open arms because it is taking people to a higher level’ (I).

Another important factor in the success of the Unit Managers was that their posts were advertised and interviews were held to select the most appropriate candidates: nurses were not automatically
put into the posts because they had worked at the hospital the longest (D). This meant that the Division attracted managers with the right skills and personalities who had demonstrated commitment to the responsibilities that the post entailed. Furthermore, the Project has provided the Unit Managers with training in a variety of skills (such as labour relations, drawing up rosters etc.): this training is still ongoing (D, I). Unusual to the hospital is also the practice of providing senior nurse managers with in-service training in management-related issues: this is organised and presented by the Divisional Head of Nursing (I).

As the nursing hierarchy has been flattened, the Unit Manager now has direct access to the Assistant Nursing Managers and Nursing Manager: if she needs to discuss an issue, she can either phone them immediately or walk to their offices nearby. A cumbersome hierarchy has been replaced by ‘a five-minute linkage now’ (D) and, from the perspective of nurses, there is much better communication and stronger relationships (I). The empowerment of Unit Managers has also led to ‘pride and [a sense of] possession’ that contributes to motivation as managers and competition between them to excel (D). This is crucial to the success of the new initiative, as one respondent point out, because ‘I think that in breaking down the silo one had to be careful not to disempower nurses, to have them feel that here was someone coming along and taking over’(D). However, Unit Managers still experience a constant tension between their management and clinical roles, given remaining staff shortages in the wards (Khalvest Consulting 2009).

Another innovation of the Project was that it developed norms for the number of staff required per bed, taking into account patient acuity levels (this process included training nurses to assess acuity levels which, in itself, was an achievement of the Project) (van der Walt 2008). The number of nurses required in a ward is now adjusted in a dynamic way, depending on need. Additional agency nurses are contracted when demand is high. This has protected the quality of nursing care by preventing excess patients from other departments being placed in Surgery beds without the requisite staff (if other departments let Surgery know that they need to use Surgery beds before 2 p.m., Surgery arranges additional staff, otherwise patients are not accepted) (see Story 3).

**Story 3: Juggling beds in Surgery**

> So when you want to move patients into my ward, you come to me, rather than saying, “I’m the boss, I’m just going to put patients wherever I like.” Go to the surgical matron and say, how many beds can you give me? She’s never going to say to you, “None!” She’ll say, “There are 15 beds open in this ward but we’ve only got enough nursing for 5 so we’ll take 5.” Not the usual thing where we put 15 in and everyone’s nursing deteriorates. So it was … bringing the operational control to the level at which the operational level was working. ‘(D)

Several key informants felt that wards are now managed much more effectively: they are cleaner, doctors now do rounds together with nurses and Standard Operating Procedures have been developed to deal with a number of issues (some of these documents were given to the evaluator and are summarised in Table 8). Each Unit Manager is responsible for adapting management procedures to the specificities of her own ward (so that an orthopaedic ward may be run slightly differently from a chronic septic ward, for example). The purpose of Standard Operating Procedures is to ensure that correct procedures are followed in each ward and that these procedures can be referenced, even when the Unit Manager is not available. They also provide data that senior managers can analyse so that they understand the reasons for problems experienced in wards (for
example, whether dirty wards are due to the fact that there was no cleaner) and demonstrate the impact of problems experienced with external services (for example, weekly linen reports demonstrate the chronic – and sometimes extreme – shortage of linen per ward) (I). Senior managers follow up the issues raised by Unit Managers on the checklist and, if necessary, forward them to the Systems Manager (see later) who escalates them to the relevant people (I). Many of the Standard Operating Procedures are not available elsewhere in the hospital.

Table 8: Examples of Standard Operating Procedures developed by the nursing section

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses’ Code of Conduct booklet</td>
<td>This is a pocket-sized booklet that provides guidance to nurses on ethical issues</td>
</tr>
<tr>
<td>Inpatient information guide</td>
<td>Explanation of Division’s obligations to the patient and the patient’s responsibilities; information that the patient needs to know; contact details for Division managers</td>
</tr>
<tr>
<td>Daily surveillance check-list</td>
<td>Record of how many nurses (including agency staff), cleaners, ward attendants and clerks working, as well as over-time; assessment of the cleanliness of the ward area, toilets, ablution block and surroundings; indication of whether there is compliance with waste disposal; assessment of the appearance of beds; indication of the availability of linen of various sorts; indication of urgent needs and complaints regarding the pharmacy and stocks and supplies.</td>
</tr>
<tr>
<td>Emergency Ward Call Process</td>
<td>Clarification of emergency codes (green, orange and red) in order to indicate urgency of situation to doctor; information on the patient that needs to be provided to the doctor under each code</td>
</tr>
<tr>
<td>Transfer Report</td>
<td>Details of patient, referring doctor and unit, and receiving unit; details of condition and treatment</td>
</tr>
<tr>
<td>Post-operative care procedures for range of conditions</td>
<td>Currently being reviewed</td>
</tr>
<tr>
<td>‘Red Flag’ notice</td>
<td>This is a prominent red sign that is being piloted: it will be hung above the bed of patients requiring special observation to ensure that they receive sufficient care</td>
</tr>
</tbody>
</table>

Source: Documents produced by Nursing Section of Surgery Division, (I)

These efforts have all been directed at improving patient care. Specific quality control measures have also been put in place. As one key informant closely involved in nursing put it, ‘if there had not been this project, things would have blown out’ (I): this was a reference to the scandals and adverse media coverage that accompany ‘adverse incidents’ at the hospital (that is, instances of poor quality care and sometimes negligence that lead to poor health outcomes or even the death of patients). Because the new nursing management structure is manageable in terms of its size, it is possible for nurse managers to respond to adverse incidents directly. This allows crises to be addressed quickly, including engaging with patients’ families to demonstrate empathy and explain circumstances accurately: for nurses, this avoids ‘people’s anger … overflowing [and] is based on the relationship of trust, even in the community’ (I). It has also become possible to institutionalise morbidity and mortality meetings for nurses themselves, so that all adverse events are scrutinized with the aim of improving nursing practice and the running of the wards (I).
The same ability to respond to the needs of patients’ families has been extended to caring for staff who become ill or are injured. This has promoted trust amongst staff and shown them that management has the interests of its staff at heart: ‘prompt action says that you care and that you want to be with them’ (I).

Although the authority of the Unit Manager is reasonably well-entrenched within the Surgery Division, as is the integration of nursing management into the overall management of the Division under a single Head, there reportedly remains some misunderstanding and resistance to these concepts in the wider hospital. The previous central Head of Nursing had initially been against the proposals when they were mooted and then had become won over to the idea, reported several respondents (D, I); as one person said, ‘she laid her soul out to say the project will succeed and I will do everything in my power to help it succeed’ (I) but sadly she was killed in a car accident. Currently, the nature of the interaction between the Divisional and central Head of Nursing is still not well-defined (C) and there are instances when the former tries to over-ride the authority of the Divisional Head (for example, in the allocation of night duty rotations to nurses within the Division) (D).

Unfortunately the Division still suffers a severe shortage of permanent nursing staff and is overly reliant on agency staff (personal communication with D). For example, a study done in March 2007 found that 39 percent of nurses were agency nurses (Surgical Division ExCo 2007). By November 2007 this percentage had risen to 60 percent as a result of attrition of staff and problems recruiting new staff due to the national nursing shortage (van der Walt 2008). Lessening reliance on agency nursing staff is one of the Division’s key priorities (Surgical Division 2009).
**Table 9: Progress made by the nursing management section**

<table>
<thead>
<tr>
<th>BROAD ACTIVITY</th>
<th>SPECIFIC OUTPUTS</th>
<th>OUTCOMES</th>
<th>EXTENT ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creation of new Nursing management structure plus appointments</td>
<td>- Appointment of:</td>
<td>- Single, clear line of reporting that creates direct accountability of nurse managers to Divisional Head</td>
<td>ACHIEVED</td>
</tr>
</tbody>
</table>
|                                                                                 |   - 1 Head of Nursing  
   - 3 Nursing Service Managers  
   - 23 Unit Managers (one per ward)  
   - Agreement by CEO that Divisional Head of Nursing report to Division Head rather than central Head of Nursing                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                     |                 |
| Transformation of Nursing management approach with flattened hierarchy            | - Flattening of Nursing hierarchy into 3 levels  
   - Development of job descriptions for Unit Managers and Nursing Service Managers, together with work processes and accountabilities  
   - Senior Nursing Managers participating actively on key management committees, including ExCo | - Rapid solution of problems (i.e. increased responsiveness)  
   - Participatory management  
   - Improved communication and improved relationships, including trust between management and staff  
   - Decentralisation of authority to Unit Managers  
   - Improved co-ordination through integration of ward activities  
   - Improved pride in the ward and motivation  
   - Noticeable improvement in nursing morale | ACHIEVED        |
| Empowering of Unit Managers, including skills development                         | - Delegation to the Unit Managers of full authority and accountability to manage all aspects of the ward (including cleaners)  
   - Advertising of positions  
   - Interviewing of nurses for positions and appointments  
   - Skills development of Unit Managers with respect to procurement, budgeting, information systems, industrial relations, HR management, basic management skills etc.  
   - Weekly Unit Manager meetings with their managers, including peer review | - Clear lines of accountability for specific tasks  
   - Buy-in of staff to Standard Operating Procedures  
   - Availability of Procedures to guide staff when Unit Manager is not present  
   - Nurses empowered to complain when | ACHIEVED although further skilling up of Unit Managers required |                 |
| Development of Standard Operating Procedures                                     | - Standard Operating Procedures developed by Committee of Unit Managers (and then adapted for specific ward situations)  
   - Clarification of processes and accountabilities | - Clear lines of accountability for specific tasks  
   - Buy-in of staff to Standard Operating Procedures  
   - Availability of Procedures to guide staff when Unit Manager is not present  
   - Nurses empowered to complain when | ACHIEVED but the development of new procedures in an ongoing process |                 |


<table>
<thead>
<tr>
<th>Implementation of specific processes to improve patient care</th>
<th></th>
<th>they observe poor quality of care (e.g. by doctors)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Development and implementation of nursing norms (e.g. staff per bed, adjusted for acuity levels)</td>
<td>• Development and printing of pocket-sized booklets on a nursing Code of Conduct</td>
<td>• Dynamic daily adjustment of staffing according to bed needs</td>
<td>ACHIEVED but needs continual vigilance</td>
</tr>
<tr>
<td>• Development and printing of pocket-sized booklets on a nursing Code of Conduct</td>
<td>• Mortality and Morbidity meetings of nursing staff to scrutinise adverse events</td>
<td>• Ongoing staff development</td>
<td></td>
</tr>
<tr>
<td>• Mortality and Morbidity meetings of nursing staff to scrutinise adverse events</td>
<td>• Quick response to complaints referred by central administration’s Quality Control section, often involving dialogue with the patients and their families</td>
<td>• Clarity on standards of patient care</td>
<td></td>
</tr>
<tr>
<td>• Quick response to complaints referred by central administration’s Quality Control section, often involving dialogue with the patients and their families</td>
<td>• ‘Care of caregivers’ adopted as Divisional practice</td>
<td>• Guidance to nurses on how they should behave when faced with ethical issues</td>
<td></td>
</tr>
<tr>
<td>• ‘Care of caregivers’ adopted as Divisional practice</td>
<td>• Consistent in-service training for senior nurse managers organised and presented by Head of Nursing</td>
<td>• Improved relationships, including trust between management and staff</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improved liaison between doctors and nurses</th>
<th></th>
<th></th>
<th>ACHIEVED but needs to be maintained</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Meetings with doctors in wards to review cases and discuss effectiveness of procedures</td>
<td>• Good communication between doctors and nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Good communication between doctors and nurses</td>
<td>• Improved relationships</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Establishment of Linen Management Committee to develop linen policies</th>
<th></th>
<th>INITIAL PROGRESS but had to be discontinued because Laundry did not have enough linen to implement the policy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Establishment of Linen Management Committee</td>
<td>• Development of linen management policies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: D, D, I,(von Holdt 2008; Khalvest Consulting 2009; Surgical Division 2009)
5.3. Transformation of medical management

As mentioned earlier, doctors have responsibility for patient care whereas nurses have responsibility for ward management. Resolving the tensions that arise from these overlapping responsibilities is a recurring theme in any hospital. The Project’s solution has been reinforcing the doctor’s authority over patient care by ensuring that nursing management is answerable to the clinical Head of Department, while at the same time encouraging the doctor to acknowledge the Unit Manager as the contact person in the ward setting. As one respondent said, ‘I think it’s not that [doctors] feel they’re reporting to the Unit Manager, but that they have a responsive individual’ (D).

Getting doctors to agree to these new arrangements required considerable negotiation on the part of the Project, especially as the clinical Heads of Department had formerly enjoyed free reign, reporting only to the CEO. One respondent reflected that, ‘you need a very special skills set to bring [them] into a cooperative environment and one of the things is, give them their domain, don’t disempower them’ (D). Accordingly, to a large extent Heads of Department remain with the freedom to run their own Departments as they see fit: it is important that the Divisional Head is supportive of this (I). However, they participate monthly in meetings of the Division’s Executive Committee (while representatives are also involved in other committees). Here they engage with the other sections of the Division which provides an opportunity for all sections to resolve problems quickly and innovatively. For the first time, different sections sit as equals around the same table.

The Khalvest Consulting report confirms this perspective, noting that respondents reported that the changes have ‘resulted in more cooperation not only within the SD [Surgical Division] but with other units like Theatre. One of the respondents acknowledged that better communication between the SD and Theatre had been enhanced and this resulted in exchange of ideas on transforming their division’ (Khalvest Consulting 2009: p31).

It appears that not all clinical Heads feel that they have benefited from this new arrangement, however. The Khalvest Consulting report quotes one respondent expressing the view that ‘integration of the clinical specialties has increased bureaucracy. Prior to integration, heads of specialties had direct access to the CEO and this increased the decision-making process’ (Khalvest Consulting 2009: p31). One of the key informants in this evaluation countered that this meant that previously, while some clinical Heads of Department could successfully lobby the CEO for their own Department’s needs, this was done without taking the needs of the rest of the Division into account, leading to an unfair allocation of resources between the different Departments (D). One external commentator felt that the inability of the Project to win over all its clinical Heads was one of its major weaknesses, throwing into question the feasibility of rolling out the Project to other Divisions.

With respect to improving the quality of medical supervision of patient care, the Project introduced two particular strategies (see Table 10). One was the restoration of joint ward rounds between doctors and nurses. A second was the implementation of weekly Morbidity and Mortality meetings that scrutinise the reasons for adverse events and take follow-up action where patient care was not satisfactory. The new status enjoyed by the nursing establishment also enables nurse managers to

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1 The surgical sub-specialties are: Ear, Nose and Throat; Maxillo-facial surgery; Orthopaedics; Neurosurgery; Plastic Surgery; Urosurgery; Paediatric Surgery.
alert the Head to any medical irregularities of which they might become aware in the ward (D). The guide to nurse conduct that was mentioned earlier is important in this regard. As Story 4 shows, increased engagement between doctors and nurses is vital for the appropriate running of wards.

**Story 4: Getting nurses and doctors to engage more**

'It required a bit of a policing function but not enormous. I’d walk into a ward and read the operating list and I couldn’t read what it said. I’d go to the Unit Manager and say, “Just tell me which patients are on the operating lists for tomorrow,” and she’d look at it and say, “I can’t read it.” Then I’d say, “How can you accept it from the doctors?” She’d look at me and say, “What do you expect me to do?” Then I’d say, “You get on the phone and you call the head of the unit and you tell him or her that you can’t read the operating list and he must bring the list. How can you tell what you need for tomorrow?” “No, the doctors will tell us.” And I’d say, “No, that’s not on. This list has got a purpose. So, you’ve got to know what’s going on in your ward. How do you know how many nurses you’ve got to organise to be on duty tomorrow? What happens if you’ve got five or six big operations happening as opposed to five or six tiny operations?” So it was that kind of input. But I must say I left it largely to the nurses. People just knew that I was watching. They knew that at times I would show up in places and ask questions, but I wasn’t a policeman. When they saw me it wasn’t, “Ah, he’s coming to check up on us.” They knew that I was interested, and that I could ask, so that was ... what was important in my role in bringing about nursing.’ (D)
<table>
<thead>
<tr>
<th>BROAD ACTIVITY</th>
<th>SPECIFIC OUTPUTS</th>
<th>OUTCOMES</th>
<th>EXTENT ACHIEVED</th>
</tr>
</thead>
</table>
| Integration of Surgical specialities under the Head of Division | • Negotiation of agreement between Heads of different surgical departments and sub-specialties to report to Head of Surgical Division rather than CEO  
• Creation of Clinical Heads of Department Committee  
• Regular meetings of Committee to discuss issues of common concern | • Improved cooperation between sub-specialties  
• More rapid and innovative solutions to problems of clinical organisation                                                                                                                                   | ACHIEVED                                  |
| Institution of regular review of morbidity and mortality | • Weekly meetings to review mortality and morbidity with each Department presenting once every five weeks  
• Interrogation of the causes of adverse events                                                                                          | • Improved cooperation between sub-specialties  
• More rapid and innovative solutions to problems of clinical organisation                                                                                                                                   | ACHIEVED in some sub-specialties and being extended to others |
| Action to address problems of clinical organisation, including creation of Trauma Unit | • Paediatric Surgery engaged with Theatre management to improve the functioning of the Paediatric Theatre  
• Establishment of high care Trauma Unit in general surgery to consolidate patient care  
• Engagement between Orthopaedic Trauma and Trauma Unit  
• Agreement to structure relations between surgeons and Anaesthetics Department                                                                                         | • Reduction of frustration, miscommunication and delays  
• Improved patient care                                                                                                                                    | ACHIEVED                                  |
| Formal engagement between nursing and medical staff | • Joint participation of representatives on senior management committees  
• Regular ward meetings between doctors and nurses (roughly every two weeks, depending on unit)  
• Doctors recognising ward as a nurse domain  
• Joint ward rounds by doctors and nurses                                                                                                               | • Improved communication between doctors and nurses  
• Joint solution of problems                                                                                                                                | ACHIEVED                                  |

Source: I, (von Holdt 2008; Khalvest Consulting 2009; Surgical Division 2009)
5.4. Transformation of human resources management

The central HR function at CHB Hospital is notoriously problematic (C) because dealing with the needs of around 5,000 people is ‘totally unmanageable, totally’ (I) (see Story 5). Staff time is consumed with basic administration and dealing with crises. As the hospital is spread out over a vast campus it is difficult and time-consuming for employees to visit the central HR offices (I). In addition, labour relations have always been tense and the hospital is subject to numerous strikes, not all of which are covered by the media (D).

Story 5: Responding to staff in a large institution

‘So we have an HR department in Surgery because in Surgery only there are [many] nurses. You try and control the conditions of employment of [so many] nurses once a month from Sauer Street. Please, they get sick, their children die, they have a motor car accident, they feel depressed by the HIV load that they’ve got to deal with, they don’t have enough equipment, and you’ve got to keep motivating these people to stay at the bedside and nurse in a meaningful way. Don’t tell me you can do that centrally. You’ve got to have an HR practitioner who’s on their doorstep and walks into that ward on a daily basis and says, “Here I am. How can I help?” Don’t ask the nurse to leave the ward and go to HR. Don’t expect them, as they used to before the Surgical Division, to go and walk up to the 4th floor of the tower block, to get their pay slip. It’s three hours out of their day, three hours! Now it’s delivered to the bedside. If you don’t bring those things down to the smallest level of managerial accountability … you will not succeed in effecting health care services.’ (D)

Accordingly, the Division set up a Human Resources Section that includes a labour relations unit, communications, salary administration and training and has taken over most of the tasks formerly handled by central HR (except the employment of staff above Level 12) (see Figure 5). The focus has been on effecting a shift from personnel administration to active human resources management, responding to employees’ needs, restoring labour relations and facilitating the employment of staff.

A highly skilled senior manager who had formerly worked in central HR and had an in-depth knowledge of the system was employed as the head of Divisional HR. Another critical appointment was a skilled labour relations manager who has been very effective. The Section has now reached a size of 10, although the filling of these posts has taken a long time.

As shown in Table 13, the new HR section has made considerable progress in areas that have historically been flashpoints for the hospital – vacant posts are filled much more swiftly, employee queries and grievances are resolved rapidly and labour relations are well-structured and productive, even during times of labour unrest such as the strike of 2007 (see Box 5). Dealing with grievances inherited from the 1990s was an important strategy in putting labour relations on a new footing (D).

Box 5: Protecting essential services during a recent strike

During a recent strike, the Division reached an agreement with unions that industrial action should be modified in a transformative situation such as the Project. Unions agreed to respect the concept of Essential Services and allow skeleton staff to continue working in the Division, reducing the impact on patient care. This was not the case in the rest of the hospital. This created some tension for unions between their hospital branches and the larger union. The agreement eventually collapsed due to factors in the wider hospital environment.

Sources: C, (Surgical Division ExCo 2007)
As Table 13 shows, some of the reasons for this change are a new management culture that emphasises service to employees, respectful and open relationships with unions and dedicated follow-up of complex administrative processes (especially around the employment of new staff). Decentralisation of authority and accountability has been essential to this process: one key informant was emphatic that ‘we cannot go another route than being closer to the client [i.e. employees]’ (I). This same person said that the HR function is now ‘manageable and so easy’ (I). This has been achieved despite still having to use the services of the GSSC and despite considerable resistance from the former central HR Director (I, C).

Furthermore, the Project seems to have empowered an echelon of mid-level black managers, especially nurses. The Khalvest Consulting report notes that, in November 2008, 5 out of 10 senior managers were White but 12 out of 15 middle managers, and all 11 managers, were Black Africans; consequently, two-thirds of all managers were Black Africans (see Table 11). Overall, 100 percent of nursing and support staff, and 93 percent of administrative staff, were Black Africans although 49 percent of medical staff were White (see Table 12). From the interviews conducted by this evaluator, the only appointment that seems to have been sensitive within the Division on race grounds was that of the head of the Divisional Human Resources section who was a highly skilled white woman: this appointment was discussed extensively with unions beforehand and the appointment eventually received their approval (D).

Table 11: Surgery Division staff in different management positions, November 2008

<table>
<thead>
<tr>
<th>Population group</th>
<th>Black African (no.)</th>
<th>White (no.)</th>
<th>Coloured (no.)</th>
<th>Indian (no.)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Manager</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Middle Manager</td>
<td>12</td>
<td>3</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Manager</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>8</td>
<td>1</td>
<td>3</td>
<td>36</td>
</tr>
</tbody>
</table>

Source: Surgical Division, November 2008, as reported by (Khalvest Consulting 2009: p40)

Table 12: Surgery Division staff in each occupation, November 2008

<table>
<thead>
<tr>
<th>Population group</th>
<th>Administrative staff (%)</th>
<th>Medical staff (%)</th>
<th>Nurses (%)</th>
<th>Support staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black African</td>
<td>93</td>
<td>26</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>White</td>
<td>7</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coloured</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indian/Asian</td>
<td></td>
<td></td>
<td>1</td>
<td>24</td>
</tr>
</tbody>
</table>

Source: Surgical Division, November 2008, as reported by (Khalvest Consulting 2009: p40)

Evidence of the success of the Divisional HR Section is that, during 2009, the then acting CEO asked the Section to manage the Occupation Specific Dispensation for doctors for the whole hospital (I). She also asked the Section manager to run the central HR for hospital while the Director was away. In addition, staff from other Divisions reportedly often come to the Surgery Division to ask whether the HR Section there can sort out problems that have not been resolved by central HR.
The manner in which the Project has worked with the unions is its most unique feature, impacting on, and facilitating, most of the Project’s other achievements. Unions are involved integrally in making decisions on issues that concern them (such as job descriptions and allocating levels to jobs): they are informed about these issues in advance, consult with their members and then feedback to the Division’s management structures. As one informant said, ‘they need to be appraised so that they are never taken by surprise’ (D) (see Story 6). As another implementer said, ‘We consult a lot with labour regarding whether I am on the right track’ (I).

Story 6: Negotiating job levels

“We might say it’s a very simple thing, let’s make [an old Level 2 job] a Level 3 because it fits the job. But if you do that it has a broad implication across all other levels. So the union needs to go and sell it first and say, listen, Smith says that he thinks that job is a Level 3 but it doesn’t mean that all Level 2s now become Level 3. So they get together and they have mass meetings ... and they come back and say, “No, its okay, that one you can make a Level 3.” It takes a bit longer but you can’t do that in a centralized management thing where you have to work through the central bargaining unit. These things are determined at the local level, right there on the ground and it works.” (D)

The unions have also been instrumental in discussing the concepts underpinning the project with their members, getting them to buy-in to change and developing support for appropriate disciplinary processes (see Story 7). This has led to greatly improved discipline in the Division. As discussed elsewhere, the unions have also been instrumental in building political support for the Project within the ANC at a national level.

Story 7: Defusing tension between workers

“We could now establish a new mode of conduct between the partners. And labour, organized labour understood this very clearly and they were very supportive and now when we get into a confrontation in the ward, say between a nurse and the cleaner, the nurse belongs to DENOSA and is the senior appointed manager, the cleaner works for the province, Level 2, NEHAWU. What happens now is that the labour representatives dash to the ward, and the nurse phones the labour relations guy and says we’ve got a problem, can you organize and we’ll all come together. The cleaner in the room and the nurse in the room and their representatives there and they sort it out. There’s no charges, there’s no dadidadida and it’s all sorted out, who may be wrong etc. They sort it out amongst themselves, industrial peace and everybody goes on their way. They can only do that if organized labour believes there’s an honest broker somewhere in all of this and the honest broker is the clinician manager, because why?: he’s concerned with patient care, he doesn’t kowtow to managers, he doesn’t kowtow to the unions. He says, “You come here as my assistants, as one of the tools that I use, for patient care.” (D)

The mechanisms through which the Division has engaged the unions are both formal and informal. The revitalisation of existing mechanisms is what, in the first instance, restored labour relations onto a normal footing (D). These are multi-lateral and bi-lateral meetings between unions and management that happen at both the central and Divisional level. Systematic and open engagement grew out of the early days of NALEDI’s involvement in the Project, even before its formal implementation. At multi-lateral meetings, all four of the unions active in the hospital are present. Unilateral meetings are reserved for issues that only relate to one union or are of a confidential matter (D). Engagement by the Division in these meetings is so institutionalized that the Head no longer has to attend them and is well-represented by his HR section.
Informal mechanisms are ad hoc engagements between unions and Divisional management, either through invitations to union representatives to participate in meetings where relevant, or by casual interaction between individuals, especially in the HR section. Union representatives reportedly ‘drop in’ to visit the HR section or feel free to call when they have an issue to discuss. Said one informant, ‘It’s worked fantastically. I mean, the cooperation here from NEHAWU and these other unions has been amazing because they’re now partners in a small group of people who know each other and can actually talk to each other and resolve issues’ (D).
### Table 13: Progress made by the human resources management section

<table>
<thead>
<tr>
<th>BROAD ACTIVITY</th>
<th>SPECIFIC OUTPUTS</th>
<th>OUTCOMES</th>
<th>EXTENT ACHIEVED</th>
</tr>
</thead>
</table>
| Creation of Human Resources Management Section within Surgical Division plus appointments | - Appointment of:  
  o 1 Divisional Head of Human Resources  
  o 3 staff to manage Salaries Administration, Labour Relations and Wellness  
  o 6 administrative clerks  
  - Establishment of Human Resources Office in same building as Surgery Division for ease of access by Divisional staff, including provision of furnishing and equipment | - Highly skilled management team  
  - Engagement between managers and staff at the point where they work  
  - Alleviation of burden on central HR  
  - Direct communication with GSSC | ACHIEVED but still need one more Level 11 post (for skills development) and 8 clerical posts |
| Transformation of HR management approach with flattened structure and culture of service to health workers | - Flattening of hierarchy  
  - Upgrading of specialised posts in order to attract skilled staff (e.g. Labour Relations)  
  - Locating of team leaders in the same office as those they supervise  
  - Clarification of roles of Section staff, with reorientation towards teamwork, efficiency, serving the needs of Divisional staff (who are now seen as ‘customers’) and supporting the clinical process  
  - Clarification of processes and procedures relating to human resource management (including weekly training of HR staff on Friday afternoons with respect to new policies and circulars)  
  - Participation of Sectional staff in executive and operational committees  
  - Culture of regular visits by Sectional staff to wards and medical staff  
  - Fostering of a Sectional culture of tidiness, order and politeness | - Integration of HR function into overall management system  
  - Reduced bureaucracy, freeing staff to focus on management  
  - Increased user-friendliness of Section for Division employees  
  - Better understanding of the needs of Division employees  
  - Fast resolution of issues  
  - Increased support and supervision of Section staff (including in-service training)  
  - Ability of senior managers to engage in audit of Section functions, which is not possible at central level due to workload  
  - Increased professionalism of Section staff | ACHIEVED but continually improving HR management is a high priority |
| Development of needs-based staff                    | - Establishment and maintenance of database of Division employees  
  - Analysis of turnover of staff (once-off) | - Partial analysis of staff establishment | LITTLE PROGRESS because the hospital has been unable to fund HR |
| establishment for Division | • Skills audit (once-off)  
• Analysis of shortfalls in staff (done on an ad hoc basis) | software for the Division to analyse the staff establishment |
|---------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------|
| Recruiting and retention of high calibre managers for the Division (up to Grade 7) | • Injection of Project funds to employ additional Divisional staff, especially in the wards  
• Stream-lining of the process from identifying the need for a new staff member to employment  
• Dedicated follow-up of process with GSSC to avoid unnecessary delays  
• Practice of interviewing and short-listing alternatives, so that if first choice person resigns soon after taking up the post there is an immediate replacement  
• Employment of staff on contracts when there is no other way to get a post filled rapidly | • Better staffing of wards  
• Staff employed within 10 days of interviewing them  
• Reduction of overall time taken before staff are employed from 4 months or much more to 2 months, which is the standard for the private sector | ACHIEVED to a large extent; completing the appointment of remaining managerial staff with the requisite skills is a high priority |
| Improved salaries administration for Division | • Processing of salaries  
• Delivery of pay-slips to staff in the wards | • Ward staff do not have to leave wards to collect pay-slips  
• Enhancement of the relationship between employees and management because the need to efficient and accurate salary payment is recognised | ACHIEVED |
| Improved handling of queries about conditions of employment | • Stream-lining of the process for dealing with queries (so that employees do not have to pass through a number of levels to get their query handled)  
• Setting up of a Help Desk for Divisional employees (which they can visit or phone): this Desk can immediately sort out minor queries by checking on a computer | • Ward staff do not have to leave wards for a long time to make queries  
• Enhancement of the relationship between employees and management  
• Reduction of queries by about 65% | ACHIEVED |
| Improved performance assessment | • Support to managers with respect to distributing forms and reminding them about the assessment process and giving advice on how it should be done | • Almost 100% compliance with performance assessment requirements | ACHIEVED |
| Skills development and career | • Some HR training provided to medical managers and unit managers (e.g. on labour relations)  
• 20 Enrolled Nurses given access to bridging programmes at the nursing college in order to upgrade to | • Some improved competency of managers in managing the staff under them  
• Hopefully, increased nurse retention as their need to advance along a career path | LIMITED PROGRESS because a Skills Development Officer has not yet been appointed; |
| Pathing | Professional Nurse  
- Exploring possible training for ward clerks | has been recognised  
| Improved labour relations process  
- Structured, regular and generally revitalised engagement with unions through multi-lateral and bi-lateral meetings at Divisional level  
- Informal and ad hoc engagement with unions through courtesy visits and telephone conversations  
- Prompt action on grievances  
- Customer Services box situated at HR office and forms also taken out to the wards for employees to complete | Elimination of historical backlog of labour relations queries and grievances (dating back to the 1990s) within 3 months of appointment of labour relations staff member  
- Current grievances dealt with immediately (usually within a few days)  
- Responses to complaints in Customer Services box dealt with within 24 hours  
- Around 85% of comments received in box are favourable  
- Impact of the strike was delayed by reaching agreement for skeleton services | ACHIEVED  
| Improved disciplinary process, including termination of service  
- Development of rapid, effective and fair disciplinary process in line with Labour Relations Act and other relevant regulations  
- Regular engagement with trade union representatives to displace disciplinary confrontation at the level of the ward into this formal process  
- Elimination of the backlog of disciplinary issues inherited from the central HR department  
- Issuing of formal warnings to wrong-doers, ranging from senior clinicians to cleaners | Culture of improved discipline within the Division  
- Perception amongst staff that management acts against wrong-doers and that the process is fair, addressing one of the key reasons for staff dissatisfaction with the working environment | ACHIEVED  

Sources: (von Holdt 2008; Khalvest Consulting 2009; Surgical Division 2009), D, I, D, I
5.5. Transformation of financial management

In order to plan clinical services, the Divisional Head needs information on the budget available to the Division and ongoing analyses of expenditure against this budget. Unfortunately, the hospital has never provided budgets to Divisions. Neither are the hospital accounting systems able to track expenditure on a Division by Division basis; nor has the Division received delegations to manage its own funds and expenditure. In addition, the post of Head of the financial section has been an unstable one and has been unfilled for almost a year.

Only when the Division is provided with a budget and expenditure is linked to the Division on a real-time basis will the Division be able to understand the distribution of costs (by line item and procedure, for example) and manage its expenditure actively (I). Some preparatory work by the Project has attempted to ready the Division for this, for example, through designing a Cost Centre Analysis System and independently tracking expenditure on goods and services as well as petty cash (this has helped the Division discover that surgical consumables being used by the St. John’s Eye Hospital were erroneously being allocated to Surgery’s account). The Division has identified as one of its key future priorities ‘placing finance at the centre of data streams to enable cost management and the production of budgets based on clinical need’ (Surgical Division 2009: p3). At present, however, the Division is in the uncomfortable position of being told on the one hand to stop spending on goods and services because the central budget has run out, and yet needing to continue service provision because ‘it’s vital for patient care’ (I).

The Project has made significant progress in other areas, however, as shown in Table 14. Something that is new to the hospital is the follow-up of payments by third-party payers (such as the Road Accident Fund, Workmen’s Compensation, Correctional Services) in order to improve the hospital’s income. This income benefits the hospital as a whole and is not kept by the Division.

Most notable, though, is the active management of the supply chain, another flashpoint area in the rest of the hospital. Supply chain management is overseen by the reportedly very effective Supply Chain Management Unit (SCMU) which is run by the Systems Manager (see later) but interacts in a crucial manager with the Divisional finance section. The finance section ensures that payment of suppliers runs smoothly and does not hold up the supply of crucial supplies and equipment (see Box 8 and Story 8). The Division has been awarded a delegation to authorise purchases up to R50,000 (unlike the R30,000 in the rest of the hospital, although respondents noted that, now that the Division has proved that it can manage these amounts well, it should be authorised to spend higher amounts, something to which Arthur Manning had agreed before he left but had never put in writing (D, I)). As Box 8 shows, the strong relationship that the Divisional Head has with suppliers is a key factor in ensuring uninterrupted supplies, despite problems central Finance has in paying supplying companies: this relationship is based on trust and ‘negotiation through good faith’ (D).

Box 8: Making the supply chain work

The rest of the hospital commonly has the problem of supplies being interrupted when central Finance is unable to pay invoices. This problem has been all but eradicated in the Division. Either the Division ensures that payment is made on time or it negotiates with companies to deliver ahead of payment. This is a result of the relationship of trust that has been built up between the Division (especially in the persons of the Divisional Head and Systems Manager) and the companies. This has taken time and required a huge amount of effort, and relies on the principle of patient care taking precedence.
Commenting on the supply chain, one respondent commented, ‘That’s why we’ve got our finance and procurement people together in the office next door to each other; the one makes sure the things get ordered properly, the other makes sure they get paid properly. Surgical Division gets all the stuff it needs.’ (D) Most invoices are paid within 30 days: this is unlike the rest of hospital where there are often invoices outstanding at 120 days and companies refuse to make deliveries. The Division still has to use the GSSC but, just as in HR, it has employed people dedicated to following up the progress of payments and fast-track the procurement process (I). Recently, having this capability prevented the lapse of an important equipment lease that central Finance had not been able to manage (D). As Story 8 shows, too, galvanizing the unwieldy bureaucracy also requires to the Head to ‘put oneself on the line’ (D). The relatively recent appointment of a Systems Manager has also provided the capability to build relationships with suppliers and deal with urgent issues (I). As with the HR section, Finance staff are also encouraged to go out into the wards to understand clinical needs better and to make presentations to ward staff (I). Flexibility around job descriptions is another feature as is responsiveness: ‘It’s easy for them to pick up the phone and phone us’ (I).

As financial controls and accountability are of huge concern to central hospital management, including the CEO and the Board, the Project has been careful to ensure that these remain intact. Accounting has been strengthened, in fact, through SCMU which ensures that purchases conform to Divisional priorities and that purchases arrive in time and do not go astray, as well as by direct reporting by the Head to the CEO.
<table>
<thead>
<tr>
<th>BROAD ACTIVITY</th>
<th>SPECIFIC OUTPUTS</th>
<th>OUTCOMES</th>
<th>EXTENT ACHIEVED</th>
</tr>
</thead>
</table>
| Creation of Financial Management Section within Surgical Division plus appointments | ● Design of finance functions and structure  
● Advertising of posts and interviewing  
● Appointment of:  
  o 1 Divisional Head of Financial Management (which is now vacant and being re-advertised) and a Deputy Head  
  o Debtors’ clerk and Creditors’ clerk  
  o Supply chain manager (procurement) and 2 procurement officers  
● Establishment of Financial Management Office in same building as Surgery Division for ease of access by Divisional staff, including provision of furnishing and equipment | ● Skilled management team  
● Engagement between finance managers and staff at the point where they work  
● Alleviation of burden on central Finances  
● Direct communication with GSSC | ACHIEVED but still need 3 more clerks |
| Negotiation of financial delegations to Division | ● Negotiation of delegations with central Finance and acceptance | ● Delegation of authority to Divisional Head to purchase items up to R50,000 (as opposed to R30,000 limit in rest of hospital) (Arthur Manning had agreed to increase this delegation to R200,000 before he left but never put this in writing) | ACHIEVED but at one stage there was an attempt to withdraw these by central administration; a delegation to authorise purchases of higher amounts are now needed |
| Transformation of financial management approach | ● Gap analysis of procedures and development of new Standard Operating Procedures  
● Proposals for re-engineering work streams  
● Financial staff visit the wards and give presentations | ● Financial staff more aware of needs of clinical process  
● Engagement between finance and other staff | ACHIEVED |
| Development of zero-based budget system | ● Budgets being developed for each surgical department with the intention of aggregating them into a Divisional budget | ● Collaboration between clinical heads and financial staff in developing budgets  
● More accurate budgets that focus on priority activities | INITIAL PROGRESS but Division not yet provided with a budget by central |
<table>
<thead>
<tr>
<th>Area</th>
<th>Achievements</th>
<th>Status</th>
</tr>
</thead>
</table>
| Monitoring of expenditure against projected budget                   | - Development of Excel spreadsheets to track expenditure and commitments to goods and services (as hospital accounting systems unable to supply this data disaggregated by Division)  
- Reconciliation of these data against those held by hospital and correction of items incorrectly allocated to the Division by central Finance (e.g. surgical supplies were formerly allocated entirely to Surgery, whereas some are consumed by other Divisions) | SOME PROGRESS in terms of in-house monitoring of expenditure on goods and services, but hospital has not yet provided Division with financial management software |
| Development of debtors’ System to recoup user fees                    | - Billing of referral hospitals for costs of medical materials and days of stay  
- Billing of patients covered by third-party payors (e.g. Road Accident Fund, Workmen’s Compensation Fund, Correctional Services) | ACHIEVED                |
| Procurement and supplier payment system                               | - Separation of financing and purchasing functions  
- Negotiation with suppliers to continue supplying when GSSC payment process is delayed  
- Monitoring of orders and payments | ACHIEVED but delegation up to R300,000 required |
| Cost Centre Accounting System                                         | - System designed  
- Investigation of multiple sources of input costs (HR, Pharmacy, Public Works etc.) | LITTLE PROGRESS because hospital has not yet given Division a functional accounting system |

Sources: D, I, (von Holdt 2008; Khalvest Consulting 2009; Surgical Division 2009)
5.6. Transformation of systems management

The Project argues that the complexity of hospital care requires the capability to manage the interface between a number of functions, both external and internal to the hospital (see Box 7). This includes ensuring that engagement with all of these functions proceeds smoothly as well as setting up internal information systems (see Table 15). Hence, the Project placed a Systems Manager in a senior post (converted from a Clinical Executive post). This person is the key administrator supporting the Head of the Division and is essentially ‘the general manager’ of the Division. A number of sub-departments have been created under her authority (namely, Procurement, Logistics, Communication and Information Technology). In addition, she is responsible for providing support to, and coordinating, the functions of Nursing, Human Resource Management and Financial Management. Thus, unlike the traditional Clinical Executive who tends to concern himself with sorting out daily problems on an ad hoc basis, the Systems Manager is responsible for developing systems that ensure the smooth functioning of the Division. This is another key innovation of the Project.

Box 7: Entities with which the Division has to engage

<table>
<thead>
<tr>
<th>Clinical services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Theatre</td>
</tr>
<tr>
<td>• ICU</td>
</tr>
<tr>
<td>• Other medical departments</td>
</tr>
<tr>
<td>• Allied disciplines (especially Physiotherapy)</td>
</tr>
<tr>
<td>• Pharmacy</td>
</tr>
<tr>
<td>• Radiology</td>
</tr>
<tr>
<td>• Laboratory services</td>
</tr>
<tr>
<td>• SA Blood Transfusion Service</td>
</tr>
<tr>
<td>Hospital services:</td>
</tr>
<tr>
<td>• Laundry</td>
</tr>
<tr>
<td>• Kitchens</td>
</tr>
<tr>
<td>• Portering</td>
</tr>
<tr>
<td>• Grounds maintenance</td>
</tr>
<tr>
<td>• Mortuary services</td>
</tr>
<tr>
<td>External providers:</td>
</tr>
<tr>
<td>• Public Works</td>
</tr>
<tr>
<td>• GSSC</td>
</tr>
<tr>
<td>• Companies delivering supplies and equipment</td>
</tr>
</tbody>
</table>

In the past, patient care was severely affected by delays in services provided by the entities listed in Box 7. Respondents gave the example of operations being cancelled because Theatre has no linen or has been flooded by burst pipes (I). Arranging an operation therefore becomes ‘a logistical exercise’, noted one respondent (D) (see Story 9).

The Systems Manager tries to avoid these logistical problems and delays or devise alternative solutions when it proves difficult to eliminate delays. The aim is to make the engagement with other entities and functions ‘more seamless and systematic’ (D). Creating an internal system for ordering and storing crutches is an example of finding a way to decrease patients’ length of stay (see Story 10).
Progress in Systems Management was initially slow as there has been a turnover of personnel with initial appointees achieving little. However, early in 2009 an effective person was appointed as the new Systems Manager. ‘She’s doing a wonderful job,’ said one respondent (I). ‘We need her because she knows everything, connects all of us to one another and can respond to different things’ (I). This person, together with others in the Supply Chain Management Unit, has made a notable difference to supply chain management, another flashpoint area in the rest of the hospital (see Box 6). There have been more limited successes in other areas because of persistent management inefficiencies and resource shortages in these entities (such as Laundry, Public Works and Theatre) (I, I). The Division hopes to eventually move towards service level agreements with these entities so that there could be penalties if they did not deliver the services promised (I).

Box 6: Making the supply chain work

The SCMU is comprised of a range of senior managers in the Division (Heads of Systems, Nursing, Finance; procurement manager; specialist from Orthopaedics). This Committee meets weekly and vets motivations for goods and services that have accumulated during the week. Decisions are communicated back to the applicants within a couple of days, and approved motivations are processed rapidly and followed up actively by the procurement management system. In particular, this means following up on the applications once they have been submitted to the GSSC. As already mentioned, the SCMU liaises closely with the finance section: this ensures smooth processing of payments whilst maintaining the separation of financing and purchasing functions, an innovation introduced by the Division, partly as a strategy to combat corruption.
In the meantime, staff in the Systems Management section, like HR and Finance, make sure that they are aware of the ward environment and are accessible to staff. In particular, they respond to requests from these Sections to deal with problems that are outside their area of control. The intention is to ‘give people access to solutions’ (D) so that they know where to seek help when they have a problem. ‘So the one thing is to make sure the reporting structure is better. So we have a facilities manager who isn’t far away so we have to rely on the Unit Manager to call him or her. But to have someone who walks around and looks and says, “Hey, what’s that noise, why’s that toilet running, how long has that been happening for?”’ (D).

One of the functions of the Systems Manager is to assist the Head in monitoring critical events and processes in the Division. To this end spreadsheets have been developed that provide monthly summaries of, for example: key utilisation indicators; adverse events and remedial action to address these; reasons for cancellation of operations; decisions made at Mortality and Morbidity meetings (including analyses of the causes of preventable problems); key nursing indicators in wards; human resource trends (including the staff complement and cost, absenteeism, leave and disciplinary procedures); income and expenditure by the Division; and procurement processes (I).

However, the Division has some way to go in ‘ensuring that all decisions are information based,’ hence the priority it places on ‘establishing a single operating platform for data accumulation and management’ (Surgical Division 2009: p3).
Table 15: Progress made by the Systems Management Section

<table>
<thead>
<tr>
<th>BROAD ACTIVITY</th>
<th>SPECIFIC OUTPUTS</th>
<th>OUTCOMES</th>
<th>EXTENT ACHIEVED</th>
</tr>
</thead>
</table>
| Creation of Systems Management Section plus appointments | • Conversion of Senior Clinical Executive post to that of Systems Manager  
  • Appointment of incumbent                                                                                                                                                                           | • Senior administrator available to support Head of Surgery and facilitate coordination between different functions  
  • Improved relationship with Public Works  
  • Turnaround for facilities’ repair improved but still difficulties in getting prompt response from Public Works  
  • Improved liaison with wards  
  • Some wards upgraded and painted                                                                                                                                                                           | ACHIEVED but effective incumbent only appointed in early 2009                                                                                                                                                                                                                           |                 |
| Communications sub-department (in charge of intra- and extra-Divisional communication) plus development of policies, hardware and networks | • Created Information Systems Department  
  • NALEDI appointed communications expert who developed communications strategy based on assessment of existing systems compared to future requirement (i.e. gap analysis) (e.g. developing newsletter, calling meetings, ongoing engagement with people etc.)  
  • Established the hardware and networks for internal communication within the Division  
  • Readied this system for connectivity  
  • Designing webpage that will be a link on the hospital webpage  
  • Engaging in other communication strategies, such as e-mails, memos, verbal communication, organising workshops                                                                                                                                                                                                                                           | • Improved communication  
  • Hardware and software ready for internet connection                                                                                           | INITIAL PROGRESS but insufficient funds and time to implement NALEDI communications strategy                                                                                                                                                                                                 |                 |
| Creation of logistics sub-department to manage facilities and assets, and to liaise with Public Works | • Recently appointed logistics and asset manager  
  • Manages facilities and checks on the physical status of the wards using checklist  
  • Liaison with Public Works  
  • Feedback to Unit Managers  
  • Creation of some warehousing capacity (e.g. storage of crutches)                                                                                                                                                                                                                                                                  | • Improved relationship with Public Works  
  • Turnaround for facilities’ repair improved but still difficulties in getting prompt response from Public Works  
  • Improved liaison with wards  
  • Some wards upgraded and painted                                                                                                                                                                                                                                                     | INITIAL PROGRESS                                                                                                                                                                                                                                                                       |                 |
| Creation of procurement sub-department for supply-chain management | • Appointment of manager to regulate all aspects of supply of materials and services from point of manufacture (or company providing the service) through the various middle-men and into the Division | • Ordering in line with Divisional objectives  
  • Greatly improved management of supply chain, including interface with financial management section                                                                                                                                                                                                                                                                          | ACHIEVED                                                                                                                                                                                                                                                                                                                                           |                 |
<table>
<thead>
<tr>
<th>Creation of Supply Chain Management Unit (SCMU) to approve purchases</th>
<th>Reduction in time lag between ordering and delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of quality and standards of manufacture</td>
<td>Correct items being delivered</td>
</tr>
<tr>
<td>Shift from capital purchases to leasing supported by service contracts</td>
<td>Reduction of shrinkage</td>
</tr>
<tr>
<td>Payment of suppliers within 30 days</td>
<td></td>
</tr>
</tbody>
</table>

**Creation of information Technology sub-department**

- Recent appointment of new data capturers, one of whom is capturing data on patients at new oncology clinic

**Coordination and monitoring if different Sections within Division**

- Response to requests from different Sections that are outside their domain of control
- Development of spreadsheets to monitor critical events and processes in the Division

**Development of service level agreements with internal entities and external agencies**

- Service Level Agreement with Theatre Services developed but never implemented by Theatre Services
- Proposal developed for improved functioning of Public Works Department but not acted upon by Public Works
- Proposal developed for more efficient linen policy but not implemented by Laundry

**Sources:** D, I, (Eisenstein 2007; NALEDI 2007; Smith 2007; Spent Arrow Communications and Public Relations 2007; von Holdt 2008; Khalvest Consulting 2009; Surgical Division 2009)
5.7. Transformation of the pharmacy

The central Pharmacy is beset by severe staff shortages, resulting in long waiting times for outpatients and other problems with the quality of the service (see NALEDI focus group discussions with central Pharmacy (NALEDI 2004g)). Although not initially intended to be part of the Project, a former CEO requested NALEDI to address this problem by designing a plan for transformation of the central Pharmacy and the outsourcing of chronic medicines. NALEDI duly did this and its proposal for the outsourcing of chronic medicines was piloted very successfully in the renal unit. Plans were also drawn up for converting a ward into a Surgical Pharmacy. These were accepted by Arthur Manning and a drug company was approached to fund the cost of renovations as funds were not available from the hospital. The intention was to create a facility for the warehousing of all surgical drugs, disposables and consumables which would form part of the new supply chain and increase efficiency. There would also be specialist pharmacists who would serve the Division, including participating in ward rounds.

These plans had to be abandoned when Arthur Manning left because there was no longer support for the proposals.

6. The impact of the Project on key problems

Column 3 of the Tables in the previous section identifies how the Project interventions (described as ‘outputs’ in Figure 3) led directly to a number of consequences (described as ‘intermediate outcomes’). Together, these consequences reflect a marked change in management effectiveness within the Division.

This section summarises how improved management effectiveness impacted on the key problems – or ‘final outcomes’ – that the Project was intended to address, namely, efficiency, staff morale and patient care. As indicated in the Project’s conceptual framework (see Figure 2), while improved efficiency and staff morale are ends in themselves (as they address some of the historical problems identified in Figure 1), they are also important contributors to improved patient care.

As Project staff have identified, the Project still has some way to go before it is fully implemented. The most important outstanding issues are the completion of the skilling of Unit Managers and the implementation of systems to capture data on human resources and finances (the latter is dependent on support from the hospital). There are still some outstanding posts that have not been filled. However, before the rest of the hospital has transformed, not to mention other government entities with which the Division engages, it will not be possible to make all the improvements in efficiency, staff morale and patient care that the Project originally set out to achieve. There is also a danger that, if some of the Project’s interventions are dismantled, some of the gains achieved so far will be reversed.
6.1. Improvements in efficiency

CHB Hospital does not have a health information system that produces reliable trends in key efficiency indicators, such as average length of stay and bed turnover for different Divisions, let alone wards. This means that it is not possible to compare the current performance of the Division against its earlier performance or against the performance of other Divisions. In any case, such comparisons, while they could pick up inefficiencies, would not be able to identify the cause. Thus, an abnormally long stay for a relatively simple surgical procedure could be due factors beyond the control of the Surgical Division – such as the cancellation of an operation because of a problem in Theatre – rather than to inefficient management within the Division itself.

Nonetheless, as reported in Section 5, key informants identified many areas where efficiency improvements have been achieved (see Box 9). Several of these address chronic problems that created considerable frustration in the past. While in most cases it is difficult to quantify the level of improvement, there are examples where key informants were able to produce figures. Thus, the time it takes to appoint a new staff member after identifying the need for a new appointment has been reduced to 2 months (from 4 months or longer), documents received by the Human Resources section are now processed within 24 hours (instead of days or weeks), most suppliers are paid within 30 days (instead of a few months) and the number of queries around conditions of employment has dropped by around six-five percent. While these achievements may seem commonplace in the private sector, they are significant for a system with a history like CHB Hospital. As one respondent said, managing to get a doctor appointed to a senior specialist post within two weeks is ‘a remarkable achievement in this chaos’ (D). As another noted, ‘They have a supply-chain management unit which I think every Division should have copied’ (C).

One of the main reasons for improvements has been putting systems in place and appointing staff dedicated to ensuring that they work, including following up requests that have to be channelled through other entities: as one person commented, ‘All you’re doing now is that you’re motivating [administrative staff] in a different framework, and it’s a miracle. You know the moment that you set people free, you give them the freedom to believe that they are their own initiators ... There are now people who are dedicated to this task, now it’s personal. They know the byways and the forms and who to phone. And it gets done. We’ve proven it’ (D). This even applies to processes that are partially dependent on the GSSC which has always been notoriously slow.

The fact that Theatre Services still experience many problems and therefore have to cancel operations is one of the biggest problems impacting on the efficiency of the Division (D). This problem has a particularly direct impact on patient care. One commentator felt that, given the close relationship of the Surgery Division to Theatre Services – expressed by the close teamwork between theatre sisters and surgeons – transformation of the two entities should have proceeded in parallel (C).² Key informants pointed to a host of problems in other sections of the hospital that impact on the efficiency of the Division, such as continually waiting for drugs from the pharmacy and the chronic shortage of clean linen and pyjamas in the wards (D, I).

² Over time Surgery and Theatre services did cooperate in purchasing equipment through Surgery’s supply-chain management system (C). A draft Service Level Agreement was also developed between the two entities but never became operational (NALEDI 2007).
Box 9: Improvements in efficiency

Overall
- Reduced bureaucracy, freeing staff to focus on management
- Improved liaison with wards
- Early identification of critical events and ability to respond rapidly
- Alleviation of administrative burden on CEO and central hospital management
- Direct communication with GSCC

Human resources management
- Reduction of overall time taken between identifying need for more staff to staff being employed from 4 months or more to 2 months
- Staff employed within 10 days of interviewing them
- In ward, dynamic daily adjustment of staffing according to bed needs
- Almost 100% compliance with performance assessment requirements
- Accurate salary payment
- Pay-slips delivered to ward (staff do not need to leave the ward to collect them)
- Ward staff do not have to leave wards for a long time to make other queries because of close proximity of HR section
- Reduction of queries made by staff by 65%
- Culture of improved discipline within the Division
- Elimination of historical backlog of labour relations queries/grievances (dating back to the 1990s) within 3 months of appointment of labour relations staff member
- Current grievances dealt with immediately (usually within a few days)
- Responses to complaints in Customer Services box dealt with within 24 hours
- Around 85% of comments received in box are favourable
- Impact of strike delayed by reaching agreement for skeleton services

Financial management
- Improved tracking of expenditure and commitments
- Greater understanding of costs
- More accurate budgets that focus on priority activities
- Improved billing
- A decline in outstanding debts
- An increased revenue stream for the hospital
- Payment of suppliers within 30 days

Procurement
- Ordering in line with Divisional objectives
- Greatly improved management of supply chain
- Reduction in time lag between ordering and delivery
- Correct items being delivered
- Reduction of shrinkage
- Turnaround for facilities’ repair improved

Source: Tables in Section 5, (von Holdt 2008; Khalvest Consulting 2009)

6.2. Improvements in staff morale

A consistent theme amongst all designers and implementers was the improvement in relationships between different staff categories, in staff morale and in labour relations within the Division. ‘There is in fact a completely new level of trust, cooperation and respect,’ said one respondent (D). People interviewed demonstrated a striking enthusiasm and unity of purpose, as well as a sense of relief that inter-personal relations were well-structured and respectful. As one person said, ‘You feel that it’s quite nice to work here, there’s a difference in the workplace’ (I) while another said, there is
‘more opportunity and freedom to do what I think best’ (l). The same person said ‘we are seen here ... I feel much better respected but the feeling is mutual ... We have started to see each other as human beings’ (l). Another implementer characterised management meetings as allowing ‘openness, opportunity for growth, freedom of expression without any fear of intimidation, constructive criticism ... The team spirit kept me [going]’ (l). Referring to nurses’ satisfaction, one commentator said, ‘Nurses? They seemed to be better. I think there’s a lot of allegiance. I sense a lot of allegiance towards the department’ (C).

This is borne out by the survey of almost 13 percent of Divisional staff from different professional categories conducted in November 2008 by Khalvest Consulting (Khalvest Consulting 2009). Almost 60 percent of the people surveyed had been with the Surgical Division for 10 years or more (almost 78 percent had worked in the Division for six years or more). This relatively stable workforce had been present in the Division before transformation and was surveyed roughly a year after proper implementation had begun.

Overall, three quarters of respondents said that they were satisfied with the Surgical Division as their workplace (Khalvest Consulting 2009). Two thirds said that they had seen an improvement in their workplace as a result of the Transformation Project. Staff also revealed that they experience unusually positive relationships and a sense of collaboration (see, in particular, the shaded areas in which around 80 percent or more of respondents give positive responses). Thus, the Khalvest Consulting report concluded from the survey and key informant interviews that there is ‘a good relationship and team work amongst staff. As a team they share and exchange information’ (Khalvest Consulting 2009: p51).

Strictly comparable data are not available from other departments but a 2005 survey of 217 medical and nursing staff across the hospital found high levels of burnout as expressed through emotional exhaustion and a sense of depersonalization (Schneider, Oyedele et al. 2005). A 2006 survey of 310 staff within Surgery also found high levels of burnout (Rajaram 2009). Both studies identify inaccessible and disinterested managers as one of the contributors to burnout. These studies, which were both conducted before implementation of management changes in the Surgery Division, seem to describe a situation that contrasts with the figures in the shaded rows in Table 16 which date from 2008.

3 The subsequent five rows in the Table present a more mixed view of the relationship between managers and staff (as opposed to the relationship between colleagues) although the way the questions were asked does not distinguish between managers within the Division and those from central administration and so it is difficult to interpret their meaning and reconcile them with the positive responses in the shaded rows.
Table 16: Selected employee survey findings from the Khalvest Consulting report, end 2008

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>‘STRONGLY AGREE’ AND ‘AGREE’ (%)</th>
<th>‘STRONGLY DISAGREE’ AND ‘DISAGREE’ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, I have a positive relationship with co-workers</td>
<td>88</td>
<td>6</td>
</tr>
<tr>
<td>Employees regularly share and exchange ideas</td>
<td>79</td>
<td>4</td>
</tr>
<tr>
<td>Employees in my workplace work together as a team</td>
<td>79</td>
<td>12</td>
</tr>
<tr>
<td>Teamwork is encouraged</td>
<td>85</td>
<td>8</td>
</tr>
<tr>
<td>Someone shows concern for my well-being</td>
<td>65</td>
<td>6</td>
</tr>
<tr>
<td>Employees are valued at work</td>
<td>46</td>
<td>23</td>
</tr>
<tr>
<td>Employee relationships with management are based on trust</td>
<td>60</td>
<td>13</td>
</tr>
<tr>
<td>There is open communication between management and staff</td>
<td>44</td>
<td>26</td>
</tr>
<tr>
<td>Overall management is effective</td>
<td>53</td>
<td>18</td>
</tr>
<tr>
<td>My workload is reasonable</td>
<td>39</td>
<td>37</td>
</tr>
<tr>
<td>I have the necessary equipment I need to perform my work</td>
<td>33</td>
<td>38</td>
</tr>
</tbody>
</table>

Source: (Khalvest Consulting 2009)

Where dissatisfaction was expressed in the Khalvest Consulting survey, it seems to have stemmed rather from a shortage of resources as evidenced by the responses relating to equipment and workload, factors not directly under the control of the Project. In fact, when the figures are disaggregated into different professional groups, 50 percent of doctors and 42 percent of nurses felt that their workloads were too high, reflecting the staff shortages in the Division at that time which still prevail to some extent today (Khalvest Consulting 2009). Apart from additional staff and equipment, additional training was also identified as one of the three top interventions that would improve job satisfaction.

With respect to labour relations, there is no longer the ‘general environment of hostility towards unions’ that characterised the 1990s (D) and in which ‘employees used unions as a buffer for whatever problems they might have with management’ (Khalvest Consulting 2009: p34). The closer working relationship with labour is something that seems to be widely acknowledged (C). This was achieved by the Project partly ‘through engaging unions as co-partners in decision-making’ (Khalvest Consulting 2009: p36). It also resulted through the creation of a functional labour relations unit within the Division which is well-informed, trained and takes responsibility for engaging with unions (Khalvest Consulting 2009). Said one respondent, ‘they [union representatives] come in here and chat – we never had that relationship before’ (I). These factors are important for improved communication and coordination, and allows tensions to be diffused before they become chronic problems or cause labour unrest. This clearly has implications for efficiency and patient care (as demonstrated by the conceptual framework). It has also led to a marked impact on levels of ill-discipline (D) and a reduction of absenteeism (Khalvest Consulting 2009).

The ability of the Project to foster empathy between groups and between individuals seems a particular strength: respondents reported that it is this growing empathy that allows them to accommodate colleagues who, at times, behave in an inappropriately angry or rude manner. One respondent said, ‘Another important thing is the improved relations, even among the doctors. The head of X just used to work with his doctors. Now they see each other at meetings, everyone knows each other. The same between nurses and doctors. It is a nice feeling: I look forward to coming to
work. If someone is not behaving in a nice way, you know if they have personal or social problems so you can empathise with them. You can talk to them about it’ (I). That this kind of tolerance is seen as necessary is testimony to the highly stressed and fraught circumstances under which hospital staff work and live.

The designers reflected that this goodwill has been generated by a number of strategies employed by the Project. One has been the reorientation of management towards patient care: ‘I think they feel enabled because they know that when I come down on something, it’s not because we wasted money, it’s because the patient outcome has been affected’ (D). Another has been the use of a participatory management style that has been combined with capacity development to ensure that managers feel able to participate fully: ‘I feel that people feel to some extent supported. They feel they have a place to go to get someone to help them to deal with a problem. So they’re consulted but they [also] …. have a supportive environment … an environment that they knew was their environment, it wasn’t just a hospital-wide environment, where these things can happen’ (D).

Another implementer commented, though, that ‘You can only do that if the system demands it of you. You can’t try and foster inter-personal relationship and include bureaucracy in patient care, if nobody knows what the framework is. Somebody’s got to understand the ground rules. You can’t do the one without the other. But the framework comes first and the systems management’ (D). This was corroborated by another respondent who said, ‘I’m trying to give people access to solutions’ (D).

This assessment by key informants tallies with the findings of the Khalvest Consulting report which concluded that, ‘the new management structure has resulted in improved communication, team work, coordination [and] easy decision-making within the Surgical Division’ (Khalvest Consulting 2009: p2).

Not only is this situation a lot better than that experienced by the Division until the early years of this century, it also marks an improvement for many Divisional workers since the early days of the Project. Respondents characterized the early days as ‘quite hectic’ (I) because a lot of jealousy was generated amongst other staff who thought that Divisional workers were receiving better pay than their equivalents in other parts of the hospital. This is untrue, a matter that the unions played a big role in clarifying (I). There is a danger that current uncertainties about the future of the Division will affect staff morale adversely: one respondent noted that there are already signs that uncertainty has ‘depressed the spirits’ of staff (I).

Some critics of the Project reportedly argue that the improvements described above are simply the result of ‘staffing norms [that] were way much more acceptable compared to the rest of the hospital’ (C). It is true that in the early days of implementation the Division recruited 100 new nurses. In addition, Arthur Manning allowed the Division to contract more agency nurses once it had put its staffing norms in place. However, there has been a constant attrition of nurses from the Division for the usual reasons and also because the Division lost the nurses working in the Trauma Unit when it amalgamated with the general ICU in 2008 (D, (van der Walt 2008). Staff shortages have thus always remained a severe problem for the Division, as indicated in the Khalvest Consulting survey. This evaluator has to conclude from all the evidence presented in this section, therefore, that significant improvements in staff morale and labour relations were the result of transformed management systems and a change in organisational ethos.
6.3. Improvements in the quality of care

As with efficiency, the quality of care provided by the Division is itself influenced by a host of factors apart from those under which it has direct control (such as the cancellation of operations due to problems in Theatre or the failure of equipment to be delivered by contractors because they have not been paid by the GSSC) (see Story 11). Untangling these influences would in itself be a difficult task. It is complicated, however, by the fact that the hospital has no baseline data with which to compare current trends because, like many other public facilities, it has been unable to implement a reliable health information system. Thus, the hospital is unable to generate data that compares the performance of the Surgery Division with its past performance or with that of other Divisions (although last year there was reportedly an assessment of the incidence of bed sores – a measure closely related to standards of nursing - which indicated a decline in incidence (C)). As one respondent concluded, ‘We can’t measure them [quality of care indicators] in this chaos, it’s impossible’ (D). A later section returns to the issue of whether the Project could have set up its own system for monitoring proxy indicators of improved patient care.

Story 11: Allocating blame for poor health care

‘But let’s be kind and say, in an efficient hospital, the repair of a leg ulcer or flap, you come in the night before and you’re out by lunchtime the next day.  [At CHB Hospital] it now takes five days so you say, “Ooh, bad Surgical Division - they can’t get it together!”  Now, let’s go through what could have been the problem.  The patient got to the ward but the ward was full because the crutches hadn’t arrived and therefore there was no bed, so the patient slept on the floor.  And then the patient could have gone to theatre the next day but the pipes broke in Theater, which they do on a regular basis, so it was flooded.  So they could only dry theatre out two days later and then,… as the patient was being wheeled up to Theater, the oxygen tank was empty because the Province hadn’t paid Afrox.  So, you see, … where do you want to allocate the blame?  Is it Smith who is wrong?  Is he a bad surgeon? Was he lazy, he didn’t come to work that day?  No, he was at work.  And the nurses? – they were at work.  Were they lazy nurses? Were they just drinking tea, was that the case?  I’ve explained a scenario to you that shows you that in attempting to measure or to produce an index of whether this model has produced a more effective outcome, you absolutely cannot, because there are so many other extraneous inputs that are beyond the control of a sub-set.  Now,… if this model had been allowed to come to fruition, in its fullest sense, with its own budget and checkbook and procurements, that functioned independently as a 700 bed hospital, then you could have said, “Lazy doctors!  Lazy nurses!” or whatever.  But … how does Smith control the boiler, how does he control the Works Department that, no matter what you do, refuses to fix anything, even though they carry the budget.  So in this setting, even your administrative indices, are filled with, fraught with, fault-lines.’ (D)

Nonetheless, all the Project’s interventions have been directed at improving patient care, as shown in the Project’s conceptual framework.  Almost all designers and implementers spoke about how changes in efficiency and staff behaviour, as well as the improved cleanliness of the wards (C), have contributed towards this.  Thus, referring to the strategy to improve the availability of crutches (see Story 10), one informant said:  ‘Do I have proof that moving patients faster through the system because they can be discharged earlier with crutches] improves patient care?  Well, I don’t, but intuitively it makes sense to me if I discharge you earlier, the evidence would tell us there’s less hospital-acquired infections, that mobility in the home environment, even in the worst environment, is better, you’re forced to be active.  If you look at a whole host of literature about outcomes, length of stay is one.’  (D)
From the point of view of the designers and implementers, then, the sorts of things that have made the most direct difference to patient care include (D, I):

1. Unlike in the past, getting doctors and nurses to do ward rounds together so that instructions for patient care are clear. This is supplemented by other practices that encourage a team-based approach.

2. Ensuring that instructions for patient care are carried out by creating accountability in the form of the Unit Manager. This includes proper monitoring of patients (so that, for example, post-operative patients do not develop pneumonia or septic wounds).

3. Developing Standard Operating Procedures that guide nursing staff, especially now that there are more enrolled than professional nurses in the wards.

4. Empowering nurse managers to solve patient care problems themselves and raise concerns about medical care and ethical issues.

5. Having formal, regular reviews by doctors and nurses of adverse incidents.

6. Implementing a system in the general and Trauma wards whereby a consultant is permanently on-call on the premises (this is an unusual arrangement in South Africa).

7. Creating a high care Trauma Unit within the Division so that these patients can receive more intense care (one nurse cares for one patient, rather than the more usual ratio of one to five or six).

8. Responding rapidly to concerns raised by patients and their families.

9. Improving the hygiene of the environment by keeping wards clean, attending to leaking toilets and ensuring that paper towels and disinfectant are available in the wards for cleaning hands.

10. Improving staffing levels, including filling vacant posts rapidly.

11. Interviewing staff for specific posts so that staff are able to choose jobs that they find interesting and are committed to.

12. Freeing staff from administrative burdens so that they have more time to spend at the bedside.

13. Ensuring that supplies and equipment are ordered and received promptly.

This replaces a health care environment that one respondent characterised as, ‘complete disorganisation. Each one of us was doing whatever he wanted. I’m talking about heads of the units. There was no control, outcome control. There were no protocols. There was a complete hiatus between the nursing staff and the doctors. The different specialties did not have any contact as such and there was a lot of animosity and a lot of competition’ (I). Now the Surgery Division attempts to provide an ‘environment [that] supports attention to details’ (D). As one respondent said, ‘in an environment where there’s order, patient care [doesn’t] slip through the cracks. And I’ve seen it in some of the units where there’s less attention to detail and I see the chaos that happens
there and I see the Morbidity and Mortality Meetings and when we interrogate adverse outcomes I can see that there was no attention to detail. Someone just skated past and very superficially just had a look, rather than spend time really engaging. So it’s those kinds of mindsets that one wants to change, not just by … instructing people to do it, but by giving them an environment where it’s easier to do it’ (D).

In other words, rather than rely simply on individual competence and goodwill, the Project has attempted to create a structure and set of accountability mechanisms so that staff know what is expected of them and that ‘they cannot do whatever they want’ (I). Important to this has been the weekly Morbidity and Mortality meetings: ‘Look, in South Africa life is cheap, okay. By doing a decent Morbidity and Mortality, where you have your peers there, sitting there, and they’re not out for blood but they are not prepared to accept rubbish, life then becomes expensive’ (I).

Respondents also pointed to the fact that ‘relationships have definitely improved between admin and employees so [there is an] automatic improvement in patient care’ (I). The alleviation of industrial tension was also cited as a mechanism for improving patient care (D). These points refer to the link between the way patients are treated by health workers and the way health workers are treated by their employing institution, a link that has been increasingly well documented in the international literature.

In conclusion, one designer said emphatically that, ‘we have upgraded the service, the level of service … that we are offering our patients and there is no doubt in my mind, no doubt in my mind, that we have improved outcomes’ (D). Another referred to the fact that this is the perception amongst patients, too (I): patients from other Divisions who are sometimes placed in the Surgery Division because of a shortage of beds are reportedly reluctant to return to their original Divisions. ‘There is a feeling that Surgery is a Folateng’ said this respondent (I), referring to wing at the Johannesburg Hospital that has been created for private patients. In the Khalvest Consulting survey, 60 percent of respondents agreed that patient care had improved as a result of the Project (only 13 percent disagreed and the rest were undecided). Sixty-two percent reported having received positive feedback from patients.4

The Khalvest Consulting report also quotes a senior Wits academic commenting that the training programme at Chris Hani Baragwanath Hospital is now on a par with that at Johannesburg Hospital, with registrars now happy to rotate through the Division whereas previously there had been resistance: ‘The Academic scope … has grown significantly. The creation of the cluster has reduced the overload on the students … the Division has become one of the strongest in the county and created control on what is clinically possible, and provided a good opportunity to create multidiscipline [sic] in a single training environment’ (Khalvest Consulting 2009: p36).

4 The Khalvest Consulting report also suggests that there is an improvement in the bed occupancy rate and a decline in mortality in the Division but this evaluator feels that the three months of data on which this conclusion was based is not sufficiently reliable to draw a conclusion.
To this evaluator the evidence presented above seems convincing. There seem to be a host of plausible pathways through which transformed management systems and organisational culture could be impacting positively on the quality of care delivered within the Surgery Division. The fact that the Division has not produced incontrovertible proof (through measuring indicators of quality of care or health outcome) is no reason to contend that quality of care has not improved, as some critics of the Project reportedly do (rather, it is a reason to criticise the Project for failing to implement a monitoring system as one of its interventions).

It would be interesting to explore, however, why one commentator supportive of the Project noted that improved patient care is not immediately visible to other departments that engage with the Division on a regular basis. This person said that, as a result of the Project, it wasn’t possible ‘to see a change in the surgeons per se. There was no change in their behaviour or anything ... There was absolutely no change from that point of view ... There was no change in whether the patients were worked up better ... There’s still delays and nothing changed from that point of view ... So there was no change in ... attitude which did irritate because if they’re now being treated as a pilot ... with a lot of advantages, then come on guys, come to the party’ (C). It is not clear whether this point reflects a lack of engagement by the average surgeon in the processes that underpin the Project (as discussed later, doctors do not seem to have been as closely involved in transformation as were nurses) or whether it simply reflects ongoing tensions between different Divisions in the hospital.

7. Factors facilitating the progress of the Project

This section identifies factors that enabled Project implementation. Many of these factors relate to the processes adopted by the Project. The evaluator sees these as having been key to achieving the successes outlined above. In other words, how the Project was implemented seems to have been as important as what was implemented. Not all stakeholders will agree with this assessment, however, while some of these processes broke down at later stages of the Project, as reported in Section 9.

7.1. Building consensus around the need for transformation

Especially in its early days, the Project was associated with intense consultation with all stakeholders in the hospital (Tapson, Eisenstein et al. 2004; NALEDI 2004a; NALEDI 2004b; NALEDI 2004c; NALEDI 2004d; NALEDI 2004e; NALEDI 2004f; NALEDI 2004g). This was necessary because of the fractured past of the hospital. It also arose because the Project grew out of the union movement and was led by its think-tank, NALEDI, both of which are steeped in the consultative approach.

The consultative approach forged agreement across the management echelons of the hospital to implement a pilot. It was also important in achieving the buy-in of unions which remains an important feature of the Project and has prevented unnecessary confrontation and conflict. One respondent reflected that unions participate actively in the Transformation Project because, ‘They see a framework in which they can function honestly and effectively and, above all, they are listened to ... Here, when we went into the strike, they were equal partners in trying to avoid the consequences of the strike and they were magnificent. But they were only magnificent because they
believed in the system that incorporated them into management decisions. And they are an integral part of that” (D).

Transformation was a concept that successfully marshalled the support of different stakeholders: ‘it’s a discourse, it’s a language that pulls people in and that you can use to mobilise change’ (D). This built on a general desire of health workers ‘to be able to say that they were proud of the hospital’ (D) and, at least initially, created an alliance for change amongst a wide number of stakeholders (see Table 3).

7.2. Providing strong and consistent leadership
NALEDI played a critical role in generating buy-in to the Project amongst all stakeholders, working continually with the unions to sustain their buy-in and setting up a participatory management style (mainly through the efforts of Karl von Holdt, Bethuel Maserumule and Moloantoa Molaba). It was also responsible for engaging politically at the hospital level and in government and brokering the concerns of different stakeholders (D). As a very senior person in the Division put it, ‘they were a very important unifying force between all categories of staff, not just the unions’ (D).

NALEDI also conceptualised the model for management change. Colin Eisenstein, a key member of the NALEDI team, was identified by respondents as instrumental in the design of the organogramme and the implementation of the model, including in-depth support to new managers (D, D, I, I). He was described as ‘a very wise person’ and ‘a very good advisor’ (I). He was also someone with ‘remarkable logic, [a] remarkable path-finder’ (D). Respondents intimated that ongoing support by Colin Eisenstein, or someone like him, is still needed by the Division and would be essential for further roll-out to the rest of the institution: as one respondent said, ‘I couldn’t believe it when they got rid of him just before the roll-out’ (I).

The Khalvest Consulting report notes that ‘[t]he preparations for and the strategic plans that were produced through interaction with the stakeholders by NALEDI are excellent. The processes they followed and some of the documents they produced are excellent’ ([Khalvest Consulting 2009: p25]) but concludes that NALEDI ‘failed to guide the transformation project successfully’ ([Khalvest Consulting 2009: p1]). This conclusion seems to be based on the fact that the transformation model was not completed within the specified time and that the model itself was not written up in an accessible format – what the Khalvest Consulting report calls a ‘blueprint’ – so that it could be reproduced elsewhere. To this evaluator, Khalvest Consulting’s conclusion seems somewhat harsh, given the achievements of the Project and the considerable constraints it faced (see below). On the contrary, the ability to mobilise unions and create an alliance between them and clinical as well as administrative staff seems a rare skill, while NALEDI’s management support seems to have been innovative and effective.

It is true, however, that effective engagement with stakeholders dropped off as NALEDI became intensely involved with daily implementation, to the detriment of disseminating information on the impact of the Project and discussing options for roll-out. It was at this point that ‘some of the cracks in the hospital community evolved’ (D), as will be discussed in more detail later. However, this is less a failure in NALEDI’s strategic leadership than the over-ambitious nature of NALEDI’s tender bid which hoped to achieve in one year a degree of change that is highly unlikely in a complex and
bureaucratic public health system. Possibly it also reflects the need for external support to assist in change management processes of this magnitude.

Another key leader was Martin Smith. He was the main reason why the pilot was located in Surgery and was eventually appointed as the first Head of the Division. He is a Chief Specialist and Adjunct Professor and, as already described, still practises as a surgeon in the Division. He has authority and the respect of his peers, which was crucial for bringing the clinical Heads into a unified structure under his management (von Holdt 2008). Respondents describe him as an enthusiastic idealist who is also a very good manager (I, I). He is supportive of staff and listens to their issues (I).

While Martin Smith was critical in the developmental stages of the Project, the designers of the Project insist that the success of the model does not hinge on the personal characteristics of the Head (personal communication with D, D, D, D). The new management structure should be able to continue under different leadership styles, provided that the Head is a competent leader.

The Project also emphasises that the Head is a leadership rather than an administrative position: the Head does not need to have in-depth knowledge of administrative functions but must be able to delegate and take advice appropriately, with the support of a strong administrative team. He must be knowledgeable but also able to learn from his administrative staff. This has been a characteristic of Martin Smith: ‘he may not understand something, then he comes and sits in our meetings and learns’ (I).

Martin Smith is reportedly not so well received amongst some of the central hospital managers. This is probably partly because of his outspoken criticism of bureaucratic features which he feels are inefficient or inappropriate, as well as occasions when he has lost his temper. Unfortunately, this evaluator has not been given access by the senior hospital management to key informants who might be able to reflect more on the negative aspects of Martin Smith’s leadership, and is thus not in a position to comment on how these may have affected the progress of the Project. However, one commentator who had had a sometimes conflictual relationship with Surgery’s Head later said that, ‘Somehow I think he had the right vision ... Speaking to him, you know, he might [be] arrogant with dealing with people but listening to him sometimes I heard he had his head in the right place in terms of what’s supposed to happen in the Division’ (C).

Notwithstanding the positive comments quoted above, it does appear that the fact that the designers of the Project - Martin Smith, Colin Eisenstein and most of the NALEDI consultants - are white has contributed to negative perceptions of the Project in some quarters (C, C). Even though within the Division the main beneficiaries with respect to advancement through the management echelons are black (and nurses) (see Table 11 and Table 12), it is true that the ‘face’ of the Project is white and male, a disadvantage in an institution with a history such as that of CHB Hospital. Two commentators felt that the Project leadership should have been more involved in building the capacity of black consultants, including drawing on the expertise of knowledgeable individuals already placed within the hospital and provincial head office management structures.

Returning to the issue of leadership, the former CEO, Arthur Manning, was seen by several key informants as critical to the successful implementation of the Project (D, D, I, C). He championed the project and ‘threw in his lot with the need for change’ (D). As one commentator said, ‘I think he was doing a fairly good job. He was on board and he was passionate about the Project itself. ... I
think he did everything he could to make sure the Project survives’ (C). It was a great blow to the Project when Arthur Manning was unexpectedly removed from his position. Unfortunately, the fact that the Project agitated for his reinstatement seems to have created a hostile environment for the incoming Acting CEO (C). This later had negative repercussions for the Project.

7.3. Involving organised labour in an integral way

Organised labour - especially the shop stewards at CHB Hospital, but also the provincial and national leadership (D) - have been instrumental at different stages of the Project in pushing for funding and implementation, sometimes by bringing high-level political pressure to bear on the Gauteng MEC and the head office of the Gauteng Department of Health. Of the four unions at the hospital, it is NEHAWU that has been the most influential in shaping the Project and building support for it both inside and outside the hospital: this is because, ‘the branch of the union at Chris Hani Baragwanath is very influential in the region of Jo’burg and also in the province and also nationally … Bara is a very, very powerful branch’ (D).

Organised labour was also involved in ensuring that Arthur Manning was appointed as CEO (D, I). While labour’s political clout was critical to bringing the Project to fruition, it may have had some negative consequences in that the Head Office management at the Gauteng Department of Health may not have bought fully into the project (D).

Unions’ involvement did not bring them enormous material benefits, however. As one respondent said, ‘I think they [the unions] supported it in fact beyond what good trade unionism would have suggested – I don’t think they got a lot out of it actually. But it’s clear what they did get was this notion that they were the authors of this project, they are the ones bringing transformation’ (D). There were some benefits for unions, however. These included: a quick resolution of grievances outstanding from the apartheid era; a fair, rapid and transparent disciplinary process; revitalised multi-lateral and uni-lateral meetings, at least at the level of the Surgical Division; enhanced participation in decision-making; and the creation of 20 new cleaning jobs which they were involved in allocating (D, D, D).

The NEHAWU representative that was seconded to NALEDI for the duration of the Project was credited by key respondents for ensuring that union participation was effective. Said one respondent, ‘he became very much located at the hospital and could speak for labour in a very authoritative way … So suddenly instead of us almost having to translate what the shop stewards were saying or speak for them, we found that the union could speak in a very articulate way’ (D).

7.4. Empowering Divisional managers

Project designers emphasised the importance of empowering managers, not only with skills, but with the ability to have ‘power over their domain’ (D). In other words, while lines of accountability have been tightened up, at the same time managers have been given more freedom to make decisions over the area in which they are in charge. This principle has been especially important in the implementation of the Unit Manager system in wards. Several respondents pointed to the fact that giving these managers increased responsibility has increased motivation and generated pride.

It was important for the Project to ensure that new managers were supported and mentored. Thus, for example, in the development of Standard Operating Procedures, a consultant would show staff how to write the first procedure. The he would discuss the next procedure with them and get them
to draft it on their own, giving feedback on the finished product. As one respondent said, ‘I did the best I could. I used a lot of motivation, a lot of passion. I kept reminding people of why we were doing things. I kept reminding people of what power they had over the situation, so when they tried to renege on that power I wouldn’t let them get away with it ... I felt what I achieved was much more through giving people place to learn and develop and let them know that I was there to support them but I wasn’t going to solve everything. They have to take responsibility’ (D).

7.5. Making management accessible
A recurrent theme in interviews was the importance of managers being located physically near the health services they manage in a single cluster of offices. Central management offices are distant from the Division so in the past it would take people a long time to go there. This would mean that they would be away from their duties for a long time or become discouraged from engaging with management. Managers’ offices are now only a few doors away and, in addition, as one informant said, ‘we go out to people’ (I). The culture of managers visiting staff in the wards on a regular basis, and adopting an approachable manner, not only allows managers and staff to get to know one another well and resolve problems quickly, but also means that managers have a good sense of what the clinical process entails. This helps to reorient support services towards patient care: ‘You see how you bring that interface close, and that improves clinical care because everybody now, you are not an administrator of procurement, you are a carer of a patient. There’s a huge difference’ (D). The new management approach also puts more accountability on support services staff to respond to the needs of the health services.

This reorientation has been achieved using the same people who previously worked in a bureaucracy that one respondent characterized as ‘frozen in time’ (D). Now, they are stimulated to use their initiative and find innovative solutions to problems. As one support services manager said, because of exposure to the clinical process, ‘my knowledge has improved, I’m not just talking personally but as a manager’ (I).

7.6. Engaging in a slow, thorough process
Respondents emphasized that achieving the changes that are associated with the Project is a slow process that cannot be rushed, especially when the aim is participatory management: ‘we have to sit down and discuss things’ (I). Consultation has to occur in good faith, new roles and responsibilities have to be negotiated carefully (and re-negotiated as circumstances and people change) and skills have to be developed. Several respondents referred to the importance of building trust as part of a more responsive and dynamic management process. Thus, for example, trust was important in ensuring the cooperation of supplying companies in creating an effective supply chain and in retaining the support of union members, even as the Project implemented more stringent disciplinary procedures.

What the Project had not anticipated, however, was the amount of time they would have to spend keeping the Project on track, given problems in receiving anticipated funding and support from the provincial Department of Health, as discussed later.
8. Factors constraining the progress of the Project

The process of implementation within the Surgery Division seems largely to have been a positive experience for staff, especially for nursing and administrative managers. These categories were empowered to both organise and deliver health care more efficiently and to contribute to decision-making as active partners. The engagement of unions in Divisional decision-making also seems to be a strikingly positive feature of the Project. Unfortunately, the evaluator was not able to check this assessment, based on key informant interviews and documentary sources, by conducting focus group discussions with Divisional nurses, doctors and shop stewards, and health workers external to the Division, for reasons described in Section 2. As noted in an earlier section, there does seem to have been opposition to the Project on the part of some senior Divisional clinicians, for example.

The main problems with the process of implementation, though, seem to have coalesced around the relationship between the Project and stakeholders outside the Division. Despite the fact that, before it began, the Project had wide support from all key stakeholders, during its lifespan its support base eroded. This Section tries to explain how this state of affairs has arisen.

While personality clashes, professional jealousy and power struggles seem to have played a part, as they do in most institutions, this evaluation concentrates on identifying weaknesses in the way the Project was integrated with the overall strategic direction of the provincial DOH and CHB hospital, as well as managed in relation to the rest of the hospital. This is because strengthening implementation processes and mechanisms for oversight are strategies that can be put in place to manage and channel institutional politics in a more constructive direction.

Stakeholder concerns around the Project model (as opposed to its manner of implementation) are separated into a separate section (Section 9) in order to avoid confusion between design and process issues.

8.1. Postponement of Project roll-out

In 2006 the Project had had a high-profile start-up and, together with the CEO Arthur Manning, created the expectation that it would be completed within a year. Hospital staff anticipated that, thereafter, the pilot would be rolled out to the rest of the hospital and equivalent benefits would accrue to other Divisions. However, the timeframe for the pilot was extended as the Project battled to access promised financial resources.

In 2008 Arthur Manning committed the hospital to roll-out the Project in a signed agreement shortly before his redeployment. At the July 2009 hospital-wide meeting to evaluate the Project, the then MEC gave an undertaking to report back to the institution by August 2009 as to her decision regarding the future of the Division; this has not yet happened in any formal way. As one commentator said, ‘up to now, nobody knows the future of the project’ (C). It is unsettling, therefore, that recently some of the core principles and positions in the Division have been dismantled.

These uncertainties created a sense that the Project has dragged on without benefits materializing for the rest of the hospital. As the Khalvest Consulting report found, there is a ‘perception from other divisions is that a lot of money was injected in the surgical division to recruit new staff and buy
new furniture to the exclusion or at the expense of other Divisions within the Hospital. Furthermore, that the process has been reduced to promoting better access to resources both material and human by the Surgical Division’ (Khalvest Consulting 2009: p70).

Also, as discussed in more detail later, it is not clear to other hospital staff what the activities and impacts of the pilot have been (11). As one key informant summarised, ‘they had a start date. None of us knew when the end date for the pilot was. It’s starting on this date, ending on this date, these are what we are going to look at, these are going to be our outcome measures. And it just sort of carried on. And that was unfortunate for Martin, I think, because we had the elections and a new government and before that our CEO was redeployed etc. etc. etc. and it was just a pity that there was no end point’ (C). Indeed, this would have been unfortunate for any pilot because pilots – and the favouring of services in which they are implemented - are often only tolerated by the rest of the health service on the basis that they are temporary and will eventually leverage resources for the system as a whole.

Thus, although there had been a groundswell of support for the project at the time of its initiation, some of this dissipated over time as the Surgery Division appeared to benefit for an extended period from extra resources at the expense of other departments. Interviews by Khalvest Consulting revealed that, ‘Due to better working conditions and compensation, other divisions of the hospital have seen the loss of competent staff to the Surgical Division. This has resulted in poor service delivery and increased work overload in other divisions’ (Khalvest Consulting 2009: p30).

Consequently, ‘the perception is that the Surgical Division is being ‘ring fenced’ from the rest of the hospital’ (Khalvest Consulting 2009: p31). As one commentator said, the Surgery Division came to seem like ‘a pure, pure, separate hospital’ (C). It became difficult for staff in other Divisions to appreciate that ‘one’s got to look at the philosophy behind it and if it’s going to mean that the entire Bara changes then everybody’s just got to bite the bullets until it happens to the rest of the hospital’ (C).

These perceptions began to develop when, in the early days, the pilot was only implemented in 8 out of the 23 wards in what is now the Surgery Division. This created resentment amongst staff working in the other wards, especially as there was a rumour that staff in the pilot wards were receiving higher salaries and other benefits (I).

This same sentiment surfaced in other parts of the hospital at other times. For staff from other Divisions it may have been difficult to understand why Surgery Division staff were the ‘blue-eyed boys’ (I) and are the beneficiaries of extra funding, posts, offices and attention from the CEO (I). As one commentator put it, there was considerable jealousy because ‘the perception was ... they were better staffed, their nurses were better looked after, their HR practitioners were better looked after, in fact everybody was looked after better. They had nicer computers and nicer offices and whatever, that was the perception’ (C). The Division has also been able to appoint senior managers at higher levels; these senior managers may be at the same level as someone in central management who is responsible for a much larger area of the hospital, the perception being that the Divisional manager therefore has a lower workload (C), although this is not necessarily true.

The unions have been crucial in dispelling these rumours by working with their members, although it remains true that Divisional staff do enjoy some additional benefits (for example, they receive additional training, work in wards that are better staffed, participate more actively in decision-
making and have access to better career paths through the new management structures). However, within the Division medical staff have not been as actively involved in debating Project implementation as other categories of staff as they are not unionised in the same sense. The consensus-building process was also not targeted towards them. There are reportedly some senior medical staff who are not happy with the new management model or feel that some units within the department are favoured at the expense of others. Once commentator felt, however, that ‘I don’t think it’s a problem with the pilot itself. I imagine it’s a problem with people, whatever model you have, you’ll always have accusations flying around’ (C). The new management structure has also placed constraints on Divisional staff’s ability to circumvent systems for their own benefit, which has also created some internal resistance (D, I). As one respondent said, ‘now we’ve got a transparent process where everything gets approved, you just don’t get it [i.e. benefits for your unit] on your own’ (D).

8.2. Weaknesses in the linkage between the Project and the provincial head office

The involvement of the provincial Head Office in the Project was relatively limited. One reason for this might be the resource constraints facing the provincial health system as a whole; another is the fact that the Project is relatively small compared to the range of other activities undertaken by the GDOH (C). A third is that the person originally designated as the Project’s focal point in the GDOH was not very active and, when she left, was not replaced for a long time. It seems the role of this person was possibly not sufficiently well defined and clarified, leading to engagement with the Project remaining relatively superficial (one commentator also felt that the Department’s representative was ‘out of her depth’ in this role (C)). For example, the Khalvest Consulting report found that 75 percent of planned monthly meetings between the Project leadership and the Department did not happen because the Department absented itself (Khalvest Consulting 2009). This was despite an earlier successful period during the run-up to the Project when meetings happened almost weekly and, according to the designers of the Project, despite their numerous requests for meetings and opportunities to present to head office staff (D, D).

In addition, it seems that the provincial head office came to feel uncertain about the Project. Initially it had been well-disposed towards the Project as it conformed to the Department’s objectives and promised to deal with challenges that were of critical concern (namely, improving health, quality health care and efficiency) (C). As the design of the Project became clear, however, some elements caused discomfort, especially the notion of a Divisional Head who is a practising clinician and the breaking up of traditional silos (as discussed in Section 9). This critique may have been informed by communication between members of the Department and their counterparts in the senior management of the hospital who were also unhappy with the design of the Project (D, D, D, C).

It also seems that head office felt offended by some of the tactics employed by the Project leaders. First, because it was stymied by the GDOH in accessing promised resources, the Project was forced at times to make use of its ‘hot-line’ to the Premier and the MEC (and even to the office of the Presidency) (C). As one commentator noted, the Project ‘saw the power base was with the politicians ... rather than with the bureaucracy but as you know with any of these things, if you want to drive through certain projects or certain transformation efforts you have to get the bureaucracy to support that’ (C). This may have introduced a dynamic whereby the Department felt somewhat
coerced into participating on the Project’s terms: ‘it always meant that the project was forced on them,’ said one respondent (D). This was especially so as the Project wielded the power of the unions with whom departmental managers often have an uneasy relationship, given the sometimes conflicting imperatives of service delivery and workers’ rights (thus, one commentator said that ‘managers are petrified of unions; .. part of it is … that unions have a direct line to … political structures’ (C)). The NEHAWU-coordinated march which called for the removal of the Chief Operating Officer must also have soured relationships.

Second, in the early days of the Project the Department became embroiled in a bitter dispute with NEHAWU around the man-handling of a CEO at Helen Joseph Hospital during a protest by workers. Consequently, this was a particularly difficult time for the Department to engage with a Project which had such strong trade union backing. What is more, completely coincidentally, the NEHAWU spokesperson at the time was later seconded to NALEDI to work on the Project.

Third, while the Department had always been aware of the many problems confronting Chris Hani Baragwanath Hospital, it felt embarrassed by the Project leaders’ outspoken criticism of the hospital, especially in public forums (D). The high-profile march in 2006 would also have created negative publicity for the Department. The Department came to feel that these same criticisms were constantly repeated and that Project leaders failed to acknowledge improvements in the hospital’s circumstances over time or support provided to the Project by the Department (C). Similarly, it did not seem to appreciate the severe constraints facing both provincial and hospital managers in an inherently centralized system over which they themselves had little power (C). In this way, the Project seemed to be setting itself up in opposition to provincial managers and characterizing them as ‘the enemy:’ said one commentator, ‘they kind of went in with a view, you know, that head offices are bad and that … this was really their project … It’s almost like that view of certain people in the private sector have that government is bad and no matter what they do the kind of good things are never acknowledged’ (C).

In combination, these factors impacted quite severely on the degree to which the Project was ‘owned’ and supported by the Department of Health. As one commentator said, ‘the role of the head office in the conceptualization, implementation and monitoring of the Project, … I would say it was probably … ambiguous’ (C). As the Khalvest Consulting report put it, six months into the project, ‘Although the GDOH was the sponsor of the project to the tune of about R5m, it had virtually abandoned the project to be the sole concern of NALEDI’ (Khalvest Consulting 2009: p12).

This is unfortunate because, through the Public Finance Management Act, the province’s Head of Department is accountable for expenditure in the province, consequently sharing responsibility for service delivery with the MEC. For this reason alone, it would have been important that the Department was fully on board the Project. Furthermore, the Department is the only stakeholder well-placed to disseminate the lessons of the Project throughout the province and motivate convincingly for increased delegations for the Project. All these features would have made the Department a potentially powerful ally, especially as the high turnover of MECs meant that the Project’s political support was inconsistent.

As one commentator noted, ‘if [the Project leaders] had … approached the Project in a different way, I think a potential strategy would have been for head office and the regional office together to kind of lobby the DPSA and by implication the MEC for a specialised dispensation. To kind of say, if we
really want this to work, then we need to have a whole lot of things that should happen and we do it on a trial basis’ (C). In turn, it would have been constructive if head office had responded more readily to the Project leaders’ attempts to engage (D, D, D).

8.3. Inability of the CEO to drive through change

The Project had certain responsibilities for reporting back its progress to senior hospital management, most particularly the CEO. Ideally, it would have been the role of the CEO to ensure that such feedback was passed on to key stakeholders in the rest of the hospital, manage the process of transformation in the wider hospital and plan roll-out of successful aspects of the Project.

Indeed, earlier sections have described how critical were the interventions of the CEO, Arthur Manning, in ensuring that the Project was implemented. Nonetheless, in this role he faced several constraints which ultimately meant that he was not able to take the Project to the point of roll-out. First, the CEO of any hospital faces an enormous workload and CHB Hospital is particularly difficult to manage (C). Second, as NALEDI had been so active in leading the hospital-wide process that identified key challenges faced by the hospital prior to the Project, there may have been an expectation that they continue in this role. In reality, however, NALEDI’s role had changed to one of implementer within the Surgery Division.

A further problem, though, was that, while in theory Arthur Manning received new delegations from the provincial DOH, in practice they were ‘clawed back’ (D). For example, it was the provincial head office that, in effect, appointed the CEO’s senior management team (D). While Arthur Manning tried to bring these senior managers on board the Project, he was unable to establish his authority fully or mobilise them as a unified team (C, D). This was because senior managers had – and still have - divided loyalties, reporting partly to the CEO and partly through old silo structures to senior managers within the head office (example, for nursing management and HR). ‘They [CEOs] didn’t have sufficient authority,’ said one respondent (D), ‘the system works on instructions from above.’

This may partly explain why the other CEOs who ran the hospital during the lifespan of the Project were not able to contain the tensions between different individuals and levels of the hospital hierarchy, clear obstacles to the Project’s progress and leverage the experience of the Project to benefit the hospital as a whole. In addition, however, two of these CEOs do not seem to have believed in the Project as passionately as Arthur Manning.

Even the formal forums that had been set up for consultation were not convened regularly by CEOs. These forums - the hospital-wide Transformation Forum that was meant to meet twice a year and a Transformation Management Committee that was meant to meet twice a month - had been instrumental in the early days of the transformation process (C). It is a pity, too, that on the few occasions when Transformation Forum meetings were held they were badly attended by clinical heads, a continuing frustration for the Project (D). One of the reasons for poor attendance may have been that clinicians felt frustrated by the lack of progress by the Project because promised resources were not forthcoming.

As a consequence of these problems, the Project had to initiate and drive the change management process from below which was a difficult task that placed an added – and unexpected - burden on Project leaders which, as discussed later, they found difficult to manage. Some designers felt that the CEOs could have done more to oversee and promote the Project as well as manage debate in the
hospital about the relevance of the Project to future roll-out. As one respondent said, ‘I think we never achieved the true point where the hospital felt we were doing something for the hospital. And I’m not sure that it’s our [i.e. the Project’s] fault. I think it’s largely the hospital’s fault ... I don’t see one side being responsible. When you accept the responsibility of a pilot, what does that actually mean? Does it mean that it’s your [i.e. the Project’s] responsibility to keep bringing these [people] on, to keep informing them about what’s happening, or is that a shared responsibility?’ (D).

8.4. Resistance to decentralisation
Some members of the central administration team have, at times, shown active hostility towards the Project or have withstood it in a more passive way (D, D, D, C, C). As the Khalvest Consulting report stated, ‘Our sense is that the process is not well supported by some of the hospital senior management and this has been an obstacle in obtaining financial support and achieving some of the goals’ (Khalvest Consulting 2009: p68). One commentator characterised resistance amongst top hospital management as ‘very, very solid’ (C).

This is perceived to have been because central hospital management felt threatened that the decentralisation of authority – and the breaking up of silos - would reduce their own power (D, I, C). As one respondent put it, ‘it challenges the central bureaucracy ... It challenges administrative power to decide’ (D). As a designer put it, ‘so here we came along with what was a very clear line of reporting and with a promise, I think, of organisational restructuring and functionality. Without trying to understand how or why, the threat, I think, to individuals was just too high’ (D).

In order to deal with resistance the Project tried, first, to emphasise that the reason the Division had received special delegations and resources was because it had been given the specific mandate to test a new model for the hospital, in the hopes that this could then be rolled out to other Divisions. As one respondent described, it is important to explain to central management that, ‘we’re doing this thing for the hospital, we’re not renegade. We are under you, but we are in a way independent so we facilitate things. We’re trying a model that will facilitate things for the hospital. Under no circumstances are we independent, under no circumstances are we above you, but we’ve been given this delegation of being independent within your umbrella and we would like you to support us and help us if there is something we do not know’ (I).

Second, the Project tried to argue to administrators that it is geared towards alleviating their burden of operational management, leaving them free to take on the roles of policy, support and monitoring (for example, in the past approximately 15 people related to the Surgery Division would have reported directly to the CEO, whereas now it is reduced to one person, the Head). As Surgery’s management model is very different from the traditional way of running a hospital in South Africa, perhaps the Project could have done more to assist central administration staff to come to terms with its proposals by clarifying what their new role and responsibilities would be under the new model and how this would differ from that of their counterparts in the Surgery Division (C). This is particularly important in a pilot as senior managers have to operate in a context where they have full authority in most of the hospital while having to surrender it in relation to the Division. One commentator noted that this had the result of undermining senior managers’ authority in areas of the hospital that are not part of the Project (C). In addition, for some of them, particularly clinical executives, they face the possibility of their posts being made redundant (C).
In this context, arguments over the extent to which the Division should contribute to the management of night shifts in the rest of the hospital have become a flash point (D, C): on the one hand, the Division sees attempts to use its staff for this purpose as an encroachment on its hard-won rights to decentralised authority; on the other hand, senior hospital managers see the Division’s refusal to surrender staff as evidence of its lack of commitment to the hospital as a whole.

Although the Project did attempt to engage central administrative staff on numerous occasions, including in the run-up to the Helen Joseph Hospital workshop (NALEDI 2004b), very little consideration seems to have been taken of the perspective of clinical executives (formerly known as superintendents), as reflected in the Khalvest Consulting report: ‘The restructuring has affected other roles like that of hospital superintendents ... The roles of the superintendents include ensuring compliance with policies and procedures; conducting clinical audits, providing administration support and mobilising resources for the divisions. With the current structure their roles are reduced to administration as they are seen as head of systems which is basically logistics and systems which does not require a qualified doctor’ (p30-31). As the Project progressed, it is the view of the clinical director that ‘implementation was made without due regard or involvement of senior management’ (Penn-Kekana, Blaauw et al. 2004; Billa 2009). This comment is only partly true because the Project had worked intensively with Arthur Manning who had in turn spent considerable time with senior managers debating the Project.

Perhaps the clinical director’s comment reflects the high turnover of central hospital administrators which meant that new appointees were less familiar with the Project. Perhaps it also reflects the manner with which designers engaged with senior managers at certain times. As some commentators put it, Project designers seemed to have a defensive, dismissive or even arrogant response to criticism, especially when tempers flared (C, C). As one respondent said, sometimes the Project designers ‘threw their toys out of the cot’ (I). Another said that, ‘my sense is that both Karl and Martin, it’s so close to their hearts, they can’t see whether something should be done differently ... They’re very defensive the moment you raise something. They kind of right it off as most probably just another reactionary comment as opposed to kind of one which they need to reflect on and which they really want to work on’ (C). It seems to have been a particularly painful experience for some hospital managers to be labelled ‘anti-transformation’ by Project members (C). One commentator concluded that ‘if the pilot was done in a different department maybe we wouldn’t be having some of the tensions that we experienced. Because ... my own observation is that it is the personalities. One of the problems of the pilot is the personalities’ (C). This may reflect particular personality clashes, however, as this does not seem to have been the sense of implementers working within the Division.

All in all, senior managers probably felt that their common concern for improving service delivery was undervalued and that the Project did not take seriously their concerns around accountability of Divisional managers to central hospital management. The Public Finance Management Act places enormous responsibility on public managers to contain spending within the approved budget as failure to comply is treated as a legal offence which can result in imprisonment. As reported in a separate study at a district hospital, this constrains managers’ willingness to adopt interventions to improve patient care when this involves decentralization of decision-making and additional spending. In this study, a ward manager who had been made to sign a contract under the Public Finance Management Act reversed her own initiative to provide pain relief to women in labour.
because, ‘Sometimes I lie awake at night feeling sick with worry ... I worry that I made a mistake [to promote the use of more drugs] ... I worry about who will look after my kids and my father if I go to jail’ (Penn-Kekana, Blaauw et al. 2004: pi74).

This evaluator was unfortunately not able to talk to central managers to confirm that this is an issue at CHB Hospital. However, the Khalvest Consulting report does note that ‘The relationship between the head of nursing within the Surgical Division and the Hospital nursing directorate is said not to be clearly defined, given the cross-cutting function of nursing. As a result, accountability is compromised’ (Khalvest Consulting 2009: pp30-31). In addition, one commentator noted that it was anxiety-provoking for the hospital Director of Finance not to know what spending decisions were being made by the Division’s supply-chain management unit (C). Said one commentator, ‘Because I think if you don’t bring in your top management into your own confidence ... because ... the perception is from their [the Project’s] side that whatever you do there’ll be tensions because transformation by itself bring about tensions. Whereas other people [in top management] will feel that they’re not catered for adequately at the expense of the pilot... Then that will generate animosity towards the Project’ (C).

In any event, over time the sense that the Project was a pilot project of the hospital as a whole – rather than simply a venture of the Project leaders’ – was undermined. As one respondent put it, the designers of the Project sometimes did not always ‘take people with [them], sometimes leaving them behind’ (D). A consequence was that managers who attended meetings with the Project began to disengage with the debate as a form of passive resistance. As one commentator said, ‘though there were meetings that were called, I don’t think there was openness in those meetings sometimes ... Probably there was not much trust and team work’ (C). Speaking about the Project’s relationship with the Gauteng Department of Health, one commentator made a similar point, arguing that, ‘if consultation is on the basis of ‘management is bad’ ... and we basically need to vilify them at whatever opportunity we can get, it’s very hard to kind of develop a relationship’ (C).

It must be acknowledged, though, that some members of the central hospital administration were supportive of the Project. A notable example was the former Head of Nursing who had initially fiercely opposed the breaking up of the nursing silo but, shortly before her untimely death, had become committed to the new model (D, I). This implies that, once senior staff truly began to understand the nature of the new management model, they were able to understand the benefits to the hospital.

8.5. Declining vigour of the consultative processes within the hospital

First, the early stages of the project were characterised by extensive consultation, most notably through a hospital-wide workshop. This brought the hospital to the point where all stakeholders knew about the project and agreed to the principles that should guide it. Subsequently several newsletters were produced to keep hospital staff abreast of developments in the Project. However, a follow-up workshop with hospital staff was never held because the project implementers were grappling with the problems of implementation and exhausted by the many demands placed on their time (D, I). As one respondent said, ‘Over the years, because we’ve had so many different groups, in the early time we used to run very extensive workshops with people, informing them what it was. Arthur Manning used to have meetings with them, talk to them about transformation and
what we were trying to achieve in Surgery. But I think over the years it kind of stopped being as vigorous, that component. Because I think people ... were ignoring it’ (D).

This led the Khalvest Consulting report to find that, ‘although progress has been made to some extent, however it has not been communicated sufficiently to other divisions in the Hospital’ (Khalvest Consulting 2009: p68). This meant that an opportunity was missed to clarify some of the uncertainties that grew up around the Project over time (such as the timeframe) and debate controversial issues (including the cost of the Project) (D, 11). It would also have strengthened the process of monitoring and evaluation.

Second, the Project had intended to invest in team-building activities to develop closer working relationships between ward staff. The project got as far as working out times and rosters for these activities but they never came to fruition, again due to time and resource constraints. One respondent reflected that working on the ‘soft’ issues of interpersonal relationships was probably as important as working on the ‘harder’ issues of organogramme structures and systems: ‘I think that team-building would have been an important adjunct to that and ... I really am sorry that we never at least tried that at least in a few environments’ (D).

Third, and related to the above, one respondent noted that many of the clinicians are not aware of the details of the Project or of the benefits that they derive from it: ‘I think we should have informed people better ... because they came up against us [the people from other departments], even the people within our departments, even the heads of the different departments took a long time to understand what is happening. And the consultants in general surgery say, they did not get involved. It’s one thing to say they’re not interested, it’s another story to tell them about it’ (I). This has meant that Project designers were seen, in a way, as ‘lone wolves’ (I): a groundswell of support for the Project has not been generated amongst the doctors in the Division who are not ordinarily involved in management decisions. This same respondent felt that workshops and presentations have a role to play, but that more personal interaction with doctors is needed as well as using regular meetings to raise Project-related issues or get feedback from consultants. As one respondent said, ‘I think we have to start from the beginning to go and meet the people individually, face to face ... It will not be as easy but I think we should meet them ... when you talk to people you show respect’ (I).

The responsibility to inform and motivate clinicians was not Project designers’ alone, however. The Division’s Executive Committee ‘often reflected on this issue and we requested that heads of departments talk to their own staff and to other members of the hospital clinical community to inform them about the new structure and its value. However, besides a few I don’t think the doctors delivered on this issue’ (personal communication with D). Senior clinicians also became disaffected through what one designer called the ‘futility’ of the Transformation Forum meetings where it was hard to demonstrate progress and requests for more support from hospital managers and the GDOH came to nothing (D).

8.6. Inability of the Project to create a lasting coalition of allies

Given the resistance that is generally generated by fundamental change, it was important for the Project to build a strong alliance of stakeholder groups and individuals to help it drive through change. Section 8.5 has already referred to dissipation of the hospital-wide support it initially
enjoyed. In addition, there was a high turnover of CEOs which meant that there has been erratic support for the Project from the top leadership of the hospital (D). In particular, the Project lost one of its most effective allies, the CEO Arthur Manning, at a critical point in its implementation. There was also a high turnover of some of the most supportive central administrative staff as well as staff within the Division itself (most notably the Finance and Systems managers). The rapid turnover of MECs has also been problematic as it was these functionaries that originally drove the Project politically.

Furthermore, union leadership, which had been very active at the start of the Project in bringing high-level political pressure to bear on the Gauteng Department of Health, did not follow this through by providing active support in later years. As the Surgery Division reflected, ‘This became evident during the wage dispute strike where, despite a jointly agreed undertaking on conduct during the strike, the STP was adversely affected in its ability to forge a progressive labour relations model’ (Surgical Division 2009). Said one respondent, ‘when it came to really giving us protection, when it came to sticking their neck out, I don’t think they did it, I don’t really understand why ... It didn’t seem to be high enough on people’s agenda’ (D). The chronic shortage of staff at the hospital is an issue around which unions would have been expected to mobilise because it affects both patient care and worker interests, but activity around this issue did not materialise in 2007, a critical year for Project implementation.

One of the reasons for this was that the unions were also dealing with their own shortfalls in capacity. As one respondent commented, ‘one of the problems [for shop stewards] is not being highly educated and their English not being that good, and in an institution dominated by professionals, they’re always on the outside, and that’s a huge problem for the institution and for their members. And it makes it very difficult at crunch times for them to articulate and ... say the things and do the things that would easily have made a change’ (D).

Thus, while there was growing disaffection with the Project amongst the senior management echelons – both within and outside the hospital – the Project’s support base was eroding. This was compounded by difficulties the Project faced in finding opportunities to present information on its Progress, correct misperceptions and debate issues of concern to the hospital.

All in all, then, as one respondent describe it, ‘throughout its life, [the Project] has never had a comfortable environment where it can try to do what it’s supposed to do and explore its weaknesses. There’s always been an element of hostility or just disinterest or active attempts to sabotage it’ (D). This resulted in the Project designers feeling increasingly embattled, most especially during 2009. As one implementer said, Divisional managers are currently treated as ‘the people on the other side’ who have to continually defend their position at meetings and respond to accusations that ‘it’s Surgery again!’ (I).
9. Stakeholder concerns with the design of the Project

The previous section looked at weaknesses in the process through which the Project was linked to the rest of the hospital and the wider provincial health system. This section looks at some concerns with the design of the Project, as reported by some of the stakeholders.

9.1. The concept of a practicing clinician as Divisional Head

There is clearly strong support amongst senior staff within the Division for the notion of a practicing clinician as Head, for reasons described earlier. It is argued that clinical executives (who have administrative rather than clinical roles) cannot fill this role adequately because they tend not to be sufficiently skilled, are not able to exert authority over specialists and remain distant from the physical environment and day-to-day operations of the Division (this is exacerbated by the location of their offices in the central administrative block). Commentators note that, in any case, departmental heads often ignore the formal hierarchy (of reporting first to a clinical executive who then reports to a clinical director who then reports to the CEO), taking concerns directly to the CEO. This reflects a sense that the hierarchy is too long and needs to be flattened out, a lack of faith in clinical executives as being able to provide immediate practical assistance in resolving problems and recognition of the fact that the real locus of power lies with the CEO.

Key respondents reported that some senior provincial and hospital managers do not agree with this perspective, however. One commentator identified this as one of the key obstacles to roll-out and linked antagonism to a clinician Head with protection of a 'silico-management mind-set’ (C). Box 10 presents the arguments against a clinician Head as well as the counter-arguments presented by respondents. Hospitals around the world continually grapple with how to balance the needs of the individual patient with the needs of a population of patients (such as all those served by a hospital). One argument for the clinical executive would certainly be that such an administrator - as a formal member of the bureaucracy - is able to ensure that the activities of sub-sections of the hospital conform to the overall policy and resource allocation guidelines of the hospital as a whole, ensuring the equitable and appropriate use of scarce resources. The clinical executive model has reportedly worked in some other settings in South Africa: in these settings clinicians have accepted the authority and managerial abilities of the clinical executive, even when they are on a higher post level than the clinical executive (C).

One commentator who had originally felt uncomfortable with the model proposed by the Transformation Project admitted that, if the roles of clinical director, clinical executive and Division Head had been more clearly differentiated, ‘I would think ... that the divisional model is probably the best model ... Then you would make the heads of Divisions report directly to the CEO and they should take full accountability of what happens in their Divisions. And they should deal with issues of equipment and procurement issues. They can have their own people reporting to them. But purely on clinical matters they can handle them so you don’t need a clinical director/[executive] ... They should also play the full functions of a typical superintendent’ (C).
The debate around the two models – practicing clinician versus clinical executive - probably deserves further attention before it can be resolved. The evaluation raised two issues pertinent to this debate. First, do the circumstances of an academic hospital make a difference to the preferred model? In these institutions, senior clinicians are highly skilled and are employed at a very high post level. They often enjoy formidable reputations within the hospital and university itself, as well as in

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**Box 10: Arguments against objections to a clinician leader as presented by key informants**

**Doctors do not make good managers:** Divisional Heads are already doing management but without the authority to ensure that action is taken, leading to immense frustration (D). They have to have good leadership skills and an interest and talent for broad management: the administrative skills are located in the management team that advises them (D, I). The principle is that the management team provides the clinician Head with information in a format that is readily understandable: it is his role to decide how to use this information in the service of clinical care. It is true that there are examples of doctors without these skills and natural authority that have been appointed in the past (e.g. as superintendents): this means that they were the wrong appointments (e.g. a failed GP) or they were not provided with administrative support, not that the concept is flawed.

**Doctors who can do this function are scarce:** Only 5 such people are required for CHB hospital. There are about 45 people in the hospital roughly at the level of the current Head of the Surgery Division: amongst them there must be enough people who have the interest, drive and skills that are required (D, I).

**This sets an unsustainable precedent for other hospitals:** In CHB, the Head probably needs to be a senior specialist because it is an academic setting with many senior people who have strong egos. In this environment, the Head needs to be able to martial their respect. In smaller hospitals, it would be appropriate to use any type of health professional, provided they engage in clinical practice.

**This model is not current in other parts of the world:** This is not so: it is a common model including in the United States where very senior clinicians are involved in running sections. It is true that in South Africa there has long been debate about the failure of doctors to appreciate cost containment measures (in the private sector) or perform well as managers (in the public sector). There has also been resistance to the concept that only a doctor can run a hospital, to the exclusion of other health professionals and career administrators. It should be remembered that this model speaks to a sub-section of the hospital (rather than central administration), at a level where knowledge of the clinical process is paramount. It is important to remember, too, that the clinician’s job is to lead not to administer: he or she is supported by a strong management team.

**This model consumes the time of clinicians who could be focussing on patient care:** Two clinician respondents said that the job is do-able, although the developmental side is time-consuming (D, I). The current Head had been concerned that he might be overwhelmed by a bureaucratic function but has been able to maintain clinical work (e.g. doing procedures on one morning a week, operating on most Thursdays, doing ward rounds on a Tuesday, attending clinic on Fridays for a couple of hours and teaching students late Tuesday and Friday morning): ‘I just developed systems which were protected time that no-one could interfere with’ except in an emergency (D). This leads to some tension around the fact that he is not always available to respond immediately to requests from central management (D). The Project is trying to move away from these ad hoc requests and to encourage central management to refer requests to the Systems Manager.
wider society. In a place like Chris Hani Baragwanath Hospital, for decades they have eked out scarce resources to meet best the needs of as many patients as possible. Under these circumstances, they may be best placed to run a Division (provided they are good leaders and managers and are interested in playing this role). In practice it might be difficult to find a clinical executive who is sufficiently skilled and to whom senior clinicians are willing to answer (C).

Second, is the concept of a clinician leader limited to medical specialists only? There has been a long debate in South Africa around the problems associated with automatically allocating leadership positions (such as that of Superintendent) to medical doctors in the past: this practice not only elevated some individuals without management skills but excluded others who sometimes had superior management skills, often to the detriment of health care delivery. It was a hard-won victory for other categories of health worker when the legislation was changed to introduce the concept of a CEO who could be from any health worker background. One of the underlying reasons for resistance to the Project’s model of a clinician leader may be that it elevates the role of medical doctors in the management hierarchy once again (clinical executives are also doctors but without the extensive powers envisaged for Divisional Heads). Fears that this would have a negative impact on the running of the Division are not borne out by the experience of the Division, at least from the perspective of the designers and implementers of the Project, all of whom were adamant that this was a feature contributing integrally to the successes of the Project. In addition, the Divisional manager (known as the Systems Manager) does not have to be a doctor and can be any health professional.

Even so, there remain legitimate concerns around how to balance clinical with administrative imperatives. The Khalvest Consulting report notes concerns from its key informants that physician-led management ‘is seen to have the potential to create tension between [the] management and clinical role’ (Khalvest Consulting 2009: p30). This remains a challenge in health services all around the world. To further this debate, it would be particularly useful to compare the experience of the Transformation Project with that of another hospital where clinical executives have been a successful intervention, in order to develop a more substantial body of evidence around the pros and cons of the two options. It would also be useful to clarify the skills, knowledge and personal characteristics required to lead a large Division: some of the past failings of clinical executives might conceivably have been due to the characteristics of the individual person (such as their leadership qualities or skills base) rather than an ‘in principle’ problem with the concept of a clinical executive itself.

9.2. Eliminating silos through consolidating reporting lines under the Divisional Head

Another strategy of the Transformation Project for putting patient care at the heart of management is the integration of different functions under the leadership of the Head. Doing away with ‘silos’ is seen by the implementers of the Project as highly effective. As one commentator said, ‘for Chris Hani Bara maybe it is unique because there was disorder. They tried to bring order in one person’ (C). At the same time, the ‘technical’ (as opposed to line-function) link between the divisional and central hospital level is maintained: thus there is still engagement between the functions at each level with central level administrators providing guidelines to their divisional counterparts and requiring the submission of certain data and reports back to the central level. In addition, the new management structure, as well as the new management style which is based on team-work, elevate
the role of the Divisional nursing managers, giving them a stronger say in the way the Division is run. Indeed, the Khalvest Consulting report indicates that nursing staff are well-satisfied with management changes in the division.

However, in central hospital management there is some disquiet with the concept of integration. As described earlier, part of this is resistance to decentralisation as it erodes the power of central managers who are used to heading silos. There is also a perception, though, that the new management structure has reduced the influence of nurse managers on decision-making by severing their link with the Director of Nursing at the level of the central hospital administration. This applies to the other functions as well (such as human resources and financial management). This could contribute to the perception that the Project is clawing back the gains made by other categories of health worker who have been discriminated against in the past. As once commentator said, ‘I think [it] caused tensions to move that way. I think it might have been a good idea to have full accountability within the divisions, but at the same time it was breaking lines of command’ (C).

The severing of silo-based reporting practices solves a major problem – the fragmentation of functions - but generates a new one for the hospital, that is, how to achieve coordination and accountability in a decentralized management system? Even under the most favourable conditions, it is difficult to integrate horizontal and vertical functions seamlessly; trust, open channels of communication and a willingness to re-negotiate arrangements are necessary to deal with the inevitable tensions that arise from the different imperatives of different levels of management. These conditions have often not pertained at the hospital, as discussed earlier.

Added to this, the role of central hospital administrators viz-a-viz their new counterparts in the Division has never been well-defined. This must be a particularly uncomfortable situation for the people filling the central hospital administration posts as their previous roles still pertain viz-a-viz the rest of the hospital departments, even whilst they have been asked to relinquish control over the pilot Division. In addition, under the Public Finance Management Act, they presumably still retain accountability for Divisional activities; the Act imposes harsh sanctions on officials who are unable to account for activities that fall under their domain, a feature that constrains managers, and makes them nervous of introducing new practices in many settings in South Africa.

Furthermore, the Division Head reports directly to the CEO and does not meet on a regular basis with the Directors of other functions which, said one commentator, ‘I think was one of the other tensions because he’d speak directly to the CEO, even on HR matters, without the finance and the HR manager knowing, or even the clinical director’ (C). This is common practice for all heads of department and is not a unique feature of the Project; indeed, in a number of other hospitals, function directors have become a step removed from decision-making as an inadvertent consequence of the introduction of the new posts of CEO and Clinical Director (C).

5 Potentially this role could include policy-making, setting of guidelines, training, other support and monitoring and evaluation. In other words, this ‘technical’ relationship ‘provides for regular communication between the Division and centre and allows for the central head [of a function] to define the nature and contents of the reports required by him or her’ (D).
9.3. Attributing impacts to the model design

The introduction of unit managers is one innovation that does not seem to be controversial. It is well-recognised that nurses have battled for years to gain sufficient authority over ward staff (especially cleaners) in order to ensure cleanliness, order, coordination and a good quality of care. The Project has clearly achieved this and has introduced training of Unit Managers that is sorely needed (C).

However, this issue is an example of where some people feel that the Project has exaggerated its contribution, stating that the new reporting arrangements with cleaners were a hospital-wide not a Project-specific intervention (I, C). This perception is in fact not true. The Division had negotiated with unions that its cleaners would begin to report to the Unit Manager. Subsequently the hospital implemented this arrangement unilaterally in other Divisions which angered the unions considerably because the arrangement was intended to form part of the entirety of interventions associated with the Project (D, D).

Other critics argue that the problems faced by the Division are peculiar to Surgery. Others argue that the Project’s achievements are the result of an injection of resources and additional management support, rather than the implementation of a particular management model. Designers contest this: they feel that neither the complexity of management issues, nor their centrality to the problems faced by CHB and other hospitals (as shown in Figure 1), are appreciated by the top leadership (including the MECs and the provincial head office) (D). Certainly, many of the problems experienced by CHB Hospital have been documented extensively elsewhere in the country (Monitor Company, Health Partners International et al. 1996; von Holdt and Murphy 2005) and many of the problems experienced within the Surgery Division have been documented extensively elsewhere in the hospital (Commission of Inquiry into Hospital Care Practices 1999; Stack and Hlela 2002; Tapson and Baker 2002; Tapson, Eisenstein et al. 2004; NALEDI 2004a; NALEDI 2004b; NALEDI 2004c; NALEDI 2004d; NALEDI 2004e; NALEDI 2004f; NALEDI 2004g; van der Walt 2005; von Holdt and Maserumule 2005; NEHAWU date unknown).

9.4. Lack of a monitoring and evaluation framework

The Khalvest Consulting report found that ‘lack of funding, inability to implement information and financial systems compromised the accumulation of accurate data and subsequently [there was] poor monitoring of progress’ (Khalvest Consulting 2009: p68). As indicated earlier, the designers of the Project emphasise that it is very difficult to demonstrate the impact of the Project in quantitative terms because it is constrained by problems faced by other parts of the health system. This means that the Division is held hostage to problems that lie outside its area of control. In turn, this means that, if commonly used indicators of efficiency and quality of care were to be measured, they would not be a true reflection of the improvements achieved inside the Division. What is more, there are no baseline data for the Division against which to compare the current situation. The Project fears that, under these circumstances, it will not be judged fairly: long lengths of stay, for example, could be used by detractors of the Project to claim that it has failed, even though the reasons for long lengths of stay may be due to problems with scheduling of operations or in procurement, for example.

However, without some indicators of impact it is difficult for the rest of the hospital to commit to rolling out the Project. Although improvements in efficiency and labour relations are vital.
components of the Project’s contribution, it is difficult for an MEC, for example, to provide political backing for a Project unless it is able to demonstrate its impact, in some form or other, on patient care (C). In an environment where there were more trusting and collaborative relationships, it might be possible to motivate roll-out on the more qualitative evidence already presented. However, in the current climate critics of the Project tend to argue that the lack of outcome data indicates a lack of progress, especially with respect to improving health. Under these circumstances, lobbying by the Project to extend its model nationally is perceived to be based on insufficient evidence of success, particularly as the Project has not yet achieved broader influence in its own hospital and province or addressed the issue of sustainability (this is discussed further to some extent in a later section) (C). Indeed, through its internal strategic planning processes the Division has already identified as one of its priorities the need to ‘develop the necessary clinical measuring tools to assess whether the transformed operating design results in improved patient outcomes’ (Surgical Division 2009).

Importantly, any indicators developed to measure progress should be agreed up-front with all stakeholders (C).

10. Conclusions and recommendations

The Project has made considerable progress and can be proud of its achievements to date. Many of its achievements have been made in the face of significant obstacles and have led designers and implementers to ‘put their reputations on the line’ (von Holdt 2008).

It is clear at this stage that the model is certainly worthy of further consideration, a sentiment echoed by the earlier, more quantitative evaluation which found evidence of improved communication, coordination, team work, multi-disciplinary action, commitment, openness, transparency, interpersonal relations and relationships with unions (Khalvest Consulting 2009). The model offers a potential solution to the chronic management problems that beset CHB Hospital and does so in an innovative way that seeks to unlock the potential of individuals and systems to respond to the needs of patients and workers. Indeed, the Khalvest Consulting report concluded that, ‘the transformation of the Surgical Division of CHBH should be continued and be well funded and supported by key stakeholders’ (Khalvest Consulting 2009: p2).

All the respondents who were designers or implementers spoke very coherently about the Project - its underlying principles, the management structure and style it has adopted, and the impact it has made on efficiency, staff morale and patient care. There were no contradictory views and everyone was convinced that the model has established the management capability to address the problems associated with the management vacuum. As one of the new managers concluded, ‘if people do not come with open eyes, if they have preconceived ideas, they will find that we have failed. But if you ask Surgery, we will say that we have succeeded’ (I).

Other stakeholders supported the model (C, C). One commentator said, ‘As a flagship it’s a superb project ... I think it’s phenomenal’ (C). Some stakeholders qualified their support by noting that the
Project’s impacts need to be better understood and its weaknesses addressed, especially before roll-out is considered (C).

As this report has shown, however, there is reportedly some resistance towards the project, elsewhere in the hospital and in the Head Office of the Gauteng Department of Health. This is ironic as the Project was originally given a clear mandate by both the hospital and the Department to implement its model. Now it seems that critics of the Project feel deeply suspicious of the motives that drive the Project leaders. As described above, Project leaders have reflected on processes they would like to have done better or differently, to diffuse some of the resistance and misunderstanding. They noted, however, that, at the time there was so much work for the consultants to do – including mentoring numerous people - that it would have been difficult to do more (D): said one respondent, ‘we just couldn’t sustain it. It goes beyond our human [ability], I mean, just the sheer physical and mental fibre of individual humans, you just can’t do it. You’re just exhausted, battling every frustration’ (D).

It is the opinion of this evaluator that, at the very least, the model deserves to be debated more widely and in greater depth before any of its core features are rejected. This seems to have been the position of the hospital’s top management in its presentation to the July 2009 meeting that reviewed the Project’s progress (Billa 2009) (Box 11).

Box 11: Hospital management perspective on next steps for Project and roll-out, July 2009

<table>
<thead>
<tr>
<th>• Support transformation but model requires review:</th>
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<tbody>
<tr>
<td>o Clarify financial accountability for Head of Division</td>
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<tr>
<td>o Clarify roles of Head of Division in relation to CEO and Directors</td>
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<tr>
<td>o Define role of systems manager</td>
</tr>
<tr>
<td>• There is a need to look beyond NALEDI if project has to be continued with</td>
</tr>
<tr>
<td>• Define clear objectives for pilot against which it will be measured. This should be mainly on improving service delivery</td>
</tr>
<tr>
<td>• Once project finalized and fully assessed need to have clear plan for roll out to other departments if so desired</td>
</tr>
</tbody>
</table>

Source: (Billa 2009)

It is worrying, therefore, that some of the Project’s achievements (especially with respect to clinical leadership, decentralisation of authority and integration of management) might be dismantled (D). The decision to go this route could be due to resource constraints or differences of opinion on appropriate strategies for management reform. But it could also be due to a lack of understanding of what makes the model effective and the fact that similar models function well in other parts of the world (I); it could also be due to a resistance that stems from issues unrelated to the design of the model itself (such as vested interests).

Consequently, to this evaluator it seems important at this stage that the different stakeholders concerned with the Project rebuild relationships, re-establish trust in the Project and commit to interrogating the value of the Project in an open process. Increasingly, the South African literature points to implementation problems associated with management failures and poor staff morale as the root of poor health care: this Project is one of the few large indigenous experiments that seeks to address these problems and it would be a tragedy if its experience were not used to best effect to improve health care in the rest of the hospital and elsewhere. Given the history of conflict that the
hospital has endured, it is important, too, to address the expectations of hospital staff which were raised at the beginning of the Project with the promise of roll-out. Nationally, the Department of Health has recently made high-level statements regarding the need for standards in public hospitals to improve, particularly in the light of the widely-debated National Health Insurance policy: it is impossible to respond to such a call without a dynamic management system.

This evaluator was not able to assess whether there is indeed an appetite in the Provincial Department of Health or the central hospital management to engage in further dialogue around the fate of the Surgery Division model and its roll-out to the rest of the hospital. The recommendations below assume that there is, for the reasons stated in the paragraph above. It is the opinion of the evaluator that, to achieve these recommendations, the Surgery Division, central hospital management and the Gauteng Department of Health need to work in partnership.

10.1. Re-invigorate consultative processes
A lesson from experience thus far is that consultative processes need constant nurturing; consultation can become attenuated once the flow of information is interrupted or when stakeholders become alienated and do not feel able to voice their concerns openly. Open dialogue clearly needs to be restored but, again, this requires the different parties to act in good faith and with a measure of goodwill.

A starting point is for the Surgery Division to provide more information on the project to the wide range of stakeholders and leaders in the hospital, and to develop a more cohesive understanding of the Project within the Division itself. It is not that the Project has not already done a lot of this already: it appears that in an environment like that of CHB Hospital, which is often characterised as ‘chaos,’ constant repetition is necessary, especially when a radically new style of management is introduced.

First steps in this process could be to:

- document the model and its achievements in a clear and brief format;
- distribute this document to all stakeholders, including staff within the Division itself; and
- explore mechanisms for engaging in a public debate around the model, including the more controversial elements (namely, clinical leadership, the cost of the model and the extent of decentralisation) – a repeat of the two-day workshop that was held at Helen Joseph Hospital in 2004 would be one option.

10.2. Restore relationships with central hospital and provincial management
A lesson from the Project’s experience is that it is critical to involve all key stakeholders who can affect the implementation of an intervention. Even if some stakeholders appear unsympathetic or even obstructive, neutralizing them through alliances with more powerful stakeholders may only be a temporary solution.

It is not clear how to re-construct the relationship between the Project, central hospital management and the Department. One external commentator felt that getting these stakeholders’
buy-in to the Project really depends on a political solution (C, C). Nonetheless, it seems to this evaluator that increased dialogue between the Project and these stakeholders could be constructive if all parties were willing to ‘dispassionately and disinterestedly address the issues challenging the role players and stakeholders’ (Khalvest Consulting 2009: p67).

First steps in the process could be to:

- renew discussion around the interface between central hospital management and the Division (and between the Division and the Province): this could include clarifying the distinction between the roles and responsibilities of staff at the central administration and their counterparts in the Division (as one commentator noted, operational decisions could be located at the level of the Division while strategic decisions could be located at the level of the central hospital management (C));

- develop processes and structures that allow these different levels to engage on a regular and formalized basis: this is an essential part of successful decentralization and is important to achieve so that, in times of crisis, established channels are available to resolve problems relatively amicably; and

- revitalise hospital-based mechanisms to oversee the Project and review its progress (such as the Transformation Forum that was supposed to meet twice a year and the Transformation Management Committee that was supposed to meet twice a month).

**10.3. Measure the impact of the project**

The lesson here is that the relationship between a pilot and the rest of the health service in which it is located needs to be actively managed. Milestones in the progress of the pilot should be set, affording a public opportunity to assess achievements and obstacles and re-assess endpoints. It is natural for outside observers to want to see some measures of impact, especially in a pilot project that has attracted special funding and been designed, from the outset, as a model that could be extended to the rest of the hospital (11). As one commentator said, ‘Yes, [the Project’s] better for the nursing staff ... but the nitty gritty, and I think what the MEC was getting at, was whether patient outcomes are better’ (C). Even if the Project is subject to the vagaries of processes outside its control, it still claims to be making a difference and should therefore be able to identify some ‘intermediate’ measures of change.

This and earlier evaluations have begun the process of assessing impact, mainly in a qualitative sense but also, in the case of the Khalvest Consulting report, through a survey of staff satisfaction. Through these efforts some potential outcome indicators are beginning to emerge (for example, on the efficiency side, the length of time it takes to employ staff and, on the quality of care side, the conducting of joint ward rounds by doctors and nurses).

Health outcomes are difficult (and expensive) to measure and compare, not only because of case-mix differences but also because of the multiple influences on health and health care. A more workable approach might be to develop ‘proxy’ measures, largely relating to the quality of care, the rationale being that improvements in the quality of care are linked plausibly to health outcomes. Some of these indicators could be generic to enable comparison between different departments (for example, whether the doctor has written up the patient’s notes comprehensively or whether the
doctor has listened to the patient’s heart and lungs, or even the number of complaints by patients while some could be specific to the Division of Surgery or even sub-disciplines within the Division (WHO’s Safe Surgery Saves Lives proposals provide some ready examples relating, for example, to the assessment of patients just before surgery).

Even with the more conventional indicators, such as Length of Stay, mortality rate, sepsis rate and the occurrence of bed sores, it would be useful for the Division to collect these data. It would be a useful exercise to analyse where long lengths of stay or avoidable mortality rates may have been due to problems internal to the Division versus problems that were external. This would also be important for the Division to diagnose and address flaws in systems outside the control of the Division. One commentator suggested that clinical heads of units would be well placed to advise on how to collate such data (C). For these data to be truly useful, one would need comparative data from other parts of the hospital.

10.4 Debate the prospects for roll-out widely
An agreement to roll out the Project was developed under the former CEO, Dr. Arthur Manning and approved by the Medical Advisory Committee of the hospital (D). The feeling was that roll-out should happen quickly to contain the tensions arising from the so-called privileged status of the pilot site but there were concerns that the pilot had not yet been evaluated (C). Roll-out was therefore to be limited at first and accompanied by a debate amongst senior managers around what delegations should be kept centrally and what decentralised (although this was never achieved as intended) (C). Roll-out of some limited aspects of the pilot to Theatre Services (such as some human resource delegations and collaboration with the Surgery Division in purchasing of equipment) occurred ahead of evaluation (C). Reportedly this caused some tension. As one commentator said, ‘it was not a well thought-out process of rolling out’ (C).

Arthur Manning was redeployed shortly after the decision to roll out, however, and the current CEO said at the time that she did not have transformation as part of her mandate, given that she was still Acting CEO during 2009 (D). There is a sense amongst respondents that without a champion for the Project such as Arthur Manning, roll-out is unlikely to proceed in a meaningful way: ‘It needed someone to push it through. It was never going to have its own momentum’ (D). A couple of respondents felt that it is not even within the preserve of a CEO to ensure that roll-out happens in a meaningful way. For example, one respondent aid, ‘So there’s no chance in my view until somebody with political power, not provincial political power but national political power, says, this is how we’re going to do it ... But my understanding so far is there’s absolutely no political will’ (D).

It is therefore important that the CEO drive the debate on those elements of the Project that need to be replicated and the future of roll-out. In this, she needs to be supported by the Provincial Department of Health, as agreed by the internal hospital review in July 2009 (C). Unions are vital to this debate, given the fact that they initiated the Project in line with aspirations to create a ‘People’s hospital.’ Particular attention should be paid to managing relationships between members of the Surgery Division and other parts of the hospital to restore trust and avoid unnecessary conflict (I).

In 2008 NALEDI estimated the cost of rolling out the Project model to the rest of the hospital (Eisenstein 2008b). It proposed that the model be rolled out to each of the three clinical divisions in sequence over the following three years (i.e. the Clinical Support, Women and Child, and Medical
Divisions). The Non-Clinical Support Division would be rolled out concurrently over these three years.

For each of the divisions, additional managerial and administrative staff costs per annum would amount to R9.7 million in 2009 prices (although some of these costs could be off-set by the transfer of decentralised staff from central hospital management to the Division, one estimate being that this could apply to 50 percent of posts in central hospital management (Eisenstein 2008a)). Once-off costs – for refurbishment of facilities, purchase of office equipment and installation of computer systems - would be R11.6 million for each of the four divisions. If a proper pharmacy service were to be provided, the annual additional cost per clinical division would be R4.8 million (again, this cost could be partially offset against vacant pharmacist posts in the central pharmacy, only 25 percent of these posts being filled at any one time). Over the three-year period of roll-out, it was suggested that external consultancy support would be needed, costing R5.8 million per year (in 2009 prices).

Prior to any further roll-out of the Project it would be critical to interrogate these figures further. There is apparently a sense amongst senior hospital managers that ‘the model is too expensive and may not be sustainable if it were to be rolled out in current form’ (Billa 2009). As the Project leaders argue, though, the following factors have to be acknowledged when reflecting on the costs of implementation within the Surgery Division:

1. With the creation of the GSSC, resources were shifted from the hospital to the new entity. As the GSSC is inefficient, this has not brought commensurable benefits to the hospital. With decentralisation to the level of the Division, theoretically some of the GSSC staff, and even staff in the central hospital administration, could be redeployed to Divisional level. This could reduce the estimated costs.

2. For the pilot site, management staff were appointed at a relatively high level, because this is necessary when developing a new model. When the model is rolled out, it would probably be possible to employ staff at a lower level, provided they were provided with initial support (Divisional managers could possibly provide some of this support). However, it must be remembered that the Division is the size of a regional hospital: senior staff at Sebokeng Hospital, for example, are at similar levels.

3. CHB Hospital is generally severely underfunded and understaffed as a result of apartheid era practices. For example, the Project estimated that, in 2007, the Johannesburg Hospital budget for a bed per year was roughly double that at Chris Hani Baragwanath Hospital (R700,000 versus R350,000), although this gap has probably reduced somewhat over the intervening years (personal communication with D). The Project has attempted to restore staffing levels to allow a system that functions adequately. It would be impossible to generate improvements without a substantial investment: respondents note that the cost of the Project is the price of re-establishing management control (D).

4. Efficiencies introduced by the new model save costs and also improve the quality of care: it is impossible to measure this in monetary terms. In any case, the Transformation Project was never intended as a cost-containment exercise: its prime purpose was to improve the quality of care which is in line with the current government’s priorities.
CHB Hospital is generally severely understaffed: the Project has attempted to restore staffing levels to allow a system that functions adequately. It would be impossible to generate improvements without a substantial investment, especially given that the Division is, in itself, the size of a regional hospital: respondents note that the cost of the Project is the price of re-establishing management control. As with indicators of efficiency and the quality of care, expenditure figures need to be understood in the context of the failed systems that historically characterised care at the hospital.

With respect to whether provision needs to be made to fund external expertise to support further implementation and roll-out, including management of the change process, the Surgery Division Head reflects that it would have been extremely difficult to effect substantial management change in his Division without such support (D). This is because of the enormous workloads faced by managers within the public system which makes it difficult for them to engage in activities directed at longer-term goals. Expertise in change management would certainly be useful to facilitate constructive engagement with stakeholders, especially those to whom management transformation poses a threat.

Finally, if political and institutional support for roll-out were to be negotiated, it would be critical to identify sustainable funding sources, particularly given the obstacles posed by resource shortages to full implementation of the Project within the Surgery Division. As the September Commission noted way back in 1997, ‘transformation of the public sector requires investment’ (COSATU 1997: p3).
Appendix A: Abbreviated Curriculum Vitae of Jane Doherty

Jane Doherty (BVSc (Pretoria), M.Phil (Cantab), DHSM (Wits)) is a South African who joined the Centre for Health Policy at the University of the Witwatersrand, South Africa, in 1989. In 1996 she was made a senior researcher as well as Deputy Director of the Centre. Her duties included leading - and fund-raising for - several large projects, managing the Health Economics and Policy Programme of the research unit, and general oversight of the unit.

In 2001 she became an independent consultant and part-time lecturer at the Wits School of Public Health. Between 2005 and 2007 she assisted the Centre in co-ordinating the Health Systems Knowledge Network of WHO’s Commission on the Social Determinants of Health, and co-authored the Network’s final report. She currently sits on a Sub-Committee of the Ministerial Advisory Committee on National Health Insurance.

Jane’s areas of research include: the evaluation and planning of health care services, at both the primary health care and hospital level; human resource planning; the evaluation of health financing policy (including qualitative techniques); the exploration of resource allocation issues; and the conducting of National Health Accounts exercises – all with a focus on equity. Apart from contributing to the internal capacity-building programme of the Centre, she was also involved in considerable curriculum development and training at the postgraduate level and for senior managers and policy makers, including helping to develop the public health aspects of the new graduate medical degree at Wits university.

Jane’s involvement in hospital-related research includes:

- leading the Centre for Health Policy’s participation in the Hospital Strategy Project which was commissioned by the National Department of Health in 1996 to identify problems in the public hospital sector and suggest strategies for solving these problems;
- on behalf of the Committee of Deans of Health Sciences Faculties, analyzing the challenges facing academic clinicians, as part of the Committee’s response to the crises facing academic hospitals;
- assessing the resource requirements for training medical students in the clinical setting (ongoing research towards a PhD).

Jane is the author or co-author of 3 refereed books, 8 chapters in refereed books, 10 refereed journal articles and over 30 technical reports.
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